THE DISSEMINATION OF KNOWLEDGE BETWEEN MEDICAL AND NON-MEDICAL STAFF IN A HOSPITAL SETTING AS A MEANS OF PREVENTING AIDS INFECTION OF HOSPITAL WORKERS

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ABSTRACT

Knowing about AIDS and the manner in which it can be contracted in the workplace is essential for preventing infection. This thesis attempts to explore whether non-medical hospital workers are placed at risk of infection by virtue of their ignorance of the virus and further seeks to investigate whether "expert" knowledge possessed by professional health workers is disseminated to less-skilled and less-knowledgable workers. Processes around class and status involved in social closure are investigated to account for the lack of communication concerning AIDS amongst hospital workers. Two research procedures were adopted in this study, namely the intensive interview and participant observation.

Findings of the thesis indicate that although all hospital workers are at risk of AIDS infection, unskilled workers remain more vulnerable because they lack knowledge and awareness of the virus. Factors of class, status, educational opportunity and professional elitism striae the hospital workforce and result in exclusionary practices, including the non-dissemination of knowledge about AIDS in the hospital work setting.
DECLARATION

I declare that this dissertation is my own, unaided work. It is being submitted for the degree of Masters of Arts in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University, nor has it been prepared under the aegis or with the assistance of any body or organisation or person outside of the University of the Witwatersrand, Johannesburg.

(Name of Candidate)

[Signature]

14th day December, 1994.
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This research would not have been possible without the valuable time and input given by the administration and staff of the hospital in which the research was performed. Their insight, honesty and co-operation is greatly appreciated.
ABBREVIATIONAL NOTE

The use of the abbreviated initials of AIDS has been used throughout this thesis to designate the condition Acquired Immune Deficiency Syndrome which also embraces HIV, Human Immuno-deficiency Virus. The writer is cognisant of the fact that there is a difference between HIV and AIDS in medical terminology. However the decision to use the abbreviation AIDS was taken in the interests of brevity and because the term is used universally and colloquially to designate the condition.
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CHAPTER ONE - INTRODUCTION

The disease known as Acquired Immune Deficiency Syndrome, or AIDS, was only identified 15 years ago. During this period it has been more intensively researched and scrutinised than any other disease in the history of humankind and as yet no cure for it has been found. It seems likely that while medical and scientific research will continue to make slow progress during the 1990's, it is economic, social and behavioural research into the disease which will become increasingly important in an attempt to confront and retard the progress of the disease. Scientists have unlocked many secrets of the virus and now know how it is spread and its effects. The medical challenge now facing scientists is to develop a cure for the disease and possibly a vaccine to prevent it. For social scientists, the task is to develop ways of coping with the continually spreading impact of the disease which has ravaged whole societies (Whiteside, 1993:3).

Industrial Sociologists have a fundamental role to play in explaining the manner in which the threat of AIDS affects working communities. Taking into consideration that South Africa is a unique society, boasting a wide assortment of cultures, social and class components in which developed and underdeveloped communities exist and work side by side, Industrial Sociologists are well equipped to formulate distinctive perspectives and solutions to the problem of AIDS. They are able to detect weakness in the manner in which workers' needs are being addressed by employers with regards to AIDS by examining the social organisation within the workplace which would determine who specifically is cared for and which categories of worker fail to receive consideration.

Of particular interest is the manner in which health care workers are informed about the virus as they represent a section of the working community who run an above-average propensity to contract AIDS by virtue of the fact that they work with AIDS-infected people. Although at the present time there is no cure for AIDS, the virus can be prevented if certain precautionary measures are adopted. Prevention of the virus is possible if people are properly informed and knowledge is disseminated to all persons who are at risk. As more and more people contract the virus, health care workers run an ever-increasing risk of infection particularly if these workers are employed
in a hospital setting. The hospital setting as a workplace is therefore of particular interest to the research of industrial sociologists as it is here that weaknesses in social structures and the manner in which workers' needs are being addressed may be studied.

This thesis is therefore concerned with an investigation of those factors which both facilitate and hinder the dissemination of knowledge about AIDS to workers from a sociological perspective. There is a growing and urgent need to understand the relationships between workers in hospitals irrespective of whether they belong to different cultural or class groups as the first step towards developing an education program that will facilitate the dissemination of knowledge and thereby help to protect all workers from the threat of AIDS infection.

1.1 THE TWO PHASES OF THE STUDY

This research project has been divided into two distinct phases. The motivation for the second research phase arose directly in response to findings in the first phase which indicated that the well-being of some health care workers was assigned low priority within a hospital setting. It was assumed that a hospital, as a place associated with healing and recuperation would ensure that all medical workers would be knowledgeable about the diseases with which they come into contact and that through specific education, workers could take appropriate precautionary measures to prevent infection. However, the first phase of this research revealed that this was not necessarily the case.

The first phase involved assessing which workers were at risk of contracting the AIDS virus in the Hospital in the course of their duties. Once this was established, the depth of knowledge and the degree of awareness concerning AIDS amongst the workers at the Hospital was investigated. It was then established that certain workers had knowledge about AIDS and others did not.
Certain fundamental questions were left unanswered concerning why certain health workers were left ignorant of the dangers they faced in their work situation and the steps necessary to prevent AIDS infection. It was also apparent that although some workers knew about the AIDS condition they did not necessarily communicate this information to fellow workers.

Phase two of the study was therefore orientated towards establishing why non-dissemination of knowledge about AIDS occurred at the hospital. The researcher identified class, status and professionalism as possible factors contributing to the non-dissemination of knowledge and which would account for the difference in levels of knowledge regarding AIDS between 'professional' and 'non-professional' personnel in medical institutions.

1.2 AIM OF THE STUDY

This thesis therefore aims to investigate the knowledge health workers possess regarding AIDS, whether 'expert' knowledge possessed by professional health workers is disseminated to less skilled/less knowledgeable health workers and the processes around class and status involving social closure which may account for communication patterns between workers.

The question of whether there is a failure to propagate knowledge throughout the broad spectrum of workers must rest on a thorough evaluation and investigation of social relations between workers. Through insights thus gained it is hoped that a contribution will be made towards understanding why less privileged members of society are more likely to become the victims of AIDS.

The ultimate goal of the study is intended to make a number of recommendations for the establishment of an effective AIDS education program at the hospital. The effort to formulate a preliminary education program will draw on the insights of hospital social relations and the manner in which they affect communication patterns. An assumption of this thesis is that any education program which ignores these relationships is likely to be seriously flawed.
1.3 BACKGROUND TO AIDS

It is crucial from the outset to have a clear and comprehensive understanding of both the nature and background of AIDS. In this introduction the discovery, manifestation and biological nature of the AIDS virus will be outlined. Also discussed in this chapter are issues of AIDS as an occupational risk.

1.3.1. The nature of Acquired Immune Deficiency Syndrome

AIDS is a viral infection which destroys the immune system of the human body. The virus that causes AIDS is known as the Human Immuno-deficiency Virus (HIV).

HIV is a member of a family of viruses known as retroviruses which have long been known to infect man and animals and are fatal in virtually all cases. HIV, in common with all viruses, is a parasite and is transmitted by the exchange of four main body fluids, blood, semen, vaginal fluids and, to a lesser extent, through breast milk. Infection therefore occurs through:

* Sexual intercourse,
* When HIV-infected blood is passed directly into the body, eg: during transfusions of contaminated blood or blood products; sharing, re-using or accidental skin piercing by contaminated injection needles and syringes,
* From mother to child during pregnancy, childbirth and breastfeeding.

Once the virus has gained entry into the body, it needs to attach to specific target cells within the bloodstream with specific receptors, called CD4 receptors (Evian, 1993:11). An example of a CD4 receptor is a T4 lymphocyte which enables the virus to successfully attach and gain entry into the body's cells.
T-lymphocytes constitute the single key factor in the production of antibodies which protect the body from infection. Once HIV has established itself within a T-lymphocyte cell, the virus is capable of altering the normal functioning of the cell, and induces the T-lymphocyte to produce more HIV at the expense of normal antibody production. The newly replicated HIV is then released from the host cell and invades other healthy T-lymphocytes. The process ends in the complete destruction of T-lymphocytes within the body and a total inability of the body to produce antibodies. It thus destroys the body's ability to resist infection. In this way HIV cripples and destroys the immune system, allowing opportunistic infections to enter the body. The individual usually dies not from AIDS itself, but as a result of the opportunistic infections against which the body is no longer able to defend itself.

The state of the immune system is thus the best indicator of the development of the virus. Measuring CD4 is currently regarded as the best indicator of immune-deficiency in HIV disease and is used to monitor the immune status of the person.

The disease process passes through a number of stages. Immediately after infection, there is a period during which the person is both infected and infective. The infected person would experience a flu-like illness during this phase but there are not sufficient antibodies within the bloodstream for the virus to be detected through laboratory testing. This phase is known as the seroconversion phase or the window period. During this phase, the HIV antibody test usually converts from being negative to positive and can last from 4 to 12 weeks.

This is followed by a phase during which the virus is detectable through laboratory testing, but the HIV-infected person usually experiences a period of good health in which the virus remains 'silent' or latent. However the virus is active and begins its attack on the immune system. This is known as the latent phase. This phase may last between 3 and 7 years (even up to 10 years).
This phase is sometimes followed by the onset of minor overt symptoms of the disease, and is called the minor symptomatic phase. This phase occurs between 3 to 7 years after infection and is characterised by fevers, weight loss, skin rashes and swelling of the lymph nodes.

After about 6 to 8 years following HIV infection, the immune system continues to deteriorate and the person becomes more immune-deficient and signs of more severe HIV-related disease begin to appear (Evian, 1993:27). This phase is referred to as the AIDS Related Complexes (ARC) and is characterised by the reactivation of old infections like TB and herpes, oral and vaginal thrush, persistent diarrhoea and weight loss.

Finally, 12 to 18 months after the ARC phase, and about 8 years after HIV infection, full-blown AIDS results. At this stage, the infected person experiences severe immune-deficiency which allows for the development of severe opportunistic infections. To date, the vast majority of cases end in death.

It must be pointed out that it is not clear whether every HIV-infected person will progress to develop AIDS. Approximately 80% of HIV-infected people will have developed AIDS within 12 years of acquiring the infection (Evian, 1993:25). Current trends have shown most HIV-infected people will eventually develop AIDS, even if it takes 15 to 20 years.

The existing health status and socio-economic background of an individual are thought to be the factors that would determine the pace at which immune-deficiency and symptomatic disease would develop within an HIV-infected person. A person who is healthy at the time of infection, who can afford to eat well and rest for long periods of time, is thought to be able to postpone immune-deficiency and symptomatic diseases. However it is these variable time periods which make the disease sinister, difficult to detect and partially account for its rapid spread.
1.3.2 AIDS – the spread of the virus

Fifteen years ago one would not have found reference to AIDS in any medical publication. The first documented cases of what is now characterised as AIDS were briefly described amongst homosexual men in a report in the US Centers for Disease Control's Morbidity and Mortality Weekly Report in June 1981 (FitzSimons, 1993:14). It soon became apparent that whatever was causing the condition was spreading rapidly through this particular population group. It was only two years later in 1983, that Professor Luc Montagnier at the Institut Pasteur in Paris, isolated and identified a specific virus as the cause of AIDS. This led to the development of blood tests which could detect the antibodies of the HIV.

The introduction of these blood tests, along with further epidemiological studies, led to the identification of the main routes of transmission of the disease by 1985. Cases began to be detected in haemophiliacs whose lives depended on the introduction of blood products as part of their treatment. Not only haemophiliacs, but recipients of blood transfusions began to be infected. Screening of donated blood was only introduced in 1986 (FitzSimons, 1993:24). Sadly, by that time, blood products made from contaminated blood had been exported widely across the world, leading to the appearance of cases of infection in many countries. As a result it was realised that the disease was being transmitted by contaminated blood in addition to transmission via sexual intercourse.

With cases appearing in seemingly unrelated groups and types of people, the fear of a universal threat arose in the latter part of the decade. It became apparent that a virus which caused a fatal illness, and against which there was no cure or protection, was sweeping across the world. Every new report seemed to bring news of cases of AIDS or HIV infection in other countries and continents.

In Africa cases of a disease called 'slim' were increasingly being reported in Uganda and neighbouring countries, but these early signs of the epidemic were ignored internationally as attention focused on the spread of the disease in North America and Europe.
Since these first substantive reports appeared in the USA, cases have been described from the middle of the 1970’s and possibly earlier indicating the presence of the disease. The origins of the epidemic remain obscure and the subject of much speculation, ranging from deliberate experiments in biological warfare and outer space, to the use of monkey cells for polio vaccines and the introduction of monkey viruses related to HIV into humans during experiments on malaria several years ago (FitzSimons, 1993:15).

The confusion and ignorance surrounding AIDS led to the singling out of specific groups as the likely source of origin. These have included the Haitian immigrants to the USA, whilst other investigators pointed to Africa as the source of the epidemic, a speculation that is still widely believed today. If the exact pinpointing of the origin of the virus remains elusive, the important consideration must not be where the virus came from, but where the epidemic is going.

### 1.3.3 Routes and efficiency of transmission of HIV

The most common route of transmission was found to be sexual intercourse, with the estimation that two-thirds of all infection occurred via heterosexual intercourse, with rough proportions of 70% for heterosexual and 10% for homosexual intercourse (FitzSimons, 1993:24). Prostitution accounts for many heterosexual infections as one infected sex worker is able to infect many other individuals.

Pregnant infected women have a 30% chance of passing the virus on to their unborn children, and about 5 to 10 % of HIV infection cases globally are thought to be transmitted in this way.

Before screening of blood for HIV began in 1985, contaminated blood products and transfusions of contaminated blood caused many cases of transmission, and this route accounts for about 3 to 5% of all present HIV infection in the world (FitzSimons, 1993). Because of the quantity of blood administered in transfusions, the virus is passed on in profusion and the risk of infection is extremely high, with the rate of infection estimated at more than 90% (FitzSimons, 1993:26).
Direct inoculation of HIV into blood by the use of shared needles for injecting drugs or accidental needlestick injuries is an efficient method of infection. However, the risk from the sharing of injecting drug equipment or accidental injuries such as needlepricks to health-care workers is much lower because of the much smaller amounts of virus transmitted on each occasion. For intravenous drug users the risk is estimated to be about 1 in 100-200 (FitzSimons, 1993:27). This group represents a major concern. At present intravenous drug users account for about 5 to 10% of all infections in the world, but the rate is increasing as such people, frequently being young, sexually active and heterosexual, may act as a bridge into the general population.

### Table 1. Routes and efficiency of transmission of HIV

<table>
<thead>
<tr>
<th>Type of exposure</th>
<th>Efficiency per single exposure (%)</th>
<th>Percentage of global total</th>
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<tbody>
<tr>
<td>Blood transfusion</td>
<td>&gt; 90</td>
<td>3 to 5</td>
</tr>
<tr>
<td>Perinatal</td>
<td>30</td>
<td>5 to 10</td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>0.1 to 1</td>
<td>70 to 80</td>
</tr>
<tr>
<td>Vaginal</td>
<td></td>
<td>(60 to 70)</td>
</tr>
<tr>
<td>Anal</td>
<td></td>
<td>(5 to 10)</td>
</tr>
<tr>
<td>Sharing drug needles</td>
<td>0.5 to 1</td>
<td>5 to 10</td>
</tr>
<tr>
<td>Needlestick injuries</td>
<td>&lt; 0.5</td>
<td>&lt; 0.01</td>
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### 1.3.4 Pattern of spread

A number of distinct patterns in the spread of AIDS have been identified according to geographic location and population groups affected.

Pattern 1 is prevalent in more industrialised 'modern' societies and its key features are that most cases are found in homosexual/bisexual men and in intravenous drug users. Fewer instances of heterosexual transmission occur. The male to female ratio is 10:1, making paediatric AIDS transmission uncommon (Whiteside, 1993). The level of HIV infection in relation to national population is low.
Pattern II is the epidemiological pattern found in Sub-Saharan Africa. The key feature is that most cases occur among heterosexual men and women. The male to female ratio is about 1:1, thus paediatric AIDS is common. Transmission via contaminated blood and blood products also remains significant. The national prevalence of HIV infection can exceed 1% of the total population and in some urban areas up 25% of those aged 15-49 years would be infected (Whiteside, 1993:5).

Pattern III occurs in North Africa, the Middle East, Eastern Europe, Latin America and Asia. Key features are a mix of Patterns I and II.

1.3.5 AIDS in South Africa

In South Africa, AIDS emerged far later than in many other countries. This places it in a position where it should have been able to learn from others' experiences and to benefit from the knowledge that had been accumulated. Unfortunately, the problem was not adequately addressed.

South Africa is a complex society. It is not only a mix of cultures and traditions, but is also a mixture of the developed and underdeveloped world. Although South Africa is rich in AIDS data compared to most of the developing world, and whilst its research capabilities should place it at the forefront of AIDS research and surveillance throughout the continent of Africa, little progress has been made in confronting the disease. This is partly due to the fact that its health-care educators are viewed with widespread distrust by the majority of the population because of their close links to the old apartheid government. The country was also until recently, isolated from the accumulated wisdom and experience of such bodies as the World Health Organisation (WHO), because of sanctions. The effects of global isolation may diminish in the years ahead but South Africa will continue to face not only the general problems of understanding AIDS, but also the ramifications resulting from peculiar complexities which exist in its society.
Until 1987, South Africa experienced Pattern 1 AIDS, and white homosexual males comprised the majority of victims. Since then, Pattern II AIDS has been the main mode of spread in South Africa, affecting mostly the black population of low socio-economic standing in ever increasing numbers (Whiteside, 1993:5). In fact by 1990, more heterosexual than homosexual cases were being reported in South Africa (Southall, 1993:64).

In South Africa, as elsewhere, forecasts of the numbers of AIDS cases vary widely. AIDS cases and deaths are reported to the South African Institute of Medical Research, which in turn provides this data to the Department of National Health and Population Development (DNHPD). The figures released by the DNHPD in July 1992 reveal the number of reported AIDS cases to be 1,517, of whom 457 had died.

The figures arrived at almost certainly underestimate the actual prevalence of the disease as they rely on voluntary, not compulsory reporting by doctors. Furthermore, there is a difficulty of diagnosis because the actual incidence of AIDS is obscured by other opportunistic infections, such as TB, which is rife in South Africa. Thirdly, until recently, South African data artificially excluded reported cases in the 'Independent Homelands'. The extent of under-reporting of AIDS in South Africa would therefore seem to lie between the 90% rate which the WHO estimates to be the case in some parts of Africa, and the estimated 41% in the USA (Southall, 1993:62).

Peter Doyle (1993) of Metropolitan Life calculated that there have been 8,687 AIDS-related deaths from 1985 to 1993, and that AIDS will claim 9,800 lives in 1994. Doyle estimates that approximately 297,000 people were HIV positive at the beginning of 1993 and 500,000 at the year end. In an article in the Sunday Times, November 1994, Dr Clive Evian, director of the AIDS Consulting and Support Unit of Alexander Forbes Health Care Consultants, stated that by allowing for a doubling period at a conservative estimate of 15 months, the figure of 500,000 HIV-infected South Africans at the end of 1993 has probably risen to the currently projected figure for 1994 of between 850,000 and 1 million people. Dr Evian believes that if the rate of infection continues to escalate, there will be about 2 to 3 million people sick from AIDS by the year 2005.
This compares with some 350,000 reported AIDS cases worldwide in 1983. As a consequence of the long incubation period, the number of HIV-infected persons, in contrast to the number of actual AIDS cases, is thought to be much greater. The WHO estimates that in April 1991 there were around 8 to 10 million adults and one million children infected worldwide. Of these, some 6 million were in Africa and about 70% of all HIV global infections were thought to have been spread by heterosexual intercourse.

From the foregoing statistics it can be seen that the necessity for devising strategies to prevent and control AIDS is a matter of great urgency and that each society requires measures that are uniquely appropriate to it.

1.3.6 AIDS and occupational risk

The risk of HIV infection varies in different workplace settings and in the type of work done. Increasingly, as the epidemic grows and HIV infection becomes more common, people are having to confront their own attitudes and fears about co-workers, clients and patients with HIV infection or AIDS. Worldwide, as medical science becomes more able to delay the progression of advanced HIV disease, more and more HIV-infected persons remain sufficiently healthy to continue work.

The risk of AIDS infection in the majority of workplaces is, of course, in general small. The emphasis is on educating workers into accepting people who have AIDS — changing attitudes and fears so that they can work alongside infected people comfortably. However there are certain types of work where AIDS infection is a great risk and in these instances a special type of education needs to be instituted.

Occupational risk is not a new problem. Long before the AIDS era, occupational health and safety regulations were instituted in an effort to protect workers from exposure to hazardous material and working conditions. In the health care setting, infection control measures encompass precautions regarding infectious materials and persons with infectious disease. The emergence of the AIDS epidemic in the early 1980’s has engendered a heightened awareness of concern for appropriate precautions (Richmond, 1991:265).
Some occupations carry an inherent risk of exposure to potentially infectious materials such as blood and body fluids taken from HIV-infected patients. Those at risk include health care personnel, firefighters, police officers, ambulance and rescue workers and other emergency response personnel. Other high-risk occupations involve the use of skin-piercing instruments such as used by acupuncturists, morticians and dentists.

1.3.7 AIDS and the health-care field

In the past, health care was acknowledged to be an occupation burdened by risk. At no time was this more obvious than during the periods of plague and pestilence in earlier centuries. In developed countries during the latter half of the twentieth century, however, the major infectious disease have declined. This has had the effect of removing many of the hazards associated with caring for the sick, and those hazards which remain are not, for the most part, life-threatening. Accordingly, the notion of occupational risk has tended to recede from the consciousness of health care workers.

The modern pandemic of AIDS, however, has put the possibility of serious occupational hazards back on the agenda for health care workers in general. Given the drastic consequences of contracting AIDS, health care now involves an explicit, though small element of risk to life.

Potential routes of occupational HIV transmission include needlestick or cuts by other sharp instruments, splashes of fluid onto mucous membranes (for example, the eyes and mouth), and skin contact (blood or body fluids coming in contact with broken skin). For surgeons, gynaecologists, general doctors, emergency nurses, gynaecological nurses, operating theatre nurses, cleaners working in emergency wards and porters who transport emergency patients, exposure to potentially infected body fluids is commonplace and unpredictable.
Three factors have to be taken into consideration when assessing the degree of occupational risk involved. Firstly the frequency of exposure to the virus, secondly directness of exposure, and thirdly, the prevalence of the disease in a particular geographic region. The personnel of an urban hospital are considered to bear the highest risk of HIV infection by virtue of the greater number of exposures they have to infected blood and the greater volume of blood and other bodily fluids per exposure which they handle in the trauma, gynaecological and surgical units within a hospital.

Health-care workers known to have been infected through occupational exposure make up a very small proportion of the infected population, less than 1 in 10 000 (Richmond, 1991:265). However, with the rapid escalation of people becoming infected with the virus, health-care workers are being exposed to the risk of infection more frequently, thus increasing their probability of contracting the disease. This group is without doubt, becoming more vulnerable and more likely candidates for infection while performing their duties at work.

1.4 INDUSTRIAL SOCIOLOGY AND OCCUPATIONAL EDUCATION

Industrial sociology can contribute greatly to the understanding of AIDS as an occupational health risk by forwarding a unique perspective which other disciplines fail to highlight. Research by industrial psychologists, ergonomists and epidemiologists regarding occupational health risk has not taken a dynamic perspective. These professionals have tended to focus on isolated aspects of the workers' performances or abilities, and have failed to embrace the effect of social structures in the workplace and the social causes associated with work injury and disease. From the viewpoint of the industrial sociologist, occupational health risks do not occur randomly or as isolated incidents, especially when a whole group of workers are affected by them, but are influenced by a number of sociological factors operating in the work environment.
For many years injury to workers has been investigated by industrial psychologists whose research has led to a 'blame the victim' ethos. The individual's occupational health and safety has been studied from the point of view of his personal characteristics such as reaction times and attention span. The emphasis on the personal characteristics of the workers has largely absolved management from responsibility. It suggests that some workers are more prone to injury (or by implication infection), irrespective of the work situation in which they find themselves, thereby isolating the worker and his abilities as the single most significant cause of his injury. The interaction of the worker with his environment has largely been ignored. With little responsibility attributed to it, management can adopt relatively cheap practices such as the institution of training programs in order to overcome worker apathy or carelessness. In Quinlan's view (1988:194), industrial psychology research has always been orientated towards the goals of management rather than workers.

Workers' stress has received much attention as a cause of work injury. The manner in which stress in the workplace has been approached by industrial psychologists has further reinforced the 'victim-blaming ideology'. Much emphasis has been placed on stress management programmes, including techniques such as relaxation, diet, positive thinking and assertive training. They are presented as though the solution to the control of stressors at the workplace lies simply with the individual. In fact it is the stressors in the work situation which need to be examined and changed. Such research is a further concern of industrial sociology.

Ergonomics has to a large extent also contributed to seeing the individual as responsible for what happens to him in the workplace. Workers are seen as sophisticated machines whose potential for error must be minimised so that they may be better adjusted to the work environment. Industrial sociologists have attempted to view work hazards in a broader perspective and have focused attention on the labour process itself as a causal factor in work injury.
1.5 CONCLUSION

Industrial sociologists bear great responsibility in caring for workers who are exposed to the possibility of AIDS infection. In so far as sociological factors are directly involved in the transmission, spread and prevention of the virus, they require to be investigated. Research conducted in a hospital setting seems most pertinent as it provides a location for studying the operation of sociological factors in a work setting where AIDS poses a real and daily threat. A South African hospital setting adds a unique dimension as it affords an opportunity to research how cultural diversification, elitism and social structures may place workers in a disadvantaged position with regard to being infected with AIDS.
CHAPTER TWO - LITERATURE REVIEW

The social processes which enable people to acquire or be barred from the acquisition of knowledge is central to the concerns of this thesis. An appropriate theoretical framework within which to construct a research project of this nature must take account of theories concerning class, status, social closure and the role of credentialism in causing social stratification and the manner in which these factors affect the filtration of knowledge to members of society. Specifically the theoretical orientation of Max Weber has been selected as a framework within which to define stratification as his explanation allows for a broader understanding of how stratification comes about and allows for greater flexibility in explaining the findings of this thesis.

2.1 SOCIAL STRATIFICATION

Inequalities exist in all types of human life. Even in the simplest cultures where variations in wealth or property are virtually non-existent, there are inequalities between individuals. To describe inequalities, sociologists speak of the existence of social stratification which may be defined as structural inequalities between different groupings of people (Giddens, 1993).

Sociologists have long concerned themselves with stratifications that occur within society and several theories have been advanced to explain the conditions which cause them. Stratification in society is often discussed in terms of class structure. Karl Marx put forward the view that class is founded on economic factors and he theorised a society of equal wealth distribution in order to eliminate class inequalities and domination. He saw the ownership of physical property - the means of production - to be the foundation of class structure and therefore proposed state ownership of property. Max Weber argued by contrast, that a variety of factors were important in class formation not least of which was education.
According to Weber, class divisions derived not only from control or lack of control of the means of production, but from differences which are not directly associated with property ownership. Such resources include the skills, credentials or qualifications which affect the types of jobs people are able to obtain. Those in managerial or professional occupations possess qualifications such as degrees, diplomas and skills which make these people more 'marketable' than others who do not possess such qualifications.

Professional people gain their class position both within organisations and in society from their possession of credentials. The gaining of a degree or diploma is broadly referred to as 'credentialism'. Having a credential helps professional people to enjoy secure and well-paid jobs affording them power and wealth, and separates them from people who work at manual and repetitive jobs. The influence of the acquisition of skills, credentials or qualifications in stratifying a society cannot be more evident than in a hospital where employees are rigidly divided by the qualifications they possess.

The use of credentials for closure purposes has accompanied the attempts by ever increasing numbers of white collar occupations to attain the position of 'professional'. Professionalisation itself may be understood as a strategy designed, amongst other things, to limit and control the supply of entrants to an occupation to safeguard or enhance its market value. This is particularly true of the medical profession and professional nurses where the number of students allowed to enter the profession is severely limited and restricted to those who show academic superiority.

Weber points out that access to education and the possession of educational qualification used to be the primary 'property' claim of the middle class. As education has become more widely available there has been a 'clamour' to obtain qualifications not only as a means of obtaining knowledge, but as a vehicle for gaining social privilege. Credentialism does not only lead to greater social privilege but also becomes a means of effecting exclusionary closure. Social closure is any process whereby groups try to maintain exclusive control over resources limiting access to them. However, from Weber's viewpoint, exclusionary closure is related to access to education and the acquisition of credentials. Exclusion refers to strategies that groups adopt to separate outsiders from themselves, preventing them from having access to valued
resources. The exclusion of people of lower classes from places of learning ensures the reproduction of the culture of the dominant classes. Nowhere has this been more evident than in South Africa during the apartheid era when black people were excluded from most places of learning.

If property ownership is the basis of class structure as proposed by Marx, there would be only one from of social closure, ie, the control of resources in terms of property ownership. In Parkin's (1971) view however, there are many other factors which form the basis of social closure including ethnicity, race, language, religion and the possession of knowledge. These factors may belong to a minority and may be used as a basis of power over others.

Bourdieu and Passeron (1977) concluded that one of the major roles of education in society is the contribution it makes to social reproduction – the reproduction of the relationships of power, privilege between social classes and inequality. The privileged position of the dominant classes is justified and legitimated by educational success, the underprivileged position of the lower classes is legitimated by educational failure. The educational system is particularly effective in maintaining the power of the dominant classes since it presents itself as a neutral body based on meritocratic principles providing equal opportunity for all. However, Bourdieu concludes that in practice education is essentially concerned with 'the reproduction of the established order'.

Education is not the only means by which the culture of society as a whole is transmitted, but it is also the means by which the culture of 'dominant classes' is reproduced. In this manner educated classes are able to define their own culture as worthy of being sought and possessed. Bourdieu refers to the dominant culture as 'cultural capital' because via the educational system, it can be translated into wealth and power. Cultural capital is not evenly distributed throughout the class structure and this largely accounts for class differences in educational attainment. Students with upper class backgrounds have a built-in advantage because they have already been socialised into the dominant culture. They therefore possess the key to unlock the messages transmitted in the classroom. The educational attainment of social groups is directly related to the amount of cultural capital they possess.
Class stratification in society is to a large extent a result of educational opportunity. Educational certificates are often used as a means of gaining entry to key positions in the division of labour thereby preventing people who do not hold certificates from getting the job. Particularly in the field of medicine, professional medical knowledge results in social distance, with doctors and certain highly qualified nurses being afforded a superior class position. The credential becomes a powerful way to define class structures and may be regarded as a form of resource ownership.

Credentiaism is a vehicle not only to improve working conditions and salary, but it also buys the holder increased social status. In contrast to class, status refers to differences between social groups in the social honour or prestige they are accorded by others. Occupations and styles of life are accorded different degrees of prestige or esteem by members of society. A status group is made up of individuals who are awarded a similar amount of social honour and therefore share the same status situation. Unlike classes, members of status groups are almost always aware of their common status situation. They share a similar lifestyle, educational background and identify with and feel they belong to their status group. Doctors, or colloquially, "the medical fraternity" epitomises a status group.

The status of an individual is assessed by subjective evaluation and is not based on measurable material wealth. The holders of status in society have a position which they seek to protect, and one way in which professionals protect their status is by limiting access to the 'expert' knowledge they possess. Those who are educated desire exclusivity and seek to protect their privilege – they view their credentials as their personal property. This same phenomenon prompted Weber to speculate that:

When we hear from all sides the demand for an introduction of regular curricula and special examinations, the reason behind it is, of course, not a suddenly awakened thirst for education but the desire for restricting the supply of these positions and their monopolisation by the owners of educational certificates (Gerth and Mills, 1948:241).
Class and status may coincide to create a way of life that is shared by people in similar positions. Those outside the position may find themselves 'doubly' excluded - shut out in relation to the ownership of property and shut out from the cultural codes, symbols and ways of living associated with a particular elite status and shut out of the communication that occurs within a status group. The manner in which people are excluded from the cultural codes of society is one of the most important concerns of this thesis.

The occupation which an individual holds does much to define his status. Hierarchical ranking of positions within occupations is widespread and each position constitutes a status which is superior or inferior to other statuses. For example, Taylor (1989) explains that status among wage workers is indicated by their respective hourly wages, dirtiness or cleanliness of the job, seniority of position, salary, duration and proficiency are among the key factors as status distinctions.

The cleaner who works in a hospital has his status well defined as 'inferior'. He does the dirtiest of work for the least salary and is afforded no privileges or special facilities. He tends to be side-lined and ignored in matters of communal interest. The ideas, opinions and thoughts of cleaners are seldom canvassed in arriving at solutions.

In order to adequately explain the dynamics that exists between groups of people, one has to examine the proposition that status becomes much more important than class as a cause of stratification. Status frequently leads to a divide of an "us" and "them" attitude, distinguishing one group of workers from another.

In examining stratification one has to consider not only the differences between economic position or occupation, but what happens to the individuals who occupy it. The term social mobility refers to the movement of individuals and groups between different socioeconomic positions. Vertical mobility means movement up or down the socioeconomic scale. Those who gain property, income or status are said to be upwardly mobile, while those who move in the opposite direction are downwardly mobile. In modern societies there is also a great deal of lateral mobility which refers to geographical movement between neighbourhoods, towns and regions. Vertical and lateral mobility are often
combined. For instance, an individual working in a company in one city might be promoted to a higher position in a branch of the firm located in another town or even in another country.

There are two ways to study social mobility. Firstly, we can look at individuals' own careers—how far they move up or down the social scale in the course of their working lives. This is usually called intragenerational mobility. Alternatively, we can analyse to what extent children enter the same type of occupation as their parents or grandparents. It is known that parents who are professionals, e.g. doctors, tend to foster children who become professionals. Such mobility across the generations is called intergenerational mobility.

Many people in modern societies believe that it is possible for anyone to become socially mobile if they work hard and persistently enough, yet the figures in numerous studies (Sorokin, 1927; Lipset and Bendix, 1955; Blau and Duncan, 1967; Jaeger, 1980; Rubinstein, 1980; Erikson and Goldthorpe, 1986) indicate that very few succeed. Factors which discourage social mobility therefore require examination and are referred to as factors of social closure. Forms of social closure include depriving groups of people of the right to property ownership. Social closure may also occur in differences in status on the grounds of ethnicity, language or religion.

2.2 SOCIAL REPRODUCTION – EDUCATION, OPPORTUNITY AND THE SOCIALISATION PROCESS

This section attempts to relate the theoretical constructs of social stratification as proposed by Weber and others to workers employed in a hospital setting. It considers educational opportunity as a vital factor in shaping the workforce.
2.2.1 THE DOCTOR

The occupation of doctor has come to be regarded as a profession, and those who occupy it as professionals. Our image of doctors is one of prestige, trustworthiness and responsibility.

2.2.1.1 The decision to study to be a doctor

Most sociological studies have shown that the decision to become a doctor occurs at an early age. Rogoff (1957) for example, in a study of the medical school classes at the University of Pennsylvania, found that most of the students reported thinking about becoming a doctor when they were less than fourteen years old. Only 14% were eighteen or over when they first considered a career in medicine.

This study is supported by another performed by Coombs (1978) which also emphasized the early choice of students. Coombs notes that:

The decision to become a doctor comes early in the lives of most students. Even before entering college, three out of every five had made that decision. Of this number, 29 percent decided during high school, and 14 percent during junior high; 21 percent recalled only that they had "always" wanted to become doctors. One of the latter declared that he was simply "born to be a doctor" (1978:27).

Several factors are involved in the early decision to study medicine. Both an early interest in science and its application and contact with influential doctors seem to lead to the desire to be a doctor. A doctor in the family seems to have a particularly strong and early positive influence on the decision to study medicine. Coombs (1978) reports that a significant number of the students in the medical school he studied had parents, uncles, siblings or cousins in the medical profession.
2.2.1.2 Characteristics of students studying to be doctors

An important question to be raised is, who in fact is it who gets into medical school? Or, put another way, what are the common characteristics of medical students? According to Chalfant and Kurtz (1972) medical students have four common characteristics.

Firstly, medical students tend to have fathers or other close relatives who are already doctors or other professionals and who attract their children to medicine. Hall (1948) explains why doctors tend to be recruited from families of professional workers. Family members tend to envisage a particular career line for their children and encourage them to be doctors. He states that a professional orientation emerges from the socialisation process in professional families that is almost a necessity for training and assuming the professional career of a doctor. These findings have been substantiated by studies done by Chalfant and Kurtz (1972) and by Becker, Geer and Miller (1972).

Similarly, the second common characteristic of medical students is that their family income is significantly higher than the national average. Thirdly, more men than women became doctors. And finally, just as females are under-represented in medical schools, so are blacks and other people of colour. When taken together, the four characteristics of medical students have served to maintain the homogeneity of the profession of medicine.

2.2.1.3 Medical education as socialisation to a role - the shaping of a doctor

Socialisation is a central process in medical education. Armstrong (1977) characterises what occurs during medical education as a "hidden curriculum" of the school. He suggests that in addition to formal studies of scientific medical knowledge, there is an agenda aimed at the internalisation of beliefs and values thought to be important to the professional practice of medicine.
Potential doctors have to come to know and internalise the expected behaviours, patterns of interaction, attitudes and values of those who already hold this position of status. Without such 'education', smooth and efficient social interaction could not go on - this holds true for the roles within the medical environment as it is for roles played in other parts of society.

A distinction has been made between primary and secondary socialisation (Berger and Luckmann, 1967). Primary socialisation occurs during childhood; secondary socialisation is the process by which specialised aspects of the generalised world, with their roles and attitudes, are internalised. Clearly, socialisation in the medical field is a kind of secondary socialisation concerning the specific institution of medicine, although it may be passed on not only through doctors, teachers and fellow medical students but also through popular image and public opinion about the status role of doctors in society as well as via parents who are professionals through primary socialisation.

Medical education is a system of socialisation designed to prepare students to function in the role of the doctor. Through this process, the norms, values, beliefs, behaviours and skills of the doctor's status are acquired; people are shaped into individuals "endowed with appropriate attitudes, values, and ways of thinking" for their positions in the social structure (Coombs, 1978). When graduation comes six years after enrolment, the successful student will have learned how to "act" like a doctor.

2.2.1.4 The dominance of professionalism by doctors

Within the general field of health care, almost all of the health occupations are organised around the work of the doctor, and usually come under the direct contact of the doctor. As a result all the health care occupations outside of the doctor lack professional autonomy. Although nurses may emulate the role of the professional, formal professional status cannot be obtained unless professional autonomy is granted by the society in which the nurses work. In our society, we have recognised and appointed doctors as the principal ministers of health care, and as the official representative and interpreters of the ultimate value of health. Accordingly, the granting of
formal professional autonomy to any emerging occupation in the health care field has been placed in the hands of the doctors. Doctors, to protect both their class and status positions, are not likely to voluntarily dispossess themselves of any portion of their monopoly of formal professional autonomy. Thus health care workers who are not doctors are likely to be kept at the paraprofessional level as long as doctors continue to dominate and control the health care field.

Indeed doctors' dominance of professionalism operates as well at an extremely subtle level as the benchmark for all other would-be professions. Wilson (1970) points out that each variety of health worker gauges his status and professional selfhood in terms of how closely he approaches the doctor on a scale of privileges and responsibility. In essence, then, health professionals evaluate their own – and each other's – positions in terms of how closely they resemble those of the doctor.

2.2.2 THE NURSES

2.2.2.1 Who chooses to be a nurse?

We have established that doctors tend to be from upper social classes, from families already containing doctors, and these recruits tend to be white males. In nursing, however, a quite different pattern merges. In their classic study, Hughes, et al (1958) found that nursing students were predominantly women from small towns or rural areas, and of lower middle class and working class backgrounds. These students generally perceived that nursing was the most appealing avenue of social mobility available to them. If doctors have already 'arrived' in class and status terms before gaining entry into the profession (intergenerational mobility), nurses are drawn to the occupation as a means of rising in class and status terms (intragenerational mobility).

As Simpson (1979) notes, student nurses tend to be self-selectively recruited into the field. Although there are variations in the motivations for entering the field, some generalisations can be made. The major point made in most studies of nursing student backgrounds is that a strong service orientation is felt by those who choose the occupation. O'Neill (1973) found, for example,
that nursing students in the college setting were much more concerned with helping others than were fellow students pursuing other educational programs. Nursing students emphasise service over self-expression, which is associated with a lessening of such behaviours as competitiveness, development of the individual, and desire for recognition (Simpson, 1979). In short, student nurses tend to have a traditional image of nursing and they hold corresponding role expectations.

2.2.2.2 The professionalisation of nursing

While nursing has progressed towards professionalisation, it has not become a true profession because the nature and extent of work that nurses can do is regulated and controlled not by nurses, but by doctors. Thus, nurses do not have complete autonomy. However, the nurse's position in the hospital is one of offering direct care for the daily needs of the patient or the supervision of the meeting of such needs. As such the nurse spends his or her time in close interaction with and in close proximity to patients and in this way gains a great deal of information about the patient. On the other hand, the doctor spends a limited amount of time with the hospitalised patient, often appearing at the bedside of a patient once a day for ward rounds. While doctors are absent from the wards, nurses do possess a certain degree of autonomy.

Although nurses are clearly under the domination of the doctor who controls medical decision making, nurses possess a great deal of knowledge that may be useful to doctors. However, doctors often do not ask nurses for information possibly out of fear of lowering their professional standing.

Wolinsky (1980) calls attention to factors that make it difficult for nursing to claim professional status. Firstly, there is the nature of the socialisation process during the student years which emphasises a role of subordination to the doctor. Secondly, the public image of the nurse is that of one who is basically a helper rather than an independent worker. Thirdly, the fact that nursing is to a large extent a "female" profession detracts from a professional image, since the clearest professional occupations, doctors and lawyers, are
dominated by males. Lastly, doctors' perceptions of nurses are as helpers rather than as decision makers.

Traditionally nursing has been regarded as a female profession or occupation. As such, it has had a history of being subject to a number of sexist discriminatory practices. Ashley (1976) notes with regard to sexism and nursing that nursing perhaps more than any other profession has been influenced by social conceptions regarding the nature of women who were seen as less independent and capable than men.

In her book Reeftown Elite, Mia Brandel-Syriar (1971) has documented the special status that nurses are afforded within a 'Bantu culture'. Becoming a nurse is seen as a sign of upward mobility and when men marry nurses, particularly staff nurses, they are afforded greater status.

During the apartheid era the opportunity for social mobility within the black population was extremely limited. Nursing was one of the few avenues which offered urbanised black women an opportunity to improve their social and economic position and those who were able to achieve a nursing diploma were thus afforded a higher status. Nursing as a relatively clean and prestigious occupation, offered black women an alternate form of employment, removed from the performance of menial and often degrading occupations such as domestic employment and street sweeping.

In South Africa the status improvements which nurses enjoy may explain why they don't see other blacks beneath them as equals. Their newly acquired status level which leads to great respect within the community serves to divide them from others leading to an "us" and "them" ethos. Having elevated themselves from the vast majority of people despite social injustices and the unequal opportunities that have existed in South Africa, they may find it difficult to identify with lower level workers. The divide is not racial in character as they are all black and share a similar culture, heritage of poverty and class deprivation, yet the prestige that their credentials afford them may lead to an awareness of elevated status.
In recent years there are indications that nursing is ready to move into the status of profession. More emphasis on the quality and quantity of education has been laid. Recently nursing educators have in fact sought to make a distinction between the technical (assistant) and the professional nurse, a distinction based largely on education.

Technical nurses find themselves in an invidious position, not sufficiently elevated to enjoy the status adulation that professional nurses enjoy, yet ranked higher than non-medical workers because of their modest degree of credentialism. They represent a "swing" group in social terms looking away from unskilled workers, no longer able to identify with their plight yet at the same time aspiring to the elevated status levels enjoyed by professional and staff nurses.

2.3 THE SOCIAL ORGANISATION OF A MODERN HOSPITAL

The hospital may be viewed as a large-scale organisation, and as such displays characteristics of a bureaucratic structure and function. These characteristics include a hierarchical power structure, emphasis on efficiency and a specialised division of labour.

However the hospital has some special features that make it resistant to the development of a typical bureaucratic organisation. Firstly, there is an extensive division of labour and much specialisation in the hospital. Almost every worker is dependent on other hospital workers for the performance of their roles, and workers within the hospital can see function independently. If the organisation is to function efficiently, the smooth management and integration of these skills must be initiated and each part must function effectively with other parts. Moreover, hospitals depend on voluntary and informal variations in job description from health care employees and doctors, who must be able to initiate procedures and adjust quickly to challenging situations. This cannot be accomplished by rules alone.

It is these factors that led Mauksch to comment that, "it defies all logic – but a hospital does function" (1960:70). It is crucial to view this interdependency of workers in relation to the divisions created by stratification.
2.3.1 Social stratification within a hospital work setting

Social stratification and the factors that determine such stratification are much in evidence in a hospital. The presence of severe stratification within the hospital setting gives impetus and special emphasis to factors of class, credentialism, status and social closure.

Firstly it is evident that a distinct hierarchy of workers occurs in the hospital setting ranging from specialist surgeon, through professional and staff nurses to assistant nurses, cleaners porters and maintenance men. The question of class and status affects hospital workers in a fundamental way.

Blue collar workers appear to have the lowest priority in hospitals because they are the service providers in an organisation controlled by professionals who direct resources largely in terms of their own interests and the interest of their medical specialisation (Williams and Thorpe, 1992).

In hospitals, certain occupational groups remain elite by virtue of their lengthy and expensive training and create a 'professional' ethos about them which demarcates who is privileged and who is not. In contrast, unskilled labour is easily learned and the supply of unskilled labour is plentiful. In the health industry in particular there is a wall of professional power which seems to isolate and devalue blue collar workers.

Navarro (1982) argues that in a hospital setting social power relations determine the nature of the work process and the degree of exposure to risk which takes place in the workplace. The social power relations which determine the working environment also determine how the worker fits within that environment, relates to that environment and perceives himself in relation to fellow workers and to the controllers and managers of that environment. Gersuny (1981) has also pointed out that the distribution of risk is also unequal, "as risk falls disproportionately on the working class including certain ethnic groups." The service sector has a lower status than in other organisations because the professional medical ideology, with its legitimation in scientific knowledge accentuates social distance more sharply. The power/knowledge discourse of scientific medicine, with its claim to superior
knowledge and status, subordinates those without access to this discourse and consequently cements a form of social closure.

The power of medical staff is based not only on claims to expert knowledge but on two additional factors: their social status deriving from the nature of their position in society, and because of their healing powers which have historically imbued doctors with an aura of superiority. Therefore status is not only based on technical skills and training, but from the nature of the work which is highly valued and respected in its own right (Williams and Thorpe, 1992).

Furthermore, both doctors and professional nurses occupy a power position within hospitals by virtue of their place in the bureaucratic hierarchy. In addition to their status superiority, they usually have formal authority over non-medical workers, a position which probably further cements previous forms of social closure. The intersection of class and status superiority together with bureaucratic authority greatly enhances their position of power.

Because a long period in higher education is necessary for qualification, and because professionals belong to national and even international bodies who define the nature of their tasks, professional expertise cannot easily be reduced to bureaucratic duties. When professionals are employed within large organisations, they do not fit neatly within the hierarchy of authority as they are ultimately accountable not to the top bureaucracy, but to their profession. Furthermore, they usually have more autonomy in their work than others in the middle and lower levels of organisations. To a large extent, they stand outside the bureaucratic hierarchy as an entity on their own, not accountable to work place structures, nor accountable for the functioning of those whose skills they use and direct.

In order to understand the patterns of interaction within the hospital, one has to recognise that it has a rigid system of social, professional and authoritarian stratification. In particular, there is a definite and well-organised hierarchy of prestige within the hospital. Each job’s status is ranked in terms of its value to the hospital, the difficulty of the work performed and its related prestige. Each ‘status level’ is then differently rewarded according to its judged value.
The status system within the hospital is displayed in a number of ways, from the respectful and courteous behaviour exhibited toward the doctors, to the clothes each hospital worker wears, with pins, badges and lapels displaying each person's prestige and status within the occupational structure. Administrative personnel may wear business clothing with a name badge specifying their position, whereas doctors display their superior status with their white jackets and the symbolic stethoscope dangling from the neck or pocket.

Wessen (1958) studied interaction between ward personnel in a large private general hospital in the USA to see how this is associated with stratification lines. He observed that on the ward there are five levels of personnel and found that rigid lines are drawn between status groups which strictly maintain social distance. For example, observation of seating patterns in the hospital cafeteria confirmed the separation by occupational status. Each occupational status usually has its place in the dining room, and members seat themselves with one another according to this spatial pattern. The prestige implications of this self-imposed segregation are obvious.

2.3.2 Doctors and Status

The prestige, presumed value and scientific knowledge of the doctors make their status the most highly rewarded and most powerful. The doctors occupy the apex of prestige, privilege and power within the hospital setting while all other work performed in the hospital is less esteemed and has lower status.

The doctor's relationship to the hospital bureaucracy is a strange one, not found in any other social organisations. At least in the community hospital, consultant doctors are seldom regarded as employees. Nevertheless, the doctors can literally assume control over the work activities of almost all the other employees of the hospital. Consultant doctors tend to be regarded as 'guests' who have been given the right to use the hospital's services and resources. Without consultant doctors as an invited members of the medical staff, the hospital cannot function. This gives the doctor a very special and powerful place within the life of the hospital.
Studies have indicated that some hospital personnel, especially administrators and non-medical workers, charge that doctors show little concern and are relatively uninformed about most aspects of the hospital’s functions and organisation. They generally do not have as good an understanding of the problems and needs of other health workers within the hospital as others have about the doctor’s own needs and work. However, this does not mean that the doctors do not have an interest in the fate of the hospital at which they work. Doctors give much time and expertise to the success of the hospital as the hospital often serves as a convenient and specialised extension of the consultant doctors’s office. Clearly the doctor is seen as the head of the group to whom all other workers are responsible.

2.3.3 Nurses and their status

Relationships between nurses of different educational levels and other workers is a source of friction in hospitals. Ambiguities in duties, prestige differences, and role definitions create difficulties for nurses. In particular, professional nurses resent being asked to perform menial tasks they consider beneath them.

Although in recent times there have been changes in the conception of women, the medical profession and hospital roles still reflect an image of the nurse as being dependent on the advice, counsel, and the help of the doctor. The perceived prestige of nurses in the hospital is lower in relationship to their actual educational background. Even today, the fact that nursing is basically a female-dominated occupation continues to have a profound effect on the treatment of nurses.

2.3.4 Lower-level hospital workers and their lack of status

Immediately below the professional nurse, in terms of prestige, are the assistant nurses, who receive less prestige than do doctors and professional nurses because the medical care that they give is viewed as less scientifically skilled. In other words, practical nurses do not require the breadth or depth of formal training required of professional nurses and doctors. Similarly,
porters and cleaners require even less training and fewer skills than practical nurses, and are usually classified as unskilled workers. Nursing assistants, cleaners, porters and maintenance workers are at the bottom of the hospital's occupational hierarchy. As Freidson (1970) has noted, these workers are poorly paid, basically unskilled or untrained labourers who perform the dirtiest hospital work. They understandably have none of the professional orientation of other occupations.

Some hospitals attempt to provide training programs for their lower-level workers. Feldman (1977) comments, however, that such programs do not accomplish what hospital administrators intend because they do not help workers communicate better nor do they motivate them with some ideal standard of work. A positive outcome of these programs is to raise the general work satisfaction level, which reduces the problem of turnover. Nonetheless, research has indicated that these lower-level employees receive low pay, have very low job commitment, turnover and absenteeism are extremely high, while most workers feel apathetic and alienated as they have no opportunity for advancement (Etzioni, 1975).

In essence, the internal hierarchy of medical care workers is based on how each category of worker has been trained and has little to do with factors such as length of time employed and experience. The amount of prestige afforded each worker in turn depends on the amount of training, particularly scientific training, he or she has received and the amount of responsibility associated with their jobs.

2.3.5 Two lines of authority within the hospital

Just like any other organisation, the hospital has a formal authority structure and bureaucracy that enables it to work efficiently. What is interesting about hospital bureaucracies and their authority structures however, is that instead of having the one traditional line of authority within the bureaucratic structure, hospitals have two lines of authority.
This dual line of authority consists of an administrative division and a medical division (Smith, 1968). The reason for the existence of the two lines of authority emerges from the special nature of professional autonomy which has to be granted to doctors within the hospital (Freidson, 1970).

The doctors enjoy an elevated position of authority because of their prestige and ultimate responsibility for patients. In theoretical bureaucratic terms, doctors are subordinates to the superintendent of the hospital. In the practical sense however, doctors direct the superintendent and all those below them when it comes to medical matters. This duality in authority often gives rise to conflict and problems in hospital administration.

In effect what happens is that the formal bureaucratic authority structure serves only as a framework for the day-to-day running of the hospital. When doctors are confronted with a medical situation, to ensure the fulfilment of the hospital's ultimate goal of restoring health to the patient, doctors wield ultimate authority, and the day-to-day formal lines of responsibility may be nullified or overridden. Hospitals therefore tend to have a "doctor dominated" authority structure.

This unique bureaucracy which is found in the hospital has been labelled by Goss (1961, 1963) as a "advisory bureaucracy". Goss focuses on the fact that in a traditional administrative bureaucracy, the consulting staff act as technical specialists, advising management of the advantages and disadvantages of each situation and the possible outcome of various decisions prior to management making a decision. However, in advisory bureaucracies such as exists in a hospital, medical staff who possess and wield the authority to make all decisions which are directly related to issues of patients care and medical emergencies have to be consulted. As a result, in an advisory bureaucracy, the role of the formal management is reduced to providing the ways and means for the successful execution of the doctor's orders. In the hospital, the medical staff tends to direct the activity of the hospital personnel, while the administrative staff's functions are restricted to devising the most efficient and economical ways of meeting the demands of the doctors.
As medical technology advances and the sheer volume of work increases within hospitals with an ever growing clamour for medical services, the task of the administration of hospitals becomes increasingly difficult. In particular, the medical care industry in South Africa today faces increasing pressures of cost-containment and fiscal responsibility. The hospital administrators must be sure that operating revenue is available and that the daily expenses are kept to a minimum. Logically it could be asserted that within the framework of fiscal deficiency, the authority of doctors would be diminished. However, Georgopoulos and Mann (1972) feel that doctors remain a strong second authority within the hospital, maintaining their dominance. Three reasons are cited. Firstly, doctors are not employees of the hospital, but actually its truest custom in that this is where they most often practice medicine. Secondly, doctors continue to have very high social standing within society, allowing them considerable advantage. Finally, because they are the medical professionals, physicians have the ultimate authority in strictly medical matters (Georgopoulos and Mann, 1972). This imbues doctors with what Weber refers to as "charismatic authority". This kind of authority represents an authority which a person exercises by reason of having a set of followers who attribute special powers to him by virtue of which he is held somewhat in awe. One of the primary characteristics of charisma is that it defies administrative regulation. Possessors of charisma resist being encompassed in bureaucratic organisation. It is, in Weber's terms, 'the unusual problem of the hospital': the hospital has an administrative structure which must contain and regulate charismatic professional persons who are defiant of lay regulation. Thus, both administrators and doctors are authoritative figures, but for different and often conflicting reasons.

The strain produced within the bureaucracy is most acutely felt by the nurses. The reasons for this is that the nurse is in a situation of "multiple-subordination" (Henry, 1954). First, the nurse's function is an extension of what the doctor does, and is subordinate in the medical hierarchy. As such, the nurse's task is to aid the doctors wherever possible, which may be translated as doing what the doctor tells you to do when the doctor tells you to do it. Clearly, in the medical hierarchy, the nurse is subordinate to the doctor and must carry out the orders the doctor issues. On the other hand, the nurse is subordinate to the administrator, who is technically the 'boss'
of the hospital and, as such, makes the decisions concerning hiring, firing and salaries, and must promote an efficient operation as directed by management.

Other employees of the hospital are also affected by this duality. Most cleaners, porters and maintenance people have highly routine tasks that ordinarily are followed without problem. But when the doctor demands that the rules be broken, such 'lower-level' workers are powerless to resist.

2.3.6 Problems created by stratification lines

The rigid stratification in the hospital has several consequences. Firstly, there is difficulty in communication and interaction between the various status levels. Secondly, informal groups, often based on hospital occupation position, tend to develop. Thirdly, there are overlapping areas of authority in which some workers are unsure of their position relative to others in the hierarchy. Finally, the lines emphasise blocked mobility, which affect commitments to the facility and its goals.

Smith (1958) notes that specialisation found in hospital work tends to block advancement for both nurses and lower-level workers. One way for hospital employees to advance is for an occupational group to assume the functions of the next higher status and to relegate more odious duties to those below them; for example, nurses or a treatment team give bedpan jobs to nursing assistants. If nurses can shed the tasks that are clearly non-professional in nature, perhaps some small movement upward in the stratification system will be a result, but major shifts are not possible.

It is probable that a major reason for the high worker turnover in hospitals has to do with this blocked mobility. There is no on-the-job training for a better position in the hospital, and there is relatively little room for advancement between ranks. Without leaving the system, obtaining more education, and then returning in a different status altogether, nurses and lower-level employees have no way to rise above the confines of the status for which they were originally hired. Consequently, those workers not committed to the goals of the facility tend to leave it, seeking other work.
Studies have indicated that at least one-third of observed resignation among staff nurses are reported to result from job dissatisfaction (McClosky, 1975). A more recent study indicated that three-fourths of those who contemplated leaving their jobs made the decisions because of work rather than because of personal reasons (Seybolt, 1976) Weisman, Alexander and Chase (1981) found that job satisfaction was the most important determinant of whether a nurse would contemplate or intend to leave the job. Autonomy in work was one of the most significant factors in job satisfaction.

With rigid stratification and the conflicting ideologies of members of the hospital work force, it is not surprising to find that communication is difficult among the various statuses. Three essential elements for good communication are lacking: adequate channels of communication between all members of the hospital workforce, agreement on goals and means to achieve those goals, and clear role responsibilities and authority for all positions (Wessen, 1958).

Given these problems, communication generally takes place between members of the same occupational groups and conversely, the greater the social distance between groups, the less communication between these groups. Most communication between the groups moves downward in the stratification system, with the nurse tending to operate as a mediator between groups. The consequences of social stratification within the hospital workforce and the resulting lack of communication between the different strata has serious implications for the dissemination of knowledge about AIDS.

Nurses are expected to pass on the knowledge they possess about AIDS to lower level workers but because they attempt to block mobility and fail to identify with unskilled workers, it is doubtful whether such communication would exist. The same lack of downward communication about AIDS is also likely to occur from doctors to nurses as doctors see their needs concerning AIDS prevention as being unique and lacking commonality of purpose with other hospital workers.

As each group holds themselves responsible for no one but themselves, they may feel no need to establish channels of communication about AIDS and may not feel that they have or need the responsibility for instituting such communication.
2.4 CONCLUSION

This chapter has reviewed how social stratification within society comes about and how it is reflected in a hospital setting. Much of the stratification that occurs in the hospital originates from the power-knowledge of scientific medicine with its claim to superior knowledge and status. These factors tend to subordinate those without access to such knowledge, cementing a form of social closure more total than those found in most work situations. It has demonstrated how class boundaries are rigidly adhered to and protected by an aura of professionalism which seeks to exclude other workers from positions of status; upward social mobility is thus inhibited in a hospital setting. Each class of worker is left in a position of having to defend his class or status identity resulting in a lack of cohesion in the hospital workforce. Factors of differences in educational and language background together with the legacy of apartheid which has deprived black workers of educational, economic and social opportunity may widen the rifts created by stratification. Within a rigidly divided micro society, communication in general and the dissemination of knowledge from one stratum to another becomes extremely difficult. This has negative implications for determining how information about AIDS can be made available to all and particularly to low status hospital workers. The dual authority structures which exist in hospitals further exacerbate the problem in that the issue of who bears final responsibility for introducing AIDS programs remains ill-defined.
CHAPTER THREE - METHODOLOGY

The objectives of research and the methods one adopts to obtain those objectives are inextricably linked. The methodology employed in researching this thesis was largely determined by the sensitivity required when probing an issue as controversial and emotive as AIDS, and was orientated towards obtaining relevant and in-depth knowledge. The research project that forms the basis of this thesis was conducted in two phases. Although the aim of the two phases differed, the same methods were utilised.

3.1 SELECTING RESEARCH METHODS

The purpose of the first phase of this research project was to investigate the depth of knowledge and the degree of awareness concerning AIDS amongst the staff of a hospital. Also under scrutiny were the procedures that were being adopted to prevent workers from coming into direct and unprotected contact with AIDS, in that such contact would constitute a health threat to them. Finally, the study wished to establish whether there is dissemination of knowledge between hospital workers who have knowledge about AIDS, to those workers who are deficient in their knowledge of AIDS. The second phase of the study aimed at examining which sociological and work situational factors operate within a hospital setting to prevent the dissemination of knowledge between hospital workers. Such insights are regarded as being necessary in formulating an effective AIDS prevention programme.

The two procedures adopted in this study, namely the intensive interview and participant observation, were selected as methods for gathering the type of information required for this study. They appeared to be particularly suited to a study of this nature in that they could be applied to all workers at the hospital, irrespective of their level of education and work performed, and are a means by which good qualitative information could be elicited for evaluation. It was anticipated that in researching AIDS, sensitive, controversial and emotive material would be evoked requiring that a good rapport between researcher and subject would be necessary so that complete confidentiality could be emphasised and thereby 'reliable' information could be revealed.
These procedures would allow for this and afford an opportunity to probe for information rather than to evaluate static data.

The language medium used in the study was a further consideration. It was decided to use English as the subjects were sufficiently proficient in this language medium for the purpose of this study, although they came from different language backgrounds. With diverse educational levels existing amongst the subjects, the questions used in the interviews were phrased simply and an attempt was made to maintain uniformity. Doctors interviewed, to whom many of the answers seemed obvious, were found to be generally tolerant of the simple approach used.

3.1.1 The intensive interview

The advantages and disadvantages of intensive interviewing were taken into consideration before deciding whether or not it was the most appropriate method for this particular study.

There are numerous strengths to the intensive interview. These include a smaller chance that the interviewer and the interviewee would misunderstand one another during an interview. This was particularly important as subjects have different language backgrounds and clarification of some terminology was necessary. The same question could be asked in a variety of different ways if there was any doubt as to the respondents' comprehension. If an interviewee's response seemed to be inconsistent, the interviewer could probe the response. In doing so, valuable information could be brought to the fore.

An example of this was a question set to examine whether the interviewee was aware of the 'window period'. The question asks, 'When a person contracts HIV, is it possible to immediately detect if he/she has contracted the disease?'. If the interviewee answered yes, a probing question followed to ascertain whether the worker understood the concept of latency - 'Why is this the case?' This question was especially relevant for assistant nurses and non-medical staff and if the original question was not understood, the question was rephrased as follows, 'If I contracted the HIV today, and I went for a blood test today, could the doctors tell me if I had the virus today?'
Examples of two very sensitive and personal questions asked in the interview were, 'Do you know of anyone on the staff of the Hospital who has the AIDS virus?’, and "Do you know of anyone who has contracted the AIDS virus while working at the Hospital during the course of his/her duties?’ On most occasions after this question was asked, there seemed to be a moment of doubt and uncertainty for the interviewee. This reaction was a cue to add that the research was not concerned with the names of the people infected or the ward that they worked in. Once this was made clear, interviewees seemed to respond with certainty and self-assurance.

Cognisance was taken of limiting factors associated with the intensive interview. Although it is possible to minimize some of these problems, many are the unavoidable consequence of characteristics that represent the greatest strengths of the method. The researcher is aware of the fact that the lack of standardisation in the data collection process makes it difficult to replicate an intensive interview study. Problems in replicating the sampling and interviewing procedures of the original study may mean that the reliability of the method is low.

It is also unwise to generalise about an entire population from studies based on intensive interviews. In general, it is difficult to standardise an interview and control all variables. For example, even for questions asked of all respondents, the length of the responses varied considerably. This inconsistency is due partly to differences between subjects with respect to how much they would volunteer in response to the same question asked in exactly the same way.

Even when one takes all these limitations into account, the intensive interview can yield rich and fruitful material and was therefore selected for use in this study.

The type of interview utilised may be termed a ‘nonscheduled standardized interview’. This describes an interview where standardised questions are asked, but not necessarily in the same order or fashion.
In summary, the intensive interview was an ideal research procedure to use in this study due to its adaptability and its facility to probe sensitive issues with which AIDS is associated. By means of the intensive interview it was possible to follow up ideas, probe responses and investigate motives and feelings, something which could not have been done with a standard written questionnaire.

3.1.2 Determining questions to be asked

The questions in the first phase of the study were designed to probe the awareness and knowledge about AIDS and whether such knowledge is disseminated to other workers. Research in this phase also attempted to ascertain whether respondents were aware of the possibility of contracting AIDS at work, whether they knew how to protect themselves at work, and if they were aware of the protocol to be followed if they were exposed to infected blood. Certain questions dealt with the degree of stress and fatigue in the work situation. This was important to probe as stress and fatigue place workers under additional risk of accidental infection as they are not always able to attend to safety procedures consistently.

The second phase of the study involved investigating the interaction between different workers at the hospital and more specifically the manner in which social relationships may affect the exchange of information concerning AIDS. The interviews also scrutinised the respondents' attitudes and beliefs in regard to the role of status, professionalism and social differentiation within the work situation.

Certain overlapping questions were asked in both phase one and phase two of the thesis to test the consistency of the findings of phase one. These questions concerned hospital workers' interaction with AIDS patients and the degree of AIDS education and protective equipment received at the hospital. The findings of phase one were found to be consistent with the findings in phase two.
For both the first and second phase of the thesis, a pilot study was initiated using a professional nurse, an assistant nurse and a cleaner as subjects. This was undertaken to ascertain whether the questions asked in the intensive interviews would produce answers pertinent to the study. The nurses and the cleaners were randomly selected from wards which had a high exposure to AIDS patients. This proved to be a worthwhile exercise as a number of questions in both interview schedules were found to be ambiguous and others proved to be too technical in their wording. Once this process was complete, the questions for the interviews were finalised (Appendices A and B).

### 3.1.3 Participant observation

A second research procedure, namely participant observation was adopted to ascertain the nature of the labour process, the degree of risk involved and procedures being (or not being) adopted to prevent workers from coming into direct and unprotected contact with the AIDS virus. Furthermore participant observation could also establish the degree to which interaction takes place between different workers at the hospital and the degree to which knowledge regarding AIDS is disseminated.

In the first phase of the study, it was necessary to observe if workers put into practice what they knew theoretically. Correct answers may have been given to questions asked in the intensive interview, but under certain circumstances, dangerous work procedures may be perpetuated. This could only be learned from direct observation. In the second phase of the study it was necessary to observe how factors relating to class, status and social closure were manifest by workers in different groups.

The role adopted by the researcher followed a procedure of ‘limited interaction’. Observations were first made, and these were followed up later, when necessary, by asking questions in order to obtain clarification from workers regarding the content of an interaction that had taken place.
The observation and measure of sociological factors that are operating within the hospital took place by taking note of physical manifestations of status (clothing, personal possession), manner of speaking and phraseology used, recording of statements, degrees of tolerance shown by act or omission and the actual work processes. This option was pertinent to this particular research as certain observations were conducted in casualty departments and trauma wards where workers were very busy and immediate intervention would have interfered with medical treatment.

The limitations of participant observation were taken into account. In a busy hospital ward, it was extremely difficult to be aware of all interactions that were occurring at any given time. Nonetheless, many valuable observations were made. Every attempt was made to record events as they actually happened, without offering interpretation at that stage.

3.2 SAMPLING - SUBJECTS USED IN THE STUDY

A list of all personnel, both medical and non-medical employed by the hospital was requested. Each medical department was categorised, and a numerical breakdown of specialist and medical officers within each department was provided. This information was obtained from the Superintendent. The Chief Nursing Service Manager provided a list of nurses at the hospital, and the Head of Non-Medical Staff provided a list of non-medical personnel employed.

Subjects were selected from those wards in which the greatest number of AIDS patients were likely to be found. Subjects came from all levels of the hierarchical structure within the hospital. However the primary focus was on the trauma, surgical, gynaecological and medical wards as it is in these wards that contact with AIDS becomes more probable.

Once introduced to potential subjects, it was immediately determined that they had worked at the medical institution for longer than five years. A five-year cut off period was used to ensure that all subjects had had an opportunity to have attended AIDS education and awareness programs run by the hospital, as well as to ensure that they had had time to integrate into and became a permanent part of the workforce.
Using the data received from the Superintendent, the Chief Nursing Services Manager and the Head of Non-Medical Services, the number of workers to be interviewed in each department of the hospital was calculated. A proportional number of interviews within each category of employee was used. By using this process, it was possible to calculate how many interviews at each level and of each category of worker should be conducted.

Phase One involved a purposive sample of 30 interviewees and Phase Two involved a purposive sample of 40 interviewees selected from hospital workers. These numbers were determined by the constraints of time and resources available to construct the research project. The limited sample size was also due to a deliberate attempt to conduct interviews that would yield qualitative rather than quantitative data. In probing sensitive issues such as those associated with AIDS, much time had to be spent with each interviewee to elicit the required information.

In the first phase of the study, in order to obtain approximately thirty interviews, calculations indicated that 2 specialists doctors, 2 registrars or medical officers, 1 intern, 8 professional nurses, 5 staff nurses, 6 assistant nurses, 2 porters, 2 cleaners, 1 messenger and 1 general maintenance person would have to be interviewed. In the second phase of the study, in order to obtain approximately forty interviews, calculations indicated that 2 specialists doctors, 3 registrars or medical officers, 1 intern, 10 professional nurses, 7 staff nurses, 8 assistant nurses, 2 porters, 5 cleaners, 1 messenger and 1 general maintenance person would have to be interviewed.

These interviews did not include three informal unstructured interviews which were conducted. A shop steward at the hospital was interviewed to gain information about trade union involvement. The Nursing Service Manager in charge of surgical and speciality departments was questioned on specific AIDS programs run at the hospital, and a doctor was interviewed who had experienced a needlestick injury while attending to a patient who was HIV positive.
3.3 CHOOSING AN APPROPRIATE INSTITUTION

When selecting the appropriate medical institution in which to perform this research project, two initial criteria were taken into consideration.

Firstly, the medical institution selected had to have a substantial number of AIDS patients in its care to constitute a risk of infection to workers. A major provincial hospital, located in central Johannesburg, met this requirement. According to one of the Superintendents at the Hospital, there are approximately 15 AIDS patients in its wards at any one time. In terms of the size of the Hospital, this is regarded as a significant presence of the disease.

Secondly, the locality of the institution had to be taken into consideration. An urban rather than a rural setting was necessary to meet the criterion that AIDS is currently a disease that is extremely prevalent in the urban areas of South Africa. The hospital selected has busy trauma, gynaecological and surgical wards in which workers are constantly exposed to HIV infection, and serves a densely populated urban area. The hospital also had to be easily accessible to the researcher.

The hospital is situated in an area with a very high crime rate and during an average weekend, treats approximately 300 victims of violent assault, including stab and gunshot wounds. The prevalence of AIDS in the area, coupled with the sheer volume of blood which 'flows' in the hospital, made it a suitable location for the research project.

The very same institution was used as a case study for both the first and second phases of the study to provide continuity and control of variables.

3.4 GAINING ACCESS

In order to conduct this study, clearance had to be obtained from the Committee for Research on Human Subjects, University of the Witwatersrand. This requirement was necessary to ensure the confidentiality and protection of subjects, informants and researcher.
Permission to perform phase one of the research at the hospital was obtained from the Superintendent. Requirements for the research and the manner in which sensitive ethical issues would be addressed, were presented to the Superintendent in written form (Appendices C, D and E).

Due to the intervention of senior medical personnel such as the Chief Nursing Services Manager, the Nursing Services Manager and the Superintendent, excellent co-operation was afforded by all medical staff, and easy access was gained to the wards and trauma units. A cordial reception was received from non-medical staff. This was due to the intercession of a respected shop steward from The National Education, Health and Allied Workers' Union (NEHAWU). An introduction from the shop steward to non-medical workers immediately gave the research project a certain degree of legitimacy and credibility amongst these non-medical workers.

Permission again had to be obtained from the Superintendent to initiate phase two of the research. This was successfully completed in letter form (Appendices F and G). Because phase one of the study was carried out at this same hospital, the researcher was familiar with many of the medical and non-medical staff and felt that his credibility and legitimacy as an ethical and sincere researcher was already established due to previous interactions. Having established a good rapport with hospital employees, the gathering of information was made easier.

In both phases, an attempt was made to interview hospital staff in places where they would feel most at ease. The interviews were all held within the hospital to retain professionalism and most often took place in hospital offices and nurses' lounges. The porters were interviewed in the porters' lounge and the cleaners and the messenger in the matron's office. All interviews were performed individually with no other persons in hearing distance, encouraging an atmosphere of full trust in which frankness would be easier.
3.5 RECORDING INFORMATION

A mini-pocket sized tape recorder was used in all interviews as a means of recording information. All subjects were informed of its use prior to consenting to be interviewed. The tape recorder did arouse suspicion in some interviewees. Fear of the tape recorder was common amongst the nurses and doctors whose work ethic emphasises confidentiality. However, after it had been explained to the doctors and nurses that the recording would be used only to gather information for purposes of the research project, that it would not be given to the administration and would be destroyed, all subjects without exception agreed to be recorded.

3.6 ETHICAL CONSIDERATIONS

The study does not focus on patients suffering from AIDS; nor is it concerned with matters such as hospital workers' job performance, AIDS status, or any other issue that could compromise an employee's position in the hospital. However, to protect the rights of individuals and the institution studied, numerous steps were adopted. All details of the intended study were submitted to the Committee for Research on Human Subjects at the University of the Witwatersrand for approval. Furthermore, all subjects, before being requested to participate in the study, were informed of the purpose of the study, the anticipated consequences and the possible benefits of the research. Subjects were given the freedom to withdraw from the study at any time. Research participants remained anonymous and the name and location of the institution in which the research was completed have been kept confidential. Information gathered was kept in a place of safety. Every attempt was made not to hinder or delay the activities of the institution in which the research was being performed.
CHAPTER FOUR - FINDINGS

The findings of each phase of the research project will be discussed in this chapter with reference to issues and concepts reviewed in the literature. The concept of whether a work hierarchy governed by socio-educational issues exists amongst workers at the hospital is considered. In relation to this, three issues are explored: namely, who is at risk of AIDS infection at the Hospital, the degree of knowledge and awareness of AIDS amongst hospital workers and why certain workers are knowledgable about AIDS and other are not. It is further suggested that the knowledge which some workers possess is not necessarily shared or "disseminated" to other workers. If this is true the second phase of the research project will attempt to explain the non-dissemination of AIDS knowledge in terms of sociological concepts. Issues of stratification in relation to class, status, social mobility and cultural and language divides are investigated and it will be determined whether practices of exclusivity and social closure operate between hospital workers. Finally, the manner in which these influence the dissemination of knowledge will be investigated.

PHASE ONE - AIDS AS AN OCCUPATIONAL HEALTH RISK TO HOSPITAL WORKERS: AN INVESTIGATION OF EDUCATION, AWARENESS AND PREVENTATIVE MEASURES

4.1 THE HIERARCHY OF WORKERS WITHIN THE HOSPITAL AND THEIR EXPOSURE TO AIDS

An enquiry into the nature of the work performed at the hospital revealed that there are different categories of worker arranged according to a hierarchy reflecting the different duties and goal orientations of hospital workers. These correspond to the training, knowledge, skills and credentials which they possess. It becomes apparent that hospital workers can broadly be categorised as belonging to the following groups - doctors, nurses and non-medical workers. The degree of exposure to AIDS depends on the nature of the work each performs, the knowledge they possess about the virus and the means which they have to protect themselves from infection.
### A Numerical Breakdown of Staff Employed at the Hospital According to Occupation

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Total Number of People Employed</th>
<th>Percentage of Total Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOCTORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialists.........</td>
<td>63</td>
<td>16%</td>
</tr>
<tr>
<td>Registrars &amp; Medical officers...</td>
<td>126</td>
<td></td>
</tr>
<tr>
<td>Interns.............</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td><strong>NURSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional.......</td>
<td>385</td>
<td>6%</td>
</tr>
<tr>
<td>Staff................</td>
<td>232</td>
<td></td>
</tr>
<tr>
<td>Assistant...........</td>
<td>266</td>
<td></td>
</tr>
<tr>
<td><strong>NON-MEDICAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porters.............</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Cleaners............</td>
<td>206</td>
<td></td>
</tr>
<tr>
<td>Messengers.........</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Maintenance........</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td>1386</td>
<td>100%</td>
</tr>
</tbody>
</table>

For the purposes of this research project the hierarchy of workers within the hospital will be addressed in terms of doctors, nurses and non-medical workers, as each represents a category of hospital worker.

#### 4.1.1 Doctors

Highly qualified medical specialists such as surgeons, gynaecologists and anaesthetists represent the upper level of the Hospital's occupational hierarchy. Included in this category are medical officers, registrars and interns. They are the group of workers who are most exposed to risk of AIDS infection as they operate, suture and take blood, which constantly requires them to be in contact with blood. They work with sharp instruments like needles and blades, exposing themselves to injury in the presence of infected blood.
The doctors interviewed were all white and belonged to the upper class structures of society. All of the doctors attended 'white' government schools or private schools, where classes had on average been between 20 to 30 pupils. All of the doctors had an extensive scientific background as they had studied science as a matriculation subject, followed by considerable study of scientific concepts over the six years they had taken to train as doctors.

From observation and questions put to them it became apparent that their scientific training has prepared them for understanding the nature of AIDS infection, routes of transmission and methods to protect themselves from infection. They had at their disposal, all the necessary equipment to deal with possible infection: gloves, aprons, masks and shoe covers. However outside surgeries and operating theatres, doctors do not take all the precautions possible. Doctors and interns working under stress in the emergency units and those suffering from fatigue after being on duty for 30 or 40 hours, sometimes forget to take the necessary precautions to avoid AIDS infection. It was clear that work stress resulted in laxity of procedure in putting into practice knowledge of AIDS. An interview with an intern at the hospital clearly revealed the dangers:

One never knows which patients are HIV positive and which ones are not. When I am fresh and alert, I can think about what I am doing and take the necessary precautions. But AIDS scares me when I am tired. When I have to take blood or put up a drip for a patient who I suspect to be HIV positive, I am scared stiff. I will be shaking I am so tired.

Another intern who had worked very long and stressful hours, was observed taking blood from patients and labelling the tubes for laboratory analysis without wearing gloves. This occurred minutes after an interview in which she stated that gloves were worn at all times. The intern also had what looked to be dry blood all over her forearms, but seemed too tired and in too much of a hurry to think about it. Doctors' work stress, particularly in emergency rooms resulted in some degree of laxity as regards protection from AIDS infection as they dropped syringes and swabs onto the floor. Their concern for their patients seemed uppermost in their minds, and self protection was accorded lesser importance.
However, it is the very nature of the work performed by doctors, interns and registrars which places them at constant risk of infection. An interview was performed with a pathologist working at the Hospital who had experienced a needlestick injury while working with a patient. This doctor stated that the patient moved suddenly when he was working on him with a needle. He did not attribute his needlestick injury to the stress and fatigue of long working hours, but rather to the hazards involved when doctors perform medical procedures which involve sharp instruments (Appendix H).

This situation was also highlighted by a surgeon:

I always double glove when I operate, but sometimes during certain operations, I lose sight of my hands and rely solely on the sensitivity of touch. This forces me to remove one pair of gloves which places me at a greater risk of HIV infection, but it has to be done in order to perform such procedures.

A doctor in the gynaecological ward described his experience:

There are times when you have to take a person's pulse when taking blood from an artery. Sometimes with old or fat people I cannot feel the pulse through the gloves so I take off the glove from the hand I am pulsating with in order to draw the blood successfully.

4.1.2 Nurses

Nurses are rigidly separated into three categories within the hospital's hierarchical structure. These sub-categories are determined by their level of training and the amount of responsibility which they assume. Nurses are all clearly aware and are constantly reminded of their place in the hierarchy as different coloured lapels are worn on their uniforms which distinguish professional, staff and assistant nurses from one another.
Professional nurses find themselves beneath the doctors on the hierarchical order. Nurses within the sample were all black and were from lower middle-class income groups. All nurses interviewed had attended "black" government (or Bantu education) schools. Their classes had on average between 65 and 80 pupils. One assistant nurse stated that she had had 115 people in her class in her Standard Eight year.

After having matriculated, professional nurses had attained four years of specialised training at various nursing training colleges around Southern Africa. Staff nurses are less qualified, having trained for two years after matriculation. Assistant nurses do not have to attain any particular schooling standard but are required to complete a six month nursing course before working in a hospital.

All the nurses in the hospital work within a clinical environment where they are constantly exposed to blood and bodily secretions. Professional and staff nurses perform medical procedures in the casualty unit and in the general nursing wards of the hospital and often work with needles when putting up drips and giving injections. These nurses therefore run a greater risk of infection than do assistant nurses who do not perform any medical procedures. However, due to their superior training and scientific knowledge, professional and staff nurses appear to be in a better position to take precautionary measures against AIDS infection, than are lesser qualified assistant nurses. They were keenly aware of the dangers of AIDS infection and appeared to take sufficient precautionary measures. A senior professional nurse reflected on her daily contact with blood:

I believe that every person that has a job works with certain tools and materials, and these tools and materials could harm them. I am a professional nurse and the tools that I work with everyday like the needles, cause me to work with material like blood. I know about AIDS, and I know that I have to be careful.
The professional and staff nurses are generally not faced with the extreme work pressure that doctors face, except those nurses who work in the emergency unit. Nurses' work-pace is slower, although their working hours are long. Nurses have to work 40 hours a week. This is usually divided into three shifts from 7am to 7pm, with one half-day shift and three days off duty. Night duty is assigned to nurses on a rotation basis, with each nurse performing night duty for 3 to 4 months a year.

Assistant nurses have no medical duties but are concerned with bedside nursing. Nonetheless the assistant nurses also come into frequent contact with blood and other bodily fluids at the hospital, particularly when working in gynaecological wards. An assistant nurse working in a gynaecological ward described her duties:

Well I have to help the other nurses with the patients. I do see [come into contact with] a lot of blood because I am dressing the wounds of the patients and changing the sanitary pads for them in the ward. Many times there is also blood in the bedpans of the patients which I have to change. I also help treat the women who have had the abortions on the street — they are bleeding a lot.

4.1.3 Non-medical staff

The non-medical workers at the hospital represent the lowest level of the hierarchy, and fill numerous job categories. All non-medical staff at this particular hospital were black people coming from low income family backgrounds. Non-medical workers are divided into four basic categories and require no specific educational training or level of schooling to perform their duties. All of the non-medical staff interviewed attended 'black' government (or Bantu education) schools and had had no education in the sciences.

The porter's responsibility is to transport patients around the hospital, as well as to remove corpses from wards and emergency rooms. Cleaners are responsible for the cleanliness of the wards, sluice rooms, surgeries, and casualty units. Messengers transport blood samples and products to and from the hospital wards to laboratories. General maintenance men see to the general
up-keep of the hospital. All these non-medical workers come into contact with blood at a certain stage in their work and run the risk of infection.

The cleaners interviewed, who worked in the emergency room, reported frequent contact with bloody waste material and used needles. One of the cleaners described the emergency room and her duties there:

The blood is on the floors and on the walls. Sometimes the doctors use the kleenex or the gauze and because it is an emergency they just throw it down on the floor. They also use injections with needles on the patient to try and save them and throw those down. The kleenex and gauze is full of blood and the injection are also. I must go and pick up the gauze and kleenex and the injection and throw them away in that box and then I must clean the blood.

Interviews such as these highlighted the cleaners’ frequent exposure to blood during their work as well as their ignorance concerning AIDS at the hospital. The cleaner has obviously been told by a doctor or nurse to place all bloody materials in a box. When questioned further, it became apparent that the cleaner was unaware of the reason for placing this material in a special waste disposal container.

A porter described coming into contact with blood:

Blood gets onto the chairs [wheelchairs] and onto the stretchers quite a lot, especially with [patients from] casualty and with the women with the abortions.

The maintenance man interviewed also came into contact with blood when unblocking drains in the casualty and surgery wards. He explained his experience.

I put my hands right into the basins to get the plunger down close to the hole to unblock it. Sometimes the basin is full of water mixed with blood, but I wash my hands after.
It was clear that non-medical workers did not have the necessary equipment to protect themselves from infection. The maintenance man worked without gloves when unblocking bloody drains. Although given gloves to wear, he did not appear to understand the necessity for wearing them. It was also clear that he knew very little about AIDS and how it is contracted. This was revealed when he stated that he believed he would be protected from infection by washing his hands after coming into direct contact with a basin full of blood. It must be stressed that ignorance with regards to the threat of exposure to AIDS could mean death.

4.1.4 The risk of accidental injury and AIDS infection

Interviewees were asked whether they knew of anyone at the Hospital who had a needlestick injury or other accidental contact with the virus. This question revealed the presence of a high incidence of needlestick injuries at the hospital. Doctors and professional nurses were most at risk in this regard.

An intern who was interviewed revealed that she knew of two fellow interns who have had needlestick injuries from HIV patients. The intern added:

They [the interns] are not sure whether they are [HIV] positive or not as both accidents only happened a week ago...they were both wearing gloves but the needle went straight through.

A staff nurse reported that an intern had contracted the virus while at work.

There was a young intern in the hospital about two years ago that contracted AIDS here at work. His name was ***. He pricked himself with a needle in the ward when he was working with an AIDS patient. I received his results. He used to come everyday and ask me for his results and I saw when it came that he was HIV positive. I do know that many other doctors knew about it because they told him to go for the AIDS test when he pricked himself.
A senior professional nurse openly discussed a fellow nurse whom she believed had contracted HIV from a needlestick injury and subsequently died. The Senior Nurse explained that:

The nurse never returned to work after she pricked herself with the needle. The day I went to go to see her at her place, it was a pathetic situation. From my experience I could see that it was clearly full blown AIDS. The Hospital said she had carcinoma of the stomach but I did not believe this.

There was also a low level of awareness amongst the non-medical staff that accidental infection is a possibility in the course of their work at the hospital. It was observed that many of the workers such as the cleaners, messengers and maintenance men who come into contact with potentially contaminated needles and other sources of infection, often have cuts and abrasions on their hands caused by the very nature of their work. These workers are in fact at considerable risk of infection. They only sometimes wear protective gloves, and did not know why the hospital authorities have insisted on this.

4.1.5 Summation

The findings reveal that a hierarchy of workers exists in the hospital determined by the skills each worker possesses and the nature of the job performed. With the exception of people who hold administrative posts, it was noted that within the hierarchy, the degree of risk involved to each category of worker varied according to the nature of the work which each performed. However, each and every category of worker within the hospital runs the risk of exposure to infection. It was clear from observation in the workplace that all workers in the sample selected had contact with blood and/or body secretion at some stage during the labour process, irrespective of the level in the hierarchical structure in which they worked. The possibility of HIV infection is therefore constantly present, and a risk to most workers within the hospital. A number of workers have been directly exposed to the virus by accidental contact with blood or in needlestick injuries.
4.2 THE DEGREE OF KNOWLEDGE AND AWARENESS OF AIDS AMONGST HOSPITAL WORKERS

It is a basic premise that the ability to deal with the risk of AIDS infection is based on each individual's knowledge about the virus and the precautionary measures that are available to him. It has been established that most workers at the hospital are at risk of AIDS infection. The following section will explore the level of AIDS awareness and understanding amongst hospital workers as it pertains to different categories of workers. Questions were asked to ascertain how much knowledge workers had about AIDS and if they were at risk of infection.

4.2.1. Workers' understanding of how AIDS is transmitted

Workers were asked how they believed AIDS could be transmitted in a hospital setting. The responses are detailed in the table below:

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number Interviewed</th>
<th>Adequate Knowledge</th>
<th>Partial Knowledge</th>
<th>Did Not Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>5 (100%)</td>
<td>5 (100%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>13 (100%)</td>
<td>10 (77%)</td>
<td>3 (23%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>6 (100%)</td>
<td>3 (50%)</td>
<td>3 (50%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>6 (100%)</td>
<td>0 (0%)</td>
<td>1 (17%)</td>
<td>5 (83%)</td>
</tr>
<tr>
<td>Total</td>
<td>30 (100%)</td>
<td>18 (60%)</td>
<td>7 (23%)</td>
<td>5 (17%)</td>
</tr>
</tbody>
</table>

The table confirms that all doctors had adequate knowledge of the manner in which AIDS is transmitted in the hospital work environment. It is important to note that although 10 of the 13 professional and staff nurses interviewed had adequate knowledge of the manner in which AIDS is transmitted in the hospital work environment, three nurses had partial knowledge of the manner
in which AIDS is transmitted. They were staff nurses who have received less scientific education than professional nurses in their training.

Fifty percent of the Assistant Nurses had adequate knowledge on how AIDS is spread in the Hospital, while 5 out of 6 of non-medical workers interviewed had no knowledge of the manner in which they could be infected in the course of their work activities. When asked if she knew how she could contract AIDS at the hospital, a cleaner who worked in emergency replied, "I am not really sure how I can get this, but it is not important for me because I am not a nurse or a doctor; they are the ones who must know this".

'2.2 Workers' knowledge regarding the difference between HIV and AIDS

Interviewees were asked if there was a difference between HIV and AIDS. This question reveals the ability to understand complex concepts relating to latency periods and infectiousness. Understandably, a person without a basic grasp of science and having less than a high school level of education, would find it difficult to comprehend the intricate aspects of the AIDS condition. Again all doctors and interns knew the difference. Although 10 out of 12 professional and staff nurses were aware of the difference between HIV and AIDS and gave correct answers, many gave lengthy drawn out explanations which indicated a lack of clear comprehension. A example of this was an answer given by a professional nurse:

HIV is the virus which a person has got. Let's say that a doctor will tell you that you are have HIV; that means that you have that germ of AIDS. But when the HIV is dominant it does not mean that you have AIDS. When the HIV becomes active, we then say you have got AIDS. So a person can be HIV, but they are not sick.

The remaining 3 nurses (one professional and two staff nurses) had partial knowledge of the difference between HIV and AIDS. Only 2 out of 6 assistant nurses and 1 out of 6 non-medical workers had partial knowledge of the difference. An example of a response which was classified as partial knowledge was given by an assistant nurse. This nurse could not elaborate on the differences between HIV and AIDS but was aware that, "HIV is the first part
and AIDS is the final thing". The remaining assistant nurse and non-medical workers had either wrong information or did not know the difference between HIV and AIDS. A porter was convinced that:

It's all the same thing. I have heard of this word but it's just the more difficult way of saying AIDS. That's the word that the doctors and nurses are using all the time. My friends never say that word when they talk about AIDS.

4.2.3 The implication of the 'window period'

Interviewees' awareness of the 'window period' was also assessed. The existence of the window period implies that precautionary measures have to be taken constantly as it is not possible to know which patients are potentially infective. All doctors and the intern were aware of the window period, and 7 out of 13 Professional and Staff Nurses interviewed knew about it. A Professional Nurse who was uncertain about the window period responded to the question by saying:

I am not clear on this. I know that if you prick yourself with a needle you go to casualty and they take blood for a test. But I am not sure when you can tell if you have caught the disease. I'm sure it takes a few days or so.

Not one assistant nurse or non-medical worker could begin to explain the window period. Even with considerable prompting, it became clear that these hospital workers were unaware that the window period existed.

4.2.4 Workers' knowledge of prophylactic measures

Interviewees were asked how they could avoid contracting AIDS in the workplace. As expected, the highly educated doctors as well as 10 out of the 13 professional and staff nurses interviewed, had the knowledge to protect themselves from contracting the disease. These hospital workers knew that they should avoid direct contact with blood and other bodily fluids. They
stated that they wore gloves when attending to patients and disposed of bloody materials and 'sharps'.

However, only 2 out of the 6 Assistant Nurses had adequate knowledge of precautionary measures, while 4 out of the 6 of the non-medical workers interviewed had no knowledge on how to protect themselves. It must be pointed out that all non-medical hospital workers were instructed to wear gloves while at work, but the majority of these workers did not know why they had to wear them.

4.2.5 Knowing that AIDS is a potentially fatal disease

Interviewees were asked if there was a cure for AIDS. All medical workers, i.e. doctors and nurses, knew that there was no cure. However, 2 out of the 6 non-medical workers were not sure of the answer while another 2 non-medical workers interviewed believed that there is a cure. A cleaner stated clearly that she believed that there is a cure:

I hear many stories about people getting better from this AIDS disease. One man at my home in Soweto said that his uncle who had this disease went to see a doctor in Lesotho, and he is now better. I think that if I get it [AIDS] I will also go to Lesotho.

This indicated that non-medical workers have not fully understood the degree of risk to which they are exposed.

4.2.6 Summation

It would appear that all of the doctors, interns and professional nurses understand AIDS and are aware of the dangers it poses to them at work. However, certain staff nurses, most assistant nurses and non-medical workers, do not have sufficient knowledge and understanding of the virus and the threat it poses to them in the workplace. Furthermore, and a most sinister finding was that not all workers understand that AIDS is a fatal disease.
4.3 THE ACQUISITION OF AIDS INFORMATION BY HOSPITAL WORKERS: WHY ARE CERTAIN WORKERS KNOWLEDGABLE AND OTHERS NOT?

This section explores the reasons why certain hospital workers understand AIDS and are aware of the dangers it poses to them at work, while others do not have sufficient knowledge and understanding of the virus.

4.3.1 Where did hospital workers acquire their knowledge about AIDS?

Doctors and interns said that they had acquired their knowledge from lectures attended, medical journals and publications. The interns had also taken a course at medical school pertaining to the virus while the older doctors mentioned that they had also acquired their knowledge through discussion and interaction with fellow doctors.

Professional, staff and assistant nurses stated that they had received their knowledge about AIDS from hospital education programs which they themselves had initiated. Professional and staff nurses also asserted that they discussed the virus with colleagues. However assistant nurses did not seem to be included in this informal exchange of information.

Cleaners, porters and maintenance people at the hospital reported that they had acquired their knowledge about AIDS from fellow non-medical workers, friends, family, magazines, newspapers, television and radio.

4.3.2 Educational levels and its affect in the understanding of AIDS

Questions pertaining to educational level revealed a strong demarcation between those members of the hospital staff who have matriculated and those whose schooling fell short of the matriculation level (see table).
The highest education level reached by hospital workers.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number Interviewed</th>
<th>Above Standard 10</th>
<th>Standard 10 and Below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>5 (100%)</td>
<td>5 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>13 (100%)</td>
<td>13 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>6 (100%)</td>
<td>0 (0%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>6 (100%)</td>
<td>0 (0%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>30 (100%)</td>
<td>18 (60%)</td>
<td>12 (40%)</td>
</tr>
</tbody>
</table>

Assistant nurses and non-medical workers fell within the category of not having attained matriculation. This dichotomy is of importance as it indicates that it is only those workers who, by virtue of their scientific educational background, have the most complete understanding of AIDS in all its intricacies and who are thereby afforded a better means of protecting themselves from infection. Conversely, non-medical workers and assistant nurses with lower educational backgrounds, do not have the basic scientific grounding with which to comprehend the complexities of AIDS as a disease or the prophylactic measures that are necessary to prevent infection. They therefore remain more vulnerable to infection, as they are less able to protect themselves.

4.3.3 Language background and understanding AIDS

A strong relationship was found between the standard of education attained and the degree to which the workers at the hospital could speak and read English proficiently. Of the 30 interviews conducted, only 4 subjects, all of whom were specialist doctors and registrars, used English as their first language. In the rest of the sample, 7 other home languages were present. The more educated workers - the professional and staff nurses - had a high standard of English compared to assistant nurses. The problem was greater for the non-medical workers, who generally seemed to struggle with English.
The significance of this is that the language medium used in most of the Hospital's education and awareness programs and the printed material associated with this effort is English. Certain of the posters on the walls in the corridors of the hospital do appear in African languages, but significantly those publications which deal with the procedure for hospital workers to follow in the event of a needlestick injury, and the 'Protocol for AIDS' which covers precautions hospital workers must take to avoid HIV infection while at work in the hospital are only published in English (Appendices I & J). Concepts necessary for understanding the AIDS condition are frequently complex, abstract and difficult for laymen to grasp. The documents issued use complicated medical terminology, obviously targeted at the nursing staff, but there appears to be no separate, simply phrased document of procedures designed to meet the needs of the assistant nurses and non-medical staff. This causes them to remain at risk of infection.

The language problem was highlighted by a Senior Professional Nurse when asked whether she had gained anything from the AIDS education course she had taken at the hospital:

Yes I learned a lot. But for me it was alright because my English is good, but AIDS is a complicated problem and many of my fellow nurses, although they can speak English, did not understand enough English to understand what the lecturer was explaining. I think that if the lectures were given in Xhosa, Tswana or Zulu, many more nurses would have understood better.

4.3.4 AIDS awareness programs conducted at the hospital

Lectures and educational courses are conducted at the hospital to inform workers about AIDS. The efficacy of the courses has to be assessed in measuring workers' knowledge about AIDS.

In the first instance therefore, it was necessary to ascertain which AIDS awareness programs are indeed conducted at the hospital and to assess their scope and to whom they are addressed.
Enquiries revealed that it is the intention of the hospital to run extensive education courses dealing with a number of medical topics. It was established that the existing educational 'programs' run at the hospital consisted of three distinct courses.

Firstly, there is a global in-service education program which is organised by the Clinical Teaching Department (CTD) at the Hospital. The CTD runs courses on topics relevant to the hospital and health care. Every month, a different topic is dealt with during the course. These courses are mostly attended by professional nurses. The CTD did have AIDS as a theme for one month during the year. However there appears to be a major problem with regards to the fact that the education program was run during the day. All nurses are assigned to night shift duty according to a rotational roster. Those nurses on night duty during the period when the course was being held were unable to attend and no provisions were made to run further courses to educate these particular nurses.

Secondly, a specific AIDS program exists for the training of health care personnel who act as AIDS educators in the hospital. About 30 Professional Nurses from the medical and surgical wards, are sent on a week-long AIDS education and counselling program. They in turn run educational programs for professional and staff nurses during the months of February and August, when very few nurses are on leave.

Lastly, nurses in each ward have their own 'in-service' education program. Each ward at the hospital is seen as a working unit with a team of nurses. Nurses from each ward decide on a topic each week about which they feel they need further education. The professional nurse in charge of each ward then has the responsibility of investigating the topic chosen, and presenting the findings to the nurses in the ward. She may delegate a task to one of the other nurses in the ward. All reports are placed on the notice board in that particular ward and members of staff can refer to it. AIDS has been chosen as a topic for presentation from time to time in several of the wards in which research interviews were performed. It must be pointed out that all education courses are conducted in English.
This represents the entire scope of lectures on AIDS run at the hospital and as can be deduced, they are only directed towards nursing staff. A most significant finding of this study was that AIDS education programs are not offered to non-medical workers at this hospital.

To substantiate this finding, interviewees were asked if they had taken AIDS education/awareness lectures at the hospital. Responses are detailed in the table below.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number Interviewed</th>
<th>At Least One Lecture Taken</th>
<th>No Lectures Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>5 (100%)</td>
<td>0 (0%)</td>
<td>5 (100%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>13 (100%)</td>
<td>8 (62%)</td>
<td>5 (38%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>6 (100%)</td>
<td>3 (50%)</td>
<td>3 (50%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>6 (100%)</td>
<td>0 (10%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>30 (100%)</td>
<td>11 (37%)</td>
<td>19 (63%)</td>
</tr>
</tbody>
</table>

From the above table, it can be seen that the doctors and interns had not specifically participated in any lectures on AIDS at the hospital. It can be concluded that attendance at such programs is unnecessary as their specific and specialised training had included the required information. Almost two-thirds of the professional and staff nurses had attended at least one lecture at the hospital. Only half of the Assistant Nurses interviewed had attended a lecture. The reason why so many nurses had not attended an AIDS education course was due to the fact that many nurses were on night duty or off-duty at the time the course was being run.

Not one of the non-medical workers interviewed had ever attended an AIDS education/awareness lecture at the hospital. The non-medical workers' ignorance of the disease and its implications must to a great extent be attributed to this fact.
4.3.5 Protocols - their effectiveness in alerting workers to AIDS

The hospital has established a protocol to be followed in the event of an accidental needlestick injury, and a separate protocol to guide medical workers when working with AIDS patients (Appendices I and J).

Knowledge of these protocols was tested. Interviewees were asked if there was a particular procedure (protocol) to follow at the hospital should a worker accidentally come into contact with infected blood. Responses are detailed in the table below.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number interviewed</th>
<th>Complete Understanding</th>
<th>Partial Understanding</th>
<th>Did Not Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>5 (100%)</td>
<td>5 (100%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>13 (100%)</td>
<td>10 (77%)</td>
<td>3 (23%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>6 (100%)</td>
<td>2 (33%)</td>
<td>4 (67%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>6 (100%)</td>
<td>0 (0%)</td>
<td>1 (17%)</td>
<td>5 (83%)</td>
</tr>
<tr>
<td>Total</td>
<td>30 (100%)</td>
<td>17 (57%)</td>
<td>8 (27%)</td>
<td>5 (17%)</td>
</tr>
</tbody>
</table>

A high percentage of doctors and professional and staff nurses are aware of the AIDS protocol and the complete procedures to follow in the case of possible infection. However, only 33% of the Assistant Nurses knew the complete protocol while 83% of the non-medical workers did not even know that an AIDS protocol existed. This again highlights what seems to be a lack of attention by the hospital authorities to the needs of non-medical workers. Non medical workers are not targeted by these protocols which appear to be directed to doctors and professional nurses. There are no protocols specifically directed at cleaners, porters or maintenance people.
4.3.6 Workers' perception of their knowledge

Interviewees were asked if they felt they had enough knowledge to protect themselves from infection at the hospital. The responses are detailed in the table below.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number Interviewed</th>
<th>Adequate Knowledge</th>
<th>Inadequate Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>5 (100%)</td>
<td>5 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>13 (100%)</td>
<td>9 (69%)</td>
<td>4 (31%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>6 (100%)</td>
<td>2 (33%)</td>
<td>4 (67%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>6 (100%)</td>
<td>0 (0%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>30 (100%)</td>
<td>18 (53%)</td>
<td>14 (47%)</td>
</tr>
</tbody>
</table>

All doctors and 69% of professional and staff nurses feel that they have adequate knowledge about AIDS to protect themselves from infection. However, 67% of assistant nurses interviewed and all non-medical workers feel that they have inadequate knowledge about the disease and the risk it poses to them at the hospital. This again clearly illustrates the need for more detailed AIDS education and awareness programs to be offered at this hospital. Even 31% of professional and staff nurses felt that their knowledge could be improved.

4.3.7 Summation

The opportunities for lower-level hospital workers to acquire knowledge about AIDS appears to be severely limited. Doctors have knowledge about AIDS because of their specialised training. Professional and staff nurses are in an advantaged position because they have been able to attend special courses run by the hospital authorities. In addition they have been able to benefit
from these courses because they have the 'correct' educational background and scientific orientation to comprehend the content of the courses. In contrast assistant nurses, even though they have had access to courses offered, have not benefitted greatly from them because the courses are conducted in English and are often poorly timed. The most educationally disadvantaged group are the non-medical workers who appear to have been overlooked in their need for information on AIDS. This group of hospital workers have not been afforded an opportunity to attend AIDS education courses in order to acquire insights into how they are at risk of infection and the manner in which they could protect themselves from the virus.

4.4 THE DISSEMINATION OF KNOWLEDGE CONCERNING AIDS WITHIN THE HOSPITAL

It has been shown that the doctors, interns and professional and staff nurses in the hospital understand AIDS and are aware of the dangers it poses. It has also been shown that most assistant nurses and non-medical workers do not have sufficient knowledge and understanding of the virus and the threat it poses to them in the workplace. One could therefore assume that there is non-dissemination of knowledge concerning AIDS within the hospital. However, it was imperative that this assumption be proven.

4.4.1 Does non-dissemination of knowledge concerning AIDS occur within the hospital?

In order to answer this question, two specific questions were placed in the interview schedule. Firstly, doctors, interns, professional and staff nurses who represent the scientifically trained, professional health workers with expert knowledge about AIDS, were asked if they had ever passed on medical information or advice about AIDS and possible modes of occupational infection to other workers in the hospital.
The doctors and interns, admitted that besides the odd word of advice here and there, they rarely passed on any information of this kind to less educated workers. The information they gave was random and did not constitute an organised body of information. Two out of the six doctors and interns blamed their heavy work load as the reason for this omission, while the remaining four blamed long working hours and stressful circumstances for this situation.

The professional and the staff nurses also expressed concern about the lack of knowledge concerning AIDS amongst the non-medical workers. However, these nurses, although they stated that they were concerned, did very little to rectify the situation. From observations made by the researcher, professional nurses did not seem concerned. They often threw bloodied material on the floor and expected assistant nurses and cleaners to pick them up. These nurses felt that they did in fact pass on information about AIDS to other workers. As a professional nurse explained:

I have often seen the cleaners in our ward cleaning up after an abortion and there is a lot of blood. But often they [the cleaners] forget to put on their gloves. Then I always tell them to stop what they are doing to go put on a pair of gloves.

These nurses believe such communication is sufficient and constitutes the education of these workers. However, they do not realise that they are not providing sufficient in-depth information about AIDS, but are rather conveying instructions with no explanation for the action. The non-medical workers therefore do not see the importance or the relevance of this action and quickly forget what they have been told. They are also unable to apply the instructions flexibly to new situations (see quotation below).

A second question was put to the assistant nurses, cleaners and porters. They were asked if they had ever received medical information or advice about AIDS and the possibility of occupational infection whilst on duty from the doctors and professional and staff nurses.
Seven of the eight assistant nurses interviewed, as well as both porters, the messenger and the general maintenance person, asserted that they had never received any information about AIDS from any person in the hospital. Two out of the five cleaners interviewed stated that they had been given certain information about AIDS by the nurses in their wards. One of these cleaners stated that:

Yes, the nurse in the ward has told me to wear my gloves when I clean the blood in the ward and in the sluice room. She also tells me to be careful of the sick ones with the AIDS when I clean the blood near them. So I try to be careful with the blood but I am not sure why I must do this.

A response such as this indicates that these instructions which are given without explanation are not well understood by the cleaners, even though they may be obeyed. They do not provide workers with a meaningful body of information that can be practically applied and as such do not constitute the 'dissemination of knowledge'; they are rather examples of orders issued downward from those in superior positions in the division of labour to those in subordinate positions.

Cleaners and porters reported that AIDS is often discussed amongst themselves. In this manner erroneous information is often spread causing confusion and speculation about the virus. Nonetheless, the fact that AIDS is discussed indicates their concern about the virus and their efforts (inadequate though they may be) to help themselves avoid infection.

4.4.2 Summation

These responses confirmed that there is little dissemination of AIDS knowledge within the hospital between scientifically trained, professional health workers and less knowledgeable and scientifically uneducated, non-professional workers. The researcher, in asking these questions, was given the impression that not much thought had previously been directed to this issue.
A definite stratification of knowledge about AIDS exists within the hospital. The hierarchy within the hospital operates negatively not only to exclude non-medical workers from certain privileges, but also to impede their access to gaining information about AIDS. Hospital management has not instituted specific courses or programs to educate non-medical workers nor ensured that protocols are distributed to and understood by all members of its workforce. Programs run at the hospital appear to be the province of the medically elite who run their own educational lectures and who have failed to share or impart this knowledge to their fellow workers.

The more highly qualified personnel such as doctors and professional and staff nurses do appear to have adequate scientific knowledge about AIDS and its transmission, but this knowledge has generally been obtained by virtue of their specialised scientific training, rather than having been acquired through occasional lectures run at the hospital. To complete the irony, this hospital runs an AIDS outreach program designed amongst other things, to educate the public about AIDS. Although this outreach program renders an invaluable and indispensable service to the public, the hospital does not educate a large proportion of its own employees about the danger of AIDS infection which they face at work on a daily basis. The Hospital has in fact 'reached out' before it has 'reached within'.

It was felt that aside from the obvious consideration of educational and language barriers that exist in helping non-professional people gain insights into AIDS, other factors have been operative in side-lining some workers from gaining access to information. The failure to disseminate knowledge may have been an act of omission – an issue not thought of in the busy day-to-day activities of the hospital, or may have been due to other, more subtle factors that operate to prevent the dissemination of knowledge about AIDS. An enquiry into these factors deemed to be sociological in nature forms the basis for the second phase of this study.
In the first phase of the study it was shown that a definite social hierarchy of workers exists in a hospital setting and that there is little or no exchange of critical health and safety information between hospital workers from the educated to the uneducated, though both face the same occupational danger. This assertion was advanced by the discovery of a situation within the hospital, where a group of scientifically trained professional health workers with expert knowledge about AIDS, work alongside less knowledgeable and scientifically uneducated non-professional members of the staff, who remain ignorant about the virus and how it could infect them. Lower level workers were found to have little knowledge about AIDS and there appears to be little attempt made to educate them about the virus.

The second phase of the study therefore has sought to determine which sociological factors operate to create stratiation and closure which may work to exclude certain members of the workforce from obtaining information about AIDS. The blocking of the dissemination of knowledge about AIDS is hypothesised to be partly attributable to those factors in society which dominate human behaviour and act forcibly on individuals to perpetuate social standing even when a life-threatening situation that is common to all workers arises.

In instituting the second phase of this research project, it became necessary to examine how each worker arrived at their present social status on the hierarchical scale. In other words, which sociological phenomena have contributed towards bringing them to where they stand today. This touches on factors of class, social privilege and educational advantage or disadvantage.
The stratification of hospital workers will be considered in terms of:

a) class stratification reflecting differences due to race and ethnic divisions, socio-economic background, educational opportunities and the effect of credentialism.

b) status considerations as they are reflected in differing working conditions, job descriptions, elitism and the desire for social mobility.

An attempt will be made to explain how stratification affects the dissemination of knowledge throughout the hospital workforce and to consider who should bear responsibility for AIDS education.

4.6 CLASS DIVISIONS

4.6.1 Class divisions due to racial factors in hospital workers

Complex racial and status divisions exist between the three categories of workers. The hierarchical structure appears to reflect the privileges which some members of society are afforded and others denied. In South Africa during the apartheid era, race afforded a person privilege and privilege was generally the province of the white population group. It is therefore not surprising to find that the upper hierarchical level in the hospital consisting of doctors and interns, is almost exclusively white and the subsequent levels of the hierarchical pyramid are occupied by less-privileged black workers.

Doctors and interns belong to an educated elite category of worker. It is their considerable educational and scientific knowledge which places them at the pinnacle of the hospital hierarchy, affording them greater status and financial reward compared to that of the lesser educated and less scientifically knowledgable hospital worker. The remaining hospital workers, namely the professional, staff and assistant nurses, and the non-medical workers have had very little educational and social opportunity.
Although racial differences have been responsible for creating stratification within the hospital workforce, an evaluation of the information retrieved during this study tends to indicate that racial factors per se have little to do with the non-dissemination of knowledge about AIDS amongst the workers. The non-dissemination of information from doctors to other hospital workers does appear to be an issue of status with racial differences exacerbating the situation. The assertion that race discrimination is to blame for non-dissemination may be discredited when one observes the failure of black professional and staff nurses to inform black assistant nurses, cleaners and porters about the dangers they face in the handling of infected blood and infectious patients. Racial divides are not always the dominant factors that distinguish levels in the hospital hierarchy.

4.6.2 Socio-economic background as a cause of stratification in hospital workers

The socio-economic background of workers was probed to investigate whether workers did indeed come from different positions in the class structures. To this end hospital workers were asked about the occupation in which their parents had worked to assess the life opportunities and privileges or lack of privilege each worker had had. Life opportunities and privileges are often determined by the social class from which one has emerged.

All of the doctors and interns (except one), had at least one parent who was a professional. Their parent/parents were doctors, dentists, lawyers, managers and accountants. Many of the mothers of the doctors were themselves university graduates. One was a practising physiotherapist and another was an occupational therapist. It was also interesting to note that all the doctors and interns had an immediate family member or relative who is or was a doctor which indicated clear evidence of intergenerational class conditioning.

In respect of the other members of the hospital staff, none had parents who were professionals, with one exception – a professional nurse whose father was a lawyer. Most mothers of professional, staff and assistant nurses and non-medical workers were domestic workers, whilst fathers' occupations included gardeners, miners, farm labourers and machinists.
4.6.3 Educational opportunity as a cause of stratification

As education, qualification and the holding of credentials are important in defining different categories of workers, most particularly in a hospital setting, it was necessary to probe workers' access to education and the qualitative differences in their educational experiences. Subjects were therefore asked about the educational opportunities which had been available to them.

Hospital workers were asked which high school they had attended, how many pupils were in their class on average, whether they had taken science as a subject and which language was the medium of instruction in order to assess the quality of the education they had experienced.

All the doctors and interns had had easy access to schooling and higher education. It was established that 4 of the 6 doctors and interns had attended private high schools while the remaining 2 attended 'white' government schools— all were taught in English, their first language. The average class size was 28 pupils and they had all studied science as a matriculation subject and had furthered this scientific knowledge extensively while at medical school. The professional, staff and assistant nurses, as well as the porters, cleaners and maintenance people, all attended 'black' government (or Bantu education) schools. The average class size was approximately 55 pupils. Only 6 out of the 17 professional and staff nurses had taken science at school, while not one assistant nurse or non-medical worker had taken science at school.

The choice of occupation available to an individual is often the result of opportunities available to him. Upper class individuals usually have a wide choice whilst lower income people tend to take what is available to them. Furthermore political factors in South Africa limited the opportunities available to black South Africans (See below).

In order to ascertain the opportunities they had had, hospital workers were asked if they had always planned to do the jobs that they were performing at the hospital.
The distribution of hospital workers who had planned their occupation

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number Interviewed</th>
<th>Planned Occupation</th>
<th>Unplanned Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>6 (100%)</td>
<td>5 (83%)</td>
<td>1 (17%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>17 (100%)</td>
<td>13 (76%)</td>
<td>4 (24%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>8 (100%)</td>
<td>1 (12%)</td>
<td>7 (88%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>9 (100%)</td>
<td>0 (0%)</td>
<td>9 (100%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40 (100%)</strong></td>
<td><strong>19 (48%)</strong></td>
<td><strong>21 (52%)</strong></td>
</tr>
</tbody>
</table>

As illustrated in the table above, all of the doctors except one said that they had planned on becoming a doctor, some from as early as the first few years of high school. The one exception was a doctor who had had the intention of becoming a psychologist, but after completing one year of his Bachelor of Arts degree, decided to change to medicine.

The four professional and staff nurses who had not planned on becoming nurses, cited financial and political problems as the reasons for terminating their original occupational plans. These represent factors of circumstance. Two of the nurses wanted to become social workers, one a lawyer and the fourth was planning to be a doctor. The latter explained her story:

I had studied at MEDUNSA for 3 years doing a BSc degree and was planning to become a doctor. I then became very involved in student politics and was later expelled for political activities on campus. After all the hassles I had at university I was lost. My mother, who was a staff nurse, knew that I wanted to work in the medical field, so she suggested that I give nursing a try – so I did.

One assistant nurse had planned on becoming a professional nurse, but due to her poor schooling, this particular nurse knew that she could not achieve her ambition. She however, decided to pursue her plans to become a nurse, but as she put it, "at a low level". The other assistant nurses had not
planned a career in nursing. Four of the assistant nurses interviewed had in fact started as porters and cleaners within the hospital. They were then given the opportunity by the hospital to complete the 6 month course required to became an assistant nurse. This represents one of the few avenues open for social mobility within the hospital for less educated hospital workers.

None of the non-medical workers planned to enter their jobs. Due to their low levels of education, these hospital workers began looking randomly for jobs to earn money after finishing their schooling. These workers had no particular job in mind when looking for work as one cleaner stated:

I left school at Standard Six because my father he died. My mother she was not working so the monies [money] we have [had] went to the foods [food]. For three years I was at home looking after my brother and sisters when my mother was working in town. When my brother was old [enough] to look after my sisters I look for work also to buy the foods.

4.6.4 Credentialism as a factor in social stratification

Nowhere is the power of credentialism as a cause of stratification more evident than in a hospital setting. The total ambience of the hospital is dominated by an awareness of who is who by the qualification each holds. The holding of credentials is obvious in the manner of speech used by the possessor, the dress or uniform worn, the manner in which the person is addressed and the amount of respect afforded each person. Credentialism divides specialist surgeons from registrars and interns, professional nurses from staff nurses, staff nurses from assistant nurses and nurses from porters and cleaners from maintenance men.

The theoretical position which indicates that doctors and certain nurses have "power knowledge" and a claim to superior status which results in social closure in regard to their subordinates appears to be a factor that operates in causing social division within the hospital. Doctors, professional and staff nurses occasionally candidly indicated that they were the elite amongst the workers in the hospital. Their self-perception was demonstrated both verbally as well as through interaction with less-educated hospital workers.
Superior attitudes affect communication on an intergroup level (from upward downwards) in a marked way and it was noticed that most communication occurs in the form of commands which are curt and to the point. Doctors give professional and staff nurses commands, professional and staff nurses give assistant nurses commands, and assistant nurses give non-medical workers commands.

4.6.5 Cultural divisions and language usage

Stratification could to some extent be assessed in terms of the fluency and excellence with which hospital workers were able to communicate in English. Competence in English usage had much to do with the medium of instruction used at schools. Through questioning it was established that seven different languages were spoken by hospital workers. All white hospital workers had received their education through the medium of English.

Black hospital workers had received instruction in seven different languages, these not necessarily reflecting their home language. Only 3 out of 17 professional and staff nurses, 2 out of 8 assistant nurses and 3 out of 9 non-medical workers reported being taught in their home language. The majority stated that they were taught in Afrikaans, a language which was not familiar to them. This has affected their ability to both comprehend and speak English well.

4.7 STATUS AS A DETERMINANT OF STRATIFICATION

The status situation of workers at the hospital is an important consideration from the viewpoint of how it affects communication between workers. Related to credentialism are status situations which are easily observable in the hospital.

Status conditions within the hospital are defined by the nature of work performed, the length of working hours, remuneration and the amount of responsibility borne by the worker. Those of higher status are well respected and have 'cleaner' jobs and those of low status do the 'dirty work' and are
afforded little respect. Status divisions are rigidly controlled by individuals themselves who define jobs as being for them or beneath them. Utterances of elitism and superiority are the order of the day. Examples of feelings of status and superiority were expressed during interviews.

Half-way through an interview a doctor abruptly asserted:

Really, how long is this whole thing [the interview] going to take? I really don't have the time. Why don't you rather go bother someone who's got nothing to do. Go talk to the cleaners, I always see them on the grass outside - I'm sure they have plenty of time for this.

On another occasion a professional nurse was seen changing a patient's dressings in a hospital ward. She had earlier called a cleaner to dispose of the old bandages, but instead of handing the used bandages directly to the cleaner who was standing alongside her, the nurse insisted on throwing them onto the floor repeatedly which necessitated that the cleaner get down on her hands and knees to pick them up.

A similar situation occurred when a doctor was seen walking through a hospital corridor in which a patient had been left in a wheelchair in the middle of that corridor. Instead of pushing the wheelchair aside himself, the doctor shouted out, 'I want this man moved immediately! Who is responsible for leaving him here?'

It was significant to observe that assistant nurses, by virtue of their 'status position', were also abusive towards porters and cleaners. Even though the 6 month training course was the only additional education they had received compared to non-medical workers, it was enough to 'elevate' them. One assistant nurse was overheard instructing a cleaner:

I don't care if it's not your job. Get me another bedpan - can't you see I'm busy with my patients?
4.8 SOCIAL MOBILITY

Hospital workers were asked if they would change their occupation if they could, and the reasons for their decision.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number Interviewed</th>
<th>Would Change Occupation</th>
<th>Would Not Change Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>6 (100%)</td>
<td>0 (0%)</td>
<td>6 (100%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>17 (100%)</td>
<td>2 (12%)</td>
<td>15 (88%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>8 (100%)</td>
<td>2 (25%)</td>
<td>6 (75%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>9 (100%)</td>
<td>7 (78%)</td>
<td>2 (22%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40 (100%)</td>
<td>11 (28%)</td>
<td>29 (72%)</td>
</tr>
</tbody>
</table>

As the table above illustrates, all the doctors and interns stated that they would not want to change their occupation. The response of a doctor epitomised the general response of the doctors and interns and it is important to note the dual emphasis on the related class and status benefits perceived as flowing from this occupational position. He replied:

I have always wanted to be a doctor. The opportunity was offered to me so I took it. I have also always been aware of the advantages and disadvantages that accompany the profession, but I think the upsides outweigh the downsides. I know that the hours are long but my family lives very comfortably and as MD, I am a well respected in my community.

Only 2 staff nurses out of the 17 professional and staff nurses expressed their wish to change their occupation. The two nurses cited long working hours and bad pay as the reasons for wanting to change occupations. The remaining professional and staff nurses all agreed that the job was badly paid and the working hours were long. However these nurses expressed both pride
and contentment in achieving the positions that they had obtained. A professional nurse announced enthusiastically:

I would never change my job. I worked very hard to get here. My family was very poor and I had to get a part time job at a clothing shop to keep myself at school and at [nursing] college. I also had to work very hard at school to get into college because my teachers were terrible — I don’t think they knew what they were teaching.

A staff nurse stated:

I work very hard here in the hospital for very little amounts of money. But I am happy here because I know where I am now and where I have come from before. I know many people who were at school who don’t even have a job at all.

It was very significant to note that the two assistant nurses who wanted to change their occupations had never worked as porters and cleaners as they had taken the 6 month training course before entering the hospital environment. These assistant nurses insisted that they were frustrated as they could not perform the medical duties that staff and professional nurses performed and were sick of doing "the dirty work". However the 6 assistant nurses who had taken the 6 month training course after spending some time working in the hospital as porters and cleaners were content in their jobs and did not express the desire to leave. This was clearly stated by one of them:

I never thought I would be a nurse. I was a porter, but then I did this course where I learned a lot and now I can work closely with the other nurses and the patients in the wards instead of just pushing them [the patients] around — and I get more pay.
Seven out of the nine non-medical workers expressed their desire to change occupations. All seven stated that they wanted a job in which they would receive more money and would do 'different' work. Three out of the seven who wanted to change occupations wanted to become assistant nurses. A cleaner explained:

A friend of mine who worked with me is now a [assistant] nurse. She went to learn more about sick people and now she does not have to sweep and clean. I also want to do this learning and become a nurse.

Parents' aspirations for their children may be regarded as an indication of the desire for social mobility. Often their unfulfilled aspirations are manifested in their ambitions for their children. It was therefore decided to ask hospital workers whether they would like their children to enter into the occupation that they were working in, and if not, they were asked to name an occupation they would like them to enter.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number Interviewed</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>6 (100%)</td>
<td>6 (100%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>17 (100%)</td>
<td>6 (35%)</td>
<td>11 (65%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>8 (100%)</td>
<td>2 (25%)</td>
<td>6 (75%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>9 (100%)</td>
<td>2 (22%)</td>
<td>7 (78%)</td>
</tr>
</tbody>
</table>

| Total                       | 40 (100%)          | 16 (40%) | 24 (60%) |

Although four out of the six doctors worried about the stress and strain involved in being a doctor, all of the doctors declared that they would prefer and would even encourage their children to become doctors. They generally believed that it is a profession that requires hard work and dedication, but
felt that it is well respected. Other occupations mentioned by the doctors that
they wished their children to enter into were law, dentistry and commerce —
all professions of high status and an indication of a wish to keep one's status,
thereby furthering intragenerational mobility.

The large majority of professional, staff and assistant nurses did not want
their children to become nurses. Reasons stated were that the pay was poor,
the working hours long and irregular. Professional and staff nurses generally
stated that they could give their children better educational opportunities and
financial support than they had been given and believed that they could go
on to be more highly qualified, respected and better-paid than they are.

This was the response of one of the professional nurses:

No, no, no....never! Not for a second....no! I would never let my children
go into nursing. It is a very tough job with very long hours and very
little pay. The thing is also that the public do not appreciate what
nurses are doing and in fact what they can do and how well they are
trained. I mean I got a matric and spent four years at [nursing]
college. My daughters are attending a very good school and my husband
and I earn enough to pay their fees and to put food on the table. They
have very little to worry about and can concentrate on their studies.
I will not tell them what they must become, but I expect them to use
this opportunity I never had.

It is significant to note that when assistant nurses were asked what they
wanted their children to become, the most frequent answer given was a
doctor. An assistant nurse stated that:

A doctor — I would want him to be a doctor. A doctor is an important
person not like a nurse. A doctor also is very clever and knows all
about the body and how to make it well. I want my son to be clever
and an important somebody, so I would be very proud of him if he was
a doctor. A nurse is not a somebody like a doctor.
These responses tend to support the concept of intergenerational mobility. Assistant nurses appear to be acutely aware of their status situation and express a wish for upward mobility. They have a great desire to rise above their present station in life. The non-medical workers, like the nurses in the hospital, did not want their children to be doing their jobs. The general feeling of the non-medical workers was summed up by a cleaner who maintained that:

I just want my children to be educated, not like me. They must stay in school to matric and go further than I did because I left school early. I am not educated to do better work. My children must do better.

The non-medical workers did not choose specific professions or jobs which they wanted their children to do, but only wanted them to do something that was ‘better’ than that which they were doing at the hospital. It would seem that non-medical workers surprisingly accept their station in life and do not question the system whereby people were stratified. Although severely disadvantaged they appear to be content to compete within their status stratification but see no opportunity of rising above it. None of the workers said that they wished their children to be doctors and were merely content with the concept of "something better than I am".

4.8.1 Social mobility, communication and the dissemination of knowledge

The desire for social mobility does not block communication per se, but imprints upon an individual a feeling about themselves. It implies dissatisfaction with a present status which may generate feelings of inferiority. This may result in an attitude of not asking about something you do not understand out of a fear of being thought of as ignorant. On the other hand the desire for social mobility may be the driving force which steers the individual towards a more questioning attitude and a grasping for better understanding.
Observations in the hospital confirmed both these attitudes. It was noted that lower-level workers including assistant nurses, seldom asked for advice or information and tended to adopt a subservient, unquestioning attitude in the presence of those above them in the hierarchical structure. In contrast, professional and staff nurses asked questions and expressed a positive desire to further their understanding of AIDS.

4.8.2 Social contact and social closure between hospital workers

The lack of communication between worker groups in the hospital appears to be caused by a 'professional ethos' and feelings of elitism amongst the high-educated workers and is exacerbated by the lack of social contact between different levels of hospital worker inside as well as outside the hospital setting.

Social patterns within the hospital are most apparent during tea breaks. The physical design and layout of the hospital does not facilitate the interaction between hospital workers. Doctors and nurses each have their own separate tearooms. In many instances these tea rooms are situated next door to each other, but there is no thought amongst the doctors or the nurses to sit together in one room. When asked why the doctors and the nurses do not spend their tea breaks together, though they work side by side, a senior professional nurse replied that:

I believe that it is a racial issue; black and white. All of the doctors that work in this ward are white. I remember we had a black doctor here [at the hospital] last year and he was the only doctor who would come and have tea with us at all.

When a doctor was asked why the doctors and the nurses do not share the same tearoom, he replied:

We [the doctors] and the nurse have one thing in common – we both work in the same environment. Beside this, we have nothing in common. We live totally different lives...worlds apart.
The communication between the doctors and the professional and staff nurses within the hospital is therefore limited to periods of work. Communication between the professional nurse and the staff nurses is constant. This appears to be due to the fact that they shared the same type of training at nursing college and both are involved in actual medical care of patients, as opposed to assistant nurses who are not involved in actual medical procedures. Professional and staff nurses form a close-knit sub group and talk to each other constantly, frequently about the patients in their care.

The assistant nurses are part of the nursing body, but stand apart as they do not have the medical training to initiate treatment or carry out complicated procedures. It was observed that there is little communication between the other nurses and the assistant nurses. Assistant nurses tend to be socially side-lined.

The porters spend their breaks in the porters' lounge. This lounge, which is situated near the casualty unit, is where porters assemble every morning and await instructions on where their services will be needed in the hospital. The fact that the porters have a central assembly point where they can meet and socialise has created a strong cohesion between them.

The same cannot be said of the cleaners, who lack any formal meeting place and are forced to spend their breaks either on hospital balconies, in the hospital gardens or on the pavement outside the hospital. A sense of homogeneity between the cleaners is lacking, because cleaners are assigned to different wards and lack a common meeting place. A staff nurse was asked why the nurses did not invite the cleaners to sit with them in the nurses' tea-room:

I know that they don't have a tea-room like us but we [the nurses] discuss important matters during our tea breaks. We discuss our patients and their problems together and this has nothing to do with these cleaners - they won't even understand this talk anyway.
Social contact outside of the hospital was also explored. Doctors tended to socialise with the other doctors or professional people outside the hospital setting. Doctors tended to meet other doctors for meals either at restaurants or at their homes. Doctors also participate in different types of physical exercise together such as squash and gym as a means of socialising.

Further evidence of social cohesion between professional and staff nurses at the hospital is to be found in two specific ‘clubs’ which have been formed. Nurses join by paying a monthly subscription fee. These are the ‘grocery club’ and the ‘funeral club’. Both these ‘clubs’ play a definite role in forming a bond between the nurses at the hospital and also act as an exclusionary measure. Eligibility for membership of these clubs is confined to the credential you hold, and if you do not hold the correct qualification you are excluded. Club membership becomes an obvious example of social closure and is a further measure aimed at preserving status.

Patterns of socialisation between nurses and non-medical staff indicate that there is little contact between these groups. It would appear that the inferred status of nurses precludes participation in social contact with non-medical staff and is further evidence of social closure.

The only formalised and organised contact between doctors and nurses occurs once a month on Wednesdays when certain highly placed professional nurses meet with doctors to have a ‘grand round’. Professional nurses and doctors visit selected hospital wards and certain interesting or unusual cases are discussed. The doctors and professional nurses then have tea together. The selection of who may meet with the doctors becomes a matter of status and places certain nurses within a privileged spectrum. It represents promotion out of designated status positions and is greatly sought after and strived towards. It is within this monthly forum that complaints and grievances are addressed, representing the only opportunity for regular meaningful communication between doctors and nurses.
4.9 STRATIFICATION AND UNIONISATION

It could be assumed that when a common interest exists between members of a workforce, such as that posed by the threat of AIDS, a form of group cohesion which could cut across ethnic, class and status barriers may come into existence. As trade unions purport to represent workers' interests, membership of trade unions may be used as an indicator in assessing whether there is a commonality of purpose amongst hospital workers.

Generally, membership of trade unions may be a valuable indicator of social cohesion in a work situation. The pattern of unionisation at the hospital however gives further impetus to the concept of elitism. It was discovered that the National Education, Health and Allied Workers' Union (NEHAWU) was the only trade union represented at the hospital. A senior shop steward for NEHAWU at the hospital was interviewed and it was established from him that approximately 65% of the non-medical workers are paying members of NEHAWU. However less than 4% of all nurses and doctors at the hospital belong to this union, and this 4% is made up mostly of assistant nurses.

The reason why 'medical professionals' were so poorly represented within the union was aptly cited by the Nursing Services Manager in charge of surgical and special departments:

The shop stewards in NEHAWU are not professional people. That is why we as nurses find it difficult to communicate with non-professional people. I mean they have no clue of what our profession entails.

This again substantiates the point that there is a well-defined distinction between 'professional' and 'non-professional' workers at the hospital and highlights the fact that non-medical personnel are not regarded as co-workers facing a common health risk. The "elite" do not identify with ordinary workers and perceive no need for the organised representation provided by trade union membership. For the most part their specialised skills ensure their jobs, unlike the workers who enjoy little employment security.
In a highly bureaucratic structure, unionisation enables lower level workers to have a "voice" and a channel through which to state their grievances. In the health industry industrial action is one of the only ways to penetrate the "veil of professional power" which by its nature, devalues blue-collar workers more so than occurs in other industries where managers are less imbued with ideologies of superiority such as that which is encouraged by medical education.

Hospital workers cannot be regarded as a cohesive body of workers and do not operate as an integrated entity. The fact that they face a common health hazard does not in any way bind them as a group. This differentiation is expressed not only in the job description, but also in the manner in which they address the problems which face them in the work situation.

Patterns of membership of the trade union appear to clarify the manner in which different classes of people seek advancement and betterment of working conditions. Professional people take responsibility for their position whilst non-professionals, who are generally represented in the lower classes of society, prefer to deputise responsibility for their welfare to unions. This designation of responsibility appears to highlight another avenue of stratification between Hospital workers.

4.9.1 Summation

Class divisions exist between hospital workers. These class divisions have been occasioned by the differences in socio-economic backgrounds of individuals and the educational opportunities that have been available to them. Class stratifications put workers 'worlds apart'. Workers from the upper and lowest ends of the stratification have very little in common. They do not even speak the same language. This makes communication between workers extremely difficult.
Credentialism is a potent source of social closure and much of the lack of communication can be attributed to the fact that groups who hold themselves aloof and as a self-contained entity fail to look beyond their own interests. They find it difficult to identify with the needs of lower status groups. Credentialism imbues them with a sense of superiority and a need to exclude others from their social functions.

The holding of status in the hospital hierarchy is another exclusionary force which tends to diminish social and communicative contact between workers. The desire for upward social mobility focuses attention on where they would like to go and precludes workers from giving consideration to where they have come from. Those people in groups which have been designated as higher status groups do not concern themselves with the needs of lower level workers. This impedes communication.

Trade union affiliation is as yet another indicator of status and a cause of stratification. White collar workers do not identify with trade unions and see membership as an indicator of a lower status level. This has much to do with the fact that white collar workers prefer to represent themselves whereas blue collar workers need an authoritative body to intervene on their behalf.

4.10 OTHER FINDINGS WHICH MAY INFLUENCE THE STRUCTURING OF AN AIDS INFORMATION BASE FOR HOSPITAL WORKERS

Workers were canvassed for their opinion as to who should be involved in structuring AIDS education programs in order to assess whose authority would be acceptable in providing this information. Two questions were asked. Firstly, whose responsibility is AIDS education in a hospital setting? Secondly, would hospital workers more readily accept a body of knowledge about AIDS from traditional healers or medical doctors? The potential for hospital workers to act as AIDS educators to the public was also investigated. This was accomplished by asking hospital workers whether they had ever been asked about AIDS by friends, family or strangers.
4.10.1 Whose responsibility is AIDS education?

Doctors felt that it was not their responsibility to educate less knowledgeable hospital workers about AIDS as a possible health risk. Even though they did realise that they are the most educated hospital workers, they felt that they did not have the time to spend educating workers about AIDS. One particular doctor had very strong views on the matter:

It is definitely not my responsibility to educate these hospital workers about AIDS. To tell you the truth, I don't have the time to stop and explain to every assistant nurse, porter and cleaner in the hospital about the dangers of the virus. I am paid to heal the sick and not to educate the uneducated.

None of the doctors questioned felt that education was their responsibility. Certain doctors felt that it was not fair to burden the medical staff at the hospital any further, and that it was the administration's responsibility to employ outside help to educate the hospital workforce about the virus. Other doctors passed the responsibility to professional and staff nurses:

The doctors and interns here are much too busy to be involved in this type of exercise. When one thinks about it logically it is the professional and staff nurses who should be teaching these workers. They know all about the dangers of AIDS and there are so many more of them then there are of us - surely there has to be a few of them available to do the job.

Professional and staff nurses have frequent and direct contact with assistant nurses, cleaners and porters during the course of a working day. The professional and staff nurses, although understanding a need for educating the less educated about AIDS in the hospital, did feel that they were also heavily burdened with patients and suggested that the administration give certain nurses time off to educate the workers. They also suggested that outside educators should be brought in to help.
The assistant nurses, porters and cleaners, all believed that it was the hospital administration's, the doctors' and professional nurses' responsibility to educate them, as it was these people who they believed possessed both the authority and the knowledge to enlighten them about the virus.

4.10.2 Is there a role to be played by 'traditional medicine' in AIDS education programs?

A question regarding the bonding to traditional beliefs was asked to assess the degree to which hospital workers have adopted a trust and belief in medical science. This is seen as a possible indicator of cultural diversity.

Cultural diversity often dictates a matter of faith in who does the educating and whom you believe. It would be assumed that certain workers would have strong traditional bonds and would favour an orientation to AIDS education bound to traditional healing methods. However in this study it was revealed that each and every worker felt solutions were to be found not by 'sangomas', but by the scientific discipline which they have seen practised in the hospital. They placed their faith in the work of the knowledgeable doctors.

For their part, every doctor, without exception, was strongly opposed to the use of traditional healing in the fight against AIDS. They all expressed faith in the scientifically based medicine they practised. One doctor in particular was extremely critical of the 'sangomas'. He felt that certain of the rituals and practices of the sangomas which involved the piercing of the skin were dangerous and could in fact lead to the transmission of the virus.

The sentiments regarding the sangoma and traditional healing amongst the professional and staff nurses were varied. Certain nurses believed that it was important to respect other people's culture and that they must be given an opportunity to do what they wish.
This belief was aptly presented by a professional nurse:

I believe that AIDS has been around as long as the earth has been in existence. I therefore believe that the traditional healer has a part to play in treating AIDS patients. Look, it would be very difficult to tell a person not to go to a sangoma when his cultural beliefs instructed him to visit a sangoma when he is sick. However, I must say that I believe that traditional healing used to work years ago when the traditional healers were true traditional healers. Today every second person puts on a headdress and a string of beads and says he is a sangoma, but their are still a few genuine sangomas who I would trust.

Others stated that they would not allow a patient to go to a sangoma. This was the view of a staff nurses who insisted that:

If a person wanted to go [to a sangoma] I would stop them. I know of two people who have AIDS and they went to the sangoma who said that he could cure them of the AIDS. They came back to the hospital a month after visiting the sangoma and both were very sick.

Only 2 out of the 8 assistant nurse felt that a sangoma should be consulted when one has AIDS. However 7 out of the 9 non-medical worker felt that it was neither worthwhile nor acceptable to treat AIDS, or any other illness for that matter, by a visit to a traditional healer. It was interesting to note that the most recurrent reason cited for this disbelief in the healing powers of traditional medicine was a devotion to the church and a belief in God, and not an absolute and undisputed faith in the ability of scientific medicine.

4.10.3 Hospital workers as AIDS educators within the community

The introduction of an effective AIDS education program for hospital workers becomes more imperative when it is understood that many hospital workers are already acting as AIDS 'educators' outside the hospital. By virtue of the fact that they work in a hospital, people in general imbue them with an aura of authority about medical matters and they are often asked about AIDS. Working in a hospital is seen as a job of high status by the general community.
Hospital workers were asked if they had ever been asked by friends, family or strangers about AIDS.

Have you ever been asked by friends, family or strangers about AIDS?

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number Interviewed</th>
<th>More Than Once</th>
<th>Once</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors/Interns</td>
<td>6 (100%)</td>
<td>5 (83%)</td>
<td>1 (17%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Professional &amp; Staff Nurses</td>
<td>17 (100%)</td>
<td>13 (76%)</td>
<td>2 (12%)</td>
<td>2 (12%)</td>
</tr>
<tr>
<td>Assistant Nurses</td>
<td>8 (100%)</td>
<td>6 (74%)</td>
<td>1 (13%)</td>
<td>1 (13%)</td>
</tr>
<tr>
<td>Non-medical Workers</td>
<td>9 (100%)</td>
<td>7 (78%)</td>
<td>0 (0%)</td>
<td>2 (22%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40 (100%)</td>
<td>31 (78%)</td>
<td>4 (10%)</td>
<td>5 (12%)</td>
</tr>
</tbody>
</table>

The responses revealed that 88% of hospital workers have been approached at least once either by strangers, family or friends about AIDS. It is interesting to note that hospital workers tended to disseminate knowledge about AIDS to people of similar class, status and racial groupings as their own. Doctors and interns reported giving information about AIDS to professional people of high social standing within the community. The information required from doctors and interns seldom concerned how one becomes infected by AIDS, but rather involved questions about the extent of the disease. For example a doctor said:

They just want to know how bad it is. They want to know how many HIV positive patients I am treating in the hospital and how quickly the virus is spreading. Remember that these people are not stupid, they know how they can get infected [with AIDS]. They just want to know the chances of them getting it if they are not careful.
A large proportion of professional and staff nurses reported being approached by strangers about AIDS. As in the case of the doctors and interns, these nurses reported only being approached by black people. Because these particular hospital workers are well-educated and knowledgeable about AIDS, they play a critical and fundamental role as AIDS educators to those members of the public who are uninformed about the subject. A staff nurse reported a humorous situation when she was approached by a stranger on the street:

I have often been stopped wherever I go and asked questions about AIDS because I am wearing my uniform. Once a tsotsi called out to me from across the street in town at the top of his voice, 'nurse I love you'. He then ran across the road towards me. I was very scared and embarrassed. I then asked him why he said this because I was a stranger to him. He then said that he wanted to be AIDS free. I then realised that this tsotsi believed that if you are in love with a nurse you will not get AIDS because he thought nurses don’t get AIDS. I then quickly explained the basic facts to him about it.

A substantial number of non-medical workers have also been approached about AIDS, including 83% of assistant nurses and 78% of non-medical staff. As indicated previously, hospital workers have very little understanding and knowledge of AIDS. In fact the majority of these hospital workers bear inaccurate information, as they have not received formal instruction. The information they gave others is of highly dubious value.

When asked why they thought people in general had approached them for information about the virus, the assistant nurses and non-medical workers believed that it is because they work in a hospital and they are assumed by the general public to know about the virus. This was clearly expressed by a cleaner:

Every day after work I go home on the taxi to Alex [Alexandra Township]. I am always wearing my hospital I.D. badge from work, so many times the people on the taxi ask me about sicknesses, but more times about the AIDS. They ask me very hard questions and I try to answer. I tell them what I hear in the hospital.
4.10.4 Summation

The implication of these findings supports the view that the potential for hospital workers to act as AIDS educators to the public exists and strengthens the argument for providing these workers with detailed and correct information about the virus. Doctors and nurses have the correct information but may need to acquire skills in communicating the information satisfactorily to the general public. Unskilled workers do not have the required information nor the techniques to act as educators at the present time.

The findings also reveal that in general workers would be amenable to an AIDS education program based on accepted scientific medical practice. They believe that the hospital administration should initiate such a program and derive their information base from professional workers already employed at the hospital. Doctors and professional nurses did not feel that it was their responsibility to educate workers, citing work and time pressure as the reason for their non-involvement.

4.11 CONCLUSION

Hospital workers are divided by factors of professional status, educational elitism, a lack of feeling of group cohesion and group identity and a lack of common social experience. They are socially, racially, educationally and economically divided. Those professionals who occupy the upper stratum of the hospital work hierarchy tend to be satisfied with their station in the workplace, whilst every other worker strives to improve their lot looking up towards professionalism as an ideal goal to be attained. Middle strata groups, such as the professional, staff and assistant nurses, tend to exclude other lower-level workers in an attempt to cement their identity and status. The physical facilities offered by the hospital reinforce social divisions. Within such a framework it is not difficult to understand why there is a lack of communication between the groups of people involved.
In regard to the communication of knowledge about AIDS in particular, each group is not able to identify with the needs of other groups and in general feel that it is not their responsibility to act as educators. They insist on a formal arrangement to initiate AIDS education. They tend to use work and time pressure as a justification for the failure to address the problem and fundamentally appear to lack the social motivation to initiate any altruistic initiative.

Doctors in assuming the ultimate responsibility for the health of their patients and being imbued with healing "powers" are placed on the highest status level. They see their role well defined as "givers of health" and not as educators. Faced with the threat of AIDS infection themselves, they feel further stressed in the work situation, and relegate responsibility for what happens to other hospital workers and to the hospital authorities.

There is comprehensive evidence of social closure in the hospital, particularly in regards to professional and staff nurses who have improved their class and social status. Most professional and staff nurses have come from low socio-economic standing and have attained their credentials under the most adverse political and economic circumstances. They have attended segregated schools under the apartheid system and made financial sacrifices to complete their education successfully. Obtaining their qualification has been a means of uplifting themselves economically. It is therefore not surprising that they tend to have formed a "closed group" within the hospital setting and a culture of exclusion both as a means of protecting their privileged status and ensuring the protection of their credentials. The information they possess concerning AIDS is but an extension of the knowledge which they have sought to obtain through conditions of adversity. They belong to a group of socially upwardly mobile individuals who attempt to emulate doctors, whom they regard as the most prestigious of groups. In focusing on upward mobility they tend to lose sight of the needs of lower class groups.
Assistant nurses represent an interesting group of hospital workers. Although assistant nurses have a low level of education compared to that of doctors, interns, professional and staff nurses - and similar educational levels to the cleaners, porters and maintenance people, they are also very reluctant to disseminate knowledge about AIDS to non-medical hospital workers. Aside from the fact that they are themselves poorly informed, the reason for this may also be related to their ambition of social mobility. Some assistant nurses were once non-medical workers who successfully completed a 6 month nurses training course which elevated them to the position of assistant nurse. These nurses therefore feel particularly threatened by non-medical workers in the hospital as their recently acquired knowledge is the only factor which separates them from the non-medical workers. Their position of elevated status has not yet been consolidated.

Cleaners, porters and maintenance people represent an underprivileged position in the class hierarchy and have little power within the hospital. Trade unions have in general failed to address the problem of AIDS education amongst the non-medical workers in the hospital, concentrating rather on uplifting workers economically. Blue collar workers remain the victims of social stratification and social closure, even in the sphere of AIDS prevention programs.

In assessing to what extent education affects disparities among social classes of people we find that instead of reducing social differences, education tends to express and reaffirm existing inequalities far more than it acts to change them. This is most evident in the case of nurses where few altruistic ideals appear to exist in their relationships with lower-level workers. One would have thought that professional, staff and assistant nurses would have shown concern for their fellow black workers. However the need for social closure appears to be important to them even to the extent that it affects communication between them and other black workers. The white collar workers' refusal to join the trade union provides further evidence that white collar workers do not experience the need to identify with lower level workers or feel at one with them in championing their causes.
In summary, the hierarchy that exists amongst hospital workers is due to class differences and the lack of communication may be attributed to differences in status accorded to different groups. It must be concluded that exclusionary practices are in part responsible for the non-dissemination of knowledge about AIDS in the hospital work setting. In addition to this, the hospital offers few channels for communication and these problems are exacerbated by the diversity of languages used by hospital workers.

The non-dissemination of AIDS information does not appear to be a deliberate strategy to endanger the lives of lower level workers but appears to be the result of general processes of exclusion and closure which inhibit effective communication between groups, including the dissemination of information about AIDS.
CHAPTER FIVE - CONCLUSION: IMPLICATION OF THIS STUDY FOR AIDS EDUCATION IN THE HOSPITAL

It must be remembered that failure to take adequate precautions to prevent AIDS infection results in increased risk of exposure to an inevitably fatal disease. The failure to educate workers about the risks they face must be regarded not as a neutral act, but as an act of negligence since in this setting, worker ignorance brings with it a greater risk of death. It was therefore crucial that this complex and distressing situation be explored and possible solutions suggested.

This thesis hoped to identify factors which have to be addressed in structuring AIDS education programs if they are to be successful. The very structure of human interaction within the workplace, in this case a hospital setting, may have to be modified to bring about the necessary communication. It is accepted that to change a whole society is a formidable task but to effect change in a micro-society such as that found in a hospital, is much more attainable and may provide insights which can be more widely applied.

Hospital workers have a pivotal role to play as AIDS educators. Representing a diversity of cultural and language backgrounds and coming from different strata of society they are placed in a unique position to act as AIDS educators should they have sufficient knowledge about the virus. The information they need to acquire will equip them to avoid accidental infection of AIDS in the workplace and will at the same time enable them to distribute information to the community at large. The fact that workers are imbued with an aura of medical professionalism by lay people places them in a position of authority within the community.

There is an urgent necessity to implement an AIDS education program at the hospital as many hospital workers are in danger of contracting AIDS simply because they do not know enough about the virus and the manner in which infection occurs. The presence of the virus in their work situation poses a real life-threatening situation.
This study has indicated that professional workers in a hospital setting including doctors and professional nurses have the knowledge to prevent themselves from becoming infected. However their conditions of work and stress-related factors make them vulnerable to accidental infection. Instances of accidental infection have to be addressed not primarily through educational programs, but by way of changing the work situation and labour practices. In particular, stress-related factors associated with long hours of work in handling trauma patients have to receive attention.

When it comes to addressing the needs of the less-educated hospital workers, educational programs become more important. Their chances of becoming infected lie in accidental contact with the virus because they do not know enough about the virus to understand that it can be transmitted by the handling of infected needles and blood. Accidental infection for them can be avoided by taking the correct approach to the work they do. The findings of this study indicate that in regard to knowledge about AIDS, the needs of lower level hospital workers are not presently being adequately addressed.

Before an AIDS education program can be put into action, it is necessary to establish who should bear the responsibility for instituting and implementing the program. Although the notion that the doctors and professional nurses within the hospital would appear to have the resources to act as AIDS educators, this study has shown that in practice this would not be a satisfactory path to follow. Doctors have clearly indicated that they do not see their role in the hospital as one of educator.

Specialist doctors, doctors, registrars and interns need to be approached not at the level of asking them to act as AIDS instructors within the hospital but to act as "educators" in their day-to-day contact with other workers. It is not expedient to ask them to run formal lectures to impart the knowledge they have as they are already under considerable strain in the execution of their daily work. However in some instances, a change of attitude is required of them which may be effected merely by bringing the plight of lower-level workers to their attention. This would provide the necessary insights to enable them to offer a word of advice here and there as they go about their duties. More formally a lessening of autocratic positioning in regard to AIDS education could be initiated in the training of doctors at medical schools, by
the organisation of lectures on AIDS as an occupational health problem highlighting its effects on all workers and the organisation of conferences around the problem. The South African Medical and Dental Council could identify AIDS education as part of the requirements for certification. Doctors should be asked to collaborate in devising any educational program instituted at the hospital as they have the expertise and are placed in a position to observe situations which place workers at risk as they go about their daily duties.

Hospital workers have formed a rigid stratification of status and class groups based upon the credentials which they possess and groupings which they value and guard. The propensity for social closure in excluding other workers from intruding into these strata has been demonstrated and the sharing of knowledge appears not to fall within the parameters of existing class and status identities. In a sense imparting knowledge would diminish the power and exclusivity of closed groups made up of 'educated' workers who consider themselves 'better' than those who perform menial tasks.

Bridging the gap between the social stratifications within the hospital remains a challenging task. In so far as social stratification is a reflection of class structures little can be done to create a more egalitarian work force within the hospital. It is not possible to sweep away class differences which are embedded in the history of each individual as well as within different occupations. Indeed these stratifications are accepted as natural by all workers regardless of their position in the hierarchy. It has been demonstrated that it is the concern about preserving class and status differences which divides workers and interferes with communication in general and the dissemination of AIDS information in particular.

In order to gain acceptance by all groups of workers within the hospital it would therefore seem that an outside authority be brought in to educate workers about AIDS. This would prevent the AIDS educator being identified with any particular group. The hospital administration should be responsible for this appointment in consultation with the trade union at the hospital.
5.1 PREREQUISITES FOR THE SUCCESSFUL IMPLEMENTATION OF AN AIDS EDUCATION PROGRAM

The first and most important requirement in ensuring the successful establishment and implementation of an education program is an uncompromising commitment from all parties involved, (the hospital administration, the trade union and hospital workers themselves) towards the program. It must be made clear to all these parties that if this education program is to be successful, everyone involved will benefit greatly.

The complete and utmost dedication of the hospital administration to AIDS education is required. In the first instance, the necessary funds for the establishment of such a program is needed. The urgency of the matter should be addressed to the Minister of Health. Furthermore, the hospital administration would be involved in employing the personnel that may be required for the education programs and in matters such as providing facilities for lectures and schedules.

Trade unions have a vital role to play in the implementation of the AIDS education program. Trade unions are viewed in a positive light by the vast majority of blue collar workers in the hospital. The trade union could in fact legitimise the education program by alerting its members to the occupational hazards they face in the hospital, and by encouraging them to attend these programs to acquire knowledge and advice on precautions and prevention. The trade union also has a vital role to play in negotiating with the administration of the hospital to allow all hospital workers the facilities necessary to educate themselves about the virus. This includes time off for training and weekly meetings in a manner sensitive to the dynamics of the shift system.

Trade unions may also insist on physical changes in the workplace. It is essential that hospital workers be provided with equipment which makes it possible for them to protect themselves from infection while at work. Sufficient quantities of good quality gloves, gowns, goggles and masks that fit workers must be supplied to enhance the safety of workers in the hospital. The specific needs of each category of worker requires investigation to determine what these needs are.
Aspects of the actual labour process as it predisposes workers to infection should also be studied. In particular, the level of stress and fatigue of workers should be reduced. This may be achieved without the loss of working hours by introducing a daily rotation procedures in which workers would work more often, but for shorter periods of time. This would eliminate the long shifts which the workers are subjected to and at the same time reduce worker stress and fatigue. Hospital workers would then have the time to work more carefully to ensure that all possible precautions are taken to avoid infection.

An examination of physical and social amenities provided at the hospital is an obvious example of how hospital workers can be brought into contact with each other so that both social exchanges and information sharing can be facilitated. A single cafeteria and/or lounge may be useful. Less emphasis should be placed on status symbols with an encouragement of status to be exhibited by way of tolerance and teaching. Attention should be directed to the training of AIDS instructors who should be designated as a status group.

The program must be self perpetuating and must take account of the necessity for accommodating new workers as they are employed at the hospital. Timetables should ensure that every worker has the opportunity to attend lectures.

5.2 THE ESTABLISHMENT OF AN AIDS TASK GROUP

It has been established in this study that AIDS is a complicated issue to comprehend and that different workers performing different jobs in the hospital have different educational, scientific and cultural backgrounds. It is therefore imperative that the AIDS education program be implemented in such way as to ensure that each category of worker is accommodated and effective education occurs.
One of the most specific outcomes of this thesis is that the hospital work force cannot be thought of as a cohesive group where the needs of different categories of worker can be addressed by the institution of one AIDS education program. Several different types of programs have to be made available and tailored to the needs of specific groups. Each group of worker is delineated by factors of differing cultural, class, status and job descriptions as well as different linguistic competencies which determine not only how much information they require, but also the manner and media through which it should be imparted.

It is therefore proposed that workers be grouped according to their occupations within the hospital and that within these broader groups, subgroups be established to ensure similarity on the variables identified above. The grouping of hospital workers of similar educational standards and levels of scientific knowledge, and who face similar occupational hazards would facilitate learning as education programs could be targeted specifically to accommodate these group factors. A further criterion for groupings would be language competence as well as their work experience. Ideally groups should not be larger than thirty members each.

If access to credentials is an avenue by which to express social mobility, it is necessary to provide credentials or special qualification certificates to workers who are trained as AIDS instructors. It is envisaged that a special "AIDS Group" be established at the hospital with members drawn from each level of the hospital work hierarchy, who have been trained to meet the requirements of each category of worker.

Those who will act as AIDS instructors should be elected by their co-workers or volunteers could be called for. Ultimately the person elected as instructor would need the respect of the group he is responsible for as he would be required both to educate his group and monitor the implementation of prophylactic measures. Both credibility and trust enhance communication.

AIDS instructors would then attend intensive training courses which would be arranged by the hospital authorities in consultation with trade union officials affiliated with the hospital. All AIDS instructors would meet regularly to report-back findings and solve problems. The AIDS task group would, through
personal contact with other workers at the hospital, have a forum to discuss problem situations caused by stratification within the work force.

The manner in which AIDS education in the hospital should be structured infers that a Sociologist should be consulted in formulating the program. Insights into the groupings of the hospital workers is required and the manner in which status and class factors may permeate the program requires the input of an impartial outside specialist. It is envisaged that the Sociologist would act as a binding force and impartial facilitator, bridging the gap between the educators and workers in the field.

5.3 FINAL NOTE

This study has attempted to answer the question as to whether the failure to educate unskilled hospital workers about AIDS in their workplace has been an act of omission due to negligence or a reflection of the values and attitudes which exist in society. The answer is to be found in a combination of all these factors. Educated hospital workers omit to attend to the needs of uneducated workers because they themselves are stressed by work pressure and are driven to protect their status and social standing. It is an act of negligence on the part of the hospital administration as well as the trade union in that they have failed to insist that workers be properly educated about the virus. These bodies ensure that protective clothing is provided and protocols written up, but make no effort to see that these protective measures are implemented appropriately.

Given the fact that the poor and oppressed are usually the recipients of discriminatory practices, indifferent attitudes and deprivation in society, it is not surprising to discover that even within a hospital where they are faced with a life threatening situation which AIDS presents, little care is expressed for their well being. Sadly the study seems to reaffirm the unhappy truth that unskilled workers not only remain exploitable, but easily dispensable. However this does not have to be the case. AIDS education programs can be utilised not as a means to overturn the existing status and class hierarchy, but to work constructively within it to provide a chance for all to survive the AIDS pandemic.
APPENDIX A - INTERVIEW SCHEDULE FOR PHASE ONE

General

1. What is your home language?

2. How would you rate your ability to read English: poor, fair, good or excellent?

3. How would you rate your ability to speak English: poor, fair, good or excellent?

4. What is the highest educational level you have reached?

5. When did you start working here at the hospital?

6. What is your job at the hospital?

7. What do you do in your job? (specific duties)

8. Do you come into contact with blood during your work?
   If yes,
   a. In what way?

9. How many hours a day do you work?

10. How many days a week do you work?

11. How do you feel about these working times?
    (How do you feel at the end of the day?)

Awareness of AIDS

12. Have you heard about AIDS?

13. Have you ever come into contact with a person suffering from AIDS?
    If yes,
    a. Was this inside or outside of the workplace?
14. How is AIDS spread?

15. Can you see if someone has AIDS?

16. How does one avoid getting AIDS?

17. Is there a difference between having HIV and AIDS?
   If yes,
   a. Can you tell me how they are different?

18. When a person contracts HIV, is it possible to immediately detect if he/she has contracted the disease?
   If no,
   a. Why is this the case?

19. Is there a cure for HIV or AIDS?

AIDS in the workplace

20. Do you feel that you could become infected with the HIV or AIDS virus in your work at the hospital?
   If yes,
   a. How would this occur?

21. Do you know of anyone who has had a needlestick injury or who thought he/she had contracted the virus while working at the Hospital during the course of her/his duties?
   If yes,
   a. What were the circumstances under which this occurred?

22. Is there a particular procedure that is followed at the hospital should a worker accidentally come into contact with infected blood?
   If yes,
   a. Could you give me details of the procedure to be followed?

23. What preventative measures does the administration of this hospital take to safeguard you against possible infection?
24. Do you feel you have adequate knowledge to protect yourself from infection at work?

25. Do you feel you have the adequate equipment to protect yourself from infection at work?

26. Have you received any AIDS education outside of the workplace?
   If yes,
   a. When was this given to you?
   b. Where was this given to you?

27. Have you ever received any AIDS education training at work?
   If yes,
   a. When was this given to you?
   b. How was the course structured? i.e. language used, talks, videos, ...
   c. What information did you learn from the course that you did not know before the education course?
   d. Did the education course help you in your work situation?

28. Have you ever passed on medical information or advice about occupational health risk to other workers in the hospital?
   If yes,
   a. Did this information relate to AIDS?
   b. Can you give details?

   If no,
   a. Why not?

29. Have you ever received information or advice about AIDS and possible methods of occupational infection from anyone at the hospital?
   If yes,
   a. What happened?
   b. How did you respond?
APPENDIX B - INTERVIEW SCHEDULE FOR PHASE TWO

General

1. What is your job at the hospital?

2. What does your job at the hospital involve? (specific duties)

3. Do you come into contact with blood or any other bodily secretion during the course of your work?
   If yes,
   a. In what way/under what circumstances?
   b. How often does this contact occur?

4. How long have you been working at the hospital?

5. What is your home/first language?
   a. Can you speak any other languages?

AIDS and the hospital

6. Do you come into contact with patients who have AIDS?

7. Have you ever received any AIDS education training at work?
   If yes,
   a. When was this given to you?
   b. What did you learn from the course?
   c. What language was the course conducted in?

8. Are you provided with any equipment to prevent AIDS infection while you are at work?
   If yes,
   a. What are you given?
   b. Is there always enough protective equipment for you?
   If no,
   a. Do you feel that you should be provided with protective equipment?
9. Do you feel that you know enough about AIDS to avoid contracting the virus at work in the hospital?
   
   If no, 
   a. Who do you believe is responsible to educate you about the virus?
   
   If yes, 
   a. Where did you acquire this information?

10. Do you feel that you could contract AIDS in the course of your work?
   
   If yes, 
   a. How would this occur? 
   b. If you think that you have infected yourself, what procedures would you follow? 
   c. Have you ever been in a position where you have felt that you may have contracted the virus? 
   d. Do you know of a hospital worker who has contracted the virus at the hospital?
   
   If no, 
   a. Why not?

11. Do you feel that all members of staff at this hospital know enough about HIV/AIDS to avoid contracting the virus at work?
   
   If no, 
   a. Which workers do you believe would not know enough about the virus to prevent infection?

12. Are you ever asked questions by friends, family or strangers about the HIV/AIDS?
   
   If yes, 
   a. How often has this happened? 
   b. What do you tell them?

13. Do you think that traditional medicine has a place in the treatment of AIDS?
   
   If yes, 
   a. What do you think we have to learn from traditional approaches? 
   b. What do you think of the people who suggest some of these approaches? 
   c. Do you ever try to steer people towards a more ‘traditional’ approach?
If no,
  a. Do you think we have nothing to learn from traditional approaches?
  b. What do you think of the people who suggest some of these approaches?
  c. Do you ever try to steer people towards a more 'scientific' approach?

Education

14. How far did you go in your education?
   If the respondent attended post matric educational institution/s,
     a. Which institution/s did you attend?
     b. How long did you study there?

15. Which school/s did you attend?
   a. Was it a private school/government school?
   b. How would you rate the overall quality of education you received from the school?
   d. What language were you taught in at your school?
   f. How many pupils on average did you have with you in class at school?

16. What subjects did you study at school?
   If the respondent says science, then:
     a. In what language were you taught science?
     b. How would you rate the overall quality of scientific education you received from the school?
   If science is not mentioned as a subject, then ask...
     a. Why did you not take science as a subject?

17. Did most pupils matriculate at your school?
   If yes,
     a. Why do you believe this was the case?
   If no,
     a. Was there a particular reason why?
Work and status

18. Have you always wanted to be a porter/cleaner/nurse/doctor?
   If yes,
   a. Why did you decide to become a porter/cleaner/nurse/doctor?
   If no,
   a. How did you it come about that you became a porter/cleaner/nurse/doctor?
   (Probe if parents, friends or academic environment have anything to do with respondents choice)

19. What did/do your parents do for a living?
   a. Do you believe that their occupation/s had anything to do with your choice of occupation?

20. If you had a choice would you change your occupation?
    If yes,
    a. What would you prefer to do?
    b. Why would you choose this/these occupation/s?

21. Is this a profession you would want your children to go into?
    If yes,
    a. Why?
    If no,
    a. Why and what job/occupation would you like to see your child/children enter?

Social contact and knowledge dissemination

22. With whom do you usually spend your breaks at the hospital?
    a. How do you know each other?
    b. What do you talk about?
    c. Do you talk about work?
    d. Do you talk about HIV/AIDS?
    e. Where do you meet?
23. Do you attend any type of daily, weekly or monthly meetings at the hospital?

If yes,
a. How often do you have these meetings?
b. Who attends these meetings?
c. What is discussed in these meetings?

(Are there any kind of union meetings, doctors meetings, ward meetings or porters meetings)

24. Do you socialise with anybody from the hospital outside the hospital environment?

If yes,
a. With whom?
b. What do you do together?
c. Do you work closely with this/these person/people within the hospital?
d. Do you ever talk about work?
e. Do you ever talk about HIV/AIDS?

If no,
a. Why do you think that this is so?

25. Have you ever seen a hospital worker taking part in an activity which could result in his/her becoming infected with AIDS?

If yes,
a. What was this person doing?
b. What did you do?

If no,
a. How do you think you would react to the situation?

26. Whose responsibility do you think it is to educate less knowledgable hospital workers about possible occupational health risks?

a. Why do you believe that it is 'their' responsibility?
b. Would you do the same in regards to possible AIDS infection?
APPENDIX C - LETTER TO THE HOSPITAL REQUESTING ACCESS FOR PHASE ONE

DAVID ABRAHAMSOHN

** ***** Road
****** ****
JOHANNESBURG
2195

Telephone No. *******
***th ******* **93

BY HAND

Dr. ***
Medical Superintendent
*** Hospital
Private Bag ***
***

Dear Dr. ***,

I am writing to you to request your permission to undertake a study at your hospital which evaluates the knowledge and awareness of workers in a medical institution concerning the AIDS virus, with the objective of developing an occupational education program.

I am at present registered as a student in the Department of Industrial Sociology, Faculty of Arts, University of the Witwatersrand. A requirement for the completion of my course is the submission of a long essay based on a research topic. The necessary research conducted is closely supervised by the staff of the Sociology Department.

While attending an AIDS education course recently at the Johannesburg City Councils' Community AIDS Information and Support Centre, problems pertinent to health workers and related personnel employed in medical institutions which care for AIDS patients, were highlighted. Whereas these employees should be expected to act as the role models for society in their understanding and handling of patients infected with the virus, it became apparent that there were a number of shortcomings in their knowledge and perceptions of the problems involved and that there appears to be a need for correctional steps to be taken.

This would involve inter alia, the setting up of an appropriately structured and graded program to address the needs of the people employed by medical institutions, covering the broad spectrum of employee from janitor, to the surgeon. The structure of such a program is the essence of my intended study.

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REQUIREMENTS FOR MY RESEARCH.
My research would require that I interview workers from all levels of the hierarchical structure in a medical institution (including non-medical staff) to ascertain their knowledge, attitude and beliefs about AIDS, and their knowledge of the AIDS policy in the institution (if one exists). I wish also to explore the workers’ practices in the workplace, and to assess whether workers are aware of the possibilities for exposure in their work. I also wish to research what precautions they are taking to prevent this. Issues such as shift times and work stress in relation to taking precautions against infection will also be explored. This will be done by observation and eliciting responses to a questionnaire.

I estimate that it would require no more than seven days in the actual institution to complete both interviews and the participatory observation.

DEALING WITH SENSITIVE ETHICAL ISSUES.
Due to the highly sensitive issues surrounding the HIV/AIDS virus, certain ethical issues need to be addressed. I propose to keep the name of the medical institution as well as all respondents confidential. I will also ensure in the course of my research, that I do not hinder the running of the institution in any manner whatsoever by conducting interviews while staff are on breaks or off duty, as well as avoiding contact with patients.

I believe that this thesis could make a valuable contribution in establishing basic practices for health workers involved in working with AIDS/HIV infected persons and earnestly request your permission to conduct my research at your hospital.

I shall appreciate it very much if you will accede to my request and would ask that you contact me at the above telephone number if you require any further details or information. I do require written permission from you to proceed with my study as soon as possible.

Yours sincerely

DAVID ABRAHAMSCHN.
APPENDIX D - LETTER RECEIVED FROM THE HOSPITAL GRANTING ACCESS FOR PHASE ONE

TRANSAALSE PROVINSIALE HOSPITALE

IN ANY WORD VERMELED AS.
IN REPLY PLEASE QUOTE
No. 1/5/1

All correspondence must be addressed to the Superintendent.

12 October 1993

Mr David Abrahamschoi

RESEARCH PROJECT

In reply to your letter of the 29th of September 1993 regarding your research project, permission is hereby granted for you to carried out your research project at the Hospital.

We would also require a letter from the Faculty of Arts University of the Witwatersrand that you are a bonafide student.

Yours faithfully

SUPERINTENDENT
APPENDIX E - LETTER OF CONFIRMATION

DAVID ABRAHAMSON

** ***** Road
****** ****
JOHANNESBURG
2195

Telephone No. ******
**th ****** 19**

BY HAND

Dr. ***,
Medical Superintendent
*** Hospital
Private Bag ***
***
***

Dear Dr. ***,

Thank you for your letter dated the 12th October 1993. Enclosed please find a certificate of registration from the Faculty of Arts, University of the Witwatersrand to verify that I am in fact a bonafide student, as requested by you.

May I take this opportunity to thank you for granting permission to carry out my research in your institution.

Yours faithfully

DAVID ABRAHAMSON.
APPENDIX F - LETTER TO THE HOSPITAL REQUESTING ACCESS FOR PHASE TWO

DAVID ABRAHAMSON

** ******* Road
******* ****
JOHANNESBURG
2195

Telephone No. ******
* May 19**.

BY HAND

Dr. ****,
Medical Superintendent
******* Hospital
Private Bag ******
*******
****

Dear Dr. ****,

RE: RESEARCH PROJECT FOR MASTERS THESIS.

I wish formally to request your permission to undertake an in-depth study at your hospital, which seeks to evaluate the dissemination of knowledge concerning the AIDS virus.

In December of last year, you were kind enough to allow me access to your hospital to undertake a study. This study explored the level of awareness and knowledge regarding HIV/AIDS amongst all levels of staff at your hospital.

On completion, my study was very well received by members of the Sociology Department. However, this study, although very informative, brought certain crucial questions regarding the dissemination of knowledge amongst the hospital workers to the fore which require further investigation. I therefore wish to extend this research project in an attempt to address these issues. This further study would fulfil the requirements for an MA degree for which I am now registered. (Please find attached form of verification of my registration)

My research would require that I interview workers at your hospital from all levels, including non-medical staff, to ascertain their attitude and beliefs regarding the dissemination of knowledge concerning HIV/AIDS. Research will be done by observation and by eliciting responses to interview questions. The purpose ultimately of the study is to construct an effective education program for the prevention of AIDS infection in a hospital setting.

Due to the highly sensitive issues surrounding HIV and AIDS, certain ethical issues, of which I am aware need to be addressed. I propose to keep the name of the medical institution as well as all respondents confidential. I shall also ensure that in the course of my research I do not hinder the running of your hospital in any manner whatsoever. I propose to conduct interviews while staff are on breaks or off duty and will avoid contact with patients.
I believe that this thesis could make a valuable contribution in establishing an effective HIV/AIDS education program for all health workers.

I earnestly request your permission to conduct my research at your hospital and would ask that you contact me at the above telephone number if you require any further details or information. I do require written permission from you to proceed with my study.

I thank you for the co-operation that you have afforded me in the past and look forward to a favourable response to this request.

Yours sincerely

DAVID ABRAHAMSOHN.
In reply to your letter of 2 May 1994 regarding your research project for masters thesis. Permission is hereby granted for you to carry out your research project at the Hospital.
APPENDIX II - THE THOUGHTS OF A HEALTH CARE WORKER AFTER AN ACCIDENTAL OCCUPATIONAL EXPOSURE TO AIDS

This information was transcribed from a tape recording of an interview with a pathologist who was involved in a needlestick injury while working with an HIV positive patient.

Question - Can you tell me how this incident occurred?

It was in June of 1991. It was a day like any other, I was tired and over worked. Being a pathologist, I routinely perform high needle aspiration which involves placing needles into lesions which draws cells in the form of blood which is then smeared on a slide. One then looks down a microscope and examines the cells in an attempt to diagnose the patients illness.

I was working with a patient that was referred. I had a feeling about this particular patient. Over the years you develop this sense which detects potential HIV patients and I knew I had to be careful with this guy. I did a lymph node in his neck and that was okay but he also had a mass on his foot. I was attending to that and as I pulled out the needle for the last time, I don't know why, but he suddenly decided to move and the needle went into my thumb. It was a reasonably deep wound and it certainly drew blood going through the soft tissue into the skin. It was also a hollow needle, supposedly the worst type if you have a needle stick injury.

Question - How did you feel at this point?

It took me a couple of minutes to put two and two together that I had actually pricked myself on what could have been a possible HIV patient. I did not know his status at that point so I took blood from him straight away; they did the test and he was positive. This was all in about forty five minutes. When I heard he was positive I was half expecting it because as I said, you have this strong feeling when you examine and look at patients. I think the time between the injury and actually hearing he was positive was the worst time for me. I was pretty sure he was positive so the test just confirmed it for me when it came back. Looking back on it, it was a traumatic period but at the time it did not seem so bad. When they told me he was positive I thought, well that's it.

Question - Was there no set protocol to follow?

There was no set protocol. I used my common sense and immediately ran my finger under water and squeezed out all the excess blood that I could. I also then washed my hands with bleach. I was put on a course of AZT oral tablets which I had to take within the first hour of exposure and then three times a day for 28 days after the accident.
Question - When was the worst time for you?

The worst time for me was the time between exposure and my first HIV test which was three months later. That was pretty traumatic. Another traumatic time was when I was waiting for my HIV results.

To came back as I say after three months. I personally took it through to the lab and they told me that they would let me know the next day. That was the most traumatic night of my life. When I phoned up for the result the next day, that was even worse. My heart was pounding and I was shaking so much that I could barely keep the earpiece of the phone on my ear to hear the result. Thankfully it was negative.

Question - What is the procedure from there?

The recommended that you have the test 3 months after exposure and then every 6 months after that. I had tests after 9, 18 and 24 months. But its now over two years since it happened so theoretically I am clear.

Question - How did this incident effect your family life?

Luckily for me my wife is a nurse. She therefore understood much about the virus. She was very supportive. We sat down after the accident before my first HIV test and discussed every possible scenario. We decided that if I was HIV positive we would not have children and that we would take precautions until my first 3 month test. As I said, this was the most terrifying and traumatic time for me. In these discussions with my wife, it suddenly dawned on me how serious the situation was. Surprisingly, it was only at that point that I realised what a devastating effect this whole event could have on my life. I was absolutely terrified.

Question - Has it effected how you work with other patients?

I have worked with quite a few HIV positive patients since that time and I still do things in exactly the same way. I still glove up as all the doctors do for all patients. Some doctors use two set of gloves at one time but I only use one set of gloves because double gloving takes away just to much sensation and you are more liable to stab yourself if you don't have that sensation. I don't take any extra special precautions but I make sure that I am completely alert and rested when performing these procedures. I also tell the patient to keep very still and not to jump.

Question - Where you wearing gloves that day?

Yes. The needle went straight through, its as thin as a condom.
Question – So how effective do you think gloves really are?

I don't think that they are that effective, they are more of a psychological protection for a person wearing them. It's very easy to pierce them for example when one uses a hollow needle. The blood can remain in the hollow part of it (the needle) and once it goes through the rubber of the glove, you can still inject it into yourself.

Question – Do you have any other views on this issue?

Well, in those days I was working very long hours. I was tired and was not concentrating completely on what I was doing. I really should have been at home asleep and not performing any medical procedures, let alone one involving such delicate work. I also feel quite strongly that all patients that come to hospital should be tested for HIV and I don't think we should necessarily have to get permission for it. We take blood from a lot of patients without telling them what it is for. A blood sample is also very important as we can pick up other equally dreaded diseases like leukaemia and cancer that are just as liable to kill the patient.
APPENDIX 1 - AIDS PROTOCOL TO BE FOLLOWED IN CASE OF A NEEDLESTICK INJURY

NEEDLESTICK INJURY: GUIDELINES FOR HEALTH WORKERS

A. KNOWN HIV POSITIVE PATIENTS

1. Squeeze blood from injured area and wash well under running tap water. Apply adhesive dressing.

2. Report immediately to the supervisor/person in-charge and document the injury.

3. Report to Sick-Bay during the day or to Casualty if at night or over weekend and complete WCA forms.

4. Health care worker should have HIV test done to determine his/her own HIV status at the time of the injury.

5. Commence ZIDOVUDINE (AZT) prophylaxis immediately. Dosage: 300mg 4 hourly (early morning dose can be omitted for convenience, therefore only 5 doses over 24 hours). Continue prophylaxis for 4 - 6 weeks if possible.

   Baseline FBC and LFT's to be taken prior to commencement of AZT and monitored at fortnightly intervals thereafter.

NB: Zidovudine is not recommended for superficial percutaneous or mucosal exposure or for pregnant patients. Caution is needed if there is pre-existing renal dysfunction.

6. Submit blood specimens from patient for Hepatitis B surface antigen (HBs Ag) and viral status as well. If positive, manage appropriately.

7. Health care worker should be followed up by being tested for HIV at 3 monthly intervals for 12 - 18 months.

B. HIV STATUS OF PATIENT UNKNOWN

1. Squeeze blood from injured area and wash well under running tap water. Apply adhesive dressing.

2. Submit urgent blood specimen from patient for rapid HIV test. Submit separate specimen for HBs Ag and viral testing as well. If results of HIV test cannot be obtained within one hour, commence AZT immediately until patient's HIV results are back.

3. If patient is HIV negative, no further action is necessary.

4. If patient is HIV positive, follow the guidelines in part A above.

For further information please contact:

Infection Control Division Ext 2557 or page for the Infection Control Sister via the telephone exchange.

SUPERINTENDENT

/bt
MARCH 1992

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APPENDIX J – AIDS PROTOCOL AT HOSPITAL REGARDING GENERAL CARE OF AIDS PATIENTS

PRECAUTIONS FOR HEALTH CARE WORKERS

Of prime concern is blood, excretions and body secretions e.g semen, vaginal secretions, cerebro-spinal fluid which may possibly contain the virus.

OBJECTIVE:

To protect the hospital personnel from infecting themselves through accidental injury with sharp instruments and/or through contact with blood and body fluids.

1. PRIVATE ROOM:

Is not necessary as the patient can be nursed in a general ward, unless there is a contra-indication, where barrier nursing may be done e.g. excessive bleeding.

2. GLOVES:

To be used when handling the following:

2.1 Blood i.e. specimens, bleeding wounds, bleeding orifices etc.

2.2 Excretions and secretions e.g. stools, urine, sputum and nasal secretions.

2.3 Any items physically soiled with any of the above.

3. PLASTIC APRONS:

Must be worn only if there is any possibility of contamination from body fluids as mentioned in 2 above.

4. MASK:

Not necessary unless the patient is bleeding from the mouth or nasal cavity, coughing copious blood stained sputum, or if staff member is present at or carrying out a procedure which causes splashing of blood or aerosoling of bloody fluids such as during emptying of a portovac, tracheal suctioning, bronchoscopy etc.

5. STOOL AND URINE:

Ambulant patients must use the general ward toilet.

Bedridden/helpless patients must be given a bedpan or urinal which must be disinfected after use.

6. DISPOSAL OF REFUSE:

Disposable plastic bag must be used according to our hospital plastic codes. The container with the contents must be tightly closed and then be incinerated.

2/...
7. **EATING UTENSILS**

Eating utensils are washed with all other ward eating utensils with soap and water and rinsed under running tap water.

2. **LINEN**

Soiled linen must be soaked in a disinfectant first then sluiced. Linen which is not soiled is counted with other linen and sent directly to the laundry.

S. **CARE OF NEEDLES AND SYRINGES**

- Extra care must be taken when handling needles and syringes to prevent needle pricks.
- A separate needle disposal container which is clearly labelled "USED NEEDLES" must be placed at the patient's bedside.
- No syringes with blood must be left lying around in the ward.

10. **SPECIMEN**

- Blood and tissue samples from H.I.V. positive patients, must be sent to the laboratory in specially sealed double plastic bags which are obtainable from the laboratory.
- The double plastic bag consists of a small plastic bag which is inserted into a large plastic bag and each bag is separately sealed.
- Bags must never be separated and each specimen must be inserted in one double bag.
- Specimen must never be batched together, each specimen must be inserted in one double bag.
- The specimen "double bag" must never be stapled.
- A biohazard sticker must be used in order to make laboratory technicians aware of dangers involved.

*ALWAYS REMEMBER HAND WASHING*

PKT/inn
88.09.14
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Author: Abrahamsohn, David Alan.
Name of thesis: The dissemination of knowledge between medical and non-medical staff in a hospital setting as a means of preventing AIDS infection of hospital workers.

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