# The Experience of Performing Caesarean Sections on Patients with HIV – A Phenomenological Explication

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In partial fulfilment of the requirements for the degree

# Masters of Arts in Clinical Psychology

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# This is dedicated to all the individuals who bravely fight in the battle against HIV/AIDS

#### DECLARATION

I, Corné Kennedy, declare that the thesis for the degree M.A. Clinical Psychology at the University of Zululand, hereby submitted, has not previously been submitted by me for a degree at this, or any other University, that it is my own work in design and execution. Material extracted from other sources contained herein has been acknowledged and permission has been obtained where necessary.

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Date

# University of Zululand <u>Abstract</u>

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The purpose of this research was to describe the experience of working with patients with HIV/AIDS, in particular performing caesarean sections, from a medical practitioner's perspective. A phenomenological study method was employed in which each participant used in the research was interviewed in a single session.

The original sample consisted of 9 participants. They were selected by means of criterion sampling from the gynaecology and obstetrics department of different public hospitals in Johannesburg, Pretoria and Cape Town. Six protocols were selected for phenomenological explication based on the interviews with the 9 original participants. The sample consisted of 3 females and 3 males, from different cultural backgrounds, who regularly perform surgical gynaecological procedures on patients with HIV/AIDS.

The results were presented in the form of an integrative text, which accounted for all of the individual variations of the experience of working with patients with HIV/AIDS. Out of this text the researcher explicated natural meaning units, specific to each participant, which were used in

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formulating a specific description of experiencing the performance of a caesarean section on a patient with HIV/AIDS.

This study concluded with a discussion of the results, as well as a formulation of a general description of experiencing the performance of caesarean sections on patients with HIV/AIDS for all 6 participants.

Overall, this research explicated unique descriptions of individual experiences, and contributes to a general understanding of the experience of performing a caesarean section on a patient with HIV/AIDS.

## **Operational definitions**

- *Phenomenology* A department of the inductive sciences concerned with the facts that form the basis of its system.
- Caesarean section A mode of childbirth in which a surgical incision is made through a pregnant woman's abdomen and uterus to deliver a baby.
- Human Immunodeficiency Virus- A retrovirus that attacks and severely damages the body's immune system and for which there is presently no cure.
- Life-world- The space occupied by any one person in the external, physical world, as well as the internal lived-in world, consisting of emotions and cognitions.

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## Chapter 1

#### INTRODUCTION

"HIV/AIDS is among us. It is real. It is spreading. For too long we have closed our eyes as a nation, hoping the truth was not so real." (President Thabo Mbeki – Address at the Declaration of Partnership Against Aids – Oct 1998)

## 1.1 General Introduction

Today nobody can turn a blind eye to the imminent threat that HIV and AIDS hold for society as the number of individuals affected by this silent killer continues to multiply. The medical community fights on the frontline in the war against HIV and will increasingly be asked to become engaged in the challenge of caring for those affected. This poses a particular risk to the medical practitioners involved.

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) present one of the greatest challenges for healthcare practitioners all over the world (Lemelle, Harington & LeBlanc, 2000). This statement seems to be especially true for South Africa, if one reads it in conjunction with the staggering HIV/AIDS statistics. Since the virus was first documented in the 1970s, it has spread throughout the world with destructive speed.

According to the World Health Organization (WHO), an estimated 30 million people worldwide were infected with HIV by December of 1999 (WHO, 2003a). This number had grown to 40 million people by December 2003, with an estimate of 14 000 new HIV infections each day (WHO, 2004a). Research has suggested that in South Africa 4.7 million people are HIV positive (Life Line South Africa, 2003). In addition, the

Human Science Research Council's report on HIV prevalence in South Africa indicated that 11.4% of the South African population was HIV positive in 2002 (Shisana & Simbayi, 2002). According to the Women's International Network News (2001), the number of HIV infections in South Africa may escalate to 6.1 million by 2005 and an astounding 7.5 million by the year 2010.

This leads to an ever-growing need for services for the HIV-infected and patients with AIDS. The proportion of healthcare practitioners directly or indirectly providing services to patients with HIV/AIDS is therefore also likely to continue to grow. Healthcare practitioners fighting the battle in the frontlines against this silent, cunning enemy are brave but not invulnerable. Healthcare practitioners are at risk of occupational exposure to the Human Immunodeficiency Virus due to their recurrent exposure to blood and other bodily fluids (Van Dyk, 1993).

Medical practitioners have a legal as well as an ethical duty to provide quality healthcare to all people, including people infected with, and affected by, HIV/AIDS. When medical students take the Hippocratic Oath, they make an ethical promise to fulfil to the best of their ability and judgement their unique calling to "always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help" (Edelstein, 1943). Ethically this boils down to preserving life at all costs. According to the Constitution of South Africa (Act 108 of 1996), medical practitioners may not legally deny treatment to any person on the grounds of his or her HIV status, as this will not only constitute discrimination, but in doing so they will withhold a basic human right. A particularly heavy burden thus rests on the shoulders of the medical practitioners who have to perform delicate surgical procedures, of which an elective caesarean section is but one example.

As the impact of the AIDS epidemic takes an increasing toll on society, it might be expected that medical practitioners would actively and visibly join the ranks of those professionals who work with the biological and

medical crises fostered by the disease. However, it could be postulated that medical practitioners are not immune to the emotional, social and relational aspects of this crisis. One cannot help but wonder why it is that medical practitioners have been curiously silent in their own professional journals. To date little has been written about the emotional and psychological responses of medical practitioners to this crisis. The researcher can hypothesise that working under stressful and risky circumstances on a day-to-day basis shapes the medical practitioners' unique experiences of working with patients with HIV. By establishing a greater understanding of their experiences, their risks, their fears, their anxieties and their feelings, the specific needs of medical practitioners could be identified. This way an insight into the first-hand experiences of medical practitioners and more specifically into their experience of performing caesarean sections on those infected with HIV/AIDS could be gained.

#### 1.2 Problem Statement

The medical model can be criticised for its failure to attend to the individual's experience of illness and the unique meaning they attribute to both illness and treatment. The devastating effect of HIV/AIDS has surely challenged the competence of this model and brought the question of the meaning of illness for individuals, both sufferers and medical practitioners, into sharp focus. It is easy to focus on the meaning of illness for the patient, but the meaning that medical practitioners attribute to illness can too readily be cast aside (Kriel, 1991).

Throughout the researcher's experience of working within a hospital setting as a part of the multi-disciplinary team, she became increasingly aware of the emotional impact that HIV/AIDS has on healthcare workers, particularly medical practitioners. These experiences of health care practitioners are not clearly documented in literature, thus possibly

overlooking beneficial information that could attribute to the quality of healthcare as well as the psychological well-being of medical practitioners.

The primary function of this study will be to attempt find an answer for the following question:

What meaning does the experience of performing a caesarean section on a person with HIV/AIDS hold for a medical practitioner?

#### 1.3 Objective of the Research

This study aims at exploring and possibly describing the phenomenon of the psychological impact of HIV/AIDS, in particular explicating individual experiences and meaning of this phenomenon for the life-worlds of medical practitioners exposed to it.

#### 1.4 Rationale of the Research

The rationale for this research lies in the fact that a limited amount of research is available on medical practitioner's unique experiences of working with HIV/AIDS, in particular performing caesarean sections. The researcher is of the opinion that medical practitioners' psychological experience and the meaning that they attach to that experience has been overlooked. In addition, medical practitioners are trained within a strict biomedical model (Kriel, 1991) which often neglects development of the necessary psychological skills, for example, to deal effectively with the emotional or social impact of HIV/AIDS. The lack of a range of effective coping skills for the medical practitioner might in turn affect the quality of healthcare provided.

There are several studies in the literature addressing the relationship of healthcare professionals and patients with AIDS from the patient's

viewpoint (Sherman & Ouellette, 2001). The flipside of this coin has not been so thoroughly researched and little is known about the emotional experiences of medical practitioners. Furthermore, the possible psychological distress experienced by the medical practitioner has not been taken into account. Medical practitioners have a choice whether or not they will perform an abortion. The same choice is not granted to them in working with HIV. Within the South African context with its progressive Constitution, medical practitioners do not have the option as to whether or not they want to treat patients with HIV/AIDS. This could possibly contribute to a more stressful working environment, where the practitioner could experience higher anxiety levels.

The true purpose of this study is therefore to acquire a truer insight into, and an understanding of, the medical practitioner's experience as well as the meaning that it holds for the medical practitioner. A truer understanding could unveil the individual needs of the medical practitioners and shed light on their capability to respond more effectively This could lead to recommendations to introduce to these needs. therapeutic programmes for stress relief and debriefing, as well as providing practical help to deal with medical practitioners' difficulties. Ultimately it could contribute to the more effective training of medical practitioners and equipping them with the necessary coping skills to deal effectively with occupational stressors related to HIV/AIDS. It is important to note, however, that the research is of a limited scope in that it focuses only on the experiences of medical practitioners in the field of gynaecology and obstetrics.

#### 1.5 Summary

HIV medicine and the people affected by it have changed dramatically over the past 20 years. This implies that the demands on the medical practitioner dealing with HIV have also undergone some changes. Although the HIV/AIDS pandemic has received much attention in recent

years, the investigation has appeared to be rather one-sided in that the biological side has been emphasised and accorded more importance. Furthermore, little research has been dedicated to searching actively for a true understanding of the emotional and psychological impact of medical practitioners' occupational life-world. In employing a qualitative research method, this study will attempt to bridge the gap between theorising about and acting in response to the dilemma that arises for medical practitioners who have to treat patients with HIV/AIDS.

#### Chapter 2

#### LITERATURE STUDY

#### **HIV/AIDS IN CONTEXT**

#### 2.1 Introduction

HIV/AIDS has emerged as one of the most challenging, perplexing and alarming realities of recent times (UNAIDS, 2005). It is an illness for which there is currently no cure. It infects people regardless of age, race, gender or social status. The global community is gradually recognising the extent and depth of the pandemic's damaging effects all around the world. It is far from being merely a disease that demands medical attention. It has social, ethical, moral, political and psychological consequences that touch every sphere of human existence in one way or the other.

The call to fight against the pandemic has echoed through every corner of society. Taken into consideration the number of patients with HIV/AIDS in need of medical attention, it could easily be admitted that medical personnel are in the frontline of the war against the pandemic.

Ever since the AIDS pandemic began, there have been individuals dedicated to the health care of individuals with HIV/AIDS and hence medical practitioners are in more regular and prolonged contact with people suffering from HIV/AIDS than is the case in other working environments. This regular and prolonged contact carries the risk of exposure to this life-threatening disease for the medical practitioner, something which the researcher interprets as shaping their experience. However, little research has been done on the perceptions and

experiences of medical practitioners performing surgical procedures on individuals with HIV/AIDS.

Although this research examines the experience of medical practitioners, it is not medical or biological in nature. It is nevertheless important to have a basic understanding of the virus. This chapter will give an overview of the literature concerning HIV/AIDS. In order to gain a better understanding of the impact of HIV/AIDS on the healthcare community and medical practitioners' experiences, it is necessary to start with a description of HIV/AIDS and a brief history of the disease. This will be followed by an account of the global prevalence pattern of HIV, with specific reference to the South African situation, as well as the transmission mechanics of this disease and treatment modalities. A brief look at caesarean sections as mode of delivery for pregnant women with HIV in South Africa will follow. To end off, the relationship between medical practitioners and HIV will be explored with an emphasis on universal precautions and the risk of needle stick accidents in the workplace. The emotional impact that working with HIV has on medical practitioners will be closely examined.

It is the opinion of the researcher that, only when one has an understanding of HIV, can one really begin to examine or understand the experience of those who work with it every day and whose lives may be affected by it one way or the other.

#### 2.2 A Description of HIV Infection and AIDS

#### 2.2.1 Defining HIV and AIDS

**HIV** is the commonly used acronym for the **Human Immunodeficiency Virus**. It is a virus only to be found in human beings and it attacks and severely damages the body's immune system. The immune system is the body's natural inherent defence mechanism against infections and

diseases. This could explain why the prognosis of this disease is very poor and the mortality rate high.

HIV is a retrovirus. Van Dyk (2001) explains that the term 'retro' indicates that HIV does the reverse of what other viruses do. This means that the normal transcription of genetic information in cells happens from DNA to RNA to proteins. The genetic information of HIV (and other retroviruses) is contained in RNA and not in DNA as in ordinary viruses. HIV utilises an enzyme called reverse transcriptase to alter the viral RNA into DNA in order to produce more viruses.

AIDS is the acronym for Acquired Immune Deficiency Syndrome and it is caused by HIV. When HIV has damaged and weakened a person's immune system to the point that it can no longer defend the person against infections and diseases, it is said that the person has contracted a group of particular medical conditions termed 'AIDS-defining conditions or illnesses' (Van Dyk, 2001). At this crucial stage the person has then developed AIDS.

Even though in layman's terms the word disease is used when discussing AIDS, the medical term "syndrome" is preferred as it refers to a grouping of specific signs and symptoms that occur in combination and that are characteristic of a particular pathological condition. Therefore one can deduce that AIDS could be defined as a syndrome of opportunistic diseases, infections and certain cancers – each of which has the ability to kill the infected person in the final stages of the disease.

## 2.2.2 A Brief History of HIV

A few decades ago HIV a virus of the retrovirus family causing AIDS was relatively unknown (Whiteside, 1993). Today the devastating effects of the virus are known and experienced by people all over the globe.

The first report of Acquired Immunodeficiency Syndrome (AIDS) was published in the *Morbidity and Mortality Weekly Report* on the 5<sup>th</sup> of June 1981. It described a case of five homosexual men who were diagnosed with Pneumocystis carnii pneumonia. In 1984 medical researchers reported the discovery of a retrovirus, now known as Human Immunodeficiency Virus, type 1 (HIV–1), associated with AIDS. In 1986 researchers reported a second strain, type 2 (HIV-2), which shares 42% genetic homology with HIV-1, but appears to be less virulent. Scientists have done genetic sequence analysis and concluded that HIV-1 originated in the African chimpanzee and HIV-2 in the African sooty mangabey (Citron, Brouillette & Beckett, 2005). HIV-1 is the type prevalent in the West and HIV-2 is the type mainly found in Sub-Saharan Africa (Van Dyk, 2001).

The first two cases of AIDS in South Africa were diagnosed in 1982 and subsequently the first death was recorded in 1985 (Shell, Quattek, Schonteich & Mills, 2000). Today South Africa has more people living with HIV than any other country in the world and the number of infections is increasing at a startling rate (Crewe, 2002).

# 2.2.3 Theories of the Origins of HIV/AIDS

The researcher came across many weird and wonderful theories about the origin of HIV/AIDS while doing the literature review. These theories range from HIV being a weapon of biological warfare to ones that extend to the fantasy realm of outer space. A brief description of the more scientific theories will be given next.

Exactly when HIV made its first appearance is not known. It is noted that it possibly began in Central Africa in the early 1970s. Research has shown that medical clinics may have unintentionally promoted the spread of the virus in an attempt to vaccinate large numbers of people against common diseases. This resulted in needles being re-used which promoted in the exchange of bodily fluids (Taylor, 2003). It seems that the disease made its way slowly from Africa to Europe and Haiti and further on to the United States by means of American citizens vacationing in Haiti and inadvertently bringing the virus back to America.

Korber (2000) offers another explanation for the origin of HIV. It is scientifically accepted that HIV crossed the barrier between species from primates to humans. HIV demonstrates a relationship to SIV, a virus found in primates. It is proposed that the virus could have crossed the barrier between species when people were killing SIV-infected animals for food and the contaminated blood entered open cuts on the hands of these people.

The researcher is of opinion that it would not be possible to conclude with absolute certainty what the exact origin of the virus is. However, these theories contribute to a better understanding of the virus in its entirety.

# 2.2.4 Global Patterns in the Prevalence of HIV Infection and AIDS

The spread of the virus has been rapid and seems inexorable. At present the exact number of people who are infected with HIV and AIDS is probably unknown, but the pandemic is measured by the number of reported cases of HIV or AIDS infection. The World Health Organisation (WHO) has established a monitoring system through the Global Programme on AIDS to be able to make approximations about the development of the pandemic. According to FitzSimons (1993), 163 countries reported their respective statistics to the programme by the end of 1991. Due to this programme one can today monitor the global pattern of the prevalence of HIV and AIDS and the course of the pandemic can be traced as a result of regular reporting of cases.

Current approximations by Panther and Libman (cited in Citron, Brouilette and Beckett, 2005) have revealed that 40 million people worldwide are infected with HIV and a further 3 million died of AIDSrelated illnesses in 2004. The most severely affected area is Sub-Saharan Africa, with the highest prevalence in Botswana, South Africa and Zimbabwe. In Asia and India the pandemic is also rapidly on the increase. Eastern Europe is experiencing a rise in the number of infections, especially in the Ukraine. In Latin America and the Caribbean region, HIV infection rates continue to rise. The incidence of AIDS in the USA increased rapidly in the 1980s, peaked in the 1990s and declined after that. The availability of medical services and the correct treatment is said to have decreased the number of deaths that could be attributed to HIV infection. It is now estimated that 40 000 new cases of HIV infection occur in the USA every year (http://www.unaids.org).

When critically examining the above-mentioned data describing the increase in infection rates, the researcher can deduce that globally the HIV pandemic has affected socially and economically disadvantaged communities disproportionately. A few reasons could be offered as a possible explanation for this disproportionate spreading of the pandemic. The researcher contends that low literacy rates and remote living areas could have hindered individuals' access to health care and information. Antiretroviral medicine is also not readily available and surely not easily affordable in certain developing countries such as Zimbabwe, Botswana and Thailand. The healthcare infrastructure to appropriately monitor and care for individuals with HIV/AIDS are also not in place everywhere, as it is in first world countries.

For thoroughness sake, it is also necessary to consider the other side of this rather bleak picture. Despite the lack of universal access to medication, some developing countries have shown a decrease in the incidence of HIV. This could probably be attributed to the initiation of intensive prevention programmes dedicated to public education about

safer sex, clean needle use, sexually transmitted disease prevention and treatment, and prenatal care.

## 2.3 The Mechanics of HIV: Transmission and Infection

HIV is what the medical community terms a fragile virus. All diseases have a reproduction number, which could be explained as the number of people an infected person will infect in their lifetime (Whiteside & Sunter, 2000). HIV has a reproduction number of five (5), which is minimal when compared to, for example, the one hundred (100) of malaria. The reason for this can be attributed to the modes of transmission.

A brief look at the different modes of transmission would be insightful at this point.

HIV has to enter the body in substantial quantities. It has to pass through either the skin or a mucous membrane in order to enter the bloodstream. It is thus transmitted in the following ways, in order of importance:

- Unprotected sexual intercourse;
- Mother to child transmission;
- Intravenous drug use with contaminated needles;
- Occupational exposure;
- Via other modes such as bodily contact involving open wounds.

The following table gives the probability of HIV infection per exposure (Citron *et al.*, 2005, p.3 and Whiteside & Sunter, 2000, p.11).

Mode of Transmission	Infections per 1000	
	exposures	
Male to Female unprotected vaginal sex	1-2	
Female to Male unprotected vaginal sex	0,33-1	
Male to Male unprotected anal sex	5-30	
Receptive Oral Sex	Unknown	
Needle stick (occupational exposure)	3	
Needle Sharing (Drug use)	6 - 30	
Mother-to-child transmission	130-480	
Exposure to contaminated blood products	900-1000	

#### Table 1: Risk of transmission according to mode of transmission

HIV, similarly to other viruses, can only reproduce itself inside a living cell which it parasitises for reproduction purposes. Once the virus enters the bloodstream, it enters the CD4 cell or other immune system cells, the microphage. The virus then uses the cell's own RNA and copies it into DNA. New viral proteins are manufactured, which are assembled into viruses. The new viruses then break out of the cell. In the process the host CD4 or microphage cell is destroyed, weakening the immune system. The viral load is the number of HIV virus cells in the bloodstream.

To sum up, the virus enters the bloodstream, invades the very cells that are supposed to protect the body against invasions from viruses, and then the HIV virus uses those cells to replicate itself. During this process the virus destroys the CD4 cells, whose main role in the body's immune system is to protect the body from invasion by bacteria and viruses. One way of viewing the process is that the HIV virus hijacks and uses the immune system against the body.

Another important factor to consider is the issue of the window period. This is a short period of time between infection by HIV and the person first developing antibodies that can be picked up by the standard HIV tests. Antibodies are the chemicals the body produces as a reaction to an infection. Meyohas, Moran-Joubert, Van De Weil, Mariotti and Lefrere (1995) suggest this window period is 2-3 months from time of infection. This period is one in which the person is highly infectious. The reason for this is that a rapid multiplication of both the virus and the CD4 cells occurs. The body produces more CD4 cells in an attempt to destroy the invader virus. The virus destroys these CD4 cells at a faster rate that the body can replace them. In a healthy person there should be about 1 200 CD4 cells per micro-litre of blood. As the virus continues its advance, this number falls to 200, which is the threshold where the person is then said to have AIDS.

In Western countries it takes on average 10 years for an infected person's CD4 count to fall from 1 200 to 200. If no treatment is received, death usually occurs within 12 to 24 months. In Africa it takes on average 6 to 8 years for the CD4 count to drop to the level of HIV becoming AIDS. The reason for this reduced time frame is said to be: more exposure to opportunistic diseases, poor nutrition and more stressful lifestyles (Whiteside & Sunter, 2000).

#### 2.4 Treatment of HIV

At present there is no cure for HIV, but there are various treatments available. Whiteside and Sunter (2000) outlined a three-stage treatment plan. The first stage is one of 'positive' living, which includes education of the patient (Whiteside & Sunter, 2000). This involves a balanced diet and basically applying healthy principles in order to remain healthy. The second stage begins when the CD4 count starts to decrease and the patient starts prophylactic treatment to prevent opportunistic diseases such as tuberculosis. The final stage occurs when the CD4 count falls below 350 and it involves the use of antiretroviral drugs, which fight the HIV directly. The last two stages thus entail the institution and maintenance of a combination of antiretroviral therapy and prophylactic therapies against opportunistic diseases. Panther and Libman cited in

Citron *et al.* (2005) adds to this plan the management of the side-effects and complications from these therapies.

These treatments can be used in single therapies (one drug), double therapies (two drugs) or triple therapies (three drugs). The ideal therapy is the triple therapy, as it causes the viral load to drop more quickly than double or single therapies. It furthermore avoids possible mutation into drug-resistant strains, as may occur with the single therapies. Single therapies are generally used to try and prevent mother-to-child transmissions. The treatments work by preventing the HIV from being able to convert the RNA and/or use the cell to manufacture viral protein (Wilson, Naidoo, Bekker, Cotton & Maartens, 2004). One can thus understand that in this way the HIV is not destroyed, but rather rendered unable to increase its viral load.

Highly Active Antiretroviral Therapy (HAART) is an antiretroviral regimen which can suppress HIV for a substantial period of time, even up to several years. It usually involves the use of two reverse transcriptase inhibitors and one protease inhibitor. The transcriptase inhibitors prevent the virus from using the cells' RNA, while the protease inhibitor inhibits the creation of viral proteins. Many doctors choose to start patients on double therapies and then increase the treatment gradually. The reason for this is two-fold: (1) the cost implications of the treatment, and (2) to set aside other options in reserve in case resistance to the medication should develop.

## 2.5 HIV in South Africa

It is necessary for the purpose of this research to provide evidence of the extent of HIV prevalence in South Africa. The researcher feels that doing this will provide the framework within which the medical practitioners work, as this prevalence may have an impact on their

attitude to HIV and performing procedures that carry a risk of occupational exposure.

If HIV is prevalent in the country as a whole, it is probably even more so in the hospital populations. It follows that there is then a greater chance that the patients with whom the medical practitioners are working are HIV positive. This could therefore increase the risk of occupational exposure, especially in the case of surgical procedures that carry a high risk.

Dr Singh (2000) found that 32,5% of all women attending antenatal clinics in Kwa Zulu Natal are HIV positive. Dr Singh also stated that healthcare workers have almost a 50% risk of being exposed to an HIV-positive patient in cases where the worker sustains an occupational injury. Whiteside and Sunter (2000) found in their research that 30% of paediatric admissions and 50% of adult admissions in Gauteng hospitals were HIV related and adult HIV-related admissions varied from 26 to 70%.

The data in the following table were taken from a LoveLife supplement which formed part of a special edition of the *Sunday Times* (June 17, 2001). It represents a sample of some of the projections as regards best- and worst-case scenarios of HIV-infected individuals in South Africa. It should be taken into account that this table includes only HIVpositive individuals and excludes those people classified as having AIDS.

|--|

Year	1999	2002	2008	2010
Best case	2,900,000	4,250,000	5,900,000	6,000,000
Worst case	3,000,000	4,750,000	7,100,000	7,500,000

When the abovementioned projections are coupled with the aforementioned statistics from various hospitals, the researcher can deduce from this a prospect of a medical system that will be having to treat an increasing stream of HIV-positive patients and this is a trend that looks set to continue.

The statistics above portray the reality of the HIV scenario that hospitals in South Africa are faced with at present. These statistics are crucial, as they are not mere projections and speculation which could be open to debate, but rather the hard facts. They paint a picture of a high incidence of HIV that seems to be ever increasing. The researcher regards this as an important consideration as it might play a role in affecting the experiences of the medical practitioners working under these conditions.

#### 2.6 Women and HIV

At the end of 2001 UNAIDS estimated that there were 37,1 million adults living with HIV/AIDS. Of those, about 50% were women. Epidemiological studies have shown that women can and most often do become infected with HIV by means of sexual transmission more easily and at higher rates than men. Due to the fact that women represent such a significant and growing part of the pandemic, the researcher thinks it is important to recognise the specific services and medical needs that pertain to this particular group.

The researcher feels it necessary for the purpose of this research also to look specifically at the HIV sero-prevalence for pregnant women in South Africa. It is documented in the HIV/AIDS Surveillance Data Base that during the mid-1990s, the HIV pandemic had exploded among pregnant women in South Africa and continued to show a steady increase.

The graph below, adapted from the Department of Health (2001), demonstrates the increase in the numbers of pregnant women with HIV since 1990.



# Figure 1: Prevalence percentage of HIV among pregnant women in South Africa

## 2.6.1 The Diagnosis and Care of Pregnant Women with HIV

Sherr (as documented in Citron *et al.*, 2005) highlights the fact that it is standard practice of prenatal obstetrics to offer HIV testing to all pregnant women. In an attempt to reduce mother-to-child transmission, it is vital to do HIV testing during pregnancy (Dabis, Msellati & Meda, 1999; Ergin, Magnus, Ergin & He, 2002).

Van de Perre (1995) highlights the three elements around which treatment for pregnant women currently revolves:

• The use of antiretroviral treatment in pregnancy, labour and for the infant to reduce the risk of transmission;

- The use of caesarean section to avoid exposure to vaginal secretions;
- The avoidance of breastfeeding.

#### 2.6.2 Modes of Delivery for Babies of HIV-Positive Mothers

This particular research project directs its attention to the second element of the treatment plan for pregnant women with HIV/AIDS. A caesarean section can be defined as a mode of childbirth in which a surgical incision is made through a pregnant woman's abdomen and uterus to deliver a baby. Obstetricians recommend a caesarean section when a vaginal delivery might lead to medical complications or might pose a risk to the mother or baby (Wikipedia, 2006). Elective (planned) caesarean sections, undertaken before rupture of membranes, are the preferred method of delivery by medical practitioners for women with HIV, as research has shown that this can reduce the risk of mother-tochild transmission by about half (Wilson, Naidoo, Bekker, Cotton & Maartens, 2004). In most government health care facilities in South Africa caesarean sections for HIV-positive women will, however, not be possible for several reasons, including cost considerations and the possibility of infections after the surgery which might pose a risk to the HIV-positive mother.

HIV can be transmitted to an infant during childbirth, especially if waters break more than four hours before delivery and if labour is difficult or prolonged. HIV transmission is most likely to happen when mothers are not on antiretroviral treatment and have higher viral loads. However, it can occur when the child is delivered vaginally, even when the viral load is undetectable, possibly because of HIV localised in the genital tract.

In first world countries women who have elective caesarean sections before going into labour are much less likely to transmit HIV to their infants than women who deliver vaginally. Studies have shown that even when viral load is undetectable in women on antiretroviral therapy, a planned caesarean section can lower the risk of HIV transmission to the infant (International Peri-natal HIV Group, 1999).

However, given the relatively low risk of HIV transmission when the mother's viral load is undetectable on stable antiretroviral therapy, most guidelines advise that vaginal delivery should still be considered as an option for women with undetectable viral loads and they should be informed of the risks as well as the benefits associated with caesarean sections (Parrazini, 1999). In poor and middle-income countries it is unclear what the safest option for a mother and her child is, as invasive medical procedures present a risk of infection and other complications.

Studies performed before viral load testing and combination antiretroviral therapy became a routine part of clinical practice have shown that planned caesarean delivery, performed before the onset of labour and rupture of membranes, is consistently associated with a significant decrease in HIV transmission compared with other types of delivery (Parrazini, 1999). Reductions are shown to be between 55% and 80%.

Despite the strength of the evidence, there has been some disagreement over whether the use of elective caesarean delivery for all pregnancies in HIV-positive women should be recommended (Mofenson, 1999). This is primarily due the success of potent antiretroviral therapy, which has reduced HIV transmissions to zero in some studies, leading doctors to deem caesarean sections unnecessary in women with good virological response to HIV treatment (Morris, 2000).

## 2.7 Medical Practitioners and HIV

## 2.7.1 Universal Precautions to Prevent HIV Infection

The Centre for Disease Control in North America developed specific strategies for universal blood and bodily fluid precautions to address concerns about the transmission of HIV in hospitals (Van Dyk, 2001). Universal precautions can be described as the sensible measures that should be used by all healthcare professionals to protect themselves from occupational injuries and exposure to contaminated products. The universal aspect implies that these precautions should be followed for any patient that is treated, without any exceptions.

The universal precautions form an integral part of the training programme of the medical students at the University of Witwatersrand Medical School:

- Always take care when handling, cleaning or disposing of needles, scalpels or other sharp instruments;
- Never attempt to recap or re-sheath used needles and not to manipulate those needles in any way;
- Always dispose of sharp implements in the designated waste containers – called sharps bins;
- Make use of protective barriers such as latex gloves, aprons and eyeglasses;
- Immediately wash any skin surfaces that may be contaminated by blood or other bodily fluids.

This information booklet also states that the best prevention against occupational exposure is to follow the universal precautions, adding that the universal precautions are based on the assumption that everyone is HIV positive and as a precaution utmost care should be taken in every case (WITS Medical School, 1999).

It might seem that these guidelines are common sense and logical, and therefore one might assume that they are universally followed without question. Elford and Cockroft (1991), however, prepared a report in which they found that staff at a London teaching hospital did not adhere to the precautions, with most of the students and half the consultants failing to adhere to them. The students justified their actions by stating that they would wear protective gear and be more careful with needles in a case where they knew the patient's HIV status to be positive. The students also doubted the effectiveness of the precautions and felt that compulsory HIV testing would be a better means of infection control.

Following on from this theme of non-adherence, Elford (1991) reported that information from the 1991 International Conference in Florence, Italy indicated that universal precautions are being universally ignored. Despite this, studies have shown that health care workers remained anxious about HIV infection in the workplace and that the use of antiretroviral drugs is increasing after possible occupational exposures. Furthermore, Elford (1991) states that a study conducted in France involving 58 nurses with a reported 179 exposures to blood found that 49% of the exposures could have been avoided had the universal precautions been followed. The reasons given at the conference for lack of adherence to the universal precautions ranged from force of habit to lack of time to reduced dexterity and putting patients' needs first.

The aforementioned two articles are deemed important by the researcher in that they illustrate a paradox around the issue of HIV and protection for the medical practitioners. Although it would seem that there is a high level of anxiety, there is still a lack of compliance with the universal precautions. This is not to say that the precautions would reduce anxiety, as the first article mentioned; some feel the measures to be ineffective. Whatever the reasoning may be, this paradox needs to be kept in mind in terms of the findings of this research. Also of interest is the idea that medical practitioners put the patients' needs first, ahead of their own safety.

Although the above literature refers to research conducted with doctors in the United Kingdom, it is relevant to this research project, because it gives an insight into the practices followed by medical practitioners with respect to their attitudes towards the measures that are supposed to protect them from occupational exposure to HIV. But this is not to say that these attitudes are universal amongst medical practitioners and one also needs to bear in mind that HIV prevalence in those countries is much lower than in South Africa. It is interesting to note that despite the anxiety and fear around HIV transmission, there is an apparent lack of concern when following procedure, in that the universal precautions are ignored in some instances, or there is an apparent unawareness of the risk of transmission.

#### 2.7.2 Needle Stick Accidents

Treatments such as highly active antiretroviral therapy has dramatically improved and prolonged the lives of patients infected with HIV, but it has also led to an increased demand for surgical interventions within this population of patients. Despite meticulous safety precautions, occupational blood exposure cannot be completely prevented. Healthcare practitioners are at risk of acquiring HIV through occupational exposure to the blood of HIV-infected patients.

When looking at various research articles, it becomes evident that a needle stick accident is a common type of injury in the medical workplace, especially during surgery and it creates a substantial amount of anxiety and fear among medical practitioners (Regez, Kleipool, Speekenbrink & Frissen, 2005). The researcher has deemed it necessary to look briefly at this type of occupational exposure so as to develop a better understanding of the stressful aspects that play a role in shaping the experiences of medical practitioners.

For the purpose of this research, a needle stick injury will be defined as any injury, either self-inflicted and/or inflicted by another, whereby the skin is punctured or lacerated (Regez *et al.*, 2005). The needle involved must be a used needle, having been used by the doctor him/herself or left exposed by another medical professional. The skin may have been punctured or scraped with the sharp object.

The following graph was taken from the conference material presented by Dr Singh and gives an indication of the prevalence of needle stick injuries compared to other types of injuries.



# Figure 2: Prevalence of needle stick accidents compared to other types of injuries

## 2.7.3 Risk of Transmission: Actual and Perceived

In Figure 2 the risk of HIV transmission from a used or shared intravenous drug needle is calculated at 3 out of 1000 exposures. Lachman (1997) quotes the same figure for the needle stick injuries that medical practitioners face. Elford (1991) reports that the Centre for Disease Control (CDC) in America estimates a 0,31% risk of transmission after percutaneous injury, which amount to 3 out of 1000. O'Neill, Abbot and Radecki (1992) report a figure of 0, 42% from the

CDC, which is slightly higher, but no explanation for this higher incidence was given.

In looking at the injuries themselves, the following information was gathered from a report released by the Centre for Disease Control (1996). It states that the risk of transmission is greater if:

- There is clear evidence of contaminant on the needle;
- The needle is a hollow bore variety;
- It is a deep injury;
- The doctor punctures his or her vein or artery;
- The clinical picture of the patient suggests severe disease that is AIDS related.

It needs to be mentioned that, apart from the above factors, it would seem that doctors try to predict risks based on markers from the patient. Stern and Dickinson (1995) bring this to light when they advise that the calculated risk attitude being adopted by some medical practitioners is more like a guess, in that there are no markers that can identify with any certainty who may be HIV positive and who is not. Apart from being unprofessional, they view this as inappropriate and dangerous behaviour.

Elford (1991) reports that of 1 340 Italian medical practitioners being treated for possible infection, needle sticks accounted for 56% of the injuries and that 2 sero-conversions occurred. Elford (1991) quotes a report from the CDC which states that, of the 22 health care practitioners who reported occupationally acquired HIV, 18 were a result of a needle stick injury (Elford, 1991).

In research conducted in South Africa Miller (1992) reports that, of the 37 documented cases of exposure, 2 had sero-converted. The reason for such a high incidence of infection was not made clear.
It would seem that from the above that a needle stick injury is not an uncommon occupational injury and that there is consensus on the risk of transmission being 3 out of every 1000 exposures, or 0, 3%. It would also seem from the above statistics and reports of non-adherence to universal precautions that medical practitioners around the world are being injured through needle stick injuries and that some have contracted HIV as a consequence.

The researcher can further advance this strand of reasoning through the fact that HIV figures that are steadily on the rise in South Africa and needle stick injuries are not rare, so it stands to reason that with an increase in needle sticks, there will be a parallel increase in HIV sero-conversions. It is of interest to note that the high rate of needle stick injuries was also experienced by foreign doctors working in South Africa. De Graaf, Houweling and Van Zessen (1998) point out that 61% of a group of 99 Dutch doctors reported injuries during a twenty-one month stay in South Africa. The researcher is of the opinion that this may be a reflection of workload and corresponding pressures rather that an issue of staff training around correct and safe procedures.

A concept linked to the actual risk of HIV transmission is that of perceived risk. The researcher feels it is important to examine the attitudes of medical practitioners and other healthcare staff towards HIV and HIV infection, as it reflects to some degree their anxieties, fears and thoughts.

#### 2.7.4 Attitudes of Doctors and Nurses to HIV and AIDS

Willingness to provide care and treatment to patients with HIV/AIDS is an important personal and professional requirement for medical professionals who work with patients suffering from this disease (McCann, 1997). This could have serious implications for the quality of health care that is provided as well as for the patient-doctor relationship.

For the researcher this is a very important issue as international literature deals with the willingness to care and the attitudes of practitioners much more readily than is the case in South Africa, as in other countries practitioners has a choice whether to treat or not to treat individuals with HIV. However, in South Africa medical practitioners do not have this choice. The researcher can then not help but wonder whether this has an influence on the attitudes of medical practitioners in South Africa.

A study by Bhushan and Cushman (1995) focused on the attitudes of paediatricians in New York City. They initially quoted a study which found that 47% of paediatricians in New York hospitals felt they had a 1 in 1,000,000 chance of professionally acquiring HIV, although 86% felt a mild to moderate concern regarding acquiring HIV from a patient. These statistics confirmed the aforementioned researchers' findings, with nearly two-thirds of the paediatricians feeling that AIDS is a serious professional hazard and 50% of attending physicians and 78% of residents, intern and fellows regarding HIV as a serious professional hazard.

This fear of HIV seems to affect attitudes towards patients. According to Anderson, Vojir and Johnson (1997), a significant number of practitioners reported feeling fearful and reluctant to treat HIV-positive patients. These researchers feel that this has prompted some medical schools to implement a programme to improve knowledge of HIV and to improve the attitude towards HIV-positive patients. Orlander, Samet, Kazis, Freedberg and Libman (1994) found that 62% of doctors interviewed in one survey were reluctant to treat HIV-positive individuals, and these researchers found similar programmes to the ones mentioned by Anderson *et al.* (1997) being implemented. This reluctance to treat HIVpositive patients sometimes results in inferior care being administered; the study by Ross and Hunter (1991) points out that 32% of staff at one hospital felt that patients received inferior care and over half the staff felt that they spent less time with HIV-positive patients.

An article by Sadovsky and Gillette (1997) mentions the stress that health care practitioners experience in general and in relation to HIV. The article introduces the idea of support groups for health care practitioners.

The following graph was taken from data presented by Dr Singh (2000) of King Edward Hospital in Durban and reflects, by rank, the number of needle stick injuries incurred by the staff at that hospital.



Figure 3: The number of injuries per rank designation

The reality is thus that occupational injuries do occur and they occur across all levels of training. An editorial in *The Lancet* (1992) states that between 25% and 80% of medical students and junior staff injure themselves during the first six to twelve months at a post. O'Neill *et al.* (1992) convert a reported rate of injury of 71% amongst students in a training year to being the equivalent of one student sero-converting every two to three years. What is important is that, although this figure is low, it is only for a single hospital in the United States of America, and the exposure to HIV-positive patients in America is given as 9,5%, which is quite high. Despite this, if one doctor a year were to sero-convert, it would put HIV infection alongside motor vehicle accidents as the joint

leading cause of death for that age group (students). When one considers that the HIV infection rate for South Africa is considerably higher, it follows that the number of medical staff who sero-convert would then also increase.

# 2.7.5 The Imminent Threat of Exposure to HIV in the Workplace: An Emotional Outlook

From the preceding review an impression is formed that there is an anxiety and apprehension about HIV amongst medical staff, that universal precautions are not being adhered to for a variety of reasons, and that needle stick injuries are the leading type of occupational exposure. The tragic reality is also that medical practitioners have contracted HIV through occupational injuries.

It is the researcher's opinion that it is necessary to try and look beyond the figures and talk of risk, to explore the unique emotional experiences of those who work under these stressful circumstances on a daily basis and face the threat of occupational exposure.

There is a very little literature on medical practitioners' experiences in working with HIV, especially in describing the emotional and psychological impact on medical practitioners. An article that attempted to address the emotional aspects was one by Cockroft, Oakley, Gooch and Mastin (1994), who examined anxiety levels among medical practitioners following an accidental exposure to blood or bodily fluids. The anxiety levels were measured at two subsequent interviews. The results showed that those who perceived that they were at a higher risk due to their knowledge of the patient's HIV status were more anxious than those who perceived their risk to be lower. Levels of anxiety within the staff member's families were measured and they were typically more worried and anxious about the occupational safety of their family members. There was no correlation between their level of knowledge of

HIV and the level of anxiety experienced, and even those with better knowledge of HIV exhibited anxiety levels as high as those with poorer knowledge on the subject.

Miller and Gillies (1999) aimed in their research to identify ways in which work stress affected the domestic and social lives of medical professionals working in the field of HIV and oncology. It is noted in this article that one quarter of the 103 HIV/AIDS professionals who took part in the research reported their relationships to suffer as a result of their work with HIV.

According to Catalan, Burgess, Pergami, Hulme, Gazzard and Phillips (1996), is it well known that the health care practitioners, in particular those dealing with individuals suffering from serious illness and those exposed to multiple deaths, are at risk of developing work-related These mental health problems may be psychological disorders. attributed not only to job dissatisfaction and possibly impaired work performance, but also lead to a significant number of days lost. In their research they highlighted the psychological impact on 70 doctors and nurses working with people with HIV/AIDS and found substantial levels of psychological morbidity as well as high levels of work-related stress. The factors associated with the presence of high levels of psychological and with abnormal levels of emotional exhaustion, morbidity depersonalisation and concerns about personal accomplishments were identified as high levels of anxiety, the presence of social dysfunction and poor leisure adjustment, stressful situations at work, lack of support and the fact that they deal with patients who have a poor prognosis and for whom therapeutic options are limited.

Being continually exposed to the threat of contracting HIV/AIDS, together with the severely stressful working conditions of these professionals, the researcher has found it necessary to review the relevant South African literature pertaining to this phenomenon.

Turning towards South Africa, Smit (2005) conducted research that examined the perceptions and experiences of 35 nurses caring for people living with HIV in the public health sector. The researcher deemed this study particularly important as it almost parallels the study undertaken by the researcher. As it is a South African study, the results are particularly relevant. The researcher could also interpret and apply it much easier as she has a good understanding of the circumstances in the public health sector.

The findings resulted in the following seven themes that were important to this research:

#### Negative perceptions and experiences:

Helplessness

The majority of participants in the study experiences feelings of helplessness and powerlessness when caring for patients with HIV. This could be attributed to the fact that there is no cure available for HIV/AIDS and many participants experienced a sense of futility while caring for these terminally ill patients.

• Emotional stress and fatigue

All the participants expressed a sense of both physical and mental fatigue. This could possibly be a result of the fact that providing care for patients in general, especially patients with HIV/AIDS, is demanding and draining. Not only physical weariness, but also emotional exhaustion and stress were a big concern for the participants.

Fear

The majority of participants did not express high levels of fear and anxiety. This may be because all the participants in the study had

undergone AIDS-specific education. Some did, however, voice a need for further in-depth and on-going education on HIV/AIDS.

The participants did articulate concerns about the low quality and sometimes infrequent availability of gloves, aprons, masks and incontinence aids, which increased their risk of accidental exposure to HIV.

Of the 35 participants interviewed, 16 recalled exposure to HIV-infected bodily fluids, either through a needle stick injury or blood being splashed into their eyes. Although the participants did not in general express high levels of fear and anxiety, the risk of contracting HIV as a result of accidental exposure was noted as always present. They viewed the possible exposure to HIV as a part of their job and something they had to cope with this mentally.

Rather than expressing fear for their own safety, the majority of the participants indicated that significant others were extremely concerned about them being exposed to HIV in their occupational environment.

Anger and frustration

The participants' sense of anger was not so much associated with negative feelings harboured towards the HIV-positive patients per se, but was rather related to three other issues:

- Anger towards and frustration with some patients who treated them with disrespect and were unappreciative of the care they received;
- Anger and annoyance at the manner in which the government dealt with HIV/AIDS;
- Anger at members of society treated them, as nursing staff, with contempt.

# Occupation-related concerns

The participants voiced concerns about the deterioration of hospital infrastructure, insufficient medical equipment and too few staff. This created a situation where the participants were not only expected to provide care for an increasing number of patients in overcrowded wards, but also had to perform duties beyond the scope of their job description. They felt that they received little or no support from hospital management.

# Positive perceptions and experiences:

• Empathy

More than half of the participants expressed feelings of empathy and compassion towards the patients suffering from HIV/AIDS.

• Self fulfilment

Even though the care of HIV-positive patients can be physically and emotionally taxing, some participants expressed how caring for these patients magnified their experience of self-fulfilment.

This is congruent with the findings of a Canadian study by Olivier and Dykeman (2003), where nurses expressed feelings of satisfaction from providing care for patients with HIV/AIDS.

# 2.8 Summary

HIV infection and AIDS are of immense public health importance, especially in South Africa. The researcher postulates the reasons for this as follows: (1) HIV infection and AIDS have a high mortality rate; (2) there is no effective vaccine or treatment for HIV infection and AIDS; (3)

a high proportion of infected people become chronic, asymptomatic carriers and are potentially infectious and are at great risk of developing diseases; and (4) cases of HIV infection and AIDS continue to increase at an exponential rate. Furthermore, the researcher also takes into account the significant changes that the HIV pandemic has brought to the field of medicine and the demands it places on medical practitioners.

This chapter has dealt with the relevant literature regarding HIV/AIDS and the immense influence it has on the public health sector and individuals working within this context. It has covered information regarding HIV prevalence as well as modes of transmission. A relevant South African study was reviewed.

# METHODOLOGY

# DESCRIBING THE PHENOMENOLOGICAL APPROACH

"Phenomenology does not yield new information in the way that science pushes back the frontiers of knowledge. Its task is less to give us new ideas than it is to make explicit those ideas, assumptions, implicit pre-suppositions upon which we already behave and experience life. Its task is to reveal to us exactly what we already know, and that we know it, so that man can be less puzzled about himself. Were it to tell us something we did not know, it would not be telling us anything about ourselves, and hence it would not be important" (Keen in Ashworth, 1976, p. 363)

# 3.1 Introduction

This study is intended to be a qualitative design taken from a postpositivist, phenomenological paradigm. Therefore this chapter proposes to illuminate some philosophical underpinnings of the phenomenological approach to research. A general description of the layout of a study with respect to this philosophy will also be given. This chapter will also describe the method of data gathering and data analysis, unique to this study and appropriate to its goal.

# 3.2 Phenomenology Defined

The main idea of phenomenology is expressed in the word "phenomenon". The word phenomenon is derived from the Greek word, *phaenesthai*, which means to "blaze or flare, to scintillate, to show itself in itself, to appear in totality" (Heidegger, 1962, p.26). A phenomenon is defined as "that which appears or that which is given" (Hergenhahn 2005, p. 418). Another definition of phenomenon is "any occurrence that

is open to observation" (Reber & Reber 2001, p.533). It thus becomes evident that phenomena, in this sense, serve as the basis for inferring reality. Within this paradigm the researcher is interested in the meaning a person attributes to his or her experiences of reality, his or her lifeworld and his or her relationships.

Merleau-Ponty (1945) suggests that phenomenology may be viewed as:

...the study of essences...a philosophy for which the world is always already there before reflection begins...and all its efforts are concentrated upon re-achieving a direct and primitive contact with the world...it tries to give a direct description of our experience as it is, without taking into account its psychological origin and causal explanations which the scientist, the historian or the sociologist may be able to provide (p.vii).

Phenomenology, according to Merleau-Ponty (1945), refers to a transcendental philosophy; it employs a style of thinking that focuses primarily upon re-achieving a direct and primitive contact with the world by discarding traditional ways of understanding man. This transpires through a suspension of preconceived notions about human being's true nature.

The subject matter of phenomenology began with an investigation of consciousness and experience, and later moved on to include the human life-world by Heidegger, and to include human action by Sartre (Kvale, 1996). A life-world can be defined as the space occupied by any one person in the external, physical world or environment as well as the internal lived-in world, consisting of emotions and cognitions at any given time. This can thus be understood as the content of one's awareness (Hergenhahn, 2005). The life-world is the world lived by the person and is not seen as being separate of the person. The life-world is constructed by the unconscious and is independent of scientific interpretations.

In the light of the above-mentioned, the researcher interprets phenomenology as a quest to understand and define a person's cognitive experience, as it is only through this that the true essence of the person can be realised.

#### 3.3 The Phenomenological Approach to Research

At the start of venturing down any research path, it is essential to have a clear understanding of the way in which the researcher will view and process the knowledge under investigation. The researcher will thus attempt to offer a brief description of the way in which phenomenology appreciates knowledge.

An approach that is true to the phenomenological philosophy will echo the motto: "to the things themselves". The "thing" that is referred to here can be interpreted as a phenomenon or anything which a person is conscious of. Anything of which one can be conscious is a justifiable area of philosophical concern. This, according to Husserl, can be many different things, including natural objects, affective states, values, behaviours, etc. Phenomenology is thus a programme for a systematic investigation of the content of consciousness (Stewart & Mikunas, 1974). Husserl proposed that all experience is intentional (Gergen, 2001). The researcher takes this to mean that an individual's experience is always directed towards or absorbed by some object or person in the external Therefore conscious experience is fundamentally environment. relational. Gergen paraphrases this as meaning: "my existence requires you in order for it to have content; you exist for me only in so far as I bring experience to bear on you"(1999, p. 128).

This chapter is concerned with outlining an appropriate research strategy and will therefore not offer an elaborate philosophical discussion of phenomenology. This study is devoted to an understanding of

phenomenology's philosophy only insofar as it pertains to a method of conducting research.

In the literature on phenomenology one finds two major research groups that demonstrate a preference for employing the phenomenological approach in research. Hedegaard and Hakkarainen (1986) list them as the following:

- The Duquesne group in the USA;
- The INOM group in Goteberg.

In the relevant research literature the Duquesne studies are frequently mentioned and several of these studies will be cited in the section of this chapter that pertains to methodology.

# 3.3.1 Comments on the Philosophical Assumptions Underlying Phenomenological Research

In the early part of the twentieth century science and technology were growing rapidly. Edmund Husserl, (1859-1939) the acknowledged father of phenomenology, formulated the ideas of Kierkegaard and Nietzsche into a new discipline called phenomenology (Giorgi, Barton & Maes, 1983). He was interested in finding true knowledge and was concerned with empirical science's methods of researching consciousness. He felt it necessary to illuminate the essences of the 'universal' concepts psychologists were using and he criticized naturalism for overlooking the fact that there is not only one perspective on reality. He argued that truth cannot only be obtained through logic and rationality. Consequently he formulated the new method of phenomenology intended to clarify our implicit understandings of the world and to study conscious phenomena in a scrupulously scientific way, whilst avoiding the mistake of naturalizing consciousness.

For Husserl, the defining trait of consciousness is that it presents all objects to the observer. Consciousness is therefore impossible to

sidestep because, whether recognized or not, it is the means of accessing everything that is brought to awareness. In developing phenomenology, Husserl was attempting to raise the psychology of consciousness to a science by suggesting that, when seeking knowledge, it is more appropriate to recognize and consider the role of consciousness rigorously than not doing so (Giorgi, 1997; Jennings, 1986).

Husserl also believed that it is necessary to examine the essence of everyday conscious experience in order to fully understand the world. It is said that Husserl was one of the first philosophers who attempted to create a phenomenological understanding of the world that was outside traditional beliefs, religious beliefs and modern scientific theories (McLeod, 2001).

It is apparent in modern literature that the phenomenological approach to research is becoming more widely recognized and it has recently been felt that providing reasons and justification for doing so in research is no longer considered necessary. Examples of this can be seen in the work of Giorgi (1992b), Thorpe (1989) and Todres (1990). This partly supports an appeal from Peterson (1994) in which he urged phenomenological researchers to explain what led them to their study and to spend less time on critiques of positivist ideas. Traditional research has given prominence in the past to validity, reliability, hypothesis formulation, operationalism and all the other principles of traditional scientific research. This would have placed great restrictions on the research matter of this particular project. The research matter ultimately determined the nature of the research strategy.

The foundation of this research is the aim to enter the life-world of medical practitioners who perform surgical procedures on patients with HIV/AIDS. The research situation then is the lived world of working with HIV/AIDS, as experienced by gynaecologists and obstetricians.

Giorgi (1970) states that phenomena are often studied more on the basis of the availability of methods than on how the phenomena appear. Furthermore, phenomenology attempts to get beyond immediately experienced meanings in order to articulate the pre-reflective level of lived meanings, to make the invisible visible (Giorgi & Giorgi, 2003; Huysamen, 2001; Giorgi, 1997; Kvale, 1996; Churchill, 1990). The phenomenological approach stresses the necessity of the modification of psychological research methods so that they effectively relate to the revised research object in psychology. This does not, however, imply that this method is less empirical, objective, scientific or psychologically valid than research methods and psychology formulated by means of natural scientific approaches. The researcher can thus infer that a phenomenological approach to research recommends different thoughts and understanding of these themes and offers the necessary tools to this project to "make the invisible visible" (Giorgi, 1970).

It is thus relatively easy to get the impression that the researcher is trying to replace or compare traditional methods of conducting research with more qualitative methods, which is not the case in this instance. One can quote Bugental (1965:14 as cited in Du Toit, 1991) to illustrate this point: "Humanistic psychology does not deny the contributions of other views, but tries to supplement them and give them a setting within a broader conception of human experience". And therefore the researcher can view this alternative approach as complementary to what has already been researched quantitatively on a research topic.

The researcher would now like to refer to the goal of the research, namely to make explicit the medical practitioner's experience of performing elective surgery on a patient with HIV/AIDS. The research object is the medical practitioner and the research situation is the lived world of performing elective caesarean sections on patients with HIV/AIDS in which psychological well-being is contextually and processionally embedded. It is thus the task of the researcher to try and explicate the medical practitioners' experiences from within this context.

It thus becomes more evident to the researcher that, in keeping with the above-mentioned ideas, the traditional concepts and formulations relevant to research should therefore be redefined to complement these aims and purposes. The solution that phenomenology offers is heard the main principle of this alternative approach of the description of phenomena as they appear. This solution echoes the dictum of phenomenology: "Back to the things themselves" (Ashworth, 1976, p. 52). In keeping with Giorgi's (1985) urge to do justice to the lived aspects of human phenomena, the essential contents of psychological science are redefined using the central concepts of phenomenological philosophy (Hedegaard & Hakkarainen, 1986).

To help illustrate the heart of what is being explained, one can make use of Brockelman's (1980:52) definition of existential phenomenology:

.....the attempt to reflectively evoke and verbally articulate by means of the phenomenological method of description, various structures or conditions of our experiences to itself as it is livedthrough within the 'world' or horizon of ordinary experience.

Phenomenological research thus advocates an approach that will strive to remain original and without preconceived notions about an expected outcome (Du Toit, 1991). It can be argued that no research can be purely phenomenological, since the researcher still possesses the preconceived notions that motivated the specific study in the first place (Giorgi *et al.*, 1983). The researcher can, however, be true to the phenomenon by acknowledging these preconceptions and by allowing openness to new and unexpected phenomena. This idea of understanding is termed a transcendental attitude (Moustakas, 1994).

# 3.3.2 Identifying Strengths of Phenomenology

Before the researcher chose the specific research paradigm that would be used in this research, the strengths and weaknesses of different paradigms were considered. It was decided that phenomenology, as an alternative means of doing research, offers the strengths and contributions to the research that the researcher required. The most outstanding aspect for the researcher that prompted the choice of phenomenology for this particular research project is that it provides a very rich and complete description of human experience and the meanings attributed to these experiences. A further strength of this research paradigm can be seen in the fact that within phenomenology findings emerge naturally and are not imposed by the method or the researcher. The techniques used in the phenomenological method also ensure the faithful handling of the data, as demonstrated in the focus being on describing rather than interpreting the data. It could be argued that such a qualitative method could easily lead to the researcher being subjective and thus influencing the findings in a negative manner. Phenomenology, however, uses the technique of bracketing, which implies minimal researcher influence on the findings.

# 3.3.3 Identifying Weaknesses of Phenomenology

A consideration of the strengths of an approach also necessitates a careful consideration of its weaknesses. The researcher felt that the following weaknesses stood out from the literature on phenomenology (Braud & Anderson, 1998). The phenomenological method as outlined earlier in this chapter illustrates what can be viewed as one of its major weaknesses. This relates to the method that depends heavily on the articulation skills of the participant in order to ensure a rich description. Another weakness that links well with this one is that the use of language and terms used by the participants may be obtuse or imprecise and would thus not provide the researcher with a rich description. Although

these weaknesses can be attributed to the phenomenological approach, the researcher felt that they would not impact on the quality of the research being undertaken because of the specific nature of the topic. The researcher does not foresee the articulation skills of the chosen participants as a hindrance, because all of the participants have been in the medical profession for over eight years and has a clear understanding of the biological aspects of this topic. However, the researcher does understand that the participants may not all be able to articulate their emotional experiences proficiently.

It could also be argued that the conclusion the researcher draws depends on the participants who were chosen for the research. This weakness need not be a huge concern for the researcher as the chosen participants were all gynaecological registrars and therefore had firsthand experience of the phenomenon under investigation. Another weakness of phenomenology is that it has little interest in explaining the experience. The researcher does not view this as a weakness for the study, as she is aiming to give a description of the medical practitioners' lived experiences.

# 3.4 The Format of Phenomenological Research

Polkinghorne (1989, p. 46) has set out a general format for the phenomenological investigation of consciousness by psychologists. This follows a three-step procedure in which the researcher should:

- Gather a number of naïve descriptions from individuals who are having or have had the experience under investigation;
- Engage in a process of analysing these descriptions so that the researcher comes to an understanding of the constituents or common elements that make the experience what it is;
- Produce a research report that gives an accurate, clear and articulate description of an experience. The reader of the report

should be able to come away with the feeling that "I understood better what it is like for someone to experience that".

The empirical phenomenological method focuses on the analysis of protocol data provided by the participants in the research in response to a question or multiple questions posed by the researcher which pinpoint and guide their recall and reflection. There is a straightforward general progression in the various genres of this type of research (Von Eckartsberg, 1986).

Firstly, the researcher proceeds from unarticulated living to a protocol or account. A "life-text" (Von Eckartsberg, 1986, p.27) is created which renders the experience in narrative language, as a story. This encompasses the data. Secondly, the researcher progresses from the protocol to the process of explication and interpretation. Finally, the researcher engages in the process of communication of findings (Von Eckartsberg, 1986).

It is crucial that the researcher's own stance be discussed before one can commence concretizing this procedure for greater clarification, and before it is uniquely formulated for the purposes of this research.

# 3.4.1 The Researcher's Stance: The Shift from the Natural to the Philosophical Attitude

The researcher who embarks upon a phenomenological research journey assumes a different stance from the researcher who engages in a scientific, quantitative study. There are three important terms that can explain this transition from a scientific to a philosophical attitude. These three terms can also be viewed as the distinguishable yet interrelated steps that make up the phenomenological method. They are as follows:

- Phenomenological epoch;
- Phenomenological reduction; and

Bracketing.

#### 3.4.1.1 Phenomenological Epoch

The following quote by Husserl in Ashworth (1996, p. 7) helps to explain the shift in attitude that an aspiring phenomenologist should assume before he or she attempts any explication of narratives.

The psychologist as such in his enquiry must...take and have no position: he must neither concur nor refuse, nor remain in problematic suspense, as if he had some say in the validities of the persons who are his subjects. So long as he has not acquired this posture as a serious and consciously established one, he has not arrived at his true subject matter; as soon as he violates it, he has lost his subject matter.

This implies the bracketing off of all theoretical-scientific constructs about the nature of the subject matter. The epoch instructs the researcher to "put out of action" any beliefs that he or she may have about the independent existence of the world as he or she sees it (Solomon, 1980). Rahilly (1993) has explained this as the requirement that the researcher has to suspend any presuppositions and prejudices about the cause of the phenomenon under investigation.

It would be wise at this point to draw a distinction between the terms 'epoch' and 'bracketing' for the sake of clarity. Epoch is understood to be the attitude and bracketing is understood to be the active operation. A study by Rahilly (1993) on authentic experience helps illustrate the distinction. She clearly formulated her own presuppositions about feeling authentic. This, although not implicitly stated, was after having assumed the phenomenological epoch and prior to any explication of her data.

In this particular research the researcher is interested in the phenomenology of medical practitioners' experiences when doing

elective surgery on patients with HIV/AIDS. Therefore the process will begin with the first-person, subjective accounts of the relative experiences of individuals who perform this kind of surgery on patients with HIV/AIDS on a day-to-day basis. Once these accounts have been obtained, another level in the shift from the natural to the philosophical attitude has to be reckoned with and this pertains to the phenomenological reduction.

#### 3.4.1.2 Phenomenological Reduction

In phenomenological reduction the quality of the experience becomes the focus. The aim of reduction is to describe the general features of an experience, excluding everything that is not immediately within one's conscious experience. Thus a researcher needs to literally reduce the world to a world of pure phenomena, where the reduced phenomena are claimed to be as they are for the consciousness that beholds them, with no mention of the facts of the experience (Giorgi *et al.*, 1983).

The researcher can thus deduce from this that the purpose of the reduction is to satisfy the demands that are described as central to phenomenology – to guarantee the 'purity' of description and to aid in the discovery of the essences that are the key to Husserl's analysis of phenomena. The reduction ensures that the object described by phenomenology will be the phenomenon or intentional object of experience and not something else – especially not a construction made by scientists or a trans-experiential object that 'common sense' teaches us to see (Miller, 1984). The reduction thus forces the researcher to look at what he or she simply sees.

Applying the above to this research, one understands that when the narratives used in this study have been read, the researcher has to limit herself to what is immanent to the participants' experiences. Davidson and Cosgrove (1991, p. 93) explained this by saying that the researcher

has to look more deeply "into" the experiences of the subjects rather than "outside" of them.

As a result of this reduction, one acknowledges an entirely different sphere from the one traditionally regarded by science as constituting the subject matter (Davidson & Cosgrove, 1991). Rahilly (1993) employed phenomenological epoch and bracketing before she formulated a research question about authentic experience. Many researchers have explicitly bracketed and formulated their presuppositions about the phenomenon under investigation, for example, Guglietti-Kelly and . Westcott (1990) and Denne and Thompson (1991).

In his later work called *Cartesian Meditation*, Husserl continues to use the phrase 'phenomenological reduction', but in this period the reduction becomes a transcendental reduction. There is a difficulty in that Husserl uses his old terminology to describe something new, but it is clear that the transcendental reduction is not meant to be added to the other reductions but rather to replace them all (Solomon, 1980). The transcendental reduction represents a step back to the work of Descartes, for it is no longer a reduction to pure consciousness as much as a reduction to the transcendental ego and the transcendental realm.

It is referred to as 'transcendental' because it moves beyond the everyday to the pure ego in which everything is perceived freshly, as if for the first time. Schmitt (1967, p. 61) explains that it is called 'phenomenological', because it transforms the world into mere phenomena. It is called 'reduction' because it leads the researcher back to the source of the meaning and existence of the experienced world.

#### 3.4.1.3 Bracketing

Bracketing is done in order to understand the experiences of the participants as they truly are (Giorgi *et al.*, 1983). According to Husserl,

bracketing is a preparation for deriving new knowledge, but also a process of setting aside prejudices and predispositions (Moustakas, 1994). In order to achieve this, the researcher has to be prepared to enter the world of the participant with an open mind, free of preconceptions. This is done by making the presuppositions and assumptions explicit by laying them out so that they appear in as clear a form as possible to oneself (Valle & King, 1978).

As the researcher brackets the assumptions and presuppositions, it is believed that more emerges at the level of the reflective awareness. Regular practice of bracketing is believed to increase the researcher's competence in achieving this state. It should, however, be noted that certain entities, such as life experiences that are intensely ingrained so that they are not part of conscious awareness, are not easy to bracket (Moustakas, 1994). Husserl insists, though, that with hard work and commitment to the process bracketing is possible (Moustakas, 1994). Valle and King (1978) state that the process of bracketing and rebracketing enables the researcher to move from the natural attitude to the transcendental attitude. This attempt to reach a transcendental attitude is called reduction.

Once the researcher has obtained a thorough description of the phenomenon under investigation, and after the formal and scientific explication has been completed, the stance might then change to an interpretive stance, where the researcher moves beyond what is immediately evident. Giorgi (1992b) has distinguished between description and interpretation. He cites Mohanty (1989, p. 19) as defining description as the use of language to articulate the intentional objects of experience within the constraints of intuitive or presentational evidence. This means that one describes what presents itself **precisely as it presents itself** – neither adding nor subtracting from it (Giorgi, 1992b, p. 121). This description them implies the employment of the attitude of phenomenological reduction (Giorgi, 1992b) as set out above.

Interpretation as explained by Giorgi (1992b, p. 122) "would be the clarification of the meaning of experienced objects in terms of a plausible, but contingently adopted theoretical perspective, assumption, hypothesis, and so on". It is thus understood as description being the deposition of meanings and interpretation being the clarification of meanings.

At this moment, after the discussion of the researcher's stance, one could proceed to the steps in phenomenological research.

# 3.4.2 Steps in Phenomenological Research

#### Step 1: The problem and question formulation

At the beginning of any phenomenological research task, the researcher should outline the focus of the investigation (Von Eckartsberg, 1986). This implies that the researcher should specify the phenomenon that he or she is interested in and that the research will focus on.

#### Step 2: The selection of the participants

The participants are chosen who are able to serve as informants by providing the researcher with rich descriptions of the experience being investigated. In phenomenological research these participants could be referred to in different ways such as co-researcher, research partner, research collaborator and co-author (Polkinghorne, 1989). According to Polkinghorne (1989, p. 47), this assists in emphasizing that phenomenological research interrelates in a personal manner with those asked to provide examples from their experience.

It is understandable that the fundamental criterion for participation in the study concerns the fact that the participants have had an experience with the particular phenomenon under investigation. This would point to the participant's ability to give a detailed account of his or her specific experience. Van Kaam (1969 cited in Rahilly, 1993) recommended six important criteria for participation in a phenomenological study:

- The participants must have a capacity to express themselves with relative ease;
- 2. They must have the capacity to sense and express their inner feelings and emotions without shame and inhibition;
- They must have the ability to sense and to express the real experiences that accompany these feelings;
- 4. The participants must have experienced the phenomenon / situation under investigation at a relatively recent date;
- 5. A spontaneous interest in their experience;
- An atmosphere which the subjects find sufficiently relaxing to enable them to put the necessary time and orderly thought into reporting or writing what was happening to them.

#### Step 3: The data-generating situation

There needs to be harmony between gathering the raw data, the method of analysis and the outcomes that are sought. The driving force behind the analysis of the descriptive data in the phenomenological method is the search for psychological meaning as lived by each participant; therefore medical practitioners' detailed descriptions of their experiences are an obvious and good source of data (Giorgi & Giorgi, 2003).

The purpose of the data-collection phase is to collect natural descriptions from the participants regarding the experience under investigation. The natural descriptions will provide the researcher with "specific instances from which the researcher can tease out the structure of consciousness that constitutes the experience" (Polkinghorne, 1989, p. 46). It is these descriptions that Von Eckartsberg (1986, p. 27) has referred to as "the protocol life-text".

There are three main sources that a researcher can use to generate descriptions of experiences (Polkinghorne, 1989). Firstly, personal reflections on the phenomenon of the topic that has been studied can be used. Secondly, other participants can be employed to describe the phenomenon under investigation. These participants can be referred to as co-researchers (Von Eckartsberg, 1986). Thirdly, accounts of the phenomenon can be acquired from outside the context of the research project itself, for example, from novelists or previous psychological and phenomenological investigations.

#### Step 4: Data analysis

Data analysis is the core stage of the phenomenological research endeavour and its goal is to derive from the naïve descriptions a description of the essential features of the specific experience. Various terms have been used to label the process through which a researcher moves from a collection of naïve descriptions to a structural description. Van Kaam (1969) refers to it as '*explication*' - the process by which the researcher seeks the essential structures of the experience under investigation.

Polkinghorne's views (1989) fit in with the above-mentioned points and he describes the process of analysing data as follows:

"Its purpose is to derive from the collection of protocols, with their naïve descriptions of specific examples of the experience under consideration a description of the essential features of that experience. The researcher must glean from the examples an accurate essential description of their contents and the articular structural relationship that coheres the elements into a unified experience" (Polkinghorne, 1989, p. 50).

There is an assortment of steps that can be included in this explication (Von Eckartsberg, 1986). A literature review on phenomenological research studies shows that most of the psychological studies that have been carried out at universities throughout South-Africa, for example, the University of Zululand, the University of Pretoria, the University of Witwatersrand and Rhodes University, are all strongly anchored in the Duquesne tradition. They all seem to concentrate strongly on the works of Giorgi (1985).

Giorgi's (1985) steps will now be very briefly outlined as they have been selected for this research on the experiences of medical practitioners when they perform an elective caesarean section on a patient with HIV/AIDS. The method as illustrated by Giorgi (1985, p. 10) contains four essential steps that are outlined below.

Firstly, the researcher has to read the entire description to get a general sense of the whole statement. Secondly, the researcher goes back to the beginning and reads through the text with the specific aim of discriminating meaning units from within a psychological perspective and with a focus on the phenomenon being researched. Thirdly, once the natural meaning units (NMUs) have been distinguished, the researcher then goes through all of the meaning units with the aim of expressing the psychological insights contained in them more directly. Lastly, the researcher integrates all of the transformed meaning units into a consistent statement on the subjects' experiences.

Phenomenology deals with experiences and meanings and thus its scientific status is often regarded with suspicion. But nothing prevents the method from following the general dictates of science (Giorgi & Giorgi, 2003). In order to maintain standards that satisfy the

requirements of both science and phenomenology certain steps can be followed in analysing the data.

The researcher selected the method sketched in Giorgi's work (1970) for the research. This involves interviewing subjects:

- 1. who have experienced the phenomenon under investigation;
- 2. who are verbally articulate;
- 3. who are proficient in English; and
- 4. who are naïve with regard to psychological theory.

#### Step 5: The presentation of the results

Von Eckartsberg (1986) describes this as the phase where the results are presented for sharing and criticism. It appears as if there are no consistent guidelines as to the manner in which the results need to be presented and this can be done in various ways. The researcher views this as one of the strengths of phenomenological research – having the freedom to express the findings in multiple ways that can do justice to the phenomenon under investigation without forcing it into specific scientific moulds.

There is an additional step that has not been explicitly acknowledged and which refers to validation. This remains a contentious issue in phenomenological research (Polkinghorne, 1989) and the researcher feels that it is thus necessary to discuss this matter briefly.

#### 3.4.3. Comments on the Validation of Phenomenological Research

The phenomenological researcher needs to be concerned with the validity of the findings throughout the research process. This includes whether or not the findings can be trusted and used as the basis for future inferences. It should be kept in mind that phenomenological

research approaches validity, like all other research constructs, but with a different and more general perspective.

Polkinghorne (1989:57) has noted that the validity of phenomenological research concentrates on the question: "Does the general structural description provide an accurate portrait of the common features and structural connections that are manifest in the examples collected?"

One method of validating data that is often found in phenomenological research is that of returning to the subjects to validate their own data. This method is illustrated by Rahilly (1993), where Polkinghorne's (1989) guidelines are followed and she returned to the subjects to obtain concurrence with the general description.

Polkinghorne's (1989, p. 53) underlying principle explained in his own words is that the general structural description of the experience should be communicated to the subjects in order to gain feedback from them as to whether it accurately reflects their experiences. Ely (1991) also adheres to this method of discussion and working towards reaching consensus on findings and processes with others, particularly the participants, which will ensure the credibility and accuracy of interpretations.

Visser (2001) points out a controversy in the literature with regard to the above-mentioned method of validation. This has to do with the work of Ashworth (1993), who casts theoretical doubt on this method. His doubts are grounded in the fact that resistance to being understood and eager acceptance of understanding are both pervasive possibilities of all social interaction (Ashworth, 1993, p. 11). He also states that certain subjects, when asked to approve findings, may show resistance to objectification. The other side of the coin might also be that a reaction may be one of delight at truly being understood. This implies that fundamentally resistance to being understood as well as the eager acceptance of descriptions are possible reactions to objectification; both

responses are rooted in a fundamental anxiety about self-representation. One can infer that this argument has profound implications for the use of participants as sources of validation.

Other means of acquiring validity are the use of auxiliary subjects or additional analysed protocols. Scholtz and Fiedeldy (1994) made use of an external registered clinical psychologist, uninvolved in the research but experienced with phenomenological interpretation, to confirm findings. A comparison in this regard could aid in the demonstration of validity.

# 3.4.4 The Aim of the Research

The aim of phenomenology is to provide a method whereby the following can be achieved (Schneider and May, 1995, p. 59):

- Human existence can be studied in its natural environment and not in a controlled laboratory setting;
- The researcher suspends any preconceived ideas about the phenomena being studied. These preconceived notions will reside in the researcher and these will need to be considered during the analysis phase;
- The researcher immerses himself or herself in as many aspects of the phenomena as possible;
- The researcher must attempt to describe the phenomena that are being studied as richly and fully as possible;
- 5. The researcher must collect and integrate all the descriptions to provide a 'saturated' interpretation of the phenomenon.

Taking the above into consideration, the researcher's aim is to try and understand, convey and describe the emotional facets and experiences of medical practitioners who perform surgical procedures on patients with HIV/AIDS. It was decided that this research should focus on elective caesarean sections as one procedure that carries a risk of occupational exposure and it may therefore better highlight the impact and many aspects of operating on a patient with HIV as experienced by medical practitioners.

# 3.4.5 The Method

As mentioned earlier, the method outlined by Giorgi (1970) was selected for this research. The researcher also made use of open-ended questions adapted from the *Witness to Violence* semi-structured interviews as developed by Paraskevi Stavrou, a researcher at the South African Centre for Violence and Reconciliation (1994). The questions were slightly altered to be able to address the unique needs of this research.

The questions formulated for the informal interview were:

- Could you describe to me what your occupational life was like before you had the experience of performing elective caesarean sections on patients with HIV/AIDS?
- 2. How did you feel after your experience?
- 3. What was your reaction to having this experience?
- 4. Could you describe to me how your experience affected your life and activities?
- 5. What would you say are your biggest concerns about experiencing what you do in your occupational setting?
- 6. How would you say your family and people around you reacted to what happened to you?
- 7. What are your biggest fears now after your experience?
- 8. How do you see your future?

The method followed in the research has the following phases of analysis:

- The researcher brackets any personal preconceived ideas and judgement about the data and remains faithful to the data outlined in each individual protocol;
- 2. Each protocol has to be read as a whole with the aim of obtaining a holistic overall picture before initiating any analysis. Once the descriptive statements have been read, they have to be read again in a more reflective way in order to understand the variations present in the description. Once a sense of the entire protocol is achieved, it has to be read once again to distinguish the Natural Meaning Units (NMUs). Stones (1988) described an NMU as that which can be observed when a transition in meaning pertaining to an aspect of the subject's experience occurs in his or her statements. Giorgi (1970) points out that one obtains a series of meaning units or components, implying that one differentiates a part in such a manner that one remains aware of the whole.
- 3. Once the NMUs have been articulated and the central themes outlined, the researcher reflects on the intended meanings or verbalizations of the subjects using imaginative variation. The naïve descriptions given by the subjects are altered by the researcher into psychological language in order to convey the intended meaning of the subjects more clearly. Stones (1988) highlighted that "wherever possible, the subject's own phraseology should be adhered to in order that the data may speak for itself. However, since the shared nature of our lived-world suggests that we are able to understand others' meanings, it is permissible for the researcher to articulate the essence of each NMU (central theme) in words other than those used by the subjects in order to convey the intended meaning clearly" (Stones, 1988, 1988).

p. 153). In this way the richness of the data will be illuminated and in turn explicated in the phrases that follow.

- 4. During this specific phase of explication, the insights obtained from the NMUs are considered and integrated into a significant description of the experience for each subject, in what will be referred to as the specific description. It is of the utmost importance that the researcher continues to maintain a stance of openness to the descriptions provided by each subject. According to Stones (1988), "the specific description is one which communicates – through a psychological perspective – the unique structure of a particular phenomenon in a particular context" (Stones, 1988, p. 154).
- 5. As soon as the previous phase is completed, an attempt is made at a separate general description of the medical practitioners' experience of performing an elective caesarean section on a patient with HIV/AIDS as a conclusion to the discussion (see Chapter 5). This general description is based on the specific description of the experience of each individual. In effecting a general description, the researcher attempts a dialogue between the specific description of an individual's experience and what it in turn reveals about the phenomenon being investigated. Stones (1988) points out that "a general description is one which communicates the meaning structure of a phenomenon in general and which attempts to overcome the limitations imposed by any specific context" (Stones, 1988, p. 154).

Formulating a general description of each specific description may not be necessary if the essence of the meaning of the phenomenon for each individual in the specific description is comprehended. Wertz (1985) has employed Giorgi's (1970) method with slight variations. He uses a method which offers a general description based on all the specific descriptions, rather than a general description at the end of each specific description. Giorgi's approach, however, seemed more pertinent to this study and therefore an extended general description based on all the specific descriptions is given.

Thorpe (1989) encourages the use of a moderator familiar with the method employed in the study to test the analysis of the data in order to validate the results. The recommendations and insights of the moderator are taken into consideration. Reading the specific descriptions to the subjects is also important in order to validate the account. The subjects can also be asked for clarification. Kvale (1986) highlights that the validity of any interpretation made, is based on the subject's acceptance of it as well as consensus amongst theoretically competent persons. This approach was utilised in this research project in the form of supervisory sessions used to validate the accounts used.

The final product of phenomenological scientific analysis is not just an 'essential structure', but also an account of how this structure relates to the diverse expressions of an essential identity. In other words, the ultimate aim is to explain how the things that the participants said fall within a structure, as well as how they vary within this structure (Giorgi & For example, while it was found that all participants Giorgi, 2003). experienced anxiety regarding the performance of elective surgery on a patient with HIV/AIDS, each participant had a different reason for this Ultimately "the task is to language the phenomena from the feelina. standpoint of the guiding principles of one's discipline" (Churchill, 1990. p. 55). The final step then was to take these essential structures of the experiences of the medical practitioners performing an elective caesarean section on a patient with HIV/AIDS, as key to understanding other human behaviours.

#### 3.4.6 The Investigation

# 3.4.6.1 The Main Research

#### 1. Selection of participants

Finding participants for a phenomenological study involves 'criterion' sampling, in other words, finding individuals who have experienced the phenomenon under investigation (Cresswell, 1998). To achieve the main objective of the study, the researcher approached both qualified gynaecologists and gynaecological registrars in various government hospitals. Permission from the superintendents of the various hospitals was obtained (see Appendix A). A total of nine (9) medical practitioners were identified who perform surgical gynaecological procedures on patients with HIV/AIDS on a regular basis and therefore have sufficient experience. It was regarded as important to include both females and males in the research. The researcher attempted to obtain participants with different years of working experience within the identified field of study.

They were contacted and informed about the research, and given the opportunity to decide whether they wanted to participate in the study. The researcher met with the participants to make it clear that participation was voluntary and that all information obtained would be used for research purposes only and would be treated with the strictest confidentiality. The participants were assured that anonymity would be respected at all times. Any concerns that the participants had were also discussed at this time. Upon their agreement to participate in the study, an informed consent form was signed by each of the participants.

Appointments were then made with each participant in order to book a time that suited both the participant and the researcher. The venue was at the discretion of the participant. The venue, however, was private and the meeting had to proceed with no interruptions.

#### 2. Method of interviewing

The researcher met with each of the participants before commencement of the interviews in order to establish rapport and she attempted to make each individual feel comfortable and at ease with the researcher.

The researcher began the data-collection procedure by asking the participants to write a story about performing an elective caesarean section. This was followed by an open-ended qualitative interview with each participant who was able to offer access to and describe the lived everyday world of the participant. The interview included a set of eight (8) semi-structured questions that were put to each participant. The researcher included the questions in order to obtain a more in-depth description of each individual's unique experience. The participants were asked to provide as much detailed information pertaining to their experiences as they possibly could. The narrative account (story) was to serve as an introduction to highlight each subject's individual experience. The open-ended questions served as the basis for data analysis, from which the Natural Meaning Units, specific to each subject, were explicated.

The duration of each interview varied and depended on the verbosity of each individual participant. The interviews were recorded and were later transcribed verbatim. The interviews were also analysed in accordance with the method described in section 3.3.5.

The experiences of six (6) participants were chosen for this study. The criteria for the selection of these six protocols were the ability of the participants to express their inner feelings and emotions with relative ease and their ability to produce a rich description of the phenomenon under investigation.
The main interview was based on the **Witness to Violence** interview that was developed by Paraskevi Stavrou (1994). This was adapted to serve the unique needs of this particular research. This interview mainly consisted of the following parts:

## Opening with the participant

This is where the researcher has to establish the focus of the interview, as well as the defining of his or her role in relation to the subject.

## Reliving the trauma / experience

This is the part where the participants were given the chance to verbally relive the experience and reconstruct what has happened in detail. While each participant was conveying their experience, the researcher reflected on feelings to keep participants on track. The reflection also served as a means for the researcher to confirm that she understood what the participants were trying to convey. Reassurance was given to the participants while they were relating emotionally laden information.

## • Closing with the participant

The researcher used this part to recap and summarise the main experience and themes explicated during the interview. The expected course of the experience was discussed with each participant and the researcher expressed gratitude for each participant's willingness to share their experience. The researcher remained sensitive at all times to the possibility that the interview might raise painful emotions for some participants and furthermore tried to end the interview on a more positive note. The interview ended with the questions: (a) How are you feeling now? and (b) How did it feel to talk about your experience?

## Ending the interview

The interview ended with the researcher giving each participant the assurance of future support, should the need arise. The researcher further had a support service available to which participants could be referred, if necessary, but this was not used.

The participants were also given the option to maintain ownership of the transcript of their interviews following the research.

Pertaining to the issue of validation, the researcher went back to the participants in the form of a follow-up session. During this session the researcher had the opportunity to test the accuracy of her interpretations, as well as reflect on the emotional content of the relived experiences. Validation of the findings was also received in the form of supervision, by a clinical psychologist, of each interview and subsequent follow-up sessions.

### 3. Credibility of the research

The use of quantitative methods probably denotes better inter-subjective agreement among researchers; however. the psychological comprehensiveness of a phenomenon is usually sacrificed. Qualitative methods lean, at times excessively, towards maintaining "fidelity to the phenomenon" and these methods may therefore suffer from a lack of inter-subjective agreement (Giorgi & Giorgi, 2003, p. 49). There are certain ways that this could be minimised. From a phenomenological perspective, psychological research needs to enter into the participant's subjective world as fully as possible, but scientific knowledge needs to be systematic, methodical, general and critical (Giorgi, 1997). Therefore, while the world of the participant is subjective, the scientist's method of capturing that world is inter-subjective or objective (Giorgi & Giorgi, 2003). For the researcher this objectivity reflects one of the strengths of the phenomenological method as it ensures faithful handling of the data. As mentioned earlier in the chapter when discussing the strengths of the method, this objective capturing of the life-world can be seen in the fact that within phenomenology findings emerge naturally and are not imposed by the method or the researcher.

"Trustworthy work must be credible, transferable, dependable and confirmable" (Bryant, Corbett & Kutner, 2001, p.938). In this research

the researcher aimed to meet the standard of credibility by encouraging participants to elaborate on their responses in order to generate rich descriptions of their experiences during interviews. A thorough review of the available literature was also carried out. Although the researcher recognizes the fact that transferability is very limited in a study of this small size, purposive sampling and rich description will, as far as possible, provide as much information as possible so that other observers may judge the applicability of the results to other contexts, for example, other groups of medical personnel who also have frequent contact with people living with HIV/AIDS.

Dependability means that another person might reasonably draw the same conclusions from the data and essentially what is important is how the natural meaning units are transformed (Giorgi & Giorgi, 2003). The researcher has aimed to leave as complete a track record of the process as possible in order to provide for critical other researchers the way that the meaning unit discriminations were made, as well as the final transformations for each meaning unit that constitutes the foundation for explaining the structure of the experience. All narratives, interview transcripts and notes will remain accessible from the supervisor of the research, thus providing a dependability audit trail. Furthermore, all six chosen interviews and the subsequent analysis into meaning units and the analysis of them are made available to the reader in Chapter 4.

Confirmability relates to the extent that the results of this research are products of the true investigation and not the researcher's bias. The researcher proposes that the best guarantee for this is a welldocumented audit trail, but in addition phenomenology requires that the transcripts be confirmed by the participants as accurate (Bryant, Corbett & Kutner, 2001). This was attempted by means of a reflection of participants' emotions during the interviews as well as follow up sessions after analysis of the data for the participants to provide feedback on the accuracy of the material.

It is imperative for the researcher to stress that these guidelines are not guarantees of objectivity, but rather offer standards to ensure credibility of the outcomes (Giorgi & Giorgi, 2003).

## 3.5 Bracketing the Researcher's Assumptions

Now that the researcher has given all the facts on methodology and the paradigm at hand, and is about to move on to the analysis of the participants' experiences, the researcher feels that this is the perfect opportunity for her to make her presuppositions explicit so as to avoid influencing the descriptions of the participants. The following presuppositions are what the researcher felt may need to be bracketed so that they do not interfere with the analysis of the data:

- The researcher's own fears about HIV/AIDS;
- The researcher's own ideas of what medical practitioners' fears are about;
- The researcher's own assumptions surrounding the lack of literature pertaining to medical practitioners' emotional experiences;
- The researcher's belief that most medical practitioners come from a very strong medical model and thus find it difficult to allow themselves to experience their emotions as this might impact on the way they work;
- The fact that the researcher knows one of the participants on a social level which might have an impact on her views.

In essence phenomenology focuses on developing a complete, clear and articulate description and understanding of a particular human experience. It achieves its goals in research by adopting a special researcher stance and approach, and through specialised methods of participant selection, acquiring of data, treatment of data and constructing of the final report.

## **Chapter 4**

## RESULTS

## 4.1 Introduction

The following chapter consists of verbatim transcriptions of each protocol derived from the original interviews conducted with each of the subjects. These transcriptions have been divided into natural meaning units (NMUs) which are offered in the left-hand column of the page. The NMUs have in turn been altered by the researcher from the naïve language of each subject into psychological language through means of imaginative variation and reflection. These alterations are located in the right-hand column of the page. These descriptions, which were derived from the NMUs are integrated into a significant description of the phenomenon under investigation, and are referred to as the specific descriptions. A general description of the phenomenon is given as a concluding part of the discussion in Chapter 5. This general description is based on the understanding gained from all the protocols.

## 4.2 Protocol for Participant A

## Sex: Female Age: 35

"The experience that jumps to mind...mmm... a very anxiety provoking experience... at the beginning of the year I was doing an elective caesarean section at a government hospital. During the closing of the skin I pricked myself, despite the fact that I was wearing double gloves, with a colt's needle. The patient was unconscious, so initially no consent could be obtained from her to do an HIV test. But the superintendent's consent was later obtained. Both the patient and I had to be tested...and mmm... the patient was HIV positive. I was on one month of antiretroviral treatment thereafter".

## 1. Could you describe to me what your occupational life was like before you had the experience of working with HIV+ patients?

Well, registrars work very hard... and it is very stressful...you have studying and clinical work and the course and all the responsibilities as well. So, it is not easy to start off with...but the experience...it does not really change anything at all...you still have to do the next caesarean...you can't go home or take some time off...you just have to carry on...no time off work, the workload is very big...if you take time off it just means that someone else has to do your work...damn odds. It is stressful from the point of view that if any occupational injuries do happen, there is pressure on you to get consent and time is ticking by to go on to antiretro-viral treatment (ARVs)...the first hour after the injury occurred is the most crucial.

You don't get pre- or post-counselling if you, for example, prick yourself. Like for myself...never had a place to be counselled...and many say it is my own fault, but it is just a schlep...you just have to carry on with your work and then go home and debrief at home with family. You are just not allowed to be emotional...you just have to carry on.

### 2. How did you feel after your experience?

The most stressful thing possible is to do the test...as you know gynaecological obstetrics carries a much higher risk for occupational exposure as you are always immersed in bodily floods...blood, urine. You cannot help but think...what if? What if blood comes in my eyes or what if urine drips on my feet...there is literally fluids everywhere! After this experience...it was extremely anxiety provoking for me...not only because of the event itself, but also because of the test that has to be done. The waiting period for the results...to find out whether you are HIV or not...it is dreadful.

### 3. What was your reaction to having this experience?

It was one of...ag, not another thing to make your life more difficult...being a registrar is stressful on its own...now it means ARVs and with that also brings carefully considering your partner like in having protected sex and it also means thinking about your young child and again the fear of what if you get HIV...it is dreadful.

## 4. Could you describe to me how your experience affected your life and activities?

Well, it's...mmm...it doesn't really make you more careful. You sort of...you don't really want to do caesareans after you pricked yourself...for the first say five procedures after that...you are scared, but then you push it to the back of your mind and you carry on with what you have to do. To bring it to the forefront and to think about it...it is just too much.

## 5. What would you say are your biggest concerns about experiencing what you did?

My biggest worry is if I do seroconvert from a needle stick injury ... I worry about my husband because he is also at risk and your life expectancy is then about 20 years less than it is... you see ladies with HIV everyday and you know what the disease does... you just do not want to go through it.

# 6. How would you say your family and people around you reacted to what happened to you?

My husband is very...I suppose it is probably a bit strong to use the word blaming...more concerned for my well-being...he thinks that I need to be more careful. My family...they do not have enough insight as they do not see people with HIV and I suppose it is too big for them to think about all the ramifications. At work the people are quite...sort of like...ag, ja...it could probably be them the next week...so there is no space for anxieties and fears.

## 7. What are your biggest fears now after your experience?

My biggest fear is sero-converting – it is a constant fear at the back of my mind – always... not just during a c-section, but all the time. I have a lot of sympathy with patients when you present them with a choice to have an HIV test, as I know how scary it is for me. I have to admit that after ARV treatment I am usually too scared to go for the follow up test.

## 8. How do you see your future?

I think what helps you to get through it is the thought that it is just four years as a registrar...and then you can leave state health institutions...so there is a light at the end of the tunnel. One thing that makes it difficult to work in state health institutions, especially with a procedure like a caesarean...you have to bring all your own protective gear – boots, goggles, etc., but then theatre is too hot and your goggles steam up which means that you have to take the goggles off to be able to see and then you are at risk again.

## 4.2.1 Natural Meaning Units for Participant A

## Meaning Unit

## Interpretation

## (1)

1. Participant A works very hard.

2. Participant A's work is very stressful.

3. Participant A has multiple responsibilities including studying, clinical work and course work.

- 1. Participant A has a difficult working life.
- 2. Participant A experienced a lot of pressure and stress at work.
- multiple 3. Participant A has a lot to bear.

4. Even before the experience, Participant 4. Participant A's occupational life was A's occupational life is not easy to start off already stressful and demanding before her

with.

experience.

5. Participant A just has to continue with 5. Participant A has a large workload that the next Caesarean section.

off from work.

7. Participant A just has to carry on.

8. Participant A's workload is very big.

9. If Participant A takes time off, it just 9. Participant A feels guilty if she takes means that someone else has to do her time off. work.

10. Participant A uses the expression "Damn odds!"

11. Participant A says it is stressful.

12. consent.

13. Participant A describes time as ticking by.

14. The first hour after the injury has occurred is most crucial to Participant A. has to continue no matter what.

6. Participant A can't go home or take time 6. Participant A's schedule does not allow her a break from her duties.

> 7. Work for Participant A just has to continue regardless of what happens.

> 8. Participant A stresses the huge amount of work that has to be done.

10. Participant A feels stuck.

11. Participant A experiences a lot of pressure and stress

Participant A has pressure to get 12. Participant A experiences difficulty with the protocols that need to be followed if occupational injuries had to occur.

> 13. Participant A stresses the importance of receiving treatment timeously.

14. Participant A is feeling pressure and anxiety surrounding occupational injury and

receiving the necessary treatment in time.

15. doesn't get pre- or post-counselling.

If Participant A pricks herself, she 15. Participant A feels that she is not able to get support when faced with an occupational injury like pricking herself with a needle.

that she never had the support that was

16. Participant A never had a place to be 16. In Participant A's experience she feels counselled.

17. Many say to Participant A that it is her 17. Participant A feels blamed by others. own fault.

18. It is just a schlep for Participant A.

19. Participant A just has to carry on.

18. Participant A feels overwhelmed by procedure and protocol and that it possibly isn't worth it

19. Participant A just has to carry on with her schedule regardless of what has happened.

20. Participant A goes home and debriefs 20. The only place that Participant A finds the support that she needs is at home with with her family. her family.

required.

21. Participant A is just not allowed to be 21. Participant A does not feel that she is emotional. allowed to express her emotions at work.

## (2)

22. Participant A feels that the most 22. The participant reports that she is stressful thing possible is to do the test. feeling great anxiety surrounding having to

### undergo an HIV test.

23. Participant A feels that gynaecological obstetrics carries a much higher risk for occupational exposure.

24. what if...

provoking for Participant A.

26. Participant A feels the anxiety because 26. Participant A is feeling anxiety on a of the event, but also because of the test number of different levels. that has to be done.

to wait for the results.

she is HIV or not....it is dreadful for her.

23. Participant A reports that she feels to more exposed risks then other disciplines in her profession.

Participant A cannot help but think 24. Participant A is feeling troubled by thoughts of what may happen.

25. The experience is extremely anxiety 25. The experience caused a lot of anxiety feelings for Participant A.

27. After the experience, Participant A has 27. Participant A experiences added stress having to wait for the results.

28. Participant A has to find out whether 28. When it is time for the results, Participant A has an intense fear of the result being positive.

### (3)

29 make her life more difficult.

30. stressful on its own.

31. Now it means ARVs for Participant A.

Participant A's reaction after the 29. Participant A feels that the experience experience is one of not another thing to has caused more pressure and anxiety in her life

Participant A's life as a registrar is 30. Participant A's occupational life is already busy and stressful.

> 31. The idea of having to take ARVs causes a lot of stress in Participant A's life.

32. Participant A now also has to consider her partner like in having protected sex.

her young child.

Participant A fears what if she gets 34. 34. HIV.

(4)

35. Participant A's experience didn't really make her more careful.

36. Participant A didn't really want to do caesareans after she pricked herself.

37. After Participant A's experience, she 37. felt scared for the next few procedures.

38. Participant A had to push it to the back 38. of her mind and carry on.

39. If Participant A had to bring it to the 39. forefront and think about it, it was just too capable of dealing with the thoughts of the much for her.

Participant A's reaction to 32. this experience also has an impact on her personal relationship and sex life.

33. Participant A also has to think about 33. Another reaction to the experience is that Participant A fears for her child.

> Participant A has an intense fear of possibly being infected by the HIV virus.

> 35. Participant A expressed that the experience didn't really make her more cautious.

> The experience left Participant A 36. feeling hesitant and uncomfortable in her work.

> The idea of performing any further procedures was extremely anxiety provoking for Participant A.

> Participant A has to try and forget about her experience while working and carry on with her duties. It seems that she is indeed a candidate for repression of the event.

> Participant A feels that she is not experience and therefore needs to push it

away.

(5)

converting from a needle stick injury.

41. husband, because he is also at risk.

expectancy will then be 20 years less.

43. does.

44. Participant A just doesn't want to go 44. through it.

40. Participant A's biggest worry is sero- 40. Participant A's biggest fear is if her HIV status were to change followina ап occupational injury.

Participant A would worry about her 41. Participant A not only fears for herself but is also concerned about the health of her husband.

42. Participant A is concerned that her life 42. Participant A fears that her own Lifespan may be shortened.

Participant A sees ladies with HIV 43. Participant A feels great anxiety about everyday and knows what the disease the course of the illness as she has witnessed it first hand.

> An HIV/Aids diagnosis would be something that Participant A could not deal with.

## (6)

45. Participant A's husband reacted in a 45. Participant A feels blamed by her very blaming manner and was concerned husband and that the injury she for her well-being. He thinks that she experienced was her doing. needs to be more careful.

Participant A's family does not have 46. Participant A feels that her family does 46. enough insight as they do not see people not have the adequate skills to support her. with HIV.

47. Participant A supposes that it is too big 47. Participant A also feels that her family her family think for to ramifications.

48. Participant A's colleagues feel it could 48. no space for anxieties and fears.

(7)

49. biggest fear is sero-converting.

50. After Participant A's experience there 50. is constant fear in the back of her mind.

51. After Participant A's experience, she 51. has fear all the time and not just during a c- encompassing. It doesn't just relate to section.

52. Participant A has sympathy with patients when she presents them with the understanding for the fear that her patients choice to have an HIV test as she knows how scary it is.

53. Participant A is usually too scared to 53. go for the follow up test.

about the would not be able to grasp the enormity of the situation.

Participant A reports the fear to be probably be them the next week, so there is shared among her colleagues and thus no one can support the other.

After Participant A's experience, her 49. Again the reality of perhaps contracting HIV/Aids is expressed as the biggest fear for Participant A.

> Fear is constantly in the mind of Participant A.

> Participant A's fear allis routine work but to other occupational situations as well.

> 52. Participant A's expresses an are going through if they have to undergo an HIV/AIDS test as she knows what it feels like.

> Participant A expresses a fear of having to go for re-testing.

(8)

54. What helps Participant A to get through 54. Participant A's experiences are made

it is the thought that she can leave state easier by the fact that she can leave the health institutions in four years. state hospital system after qualifying.

55. What makes it difficult for Participant A 55. to supply her own protective gear.

Participant A feels unsupported and to work in state institutions is that she has unprotected by her employer as she has to provide her own necessary precautionary garments in order to work safely.

56. When Participant A is in theatre it is 56. Participant A reports working too hot and she has to remove her conditions are not ideal and causing her to protective gear which places her at risk be at risk of exposure. again.

#### 4.2.1.1 Specific Description of Experiencing HIV for Participant A

Even before the experience, Participant A's occupational life was difficult and demanding, and fraught with pressure and stress. She had a heavy workload and could not afford to take time off. She felt overwhelmed by the pressure yet had to carry on regardless. She didn't feel entitled to fulfil her own needs as this would mean neglecting those of her patients as well as her colleagues and this would result in feelings of guilt. She acknowledges that occupational injury requires prompt attention and treatment; however, she indicates that she does not do this because of the considerable pressure in her work Therefore Participant A does not feel supported in her work schedule. environment and in fact sometimes feels blamed by others. As a doctor, Participant A feels that she is not allowed the space to express her emotions at work.

After the experience Participant A became very anxious regarding having to go for an HIV test. In her opinion her discipline exposes her to more risks for occupational exposure than other disciplines in medicine and she is therefore constantly troubled by the fear of contracting HIV. The experience was therefore extremely anxiety provoking for Participant A on various levels and waiting for HIV test results were particularly stressful.

The experience added further pressure and stress to Participant A's already demanding life. The idea of having to take antiretroviral therapy as well as the possibility of exposing her family to the risk of contracting HIV caused her intense fear and anxiety. There seems to be a fear of intimacy in Participant A following the experience as she was concerned about having unprotected sex.

The experience seems to have affected Participant A's life in a paradoxical manner as she expressed ambivalence in her reactions. Although the idea of performing further procedures was extremely anxiety provoking, Participant A tried to forget about her experience and carry on with her duties as if nothing had changed. It seems that she may have repressed and denied her experiences in order to be able to face the fear that she has to confront in her occupation on a daily basis.

Participant A's biggest fear is to become HIV positive. She fears not only for herself but also for her husband. Due to the nature of her work, she is very familiar with the course of the illness and therefore feels that she would not be able to cope if she were to become HIV positive.

Participant A experiences her working environment as unsupportive and finds comfort and solace in her family. However, with the needle prick injury that she mentioned in her narrative, her family did not have the adequate skills to support her and did not grasp the enormity of the situation. It would appear that she feels blamed by her husband for the injury she sustained.

For Participant A her most pressing concern is the possibility of contracting HIV due to occupational exposure. This fear is all encompassing and relates to all areas of her work, but it also allows her to have more empathy and a cleared understanding for her patients who are undergoing HIV testing.

Participant A feels that her immediate working environment, i.e. state health institutions, is unsupportive and does not look after her interests and safety. However, she feels comforted by the fact that she can leave the state health system after qualifying.

## 4.3 Protocol for Participant B

Sex: Male Age: 33

"Sho, now you've got me...that is many ceasers ago. I was in the rural Eastern Cape...mmm...I was doing my community service. There when I arrived there, the nursing staff and all the doctors saw this new blood...they were so happy...thinking he is fresh from medical school. just qualified...has all the new techniques and he knows better. So, they expected me to do all the things...operations, anaesthesia. everything...just let him do it all. It is like they were thinking a lifesaver has arrived. So, ag then the first day they called me and said there is a patient in theatre and they can't get hold of any of the other doctors in the hospital. The patient works in X, but had come home to the Eastern Cape for the delivery. So, the nurse told me that the patient is HIV + and they cannot deliver the baby. She has been in labour for a long period and the baby was in foetal distress as the heart was beating so slowly. I remember thinking to myself that this is such a dangerous situation. When I arrived I got the impression that they were like...Ok, Dr. B is here and he is fresh from his training, so he'll just do it...all the procedures. So, when I arrived at the theatre...luckily I had been trained in doing anaesthetics...you know the spinal one...so, I was confident in that, but doing a caesarean without a supervisor present...sho, I was not confident at all.

I went to the theatre and gave the spinal and the sister had already scrubbed and cleaned the patient. Then I went to scrub, all the time feeling anxious...

to leave the patient under anaesthesia to just a staff nurse is surely risky. After anaesthesia, the staff nurse did the BP. No other doctors do it that way you see, there is always a doctor in theatre...one doing the anaesthesia and another to do the operation...but in this hospital things seemed to work differently. I said I needed a supervisor to assist and supervise me while I do the procedure. Well, the sister said no, I am here, I am your assistant. We can't get hold of other doctors so, I will be assisting you during the procedure. So, they were cleaning and draping the patient...at least I knew how to make an incision. In my mind I was saying:" I have never done a caesarean alone on a woman with HIV plus I have no supervision. If a problem arose in theatre, who am I going to consult... I had no support". Well, I started the operation, cutting the way I was used to, but I worried as I was not sure how to do it differently in the case of HIV. For example, for HIV+ patients you should minimize blood loss and those things. Well, I continued with the operation until I was inside the abdomen and then (laughing) I became confused...I just lost it...sweating, shivering...and I was like touching this and that and not knowing what I was seeing...I was so nervous.

The sister was so experienced, she showed me all the different organs and how to deliver the baby. In that process while the sister was showing me what is where, I cut the sister on the hand. Sho, then the whole operation got just too complicated. The sister had to go and wash her hands and I was left alone there. I am not sure if she took ARVs because in that hospital prophylaxis was not readily available...I just remembered her coming back with new gloves. She patiently showed me how to close the uterus...step by step...and ag, it went well. Luckily the procedure was not complicated and we closed the uterus and all the layers of the abdomen.

During this period I went to the labour room...just to go and see how the baby was doing. The sisters were busy resuscitating the baby and I had to jump in and help as they were giving up. I got that feeling from them like yes thank you here is the doctor. So, I took over the resuscitation and we then incubated the baby with a tube to help the baby breathe. I wanted to refer the baby to a hospital that was three hours away as I thought the baby needed tertiary care, but it took me a long time to get hold of the doctors on the other side. After 40mins on the phone, they accepted the baby. The next step I had to organise for an ambulance to transport the baby, but to my despair...the ambulance had already gone to this same hospital three hours away to fetch medication. I just thought to myself the doctors here are really irresponsible. In summary it took about six hours before the baby reached the tertiary centre and um...the baby passed away the same night, I have to add. That was terrible. I think I was stressed and became depressed for about two weeks. I did not want to go back to work, but I had to go...I had no choice.

In between calling the hospital we took the mother back to the ward and luckily there were no complications. The nurse gave me the confidence to do a c-section. When I look at that retrospectively, I realised the patient was neglected in labour...she stayed there for two days and when I arrived, she finally got help. I thought it was wrong for me to give anaesthesia – being put under pressure by the nursing staff and going to operate on a HIV+ patient without support or supervision...I did so many things wrong...but the situation forced me to do it...I was the only person who could help at the time.

Unavailability of HIV prophylaxis in the hospital...that was very serious. I could have cut myself and contracted HIV and then it would have cut my career short. I was supposed to have used double gloves... I thought retrospectively...jees, I risked my life...I was only wearing one pair of gloves and no goggles. I took such a huge risk at the time. Now, I take all the precautions.

I look at this as a system failure – the whole health system fails us...take a junior doctor without the necessary support and just feeding them through the system. That became my drive...I looked at the babies and the mothers that died due to HIV and birth complications and I wanted to go and learn to be able to make a difference".

## 1. Could you describe to me what your occupational life was like before your experience of working with HIV/AIDS?

I was an intern for one year before that and still received training and was also not solely responsible. We are overprotected while I was learning to make sure we don't make any mistakes...covered by both an MO and a consultant...yes, so there was always lots of cover.

## 2. How did you feel after the experience?

## Sho...mmm. (Silence for 10 seconds)

Especially after I had cut the nurse...I started to think. I went to workshops in the Eastern Cape about HIV education and I invited people to that hospital to come and give talks there as well. After that the whole practice started to change. They had little information about transmission and they were so poorly resourced for example, I don't remember seeing sterilisation being the number one concern. But after the workshops things started to change and staff all became more cautious. We started a pattern of making follow ups, reinforced and did audits to make sure the correct procedures are being followed.

Also about two weeks after the incident, when examining a patient and usually you don't need to wear gloves, but I started to if the patient was HIV+.

## 3. What was your reaction to having this experience?

Of course, I began to organise workshops on HIV via the super who know began to see the light. I became overly cautious for a period of time. If I knew the patient was HIV+, I'll be extra cautious. This, however, did not last for a long period.

## 4. Could you describe to me how your experience affected your life and activities?

I was depressed for a week or two...that is how it affected my life. I think as I became more exposed to these experiences, I started becoming less depressed and as my confidence with medical procedures grew I realised that I will have these unsupported experiences or procedures... so I had to be confident in my own abilities.

But for a while I couldn't sleep and I self-medicated...and used Prozac...I went through all the stages and came to the stage of anger at the government. I remember thinking to myself: "Why do they dump us here without support"?

What I went through made me attached to the maternity ward and I became adamant not to let another baby die.

## 5. What would you say are your biggest concerns about experiencing what you did?

I gave anaesthetics, left the patient with a staff nurse and went to operate...all the pressure on me to do all these different things without any support and I did a lot of incorrect things. No one informed me about using double gloves or goggles...you know, I would say those were the biggest problems.

# 6. How would you say your family and the people around you reacted to what happened to you?

Oh well, I was living with my grandmother at the time and she was so concerned and shocked when I told her what had happened. She often said to me: "No, don't go there please. They leave you alone, let the other doctors go." She actually became overprotective of me.

## 7. What are your biggest fears now after your experience?

At present...ag, I think I am not really afraid as much as before. I have done in the region of five hundred c-sections in the past years and I have never pricked myself, touch wood. I was pricked by an intern, but it was okay. HIV is a part of our everyday life and we have to accept it. I am very cautious and anxious when I operate on an AIDS patient with a CD4 count of 200 or below...then I become extra cautious. I would actually avoid doing a c-section in that if possible.

#### 8. How do you see your future?

Ag me... I think... I want to make an impact, in fact I want to make changes in the health system. I would like to stay in an academic setting and probably do some research that I actually improve women's health and I would need support from my supervisors etc. I would get enough experience from the academic setting so that I can go back to my province to influence policy making and the health system. In general, I can say... ag, I don't like private practice.

## 4.3.1 Natural Meaning Units for Participant B

## **Meaning Units**

Interpretation

(1)

1. Participant B was an intern the year 1. Before Participant B had the experience of experience, it appears that he had not before he had the performing a caesarean on an HIV- yet been fully qualified and was still in positive woman. He was also still the process of learning. receiving training at that time.

2. He stated that he was not solely 2. As a student, it seems that Participant B did not have to take full responsible. responsibility for performing surgery.

3. Participant B is of the opinion that they 3. Participant B felt that they were were overprotected while they were still overprotected as students and never learning.

allowed to develop their оwл confidence.

4. He thinks that the reason for this was 4. to ensure that they didn't make any Participant B was to prevent mistakes mistakes.

The overprotection according to in surgery. It seems that even the

supervisors knew that they could still learn more.

5. Participant B had the cover of both a 5. Participant B had lots of protection Medical Officer and a consultant.

and had more experienced doctors to fall back on. It seems that this brought Participant B a sense of security and a feeling of support.

6. Participant B repeats the fact that there 6. Participant B gives the impression was always lots of cover while he was still that there was less pressure on him. learning.

(2)

7. Participant B uttered "Sho!" as an initial 7. "Sho" seems to reveal how he felt response to the question.

when thinking about his emotional reaction to the experience. He seems to express а sense of being overwhelmed.

8. Participant B states that especially after he had cut the nurse during surgery did he start to think.

9 After the experience, Participant B started going to workshops about HIV education.

10. Participant B also invited people to 10. the hospital where he was working to give talks on HIV.

8. The experience of cutting the nurse during surgery caused Participant B to consider the enormity of the situation.

9. After the experience, Participant B had a need to educate himself about HIV and attended workshops to gain more knowledge.

Participant B also wanted to educate other people in his working environment about HIV.

11. Participant B stated that the whole practice started to change after the workshops.

12. Participant B is of the opinion that the hospital staff at the hospital where he was working had transmission.

13. according to Participant B.

14. explained that he never remembered seeing sterilization being the number one concern.

15. It is the opinion of Participant B that 15. after the workshops things started to change.

all became more cautious.

17. Participant B pointed out that they 17. started a pattern of making follow-ups, hospital to initiate a plan for safety

11. This was a life-changing event for Participant B. It seems that the education contributed to a positive change in the way things were done at the hospital where Participant B was working at that time.

12. Participant B was under the impression that the hospital staff was little information about not knowledgeable about HIV and the possible ways of transmission. This gives a sense of unsafe working practices at the hospital.

They were also poorly resourced, 13. Participant B felt that the hospital was ill equipped.

As an example, Participant B 14. Participant B highlighted the fact that safe practices were not always followed and used sterilization as an example. It seems that this created anxiety for Participant B.

> The education on HIV brought about a positive change in practices at the hospital according to Participant B.

16. Participant B thinks that hospital staff 16. The education caused the staff to follow safety precautions.

There was an attempt at the

reinforced and did audits to ensure the protocols to be followed and a method correct procedures were being followed.

18. Participant B also felt that about two weeks after the incident mentioned. where he usually did not wear gloves when examining a patient, he started to wear gloves when the patient was HIV positive.

of checking whether these precautions were followed.

18. After the experience Participant B also took extra precautionary measures to protect him when he was examining an HIV positive patient.

(3)

19. In reaction to his experience, Participant В began to workshops on HIV.

20. the 20. Participant В felt that superintendent of the hospital now began to see the light.

21. Participant B became overly cautious 21. Another reaction from Participant for a period of time.

22. If Participant B knew the patient was 22. Knowing the status of a patient, HIV+, he would be extra cautious.

19. In reaction to his experience, organize Participant B felt a need to seek further education on HIV.

> Participant B used a sarcastic tone when he stated that even top management had learnt something from his experience.

> B was to become overly cautious for a certain period of time. It seems that the experience left B with anxiety.

> would trigger Participant B to take extra safety precautions.

23. Participant B added that this overly 23. The overly cautious behaviour cautious behaviour did however not last was short lived for Participant B. It

for a long period of time.

seems that the anxiety subsided after a period of time.

(4)

24. Participant B stated that the 24. The experience had an emotional experience affected him in such a way impact on Participant B and that he became depressed for a week or depression followed. two.

25. Participant B explained that as he 25. The more Participant B was became more exposed to the experience, it lead to his confidence with medical and his anxiety was reduced. procedures to grow and he became less depressed as a result.

26. Participant B came to realize that he 26. Participant B's realisation that he would have these experiences or procedures and would highlighted the fact that he had to thus have to be confident in his own develop confidence in his own abilities abilities.

unsupported was now responsible for himself, in order to feel less anxious while operating.

exposed to HIV, his confidence grew

27. Participant B could not sleep after the 27. As a result of the experience, experience.

28. Participant B self-medicated and 28. used Prozac.

29. He felt that he went through all the 29. stages.

Participant B had difficulty sleeping.

Participant B couldn't cope and needed medication to assist.

Participant B went through a process in trying to deal with the experience.

30. Participant B reported that he came to the stage of anger at the government. Participant B felt that government had dumped them in a place without support.

31. Participant B felt that what he had 31. gone through made him attached to the affected maternity ward.

32. Participant B became adamant not to 32. Participant B put a great deal of let another baby die.

## (5)

about experiencing what he did was the was the lack of support at the specific fact that he had to give an anaesthetic hospital where he was working. then left the patient with a staff nurse and then went to operate.

34. Participant B felt that he had a lot of 34. Another fear for Participant B was pressure on him to do different things the total lack of support that he felt. without any support.

of incorrect things.

external source, namely an the government. Participant B felt forgotten and isolated and blamed government for not providing him with the support that he needed.

30. Participant B turned his anger at

The experience left him deeply and feelina especially connected to the maternity ward.

pressure on himself to save lives.

33. The biggest concern for Participant B 33. Participant B's biggest anxiety

35. Participant B stated that he did a lot 35. A big concern for Participant B was the mistakes he made during the procedure. It seems that he is evaluating his own performance.

Another concern for Participant B 36. A further anxiety for Participant B 36. was the fact that no one informed him was his lack of knowledge that put him

about the use of double gloves or at risk. It seems that he externalises goggles. this fear by blaming others for his lack of knowledge.

(6)

37. grandmother at that time and he stated had, that she was both concerned and grandmother. shocked when she heard about what had happened to him.

Participant B was living with his 37. The experience that Participant B stunned and upset his

38. Participant B also said that his 38. Participant B's grandmother grandmother became overprotective of supported him and she became him. overprotective of his safety.

## (7)

39. Participant B stated that he thinks he 39. Initially the experience impacted is not really afraid as much as he was on before.

40. Participant B has done in the region 40. B feels much more experienced of 500 c-sections in the past years.

41. Participant B also stated that he has 41. Participant B expresses relief at never pricked himself.

his sense of security. but Participant B feels less scared and anxious now.

and knowledgeable in his occupational life.

the fact that he has not yet had a needle prick injury that was selfinflicted in his career.

42. Participant B used the expression "touch wood".

43. Participant B reports that he was pricked by an intern but that it was okay.

42. Participant B realises the possibility that he might one day be exposed to a needle stick injury and does fear the possibility.

43. Participant B stated that he was injured by an intern and seems to minimise the enormity of a possible exposure to HIV.

44. Participant B stated that HIV is a part 44. of their everyday life and that they had to Participant B there is no way of accept it.

45. Participant B mentioned that he is 45. Participant B appears to become very cautious and anxious when he has more anxious and scared when he to operate on an AIDS patient with a CD perceives the patient to be very ill. count of 200 or below.

46. becomes extra cautious to operate on a risk in a diagnosis of AIDS than one of patient with AIDS.

For а avnaecologist like avoiding HIV.

Participant B affirmed that he 46. Participant B perceives a greater HIV and takes extra precautionary measures when operating on a patient with AIDS.

47. Participant B further stated that he 47. Participant B would avoid doing a would avoid doing a c-section in those c-section on a patient with AIDS. It circumstances if possible.

appears that this is a great fear for B.

(8)

48. Participant B wants to make an 48. Participant B has the desire to make a difference. impact in future.

49. Participant B stated that he wants to 49. Participant B would like to change make changes in the health system.

50. Participant B also wants to stay in an 50. In future, Participant B aims to academic setting and do research to improve women's health.

the health system.

influence women's health through research and thinks that staying in an academic setting would help him to reach this goal.

51. Participant B feels that he would get 51. Participant B's future plan is to enough experience from the academic gain enough knowledge to be able to setting to be able to go back to his have a say at provincial level and province to influence policy making and contribute to changes in the health the health system.

52.

dislikes private practice.

Participant B also noted that he 52. Participant B does not show an interest in private practice.

system.

### Specific Description of Experiencing HIV for 4.3.1.1 Participant B

Participant B felt well supported and protected before the experience as he was still an intern and in training. He had the supervision of a medical officer as well as a consultant which reduced the pressure on him, but diminished his responsibilities, thus undermining his confidence.

This appears to have been a life-changing event for Participant B and it affected him deeply. After the experience, Participant B was particularly affected by his negligence in exposing a nurse to possibly contracting HIV as well as his lack of knowledge regarding HIV/AIDS. He developed a pressing need to be educated about HIV as well as to educate others around him. It seems that an environment where the hospital staff lacked sufficient

knowledge about HIV caused much anxiety for Participant B. This education seems to have lessened his fear as he felt empowered and safer as a result of this added knowledge. Prior to the education, the hospital was ill equipped to deal with HIV according to Participant B, but did try to implement safety precautions after being better informed. The experience further led Participant B to take extra precautionary measures when working with patients who are HIV positive.

It seems that in order to deal with his anxiety, Participant B reacted by becoming preoccupied with HIV education and overly cautious in his dealings with HIV positive patients. However, this overly cautious behaviour was short lived as his anxiety subsided and Participant B became more proactive in advocating HIV related programmes.

The experience was an emotional one for Participant B and resulted in him becoming depressed. He possibly also went through the stages of denial and anger as he had trouble sleeping and needed medication to assist him in coping. He externalised his anger towards the government in not supporting him enough in his service to community. To combat his emotional reaction, Participant B confronted his fear and anxiety by not backing away from exposure to HIV and became more confident in his abilities as an obstetrician. He also placed unrealistic expectations on himself to never lose another baby's life. This could possibly be due to the guilt that Participant B experienced when he lost the baby after the operation.

The biggest concern for Participant B after the experience was the striking lack of support that he experienced during the operation. This lack of support seems to have created a lot of anxiety for him, but instead of owning his responsibilities he externalises his fear by blaming others for his lack of knowledge.

Participant B's grandmother was extremely upset and shocked following the experience. Although she was supportive, she became over protective and did not want him to go to work at that specific hospital.

Participant B indicates that he is much less anxious now than before regarding occupational exposure to HIV. He is relieved that he has not yet experienced a needle prick injury in his career, but is aware of the probability of this reality. Participant B is particularly anxious when having to deal with patients suffering from AIDS as he perceives a higher risk within this context for contracting HIV. Participant B would be very reluctant to perform a caesarean section on a patient with AIDS.

Participant B expresses a strong need to change the current health system through research and academic work. He does not feel that this could be achieved through private practice.

## 4.4 Protocol for Participant C

## Sex: Male Age: 35

"In 2000 at Hospital X, I was required to perform a caesarean section on a primigravida woman 38 weeks pregnant - the goal being to decrease the chance of intra-partum mother-to-baby HIV transmission.

I experienced greatly conflicting emotions and concerns for the many parties involved. Being honest, I must admit that my primary concern was for myself the chance of me contracting HIV from exposure to the mother's blood. Knowing that this was an inherently "high-risk" procedure (the baby must be delivered quickly to prevent foetal distress), and the "bloody" nature of the surgery per se, I wore a waterproof gown, 2 pairs of long sleeve gloves, and a plastic visor to prevent eye-splashes. Despite this, I still felt very "at-risk". Next in line was my concern for my assistant and the rest of the theatre team. I insisted that my assistant and scrub sister take the same precautions as me, and made sure that no contaminated sharp instruments would be handled by anyone other than me. Still, I felt a heavy sense of responsibility that my decision to perform this procedure was putting many colleagues at risk. I was worried about the possible recriminations, consequences and inevitable guilt if somebody was to become infected as a result of my decision.

I also felt anxiety about the possibility of surgical complications to the mother. The mere fact that she was immune-compromised would have effects on her wound healing and post-operative recuperation. Was I not exposing HER to unnecessary risk for the sake of a baby who was not yet even born? In event of her death, I would have made the child an instant orphan!!! This concern too was not entirely philanthropic. I was worried that my judgment and surgical dexterity might be questioned should any complication occur. In a similar vein, I was worried that, should I inadvertently cause injury to the baby during the procedure (with a scalpel or forceps- which incidentally happens very often!), that I would in fact have increased the risk of the baby contracting HIV - more so than a normal vaginal delivery, thus effectively negating the perceived benefit of the C-section.

Beyond the technical and clinical factors, I was struggling with a myriad of moral and social issues. Should HIV positive women be having children at all??? (In my opinion, an emphatic NO!) Shouldn't all HIV mothers undergoing a C-section be obliged to have sterilization during the procedure (In my opinion an emphatic YES!) But then what about the men who were infecting these women? Would a barren wife, coupled with their primitive drive to procreate at any cost to prove their masculinity, not compel these men to impregnate – and thus infect - another unsuspecting woman? (I fear so!) Was the small chance of benefit to the baby worth the considerable risk to everybody else??? (I honestly don't know.) Was this not a pointless exercise almost ensuring that this child would survive to be an orphan in a system already swamped by a multitude of similar children, and completely incapable of adequately caring for him? Was I not interfering with a form of "natural selection", cruel as it may sound, and adding to the social burden rather than alleviating it? Was I not merely delaying the inevitable - after all, this child had a significant chance of contracting the disease from his mother during infancy and childhood anyway - particularly seeing that these were rural, "traditional" people who could not access or afford (or probably even reliably take) anti-

retro-virals, and that breastfeeding (unprotected) was the only feasible way to nourish this baby in the rural setting.

To summarize all the above: Was I entitled to "Play God" in this situation with all the intricate variables involved??? Again, I don't know.

Finally - do I think I did the right thing, and would I do it again under similar circumstances? That is easy......Yes, and Yes!!! Every time!!!

"Why?" you may ask. To quote a favourite film of mine- "The Terminator" with Amold Schwarzenegger: "There is no fate but what we make. The future is not certain. It is impossible to predict how the decisions we make today will affect tomorrow." (Sarah Connor - in a letter to her unborn son John - future leader of the Resistance) I don't know whether the baby's mother will live to see a cure for HIV. I don't know whether a wealthy loving family will adopt the child once he is orphaned. I don't know whether he will become a doctor, a researcher, a statesman, an astronaut, or merely another statistic...

What I DO know is that I gave him a slightly better chance than he would have had had I done nothing...

Incidentally, the procedure was successful, mommy healed well, and baby was born HIV - and remained so for the three months after his birth - at which point they went home to Mozambique, never to be seen again.

Where is he now? I haven't the faintest clue - but I hope he is happy, and most importantly, healthy! "Hasta la vista, Baby"

## 1. Could you describe to me what your occupational life was like before your experience of working with HIV/AIDS?

It was certainly more selfless because one could work with very little regard for yourself and only with concern for your patient...and decisions were easier taken because there weren't the considerations that you were doing something that could harm those around you...like the rest of the team. You had fewer concerns, like for example, social responsibilities and the thoughts about a baby that might be orphaned in a few years. Life and the protection of life was sacred and your main and only concern.

### 2. How did you feel after your experience?

It is impossible to give you a simple straight answer...very conflicted. Very conflicted due to several reasons. I thought about the fact that I was delivering a child, soon to be orphaned. The fact that I was performing a procedure that was placing many people at risk – not just the woman due to her immuno-supression, but also the rest of my medical team were at risk. But in the final analysis, I felt that I had taken the correct decision and I felt good about what I had done, because if we failed to do anything to decrease the risk of the child contracting HIV, then I think it would've been neglectful. Neglectful to not offer the child any chance, any advantage, any possibility of reducing his possibility to become HIV infected. Because what happened subsequently to his birth was not within my control, but I did have control to a small degree whether he would have been born HIV positive.

### 3. What was your reaction to having this experience?

A profound reassessment of the blueprint, the code or the plan that I would apply to this kind of situation...a pregnant lady and a baby...it really changed...mmm...it made me reassess what I had up to that point regarded to be the incontrovertibly correct plan or approach. Because in the past I was convinced of the rightness and the incontrovertible rightness of the plan whereas now there were more factors...more external factors playing a role that made you had to reassess whether what you were doing really was in the best interest of all the different parties involved.

## 4. Could you describe to me how your experience affected your life and activities?

It made me, for the first time, realise that when in theatre I was not merely responsible for my patient and my patient's safety, but also for my own safety and for the safety of my team, so how it affected me was that...it made me more cautious and it gave me a greater sense of awareness of the gravity or weight of responsibility that I carry in theatre. And it made me think more long term about it because before it was a
case of I am completely responsible for this patient as this is the focus of my responsibility. But now all of a sudden you are responsible not to injure yourself because in the past that was never an issue...for example you cut your finger, so what, you change your gloves, you carry on. It had no far reaching...mmm...consequences. Now it is not only the patient, but it is me and it is my assistant... I can't injure him...mmm...the person who is going to resuscitate the baby - I have potentially placed him at risk. What about all the circulating nurses and people who are dealing with the sharps long after I have finished the operation? I put them all at potential risk. And it also made me think more long term about it. That it is not just for the hour that you are operating that that responsibility is there, but the fact that there are others...mmm...it has ramifications right down to the cleaning staff in CSD (central sterilisation department) who are going to be dealing with those instruments later this afternoon or tomorrow. And the fact that if there is an incident it has effects reaching down to years where someone might have seroconverted months after the procedure and it can affect the rest of their life.

### 5. What would you say are your biggest concerns about experiencing what you did?

Um, I want to answer your question directly, I don't want to skirt around it. I am concerned about the fact that things are no longer, since that experience, black or white in considering surgery on an HIV+ patient. More so in delivering a baby of an HIV+ mother it is my concern that it might cause one to lose the patient as your primary focus which as a doctor you should never do. Your patient should always be your primary responsibility. And now with HIV you are considering also the bigger picture which actually by right should not be...you should do what is right for the patient and not think about what is right for the doctor or the team. What concerns me is that it might be impacting on the ethics of the decisions I make. [Silence for 5 seconds] Are you denying a patient surgery because they are not a good candidate or are you denying purely because of the disease or the social concerns.

### 6. How would you say your family and people around you reacted to what happened to you?

They have a much higher anxiety level about my exposure and the danger I face at work. My wife is very concerned about me and often asks whether I use double gloves when in theatre.

#### 7. What are your biggest fears now after your experience?

I could say so much...um...unfortunately it is an internalisation of what I already said. Biggest fears...um...biggest fears about the environment that I work in...um...is the fact that the extent of your responsibility and the people who fall under your responsibility is now so much greater that it was before and the decisions you make...um...and that that is a heavy burden to bear. And of course with special regard to delivering a baby of an HIV+ mom in a manner to try and prevent transmission...um...my biggest fears are that we are creating a generation of orphans. We are, that is a fact! The parents are going to die...um. The children are negative and if they thrive and outlive their parents, we are definitely creating a generation of orphans. My other fear is that in the past, pre-HIV, your decision making in medicine and surgery was based on strict guidelines which were well taught to you. Things you could defend scientifically. You could defend the decisions you take by saying: "That is the way we were taught to do it, that is the way it will continue to be." HIV is such an ethical minefield that more and more you have to run the risk of playing God, and you really do run the risk, when you...when you more so than in the past...um...because your decisions were based on a sound foundation. Now you have to individualise and say: I am not going to OR I am...and HIV is or becomes the consideration. The validity thereof and the fear that we might, because it is making the decision making so much more difficult ... um ... we might be wrong or allow an emotional side or the social concerns to dictate what the primary issue is.

#### 8. How do you see your future?

How do I see my future in medicine in dealing with people who are HIV positive? I see it as one where I will continue to place my patients'

needs first, but for the same token increase my awareness of my own...mmm...my own safety and the precautions that I need to take. So, I can't let it influence – as far as possible – the way I treat my patients and I will still treat patients individually and ethically correct to the best of my knowledge, but will take the necessary precautions to protect myself. And I see...umm...to come back to the story that I told you to come back to the point...I have no control over what happens outside the walls of the hospital. All I can do to is try and make a difference within the walls of the hospital in my theatre and I am not going to let the, well I can't afford to let the external social concerns and so on influence the way I treat my patients, because I've got no control over that. I've got control over what is in front of me and there I must do the correct thing. I can't extrapolate.

#### 4.4.1 Natural Meaning Units for Participant C

#### Meaning Unit

#### Interpretation

(1)

1.Participant C described his1.Before HIV, Participant Coccupational life before HIV as being<br/>certainly more selfless.experienced his occupational life as<br/>more unselfish and altruistic as<br/>compared to after HIV.

2. Participant C could work with very 2 little regard for himself.

3. Participant C stated that he could 3. work with concern for his patient only. with

2. Participant C could work very unselfishly without taking his own safety into consideration.

3. Before the experience of dealing with HIV, concern for the patient was of utmost importance.

Before HIV, it was easier for 4. Participant C found decision making 4. Participant C to make decisions in his to be less complicated before he had work.

to the fact that there were no considerations that the doctor was felt more pressured. doing something that could harm the people around him such as the rest of the team.

6. Participant C thinks that doctors 6. For Participant C his occupational had fewer concerns, for example, life was easier with fewer things to social responsibilities.

had fewer thoughts about after a few years.

the experience of dealing with HIV.

5. Participant C thinks that this is due 5. Participant C experienced a change in responsibility and it seems that he

worry about before the era of HIV.

7. Participant C further felt that he 7. For Participant C different concerns the arose that seemed to have had a possibilities of babies being orphaned complicating effect on his occupational life such as social or emotional concerns.

8. For Participant C life and the 8. Before HIV came along, Participant protection of life was sacred and his C experienced his main priority as main and only concern. protection of patients' lives.

#### (2)

Participant C 9. Participant C stated that it was 9. had difficulty impossible for him to give me a expressing his feelings as there were straight answer. He felt very many reasons for his inner conflict. conflicted and that there were several reasons for this.

10. After the experience Participant 10. After delivering the baby. C thought about the fact that he Participant C was concerned that the child soon delivered а to be mother, being HIV, would soon die. orphaned.

11. reason for feeling conflicted as the that fact he was performing procedures that was placing many people at risk i.e. the patient and the rest of his medical team.

Participant C gave a further 11. Participant C felt a strong sense of responsibility for his patient and medical team and did not want to place anvone at risk.

he had done because if he failed to HIV. do anything to decrease the risk of the child contracting HIV, it would have been neglectful.

12. In the final analysis Participant C 12. Participant C felt that he had made felt that he had taken the right his best effort and received a good decision and he felt good about what result in that the child did not contract

have been neglectful to not offer the child any chance, any advantage, any possibility of reducing his possibility to become HIV infected.

14. Participant C stated that. control, he did have control to a small degree whether he would have been born HIV positive.

13. Participant C added that it would 13. It seems that Participant C needed to reassure himself that he made the right decision by repeatedly emphasising the successful outcome of the caesarean.

14. Participant C stated that he had no although what happened subsequent control over what happened to the to the baby's birth was not within his baby prior to his birth, but is able to influence the baby's future. It seems that Participant С felt а great responsibility towards the baby's health.

15. experience was а reassessment of the blueprint or the his code that he would apply to this kind regarding caesarean sections. of situation. The experience made him reassess what he up to that point had regarded to be the incontrovertibly correct plan or approach to a c-section on a HIV positive mother.

Participant C's reaction to the 15. Participant C expresses that the profound experience caused him to re-evaluate rigorous previous knowledge

16. Participant C stated that in the past he was convinced of the incontrovertible rightness of the plan he had followed, but now there were more external factors playing a role that made you had to reassess whether what you were doing really was in the best interest of all the different parties involved.

16. For Participant C, before the era of HIV, there was only one blueprint of performing а caesarean section However, HIV has complicated the procedure because of the additional social and emotional concerns.

#### (4)

(3)

he was in theatre he was not merely responsible for his patient and the patient's safety, but also for his own safety and the safety of the team.

17. The experience made Participant 17. The experience caused Participant C realise for the first time that when C to become aware of the enormity of his responsibility in this particular situation.

18. The experience affected 18. Participant C became more careful

Participant more and aware of safety precautions after С to become cautious. the experience.

19. The experience further caused patient and that was the sole focus of future and safety. Now all of a his responsibilities. sudden Participant C was also responsible not to injure himself. In the past this was never an issue for Participant C as injuring himself had far reaching consequences no before.

20. Participant C highlights the fact 20. assistant. the also the resuscitating the baby, the circulating his sense of being overwhelmed. nurses and people dealing with the sharps as well as the patient.

term about more long responsibility, not just to consider the while operating. but hour the ramifications all the way down to cleaning staff in the hospital.

19. Participant C realises that he is not Participant C to think more long term. only responsible for the safety of his Where before it was a case of C patients, but also for his own safety. being completely responsible for the His focus became more towards the

Participant C emphasises his that it affects not only himself, but responsibility for each person on the person medical team thus possibly indicating

21. Participant C further stated that 21. Participant C again highlights his the experience made him think even responsibility and the far-reaching the consequences of his actions.

22. Participant C stated that he 22. It seems important for Participant wanted to answer the question C to provide an honest and direct directly and not skirt around it. response.

23. Participant C said that he was 23. concerned about the fact that since the experience things were no longer black or white in considering surgery on an HIV-positive patient.

24. Participant C was also concerned 24. that delivering a baby of an HIVpositive mother in particular, could cause him to lose the patient as his primary focus, which as a doctor, he should never do. Participant C emphasised that the patient should always be the primary responsibility, but with HIV he also considers the bigger picture which actually by right should not be. According to Participant C, one should always do what is right for the patient and not think about what is right for the doctor or the team.

Since the experience, aspects regarding surgery on a HIV-positive patient were no longer clear-cut for Participant C.

Participant C is scared that he might lose the patient as his main focus due to personal considerations. It seems that Participant C experiences difficulty in reconciling his responsibility for his patient and for his team and himself. It is possible that Participant C is experiencing person-role conflict.

the decisions he makes.

25. Participant C is concerned that it 25. Participant C is worried that he will might be impacting on the ethics of make the wrong ethical decisions as other considerations override his interest for the patient.

(6)

26. Participant C's family has a much 26. Participant C perceives his family level about his as being more fearful than he is higher anxiety exposure to HIV and the danger he regarding his exposure to HIV at work. faces at work.

27. Participant C stated that his wife 27. Participant C's wife is scared for is very concerned about him and his safety and inquires after his often asks whether he is using double adherence to safety precautions. gloves when in theatre.

(7)

28. Participant C repeated the words 28. 'biggest fears' and then stated that contemplated the his biggest about the fears environment that he works in, is the fact that the extent of his responsibility and the people who fell under his responsibility as well as the decisions he has to make is now so much greater than it was before. Participant C stated that that was a heavy burden to bear.

It seems that Participant C question before giving his answer. Participant C's biggest fear was that HIV has now radically changed the scope of his responsibility. Participant. C experiences a great deal of pressure and anxiety as a result.

29. A further fear for Participant C is 29. one with special regard to delivering a baby of an HIV positive mom in a manner as to prevent transmission. doctors are creating a generation of generation orphans. He stated that this is a fact.

Participant С sketches the importance performing the caesarean section in a manner that prevents the transmission of HIV to the infant, yet Participant C's biggest fear is that he fears contributing to creating a of AIDS orphans. Participant C seems to be caught in a

moral dilemma which causes him much distress.

30. Another fear for Participant C is based on the fact that in the past, pre-HIV, a doctor's decision making in medicine and surgery was based on strict guidelines which were well taught to the doctors. This related to things that could be scientifically defended. Participant С also explained that these decisions could be defended by the doctor by saying that is the way we were taught to do it and that is the way it will continue to be.

31. Participant C stated that HIV is such an ethical minefield that more and more doctors run the risk of playing God. He feels that they do run the risk, more so now than in the past because in the past decisions were based on a sound foundation. He is of the opinion that now doctors have to individualise and decide whether they are going to operate or not and this for Participant C means that HIV becomes the consideration. He is scared that he might allow an emotional side or social concerns to dictate the primary issue. 30. Participant C also fears that what he has learnt may no longer be relevant in that HIV has complicated medical procedures and decisions and the textbook case no longer applies. This shifting of structure in his occupational life-world appears to perturb Participant C greatly.

31. For Participant C, HIV has now become a deciding factor in medical decisions that perhaps doctors do not have the right to make and involves a responsibility that perhaps not all doctors are ready for. Participant C is of the opinion that a set standard does not apply to all cases anymore but each case is unique and needs to be considered individually. It seems Participant C has a very strong sense of ethics and is extremely passionate and committed to his work, but cannot let his emotions to rule his decisions. (8)

first.

32. Participant C stated that he will 32. In future, Participant C wants to continue to place his patient's needs continue to have his patients' best interest at heart.

33. Participant C also stated that by 33. Participant C now also realises the same token he would also that he needs to take care of his own increase his awareness of his own safety. safety and the precautions that he needs to take.

34. Participant C highlighted that he 34. Participant C does not want to let possible. the way he treats his patients. He would still treat his patients individually and ethically correct to the best of his knowledge. but he will take the necessary precautions to protect himself.

35. researcher's attention back to the story that he told initially to emphasise the point that he wanted he can do is to try and make a difference within the walls of the hospital in his theatre. Participant C further stated that he is not going to let - and added that he cannot afford

cannot let it influence, as far as his concern for his own safety overtake his concern for his patients.

Participant C brought the 35. Participant C is aware of the fact that he cannot control everything; however, what is within his control he needs to ensure the best possible to make. He stated that he has no outcome by doing the best he can. It control over what happens outside seems that Participant C experiences the walls of the hospital and all that frustration with his limitations in not being able to control the environment in which his patients exist.

to let – the external social concerns influence the way he treats his patients as he has no control over that. C said that he has control over what is in front of him and there C must do the correct thing. C added at the end that he can not extrapolate.

### 4.4.1.1 Specific Description of Experiencing HIV for Participant C

Before the era of HIV, Participant C experienced his occupational life as more unselfish and altruistic, because he could work without having to take his own safety into consideration. Prior to HIV, concern for the patient was of utmost importance to Participant C, and decision making was less complicated and simpler. Participant C feels that HIV has confounded his occupational sphere and increased his responsibility as a doctor, resulting in added pressure and stress.

Participant C found it difficult to express his feelings about the incident as it appeared to have resulted in various inner conflicts. It seemed important to Participant C to constantly reassure himself that he had made the right decisions and did the best he could in the situation. There is a strong sense of responsibility in Participant C to ensure the safety of his patients as well as his medical team, and in his opinion, he has fulfilled his duties and prevented the transmission of HIV to the baby.

For Participant C, before the era of HIV, there was only one blueprint of performing a caesarean section. However, HIV has complicated the procedure for him because of the additional social and emotional concerns. The experience led Participant C to seriously re-evaluate his previous learnt principles about performing a caesarean section.

There seems to be an enormous sense of moral responsibility and obligation in Participant C. His experience further enhanced this sense of responsibility and caused Participant C to become even more aware of his actions and their consequences. Participant C has become extremely aware of safety precautions.

Participant C was strongly affected by the experience in that it seems to have disorientated his perspective on surgery. He was extremely concerned that his regard for himself and his medical team may disadvantage the patients' interests and that he will make the wrong ethical decisions. It appears that Participant C experiences difficulty in reconciling his responsibility for his patients and for his team and himself. It is possible that Participant C is experiencing person-role conflict.

Participant C perceives his family as being quite anxious for his safety at work and constantly inquires after his adherence to safety precautions.

Rather than being concerned for his own safety, Participant C's biggest fear was that HIV has now radically changed the scope of his responsibility and as a result experiences increased pressure and anxiety. Although Participant C is well informed with regards to performing a caesarean section in a manner that prevent the transmission of HIV to the infant, he fears that he is contributing to a generation of AIDS orphans. Participant C seems to be caught in a moral dilemma which causes him much distress. Participant C further fears that what he has learnt may no longer be relevant because HIV has complicated medical procedures and decisions. This shifting of structure in his occupational life-world appears to perturb Participant C greatly.

For Participant C HIV has now become a deciding factor in medical decisions that perhaps doctors do not have the right to make, and involves responsibility that perhaps not all doctors are ready for. Participant C states that HIV is an ethical minefield in which doctors run

the risk of playing God. It seems that Participant C has a very strong need to be ethical and is extremely passionate and committed to his work, but feels that he cannot allow his emotions to rule his decisions.

With regards to the future, Participant C would like to retain his principle of having his patients' best interests at heart, but at the same time also take care of his own safety. He is quite adamant that his concern for his own safety should not override his concern for his patients. Even though Participant C is frustrated that he cannot control everything pertaining to his patients, he is determined to do his best in situations that are within his control.

#### 4.5 Protocol for Subject D

#### Sex: Male

#### Age: 40

"During my internship I had to do an elective caesarean section on a patient at Y Hospital, known to be HIV+. The HIV status of the patient made me very anxious about the possible exposure to the virus for myself. When you do not know the HIV status of the patient, even if there is a high probability of the patient being HIV+, I feel much less anxious about doing the procedure. So, knowing her status made it actually more difficult. I used double gloves and accidentally pricked myself after inserting an IV cannula. At this stage the patient was already under anaesthesia and time was the crucial element. So, I had to be tested for HIV at the hospital laboratory. For this I had to go to the casualty department of Pretoria Academic Hospital which is about forty minutes travelling away. A doctor had to document the needle prick site on my hand and took blood for HIV testing. Only after this result became available was the hospital prepared to supply me with anti-retro virals. I knew that for these drugs to be most efficient you have to take them as soon as possible, preferably within one hour after the injury occurred.

So...knowing this was now already beyond this time span and I knew the risk of transmission is higher. The hospital was also not prepared to supply me with triple therapy and I had to purchase the third drug myself at an enormous cost of R 6000...that was back in 1997. My initial feeling was that of shock and complete denial and I actually did not want to go for any testing nor take any medication. I then thought that I would never be able to forgive myself should I sero-convert and did not do everything possible to prevent this from happening. I was shaking and sweating and could hardly drive to the other hospital. I was also terrified of having to have an HIV test, knowing I was exposed to the virus before. Getting a HIV negative result provided me with initial comfort, but thereafter an intense fear of possibly sero-converting. The ARVs made me feel physically ill, tired and weak all the time and I couldn't sleep at night or concentrate well on my work. I think I became depressed. My follow up HIV testing was done at one month, three months and six months. With every test my world came to a standstill. With huge relief after a negative test, but then I started wondering if maybe they didn't swap the blood samples or I questioned the reliability of the test. At the end it all turned out okay."

#### 1. Could you describe to me what your occupational life was like before you had the experience of working with HIV?

I never felt exposed to serious occupational hazards before the era of HIV patients. I was not scared of having to operate on patients or being exposed to their blood or other body fluids. I think I can say that...mmm...I would fight harder for the life of a patient especially in a resuscitation scenario, before HIV.

#### 2. How did you feel after this experience?

Anxious most of the time...mmm...unable to concentrate on my work....constantly thinking what I am going to do if I sero-convert. After a few weeks, I think I can say that I became emotionally blunted...maybe even depressed.

#### 3. What was your reaction to having this experience?

I started to carry an ARV starter pack with me in my bag at all times because this experience taught me how many delays there could be in getting treatment. This totally convinced me to seek a speciality in medicine where I would not be exposed to HIV.

### 4. Could you describe to me how the experience affected your life and activities?

I felt that my life was being put on hold, waiting for the six month...hopefully negative HIV result. I had difficulty counselling patients about being HIV positive.

### 5. What would you say are your biggest concerns about experiencing what you did?

Sero-conversion. Also rejection from the people around me especially family and friends...or I should rather say blaming more than rejection.

### 6. How would you say your family and people around you reacted to what happened to you?

Some colleagues supported me...colleagues who had the same experience supported me each step of the way. I felt they really understood what I was going through. Most of my family were dismissive of my fears. They said if I just take the medication I would be fine.

#### 7. What are your biggest fears now after the experience?

An ongoing fear about sero-converting. There are a few cases described in the literature where people only sero-converted after two years or even longer.

#### 8. How do you see your future?

I have chosen a speciality where I am not exposed to blood and am thus much less concerned about future HIV exposure. However, this needle prick injury still haunts me.

### 4.5.1 Natural Meaning Units for Participant D **Meaning Unit**

#### Interpretation

(1)

1. Participant D stated that he never 1. Participant D feels that HIV has felt exposed to serious occupational changed the way he views his hazards before the era of HIV occupational life and the threats patients.

involved fundamentally.

2. Participant D was not scared of 2. Before the introduction of HIV to having to operate on patients before Participant D's occupational arena, the experience of working with HIV.

3. Participant D also reported that he was not scared of being exposed to patient's blood or other bodily fluids.

4. Participant D thinks that he might 4. For Participant D his role as a have fought harder for the life of a doctor had fundamentally changed patient before the era of HIV.

surgical procedures. 3. The exposure to a patient's blood

he had no fear when performing

or bodily fluids did not hold a threat for Participant D in the past.

with the arrival of HIV.

5. This is especially true Participant D, in a resuscitation a specific example of this change for scenario.

for 5. A resuscitation scenario serves as Participant D.

(2)

6. After his experience Participant D 6. The experience left Participant D

felt anxious most of the time.

7. The experience also Participant D unable to concentrate Participant D's cognitive abilities as on his work.

with a great deal of anxiety.

left 7. The experience had an impact on he had difficulty keeping his mind on his work.

Participant D was constantly 8. The fear of sero-converting was 8. thinking about the fear of sero- never far from Participant D's mind. converting.

9. Participant D became emotionally 9. Participant D's reaction to the blunted for a period of time.

depressed.

- experience had profound emotional implications for him.
- 10. Participant D was perhaps even 10. Emotionally Participant D felt that it was too much for him and depression possibly set in. This could be viewed as a defence in reaction to this experience.

#### (3)

11. Participant D's reaction to his 11. Participant D became overly experience was that he started to prepared for occupational exposure carry an ARV starter pack with him at to HIV. all times.

12. Participant D's experience taught 12. him about the delays in getting the Participant necessary treatment.

In reaction to his experience, gained D awareness about the inefficiency and time constraints in acquiring the necessary treatment for a needle prick injury.

13. Participant D was totally 13. There was an attempt to convinced that he had to seek out a consciously avoid the experience by speciality in medicine where he changing direction within his career of would not be exposed to HIV. medicine.

#### (4)

14. Participant D felt that his life was 14. It seems that Participant D's life being put on hold.

came to a standstill.

Participant D's life was also 15. affected whilst he had to wait for the six month, hopefully negative, HIV result.

16. Participant D reports that he had 16. difficulty counselling patients about counselling others made him have to being HIV positive.

15. The waiting period for the HIV test results upset Participant D's life. Doubt towards the result is expressed by Participant D.

Because of his experience, face his fears and anxieties, which was difficult.

#### (5)

17. Participant D's biggest concern is 17. The reality of sero-conversion is sero-conversion.

expressed as the crucial concern for Participant D.

around him.

18. Another concern of Participant D 18. A further concern for Participant is the possible rejection from people D is the reaction of other people and the possibility that people might reject him. This might add to the anxiety that Participant D experiences.

19. This concern of rejection is 19. Participant D's fear of rejection is especially centred on Participant D's particularly true for his family and friends. family and friends.

20. should rather say blaming more than implies more about him being made rejection.

Participant D stated that he 20. Participant D highlighted that it to feel responsible than him being pushed away by family and friends.

(6)

21. Participant D felt supported by 21. There were certain people in Participant D's working environment some colleagues. that he felt more supported by than others.

22. Participant D highlights that 22. Participant D felt well supported colleagues who had the same by colleagues who also experienced experience as him supported him occupational exposure to HIV. each step of the way.

23. Participant D felt that they really 23. understood what he was going Participant D's colleagues shared a through.

Due to the fact that some of similar experience, it seems that he could identify with them and thus felt more supported.

24. Participant D also felt that most of 24. Participant D felt that his family his family were dismissive of his had no respect or sensitivity towards fears.

his fears and he therefore didn't feel well supported.

(7)

25. Participant D's expressed that his 25. biggest fear was an on-going fear seems to be a pressing issue in his about sero-converting.

26. Participant D also mentions literature of people sero-converting after two years.

The fear of sero-converting life world.

26. Participant D recalls literature on people sero-converting after a longer period that is the norm in medicine. It seems as if this fuels his fears and anxieties on even more as it serves as proof that safety could be a more elusive aspect than he thought initially.

(8)

chosen a speciality where he is not converting directed a change in exposed to blood

27. For Participant D's future he has 27. Participant D's fears about serospecialities within his chosen field. He would not be in contact with blood any more in the future.

28. Participant D's states that his choice made him feel much less Participant D made to his medical about HIV concerned future exposure.

28. As a result of the change speciality, he now feels much less anxious about HIV exposure in the future.

29. Participant D's needle stick injury 29. Participant D has never forgotten still haunts him. the intense emotional reaction to his needle stick injury.

#### 4.5.1.1 Specific Description for Participant D

Participant D feels that HIV has fundamentally changed the way he views his occupational life and the threats involved in it. Before the introduction of HIV into Participant D's occupational arena, he had experienced less fear, anxiety and pressure when performing surgical procedures. The possibility of being exposed to a life-threatening disease through occupational exposure to contaminated blood or bodily fluids was never a vital issue in the past for Participant D. The way Participant D views his primary role as a doctor has changed since the introduction of HIV/AIDS and all the related aspects into his working arena.

Participant D's reaction to the experience had profound emotional implications for him. After the incident experienced by Participant D, he became very anxious and fearful. His cognitive abilities also seemed compromised. He was overwhelmed and possibly became depressed as the fear of becoming HIV positive was never far from his mind.

In reaction to his experience, Participant D became overly prepared for, and paranoid about, occupational exposure to HIV. He became aware of the inefficiency and time constraints that existed in acquiring the necessary treatment after exposure. Participant D started thinking about changing his career to a discipline that did not involve exposure to HIV as to lessen his risks.

Following the experience Participant D's life came to a standstill. Waiting for the test results was extremely anxiety provoking for him due to the enormous implications it would have on his life. It was difficult for Participant D during this time to counsel HIV positive patients as it forced him to confront his own fears.

The biggest concern for Participant D was that of contracting HIV. He is particularly worried about people's reactions and fears that they may

blame him for his carelessness and thus reject him. He is especially worried about being rejected by his family and friends.

Participant D felt supported by colleagues who have experienced similar incidents, but not really by other colleagues. He further experienced his family as insensitive and unsupportive.

Participant D's biggest fear remains that of becoming HIV positive and has a pessimistic outlook on his occupational safety. It seems that he now views safety as a more elusive aspect than he initially thought it to be.

Participant D's experience of the needle stick injury and the subsequent fear about sero-converting was so intense that he has now changed his speciality so as not to be in contact with blood anymore. Participant D feels disturbed and preoccupied to this very day by the needle prick injury that he experienced while performing a caesarean section of an HIV positive patient.

#### 4.6 Protocol for Subject E

#### Sex: Female Age: 38

"I worked as an intern in a government hospital and had to do caesarean sections as part of my duties. The thought of cutting another person upset me and made me anxious. The first patient was also HIV positive. Even though I told myself that should not make a difference, it made me even more anxious. I was concerned about the chances of getting a needle prick and possibly contracting a chronic illness. I would not have been able to deal with that or to explain to my husband as he does not really understand illness or the demands of my job. I wanted to complete the procedure as quickly as possible without pricking myself. I was exhausted afterwards of concentrating so much not to hurt myself or the patient."

# 1. Could you describe to me what your occupational life was like before your experience?

I had a needle prick accident with a small baby in my fourth year, while doing a rotation at the community clinics. Thereafter I was extra careful when working with any patient – regardless of their HIV status – as you can't tell the status by looking at any patient's face.

#### 2. How did you feel after your experience?

I felt numb and had recurrent thoughts of what it would have been like to have a needle prick. I was extremely grateful for having escaped occupational exposure.

#### 3. What was your reaction to having this experience?

I became even more careful and started wearing protective gear especially when I didn't know the status of the patient. I also took out more life coverage...just to be on the safe side.

### 4. Could you describe to me how your experience affected your life and activities?

I was avoidant of doing c-sections. I was lucky to have had a colleague who seemed to enjoy doing the procedure a lot and took over from me at times.

## 5. What would you say are your biggest concerns about experiencing what you did?

My biggest concern was sero-converting and passing the virus on to my husband or other patients.

# 6. How would you say your family and people around you reacted to what happened to you?

My husband wanted me to leave the department as he felt it was an unacceptable risk.

#### 7. What are your biggest fears now after your experience?

Although I really enjoyed obstetrics and gynaecology, the risk of contracting HIV through occupational exposure influenced me to change my career direction and I decided to go into a non-surgical discipline.

#### 8. How do you see your future?

It always remains a concern that you might be put into a position where you might be exposed to HIV and to contract the virus despite taking precautions.

#### 4.6.1 Natural Meaning Units for Participant E

#### Meaning Unit

#### Interpretation

(1)

 Participant E experienced a 1. Participant E experienced needle prick accident in her fourth occupational exposure to HIV early year while doing a rotation at a in her career. Participant E seems community clinic.
 to not recall her occupational life before the injury.

2. After Participant E's experience, 2. The experience changed her she was extra careful when approach to all her patients; their working with any patient, status was irrelevant in that regardless of their HIV status. decision. 3. After the experience, Participant 3. The experience created a great E felt numb and had recurrent sense of fear and anxiety that she thoughts of what it would have constantly relived. been like to have a needle prick.

 Participant E was extremely 4. Participant E had a great sense grateful for having escaped of relief when she was tested HIV occupational exposure. negative.

#### (3)

5. In reaction to her experience, 5. Participant E reacted in an Participant E became even more extremely cautious manner. careful.

Participant E started to wear 6. Participant E became overly protective gear even in cases cautious in all areas of her work. where she didn't know the status of Knowledge of the patient's status the patient.
 did not increase or lessen her cautiousness.

7. Another reaction to Participant
 7. In reaction to the experience
 E's experience caused her to take she had to face her own mortality
 out more life coverage.
 as well as realizing the value of her
 life.

 Participant E expressed that 8. Participant E also learnt the this was done just to be on the safe necessity to be safe.
 side.

(2)

(4)

9. Participant E reports that the 9. experienced affected her in such a Participant E's ability to perform manner that she became avoidant her duties. of doing c-sections.

The experience affected It seems that she became avoidant as a defence to the reality of her fear.

Participant E feels herself 10. Participant E felt a huge relief 10. lucky to have had a colleague who and support that others were willing enjoyed doing c sections and could to carry her load at times. take over form her at times.

(5)

11. The thought of sero-converting 11. Participant E's biggest fear is appears to have been Participant sero-converting. E's biggest concern.

12. Participant E is also concerned 12. Participant E is also concerned that she could pass the virus on to about her family and patients' her husband or other patients.

health and safety as she could put them at risk.

#### (6)

husband 13. Participant E's husband was 13. Participant E's wanted her the extremely fearful for Participant E's to leave safety. department.

Participant E's husband felt 14. Participant E's husband felt that 14. that the experience it was a risk that should never have was an happened and could have been unacceptable risk. avoided.

(7)

of obstetrics and gynaecology.

15. Participant E reports that she 15. Participant E was fond of the really enjoyed working in the field speciality in medicine that she used to work in, namely obstetrics and gynaecology.

16. Participant E feels that the risk 16. of contracting HIV occupational exposure influenced she followed in medicine towards a her to change her career direction.

The anxiety and fear for through Participant E directed the path that safer speciality.

17. into a non-surgical discipline.

Participant E decided to go 17. Participant E decided to move far away from possible exposure to blood.

#### (8)

future it always remains a concern with fear of possible exposure. to her that she might be put into a position where she miaht be exposed to HIV.

18. Participant E states that in her 18. Participant E's future is filled

19. Another future concern for 19. It appears that Participant E still Participant E is the possibility of doesn't feel safe regardless of what contracting HIV despite taking safety precautions are precautions. implemented.

#### 4.6.1.1 Specific Description for Participant E

Participant E experienced occupational exposure to HIV through a needle stick injury early in her career which appears to have coloured

her entire perspective towards her work as she seems to not even recall occupational life before this incident. Participant E practises extreme caution in her approach to all her patients, irrespective of their HIV status.

It seems that to this day the incident still haunts Participant E. She constantly relives the experience with enormous fear and anxiety. Participant E was greatly relived to have been tested HIV negative.

Through the experience Participant E came to value her life and safety more and mortality became a reality for her. She became overly cautions in all areas of her work regardless of patients' status.

Participant E experienced great difficulty in performing her duties following the incident and became avoidant of her work due to her constant fear. She felt relief and supported because there were other who were willing to assist her.

Participant E's biggest fear is contracting HIV through occupational exposure. She is further concerned that she would place her family and other patients at risk.

In reacting to Participant E's accident, her husband was extremely fearful for her safety and felt that such risks were unacceptable.

Although Participant E truly enjoyed working in the field of obstetrics the risk of contracting HIV outweighed the benefits. She has moved to a discipline in medicine where she would not have to risk exposure to HIV.

It always remains a fear for Participant E that she may be placed in a position where she might be exposed to the risk of contracting HIV.

#### 4.7 Protocol for Subject F

#### Sex: Female

#### Age: 36

"An elective caesarean on a HIV positive mother is the same as any elective caesarean for me except for two important things:

1. Protection of the surgeon and his assistant against exposure to the virus.

2. Protection of the baby against contracting the virus.

For the above-mentioned reasons I wear double surgical gloves on each hand, a plastic apron underneath the theatre gown and protective goggles for my eyes whenever I do an elective caesarean on a patient with HIV. I also take the time to explain to the mother that breastfeeding could increase the chances of the baby to become HIV infected. The baby also needs to take anti-retroviral treatment for the first week of life for protection."

1. Could you describe to me what your occupational life was like before you had the experience of working with HIV/AIDS?

Before the experience I didn't take so many precautions to protect myself against contracting blood-borne infections during surgery.

#### 2. How did you feel after the experience?

I discovered that my joy has huge risks and that I should be very cautious. I am a parent of two small children and suddenly realized that I have to protect myself for their sake.

#### 3. What was your reaction to having this experience?

I developed anxiety towards a needle prick injury.

# 4. Could you describe to me how your experience affected your life and activities?

I try to be very cautious especially when I am tired, because that is when needle-prick injuries happen easily. I also warn colleagues and staff regularly to be careful.

### 5. What would you say are your biggest concerns about experiencing what you did?

I have an obligation to ensure that as little babies as possible will be born with HIV. I have to adjust procedures to protect myself and my family.

# 6. How would you say your family and people around you reacted to what happened to you?

My husband is supportive towards my fears and encourages safety precautions.

#### 7. What are your biggest fears now after your experience?

I do not want to be HIV infected. I am afraid of what it would do to my health and my family.

#### 8. How do you see your future?

I am no longer involved with surgery since I changed to consultation orientated work. I feel surgery is very risky and stressful. I am still seeing HIV positive patients on a daily basis and am passionately trying to improve their health and preventing the virus from spreading.

#### 4.7.1 Natural Meaning Units for Participant F

#### <u>Meaning Unit</u>

#### Interpretation

(1)

1. Before Participant F had her 1. Before Participant F's experience she did not take many experience she did not feel the

precautions during surgery. need to take many precautions to protect herself against blood borne infections during surgery.

(2)

2. Participant F discovered that her 2. It seems that Participant F's experience made her become more aware of the fact that her job carries high risks for occupational exposure.

3. After the experience Participant 3. Participant F's experienceF discovered that she should be seemed to foster a need to be very cautious.more cautious in her job.

4. Participant F is a parent of two
4. The experience reminded her of small children.
the fact that she is a mother and that she has two small children.

5. Participant F suddenly realised 5. After the experience it seems that she had to protect herself for that she reassessed her role as a their sakes. parent and her duty to protect herself for her children's sake.

(3)

6. Participant F developed anxiety 6. Participant F became anxious towards needle prick injuries as a about sustaining a needle prick reaction to her experience.

(4)

7. Due to Participant F's 7. The experience impacted on experience she tried to be very Participant F's sense of caution cautious especially when she was and she realised the need to be

tired.

more careful and attentive when tired.

F also warned her colleagues and inform others about the dangers of staff regularly to be careful.

8. After her experience Participant 8. Participant F felt a need to working with HIV.

#### (5)

babies will be born with HIV.

9. Participant F feels obligated to 9. It seems that Participant F feels ensure that as few as possible a great responsibility to ensure that mother-to-child transmission is limited.

10. Another big concern of 10. Participant F feels that her Participant F is that she has to biggest concern after the adjust procedures protect experience is that she needs to to herself and her family. adjust her ways of working to protect both herself and her family.

#### (6)

11. Participant F feels that that her 11. Participant F feels that she husband supports her fears. obtains adequate support from her husband.

12. Participant F also feels that her 12. Participant F also feels that her husband encourages precautions.

safety husband understands the need to be cautious and encourages such procedures.

#### (7)

13. Participant F's biggest fear 13. Contracting HIV is expressed after the experience is that she as the biggest fear for Participant does not want to be infected with F.

HIV.

14. Participant F is afraid of what it 14. Another fear for Participant F is would do to her health and her how her family and health would be family. affected if she were to be infected with HIV.

#### (8)

15. Participant F is no longer 15. Participant F's future is no involved with surgery since she longer in surgery. changed to consultation orientated work.

16. Participant F feels that surgery 16. The idea of performing surgery is very risky and stressful.

in the future is just too stressful and anxiety provoking for Participant F.

17. Participant F still sees HIV 17. Participant F is still committed positive patients on a daily basis. to working with individuals with HIV.

18. Participant F is trying 18. Participant F expresses a passionately to try and improve burning desire to have an impact their health and preventing the on the lives of individuals with HIV virus from spreading. and to stop the spreading of the virus.

#### 4.7.1.1 Specific Description for Participant F

Before her experience Participant F did not feel the need to take many safety precautions during surgery to prevent occupational exposure to HIV.

Participant F's experience has increased her awareness of the high risks her job carries. It has fostered a need to be more cautious in her job and to protect herself. It seems that the experienced caused her to review her role as mother and this role urged her to take extra precautionary measures at work for the sake of her children.

After the experience, Participant F became constantly anxious about sustaining a needle prick injury.

As a result of her experience, Participant F realised the need to be more careful and attentive particularly when she is tired. She further felt a need to educate others about the dangers of working with HIV.

Participant F's biggest concern after the experience is that she needs to protect both herself and her family through adjusting her ways of working. At the same time Participant F feels a great responsibility to minimise mother-to-child transmission of HIV.

Participant F seems to receive sufficient support from her husband in that he understand the need to be cautious and encourages her to adhere to safety precautions at all times.

Contracting HIV is expresses as the biggest fear for Participant F. In addition, she is concerned about how her health would be affected as well as the impact on her family is she was to become HIV positive.

Participant F seems to be overwhelmed by the idea of continuing to perform surgery in the face of all the risks involved. She therefore has changed to consultation based work although she remains committed to working with HIV positive individuals. Participant F expresses a strong passion to make a difference in the lives of HIV positive individuals.

#### Chapter 5

#### DISCUSSION

#### 5.1 Introduction

The results obtained in this research have illuminated many facets of experiencing HIV/AIDS, in particular in performing a caesarean section, and have in turn yielded a rich understanding of the occupational lifeworld of a medical practitioner involved in the care and surgery of HIV positive patients.

A variety of authors have noted the effects of dealing with HIV/AIDS on the medical practitioner (as discussed in Chapter 2), as it tends to affect most aspects of the medical practitioners' life. A comparative analysis will be attempted where the findings of this study will be discussed in relation to the literature available. A general description of performing caesarean sections on HIV positive patients will be formulated.

#### 5.2 Emotional reactions

#### 5.2.1 Fear

All the participants expressed a strong fear of contracting HIV as a result of accidental occupational exposure. This correlates with the findings of the study by Smit (2005) where, although the participants did not express high levels of fear, the risk of contracting the virus always lingered in the back of their minds. In the current research those who have experienced accidental exposure to the virus expressed considerable dread about the incident and having to undergo HIV testing. For many the period of having to wait for the results seemed especially difficult. Those who did
not experience an occupational injury voiced constant fear of its possibility and imminent reality.

#### 5.2.2 Anxiety

Closely linked to fear is the anxiety that was prominent in all participants, although they had different reasons for this. It seems that HIV has brought on a whole new set of considerations and requires a different way of thinking for the medical practitioners. This introduces much uncertainty and unfamiliarity to their life-world and their anxiety revolves mostly around this "unknown" aspect. As Elford (1991) mentioned in his study, healthcare workers remain anxious about HIV infection in the workplace and this is understandable when considering the implications of an HIV diagnosis. The participants in this research were all well aware of the universal precautions necessary to prevent HIV infection, but some indicated that their working environment was not well equipped with the protective gear needed to safely work with HIV patients. This was echoed in the study by Smit (2005), where the unavailability of protective gear caused participants further anxiety.

#### 5.2.3 Emotional distress

In addition to the already demanding nature of medical practitioners' occupation, working with HIV-positive individuals further aggravated the emotional distress experienced by the practitioners. According to Catalan *et al.* (1996), healthcare practitioners who deal with individuals suffering from serious illness and those exposed to multiple deaths are at risk of developing work-related psychological disorders. Several of the participants mentioned that they in fact felt depressed following their experiences of operating on HIV-positive patients and were overwhelmed by the pressure and responsibility they faced. Smit's (2005) study also confirms the emotionally taxing nature of dealing with

patients with a life threatening disease. For some of the participants in this research, emotional distress was further exacerbated by the highly stressful nature of their work, which requires them to be emotionally distant.

#### 5.2.4 Anger

Feelings of anger were expressed by some of the participants. This anger was directed more towards the government for having placed them at risk of contracting a life threatening disease without providing necessary resources such as support, protective gear and infrastructure conducive to safe practice. This was also found in the study done by Smit (2005), where participants' sense of anger was not towards the patients, but more an annoyance towards the government for the manner in which they dealt with HIV/AIDS.

#### 5.3 Cognitive reactions

#### 5.3.1 Impact on cognitive abilities

Participants who have had an accidental exposure to HIV though a needle prick injury referred to their cognitive abilities such as concentration and memory being affected following their experiences. This resulted in their having difficulty in performing their duties and thus compromises their work competency. Catalan *et al.* (1996) also make mention of impaired work performance in healthcare practitioners who deal with individuals with serious illnesses such as HIV.

#### 5.3.2 internal moral debate

HIV has brought social and moral concerns to the forefront of medical practitioners' attention. This highlighted the dilemma between safety of the patient and that of the doctor. Elford (1991) found that one of the reasons given by nurses for lack of adherence to universal precautions was that they wanted to put the patients' needs first. The participants in this research expressed a similar dilemma in that, in having to consider their own safety during surgery, they would be going against the Hippocratic Oath and not put their patients first at all times. Anderson et al. (1997) highlight in their study that many practitioners reported feeling fearful and reluctant to treat HIV-positive patients. It is possible that this fear may also be present in the participants of the current research, and contributes to their ambivalence and internal conflicts between personal fears and professional obligations. In South Africa working with HIV positive patients is not optional, where in most other countries doctors are given a choice. It is possible that this could cause even more difficulty for medical practitioners in this country as the threat and fear of contracting HIV is a daily reality and not just a valuation of a personal value system.

HIV seems to have huge ramifications on medical practitioners' responsibility to society as a whole. This sense of social responsibility creates an ethical minefield and increasingly forces medical practitioners, as one participant stated, "to play God". Taking this into account, it would not be surprising that medical practitioners become overwhelmed by their enormous responsibility and the implications thereof. It appears that for these participants their professional knowledge and demeanour comes into conflict with personal feelings and values. One can therefore question whether one can expect genuine ethical and procedural behaviour at all times from professionals, in this case medical practitioners, where the "self" is involved in their daily activities.

#### 5.4 Methods of Coping

#### 5.4.1 Over-cautious behaviour

All participants seemed aware of the universal precautions necessary to prevent contracting HIV as a result of occupational exposure and this seems to be consistent with international research (Elford & Cockroft, 1991). However, international research shows that most practitioners do not adhere to these precautions at all times. This was not the case with the current research and could probably be due to the high prevalence of HIV/AIDS in South Africa compared to other countries.

Over-cautious behaviour was described by participants who have had occupational exposure to HIV in that they started to carry antiretro-viral treatment with them at all times and were constantly aware of using protective gear when dealing with all patients, regardless of their HIV status. This overly cautious behaviour, however, was only short lived for two of the participants.

#### 5.4.2 Repression / Denial

For most of the participants it seems that they constantly repressed their fear of contracting HIV in an occupational context, for example, by not allowing themselves to think about the fear and therefore not having to deal with the implications, and instead just carrying on with their duties. For those who have had occupational exposure to HIV, some seem to deny their experiences by not adhering to precautionary measures. In doing so they are perhaps trying to turn away from the existence of the disease. It was also noted that, while waiting for their own HIV test results after their injury, some participants were reluctant to interact with HIV positive patients. This could be due to their need not confront their own possibly similar reality.

#### 5.4.3 Intellectualisation

Another coping method exhibited by one participant was that of intellectualisation. He displayed a desperate need to acquire and posses as much information as possible about HIV/AIDS and in doing so seemed to feel more empowered and armed to cope with his seemingly overwhelming anxiety. By focusing on the academic and clinical knowledge of HIV perhaps enabled this participant to avoid having to deal with his emotional reactions to HIV. A positive outcome of this participant's need for education was the workshops on HIV/AIDS and programmes implemented for the benefit of the entire hospital. Research has shown that improved knowledge of HIV/AIDS enhances attitudes towards HIV patients (Anderson *et al.*, 1997). Several researchers recommend the implementation of HIV workshops (Orlander *et al.*, 1994; Smit, 2005).

#### 5.4.4 Changing career paths

Half of the participants indicated that they are intending to change their discipline within the medical profession from that of gynaecology and obstetrics to others that do not involve surgery and thus exposure to contaminated blood and bodily fluids. This may be a direct reaction of their fear of having to treat HIV-positive patients. Such fears were also found in the study by Anderson *et al.* (1997) and Orlander *et al.* (1994). Interestingly this was not the case in the study by Smit (2005). This may be due to the fact that nurses are not as directly and closely involved in the surgery as medical practitioners are.

#### 5.5 Family reactions

All the participants indicated that their families were extremely concerned and anxious about their safety in their occupational environment in terms of HIV/AIDS. Smit (2005) noted in her study that significant others were extremely concerned about the risks in the work environment. However, the concerns in this research were expressed in a variety of ways by each family. For the participants who disclosed that they experienced a needle stick injury while operating on an HIV-positive patient felt that they were not sufficiently supported by their families. Most of the participants felt that they were not understood and some even felt blamed for their actions. Due to these feelings, Sadovsky and Gillette (1997) suggested that there should be support groups available for healthcare practitioners.

It was interesting to note that in this current research the female participants all expressed a concern for their husbands and children, whilst the male participants did not raise similar concerns.

#### 5.6 Observations of the researcher

The researcher deems it relevant to discuss the interesting pattern that emerged within the interview process. The researcher was interested in the meaning of performing a caesarean section on a person with HIV/AIDS holds for a medical practitioner. Four of the participants related incidences of needle stick injury which seemed to characterise their experience of performing caesarean sections on HIV-positive This is consistent with research that revealed needle stick patients. injuries as the most common type of injury in the medical workplace, especially during surgery (Singh, 2000). The research further indicates that this creates a substantial amount of anxiety and fear for medical practitioners. This can therefore explain why a needle stick injury was at the forefront of the participants' experiences. It appears that these experiences colour the participants' lenses through which they view their own experiences with HIV/AIDS and determines all their future decisions regarding HIV/AIDS.

# 5.7 General description of performing a caesarean section on an HIV positive patient

#### 5.7.1 Life before the experience

Prior to HIV/AIDS being a serious consideration in the medical arena, the participants experienced their occupational life-world as less pressurised and stressful. Fear was not a part of their daily work and they did not have to be confronted daily with their mortality. Prior to HIV/AIDS there were few serious work-related risks and the participants could therefore carry out their duties very unselfishly and more altruistically. The first and foremost consideration was always for the patient and his or her safety.

# 5.7.2 Experiencing performing caesarean section on an HIV positive patient and its effect on the medical practitioner

With the experience of working with HIV/AIDS, particularly in performing a caesarean section, the participants' occupational life-world began to change. Participants' experiences seem to differ between the ones that were exposed to HIV/AIDS as a result of occupational injury and those that were not exposed, although all of them have become more aware of the risks for occupational exposure and have begun to take extra precautionary measures in order to protect themselves within their occupational environment.

The participants who did not experience occupational injuries felt less fear and anxiety, but instead processed the experience more cognitively in an attempt to integrate and make sense of this disease and its implications in their life-world. Their reactions were more rational and logical, and revolved around intellectual knowledge and moral dilemmas. The participants who did experience the threat of contracting HIV/AIDS directly expressed high levels of fear and anxiety regarding their own safety and mortality. Their experiences invaded their lives and overwhelmed them. It impacted on them on an emotional level rather than a cognitive level.

#### 5.7.3 The impact of the experience

The prominence of the experience and its impact brought about a major shift in the participants' life-worlds. This shift and its consequences were unexpected and never thought of by the participants and therefore overwhelmed and engulfed them. A variety of feelings were elicited by the experience, which included fear, anxiety, anger and shock. The participants live in constant fear of the possibility of contracting HIV. This fear paralyses them and is always at the back of their minds.

Many coping mechanisms were adopted to deal with their experiences, such as repression, denial, avoidance and intellectualisation. Another impact of the experience was that it resulted in overly cautious behaviour in the participants.

The participants became aware of a paradox within their occupational context, where their concern for self came into conflict with their concern for their patients. This places the participants in a double bind, where they constantly feel cornered yet there is never simply a right or wrong decision.

#### 5.7.4 Prospects for the future

Although in general the experience was emotionally challenging and overwhelming for some, it has not eroded their passion for and commitment to caring for patients with HIV/AIDS. All participants appear

to have a sharper awareness of the implications associated with their occupational environment. They have gained a deeper appreciation of their own lives as well as the significance of their profession for the future of the greater society.

Those who have experienced needle stick injuries, however, feel less reluctant to be performing surgery on patients with HIV/AIDS as this places them at higher risk for occupational exposure to the virus. Two of these participants redirected their career paths towards consultation-based work. Those who were not exposed to occupational injuries expressed more passion with regards to contributing to and assisting with the battle against HIV/AIDS and did not express any intention of changing their discipline.

#### 5.8 Conclusion

This chapter has shed light on the prominent themes which have emerged through the phenomenological explication of medical practitioners' experiences of performing surgery on an HIV-positive patient. These themes include issues related to emotional reactions, cognitive reactions and methods of coping. A general description of the experience of performing caesarean sections on patients with HIV/AIDS was also provided.

#### Chapter 6

#### **CONCLUSION AND RECOMMENDATIONS**

#### 6.1 Introduction

Although the HIV pandemic has spread through South Africa with rapacious speed and can thus be considered a 'common' phenomenon in our society, not much is known about its precise impact on the medical practitioners who are dedicated to the care of patients infected with HIV/AIDS. Those who hear about it tend to oversimplify its effects without realising the true extent of its impact on medical practitioners. This research has attempted to shed light on the experience of medical practitioners working with patients with HIV/AIDS, particularly those of gynaecologists/ obstetricians performing caesarean sections.

#### 6.2 Strengths of the Research

This research makes a contribution towards addressing the gap in the literature with regards to South African medical practitioners' experiences of working with people with HIV/AIDS.

A further strength of this research is that the method of phenomenological explication complements and is consistent with the aim of the research in exploring the experience of a particular phenomenon. In other words, the breaking down into natural meaning units of medical practitioners' experiences provided the researcher with a sound and true reflection of the phenomenon under investigation.

Despite the small sample, the researcher attempted to ensure diversity in the participants by recruiting participants of different background, culture, experience, age and geographical region. Although this does not mean that the results are generalisable to other medical practitioners, it is the researcher's opinion that it offers a better all-round reflection of this particular experience.

The researcher has utilised the technique of bracketing in order to set aside her personal values and assumptions and therefore facilitating the objectivity in this research.

It is the researcher's opinion that trust was established with the participants, which facilitates the genuine and truthful expression of their accounts. It was the researcher's intention to offer the participant's a safe space within which they could feel open and comfortable enough to discuss their experiences. The researcher feels that this was successfully achieved.

Trustworthiness was further achieved in this study. The researcher disclosed her research orientation and explained the social and cultural context of the investigation. Credibility was also achieved through peer reviews, supervisor reviews and verifications with participants.

#### 6.3 Limitations of the Research

Due to the exploratory nature of this research, only six participants were interviewed in this research. As it is a limited study, the findings for the participants in this research cannot be generalised to other gynaecologists' or obstetricians' experiences on performing a caesarean section or even to other contexts. This is not to say that the data gained in this study are not valid, but rather that the information acquired is only applicable to these participants in this research at the time they were interviewed. The themes that are identified in this research can only

serve as guidelines for conceptualising medical practitioners' experience with HIV-positive patients and should not be used as a formula.

The research depended on personalised self-reported data during a qualitative interview, which might have been influenced by a social desirability bias in participants to be seen in a favourable light.

Participants who took part in this research were all, at the time of the interviews, working in the public health sector. Therefore the findings are only applicable in this setting and cannot be generalised to other settings.

Although the researcher did try to bracket her own biases and promote dependability in this research, the analysis of the natural meaning units was nevertheless coloured by the researcher's perspective and was influenced by her values and principles. Another researcher would perhaps have constructed different natural meaning units and therefore derived at different themes.

A further limitation to this research is the personal and unique nature of the data elicited. Even though the researcher made all attempts to protect the participants' identities by omitting identifiable data, their personalised experiences could results in their being recognised by a reader.

#### 6.4 Recommendations

In terms of future research a bigger sample can be employed in order to achieve generalisability and validity. It would also be beneficial to extend the research context to include the experiences of medical practitioners working with patients with HIV/AIDS in the private sector. Future studies could be conducted from a quantitative paradigm, thus yielding more objective results. In terms of recommendations for future HIV/AIDS initiatives, it is suggested that the importance of more proactive institutional initiatives to support medical personnel in coping with occupational stress and emotional concerns be recognised and implemented. These initiatives can include stress management courses, support groups, a debriefing service especially after occupational injury, and educational programmes. In order for medical practitioners to provide good-quality service, the health institutions should offer a working context sufficiently equipped to cope with the demands of HIV/AIDS.

#### 6.5 Conclusion

This research has provided valuable information regarding the experiences of medical practitioners in performing a caesarean section on a patient with HIV/AIDS. It has demonstrated the complicated and ambivalent nature of this experience and the significance in exploring this phenomenon.

Specific themes pertaining to the participants' experiences were articulated and discussed, and a general description of this phenomenon was also offered. The qualitative research method used in this research proved to be a valuable way to obtain the type of information required. Some important areas for future research as well as HIV/AIDS-related initiatives were recommended.

The phenomenon of HIV/AIDS crash-landed in the medical field and its ripple effects still have not yet stopped and nor can this be accurately assessed. The participants in this research displayed profound emotional reactions to this phenomenon characterised by ambivalence and inner conflict. Despite the fear and anxiety the disease evokes in them, the participants remain committed to their profession and the

cause of saving the human race, trying to find comfort in life, as well as in death.

AIDS is like God: it doesn't discriminate, it doesn't pick and choose and neither may we as [medical professionals]. I've been [working] for 18 years now, and it's always been wonderful to see a patient recovering after an illness, to see the grace of God and knowing that I did my best. But it is also rewarding in a strange way to see a patient die with dignity and so come to the end of a journey of suffering (Quoted from a participant in Smit, 2005, p.27).

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#### Laws:

Constitution of the Republic of South Africa Act, No 108 of 1996.

## **APPENDIX 1**

# **CORNé KENNEDY**

### REGISTERED INTERN CLINICAL PSYCHOLOGIST / GEREGISTREERDE INTERN KLINIESE SIELKUNDIGE BA (HONS) Psychology Stellenbosch / MA I Clinical Psychology Unizulu

#### HPCSA REG NR PSIN 0093351

### **RE: AUTHORISATION FOR RESEARCH**

I am an Intern Clinical Psychologist at Sterkfontein Psychiatric Hospital. I am currently in the process of completing my dissertation at the University of Zululand. My research entails the study of medical practitioners' emotional experiences when performing elective caesarean sections on HIV positive patients. As follows I am kindly requesting your assistance in identifying suitable candidates that would be willing and able to participate in my research.

Participations would involve a brief informal interview regarding their personal experiences whilst performing the above-mentioned procedure. Please note that every effort will be made to ensure that strict confidentiality and anonymity will be upheld throughout the study.

Further, I have attached a copy of my approved research proposal for your perusal. Should you have any queries, please do not hesitate to contact me.

Sincerely

Corné Kennedy