# DISCRETION AMONG STREET LEVEL BUREAUCRATS: A CASE STUDY OF NURSES IN A PUBLIC HOSPITAL IN CAPE TOWN

MASTERS IN PUBLIC ADMINISTRATION

MINI-THESIS

**NAME: TIMALIZGE ZGAMBO**

**STUDENT NUMBER: 3204673**

**SUPERVISOR: Prof. GREG RUITERS**

**SCHOOL OF GOVERNMENT**

**UNIVERSITY OF WESTERN CAPE**

**2014**

This mini-thesis is submitted to the School of Government, University of the Western Cape, South Africa, as part of the requirements for completion of a Masters degree in Public Administration.

I declare that this is my own work and all quotes and references used have been acknowledged throughout the document.

ABSTRACT

There are often noted gaps and tensions arise between official government policies and what is implemented on the ground. The two theories that consistently argue antagonistically about the policy processes are the rational bureaucratic model also called the "top-down approach" as opposed to the incremental or bottom-up approach. This research was inspired by a bottom-up perspective and involves a detailed investigation of Lipsky's street level bureaucracy (SLB) theory. Over the years since Lipsky's research much international work has be done on the subject of discretion among policy implementers but in the South the focus has been more on top-down ideas such as increasing state capacity and monitoring workers and not on the Lipsky problematic. SLBs according to Lipsky, due to their interface with the public, inevitably exercise critical discretionary powers in their work, thus, making policy happen in unexpected ways. They are often seen as the 'real policy makers'. On the other hand, the top down approach sees the exercise of discretion in service delivery as a drawback leading to problems that make the public service less impersonal, hindering the outcome of public services.

Hence, this study specifically focuses on studying the extent, intentions and uses of discretion. Intentions are looked at in a threefold manner: *good, bad and conflicting,* among nurses as SLBs in a public hospital in Cape Town, in view of the two conflicting approaches to policy implementation. I found that the discretion practices among nurses do 'more good than harm' as opposed to the view held by the top down approach. The study further revealed that discretion is also often conflicted or ambivalent. Moreover, it is often based on tacit collective understandings and practices among groups of nurses. This is one element that needs to be explored further in future studies in order to contribute to the body of knowledge. Notably, there appears to be a gap in South African literature on this vital subject area.

Acknowledgements

I wish to acknowledge and appreciate the tireless efforts of the people who helped in the successful completion of this thesis. First and foremost, I want to thank my supervisor, Professor Greg Ruiters and the academic staff-School of Government (SOG) for their persistent encouragement and commitment. I wish to extend great appreciation to Ms Lynette Festers, the Post-graduate administrator (SOG), my family and friends for their endless support. A special thanks to the Provincial Health Department (Western Cape) for the quick research approval, the Hospital Management were the research was conducted, and the cooperative respondents/nurses who spared their limited time to participate in this research study. Above all, I thank the almighty God, from whom I draw all my strength at all times.

## Table of Contents


**CHAPTER 1: INTRODUCTION AND RELEVANCE OF STUDY** ..... 1

BACKGROUND ..... 3

PROBLEM STATEMENT AND ARGUMENT ..... 5

DEFINING CONCEPTS ..... 6

RESEARCH OBJECTIVES AND DESIGN ..... 8

Sampling ..... 9

Description of Research Site ..... 9

DATA COLLECTION METHOD AND RESEARCH INSTRUMENTS ..... 10

DATA ANALYSIS ..... 13

LIMITATIONS ..... 14

**CHAPTER 2: THEORY AND LITERATURE REVIEW** ..... 16

**POLICY IMPLEMENTATION: TOP DOWN VERSUS BOTTOM UP APPROACH** ..... 18

**DEBATING STREET LEVEL BUREAUCRACY AND DISCRETION** ..... 26

**CHAPTER 3: THE NURSING PROFESSION IN THE SOUTH AFRICAN CONTEXT** ..... 35

INTRODUCTION ..... 35

NURSING ACT ..... 38

CATEGORIES OF NURSES ..... 39

*Professional nurse* ..... 39

*Staff nurse* ..... 40

*Auxiliary nurse* ..... 40

NURSING RIGHTS AND PROFESSIONAL CONDUCT ..... 41

MENTAL HEALTH NURSING IN SOUTH AFRICA ..... 42

Nursing ethics and discretion ..... 42

NURSING CRISIS IN POST-APARTHEID SOUTH AFRICA ..... 46

**CHAPTER 4: QUANTITATIVE DATA ANALYSIS ..... 50**

ANALYSIS OF FINDINGS ..... 67

DISCRETION PRACTICES ..... 70

ESTABLISHMENT OF RULES ..... 72

DISCRETION GOOD, BAD OR/AND CONFLICTING ..... 74

**CHAPTER 5: QUALITATIVE DATA ANALYSIS ..... 77**

ESTABLISHMENT OF RULES ..... 92

MAJOR EMERGING ISSUES FROM IN-DEPTH INTERVIEWS ..... 94

Staff shortage ..... 94

Field observations ..... 95

Unsafe working environment and insecurities ..... 95

DISCRETION GOOD, BAD AND CONFLICTING ..... 97

**CHAPTER 6: CONCLUSION ..... 100**

**BIBILIOGRAPHY ..... 105**

## CHAPTER 1: INTRODUCTION AND RELEVANCE OF STUDY

The theory of street level bureaucracy was first coined by an American scholar Michael Lipsky (1980), whose work in this area mainly focused on the key role of font-line workers at lower levels of public institutions. Against the conventional wisdom, he argued that the lowest public service officers in the chain of command were the actual policy makers and policy implementation occurs as an ultimate function of the actions and activities exerted by those that can be termed "street level bureaucrats".

Lipsky (1980) captured activities carried out at the point of the interface between the lowest public service worker whom he named 'Street level bureaucrats' (SLBs) and the public service receiver/ general public. He showed that discretionary action and decision-making imply that front-line workers hold a privileged position in face to face interactions with the public. This argument contradicts the Weberian bureaucratic structure (rational top-down) and strongly advocates a bottom-up, more democratic approach to effective policy implementation and service delivery as well as understanding power issues and how SLBs can both facilitate and even obstruct policy.



This research study is an application of and reflection on Lipsky's SLB theory that has inspired much research over the years since 1980s when he first published his famous book called '*Street-Level Bureaucracy: Dilemmas of the Individual in Public Services.* Lipsky's SLB theory curiously is under-researched in Africa.

The study of SLB has been neglected in recent South African policy debates, despite the state's rhetoric of inclusive public policy making (Walker and Gilson, 2004; Von Holdt, 2007, 2010). Hence, the aim of this research study is to investigate discretion among nurses in line with Lipsky's findings, as well as the context of and how and why discretion is exercised by nurses in healthcare service delivery. Does the level of this practice enhance their work in any way, in terms of efficiency or making health service delivery easier on their part or does it have more to do with personal enhancement and motive? These issues have a lot of significance in helping us understand and analyze policy implementation and service delivery, hence, the relevance of this study.

The rationale for testing Lipsky's SLB theory in this research study was to, probe the nature and levels of discretion practiced in the nursing profession. The novel element and uniqueness of this study is that it investigates street level discretion in a threefold manner: *good, bad and conflicting intentions in discretionary situations.* The findings from this study could contribute to a better understanding of the daily practical work of nurse's divergences from the stipulated guidelines/policies and possible improvements. Additionally, the study opens questions for larger scale studies on SLBs in South Africa, considering that there is limited literature in this field, thereby, adding more knowledge through exploring the use of discretion in policy implementation and service delivery.

## BACKGROUND

South Africa is among many other developing countries faced with challenges in health service delivery because of several pitfalls to do with public policy and its implementation. One of the problems, lies in disparities between *what government policy states* on the one hand, and *what is actually implemented,* on the other, as well as *who the actual policy makers are.* All these issues if not addressed properly affect the outcome of policy no matter how well formulated and structured.

Generally, policy implementation and service delivery in South Africa, since the end of apartheid is said to have suffered from 'dysfunctionality and institutional failure' (Von Holdt, 2010), despite the progression in adopting remarkable and substantive policies. In terms of health service delivery, "Public hospitals are characterized by dysfunctional management and poor clinical outcomes" (Von Holdt, 2010:242), also see (Von Holdt & Muserumule, 2005; Atkinson, 2007; Southhall, 2007; Von Holdt & Murphy, 2007). There appears to be a consensus among many of these scholars that health services have indeed come to a state of flux and complexity in the country's bureaucratic system.



A study conducted by Von Holdt and his colleagues, revealed that public hospitals and health services in South Africa appear to have been experiencing a high degree of institutional stress (Von Holdt and Maserumule 2005; Von Holdt and Murphy 2007). Among other factors, over-centralization, fragmentation, low management capacity and understaffing were seen as causes of institutional stress, which ultimately produce such dyfunctionality in the hospitals (Von Holdt, 2010). It is also worth noting that Lipsky (1980),

has pointed out the effects of such high levels of stress faced by SLBs, lead to the development of certain coping strategies given resource and organizational constraints that become daily practices outside the regulated rules.

Von Holdt (2010) study also revealed that public hospitals are ineffective and characterized by disorder. For example, poor drug supplies, procurement failures-no linen in the admission wards, unclean wards, staff indiscipline among other things (Von Holdt, 2010). Consequently, such unpleasant working conditions created by structural defects either in administration or at the policy-making level, lead to loop holes in the bureaucratic chain. Clearly, in a bureaucracy, the behavior of all public service workers is altered by respect for chain of command and authority, rules and regulations, code of conduct and so on, thus every employee is expected to uphold these values and conform to the 'basic rules of the game' (Anderson,2006). However, conformity with the rules is less practical in most situations, especially when conflicts arise between the rhetoric and the functional. According to Lipsky's line of thought, ensuring public services carry on under difficult conditions, gives room, power and a certain privilege to the lower level/bottom line workers (SLBs) to institute their own 'rules of the game', thereby becoming policymakers themselves. This eventually, springs out as a deviation from standard rules, thus, bending of rules and arriving at discretion.

Nevertheless, nonconformity or lack of compliance to the regulated rules does not only originate from structural defects in the system, but also lack of policy knowledge or ignorance as well as deliberate actions directed by personal motives of individual workers (Anderson,2006). Thus, nonconformity or bending of rules can either facilitate effective

policy implementation or not. This is why studying the behavior of SLBs is highly relevant in understanding effective policy implementation and service delivery. Certainly, the unresolved dysfunctionality in public hospitals, indeed affects the outcome of health care in the country, as well as what can be done to ensure that policy is implemented. Determining positive factors as to what helps in the policy implementation process should be considered paramount as opposed to mechanically following rules or making alternative choices depending on need and circumstances, in achieving effective service delivery.

## PROBLEM STATEMENT AND ARGUMENT



It is without doubt that the role of nurses or doctors in the health sector is a very critical one in the provision of quality health care to the public. Von Holdt (2010) argues that the establishment of rules, routines and procedures, guidelines or protocols is very critical for particularly effective medical intervention and professional discretion does not reduce the need for the establishment of these protocols. He points out that both the exercise of professional discretion and strict rules complement each other in this kind of human service provision as it is a delicate and highly complex unpredictable phenomenon (Von Holdt, 2010). According to Von Holdt (2010:7), "strict routines must provide both information base and the space for discretion and judgment based on the skill and experience of health professionals". Drawing from a practical example of a medical ward which is essentially structured by the need to follow strict rules and time-bound routines such as checking patient temperatures, administering drugs on time, reports and recording including other

policy implementation or not. This is why studying the behavior of SLBs is highly relevant in understanding effective policy implementation and service delivery. Certainly, the unresolved dysfunctionality in public hospitals, indeed affects the outcome of health care in the country, as well as what can be done to ensure that policy is implemented. Determining positive factors as to what helps in the policy implementation process should be considered paramount as opposed to mechanically following rules or making alternative choices depending on need and circumstances, in achieving effective service delivery.

## PROBLEM STATEMENT AND ARGUMENT

It is without doubt that the role of nurses or doctors in the health sector is a very critical one in the provision of quality health care to the public. Von Holdt (2010) argues that the establishment of rules, routines and procedures, guidelines or protocols is very critical for particularly effective medical intervention and professional discretion does not reduce the need for the establishment of these protocols. He points out that both the exercise of professional discretion and strict rules complement each other in this kind of human service provision as it is a delicate and highly complex unpredictable phenomenon (Von Holdt, 2010). According to Von Holdt (2010:7), "strict routines must provide both information base and the space for discretion and judgment based on the skill and experience of health professionals". Drawing from a practical example of a medical ward which is essentially structured by the need to follow strict rules and time-bound routines such as checking patient temperatures, administering drugs on time, reports and recording including other

important medical vitals, in order to be effectively functional, otherwise patient care becomes compromised, hence poor service delivery (Von Holdt, 2010).

The main argument in this research study is centered on current debates between the top down and bottom up proponents. I do not argue by taking either of the sides. However, I agree with scholars that see bureaucratic discretion as inevitable and vital in policy implementation and highly value the insertion of positive discretionary actions practiced by SLBs in contributing towards effective service delivery. I do not attach a definition to what is meant by effective policy implementation and service delivery, as it cuts across a variety of factors outside the confines of this study. However, I wish to refer to it as *doing what best fits the situation* in order to get the job done, similar to the beliefs of the bottom up proponents. Additionally, the ultimate analysis of this study is to generate the profound role that discretion plays in policy implementation and service delivery.



**DEFINING CONCEPTS**

The basic interpretation of bureaucracy is hierarchy in a chain of command, strict rules and regulations and political neutrality. Max Weber's ideal type included; formal rules and rigid procedures, a hierarchical structure, occupation of offices based on expertise and training, written down records, and permanent employees (Held, 2005).

The concept of discretion in public policy and implementation challenges the rigidity of top-down rules (Ham and Hill, 1984). Davis (1969) provides a useful definition of discretion, that many other researchers (Ham and Hill, 1984, Tummers, 2011) have used. Davis (1969:4) states, "a public officer has discretion whenever the effective limits on his power leave him free to make a choice among possible courses of action or inaction". Similarly, Evans (2010:

11) adds that discretion is the "freedom in exercising one's work role". This forms the central focus of Lipsky's street level discretion.

In this study, I adopt both Davis's and Evans's definition of discretion. However, I will mainly focus on using the term to describe patient related workplace actions exercised by nurses outside the established rules or guidelines. Bottom-up theories stress the complexity of decisions made by implementers and dilemmas they face. Discretionary power is exercised by implementers since rules cannot cover every situation and because the means to implement are often in short supply and so implementers must "make do". But Erasmus and Gilson (2008:35) add that small "p" power is important: hence "even apparently isolated or fairly trivial practices can represent exercises of power".

Elmore (1979) tried to combine the bottom up and top down paradigm but not very successfully according to Hudson and Lowe (2010). Elmore sees authority relations within organizations as "reciprocal: formal authority runs from top to bottom, but the informal authority necessary for problem solving runs from bottom to top" (cited in Erasmus and Gilson, 2008: 39). This speaks to the ideas expressed by Erasmus and Gilson (2008). As Erasmus and Gilson (2008), who stress power relations, argue "the top-down model of implementation emphasizes power as the co-ordination and control (of others) by those with authority located at the upper reaches of the bureaucratic or organizational hierarchy, in pursuit of pre-determined policy objectives.

The word 'policy' has many definitions but the general way of using the concept is to view it as an enshrined law and legislative directive (Ham and Hill, 1984). On the contrary, the

bottom-up approach sees policy more flexibly as a set of goals and as what occurs at the point of implementation (Hudson and Lowe, 2010). As Pressman and Wildavsky (1973:14) point out "a verb like *implement*, must have an object like *policy*".

Policy implementation is viewed differently between the top downers and bottom uppers (this is discussed in more detail in chapter two). Generally, implementation is defined as "those actions by public or private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions" (Van Meter and Van Horn, 1975:445). Policy implementation in this study is defined as actions that lead to successful service delivery and achievement of policy goals.

## RESEARCH OBJECTIVES AND DESIGN



The main research goals were: to establish the practices of discretion against local understandings of official rules, policy/guidelines; to find out how informal decision making and establishment of rules arises among nurses as SLBs in the hospital; to establish the level of discretion practiced among nurses, in terms of good, bad or/and conflicting.

A research design gives a detailed plan on what data to collect, how and from whom it will be collected as well as how it will be analyzed (O'Sullivan and Rassel, 1995). It also gives guidelines on what form a study takes. A "sample is a subset of units selected from a larger set of the same units" (O'Sullivan and Rassel, 1995:114). This research was conducted at a

general mental public hospital, within a reachable locality. Thus, the sample was selected from the available nursing staff on duty in different clinical wards.

**Sampling**

The selection of 30 respondents was sampled using the purposive sampling technique, drawn from non-probability sampling design. The justification for using this type of sampling is simply based on the nature of investigation and the limited availability of respondents considering the intensive service the institution offers. Interviewing was conducted over a three week period in different clinical wards. However, the sampling was not meant to generate statistics per se but to ensure a spread of staff in terms of age, gender, experience and the different departments in the hospital for capturing a wider context of findings.

**Description of Research Site**



The research site is located in the southern suburbs of Cape Town. It is one of the four government specialized mental hospitals, that offer tertiary psychiatric services, being the major referral centre of such cases in the Western Cape Province. Additionally, it also offers specialized psychiatry training for nurses. Being an old hospital, built in 1891, it has suffered several challenges in terms of service delivery and almost closed in 1998 (Extracted from hospital information files).

The hospital offers general mental services and other specialized forensic and acute admission units. Patients admitted to this hospital are taken in voluntarily or non-voluntary and also on observation basis owing to behavior disturbances, psychotic illnesses and

several different kinds of mental disorders. The number of usable beds is estimated at 340-bed capacity.

First, this research site was selected because it is a government institution with nurses as professional SLBs. The importance of selecting a mental hospital as a research site for this particular study was based on it been a specialized service as compared to a general hospital providing diverse services. Additionally, the nature and sensitivity of mental healthcare demands specific attention from the service providers/nurses as it is a different setting from general health care. Thus, studying discretion among nurses in such an institutional setting (specialized service) would produce a narrowed down deeper understanding of how and why SLBs act the way they do. Ethics clearance was obtained from the hospital authorities and through the University processes.

**DATA COLLECTION METHOD AND RESEARCH INSTRUMENTS**



The data collection method used in this research study was both quantitative and qualitative. The reason for using both methods was to ensure that the data is more reliable and contextualized. Both approaches are known to have different strengths and weaknesses over each other, which were well complemented in this study. Moreover, even though, the type of question addressed in this research was qualitative in nature, it also had a statistical element that required measurement. For instance, attaching a number or percentage to who said what and how strongly they said it, validated the findings well in the analysis even though the sample might have been small. Because the sample is small, the quantitative aspects are meant to be suggestive rather than definitive.

This research study was an analytical study and the main aim of the study was to find out the level of and intentions behind using discretion among nurses, in terms of good, bad and conflicting intentions. In order to measure the level, it was imperative to have a scale of measurement, thus, the quantitative approach made it possible to produce findings to answer the question more accurately. In order to enhance the value of the statistical findings, a qualitative approach was employed.

The first data instrument used to collect data was a self-administered structured questionnaire with closed ended questions, where respondents had to select their answer of choice from a set of structured responses. Even though, the questions were structured, the questionnaire was not biased because it provided room for 'not applicable/no' and 'not sure' in order to completely ensure that respondents did not feel pressured. There was also a space for 'add/other' option on some responses to give more freedom of expression to respondents and generate as much information as possible. Additionally, the last question was open ended, to give room for open comments, opinions or pressing issues of concern. The reason for using structured questions was to generate specific responses to help answer the research objectives. The questions in the questionnaire were formulated using the guidance from the literature review and theoretical approaches, particularly looking at some perceptions and motivations for practices of discretion considered to be good, bad or conflicted.

The main data instrument used to collect qualitative information was a semi-structured interview guide with open ended questions designed for in-depth interviews. The questions addressed interview guide were similar to those in the self administered questionnaire but presented in a broader context in order to generate more insight, views and opinions from the respondents. Eight in-depth interviews were conducted, which appears to be a small sample, nonetheless, the information collected was representative of different categories starting from nursing assistant to professional registered nurse. However, time was a limiting factor in using this approach as the research participants (nurses) only had little time to avail for in-depth interviewing. From the eight respondents, two had an opportunity to fill in the self-administered questionnaire while the rest of the interviewees had not participated in answering the self administered questionnaire. This highlighted issues of insecurity to answers questions openly and honestly in a face to face interview as compared to answering questions individually on a paper. This was another limitation presented with in-depth interviewing; further details are given in chapter 5.



Another, unplanned instrument was informal conversations. it was not known from the beginning that informal conversations could generate adequate and relevant information for the study. Lastly, my direct observations in the field proved to be very helpful in cross-referencing what was said and what was being done. It also provided an opportunity to connect the theory to practice.

Ethical issues pertaining to research subjects were carefully considered. The data collection methods used in this research did not cause any harm or disturbances to human subjects.

The data collection commenced at the research site after a letter of approval and ethical clearance from the Western Cape Provincial Department of Health, on 22 July 2013. The interviews were conducted after permission and consent was granted by the research participants as well as the hospital authorities. Regarding the structuring of questions, it was incumbent for the researcher to ensure that the questionnaires and interviews were structured in a way that does not offend, discriminate, intimidate, threaten or cause any form of discomfort to the interviewee. Additionally, all respondents/interviewees were given a choice to drop out of the interview if they so wished to, at any point, or not feel pressured to answer questions that made them feel uncomfortable.

## DATA ANALYSIS

The quantitative data was analyzed using the quantitative Statistical Package for Social Sciences (SPSS), in which the data had to be entered into the program and analyzed. The scale of measurement used for the quantitative data was mostly nominal and ordinal. Data from 30 self-administered questionnaires covering 15 variables/questions was coded and entered into SPSS. The data was then categorized under the appropriate scale of measurement. The data categorized under the ordinal scale was measured using the Likert scale by grouping responses according to strength, for example, 'agree, strongly agree; disagree; strongly disagree; somewhat' for some specific questions. The Likert scale is considered a strong and effective scale for this kind of measure (Neumann, 2009). Thus, this scale was very significant in measuring strong opinion on some of the questions requiring a clear understanding of strongly felt opinions by respondents.

The qualitative data collected through in-depth interviews was analyzed manually by grouping similar responses together according to the objectives. Since the number of interviews conducted was small, it was easy to group similar responses together manually without a software program package. The responses were grouped under the following themes: 'Discretion and decision making', 'establishment of rules', and 'discretion good, bad and/or conflicting'. In this analysis, I linked the findings and the literature presented by both approaches. I pro0bed "good/bad/conflicting by asking "How would you view the use of discretion in your work as a nurse?(for example, working extra hours voluntarily to finish a task, deciding on your own which patient to attend to without following the queue, skipping normal routine due to time limitation".

## LIMITATIONS

First and most, this research was only limited to studying nurses at this particular hospital and only one site was selected due to both time and financial limitations, nonetheless, this does not undermine the value of the findings produced from the study, instead, it marks a fundamental opening to large scale studies. Secondly, this research study does not particularly centre on a specified policy in health service provision, rather on general bureaucratic guidelines or policies, standard operation procedures in a public hospital dealing with the work of nurses in terms of what they are allowed/not allowed to do and the use of discretion. Discretion in this case is considered as an act outside the rules/guidelines, procedures or job description.

Thirdly, there appears to be limited resource material on nursing and discretion in South Africa, for example most books on nursing by South African authors referred to in this study,

talk about the work environment and job description of different nursing categories with a minimal mention of discretion. Hence, the study will add to the body of knowledge in the area of discretion practices among nurses as SLBs in South Africa.

Lastly, there were time constraints in conducting in-depth interviews with the nurses due to the busy nature of their work and mostly the wards were under-staffed. As observed, the nursing environment is a busy environment due to the nature of the work and it is well known that in-depth interview require a good amount of time. Thus, it was not possible to conduct all 10 in-depth interviews as scheduled. However, despite this limitation, quality often matters more than quantity, hence; there was adequate information from the few in-depth interviews that were conducted. Moreover, I had to catch up with my data collection timeline as well, having had waited a long time to acquire permission/ethical clearance and approval from the provincial health department office.

## CHAPTER 2: THEORETICAL BACKGROUND AND LITERATURE CHAPTER 2: THEORY AND LITERATURE REVIEW

The broad theories of policymaking discussed in this research are the rational top down and bottom up approaches to policy implementation and service delivery. However, it is important to briefly look into the debates about public sector reforms in public administration systems that have affected public services; the Traditional Public Administration (TPA)/bureaucracy, New Public Management (NPM) and the growth of the governance/networking perspective. NPM in the 1990s was meant to replace the "outdated and inefficient" TPA system, leading to the adoption of business techniques (Hughes, 2003). This also meant 'letting the managers manage' (Hood, 1994), hence, allowing room for high-level decision-making and discretion.



However, NPM critics, raising a strong case for bureaucracy, (Meier and Hill, 2005; Dunleavy et al, 2006: Pollitt et al., 2007), argued that business techniques cannot be used on non-profit making public institutions that provide public services. Additionally, NPM showed less effective impact in changing the culture of street level bureaucrats (SLBs) than was optimistically projected (Taylor and Kelly, 1998). Letting managers manage carried a strict condition of meeting performance targets. Thus, it went back to being all about rules and targets. "The ability to make policy under the rule discretion was significantly reduced by the increase in rules and accountability that restricted the deviation of formal controls" (Extracted from Rao, 2009: 176).

Then governance through multiple stakeholders and networking became a popular view, aimed at building 'horizontal steering partnerships' as opposed to the vertical chain of command/hierarchy in TPA. Governing with society rather than governing above it (Erik-Hans Klijn, 2005). In short, implying "less government and more governance" (Cleveland, 1972:13). It meant the involvement and interaction of a spectrum of stakeholders, non-state actors- private/business sector, civil society groups, Non-Governmental Organizations (NGOs) and representation from the government/public service. This is similar to Sabatier's advocacy coalition framework.

The health sector reform process to improve service delivery in many African countries has attracted global attention such that, the policy environment is deeply affected by crosscutting external relations. Although, these networks are characterized by horizontal relations, it is argued that, vertical relations also exist in which government representatives engaged in networks, are held accountable by their superiors. This view is advanced by Hill and Hupe (2007:295), who conclude that "governance of and by street-level bureaucrats is practiced in a variety of action situations, while street-level bureaucrats are held accountable in various relations; bottom-up as well as top-down, but also 'sideways' ". Thus, in the context of governance, street level bureaucracy is viewed as part of a layer in its multi-dimensional institutional system characterized by alternative forms of accountability (Hill and Hupe, 2007).

In summary, the policy process in top down systems involves a vertical line of management with full political control, and policy implementation is pre-planned. NPM is characterized by

little discretion for managers with central system control and concentration on performance targets for effective policy implementation. Governance has minimal political control but horizontal lines of management and consensual decision-making are meant to yield effective policy implementation (Peters and Pierre, 1998).

## POLICY IMPLEMENTATION: TOP DOWN VERSUS BOTTOM UP APPROACH

The top-down approach is drawn from rational bureaucratic principles developed by Max Weber. The top-down view assumes a hierarchical "chain of command, a compliant workforce and objectives that the whole organization accepts" (Hudson and Lowe, 2010: 248). This approach considers the policy process in a linear fashion as stipulated by Lasswell (1956). Lasswell (1956) first constructed the famous four stages in which the policy process takes its course: agenda setting, formulation, implementation and evaluation, in that particular order. There is a strong assumption that policy makers/formulators control of the policy process.



Gunn (1978), additionally, points out that, among other best practices set for effective policy implementation is "a small and well-defined chain of command in the management system and a single implementing authority" (Hudson and Lowe, 2009:247). Thus, the chain of command plays a vital role in subjecting the workforce to bureaucratic authority, in that, rules, procedures and regulations are not broken to ensure effective policy implementation. For top down proponents, compliance to prescribed government policy is very crucial. Noncompliance to the rules implies that workers continue to "act in undesired ways, if they

do not take desired actions, or if they cease doing what is desired, to that extent policy becomes ineffective or, at the extreme, a nullity" (Anderson,2006:240).

Therefore, any faults/failures in policy implementation are usually blamed on the failure of personnel to follow laid down instructions from the top (Dunsire, 1990). The top-down perspective not only assumes a strict linear policy process but also assumes that personal views, values, beliefs or judgment presented by bottom line workers/employees should not interfere. Hence, top-downers argue that successful policy implementation involves "the elimination of human infirmity and emotional attachment, as they contribute to the breakdown of service delivery" (Hudson and Lowe, 2010). Similar to Taylor's (1911) scientific management, employees should be viewed as machines in an organizational system. For top downers, it is important that employees are controlled and the practice of discretion by frontline workers is avoided as it compromises the achievement of policy goals. This is why, strong and tighter bureaucratic enforcement is considered highly relevant in this model.



Furthermore, referring to the South African context, Von Holdt (2010:241) asserts, "effective bureaucracy is crucial for the functioning of a modern state". As already stated in the previous chapter, he attributes the failures in health delivery to non-conformity with bureaucratic rules and the use of non- bureaucratic rationales such as affirmative action, as well as the lack of integration of structured rules and analytical discretion, in its functionality (Von Holdt, 2010). In short, the bureaucratic system does not entirely function as a typical bureaucracy, hence, there appears to be neither strong well-organized routines nor

analytical discretionary and innovative capacity, which are both critical to effective policy implementation (Von Holdt, 2010). He argues that that policy implementation works well when using both the top down and bottom up approaches which complement each other.

Others have also concluded in a broader context that an effective state bureaucracy is the key to a successful developmental state (Von Holdt, 2010; Sandbrook et al, 2007; Southall, 2007). However, in line with Lipsky's theory, such simplistic views underestimate the crucial factor in determining what happens at the end point of service delivery as to whether the implementers/SLBs act or implement the designed polices and if not, why? Thus, policy implementation and service delivery very much depend on the decisions made by SLBs in their daily operations and duties than a linearity as purported by the top down view.

Contrary to the top-down perspective, the bottom-up approach rejects the concept of the 'bureaucratic chain of command'. Dating back from the 1970's Lipsky (1971, 1980) formulated the theory that, what is practiced at the bottom of the chain is what forms policy and the implementers are the policy makers themselves. Implying that instead of policy streaming down from the top, it can be modified from the bottom. The front-line workers, who Lipsky (1980) calls 'street level bureaucrats' hold a high level of discretion in understanding and executing policies. How they work is what makes them the "real policy makers because what they do is the effective expression of the policy" (Peterson, 2007:3).

In light of the above, the bottom-up perspective views policy as action exerted by implementers. Implementation failure does not result from failure to plan adequately and

follow instructions. Instead, there is always a gap between policy goals and implementation (Hill, 1997). Hence, failure to implement policy is caused by the conformity to strict bureaucratic rules that do not correspond with the nature of real happenings at the grass root level. According to Lipsky (1980:12) "the decisions of street level bureaucrats, routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public polices they carry out". He suggests that bending of rules and recreating policies by SLBs is *doing the wrong to achieve the good.* Although street level bureaucrats are any frontline personnel in direct contact with the public, Lipsky (1980) mainly considers professionals and semi-professionals like teachers, nurses, social workers and police officers as classic SLBs. Nurses have both administrative and professional functions and have long been studied as SLB's in academic literature.

Thirdly, the bottom-up view opposes strict rules and controls over employees like cogs in an organizational machine. They believe discretion is inevitable, strict rules cannot apply to every situation; hence, personnel cannot escape practicing discretion (Elmore, 1978). "Human agency in reality determines a great deal about how a policy is implemented, how effective it is and whether or not it achieves what the designers of the policy intended" (Hudson and Lowe, 2010: 249). Thus, the product of policy is determined by the actions of street level bureaucrats, who are the key players as opposed to the policy makers. In simple terms, employees act in accordance with the nature of situations and circumstances. The other important point made by Lipsky (1980) is that SLBs work under difficulties that require bending of rules. They feel that, they do their best in providing public services considering the frustrating working conditions. Thus, SLBs are "coal miners of policy: they do the hard,

dirty and dangerous work of the state" (Maynard-Moody & Musheno, 2000:157). This also implies that, they keep services running even when the government defaults on funding provisions. This may be considered the "good side" of SLB's. Other scholars advance more complex views drawing on Lipsky's work (Walker and Gilson, 2004; Hupe and Hill, 2007; Evans, 2010). Evans (2010) for example argues that middle-level managers might also be included with the category of SLB's.

A study of the perceptions of nurses about South Africa's free health policy (Walker and Gilson, 2004), revealed that nurses are left out from the policy process, financial and human resources are limited and most importantly, their (nurses) "views and values inform their implementation of health policy"(2004:1251). This study also presented evidence that nurses felt disempowered in the policy process (including clinic coordinators),and felt they were not rewarded or recognized for the work they do but expected to implement policies that are unknown to them (Walker and Gilson, 2004). In their study, Walker and Gilson (2004), concluded that the top-down systems overlook the values and experiences of SLBs as well as their influence on policy outcomes. On the other hand, in terms of discretion, Walker and Gilson (2004), also note that the achievement of policy goals may be limited, depending on how discretion is exercised by workers at the point of implementation. Hence, SLBs have the power to determine who gets/receives what, by using their own judgment.



However, a different perspective drawn from organizational development theory perceives that implementation failure has nothing to do with both beliefs presented by top down and bottom up approach. Instead, lack of consensus and collaborative working relations between managers and street level workers leads to implementation failure. According to

this view, in order to improve service delivery, efforts should be made to prioritize organizational development, consensus building and commitment among workers at all levels. But getting employees to agree on a common understanding of policy is also another challenge in itself. In an organizational setup people have their own conflicting views (Hudson and Lowe, 2010).

But Sabatier (1986), sees a way of merging both the top down and bottom up approach in his 'advocacy coalition framework' (ACF). He sought to cement the two approaches with the view of making policy implementation work effectively through the collaboration of the policy maker, policy implementer and other relevant external actors to influence policy outcomes positively. Sabatier (1986) asserts that, all stakeholders-civil society and other non-state actors, top government officials and SLB professionals should be part of the policy process, just in the same way that governance/networks operate. The ACF is based on the fundamental belief that a coalition of partners sharing strong core beliefs and values that they adhere to, is a path to successful policy implementation (Sabatier, 1988). Thus, failure to implement policy results from lack of consensus, consultation and collective agreement with all stakeholders.

Sabatier and Mazmanian (1979) synthesizes both top down and bottom up approaches as a way to gain consensual policy in order to yield successful policy implementation. This approach also provides an opportunity for SLBs (who feel left out of the policy process) to participate and contribute to public policy by airing out their views, ideas and experiences,

instead of receiving/being given instructions and orders to act upon. The idea of involvement of bottom line workers, is perceived as a motivating factor to implement policy because of the sense of recognition and belonging (institutionalization).In this case no one bears a grudge because they feel the value of their contribution (Ostrom,2007). The synthesis by Sabatier and Mazmanian (1979) was seemingly sound but other scholars argue that blending top down and bottom up approaches is not an adequate solution to the tension between these rival approaches. This is because the two approaches run opposite each other and cannot meet, as each of their core values are in full antagonism. Hierarchy, compliance and discipline verses discretion, human judgment and strengthened relationships between workers and clients are aspects of "incommensurable paradigms" (Hudson and Lowe, 2010; Parsons, 1995).

Moreover, in as much as governance/networking is being promoted as an effective tool for inclusive public policy and improved public service delivery, much of its criticism is drawn from its weak accountability systems due to strong horizontal relations. There is a lack of enforcement and sovereign authority, hence, partners can work at their own pace without any form of control and are not compelled to perform their tasks as they would be, in the bureaucratic/top down system. If such features are dominant in the coalitions, they hinder the implementation of policy and impact negatively on public service delivery. Thus, where public service provision is concerned, building a strong case for bureaucratic systems may be appropriate as it ensures sovereign authority, control and accountability of public officers in carrying out their duties.

However, Elmore (1979) does not agree with any of the above reasons for policy implementation failure. He puts forward the view that no 'one size fits all' solution can sort out policy implementation. Implementation failure occurs comparatively. "Different issues and circumstances require different frames of reference" (cited in Hudson and Lowe, 2010: 251). This is a more contextual view which at the same time trickles down to the specifics. Thus, policy failure can also be perceived to be issue or sector specific rather than systemic.

Much of the concept of discretion has already been discussed above. At the same time, analyzing how and to what extent the use of discretion may or may not delimit health care service provision with the focus on nurses as SLBs is very crucial in this study. Although most of the literature generated from different studies in this area concentrates on how discretion makes policy implementation possible, as strongly advocated by Lipsky and his followers. The bottom-up perspective tends to overlook the bad and conflicted side of discretion. Discretion in policy implementation can discharge negative effects on public service delivery. It leads to unaccountability, arbitrariness and inconsistency in the pattern of policy implementation (Rao, 2009; Tummers and Bekkers, 2012). When discretion is practiced, it involves personal judgment, values and emotions that public service workers mix with their public duties, thereby, going against neutrality and equal service for all principles.



This study was aimed at analyzing discretion threefold manner: good, bad and/or conflicting, thus, for the purpose of the discussion, it is more suitable to adopt Davis's broad definition of discretion-"a public officer has discretion whenever the effective limits on his power leave him free to make a choice among possible courses of action or inaction" (1969:4). Moreover, most scholars (Ham and Hill, 1984; Hupe and Hill, 2007; Tummers and Bekkers, 2012) researching discretion have used this definition in their studies. These choices may be motivated by "good, bad or even conflicting" intentions and perceived outcomes.

Lipsky's (1980), particular concern in terms of discretion and SLBs is the "freedom in exercising one's work role" (Extracted from Evans, 2010:11). According to Lipsky (1980), discretion is inevitable in policy implementation but he also acknowledges that it could undermine effective policy implementation and organizational accountability (Evans, 2010). Similarly, Jacques (1969) also agrees that many delegated tasks require a certain degree of discretion. SLBs are left with no other choice but to make decisions, even if they are contrary to the rules in order to perform their duties. Lipsky (1980) suggests that it is the complicated situations and circumstances, such as limited resources or work overload that cause SLBs to act the way they act.

The other hindering factor is that, top-level decisions tend to be generic in nature, while those at the bottom are more issue specific. Different problems are encountered and different tasks/activities are performed at the bottom of the chain in order to harmonize specific situations. Hence, some policies are too ambiguous and do not fit into the local situation, since the policy makers are often unaware of what happens at the grassroots (Ham and Hill, 1984, Hupe and Hill, 2007). Lipsky (1980) took advantage of this weakness, to advocate a move away from this sort of rigid formal structures to employ day-to-day situations and conditions of policy implementation and service delivery.

Top-down thinkers view discretion as eroding policy goals. They argue that giving discretion to SLBs is what leads to policy failure because employees act in their own best interest by pursuing their own personal goals, thus, contradicting the stipulated policy (Davis, 1969; Polsky, 1993). They also believe that human agency leads to unequal provision of services. When SLBs practice discretion, there are high chances of practicing favoritism and treating

clients according to the way they personally feel they should be treated, overlooking the stipulated policy. Hence, the top down perspective opposes the freedom of decision making at street level, instead a hierarchy is put in place to control the order of activities.

Decision-making is the "process of making a choice among a number of alternatives (Anderson, 2006: 313). It is also described as a "selection of a preferred course of action from two or more alternatives" (Robbins, 1976:152). However, in a bureaucratic system, public service workers (especially those at lower levels) are not allowed to pass personal decisions or select a preferred course of action in matters pertaining to public service provision. Naturally, in a hierarchy, the top-level officials in a bureaucratic structure or any other institution hold more authority and power in decision making than the lower level personnel.

However, in a bureaucracy hierarchy serves as a tool for final decision making in cases of unclear circumstances and conflicts encountered by SLBs. As Anderson (2006: 221), states "hierarchy provides a means by which discrete decisions can be coordinated and conflicts among officials at lower levels can be resolved". According to the top down theorists, hierarchy is considered as a solution to any decision-making problems faced by SLBs. However, the disadvantage is that, the same hierarchy that is meant for control and compliance, yields non- conformity in decision making at lower level as strongly argued by the bottom up approach.

Furthermore, Walker and Gilson (2004) point out that some nurses feel that not all patients deserve free health care; some just abuse it. Similarly, other studies show various preferences in which clients are served by SLBs. A study by Goodsell (1980/1), revealed that

service providers give better services/benefits to clients who they perceive, are in greater need. However, for those clients who appear difficult or troublesome, service providers tend to engage into tactics that hinder them (clients) from receiving/getting the benefits of the service (Hasenfeld and Steinmetz, 1981). This shows critical evidence of the imposition of personal value and judgment in their work, which falls against bureaucratic principles. While, other cases show that discretion is influenced from the clients' characteristics. For example, some clients are more knowledgeable and make their own demands, hence, they seek attention from service providers by pressurizing them to bend their normal bureaucratic routines (Tripi, 1984).

Nonetheless, a study by Kelly (1994), found that organizational values supersede the influence of the level and type of discretion exercised, on the organizational structure and operations. For example, for fear of losing their jobs, employees, prefer to follow organizational rules in their operations. Generally, values are believed to have a strong influence on deciding what is bad, good, desirable, or undesirable (Anderson, 2006). Public service workers are certainly influenced by the values and principles of the bureaucratic system in their decision-making. However, this does not mean they are not bound to applying personal values, as personal and organizational values turn to conflict, thereby affecting the outcome of decision-making. It is therefore, important to note that the decisions that SLBs make in their daily activities to either use their discretion in a bad or good way, may be generated from different sources of influence - personal, professional and organizational values (Andrews, 1990).

While Aiken and Hage (1966) argue that increased formalization constrains worker decision-making, other scholars see such constraints as relevant to enhanced accountability and protecting clients from individual bias as well as SLBs who usurp authority (Blau and Meyer, 1971; Kaufman, 1977; Burke, 1986). It is for these reasons that top-down proponents minimize discretionary action and emphasize faceless equal treatment through strict hierarchical structures and the principle of applying impersonality in public service provision.

The top-down approach strictly considers full supervision of employees very important at every point and stage of the policy process. If rules are followed and not twisted to suit circumstances, then, policy goals will be well implemented without any obliteration. In similar regard, a procedure is described as "a series of interrelated sequential steps established for the accomplishment of a task (Robbins, 1976:72). Thus, procedures make up an important part of the bureaucratic system and must be followed at all times in order to accomplish service delivery. For example, procedures in a hospital are very important, particularly, standardized procedures in nursing are put in place to ensure order and effectiveness of such a delicate service. If procedures are not followed, it simply means every employee acts in their own way, which maximizes the risk of confusion and chaos. Additionally, policy makers/elected public officials also feel that, only they have the legitimate authority to make decisions because they are elected by the citizens, while, SLBs are not, hence, they do not have a legitimate right to exercise any form of discretion (Sabatier and Mazmanian, 1979; Lowi, 1993).

In contrast, Maynard-Moody and Musheno (2003), in their research found that;

> [M]oral judgments about citizen-clients infuse all aspects of street-level decision making. To street-level workers, fairness has little to do with the bureaucratic norm of treating everyone the same or even fairly implementing laws and regulations. To our storytellers, fairness and justice mean responding to citizen-clients based on their perceived worth (93-94).

The debate between the bottom up and top down perspective on the use of discretion obscures the cultural politics and values of SLBs. Some scholars who have analyzed both views contend that SLBs should be allowed to practice a certain amount of discretion, exercised by setting parameters of control (Simon, 1945; Elmore, 1979; Tummers, 2011; Tummers and Bekker, 2012). Simon (1945), in his studies on *Administrative Behavior,* concedes the need for discretion in bureaucratic institutions/organizations. He asserts;



The behavior of a rational person can be controlled, therefore, if the value and factual premises upon which he bases his decisions are specified for him. This control can be complete or partial-all premises can be specified, or some can be left to his discretion. Influence, then, is exercised through control over the premises of decision (Simon, 1945:223).

Similarly, Elmore (1979) acknowledges that mistakes and blunders are bound to happen by the use of discretion, thus, raising major issues that demand a requirement for setting of boundaries in which discretionary action may be granted. He brings out the view that;

> [P]eople lower down the systems have free will but their will needs to be psychologically attuned to perform in accordance with the central decision makers' aims. Failure to implement properly is a failure to identify weaknesses and lapses in the performance of subordinates (extracted from Hudson and Lowe, 2010:251).

Similarly, Tummers and Bekkers (2012), in defense of discretion, point out in their study on *Discretion and Effects: Analyzing the experiences of street-level bureaucrats during policy implementation,* that discretion is vital for effective policy implementation. It motivates bottom level workers who willingly feel the need to implement policy. "We can state that discretion influences the effectiveness and legitimacy of public policy programs in a positive way, because discretion stimulates willingness and reduces resistance" (Tummers and Bekkers, 2012:16).



What Tummers and Bekkers (2012) highlight here, is that, even a limited freedom for decision-making, makes SLBs feel important and part of the policy process, hence, they willingly implement policy without any resistance. Human resource management advocates, also support the view that every employee has a right to exercise decision making concerning what affects them in the work place (Kantar, 1992; Wagner III, 1994; Deci and Ryan, 2004). Hence, Tummers and Bekkers (2012) recommend that freedom/discretion to adjust policy programs be granted to implementing bureaucrats/SLBs, at the same time they also take note of the threats it poses but conclude that, any means of withdrawal from the use of discretion should involve a clear analysis of the pros and cons in a specified situation.

With such overwhelming literature in support of discretion, it is obvious that the term can be broken down in useful ways. Scott (1997), using the term 'bureaucratic discretion' points out that it is "an important topic for the field of public administration because it is linked to the achievement of objectives such as good government, effectiveness in service delivery, and citizen satisfaction" (1997:36). Its relevance in public administration research can be marked by understanding its characteristics and consequences since it is the avenue through which policy implementation may be achieved (Scott, 1997). However, measuring how much of it (discretion) is bad or good is lacking in most literature. Most of the research studies conducted by bottom up proponents' centers on *how much* discretion positively contributes to service delivery despite the bending of rules, and they have showed that at the end of the day services are provided to the public. Thus, in the eyes of the public, SLBs are the government (Elmore, 1979).



Hence, in order to build a strong case for bureaucratic discretion, it is important to critically and thoroughly examine conditions and factors that influence discretionary outcomes so as to find and accentuate the positive use of discretion (Scott, 1997). However, this is one task that cannot be easily established considering the unexpected occurrences that reality bestows upon SLBs. Simon (1945); Elmore (1979); Rao (2009), all point out that there should be a form of control on how discretion is practiced/exercised but do not explain how it can be done. As has already been clearly pointed out that, situations, circumstances, manifestations, and activities at the bottom level/point of delivery are distinctive in nature and cannot be standardized. Hence, it remains questionable on how control can be inserted in such varying circumstances. This leaves room for more research in this area.

At this point, it is also important to note that, most of the literature on discretion and implementation pays little attention to analyzing types of discretion and internal dilemmas as well as risks experienced by SLBs. Most of traditional literature is negative since it focuses on deviation from formal/legal policy. In summary, discretion in this study is classified into positive and negative practices; the top down approach considers discretion negative/bad while the bottom up advocates say it is positive/good despite the deviation from formal rules for good of the recipients of public services. However, discretion is also perceived to be conflicting in that a "negative" practice can lead to good or bad effects to either the service provider or service recipient for example, making an on-the spot decision based on need, present situation and circumstance rather than following the formal required rule/action.

Thus, my focus in this research draws attention to the kinds of discretion exercised by nurses in terms of good, bad and conflicting, with the aim of generating information that can help to analyze advantages and disadvantages of the concept of discretion in policy implementation in order to determine its relevance and contribution to service delivery.

## CHAPTER 3: THE NURSING PROFESSION IN THE SOUTH AFRICAN CONTEXT

### INTRODUCTION

The aim of this chapter is to give a brief overview of some important aspects of nursing particularly relevant to this study. The issues discussed include; a historical background of the nursing profession in the South African context, the nursing Act-scope of practice and nursing categories, nursing rights and code of ethics, mental health nursing in South Africa, and the crisis in nursing in the post-apartheid period .

"The historical processes which have shaped nursing in South Africa have played, and continue to play, an important role in defining the interface between patients and healers" (Marks, 1994: 324). The apartheid epoch largely influenced the way South Africa is structured today. The development of nursing as a profession is no exception from this influence. According to Marks (1994: 324), the historical roots of nursing are marked by the "intensity of the dynamic of race, class and gender". In the early 1900s, nursing was predominated by the English middle-class females and closely related to the church-sisterhood. It was also open to mission- educated African women who were accorded a chance to serve in respectable positions (Marks, 1994). The recruitment of black women was also accelerated by the nursing shortages experienced as the result of World War II. However, there were many racial struggles faced by African nurses to get enrolled and admitted into the profession. Even though some nurses were given better positions, they still faced racial limitations in their duties, in that, black nurses could not nurse white

patients nor have white nursing subordinates or even share the same salary scale with the white nurses, the black nurses salaries were lower (Marks, 1994). The historical racial struggles experienced by black nurses is said to have a big reflection on the behavior they exert towards their clientele, as most nurses are generally perceived to be rude to patients (Jewkes et al, 1998).

The nursing profession in the early days, initiated by the church missions groomed nursing students to apply ethos and moral living in to their duties. They were taught to go beyond looking after the sick by encouraging the right way of life drawn from religious principles. In the olden days, it was also important for a nurse to subject him/herself under the authority of the doctor while assuming predominance and control over their patients (Marks, 1994). Hence, it may be possible to assume that discretion among nurses in the olden days might have been present at a minimal level. If they were able to make independent decisions over the affairs of their patients, since they were taught to take control of the lives of their patients.



In the heyday of apartheid, the nursing profession was organised along autocratic and top down lines of management. Thomas (2008) refers to this type of management style as "military hierarchy", implying that there was no room for discretion among nurses. Nurses had to bow down to authority at all times without questioning. According to Thomas's narration of this management style;

> Nurses like my mother, literally had to work themselves up from their knees with a maid's cap perched on their heads. The ward sister had to be obeyed without

question as her underlings slowly advanced through the ranks with epaulettes on their shoulders as a constant reminder of their place (Thomas, 2008:152).

However, the modern democratized nurses seem to have drawn away from the religious principles and ethos of kindness to patients, instead, there is neglect and negligence in patient care as well as abuse. These circumstances could have risen due to high levels of autonomy that nurses hold as front line workers. Nurses in present day, certainly exercise substantive volumes of discretion that can either enhance policy implementation and service delivery or derail it. Additionally, present day nurses do not see themselves as subordinates to doctors as they are able to make decisions independently and are solely held accountable for their actions (Searle, 2000).



The post-apartheid nursing system differs from the old due to growing realization of the recognition of nurse's rights and the value of the use of discretion in patient care. More professionals today prefer a democratic style of management in which their able to use their discretion in decision making, as opposed to the so-called 'military style'. Moreover, the Nursing Act enables registered professional nurses, to be accountable for their own acts and omissions (SANC, 2006). The bottom up proponents through their various studies succeeded in illustrating the power of SLBs as policy makers in facilitating effective policy implementation. Hence, the democratic style of management takes predominance over the old military type despite rigid hierarchical structures still in place. Notably, this democratic style that can also be viewed as a bottom up system is bound to destruct service delivery according to the top down perspective, for instance when nurses abuse the use of discretion (using it in a bad or inappropriate manner). In this regard, Thomas (2008:152) states, "an

autocratic system can certainly ensure the discipline, accountability, diligence and application which are necessary for good patient care. Unfortunately it is also an open invitation for tyrannical matrons to exploit abuse and demean their underlings". Thomas (2008), further points out a similar view to Lipsky (1980), that the conditions under which nurses in South Africa operate in, precipitate actions that led to exorcizing and stamping over polices that are not practical or aligned to the realities that nurses as SLBs are faced with.

## NURSING ACT

Profoundly, the nursing profession hemmed in many struggles, firstly, for recognition, professionalization and legitimacy, and secondly for representation of nurses in the medical council before the establishment of its own independent controlling body (Searle, 1998). Two significant events mark the development of the nursing profession in South Africa. First was its first registration as a recognized profession in 1891 and secondly, the passing of the first Nursing Act in 1944 to control the profession. By 1957, registration for all qualified practicing nurses was mandatory unlike the first registration when it was voluntary (Searle, 1975). Thereafter several amendments have been made to the Nursing Act concerning the governance of nursing and different affairs related to it, dating back from the Act of 1944 (45 of 1944) to the most recent Act 2005 (33 of 2005). This Act legislatively enables the practice of nursing as a profession and makes provision for its regulation by the South African Nursing Council (SANC).Nurses fought for a breakaway from the medical council to establish their own regulatory body. Hence, SANC as a statutory body was instituted in the nursing Act 1978 (50 of 1978), and has since been in-charge of handling matters concerned

and related to the nursing profession (SANC, 2006). The following are the nursing categories as defined by the Nursing Act 2005 (33 of 2005).

## CATEGORIES OF NURSES

There are different categories of nursing in South Africa and the highest level of practice in the profession been named as a 'registered professional nurse'. The categories highlighted below include; Professional nurse, Enrolled nurse, Staff nurse and Auxiliary nurse. Nurses at the level of a registered professional nurse are trained and competent to carry out preventative, curative and rehabilitative health services (SANC, 2006).

***Professional nurse***: "is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice" (SANC 2006:25). The duties of a professional nurse include administering medication for treatment, per doctor's prescription only, medical diagnosis for referral or emergence treatment in the absence of a medical doctor, but limited to practice in accordance and within the level of knowledge and competence (SANC, 2006). In addition to the prescribed duties, a professional nurse carries out administrative, patient hygiene care, counseling and theoretical support (Searle, 2004). A professional nurse being registered with SANC is subjected to abide by the professional ethical code of practice, thus, she/he is accountable for her/his own acts and omissions (SANC, 2006).

**Enrolled nurse:** an enrolled nurse works under the supervision of a registered nurse.

***Staff nurse*:** "is a person educated to practice basic nursing in the manner and to the level prescribed" (SANC 2005:25).

***Auxiliary nurse*** "is a person educated to provide elementary nursing care in the manner and to the level prescribed" (ibid).

All of the above categories register with the SANC and are recognized as registered practicing professionals. As such only qualified and registered persons as per accepted standard requirements use the title of 'registered' professional nurse or the others mentioned above (Ibid).

This also applies to the scope of practice, only persons meeting such professional criteria are permitted to carry out functions in accordance to the profession. Thus, in accordance with the Act, "an employer must not employ or retain in employment a person to perform the functions pertaining to the profession of nursing, other than a person who holds the necessary qualification and who is registered" (SANC, 2005:25). The other categories include; enrolled nurse cutting across different specialty, for example midwifery or community service nurse. Enrolled nursing assistants and nursing assistants, going by the term 'assistant' provide assistance to all the above mentioned categories. The scope of practice of all named 'assistants' including the enrolled nurse is planned and outlined through the responsibilities given by the registered nurse, whose supervision they fall under. This also means that the scope of practice of the enrolled nurse is at the discretion of the registered nurse. Therefore, the Act makes provision for a registered nurse to be held accountable for the actions of an enrolled nurse if he/she works beyond their scope for giving them such functions that are beyond their knowledge and skill (SANC, 2006). For

example, an enrolled nurse cannot be given the responsibility to head a ward without the supervision of a registered nurse but this may happen due to different situations in which a registered nurse may not be available to supervise. Hence, the enrolled nurse may either choose to use his/her discretion to act according to need or not take up the responsibility in the ward at all because it is beyond their scope.

## NURSING RIGHTS AND PROFESSIONAL CONDUCT

Firstly, all nurses have labour rights as enacted by the South African Constitution just like any other workers. However, the following are some of the interesting nursing rights[1] that relate to this research study:

Practice in accordance with the scope, which is legally permissible for his/her, specific practice

Safe working environment which is compatible with efficient patient care and which is equipped with at least the minimum physical, material and personnel requirements

In the case of a registered person, equal and full participation in such policy determination, planning, and decision-making as may concern the treatment and care of the patient

Conscientious objection provided that;

The employer has been timeously informed in written

---

[1] Source, SANC website www.sanc.co.za/ NURSING RIGHTS. 2004 - 2013 South African Nursing Council (Under the provisions of the Nursing Act, 2005)

Does not interfere with the safety of the patient and/or interrupt his treatment and nursing

Refuse to carry out a task reasonably regarded as outside the scope of his/her practice and for which he/she has insufficient training or for which he/she has insufficient knowledge or skill

Not to participate in unethical or incompetent practice written policy guidelines and prescriptions concerning the management of his/her working environment

Working environment which is free of threats, intimidation and/or interference

These rights are well defined but it is uncertain if most of the nurses are aware of these rights. As an observer in the field, I did not see any posted documents that show these rights. Hence, it may be appropriate to question the actual applicable of these rights by the nurses, if they are aware of them or not. Moreover, one of the questions from the self-administered questionnaire addresses the issue of rights, in terms of expressing personal judgment in their work. It was found that most nurses feel limited in terms of the so called rights they hold. Along with the rights, nurses are expected to work according to professional conduct in respect to the ethics guiding the profession. Thus, violation of the professional code can lead to disciplinary action by the nursing council.



## MENTAL HEALTH NURSING IN SOUTH AFRICA

### Nursing ethics and discretion

If a nurse does not understand the basic legal, ethical, physical, biological, therapeutic, social and psychological elements of safe and considerate nursing care, if she [or he] does not understand her own rights as a registered nurse practitioner vis-à-vis her employer, if

she [or he] does not understand or comply with the fundamental principles underlying the professional conduct of a registered nurse.....we cannot call her a professional practitioner, no matter what the law says (Searle 1988: 63)

The subject of ethics in nursing is very crucial as it plays an important role in determining the behavior and attitude of nurses as SLBs. Ethics are placed in nursing to do good and avoid harm, because the power and possibilities of doing harm are fairly high (Bandman and Bandman, 1985). With ethics comes the code of conduct for nurses in service provision, which must be followed by every nurse at all times. Without going in to more details of the entire list of what the code says, there is one particular area of interest, I wish to highlight. One of the internationally accepted code of ethics is that "the nurses' relation to people is one in which nursing care is provided in an environment that respects individual values, spiritual beliefs and customs" (Tate ICN,1977: vii). This implies that nurses may not impose their personal values on a patient, it however, remains questionable how often this is practiced.



Noting that professional values add to the different complexities encountered, when one has to decide how to handle a situation objectively. It is believed that "professions tend to form distinctive preferences as to how problems should be handled" (Anderson, 2006:129). The motives behind certain actions by nurses are influenced by professional values and ideally, nursing professionals are expected to be sensitive to the needs of the public, due to the nature of their work. Additionally, it is perceived that value judgment in this profession precedes written down guidelines (Andrews, 1990). On the contrary, the rational choice

theorists hold the view that bureaucrats purely act out of self-interest and personal enhancement. Are nurses able to treat patients the same, without any practices of favoritism, mutual favors and other unethical acts outside their code of practice and conduct? While the act clearly stipulates the professional code thereby reinforcing legality into the profession, however, what happens in reality is different.

The actions of nurses vary according circumstances or situations they face on a daily basis and sometimes the ethical conduct is breached. For example, Searle (1988: 62) states that "we all know that some neglect of patients occurs daily and that slovenly, indifferent and even ignorant practice occurs at times". This is where the use of discretion comes in and discretion among nurses is used in different ways via the bottom up (good way) or top down (bad way) perspective.



Mental health is one of the basic elements of comprehensive health services for professional nursing in South Africa (Uys and Middleton, 2004). Mental health nursing differs from other general health services. Nurses who move to mental health services (from general practices) suffer culture shock, resulting from the distressing mental environment yet the pace of work is perceived to be slower (Uys and Middleton, 2004). According to (Uys and Middleton, 2004), the following components make up the process of mental health; dealing with interpersonal behavior, counseling, providing support and facilitation for health living. However, (O'Toole and Welt, 1989) see counseling as the most crucial role of a nurse in mental health service.

Contrary to the view that the work in a mental hospital may be seen as less pressured than in a general hospital, the role of nurses who provide mental health care includes many other tasks that may be considered to be outside or beyond their scope of practice. For example, Uys and Middleton (2004: 16) state that psychiatry nurses "manage the physical facilities, supervise the domestic and clerical staff, serve meals, hand out medication, respond to queries from family members, and see that patients get to occupational and other therapies". It is also important to note that, these activities are carried out by different categories of nurses according to qualifications , for example, a nursing assistant bears the responsibility of serving meals, while a professional nurse take a bigger managerial responsibility , addressing family queries and all manner of the patients/family related affairs that are classified as social worker responsibilities. Additionally, the findings in this study proved many instances that show nurses in mental health service provision taking up multiple roles, going beyond and outside their scope of practice, as well as those that go below their scope of practice due to human resource constraints.



All in all, nurses, in this particular case, ideally, a mental health nurse works in a multi-professional team or environment that consists of a social worker, psychologist, occupational therapist, pharmacist and doctor, who all have an important part to play in a mental patient's wellness, but ultimately, the duties of the others in the chain, are all relinquished to the burden of a single nurse. The nurse is found in such a position because of the many hours spent with the patients, the nurse is always by the patients' side when not all these other professionals are there. This gives them the ability to often effectively determine or predict informed decisions over the betterment/ wellbeing of the patient.

Hence, nurses possess a higher 'legitimate' say over patients than any other professional despite level of knowledge and expertise. This is what ultimately, gives them the confidence to make their own decisions and exercise discretion over patients.

## NURSING CRISIS IN POST-APARTHEID SOUTH AFRICA

The good policies formulated to improve the organization and performance of the health sector has failed to take off effectively due to a number of factors. Limited human resource leading to increased levels of stress, poor management system and supervision of staff, including the HIV/AIDs pandemic have certainly affected service delivery and the implementation of the health policy vision in South Africa. Despite the inception of an integrated national comprehensive health system, service delivery in the health sector is troubled by a substantial human resource crisis (Coovadia et al, 2009). The public hospitals countrywide, especially at district level are highly hit with shortage of staff in the nursing profession. "There has been a substantial decrease in the nurse-to-population ratio, from 149 public sector professional (i.e., registered) nurses per 100 000 population in 1998 to 110 per 100 000 population in 2007 (Coovadia et al, 2009:14; Health Systems Trust, 1998:203-16)". The nursing staff levels are also unevenly distributed in the provinces.

In 2008, about 40.3% of posts for registered nurses' were vacant throughout South Africa (Health Systems Trust, 2008). Many of the provinces recorded high percentages of vacant posts; the Eastern Cape 53.6%, the Free State 51.6%, Gauteng 34.4%, Kwa-Zulu Natal 39.6%

and Limpopo 43.7% (ibid., 2008 ). Nurses in the public hospitals complain of severe staff shortages and massive work overload. Such difficult and stressful working conditions have led to brain drain of the profession as many nurses leave the country for better conditions and less workload overseas. These circumstances, have also led nurses as SLBs admitting to bending the rules and creating shortcuts in order to lessen the burden of work overload *(www.timeslive.co.za, The Times* July 29, 2013). Additionally, other contributing factors to this shortage crisis include migration into private practices, reduced number of graduates; attrition and retirement. Forty percent of nurses are due for retirement between 5-10 years period and 16% of nurses count for those affected by HIV/AIDs (Coovadia et al, 2009).

It is unfortunate to note that the human resource challenge in the nursing profession has been an issue of concern since 1994, yet it increasingly continues to remain a burden on health service delivery. One of the programmes initiated as part of human resource capacity building to address the shortages by introducing mid-level health workers was unfortunately perceived to have produced low grandaunts unable to cover up the nursing deficits as well as other professions (Wood and Jewkes, 2006).



In spite of the 60% budget allocated to human resource activities, the management of the human resource systems appears to be weak due to poor managerial capacity. In other words, the bureaucratic system is not as tight as it used to be during apartheid. Under the domination of mostly white and male employees at senior management level, the system was centralized, uneven and more tightened. It is however, perceived by many scholars that the affirmative action policy introduced to iron out racial and gender disparities may have

compromised the systems. Due to the focus on increasing the number of black and female personnel in managerial positions without paying much attention to the skills, experience and competence required for those positions (Von Holdt, 2010; Coovadia et al, 2009). In this regard, South Africa's public administration system as produced public service managers who are seen to be struggling with the management of the public workforce. The nursing profession is reported to be characterized by ill-discipline, absenteeism, nurses admitting to moonlighting, limited support in training, among other things (Coovadia et al, 2009). All these problems have largely contributed to the unfruitful outcome of good policies that are not well implemented.

The top down approach emphasis a strong bureaucratic system to maintain order and the organization of public services but once policies are formulated and not implemented as they ought to be, the system is compromised. This is where the bottom up perspective finds room (created by the bureaucratic system) in which SLBs take over the running of the public service. Hence, discretion amongst SLBs becomes the order of the day. Similarly, in the field of nursing, because the shortage of staff seems not to be receiving the much needed attention from the government, despite it being a vital crisis, nurses as SLBs as Lipsky(1980) points outs, develop various forms of their own solutions to dealing with the crisis. Some of the solutions are evidently highlighted from the findings in this study.

Clearly, it is without doubt that the nursing staff shortage crisis needs serious and urgent intervention. Some hospitals that have performed well present the following factors as necessary and effective tools, emphasized by a senior nursing staff; in-service training and

career development, effective supervision of subordinates and induction of new recruits (Puoane et al, 2008). In addition to limited human resource, "poor stewardship at the policy level and weak management and supportive supervision at the implementation level are major obstacles to improving the health system in South Africa" (Coovadia et al, 2009:15; Schneider et al, 2007).

## CHAPTER 4: QUANTITATIVE DATA ANALYSIS

This chapter shows the outcome of the findings from the data collected through the 30 self-administered questionnaires filled in by nurses who participated in this research. The aim of the chapter is to present the findings to reveal a general overview of the information generated. Firstly, all the data is summarized in one table, followed by the discussion of findings.

### 4.1. STATISTICS OF AGE AND WORK EXPERIENCE

| | Frequency | Mode | Minimum | Mean | Maximum |
|---|---|---|---|---|---|
| AGE | 3 | 29 | 24 | 40.79 | 67 |
| PROFESSIONAL EXPERIENCE (years) | 3 | 6/25 | 0 | 15.15 | 40 |



The preceding table shows the age difference and work experience of respondents. All 30 respondents disclosed their professional work experience. As it is indicated in the table, the oldest respondent to participate in this study was 67 years old and the youngest 24, making the average close to 41. Hence, there was a fair distribution of ages in the group.

**Work Experience**

In terms of work experience, three respondents out of the 30 indicated 6 years of work experience and another three indicated 25 years of work experience. Fifteen years was the average/mean work experience.

The 30 respondents were equally divided according to male and female. 15 male and 15 female.

**Table 4.2** SEX BREAK DOWN OF SAMPLE

| | Frequency | Percent |
|---|---|---|
| FEMALE | 15 | 50.0 |
| MALE | 15 | 50.0 |
| Total | 30 | 100.0 |

The table below shows the different categories of nurses who were interviewed.

Table 4.3 NURSING CATEGORY/PROFESSIONAL QUALIFICATION

| | Frequency | Percent |
|---|---|---|
| DEGREE(BCUR) PROFESSIONAL NURSE | 2 | 6.7 |
| REGISTERED PROFESSIONAL NURSE | 16 | 53.3 |
| ENROLLED NURSE | 3 | 10.0 |
| EN/NURSING ASSISTANT | 4 | 13.3 |
| AUXILLARY NURSE | 1 | 3.3 |
| POSTGRAD DIP/SPECIALITY-PSYCHIATRY | 2 | 6.7 |
| STAFF NURSE | 2 | 6.7 |
| TOTAL | 30 | 100 |



The extended tables below represent summary findings of each question asked in the self-administered questionnaire, indicating the frequency and percentage of responses answered by respondents. Some of the questions (Questions 4, 5 and 9) were set to cover a period of 6 months preceding the research study.

**TABLES 4.4 SUMMARIES OF QUESTIONNAIRE FINDINGS**

| **FINDINGS Q.2. DO YOU FOLLOW THE INSTRUCTIONS/ORDERS GIVEN TO YOU BY YOUR SUPERVISOR** | | |
|---|---|---|
| | *Frequency* | *Percent* |
| ***Depending on situation*** | ***14*** | ***46.7*** |
| *All the time* | *8* | *26.7* |
| *Depending on Instruction/order* | *8* | *26.7* |
| *Total* | *30* | *100.0* |



The highest and most frequent response was 47 percent .Indicates that most nurses act 'depending on the situation'. They do not follow the instructions given to them 'all the time', only few of them do as showed (27 per cent said 'all the time'), while, another 27 per cent said 'depending on the instruction/order'.

**Q.3. HOW OFTEN DO YOU NOT DO WHAT YOU ARE TOLD TO DO BY YOUR SUPERIOR**

| | *Frequency* | *Percent* |
|---|---|---|
| *Never/ not applicable* | *8* | *26.7* |
| *Most of the time* | *2* | *6.7* |
| ***Not often*** | ***17*** | ***56.7*** |
| *Total* | *27* | *90.0* |
| *Missing* | *3* | *10.0* |
| *Total* | *30* | *100.0* |



The highest and most frequent response was 'not often' at 57 percent, which is more than half of the sample. This implies that the majority of nurses do what they are told by the superior officer. Very few of them (7 per cent) do as they please. Note that the 3 missing responses could have generated from fear (by nurses) to give or disclose an answer that might appear to be troublesome.

| Q.4. | | Frequency | Percent |
|---|---|---|---|
| HOW MANY TIMES HAVE YOU HAD TO MAKE YOUR OWN DECISIONS ABOUT PATIENTS DURING THE LAST 6 MONTHS? | *Never* | *4* | *13.3* |
| | *Many times (countless times)* | *12* | *40.0* |
| | ***Few times (2-3times)*** | ***14*** | ***46.7*** |
| | *Total* | *30* | *100.0* |



The most frequent response - 47 per cent of nurses made their own decisions about patients 'few times', very few of them (13 per cent) 'never' made their own decisions and 40 per cent did 'many times' during the last 6 months.

| Q.5. WHEN DO YOU ACT ACCORDING TO YOUR PERSONAL VALUES AND WHAT YOU BELIEVE SHOULD BE DONE (During the past 6 months) | *Do personal values affect your work?* | *Frequency* | *%* |
|---|---|---|---|
| | *All the time* | *3* | *10.0* |
| | ***When it is necessary*** | ***17*** | ***56.7*** |
| | *I do not/never* | *2* | *6.7* |
| | *Most of the time* | *8* | *26.7* |
| | *Total* | *30* | *100.0* |



More than half (57 per cent) of the nurses indicated that they act according to their personal values 'when necessary'. Only 7 per cent said they do not/never while the second frequent answer was 'most of the time' and 10 per cent indicated that they had done it all the time during the past 1 year

| Q.6. SHORTCUTS OR DIVERTING FROM INSTITUTIONAL RULES IS NECESSARY IN YOUR SCOPE OF WORK | | Frequency | Percent |
|---|---|---|---|
| | Agree | 6 | 20.0 |
| | Strongly agree | 1 | 3.3 |
| | **Disagree** | **16** | **53.3** |
| | Strongly disagree | 4 | 13.3 |
| | Somewhat | 3 | 10.0 |
| | Total | 30 | 100.0 |



The highest and most frequent response was 'disagree' (53 per cent), indicating more than half of the nurses do not view 'shortcuts' and 'bending of the rules' necessary. However, the second frequent response show 20 per cent agreeing that shortcuts are necessary

| Q.7. WHAT MATTERS MOST IN THIS PROFESSION IS GETTING THE JOB DONE RATHER THAN FOLLOWING RIGID RULES/GUIDELINES | | Frequency | Percent |
|---|---|---|---|
| | Agree | 5 | 16.7 |
| | Strongly agree | 4 | 13.3 |
| | **Disagree** | **10** | **33.3** |
| | Strongly disagree | 6 | 20.0 |
| | Somewhat | 5 | 16.7 |
| | Total | 30 | 100.0 |



A higher number of respondents (33 per cent) 'disagreed' to the given statement (Q7). 20 per cent 'strongly disagreed' while 17 per cent said they 'agreed'.

| Q.8. I WOULDN'T WANT TO RISK MY JOB BY EXERCISING DISCRETION EVEN IF IT MEANS PROVIDING EFFECTIVE SERVICES | | Frequency | Percent |
|---|---|---|---|
| | **Agree** | **12** | **40.0** |
| | Strongly agree | 6 | 20.0 |
| | Disagree | 6 | 20.0 |
| | Strongly disagree | 3 | 10.0 |
| | Somewhat | 3 | 10.0 |
| | Total | 30 | 100.0 |

More nurses (60 per cent) 'agreed' with the given statement (Q8) than those who answered 'disagree or strongly disagree'. This means that most respondents would not put their jobs at risk for the sake of effective services.

**Q.9 KINDLY HONESTLY ANSWERS IF YOU HAVE PRACTICED ANY OF THE FOLLOWING IN YOUR LINE OF DUTY (during the last 6 months)?**

***A. Favoritism and personal preference***

| | Frequency | Percent |
|---|---|---|
| Once | 4 | 13.3 |
| More than twice | 7 | 23.3 |
| **No** | **17** | **56.7** |
| Total | 28 | 93.3 |
| Missing | 2 | 6.7 |
| Total | 30 | 100.0 |

***B. Shortcuts or bending the rules to attend to a patient on mutual exchange basis***

| | Frequency | Percent |
|---|---|---|
| Once | 1 | 3.3 |
| More than twice | 8 | 26.7 |
| Lost count | 1 | 3.3 |
| **No** | **18** | **60.0** |
| Total | 28 | 93.3 |
| Missing | 2 | 6.7 |
| Total | 30 | 100.0 |

***C. Went against normal routine to help a patient in any way***

| | Frequency | Percent |
|---|---|---|
| **More than twice** | **14** | **46.7** |
| Lost count | 7 | 23.3 |
| No | 7 | 23.3 |
| Total | 28 | 93.3 |

***Mutual exchange basis** to provide a service in return for a favor or material items from a patient.*

| | | |
|---|---|---|
| *Missing* | *2* | *6.7* |
| *Total* | *30* | *100.0* |

***D. Expressed reservation to attend to a deviant patient or someone you felt did not deserve the service***

| | *Frequency* | *Percent* |
|---|---|---|
| *More than twice* | *3* | *10.0* |
| *Lost count* | *4* | *13.3* |
| *Once* | *1* | *3.3* |
| ***No*** | ***20*** | ***66.7*** |
| *Total* | *28* | *93.3* |
| *Missing* | *2* | *6.7* |
| *Total* | *30* | *100.0* |

***E. Establishing or inventing other rules that make your work a lot more easier when under pressure***

| | *Frequency* | *Percent* |
|---|---|---|
| *Once* | *3* | *10.0* |
| *More than twice* | *9* | ***30.0*** |
| *Lost count* | *8* | *26.7* |
| *No* | *8* | *26.7* |
| *Total* | *28* | *93.3* |
| *Missing* | *2* | *6.7* |
| *Total* | *30* | *100.0* |

| | | Frequency | Percent |
|---|---|---|---|
| **Q.10.How do you feel when you act outside institutional rules by making your own decisions or using your own judgment over a particular situation** | *I have never acted outside institutional rules* | *4* | *13.3* |
| | *I feel it is my right as a nurse to use my clinical experience and intuition in certain cases/situation* | *2* | *6.7* |
| | *Satisfied that I have performed by duty and feel valuable to the service* | *5* | *16.7* |
| | *It is better to follow instincts sometimes than rules* | *3* | *10.0* |
| | *Mixed feelings of both regret and satisfaction* | *7* | *23.3* |
| | ***B and C*** | *9* | ***30.0*** |
| | *Total* | *30* | *100.0* |



The majority of nurses (30 per cent) indicated that they feel it is their right to use their clinical experience and tuition and feel satisfied and valuable when they act outside institutional rules (i.e. use of discretion). Even though 23 per cent said they feel "mixed feelings of both regret and satisfaction. 13 per cent said they had 'never acted outside

institutional rules', while 10 per cent of respondents were in favor of 'instincts' rather than 'rules'.

**Q11. WHAT DO YOU CONSIDER THE MOST IMPORTANT THING TO DO WHEN FACED WITH A SITUATION THAT CONFLICTS THE HOSPITAL RULES**

| | *Frequency* | *Percent* |
|---|---|---|
| *Act according to what you think may be right at that moment using your personal judgment* | *5* | *16.7* |
| *Refer the matter to higher authority even if it needs urgent attention* | *8* | *26.7* |
| *Use your discretion to make a decision that aims to satisfy the patient's needs* | *7* | *23.3* |

| | | |
|---|---|---|
| | | |
| ***Strictly follow the hospital rules and regulations without any compromise*** | ***10*** | ***33.3*** |
| *Total* | *30* | *100.0* |

33 per cent was the highest response in this category, representing nurses who choose to follow the hospital rules strictly without compromise when faced with any situation. While 26 per cent said they would refer the matter to higher authority, and 23 percent indicated the use of discretion. 17 per cent said they would act according to their personal judgment.



| **Q.12.** | | *Freq uen cy* | **%** |
|---|---|---|---|
| **HOW WOULD YOU VIEW THE USE OF DISCRETION IN YOUR WORK AS A NURSE?(FOR EXAMPLE, WORKING EXTRA HOURS VOLUNTARILY TO FINISH A TASK,** | ***Does more good than harm*** | ***11*** | ***36.7*** |
| | *Does more bad than good* | *4* | *13.3* |

| | | | |
|---|---|---|---|
| DECIDING ON YOUR OWN WHICH PATIENT TO ATTEND TO WITHOUT FOLLOWING THE QUEUE, SKIPPING NORMAL ROUTINE DUE TO TIME LIMITATION | *Conflicting (50/50 situation)* | *9* | *30.0* |
| | *Not sure* | *6* | *20.0* |
| | *Total* | *30* | *100.0* |

The highest and most frequent response was in support of discretion at 37per cent, seconded by it been conflicting and the lowest score was 23 per cent from those whose indicated that discretion 'does more harm than good'. While 20 per cent were not sure whether it's bad or good



| Q.13. | | *Frequency* | *Percent* |
|---|---|---|---|
| FRONTLINE WORKERS LIKE YOU SHOULD BE GIVEN ROOM TO EXERCISE DISCRETION IN ORDER TO ENHANCE SUCCESSFUL POLICY IMPLEMENTATION AND HEALTH SERVICE DELIVERY | ***Agree*** | ***14*** | ***46.7*** |
| | *Strongly agree* | *8* | *26.7* |
| | *Disagree* | *3* | *10.0* |
| | *Somewhat* | *5* | *16.7* |
| | *Total* | *30* | *100.0* |

*The highest figure (47 per cent) in question 13 is the strong indication that nurses support the exercise of discretion in successful policy implementation, thus discretion is important to nurses. Furthermore, 27 per cent strongly agreed to discretion while very few respondents (10 per cent) showed a contrary view.*

| Q.14. | | Frequency | Percent |
|---|---|---|---|
| THE LEVEL OF INFLUENCE, ACTION AND SIGNIFICANCE OF NURSES IN POLICY IMPLEMENTATION IS UNDERMINED | ***Agree*** | ***17*** | ***56.7*** |
| | *Strongly agree* | *8* | *26.7* |
| | *Disagree* | *2* | *6.7* |
| | *Somewhat* | *3* | *10.0* |
| | *Total* | *30* | *100.0* |



58 per cent of nurses agree that there significance and contribution to policy implementation is undermined. Presents a strong indication that a most nurses feel their work is not valued as only 7 per cent felt it is not undermined.

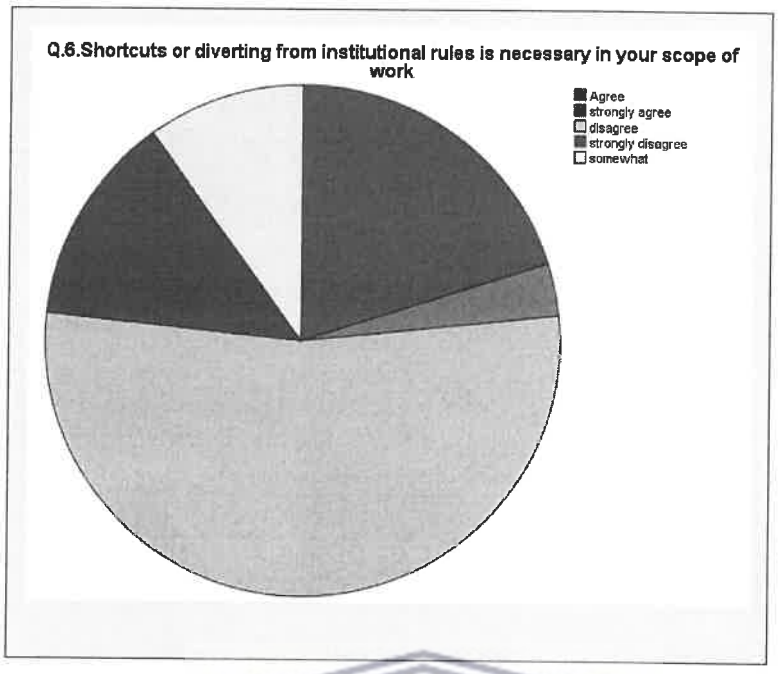
## ANALYSIS OF FINDINGS

In this second part of the chapter, the findings are analyzed with a link to the themes drawn from the research questions. The main objective of the structured self-administered questionnaire was to measure the level of discretion. From the findings shown above, it can be easily shown through the use of Likert scale that levels of discretion vary according to the kind of different practices exercised.

First and foremost, this research study showed Lipsky's SLB theory in the practice of discretion, . Clearly, some of the figures in the findings, show practices that can be described as discretion, existing in different forms, among SLBs-nurses, as indicated through the responses; **Q2,Q3,Q4,Q9C&E,Q12,Q13**.

However, it is important to note that, these findings equally portray strong loyalty to the tenets of bureaucratic rationality (and personalities) amidst the practices of discretion. The statistics shown in the table above (refer to responses; **Q6, Q7, Q8, Q9A, B&C, and Q11**), indicate diminutive practices of discretion.

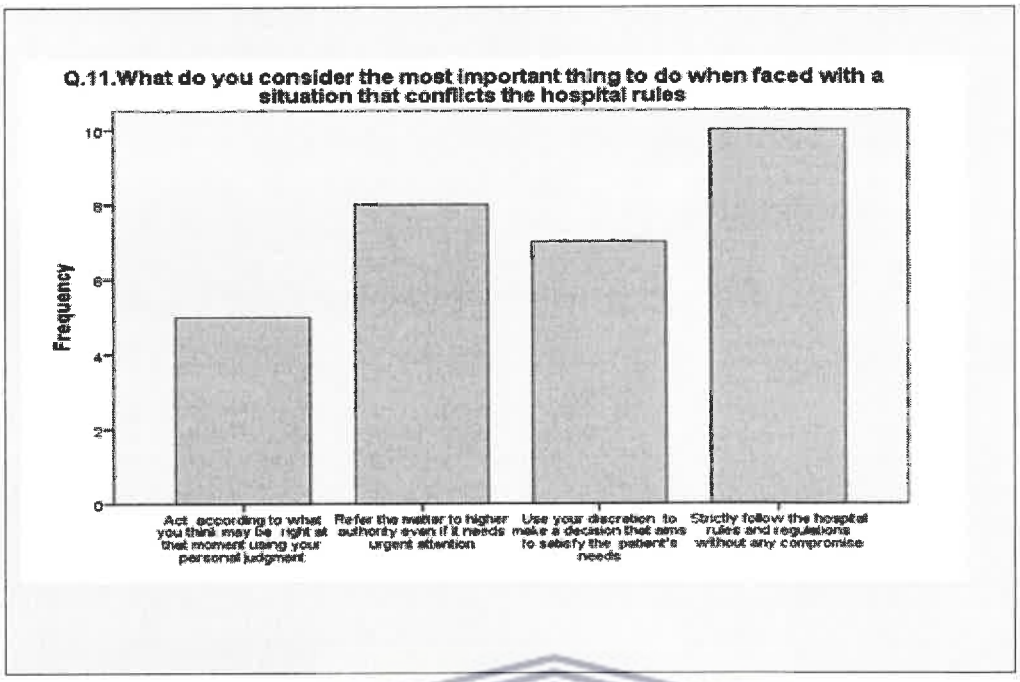
TABLE 4.5 ATTITUDES TO SHORTCUTS AND RULE BENDING




As illustrated in the pie chart, there is a larger area covering the response *disagree*. More than half respondents at 53.3% said, they do not agree with shortcuts or bending of the rules in their work. This data seemed contrary to Lipsky's theory and supports the top down approach. Yet it also may indicate that in the ideal world, frontline workers would prefer a strong rule.

It is argued by proponents of strong bureaucracy that many decisions and approval of most government activities are made by top level bureaucrats as well as institutional heads/officers, because that is what hierarchy entails. Therefore, this may give little room for decision making by SLBs. This was further proven from the responses generated from Question 11 (see table 4.4 for figures) as indicated in the bar chart below.

**Table 4.6 ACTIONS CONSIDERED WHEN FACED WITH A DILEMMA**






These statistics imply that, it is correct to assume that hierarchy is followed almost 75% of the time. In contrast to Lipsky (1980:15), who states that SLBs 'work in situations too complicated to reduce to programmatic formats' in which rules, guidelines or instructions cannot be clearly marked out. There are still strong bureaucratic lower level workers that strictly follow the rules and regulations. They follow the dictum: 'I must do as am told....and follow the rules without compromise'. Merton (1957) adds to this view by arguing that bureaucratic personalities will ensure that they conform to the rules even when faced with difficult circumstances and pressures. He further states that "Rules are bound to play a major part in their working lives" (Extracted from Ham and Hill, 1984:133). However, this does not overrule the point that discretion is inevitable as illustrated in next section.

## DISCRETION PRACTICES

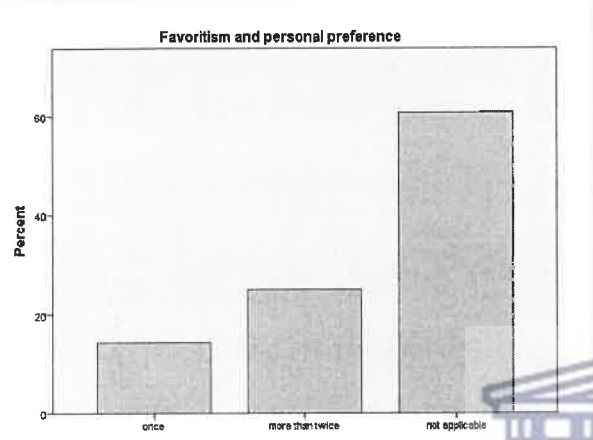
The questions structured for the forms of discretion practices presented in the tables below were specifically derived from the context of examples provided in the literature, in order to test Lipsky's arguments. However, even in as much as Lipsky (1980) is pro discretion, he also acknowledges the negative practice of discretion by SLBs that top bureaucrats condemn, for example, the use of discretion for personal gain ,or discretion that may interrupt effective flow of effective service delivery.

The findings presented below proved that all the highlighted anticipated forms of discretion described in the literature, exist among nurses at varying levels in the site that was studied. The bar charts (Table 4.7 'Question 9') below illustrate the varying responses generated from the different forms of discretion practices, in which respondents were given an option to indicate how many times each act has been performed. (Refer to the main table 4.4 for actual figures).

**TABLE 4.7 DIFFERENT FORMS OF DISCRETION**

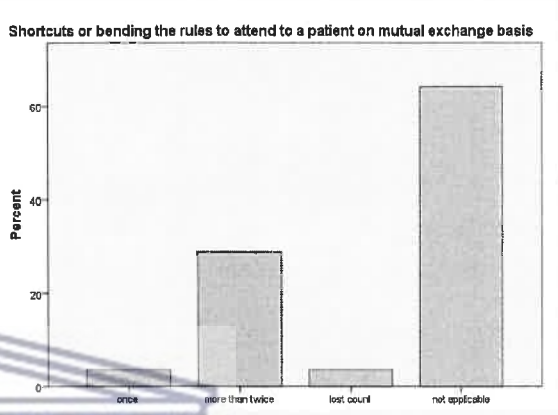
Q9A.MODE/FREQUENT RESPONSE

NOT APPLICATION



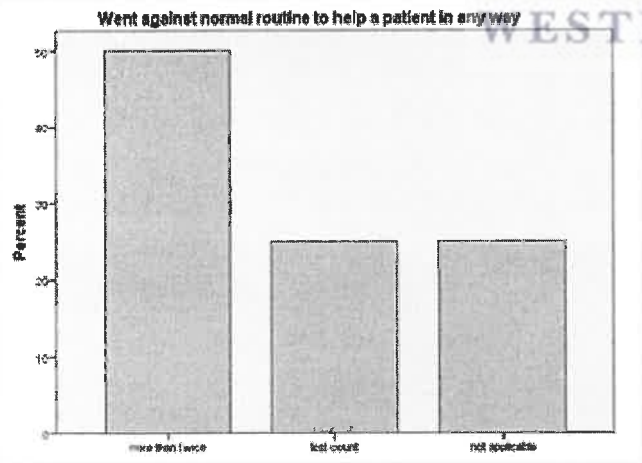

Q9B.MODE/FREQUENT RESPONSE

NOT APPLICABLE



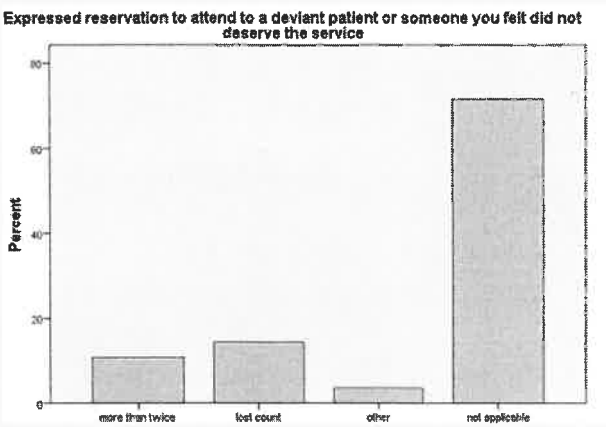

Q9C.MODE/FREQUENT RESPONSE

MORE THAN TWICE




*Q9D*.MODE/FREQUENT RESPONDENT

NOT APPLICABLE



Various studies (Goodsell, 1981; Hasenfeld and Steinmetz, 1981; Maynard-Moody and Musheno, 2003; Gilson and Walker, 2004) have showed the imposition of personal values and preference practiced by SLBs as a result of the use of discretion. In this study, practices in terms of favoritism, personal preference on who to attend to and showing reservation to attend to a deviant/troublesome patient indicated high responses as *not applicable*. Meaning that most of the nurses do not often engage in such practices (refer to Table 4.4-Q9).

Another practice of discretion pointed out by Lipsky (1980) that SLBs are known for is, bending the rules on mutual exchange basis, showed low levels of such practice in this study indicated by the majority not *applicable* responses as showed (Table 4.4-Q9c). Thus, the high numbers for the 'not applicable' response show that 'bad' forms of discretion practices as described by the top down theorists, among nurses as SLBs are uncommon even though they exist. Moreover, in support of Lipsky's (1980) assertion, there was a significant proportion of nurses who said they went beyond normal routine to help a patient 'more than twice', than any other response, which happens to be the most common discretion practice that SLBs are known for.

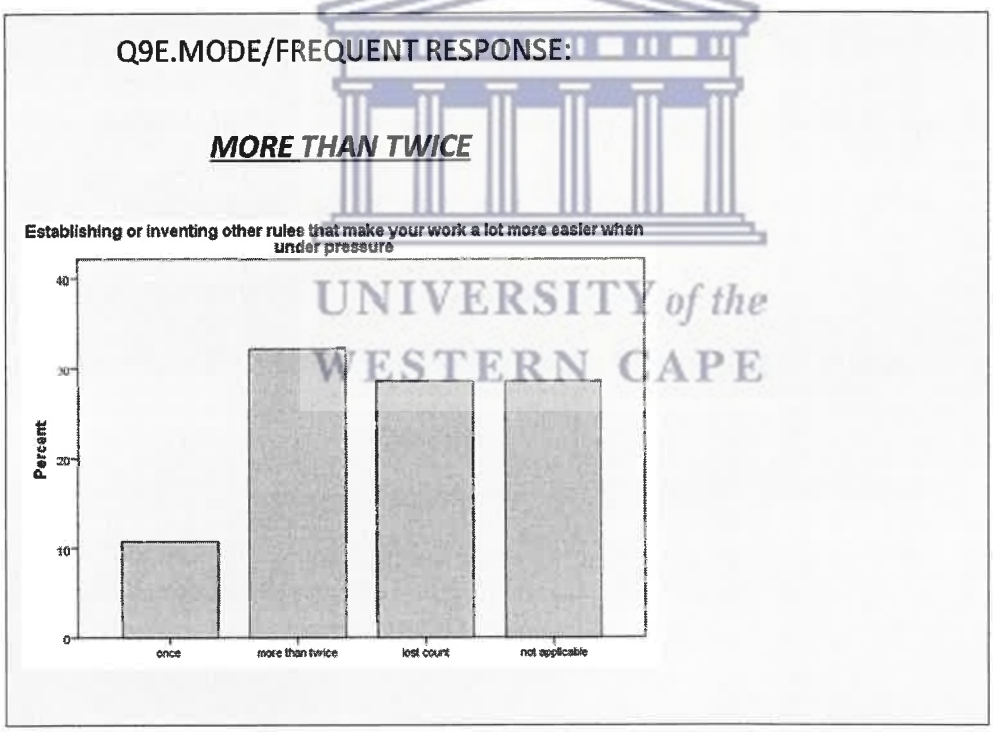


## ESTABLISHMENT OF RULES

Besides bending the rules or performing shortcuts, the establishment of rules is also known to be common among SLBs. According to Lipsky (1980:12), "the decisions of street level

bureaucrats, routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public polices they carry out". Lipsky (1980) argues that discretion cannot be reduced or eliminated. He further mentions that SLBs make decisions about other people, which calls for human judgment and this is what makes the practice of discretion unavoidable. Hence, the establishment of informal rules that suit their working situations (Lipsky, 1980). This practice was proven true, in this study as showed in the bar chart below (see table 4.4 for figures).

**TABLE 4.8: INVENTING RULES**






The highest bar represents nurses who invented rules *more than twice* to make their work easier. This showed that nurses made their own informal rules that help to ease their work.

Qualitative data reveals more occurrences of such practices, for example in some in-depth interviews, inventing of rules also referred to as 'setting ground rules' was done on a weekly basis depending on the nurse in-charge of the shift for the week. On the other hand, other responses still display loyal bureaucratic personalities implying that, even if SLBs may have opportunities to make their own rules, they are still constrained to the organizational rules.

## DISCRETION GOOD, BAD OR/AND CONFLICTING

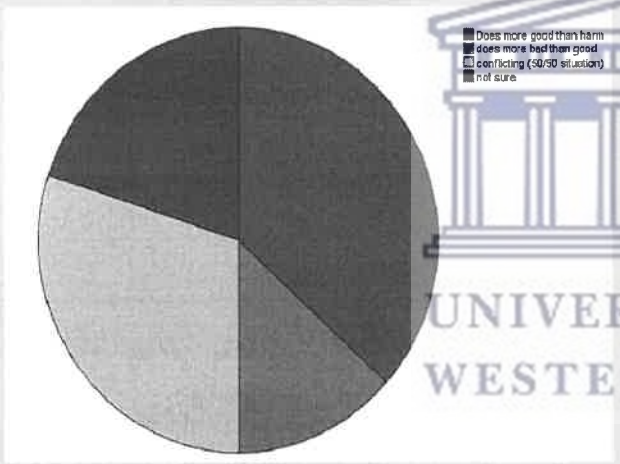
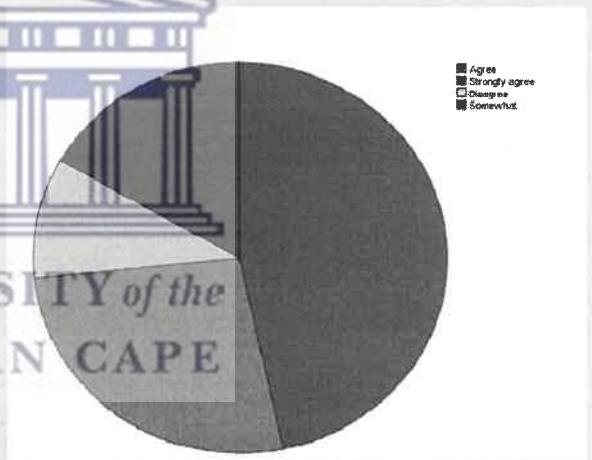
Discretion is known to be a double-edged sword. It may also appear confusing for SLBs, making decision-making even harder, especially in conflicting situations. However, most recent studies conducted by bottom up advocates as described in the literature review chapter (Maynard-Moody & Musheno, 2000, Walker and Gilson, 2004; Hupe and Hill, 2007; Evans, 2010 Tummers and Bekkers, 2012), have shown that discretion exercised by SLBs tends to be a necessity for effective policy implementation and service delivery. Thus, in line with these studies, the findings of this study show the scale weighing more on the good side of discretion, which enhances effective service delivery rather than self-interested forms of discretion.



Additionally, the pie chart below (Table 4.9-Q12) shows that more respondents said discretion *does more good than harm* at 36.7% of the sampled population, while the lowest response at 13% said it *does more bad than good*. Thirty percent of the respondents said it was *conflicting*. Moreover, it is proven from this study that SLBs, nurses in this case, aspire to the exercise of discretion in their work.

The pie chart below (Table 4.9-Q13) shows the highest responses in favor of discretion (see table 4.4 for figures).

**Table 4.9: Discretion**

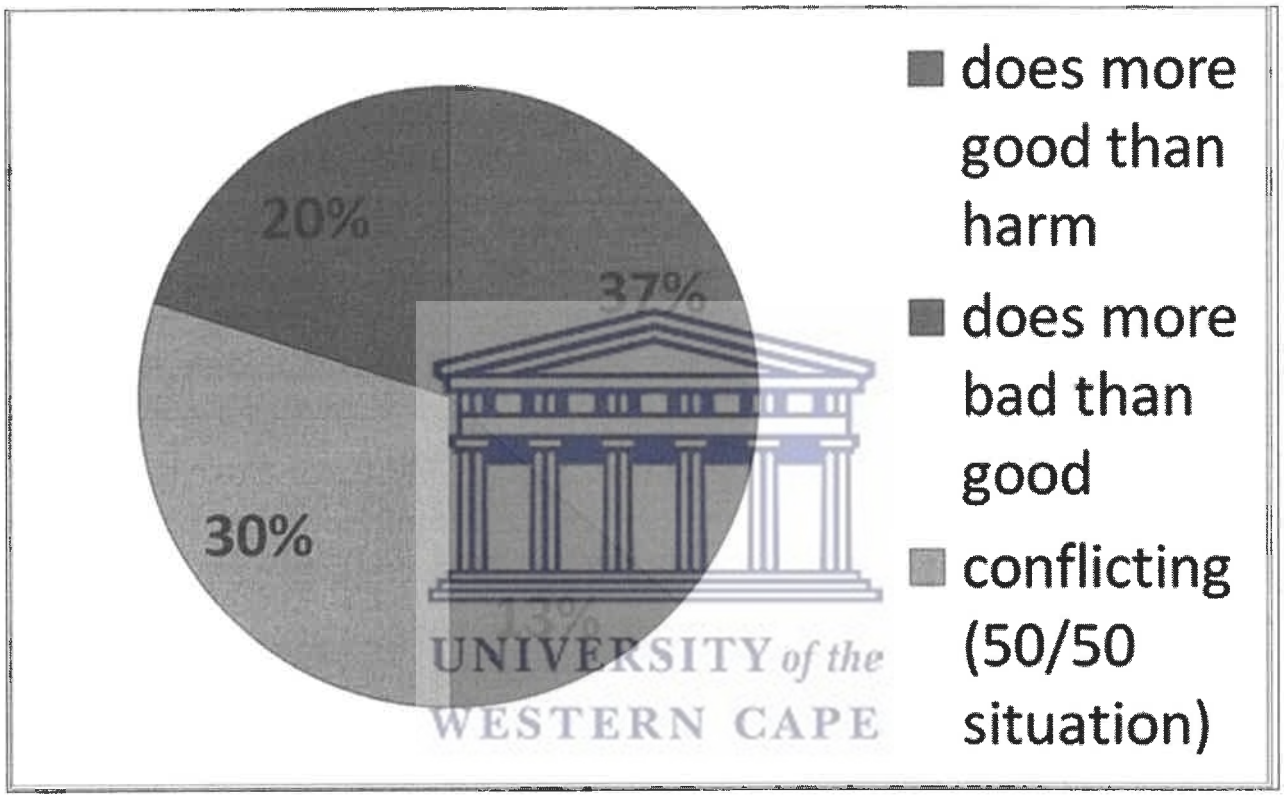
| *Q.12. How would you view use of Discretion in your work as a nurse?* | Q.13. *Frontline workers like you should be given room to exercise discretion in order to enhance successful policy implementation and health service delivery* |
|---|---|
|   |   |



As indicated in figure 4.10 below, the quantitative findings conclude that discretion among nurses 'does more good than harm'. This implies that when discretion is used, it is intended to facilitate service delivery by reaching out to different patient needs. It, in fact helps to get work done under difficult circumstances that leave nurses as SLBs with no choice but to use their discretion. However, in as much as discretion is used in a good way, the bad practices

are also exhibited, at the same time, the study further revealed that, it is conflicting. While a nurse goes out of their way to help a patient, they find themselves in controversy with their scope of practice and stipulated guidelines/rules that create a dilemma, thus, making them susceptible to stiff disciplinary action or eventually job loss.

Figure 4.10



## CHAPTER 5: QUALITATIVE DATA ANALYSIS

This chapter presents findings and interpretation of data collected from the qualitative in-depth interviews conducted. The data is presented thematically, arranged according to frequently emerging issues from the interviews, connected to the research themes. Since most of the questions used in the interviews were an expansion of the questions used in the structured questionnaire, the same main research themes are used in this section to match the information and triangulate the validity of the data in the previous chapter. The findings and analysis are presented jointly with reference to the literature and debates discussed in chapter two. Moreover, this section also includes observations by the researcher while on the site, as it is well known that participant observation is considered a powerful factor in qualitative research (Neuman, 2009).



It is important to note that while the quantitative data method was very significant in determining the measure of the level of discretion practiced, it was not entirely enough to develop full analysis of this research. Hence, employing qualitative methods of data collection was needed to construct a solid analysis going deeper and beyond statistical measures. Qualitative analysts argue that all quantitative data must be cross-referenced with qualitative findings (Neuman, 2009). Moreover, bearing in mind one of the strengths of qualitative data, is that, it is more about voices, experiences and expressions of research subjects emerging, leading to a broader contextual understanding of the topic. Especially in expanding and exploring unexpected, unpremeditated issues, which might reveal subtle power relations.

Thus, with qualitative data collection, more issues were unlocked as respondents were more expressive. It is very rare that a researcher is able to get free expressions when a respondent is bound to filling in a structured questionnaire, because they may not be much to observe. I therefore attach much importance to the one-on-one interactions, I had with the respondents. While, the structured questionnaire sought to capture a measure, the in-depth interview questions sought to explore the context and description of discretion hidden behind the numbers.

A total of eight in-depth interviews were conducted, divided between five females and three males, covering two nursing categories; registered professional nurse (RPN) and nursing assistant(NA). The age range was wide, from 24 to 58 years, while the work experience was from 8 months to 26 years.



At this point, it is important to note that specific discretionary practices differ according to nursing categories as it is shown in the summary table below.

The following extended table provides highlights of findings from the interview questions.

**Table 5.1 Extended Scope of Practice Registered Nurse and Assistants**

| CATEGORY QUESTIONS | INTERVIEW RESPONSES |
|---|---|
| WHAT IS YOUR JOB DESCRIPTION/SCOPE OF PRACTICE | **Registered NURSE (RPN)**<br><br>Order and administer drugs, liaise with doctors and social workers, administrative work-i.e. reports, patient care-i.e. hygiene, ward rounds, advocate for patients, liaise with families over patient treatment, patient transfers and escorts, recordings, monitoring schedule 5 medication, providing security (for maximum security ward)<br><br>Patient hygiene.ie grooming patients, dietary needs.ie serving food to the patients, escorts and transfers, assisting the RN when giving medication, watching patients, doing what you are told by the in-charge |
| Instances OF ACTIONS outside and beyond/below scope | **Registered Nurse**<br><br>I take on the job of NA/ stuff nurse or doctor, take on the role of social worker, police or investigator, dealing with social issues i.e.-phone relatives to visit patients, |

| | |
|---|---|
| | draw blood from patients when the doctor is not there, social recreation with patients, i.e.- soccer teams<br><br>**Nursing Assistants**<br><br>Playing with patients/outdoor activities, cutting patient's nails and hair, giving medication when RN is not there, security of patients and visitor, |

The summaries in the above table describe various activities that nurses find themselves engaged in while on duty. As pointed out by Lipsky (1980), SLBs take up many roles that go beyond their scope of practice and that many SLBs share multiple job characteristics. Along these lines, this study revealed that a nurse can take up the role of a social worker, police investigator, security officer, occupational therapist, personal counselor, mother and other roles deemed relevant to ensure that patient needs are fulfilled. This increases their workload and responsibilities, and these pressures make for increased use of discretion.

One nurse said,

> When you are working as a nurse, you are everything....you are their [patients] mother....you cut their hair, give money.....I have to call their families to ask them to come and visit them, then am a social worker.

When asked why nurses had to take up such roles, instead of leaving it to the social worker, it was mentioned that, social workers are not always available and they may be just one

available to attend to all the patients in one ward, this make them inefficient. Partly, it also has to do with the feeling of being responsible for their patients– the ethic of care, as one nurse stated; "I can't just watch something not been done...I have to help the patient, as a nurse you are a patient's advocate". Another respondent further stated,

> I feel that we are not appreciated or compensated for the work we are doing as nurses, we are still treated as nurses but we are doing too many things, taking up more different roles, for example, doctor, social work, physiotherapy and occupational therapy.

All these are examples of nurses going beyond their scope to ensure effective service delivery. If they fail to meet the needs of their patients, they appear as the failures (not the government) before the eyes of the citizens because people view them (SLBs) as 'the government'. One particularly interesting view expressed by one nurse described Lipsky's exact notions by stating that,



> when you are dealing with humans, the scope of practice is not enough, because human needs are big and complex....you can't work within the scope, you have to go an extra mile to meet people's needs...I was on my way out when you [referring to me/interviewer] came but I had to come and meet with you.

It is also important to note that nurses in a higher category, like the RPN, may not only go beyond their scope of practice but also below. They are most of the time pressured into doing the work of a staff nurse, EN or NA because of staff shortages. One RPN stated "today I had to run around like a messenger, going to look for some items in the other wards and I

also haven't had a staff nurse for some time now". This creates work overload and eventually allows SLBs to engage in shortcuts that will help them get on with the work of the day.

This was observed as I was having a conversation with one of the nurses during my ward visits. It was a RPN working alone on the ward with only one assistant, she said to me;

> what time do you think I will finish attending to all these patients if I follow all the guidelines by the book, It will take me the whole day and some of these people are discharged, they need to go home...that's why I must do shortcuts...its due to this shortage that we work like this!

The respondent was quiet outspoken and spoke with passion over the matter.



Apart from the practices described in the quantitative findings, there were more practices of discretion discovered through the interviews with the nurses. First and foremost, the findings continued to reveal that discretion is inevitable. It was viewed by the nurses as an act that is unavoidable, due to the nature of the service that they provide. What repeatedly came out from the respondents was that the nature of their work is unpredictable and the behavior of their patients is also unpredictable, it being a mental hospital. A distinction was frequently being made between the services they provide and those of a general hospital. This marked an important element of the genesis of discretion. One nurse said; "the work we do is the same but the environment is different and situations are different, you can't always follow what's planned....everyday depends on its challenges". Three nurses during a conversation collectively said that "yes when a patient is critical, you need to act immediately, because you use your discretion when a situation arises".

This implies that each day is faced as it unfolds and decisions have to be made as the situation demands. Thus, proving Lipsky's (1980:15) assertion that SLBs "work in situations that often require responses to the human dimensions of situations".

Another important point to note is that due to the nature of the service (human service provision) most of the decisions made by SLBs when exercising discretion are on-the-spot decisions (Lipsky, 1980). Nurses in this study were able to testify to this by saying that, the situations that arise, cause them to act, by using discretion. One of the common examples used by 5 respondents was a situation where, a psychiatric patient loses control and there is no doctor to prescribe medication, the RPN would administer a drug without prescription (which is not allowed). One nurse justified this action by stating that;



As long as I explain to the doctor what I did, there is no problem....I make my own decisions, I don't feel limited, these patients are unpredictable, anything can happen and its us who stay with them, so I can use my own discretion to work, I have no problem with that, if anyone asks...I give my answer! And I have never regretted any decision.

A registered professional nurse gave this example;

> Family members should come and fetch the patients according to the hospital policy, [but] when you phone the family and they are not coming, this patient is ready to go and his fine, I let them go home [on their own]. I just make sure the

patient is fine to go and I can explain to them [supervisor/in-charge] why I did such a thing, so then it's understandable.

The following example was given by a nursing assistant during an interview when asked if she does any work outside her scope;

"Yah [yes] we do a lot, sometimes we give medication, that's not in our scope, IF there is no sister"

**Q. Please give an example**? "The sister [registered nurse] didn't come to work one day and the manager came to me, to ask....she said please can you give this patient medication..."

**Q. Management is aware that you give medication?** "Yes...it's the manager who came to me to ask...the management, they know the situation.....and sometimes when I see a patient got hurt ,then I will do whatever is necessary, outside my scope but if there is a sister, I will report it".



However, there was one distinct interview, in which one nurse said contrary to the majority on the practice of discretion. She said;

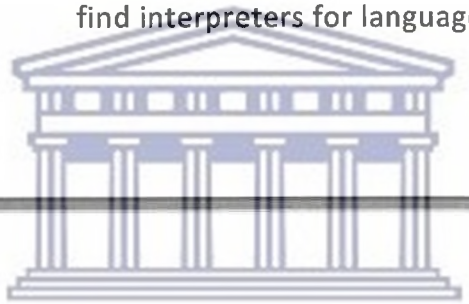
In nursing there is a standard operating procedure which must be followed, you can't make your own decisions or decide what to do. Okay.....sometimes, there are small things that you use your discretion on.....it's like we have 2-4pm visiting hour, if visitors come late with a valid reason, you allow them. You can't run away from it but I wouldn't favor it [discretion] over standard procedure.

This particular nurse was the only respondent who expressed this view, out of all the eight respondents who were interviewed that supported the use of discretion. Yet again, it is proven that loyal bureaucratic personalities exist but this does not exactly exempt them from the practice of discretion even if it is at a minimal level or termed as **'it's the small things'**. Even though this respondent showed strong commitment and dedication to organizational values, the respondent still acknowledged that discretion is unavoidable. Additionally, one nurse concluded that "sometimes we act the way we act, to bring a solution to a situation". Importantly nurses spoke as a "we". This is a crucial point as Lipsky's work does not stress the *collective* negotiation of coping strategies.

**Table 5.2 Motivations for Work and Coping Strategies**

| | |
|---|---|
| MOTIVATION TO WORK | When patients recover from illness, it's a pleasure working with my patients, love for patients and everything I do is for patients, learning more about the sickness (psychiatry), the field (psychiatry) is interesting and challenging, am not motivated cause of the dangerous environment, no too much work pressure in Psychiatry like general hospitals. |
| SITUATIONS THAT CALL FOR DISCRETIONARY ACTION AND TYPICAL COPING STRATEGIES | "Patients are unpredictable; the environment is dangerous; no challenges with my work; internal challenges-i.e. the change list/ward rotations, staff shortage, work overload, sometimes no tea or lunch break; burnout, broken and outdated equipment, geyser not working and not been repaired for a long time, supplies take long to come, language barriers, demanding patients; waking up and coming to work exhausted is a challenge; study leave is a problem; passive patients; any time you can get killed; Patients get aggressive and they can attack you but you can't hit them back". Untimely supplies is another issue<br><br>Coping strategies |

"You just have to cope with it, you have no choice, I deal with it according to my human capabilities, I do the best I can, I don't know how I manage to cope but I cope and I deal with ; be vigilant all the time and not take anything for granted, protect yourself when providing maximum security and not be the victim; sometimes you are alone, can't follow the who procedure, that is why you do shortcuts. You have to be calm and collected, do what you are supposed to do, find interpreters for language".





An untimely supply of requested items in wards is an issue that repeatedly came out from the interviews and this is closely linked to coping/making do strategies. Respondents mentioned repeatedly that items take long to be received after being ordered. Reasons were attributed to red tape and the unavailability of funds -- classic Lipsky reasons. For example, in one of the wards, it was disclosed that they had ordered heaters for the patients at the beginning of the year but had not received them to date. When supplies are not made available on time, nurses have to go out of their way to ensure that they improvise. For example, one nurse mentioned that they had to bring items like soap, toothpaste, hand wash and so on from their homes. Another nurse complained of the geyser not working in the ward even after been reported to the hospital management

several times, despite it being winter season, the matter was still not taken as a priority. She said that nurses had to boil water from the electric kettles for each patient on the ward to be able to bath hot water and this was extra work for them to do.

**Table 5.3: Decision-Making**

| | |
|---|---|
| DECISION MAKING LIMITATIONS, CONFLICTS AND DILEMMAS | "Feel limited in decision making, you can't make you own decisions without been questioned, the job is frustrating and draining and patients are unpredictable but have to be handled professionally, I can make my own decisions I don't feel limited as long as I provide an explanation for that action, I can decide to use my discretion when dealing with an urgent issue; limited decision making when it comes to multi disciplinary decisions, when a patient is critical you need to act immediately, if a situation arises you need to use discretion, we are the ones who know and spend time with the patients so we can decide". |
| DISCRETION (GOOD, BAD OR CONFLICTING) | "Discretion is good, it helps us work. It is conflicting because sometimes you can get in trouble, patients are unpredictable and you do not know what to expect. The nature of this service is different and each day comes different. It is good at times but bad because policies that are in place are not followed, discretion is good I don't think it can be bad in any |

**Table 5.4: Feeling Valued**

| | |
|---|---|
| VALUE AND CONTRIBUTION OF SLBS BY POLICY MAKERS | "We don't feel valued or appreciated. Our say is not considered. We have little or no say. I don't know if they appreciate or not. There is no feedback". |



**Table 5.5: Power issues and Pressing Issues**

| | |
|---|---|
| WHERE DOES THE POWER LIE IN DETERMINING EFFECTIVE POLICY IMPLEMENTATION AND SERVICE DELIVERY IN SOUTH AFRICA | "Power lies in both the employee and employer. Power lies in understanding patients' needs. National government policy level. Its starts with universities and colleges, because students don't show interest in the profession, maybe they are just in it for the money. It should be from the bottom level. The power always lies up there but policies are not practical. Up there, they tell us what we must do and we must do what they say, if something goes wrong, we risk been persecuted". |

| | |
|---|---|
| PRESSING ISSUES AND CONCERNS IN NURSING/ HEALTH SERVICE DELIVERY | "Staff shortage and work over load. Shortage of skilled labor and health service delivery is compromised because of it. Not working according to the patient ratios. We are not consulted. Supplies are not on time. Nurses need to be appreciated and work over load is not considered as we play multiple roles. Policies are not reviewed and prioritized. Not happy with retirement policy. Nurses should be more caring and have an empathetic approach. Red tape disturbs work. Burnout and de-motivation due to shortage. The government should stop contracting medical services, why should they have contractors for recruitment?" |

**ESTABLISHMENT OF RULES**

> "....yes we have to change rules...things can't be done the same way...each day is different and so are the challenges" (Interview with registered nurse).

The establishment of rules from the quantitative findings shows the highest percentage, indicated as performed more *than twice*. In the same lines, the qualitative findings attested to the statistics. In accordance with Lipsky's (1980) argument over the establishment/inventing of rules as coping strategies to ease the pressure of work, this study proved that informal rules/ground rounds are set to help in the organization of work. It was also revealed that these informal rules vary from ward to ward. Each ward, as a team decides what kind of ground rules to insert depending on the operational manager's views or the person/nurse in-charge of a particular shift. Hence, it seems that ground rules are collectively negotiated and decided informally within teams of health workers.



For example, some interview questions with one nurse working in the maximum security ward revealed;

**Q. Do you go against formal guidelines in your work?**

> yes, I have gone against formal rules, there are no formal guidelines....here we have our own rules, our own formal guidelines within these confines... it's like our own prison...we deal with these patients [ex-convicts], when they come here they want to be bosses, bringing the prison attitude here but we have to show them that here, they are not the bosses.

**Q. What rules exactly have you set?** *Apart from maximum security we have a seclusion cell, a holding cell were we put patients who misbehave.*

**Q.Is that a formal procedure?** *Yes! It's a formal procedure that is only recommended by the doctor, but even if the doctor is not here we just do what we have to do because these patients are dangerous....you see, those that respect themselves have to be respected and those that don't respect them themselves, get it!*

**Q. Where do these rules come from?** *The rules come from them [patients]...we go by their own rules, how they behave on the streets, this place is dangerous, everything is dangerous...I would rather victimize you [*referring to patients*] and not be the victim...its how it works...*

The following example was given in another ward by a nurse in charge of the shift;

> we set ground rules, we have the opportunity of setting rules, for example, patients having lighters, we can't allow that, they are sick people...I know in some other wards they allow them but here...no one must keep their lighters, they must be searched when going to sleep.

Additionally, another interviewed with an operational manager of a ward, revealed that setting ground rules helped to maintain order and organize the work in the wards, in order to avoid chaos, stating that;

> "You see..these patients are unstable, it's difficult to keep to the guidelines but you have to make sure that there is a system amongst yourselves that helps you deal with this daily confusion".

## MAJOR EMERGING ISSUES FROM IN-DEPTH INTERVIEWS

### Staff shortage

In all the interviews conducted, there was a loud mention of staff shortage and it was pointed out that, it has been a long standing problem. When asked why there is this shortage, most respondents alluded to government's failure in recruiting more staff and opening up more positions. Others questioned why the government has not responded to this long-term problem when they are fully aware of it. In this regard, one nurse during an interview when asked what the burning issues were concerning his work, displayed his frustration by saying,

> It's about staff shortage, we are not working according to the ratios, they can't even get people to work overtime cause they are all tired, I don't know government systems, they don't appoint more people, I don't know! I don't understand how the government works.

The table below summarizes my own key observations while in the field.

**Table 5. 6. Observations and Field notes**

| **Field observations** |
| --- |
| **The problem of staff shortage was not only an issue presented by the respondents but also an issue observed practically in the wards. Because there was a very slim chance of getting time to sit for interviewing, I would have to wait long hours until the nurse was a little bit free, thereby, giving me an opportunity to observe what is happening in the ward. While visiting the wards I was able to observe that most wards were running understaffed. For instance, I found that only one RPN was working on the ward alone, assisted by a NA, for that particular shift instead of having the stipulated three nurses as per normal work schedule. This kind of pattern was repeatedly observed in almost all the wards over several weeks. Certainly, these instances made it easy to appreciate the kind of work pressures and multiple tasks performed by one person/nurse. Some observed multiple tasks by one RPN were, answering the phone while writing in patient files, attending to patients coming in and out for whatever big or little problems (some as little as asking for a mere piece of paper).The nurse would respond while gathering papers/files, ordering drugs and preparing medication all at once but also making remarks like "oh I have put that number here or I forgot where I put that piece of paper....now where is it? ". My own interpretation from this situation is that, working in such an environment, not only causes physical stress but also mental stress , which alternately has a negative effect on work because of the mix up of handling to many issues at once, mistakes are bound to frequently occur.** |

**Unsafe working environment and insecurities**

Contrary to what is stipulated in the workers' rights as highlighted in chapter three, every nurse has a right to a "safe working environment which is compatible with efficient patient

care and which is equipped with at least the minimum physical, material and personnel requirements"(Extracted from SANC Website). It being a mental hospital, there was a general feeling of insecurity and danger expressed by the nurses, most of them indicating that, it was a challenge working in such an environment because anything is bound to happen. As most of these views have already been pointed out and presented in the summary table. As stated by one of the interviewee's, "patients are unpredictable...anything can happen, any time, you have to be alert all the time and not underestimate anyone". Another one said, "the patient[s] are unstable and can hit you...and you can't hit them back...you know there are sick...so sometimes the environment is not good".

While another nurse working in the maximum security ward, expressed that it was de-motivating to wake up every day and 'come to work' in an unsafe environment, where, what to expect for the day is not known. These nurses seem to count, each day of their working day as a risk. Overtly, the environment certainly appeared to be unsafe, even for me as a researcher, moving around hospital premises with some of the patients freely walking around, created a little bit of discomfort before getting used to environment later on.



However, it is interesting to note, as I observed, the patient-nurse interactions did not indicate any form of fear by the nursing staff. The relations between the nurses and patients appeared to be usual, just as they would appear in a general hospital or in a case of non-mental patients. Nurses could freely laugh, chat and joke with patients normally. Even so, there appeared instances, when noise would break out in the wards (behind), in the mid of an interview, then the nurse and the security officer would quickly rush there. Implying that, even although, security may not be their duty as nurses, and they risk getting injured or

killed (as some stated), they still overcome their fears, by going beyond the call of duty in service provision.

All the above mentioned emerging issues prove to be directly linked to the practice of discretion among SLBs as nurses. As stipulated by Lipsky (1980), these findings attest to the practice of discretion as a result of work overload and limited human resource, thus, establishment of coping strategies. These coping strategies according to the views of the nurses are not viewed as bending rules but working beyond the call of duty.

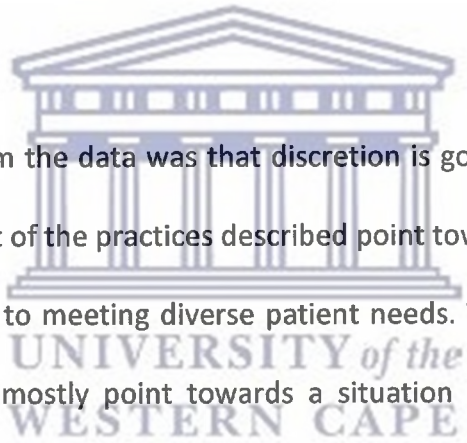
The qualitative findings give a broader picture than what the statistics revealed in the preceding chapter. As the aim of using this method, was to go beyond statistics and structured questions in order to explore the practice of discretion in a wider context. Certainly, the qualitative approach through observations and in-depth interviews as well as conservations with the participants produced more insight and revelations on many issues on the described practices of discretion.



**DISCRETION GOOD, BAD AND CONFLICTING**

Quantitative data findings (see previous chapter) revealed a higher percentage for nurses who said the practice of discretion is good for patients. Similarly qualitative findings revealed that discretion does more good than harm as expressed throughout the quoted passages from the interviews. From all the respondents interviewed, when asked if they have practiced discretion in any other way other than helping a patient, they said "NO". However, an important factor that might have limited open and honest answers was the

sensitivity of the question. Even after being assured that the information generated from the interviews was strictly confidential, some respondents might have still feared to give an honest answer if they engaged in negative/bad discretion practices. But these responses were captured on self-administered structured questionnaires, meaning it was much easier and more private for the nurses to give honest answers using the questionnaires. Nonetheless, even in the questionnaire some data was classified as 'missing' because they were still other respondents who opted not to answer the questions on the negative practices.




The general view gathered from the data was that discretion is good but at the same time also viewed as conflicting. Most of the practices described point towards good practices that enhance or at least contribute to meeting diverse patient needs. The conflicting situations reflected from these findings mostly point towards a situation that requires immediate action. Actions are performed in accordance with various pressing situations that are unprogrammed, as pointed out by Lipsky (1980). Many examples are given from the interviews illustrating how a nurse has to act first and give an explanation later. Most nurses are usually found in situations that require on-the-spot decision making.

They act in order to achieve good while not following the stipulated guidelines and this puts them at high risks of professional violations and other offences. This is what creates conflicts between doing what is required and what needs to be done on the spot. Another revelation

from this study is that, if discretion is considered good, it is only good, considered from the patient's point of view, because, the patient in the final instance is mostly the beneficiary of an act that is performed by the provider/nurse who risks his/her job. However, one nurse pointed out that "it is rare that discretion can put you in any harm but it can happen, but most of the time its good, cause it's also for the good of the patient". Hence, what is good for the patient can also be good for the health worker.

## CHAPTER 6: CONCLUSION

This is the concluding and final chapter of this research study. It reflects the outcome of the study in relation to the research objectives and in the context of Lipsky's ideas. I make a few suggestions about areas his theory overlooked as well as identify areas that need further research.

This study concludes that discretion as a concept needs to be disaggregated so that levels of discretion become a major concern and focus of research. Discretion may vary according to the forms or kind of discretion practices as well as intentions of workers. In this study both bad and good discretionary practices were tested and it was proved that both good and bad practices of discretion exist among nurse as SLBs in health service delivery. There is also evidence of a mixture of public service personnel most who strongly hold bureaucratic principles to heart and those who go more with flexibility.



Moreover, a significant addition to the notion of discretion was strongly revealed in this study, namely that discretion may not only be good or bad, but also conflicting. Conflicting in that, those that practice discretion, even if it is for a good cause, for example helping a patient, feel that they are at risk by not following the rules or operating outside the rules. (Positive discretion) This attracts adverse effects on their work ethics, yet they still go ahead and do it, because they feel the need to fulfill services to their patients.

The study, overall, revealed that the use of discretion by nurses as SLBs in health service delivery *does more good than harm* and critically that they often refer to the opinions of peers when using discretion. There is thus a strong group consensus about discretion and margins thereof. The findings in the study evidently show that many nurses go out of their way to use whatever possible means to ensure that a service is rendered to a patient depending on their need and this requires the use of discretion. It is without doubt that the use of discretion is an unavoidable act especially in this kind of human service, as the findings depict. It is also evident, as Lipsky (1980) stated that solutions cannot be programmed when dealing with humans. Different situations occur, that can never be planned for in advance by written down guidelines or rules. One can never plan *enough for unexpected eventualities.*

One of the major significant issues directly linked to the practice of discretion was the shortage of staff. This strongly came out as a problem experienced in the institution, thus, presenting a strong indication of institutional failure on the part of government to employ a sufficient number of health workers , in order to balance functionality. In this study, it was revealed that work overload was closely linked to staff shortage which consequently leads to 'shortcuts', bending of rules, establishment of rules-discretion, in order to cope with work pressures. In line with Lipsky's assertion, the SLBs who are directly affected- at the bottom of the chain, create various ways of dealing with the work overload, thereby creating public policies. Thus, loop holes in the bureaucratic structures pave the way for shortcuts, bending the rules, establishment of informal rules and so on, and the ultimate result is discretion.

The top-downers argue that the use of discretion in policy implementation is bad/ harmful, as it results in service delivery failure. Top downers as bureaucrats strongly believe in the practice of impersonality pertaining to service provision, anything other than that disturbs the flow of service delivery. To them, discretion does more harm because it promotes unfairness and disorganization, in the way rules are structured in order to maintain a standard code of practice which every public service worker ought to follow rather than each person doing as they please. Of course, rules and guidelines are very essential in maintaining order in an organization, without doubt, there is no organization that operates without rules.

However, no matter how well a policy is designed, it cannot fit in to the realities of dealing with the diverse needs of a human being. Bottom uppers have argued many times that policies often do not touch down to reality, because policies are not implemented as they are designed to be implemented. This is an element that is overlooked by the top downers.



I therefore, argue that the exercise of local discretion brings order to the dysfunctionalities caused by the bureaucratic structures. Discretionary actions penetrate through the rules to create a balance and therefore ultimately connect the broken chain to ensure that the intended outcome is achieved and this is done by SLBs (they typically take the role of the government). SLBs ensure that the system continues to run smoothly and effectively despite the poor working conditions and difficulty circumstances of both human and financial resources.

The call for a "capable" state is regarded by government and major political parties as the key to a successful developmental state. However, in line with Lipsky's theory, simplistic calls for more political muscle for the central organs of the "capable" state underestimate the crucial factor of whether the implementers/workers comply and obey the policy or not. Thus, policy implementation and service delivery very much depends on the decisions made by SLBs in their daily operations and duties than a linearity as purported by the top downers. Von Holdt (2010) recommended that South Africa adopts a practical strong bureaucratic system that meets the needs of the people. He suggests that the needs of frontline workers both political and professional are subordinate to this goal. He argues "there is a tension at the heart of the nationalist project, between the aspiration to construct a 'modern' state and the drive to assert African sovereignty through dismantling white domination" (Von Holdt, 2010:244) Certainly, this study along with others, show that SLBs through their discretion make *policy implementation happen*, the bureaucratic structure cannot function without discretion and that such discretion is most often informed by social and political values -not a Weberian adherence to rules.



Additionally, bottom up advocates recommend the legitimate practice of discretion, after all, it is inevitable, why not make it legal for SLBs to have a certain amount of power in making decisions concerning their work. Although, what does not come out clear is the *how*?, since bottom uppers demonstrate that public policies are made at the grassroots, but at this level, they are not legitimate policies because they fall contrary to what is officially formulated as policy at the top chain. If at all discretion is to be incorporated in the top down system to make it legitimate, then, *how* do the policy makers give freedom of decision making to the

implementers (frontline workers)? What criterion must be used to define parameters in which discretion can be exercised by bottom level bureaucrats? This lives more room for research because it still remains that human service provision is an area that is too diversified to programme or classify into standard forms of action.

For better or worse, policy implementation and service delivery in the public service remains in the hands of the frontline workers and the outcome of any policy very much depends on their input/actions or inactions, attitudes and their overall loyalty to public values. In conclusion, discretionary action by SLBs is an unavoidable tool for the fulfillment of public service delivery and remains a fundamental instrument in the policy process.

**BIBILIOGRAPHY**


Aiken, M. and Hage, J. 1966. "Organizational Alienation: A Comparative Analysis" *American Sociological Review* 31: 497-507.

Anderson, J. 2006. Public policy-making: An Introduction.6th Ed. Boston: Houghton Miffin.

Atkinson, D. 2007. 'Taking to the Streets: Has Developmental Local Government failed in South Africa?' In S. Buhlungu, J. Daniel, R. Southall & J. Lutchman. *State of the Nation: South Africa 2007.* Cape Town & East Lansing: HSRC Press & Michigan State University Press.

Bandman. E and Bandman. B. 1985. *Nursing Ethics in a Life Span*. New York: Appleton-Century-Crofts.

Beetham, D. 1996. Bureaucracy. Minneapolis, University of Minnesota Press.

Blau, M. and Meyer.M. 1971. *Bureaucracy in Modern Society*. New York: Random House.

Bovens, P. and Zouridis .S. 2002. 'From Street-level Bureaucracy to System-level Bureaucracy: How Information and Communication Technology is Transforming Administrative Discretion and Constitutional Control', *Public Administration Review, Vol* **62** (2) 174 – 84.

Burke, J.P. 1986 Bureaucratic Responsibility. Baltimore: Johns Hopkins University Press.

Chaska .L. 1990. The Nursing Profession: Turning Points. Mosby: University of Michigan.

Cleveland, H. 1972. The Future Executive: A Guide for Tomorrow's Managers, New York: Harper & Row.

Coovadia, H., R. Jewkes, et al. 2009. "The health and health system of South Africa: historical roots of current public health challenges." The Lancet **374**: 817-834.

Coovadia, H et al. Health in South Africa. 1st Series. www.thelancet.com published online August 25, 2009.

Davis, C. 1969. Discretionary Justice: A Preliminary Inquiry. Baton Rouge, LA: Louisianan State University Press.

Day C, Gray A. Health and related indicators. In: Ntuli A, ed. *South African health review* 1998. Durban: Health Systems Trust, 1998:203–16.

Deci, L. and Ryan.M. 2004. Handbook of Self-determination Research. Rochester: University of Rochester Press.

Dunsire, A. 1978. Implementation in a Bureaucracy. Oxford, Martin Robertson.

Eide, P. and D. Kahn 2008. "Ethical issues in the qualitative researcher-participant relationship." Nursing Ethics Vol 15(2): 199-206.

Elmore, R. F. (1985). Forward and backward mapping, *Political Science Quarterly*, **94,** 601-16.

Erasmus, E. and Gilson, L. 2008. How to Start Thinking About investigating Power in the Organizational Settings of Policy Implementation. *Health Policy and Planning.* Vol. 23 (5):361-368

Erik-Hans Klijn. 2005. Network and Inter-Organizational Management. In F. Lynn, L., *Oxford Handbook of Public Management* (pp. 51-69). Oxford: Oxford University Press.

Evans, T. 2010. Professional discretion in welfare services: Beyond Street level Bureaucracy. London: Ashgate.

Freidson, E. 2001. *Professionalism the Third Logic.* Cambridge: Polity Press.

Gilson .L. and Walker. L. 2004. 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa'. *Social Science and Medicine* **59:** 1251-61.

Goodsell, C. 1980. "Client Evaluation of Three Welfare Programs." *Administration and Society* 12:123-36.

Gunn, L.1978. Why is Implementation So Difficult? Management services in Government. November (1978).

Ham, C. and Hill, M.1984. *The Policy Process in the Modern Capitalist State*. Wheatsheaf: Brighton.

Hasenfeld, Y. and Steinmetz. D. 1981. "Client-Official Encounters in Social Service Agencies." In C. Goodsell, Ed. The Public En-counter: Where State and Citizen Meet. Bloomington: Indiana University Press, 83-101.

Hill , M . 2005 . *The Public Policy Process* . Harlow : Pearson .

Hill , M. and P. Hupe . 2002. Implementing Public Policy: Governance in Theory and Practice. London : Sage .

Hogwood, B., & Gunn, L. (1984). *Policy analysis for the real world*. Oxford: Oxford University Press.

Hudson, J. and Lowe, S. 2010. Understanding the policy process: Analyzing welfare policy and practice. UK: Policy Press.

Hughes O. E. 2003, Public Management and Administration; An Introduction. Third Edition. Basingstoke and New York: Palgrave Macmillan.

Hupe, P and Hill, M. 2007. *Street Level Bureaucracy and Public Accountability*. Public Administration Journal, Vol. **85** (2), 279–299.

Meier.K. and Hill.C. 2005. Bureaucracy in the 21st Century. In F. Lynn. L., *Oxford Handbook of Public Management* (pp. 51-69). Oxford: Oxford University Press.

Meyers, M. K., & Vorsanger, S. (2003). Street-level bureaucrats and the implementation of public policy. In B. Guy Peters, & J. Pierre (Eds), *Handbook of public administration* (pp. 245–254). London: Sage.

Michael, T. 1999. Managerialism and Nursing: *Beyond oppression and profession.* London and New York: Routledge.

Mollenkopf, John. 1980. "Street-Level Bureaucracy: Dilemmas of the Individual in Public Service by Michael Lipsky." *The New Republic* (Sept): 37-38.

Moore, S. T. 1987. "The Theory of Street Level Bureaucracy: A Positive Critique." Administration and Society, Vol **19**(1): 74-94.

Moore, S. T. 1990. "Street level Policymaking: Characteristics of Decision and Policy in Public Welfare." American Review of Public Administration, Vol **20**(3): 191-209.



Neuman.W. L. 2009. Social Research Methods: Qualitative and Quantitative Approaches. Boston: Pearson

O'sullivan. E and Rassel.G.1995. Research Methods for Public Administrators. Addison: Wesley Longman.

Parsons W. 1995. Public Policy: An introduction to theory and practice of policy analysis. Aldershot: Edward Elgar.

Peters and Pierre.1998. *Governance without Government?* Rethinking Public Administration-Journal of Public Administration Research and Theory. **Vol 8**.No.2.223-43

Peterson, B. 2007. Review of Street-Level Bureaucracy Dilemmas of the Individual in Public Services by Michael Lipsky. Logic of Inquiry in Public Administration, Valdosta State University.

Pressman. J. and Wildavsky, A. 1984. *Implementation* (3rd Ed.). Berkeley, CA: University of California press.

Puoane T, Cuming K, Sanders D, Ashworth A. 2008. Why do some hospitals achieve better care of severely malnourished children than others? Five-year follow-up of rural hospitals in Eastern Cape, South Africa. *Health Policy Plan* **23:** 428–37.

Rao.M. 2009. Role of Street-level Bureaucracy and Project Implementation Process in India. International Review of Business Papers. Vol.(5)172-184

Robbins.P. 1976. The Administrative Process: Integrating Theory and Practice. New Jersy. Prentice-Hall.

Rudes, D. S. 2005. "I Know Hundreds Like You": Imposed Identities, Discretionary Decision Making, and Relational Contexts in Parole. American Sociological Association Annual Meetings, Philadelphia.

Sabatier, P & Mazmanien, D. 1979. The conditions for effective implementation. *Policy Analysis, 5 (Fall)*, 481-504.

Sabatier, P. & Jenkins-Smith, H. 1993. Policy change and learning*: An advocacy coalition approach*. Boulder: Westview Press.

Sabatier, P. 1986. Top-Down and Bottom-Up Approaches to Implementation Research: A Critical Analysis and Suggested Synthesis, *Journal of Public Policy*, **6**, 21-48.

SANC.2006. The Nursing Act 2005. 2004 - 2013 South African Nursing Council.www.sanc.co.za

SANC.2013. NURSING RIGHTS. 2004 - 2013 South African Nursing Council (Under the provisions of the Nursing Act, 2005) www.sanc.co.za/

Sandfort,.J. R. 2000. "Moving Beyond Discretion and Outcomes: Examining Public Management from the Front Lines of the Welfare System." *Journal of Public Administration Research and Theory* **10**, 729-756.

Schneider H, Barron P, Fonn S. The promise and the practice of transformation in South Africa's health system. In: Buhlungu S, Daniel J, Southall R, Lutchman J, eds. State of the Nation: South Africa 2007. Pretoria: HSRC Press, 2007

Scott.P.1997. Assessing Determinants of Bureaucratic Discretion: An Experiment in Street-Level Decision making. Journal of Public Administration Research and Theory.Vol.**7**, 35-57.

Searle .C. 1988. *Aspects of selected nursing issues*. Durban: Butterworth publishers

Searle. C. 1986. Professional Practice: *a Southern African Nursing Perspective*. Durban: Butterworth publishers.

Simon. A. 1945. Administrative Behavior. Free Press. Glencoe.

Southall, R. 2007. 'Introduction: The ANC State, more Dysfunctional than Developmental?' In S.Buhlungu, J. Daniel, R. Southall & J. Lutchman. *State of the Nation: South Africa 2007*. Cape Town & East Lansing: HSRC Press & Michigan State University Press.

Tate. B. 1977. The Nurse's Dilemma. Geneva, International Council of Nurses.

Taylor, I. & Kelly, J. 2006, 'Professionals, discretion and public sector reform in the UK: Revisiting Lipsky.' *International Journal of Public Sector Management*, vol. 19, no. 7, pp. 629-642.

Thomas, J.C. & Johnson, V. 1991, 'The urban public hospital as street-level bureaucracy: The employee perspective', Public Personnel Management, vol. **20**, 3: 271.

Thomas. T. 2008, Women health workers in SA: half a century of observations Ruiters, In Ruiters(Ed). GENDER ACTIVISM*: Perspectives on South African transition, institutional cultures and everyday life*-Proceedings of the Rosa Luxemburg Seminar 2008, Grahamstown: Rhodes University and Economic Research.

Tripi.G. 1984. 'Client Control in Organizational Settings." Journal of Applied Behavioral Science 20:39-47.

Tummers & Bekkers.V. 2012. Discretion and its effects: Analyzing the experiences of street-level bureaucrats during policy implementation. EGPA Conference Bergen, On Public Policy, Norway, 5-8 September 2012.



---------- 2012. Policy alienation of public professionals: *The construct and its measurement*. Public Administration Review, *72* (4), 516-525.

Tummers, L. G. 2011. Explaining the willingness of public professionals to implement new policies: A policy alienation framework. International Review of Administrative Sciences, *77*(3), 555-581.

Tummers, L. G., Steijn, A. J., & Bekkers, V. (forthcoming paper 2012). Explaining willingness of public professionals to implement public policies: Content, context, and personality characteristics. Public Administration.

Uys .L. and Middleton .L. 2004. Mental Health Nursing- *A South African Perspective. Cape Town*. Juta & Co.

Van Meter .D. and Van Horn .E. 1975. The policy implementation process: *A conceptual framework*. Administration & Society, *6*(4), 445-488.

Von Holdt, K. & Murphy, M. 2007. 'Public Hospitals in South Africa: Stressed Institutions, Disempowered Management.' In S. Buhlungu, J. Daniel, R. Southall & J. Lutchman. *State of the Nation: South Africa 2007.* Cape Town & East Lansing: HSRC Press & Michigan State University Press.

Von Holdt, K. and Maserumule, B. 2005. 'After Apartheid: Decay or Reconstruction in a Public Hospital?' In

Von Holdt. 2010. Nationalism, Bureaucracy and the Developmental State: *The South African Case*. South African Review of Sociology Vol 41. 1,

Wagner III, J. A. 1994. Participation's effects on performance and satisfaction: A reconsideration of research evidence. *Academy of Management Review,* 19(2), 312-330.

Weatherley. R & Lipsky. 1977. Street-Level Bureaucrats and Institutional Innovation: Implementing Special Education Reform in Harvard Educational Review.47 (2), 171-97

Weatherly, R. 1979. Reforming Special Education: Policy Implementation from State Level to Street Level. Cambridge, MA: MIT Press.

Webster. E. and K. Von Holdt (eds). *Beyond the Apartheid Workplace: Studies in Transition.* Scottsville: University of KwaZulu-Natal Press.

Weissert. C. 1994. Beyond the Organization: *The Influence of Community and Personal Values on Street-Level Bureaucrats' Responsiveness.* Journal of Public Administration

Research and Theory: J-PART, Vol. 4, No. 2, pp. 225-25: Oxford University Press. Stable URL: http://www.jstor.org/stable/1181778

Wood K, and Jewkes R.2006. Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters* 14: 109–18.

Yates, D. 1982. Street-Level Bureaucracy: Dilemmas of the Individual in Public Services by Michael Lipsky. *The American Political Science Review* 76 (Mar): 145-146.

APPENDIX .1. Research schedule

| MONTH | ACTIVITY |
|---|---|
| WEEK 1 | - Introductory meeting with the nursing manager at the hospital<br>- hospital orientation<br>- preparation of interview timetable |
| WEEK 2 | -commencement of self-administered questionnaires<br>- 3 questionnaires per ward<br>- 6 self-administered questionnaires per day<br>- make appointments for in-depth interviews in the wards |
| WEEK 3 | -conduct 2-3 interviews per day depending on the time given by interviewees |
| WEEK 4 | -follow up questions<br>-closing meeting with hospital nursing manager |