

**A Qualitative Study Aimed at Describing &
Interpreting the Changing Symbolic Meanings
of HIV/AIDS which Encountering HIV-positive
Patients Introduces into the Personal & Professional
Identities of Selected Health Care Professionals**

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ABSTRACT

This study aimed at describing and interpreting the changing symbolic meanings of the Acquired Immuno-Deficiency Syndrome (AIDS) which encountering a Human Immunodeficiency Virus (HIV)-positive patient introduced into the personal and professional identities of six health care professionals in a subregion of the Eastern Cape. With the exponential increase of HIV/AIDS in South Africa, medical practitioners have become increasingly exposed to HIV infected patients. This study has considered the psychological structures developed by practitioners in an attempt to control and understand their situation in the context of HIV/AIDS. In order to describe these psychological structures the existential phenomenological approaches of L. Binswanger (in Needleman, 1963), A. Giorgi (1975) and F.J.Wertz (1985) were employed. Through these procedures, the structure of the experience of encountering an HIV infected patient was elucidated. This comprised the first goal of this study. The second goal focused on interpreting these descriptions by way of the symbolic meanings and definitions implicit in the structure of this experience. For this latter purpose the approach of symbolic interactionism was used, in particular the understandings outlined by H. Blumer (1969). This theory was seen as appropriate in that the encounter between the practitioner and patient was primarily located in interpersonal parameters. The findings were discussed in terms of the two dominant metaphorical frameworks used by the subjects to comprehend the disease - namely the perspectives of society and the biomedical model. These two frameworks were critically evaluated in the context of HIV/AIDS, the needs of HIV infected individuals as well as the needs of the general practitioner. The process of the encounter was found to be very significant for practitioners in terms of their conceptualisations of HIV/AIDS. Old understandings were re-interpreted within the interpersonal context and replaced with more appropriate symbolic metaphors upon which to base practise. This study has revealed these new understandings were limited and constrained with regard to understanding and treating HIV/AIDS in that the subjects were still influenced by the metaphors of the biomedical model. These constraints were examined in the light of both personal and professional meanings and identities. This study concluded by making suggestions for modification of the medical practitioner's role in the context of HIV/AIDS.

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LIST OF ABBREVIATIONS

AIDS:	Acquired Immuno-Deficiency Syndrome
ARC:	AIDS Related Complexes
ATIC:	AIDS Training & Information Centre
AZT:	Azidothymidine (also known as Zidovudine)
CD4+:	T-helper Lymphocytes
CDC:	Centre for Disease Control
CMSA:	College of Medicine of South Africa
DDI:	2',3'-dideoxy-inosine (also known as Videx)
GP:	General Practitioner
HCW:	Health Care Worker
HIV:	Human Immunodeficiency Virus
HRC:	HIV Related Complexes
HTLV:	Human T Lymphotropic Virus
IVDU:	Intravenous Drug User
KS:	<i>Kaposi's sarcoma</i>
NMU:	Natural Meaning Unit
PWA:	Person With AIDS
SAMDC:	South African Medical & Dental Council
SIV:	Simian Immunodeficiency Virus
STD:	Sexually Transmitted Disease
TB:	Tuberculosis
WHO:	World Health Organization

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INTRODUCTION

This study arises out of the prediction that the Acquired Immuno-Deficiency Syndrome (AIDS) in South Africa threatens to become an unprecedented public health crisis with large economic and social effects, and consequent psychological implications, particularly with regard to the position of the health care worker. In recent years health care professionals have had to contend with increasing numbers of Human Immunodeficiency Virus (HIV)-positive cases. It is these persons who are at the forefront of the encounter between the HIV/AIDS epidemic and society, and are therefore in a position whereby they mediate between society's perceptions towards HIV- and AIDS sufferers and the actual threat caused by this epidemic. Because of the high profile occupation of these professionals, their perceptions contribute to and influence the general understanding of HIV/AIDS held by society. Although HIV/AIDS in South Africa is still in the early stages and has not yet reached serious proportions, there is no reason to suggest that the natural history of the disease in this country should follow a course any different from that of neighbouring countries. Reports indicate that 97 000 South Africans are expected to be HIV-positive by the end of 1995 (Crewe, 1992). 1517 people in South Africa to date have diagnosed with AIDS, 430 of these in the Eastern Cape Province. A recent report shows that the incidence of infection for the first three months of 1992 in the Eastern Cape showed a twofold increase in comparison to the same period in 1991 (AIDS Training & Information Centre [ATIC], personal communication, 7 January, 1993). This figure continues to rise.

Medical practitioners, having increasing contact with HIV infected individuals, are needing to define for themselves a clear identity and framework of understanding, enabling them to comprehend effectively their personal and professional positions in relation to the phenomenon. The research began with the prediction that the following factors would contribute to and influence the formation of this identity: a) Present health care workers have never before been confronted with a disease of these proportions, inducing such concern and stigmatisation; b) Medical practitioners are now perceived to constitute a high risk group, and this increased level of personal risk will have a significant influence upon their understanding of HIV/AIDS; c) In their personal capacity,

practitioners, together with other members of society, are also subject to external influences such as the media, yet are also expected to fulfil a certain role in society, defined by a set of professional and ethical standards proposed by the biomedical model. The needs and beliefs developed by medical practitioners in relation to HIV/AIDS are likely to be substantial and distinct with respect to the magnitude of the threat this disease presents.

Given these factors the response of practitioners to HIV/AIDS will be highly complex. They are having to make important decisions in relation to the complexities which exist between personal needs and beliefs on the one hand and professional needs and role expectations on the other. These decisions have an important psychological effect on their own lives, on society in general, and on HIV infected individuals. The needs and perceptions of practitioners towards the HIV/AIDS concept being so important, it is necessary to establish a psychological understanding of this personal and professional identity in order to determine these needs and difficulties. By attending to these, the quality of the relationship between health care professionals and HIV infected persons can be stabilized and enhanced.

The goal of this study is twofold. Firstly it aims to **elucidate and describe the experience of 6 medical practitioners from a subregion of the Eastern Cape, relating specifically to the phenomenon: The experience of encountering professionally an HIV infected individual.** Secondly it aims to **interpret this experience by way of the symbolic meanings and definitions that these individuals use to understand the HIV/AIDS concept in relation to their role and situational context.** Both the role of the practitioner and the practical application of this role which occurs within a doctor-patient framework is determined by and structured upon the principles of biomedicine. This model is the dominant explanatory system for the interpretation and management of disease and illness in western society. In order to examine the phenomenon of the encounter and elucidate, through this experience, the psychological structures that comprise the personal and professional identity of selected medical practitioners, it is necessary to recognize the importance of the doctor-patient relationship and the scientific paradigm that it is founded upon.

The doctor-patient relationship is not an encapsulated and isolated event, but is an interactive process that is systematically linked to larger frames of meaning, structured in accordance with the aims and goals of the dominant view of medicine. In order to understand comprehensively the meanings that comprise these individuals' conceptualisation of HIV/AIDS, it is necessary to have a full understanding of the context within which this specific doctor-patient encounter occurs. T. Parsons (1975) describes the doctor-patient relationship as existing within a framework of social roles, attitudes, beliefs and activities that both parties bring to the situation. While this study does not aim to methodologically analyze the nature of the doctor-patient relationship *per se*, it recognises the need to understand the established paradigmatic structures that encompass and influence the phenomenon under study.

It is only once a detailed knowledge of the broader structures that circumscribe this specific event are incorporated into an overall understanding that the goals of this study can be properly implemented. It is for this reason that a modified version of the Phenomenological method, as used by Wertz (in Giorgi, 1985), will form a theoretical base to the research design. This study aims to describe the "lived reality" (Kruger, 1979) of an encounter between a medical practitioner and an HIV infected patient. Phenomenology provides a suitable theoretical and methodological framework in that it affords an insight into the subjective reality of the participants. The procedure used by Wertz, while still focusing on a specific phenomenon, is more flexible than other phenomenological procedures and is able to incorporate the broader context surrounding the event, including the temporal sequence in which the event is located. This strategy allows the researcher to focus on the encounter within the context of the doctor-patient framework, as well as making provision for the assimilation of other influences that may add meaning to this event. These influences will derive from the contextual biomedical model of management and treatment surrounding and strongly defining the event, as well as the broader context including social, geographical, cultural, temporal, epidemiological, legal and ethical factors that imbue the medical encounter with meaning. Various interpersonal themes emerging from this experience will provide a basis for further exploration into related issues and patterns of understanding that constitute these individuals' conceptualisation of HIV/AIDS. According to the theory of Symbolic Interactionism, human interaction is assumed to be mediated by the use of

symbols, by interpretation and by imputing meaning to action and the actions of others. Meanings are social products, they are creations that are formed in and through the defining activities of people as they interact. Symbolic meanings are ascribed to "objects" in the environment; these may be physical, social or abstract. This theory provides a useful analytical framework for this study because it too allows for the inclusion of the broader context when interpreting the psychological structure of the experience.

For reasons already outlined, this study provides a detailed overview of the broad circumstantial structures that influence the interactive process between patient and practitioner, and consequently give rise to patterns of understanding that constitute these participants' conceptualisation of HIV/AIDS. Thus, this study focuses on discussing the HIV/AIDS disease as a psychological, social and medical phenomenon. Section One defines and explains the HIV/AIDS phenomenon in terms of its origin, distribution, transmission and pathogenesis. The social impact and the global extent of the problems and issues raised are outlined in detail with the emphasis being on Africa and more specifically, South Africa. This section further outlines the social perspectives and metaphors by which the phenomenon of HIV/AIDS is generally understood. Section Two examines the biomedical model and the manner in which this model understands and manages HIV/AIDS. It examines the requirements, ethical considerations, and role frameworks which the biomedical model stipulates for the medical practitioner. This section focuses very briefly on the limitations of the biomedical model. Section Three discusses the position of practitioners within the established perspectives of the social and medical models, and the implications of these perspectives for the practitioner in his/her professional situation. The role of the practitioner and the patient during the medical encounter is discussed closely through a sociological understanding of the doctor-patient relationship and the sick role. This section is concerned with the actual functioning of the practitioner in the context of the biomedical and social influences, with reference to the professional and personal domains, and discusses the recent innovations brought about for practitioners in the biomedical model with regard to HIV/AIDS.

The first three sections form the Literary Overview, contextualising the parameters of the research. Section Four deals with the methodological procedures

used for the purposes of the study. This begins by giving a theoretical orientation of the procedures to be used, then examines and justifies these procedures in detail. There are two methods used in this research, appropriate to the two goals: Phenomenology is used to elucidate and describe the psychological structure of the experience of encountering an HIV-positive patient, and the meanings and definitions the subjects develop to understand HIV/AIDS. Symbolic Interactionism is used for the purpose of interpretation of the emergent meanings in this structure. Section Four further explains these two methods and demonstrates how they complement each other.

Section Five comprises the results of the research: it contains the three phenomenological stages involved in the first phase of this study: the Organisation of the Data, the Individual Thematic Description, and the Extended Thematic Description. The second phase involves the interpretation of the Extended Thematic Description through Symbolic Interactionism. These results are discussed in Section Six, which also examines the limitations of the present research and gives suggestions for future studies. The material which could not be included within the main body of the text has been placed within the appendices.

SECTION ONE: HIV/AIDS

1.1: The Physical Patterns of HIV/AIDS

This study focuses on the psychological structures which constitute the personal and professional identities of general practitioners in relation to HIV/AIDS. The aim therefore is to elucidate the idiosyncratic metaphorical nature of the practitioner's individual conceptualization of the HIV/AIDS disease, based on personal experience. In order to understand the full meaning of HIV/AIDS for the general practitioner it is necessary to establish what constitutes the two major sources of this meaning (as the situation is reflected by the literature): the meanings that derive from the practitioner's professional role in relation to HIV/AIDS, and the meanings derived from personal and socially defined understandings of the disease. Societal metaphors relating to the HIV/AIDS disease have as a basis cultural norms and beliefs. These symbolic understandings derive from certain understandings, such as that this disease is incurable, physically disfiguring, is transmitted through certain behavioural practices, and affects certain subgroups. Medical metaphors defining the disease for the practitioner are based on physical factors such as its genesis, its distribution, its transmission, groups at risk, and common symptoms. The meaning of HIV/AIDS for these individuals in their professional context will be influenced strongly by the biomedical model.

1.1.1 Definition of HIV/AIDS

In the early 1980s HIV infection was regarded only as AIDS. The disease was then described as an acute infectious disease, rapidly and invariably fatal, found almost exclusively in male homosexuals. It has since been found that HIV infection is asymptomatic for a considerable time. AIDS, as it develops clinically from HIV Related Complexes (HRC) to AIDS Related Complex (ARC) and eventually to Full Blown AIDS, is now described as a chronic, debilitating yet treatable disease with an eventually fatal outcome (Lachman, 1991). It is recognised as a multiplicity of secondary diseases caused by primary infection with the HIV virus. The Centre for Disease Control (CDC) in the USA - the American government institution which is responsible for monitoring the spread of HIV/AIDS - uses as its criteria for identifying and reporting a case of AIDS the state where a person has a reliably diagnosed disease that indicates a deficiency in the immune system not due to immunosuppressive factors such as drugs or illnesses like cancer (1987). This definition, which does not require knowing the results of an HIV antibody test, was formally established in 1982 and subsequently expanded to include additional opportunistic infections and cancers in people who tested positive for HIV antibodies (*ibid*).

In many countries, AIDS is classified according to the World Health Organisation (WHO) criteria for HIV/AIDS, which are similar to those of the CDC but have less stringent requirements for laboratory diagnosis of opportunistic infections. In Africa a clinical case definition for adult AIDS has been developed in order to facilitate diagnosis (see Sec. 1.2: HIV/AIDS In Africa). On this continent AIDS in an adult is defined by the existence of two major signs of HIV infection and at least one minor sign. These signs must occur in the absence of other causes of immunosuppression such as cancer or severe malnutrition (Colebunders, Francis, Groen, Vercauteren, Mann, Bila, Kakaonde, Hoto, Quinn, Curran, & Piot, 1987).

1.1.2 Physical Pathways of HIV/AIDS

Pathogenesis.

The Acquired Immune Deficiency Syndrome is defined as the disease caused by the Human Immunodeficiency Virus (Lachman, 1991). This virus brings about the decline and deterioration of the body's natural immune system, resulting in the condition of AIDS. The virus attacks the T-helper lymphocytes (CD4+ cells) of the cell mediated immune system and subverts the replication of these cells into producing more viral material. The HIV/AIDS disease starts manifesting serious symptoms only when the individual has lost about 80% of the normal complement of T-helper lymphocytes (*Medical Chronicle*, 1991).

The development of the disease has been documented as following a certain distinct pathway (see Fig.1 below). After seroconversion, which usually takes place six to 14 weeks after infection, there is an asymptomatic period of dormancy which lasts for a varying length of time: one to fifteen years (Antoni, Schneidermann, Fletcher, Goldstein, Ironson, & Laperriere, 1990). While this dormancy or asymptomatic period lasts the infected person enjoys apparent full health. However, the individual, while suffering no or little ill-effect, is infectious even in this stage. The duration of this stage of dormancy depends on a number of factors, such as the initial health of the individual, the state of the surrounding environment, nutritional and even psychological factors (Farthing, Brown, & Staughton, 1988) - for instance, the period in America is frequently close to ten years; in Africa one year is the usual period (Lachman, 1991). This dormant stage is followed by the HIV Related Complexes stage (HRC), in which low-grade infections develop. At the HRC stage, early diagnosis, treatment and a suitable lifestyle should enable the infected individual to continue a relatively normal life for a number of years. Without this, the individual is likely to decline fairly rapidly within a matter of months.

Immunosuppression due to the increasing activity of the virus and its replication gives rise to AIDS Related Complexes (ARC). This manifests as serious opportunistic infections. The ARC stage lasts a relatively short period before the infected person develops Full Blown AIDS, where a variable number of very serious infections culminate in death. The nature of the ARC opportunistic infections, and the final terminal diseases, are to some degree dependent upon the global area in which the disease is contracted: African AIDS and Western AIDS, for instance, have different opportunistic infections. Syphilis is a very common complication in this stage in both first and third world countries, and is in fact frequently one of the chief indicators of this stage. In the ARC stage, and especially in full blown AIDS, treatment is problematic because of adverse reactions to many of the drugs, especially antibiotics.

Full blown AIDS is a difficult concept to define in clinical terms, as the disease has no individual symptoms of its own but takes the form of various opportunistic infections. It can be said that an AIDS sufferer dies as a result of these opportunistic diseases; and it is the HIV, weakening the immune system, which allows for these opportunistic diseases to have a terminal effect. This weakening only takes place if the immune system is placed under severe strain by the invasion of foreign protein of a pathological nature, thus the HIV is in fact only an initiating factor in the progress of the disease. Professors Montagnier and Gilbert, eminent researchers within this field, have suggested that "HIV is relevant [as the agent of the AIDS disease] but not the sole causative factor; other co-factors must be involved in triggering the disease process" (cit. Lachman, 1991, p. 30). These factors are social, environmental and psychological.

THE BIOLOGICAL PATHWAY OF THE HIV/AIDS DISEASE

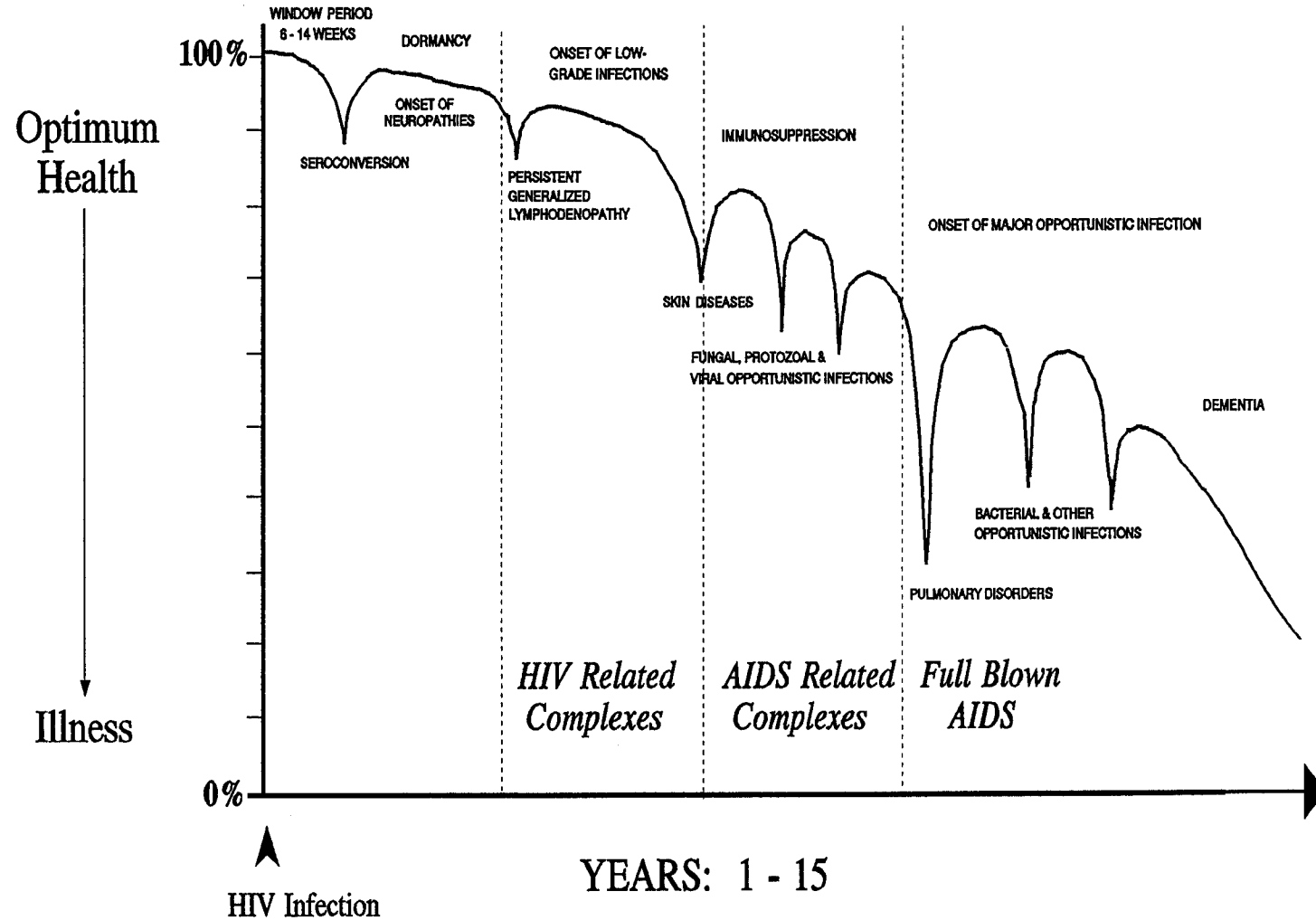


Figure One: The Biological Pathway of the HIV/AIDS Disease

Transmission.

The causative agent of AIDS - the HIV virus - exists in the body fluids, and it is through the transmission of certain of these fluids that infection takes place. Antibody tests show that the virus is present in all body fluids: in most of these it exists in insufficient quantities to cause infection (Farthing et al., 1988), however, blood, milk, semen and vaginal fluids carry the virus in quantities great enough to be transmitted. These fluids have to be absorbed into the host's bloodstream for the virus to take effect: this absorption takes place through the mucosal membranes or through introduction directly into the bloodstream. Certain medical scientists have made the point that HIV/AIDS is not in fact highly contagious: intimate contact with infected body fluids must take place before the virus can enter a new host (Montagnier & Gilbert, cit. Lachman, 1991). Sexual intercourse of either a male homosexual or a heterosexual nature is the major cause of HIV spread. The introduction of infected fluids directly into the bloodstream by the use of unsterile implements such as needles, particularly in intravenous drug users (IVDUs), is another common cause, as is (though decreasingly) blood transfusions. Perinatal infection from mother to foetus or infant is prevalent in third world countries. Cross-placental bloodflow commonly, though not necessarily, results in infection of the foetus (Lachman estimates there is a 71% chance of cross-placental infection from an HIV-positive mother, other sources reckon anything from 33% to 50% and over). Infection can also take place through breastfeeding (Lachman, 1991). These various forms of transmission follow noticeable patterns of occurrence in different communities.

1.1.3 Origin

In the attempt to understand the phenomenon of HIV/AIDS, certain dominant metaphors have arisen relating to the origin of this disease. The origin of HIV/AIDS has provided cause for much conjecture and controversy since the appearance of the disease in the early 1980s.

Most authors proclaim that it is highly likely the HIV-1 virus originated in isolated communities in Africa, where serum samples from as early as 1950 have been found to be seropositive (Farthing et al., 1988). The dominant theory is that migrant Haitian workers who spent periods of time in Central Africa in the 1960s and 1970s spread the disease. During this time Haiti was popular as a tourist resort for male homosexuals from the USA and this would seem to explain why the disease first appeared in this subgroup in that country. This theory of spread is supported by the fact that HIV/AIDS had a high prevalence in Haiti, and occurred here before it did in the United States. Further evidence supporting

the African origin theory comes from the reported cases of a number of individuals presenting in western countries with HIV/AIDS-related conditions during the early stages of the epidemic. Most of these persons came from or had links with Central African countries.

Another theory of origin examines the disease as originating from an animal source: as Dr Andrew Scott states in *Pirates of the Cell*, "The current most favoured hypothesis is that all human AIDS viruses are related to a type of virus called 'Simian Immunodeficiency Virus' (SIV), which is known to cause an AIDS-like disease in monkeys" (cit. Chaitow & Martin, 1988, p. 47). Most of the public accept it as quite possible for enough mutations to have taken place for the virus to have evolved from the known animal lentivirus to HIV-1 (McClure & Schulz, 1989), although this is a highly contentious issue.

Despite strong evidence for the theory that HIV/AIDS did originate in Africa, there is also evidence that challenges this popular view. Some researchers have concluded that before 1984, the frequency of HIV in African countries was less than that in many western countries, and that the epidemic of AIDS started in Central equatorial Africa at about the same time as the epidemic in North America. The medical perspective, however, regards the Central African theory of origin as the most tenable. Central Africa has long been an area afflicted with particularly virulent viral and bacterial diseases, of which Ebola and Congo fever are but two examples (Shilts, 1987). Environmental, social and climactical features in Central Africa provide the physical conditions for the rapid evolution and spread of disease. Given this scenario it is not unlikely that HIV/AIDS did in fact originate here.

1.1.4 Temporal & Geographic Distribution

In 1981 a total of 2323 AIDS cases had been reported to WHO. By May 1st, 1991, the cumulative number of cases worldwide was 359 272. These figures are increasing at an exponential rate: between January 1st and January 31st of 1991 there was an increase of 8769 cases reported to WHO, from 314 610 to 323 379, and between April 1st and May 1st 1991 the increase was 13 739 - from 345 533 to 359 272. These figures are, however, believed to be highly inaccurate, and WHO postulates that by January 1st, 1991, there were 1,2 million cases of AIDS worldwide. This does not include the number of HIV-positive cases, which WHO estimates to be between eight to ten million. The rate of HIV infection has also escalated: at present the South African rate of spread is postulated to double every 8.5 months - though this will not remain a stable figure (Lachman, 1991).

AIDS is unusual amongst epidemics in that within a relatively short space of time - seven years - it was diagnosed in 138 of the world's total countries (Mann & Chin, 1988), and has therefore rapidly become a global epidemic. In the global context there are three patterns of the HIV-1 epidemic (Lachman, 1991). These three patterns are dependent on three dominant forms of risk behaviour. These behaviours are most typically found in certain groups.

1.1.5 Subgroups at Risk

HIV is transmitted by distinct and deliberate forms of behaviour, therefore the various subgroups commonly engaging in such behaviours are most at risk. The three major patterns of HIV spread in different parts of the globe are to a large extent caused by the prevalence of certain groups practising varying high risk activities in these different areas (see Fig.2 below).

Figure Two: Subgroups at Risk: Patterns I & II

	<u>USA</u>		<u>UK</u>		<u>SA</u>	
	No.	%	No.	%	No.	%
HOMO/BISEXUAL	27552	54	3234	79	345	35
HETEROSEXUAL	3014	7	268	7	435	46
HAEMOPHILIAC			288	5,6	22	2.5
TRANSFUSIONS	3875	9	67	1,6	9	0,9
IVDU's	10332	24	222	5,4	7	0,7
PAEDIATRICALS			36	0,9	146	15
OTHER	2152	5	43	1	5	0,5
TOTAL	43 050		4098		964	

(Elmer-Dewitt, 1991, Lachman, 1991, Crewe, 1992)

The first pattern, most typical of first world countries, occurs through male homosexual activity. The relatively small, closed nature of the homosexual

communities in North America and Europe, and a high level of sexual activity, together with a low incidence of single partner relationships, has exacerbated the rapid transmission of HIV. The nature of sexual activity within these limited

communities puts this subgroup at a particularly high risk. Also prevalent in pattern one is Intravenous Drug Use. Here again the closed nature of these communities, and the practice of sharing unsterilised needles, enhances the chances of infection.

The second pattern, prevalent in Africa and other third world countries, is heterosexual transmission. Although this pattern is increasing in first world countries, especially through factors such as bisexuality and IVD use, it is far more common in third world countries because of factors such as the cultural, social and economic conditions. The diverse cultures of the third world have different values and beliefs to the western world, especially as regards sexual behaviour. A relatively high level of promiscuity, augmented by the Migrant Labour system, increasing urbanization, and poor living conditions and social services, puts both urban and rural communities at high risk. These factors also lower the immune system, thus making the individual more susceptible to infection. Prostitution is also a feature of such a socio-economic situation and, while female to male infection is less common than the reverse, this community is particularly open to infection. The breakdown of traditional family structures, linked with escalating urbanization, has undermined the individual's security. Poor socio-economic conditions combined with this factor encourage high risk behaviour.

Out of the spread of HIV in heterosexual communities has arisen another form of infection: perinatal infection. This form of transmission most usually occurs *in utero* through an infected mother. Infection through breastfeeding is possible (Lachman, 1991). Since HIV is most common in the sexually-active and fertile section of any population, perinatal infection is a feature very much on the increase.

The third pattern of transmission, occurring mostly in Africa, Asia and the East, is through intravenous infection. In sub-Saharan Africa tribal practises not infrequently involve the use of skin piercing tools, and in group ceremonies such as circumcision a number of people at once can be infected. The Eastern countries, Thailand in particular, have a very high proportion of IVDUs. This means of transmission is exacerbated by the large proportion of prostitutes who

are also IVDUs (Mays, Albee, & Schneider, 1989). In many countries medical facilities are lacking, and contamination through infected medical equipment, particularly needles, is a major means of transmission.

Health care workers, in dealing with HIV-positive or AIDS patients, are themselves a risk group. These individuals are by the nature of their jobs in contact with most of the body fluids which transmit the virus. Needlestick injuries and cuts or pricks incurred during surgery; contamination of the face with body fluids, especially when power instruments are involved, and the absorption of these fluids through the eyes, mouth or skin abrasions are all potential sources of transmission. For a patient diagnosed with HIV precautions can be taken, but asymptomatic HIV cases, especially in the situation of emergency medicine, present a much higher risk. The first recorded case of seroconversion due to accidental deep needlestick injury was reported on October 1st, 1988 (Sowa, 1989). The need for comprehensive safety measures against such infection and nosocomial spread was subsequently recognised.

Other groups at risk across the world are those requiring blood products. These are chiefly haemophiliacs (Haemophilia A, rather than B). The percentage of AIDS cases coming out of this group is not large: the cumulative total for the United Kingdom, for example, being 7% by 1990 (Lachman, 1991), but initially the proportion of haemophiliacs being infected was very high: in the United States at least 60% of the haemophiliac population is reckoned to be HIV-positive. (Sivak & Wormser, 1985). The risk from infected blood products is decreasing in first world countries, where HIV-screening and heat treatment minimise the chances of HIV infected blood products being used for haemophiliacs or transfusions. In third world countries, however, the level of infection from blood sources is unknown. In Africa a high incidence of sickle-cell anaemia puts such persons at risk as they require frequent blood transfusions. Inadequate medical facilities diminish the effectiveness of screening or heat-treatment for HIV in blood products (Lachman, 1991).

1.2: HIV/AIDS In Africa

The first indication of the presence of HIV/AIDS in Africa was through the identification of an AIDS-like illness among African patients seeking medical care in Brussels and Paris early in 1983 (Biggar, 1986). Subsequent serological investigations in various Central African countries showed that HIV infection and AIDS were firmly established in these regions (Ijsselmuiden et al., 1988).

According to Dr Helen Gayle, chief of AIDS International Activity division of the Centre for Disease Control in Atlanta, United States, the WHO estimated figures for Africa in 1990 for those infected by the HIV virus to be 6 million (WHO-SFI 1211, 1991). Developing countries accounted for about 66% of total HIV infections in 1991, compared to about 50% in 1985. The proportion is expected to continue to rise, reaching 75%-80% by the year 2000 and 80%-90% by the year 2010 (Lachman, 1991). The WHO comments that some African countries are not revealing the full extent of the infection (either through intent or through lack of statistical machinery and organization) (Lachman, 1990). Many African countries chose initially to ignore or deny this disease and its consequences. However, in the face of the escalating numbers of deaths (the mortality rate is more difficult to conceal than the morbidity rate), the original response of denial is now being replaced by attempts at containing the spread of the virus. Despite a more positive attitude and more realistic approach to this disease the figures continue to rise at an alarming rate. As at December 31, 1990, 58 African countries had reported 83 249 cases of AIDS to the WHO. This is a considerable increase from the 31 512 from 48 states as at October 1, 1989 and 70 724 at September 1, 1990 from 52 states. Although reporting has improved, these figures are still suspected to be very inaccurate: the WHO maintains that figures for AIDS cases in Africa as a whole may be under-represented by as much as 90%.

The major risk factor for HIV infection in Africa is heterosexual promiscuity (see Section 1.1.5 above). Vertical transmission from mother to child is the second major route of transmission. With the heterosexual mode of spread and the high birth rate, neonates now constitute a highly vulnerable group. A report by a Red Cross official from Zimbabwe, in 1989, stated that over a quarter of the children under four years of age carry the HIV virus. Blood transfusions and the use of unsterile needles are additional risk factors in most African countries (Ijsselmuiden, Steinberg, Padayachee, Schoub, Strauss, Buch, Davies, De Beer, Gear, & Hurwitz, 1988). HIV infection occurs frequently in urbanised groups and prostitutes and according to Kreiss, Koech, and Plummer (1986), it has spread in these groups at a speed comparable to that in San Francisco homosexuals.

The clinical features of AIDS most often manifested in Africa are different to those prevalent in the USA and other western countries. AIDS-related opportunistic infections in Africa tend to reflect commonly-occurring diseases that have always been present, such as gastro-enteritis, various dermatological diseases and more recently tuberculosis (there is, however, no recorded direct association between malaria and HIV infection). Infection with HIV increases the

risk of these common diseases and minimises the effectiveness of treatment (Small, Schechter, & Goodman, 1991). This is largely due to the process whereby latent infection with moribund organisms acquired early in life becomes reactivated through the breakdown of the immune system. This is particularly the case with TB, which is a serious problem in most African countries. Even in South Africa, where health services are more sophisticated, TB is a major health problem and accounts for 20 deaths per day not related to HIV-positivity (*AIDS Analysis Africa*, 1991). It is now one of the most common manifestations of HIV infection in Africa. According to a study published in the *British Medical Journal* (Elliot, Luo, & Tembo, 1990), of 346 adult TB sufferers in Zambia, 62% were HIV-positive; the prevalence of HIV-1 infection among TB sufferers in Nairobi is 16%, in Zimbabwe 34% (*Lancet*, 1990, p. 1280).

To facilitate diagnosis in Africa a clinical case definition for AIDS in adults has been developed by the WHO. In an adult AIDS is defined by the existence of two major signs of HIV infection and at least one minor sign. These signs must occur in the absence of other known causes of immunosuppression such as cancer or severe malnutrition. The major signs include weight loss greater than 10% of body weight; persistent chronic diarrhoea for longer than one month; and fever for longer than one month (intermittent or constant). The minor signs are a persistent cough for longer than one month; general pruritic dermatitis; recurrent herpes zoster; oropharyngeal candidiasis; chronic progressive and disseminated herpes simplex infection; and generalised lymphadenopathy. The presence of disseminated *Kaposi's sarcoma* or cryptococcal meningitis are recognised as sufficient by themselves for the diagnosis of AIDS in Africa (Colebunders et al., 1987, pp. 492-493). A particular enteropathic form of this disease known colloquially as *Slim disease* has been identified in Uganda and other East African countries. In this case the prevalent clinical features include chronic diarrhoea and wasting (Hooper, 1990).

Africa has another strain of the HIV virus known as HIV-2, presently acknowledged as a disease located predominantly in West Africa. In 1985 retrovirus strains isolated from blood samples collected in Senegal were tested and identified as HIV-2. Prior to this finding Senegal, unlike most other Central African countries, had reported no HIV or AIDS cases. Individual cases diagnosed in Europe and America have all been documented as persons with links to West Africa. However, persons with HIV-2 have also been reported from Central Africa, Angola, western Europe, Canada and Brazil. The scope or involvement of this strain of virus is not fully understood as yet, though it differs from HIV-1 in that it

is characterised by a relatively long asymptomatic stage. This has strong implications for the screening of blood donors for HIV-2 antibodies (Lachman, 1991). This disease was originally thought to have a less destructive action on the T-helper lymphocytes, but recent observations in the United States refute this view. In fact it has been stated that this strain of the virus may be responsible for a new epidemic of disease related to or identical with AIDS, which may indeed spread throughout Africa and elsewhere. It is possible for individuals to have dual infections with HIV-1 and HIV-2.

The relative political, economic and social instability that exists in much of post-independent Africa has greatly exacerbated the impact of HIV/AIDS. The total response and reaction of Africa to the emergent reality of this epidemic has been extremely complex and obstructive (Joubert in Van Niekerk, 1991). This scenario has provided the material conditions which form the basis for the high risk behaviours that assist and maintain the spread of the HIV/AIDS disease. Social, cultural and economic conditions have both fostered the spread of the disease in the African continent and militate against simple or effective preventative or controlling measures. Poor medical facilities, inappropriate prevention programmes orientated to a western audience and western values and ignoring the great cultural diversities existing across the continent, and high levels of illiteracy and poverty, together with the unsettled social conditions, make Africa particularly vulnerable to the disease. This is the case even in a relatively sophisticated country like South Africa.

1.3: HIV/AIDS In South Africa

The first two cases of AIDS in South Africa were identified in Pretoria, both individuals being white male homosexuals (Ras, Simson, Anderson, Prozesky, & Hamersma, 1983). By September 1992 1517 people had been diagnosed with Full Blown AIDS (ATIC, personal communication, January 7, 1993). It is generally accepted that these figures do not include privately diagnosed HIV results from insurance company requests and other avenues in private practice. According to the South African Minister of Health Dr Rina Venter, some 300 people are being infected by the HIV virus every day in South Africa. Heterosexual contact has become the most common method of HIV transmission, accounting for 54% of all cases and giving rise to a sharp increase in perinatal transmission, while transmission by means of homosexual contact has declined to 26% (*Grocott's Mail*, 1992, ATIC, personal communication, January 7, 1993).

Figure Three: Cumulative AIDS figures: South Africa by Race & Risk Group: 1992

	BLACKS		WHITES		COLOURED		ASIANS		%
	M	F	M	F	M	F	M	F	
HOMO/BISEXUAL	3		370		21		4		26
HETEROSEXUAL	374	390	14	4	13	12	1		54
HAEMOPHILIAC	3		13		1				1
TRANSFUSIONS	4		12	4	1	1			1.5
IVDUs	1		1						0.1
PAEDIATRICS	138	114							17
UNKNOWN	16		2						2
TOTAL	1043		420		49		5		

(ATIC, 1993: figures from September 1992)

The mean survival after diagnosis in this country is three months (SA Institute for Medical Research in Dept of Nat. Health, 1987), while that in the USA and the UK is at least nine months and twelfth months respectively (Rothenberg, Woelfel, Stoneburner, Milberg, Parker, & Truman, 1987). The doubling time of AIDS cases in this country has been calculated by Padayachee and Schall to be 8.5 months (1990a).

The highest incidence of HIV seropositivity is among women, who are being infected at a rate of between 120 and 140 a day, the figure for men being between 110 and 130 a day, and that for children between 20 to 40 a day. Dr M. Steinberg, head of the Medical Research Council's national AIDS Research Programme, predicts South Africa will have between 750 000 and 930 000 AIDS orphans by the year 2010, and between 20 000 and 31 000 children will be infected with the virus. He further states that existing services are not coping with the burden of AIDS in South Africa and new health care systems are needed (*Cape Times*, 1991).

The above data indicates that AIDS in South Africa is not a remote disease, as has been documented as recently as 1985: in this period S.F. Lyons stated that there was a lack of evidence of HIV-1 endemicity in Southern Africa (Lyons, Schoub, & McGillivray, 1985). Originally the HIV/AIDS epidemic in South Africa followed the global pattern 1 (Mann & Chin, 1988), where the main influences on the epidemiological profile of the disease were homosexual activity and intravenous drug abuse. The incidence of disease at this stage was largely confined to white male homosexuals. The epidemic, while still including pattern 1, is now transmitted predominantly through heterosexual contact, occurs mostly in the black population, and is consequently defined in terms of global pattern 2 (Lachman, 1991). Blood transfusion accounts for 2.6% of South African AIDS cases - at as September, 1992, there had been 22 documented instances of transmission through this source (ATIC, personal communication, January 7, 1993).

The situation in South Africa is compounded by a number of social and economic factors intrinsic to the society. These factors clearly serve to enhance the impact of HIV infection. Such factors include: Rapid urbanisation giving rise to inadequate housing facilities and poverty whereby disadvantaged groups are disproportionately affected by STDs and HIV/AIDS; the migrant labour system that separates families and causes a large preponderance of men in urban centres; the large number of high density single-sex dwellings, creating conditions conducive to prostitution and promiscuity; the large diversity of cultural groups; the fragmentary nature of curative and preventative health services; the inherent distrust of most of the population towards information aimed at prevention and education, with most sources lacking in credibility, in part because of the severe political tensions that exist in townships; and more recently the return of a large number of exiles from various Central African countries where the incidence of AIDS and HIV is very high (Ijsselmuiden et al., 1988). Joubert (in Van Niekerk, 1991) states that the characteristics and circumstances of the group in South Africa at most risk to HIV/AIDS are as follow: The people are predominantly black and demographically young; they have a low standard of education, occupational status and income levels; they live in poverty in urban or semi-urban townships, and for three generations have not been settled or established; they are highly and increasingly politicised; their daily lives have become disorganised, exposed to extreme disruption, crime and loss of life; they have low quality communal services; and their normative structures have broken down to a large extent: there is little security in their personal or communal living. These social circumstances are directly relevant to both the spread of HIV/AIDS and the techniques that are used to combat this spread. Educative

procedures such as safe sex techniques in general and the use of condoms in particular are unlikely to be very effective. A recent survey of black urban mothers in Lamontville, near Durban, revealed that not one of 122 were able to persuade their partners to use condoms (*E.P.Herald*, 8 November, 1991).

In the **Eastern Cape Province** of South Africa, HIV/AIDS is not as yet regarded by health care professionals as a major issue. In terms of the country's estimated 300 thousand HIV-positives by the end of 1991 this area contains a very small percentage. 261 new cases of AIDS - \pm 120 male and 140 female - were identified in this area for 1992: a 60% increase from 1991's 158 cases (*E.P.Herald*, 5 August, 1992), the cumulative total being 430 (ATIC, personal communication, 7 January, 1993). However, given the large rural communities in this area and the widespread poverty, it is probable that the incidence is in fact much higher, and likely to increase greatly. A general practitioner (GP) in New Brighton in the Port Elizabeth district has stated that "Practically all men abhor condoms...men are so dictatorial in every aspect of sexual behaviour that women have almost no chance of influencing their sexual partners" (Dewes, 1991, p. 4). This is true for most of Africa and sexual patterns in the Eastern Cape follow the same trends. Social conditions, as in the rest of the country, exacerbate the spread of the disease: some sources estimate a possible 175 000 HIV-positives in this area by the year 2000 (*E.P.Herald*, 17 August, 1992).

Figure Four: Cumulative AIDS Figures for the Eastern Cape: 1992

	M	F	TOTAL
BLACKS	157	241	398
WHITES	10		10
COLOUREDS	10	10	20
ASIANS		2	2

(ATIC, 1993: figures from December 1992)

Metaphorical understandings towards HIV/AIDS incorporated in the biomedical model are based in part upon the above physical patterns of the disease. The problems and needs of the disease and its sufferers, as well as the potential sufferers - the groups practising high risk activities - are approached and dealt with in terms of these metaphors. As HIV/AIDS is not purely a medical disease, but indeed has many social implications, a large number of social and personal metaphors are developed by individuals to understand and cope with the disease. A discussion of the social strategies towards the disease, and its social metaphors, follows.

1.4: The Social Dimensions of the HIV/AIDS Disease

1.4.1 Social Strategies concerning HIV/AIDS

The Acquired Immune Deficiency Syndrome (AIDS) is recognised by the World Health Organisation, the American Academy of Sciences and public health services as being the most serious infectious disease of modern times (US Department of Health & Human Sciences, cit. Kelly, St. Lawrence, Hood. & Brasfield, 1989). "AIDS is here to stay...the world has changed and will never be the same again" stated the chairperson of the Commission on HIV/AIDS initiated by the US Congress, J. Osborn (1988, p. 444). This statement carries with it an recognition of the magnitude of HIV/AIDS as a global problem and the impact that it will have on health services worldwide. The new perspectives on this disease are recognising the economic, cultural and social implications of this disease, and the fact that it has developed into an issue beyond the scope of a purely biomedical problem.

Most individuals, populations and governments have not yet, however, reached these levels of understanding. In the past decade the world's official response to HIV/AIDS has moved from initial apathy, through denial and stigmatization, to what may be described as a global panic response. This process of reaction has been clearly delineated by Lachman (1991), who outlines four "phases" of response to the disease. The first phase of the HIV/AIDS phenomenon, the *silent phase*, refers to the mid-1970s, when the HIV virus spread unnoticed to five continents. 1981-1985 is termed the *phase of discovery*. During this time the causative agent was discovered and statistics of incidence, prevalence and spread were assembled. This phase was marked by much uncertainty, giving rise to irrational understandings and actions with regard to origin, measures of control, and prevention of the disease. The scientific community, the media, and especially government and social organizations of the USA have been greatly criticised for their passive stance during this period. Certain authors (*vide* Shilts, 1987) still maintain that the full impact of the disease could have been retarded - in America, at least - had existing resources been mobilised at this early stage. Between 1986 and 1988 the third phase, that of *global mobilization*, evolved. Around this time the WHO developed the "Global AIDS Strategy". Established in 1985, and revised in 1987, the principal objectives of this draft were: (i) prevention of HIV infection; (ii) reduction of the personal and social impact of HIV infection, and (iii) unifying national and international efforts against HIV/AIDS. The 1990s constitute the fourth phase of the HIV/AIDS phenomenon, the phase of *prevention and mollification*, with attempts to implement

these processes on a global scale. The sixth International AIDS Conference, titled "AIDS in the 1990s: From Science to Policy", reflected this goal.

Dr Jonathan Mann, former director of the World Health Organization Global programme on HIV/AIDS, has been credited with dividing the HIV/AIDS pandemic into three successive waves: first, a wave of HIV infection; then the epidemic of the disease itself; and now a third wave which may be called the epidemic of economic, social, political and cultural reaction and response to HIV/AIDS (Earickson, 1990). This third wave corresponds to Lachman's fourth phase in which an acknowledgement of the reality of this disease has given rise to efforts aimed at creating an organised international response to the crisis. An example of this endeavour is the recent call of "Health for All by the year 2000" by the WHO, in an attempt to encourage individuals, communities, and governments into uniting their resources on an international level against this epidemic.

In accordance with these perspectives, W.P. Von Wartburg; A. Matter, & H. Schmid (1989) propose that future intervention strategies should be considered under five headings, in order of priority:

- i. Information/Prevention. This should involve the complex process of diffusion, which can be explained as "the communication of attitudes as well as information in modifying behaviour to prevent disease transmission".
- ii. Specific research on the virus.
- iii. Containment of the epidemic.
- iv. Assurance of medical care.
- v. Promotion of social understanding.

This above list of strategies shows a recent shift in emphasis in reflecting the importance of prevention over cure: the social dimension taking over from the Biomedical . B. Hulley and N. Hearst indicate that HIV/AIDS is a preventable disease, in that it is not in fact not very contagious and is spread through behavioural patterns which can be modified (cit. Mays et al., 1989). Although scientific research has provided an enormous and valuable pool of biological and epidemiological data in the last decade, the difficulties presented to scientists who are trying to develop a vaccine for HIV/AIDS remain immense. The mutable nature of the virus makes it difficult to create an effective vaccine. In fact there are very few examples of successful vaccines against retrovirus (Earickson, 1990). In the light of these difficulties, a *Lancet* editorial states that "The only major preventative strategy is an aggressive, continuing health education programme aimed at possible alteration of human behaviour. This should bear in mind the rights of the individual and the protection of the public" (1985, p.

1103). Transmission of HIV takes place through the exchange of certain body fluids under specific conditions that are potentially preventable or controllable through education and modification of behaviour. HIV/AIDS, therefore, unlike earlier epidemics, is a disease in which Medical Science has been rapidly able to identify that the malignant agent can be kept from spreading by specific behavioural changes (Albee, in Mays et al., 1989). Osborn (1988) elaborates on this point-of-view:

The virus is an awesome enemy, but it is not unbeatable, for it is not contagious like influenza or measles or polio, which spread by uncontrollable environmental means. Indeed, therein lies the only good news, for it is strictly dependent on intimate, consensual human activities for its transmission. That behavioural aspect of its propagation makes avoidance a feasible strategy and cessation of the epidemic a real possibility. The behaviours at issue...are so intractable and/or fundamental to human society, and so overlaid with totem and taboo, that the task of education and behaviour modification appears overwhelming. But we must undertake the task regardless (p. 445).

Strategies of education and modification of behaviours, therefore, rather than purely medical intervention, are the most constructive approaches to the prevention of HIV/AIDS. Education (and consequent behaviour modification) about high risk sexual activities and about the use of clean needles and techniques for sterilizing needles and injection paraphernalia will reduce or eliminate high risk unprotected sexual encounters and transmission between intravenous drug users (IVDUs), and thereby also reduce the infection of intravenous drug users' sexual partners, and many of the children born within this particular social group (Albee, in Mays et al., 1989). Recently health education programmes have been designed to incorporate behaviour modification: the use of condoms, safer sexual and drug use practices. However, devising effective education programmes that will lead to behaviour change in these communities is a sensitive and highly complex matter. As Brandt (1985) states:

If anything has become clear in the course of the Twentieth Century, it is that behaviour is subject to complex forces, internal psychologies and external pressures, all of which are not subject to immediate modification at all. Sexuality is subject to a number of powerful influences, social and economic, conscious and unconscious, many more powerful than even the fear of disease (p. 202).

A clear example of the difficulties in achieving effective long-term behaviour change is shown by a study undertaken in Amsterdam, Holland. A recent relapse into high risk sexual behaviour amongst attenders at a Sexually Transmitted Diseases clinic in this city has followed an initial improvement in precautionary behaviour since the early years of the HIV epidemic (Van der Hoek in *Lancet*, 1990). Similarly, a postal questionnaire to 691 homosexually active men (261 in

London and 430 in nine other cities) has elicited the same information (Hunt, Davies, & Weatherburn, 1991). 'Safer sex' practices have been abandoned with the resumption of high risk sexual activity.

In some communities, behavioural change has occurred on the basis of attitudinal change and personal experience, frequently caused by the death of relatives and close friends - an instance of this is the homosexual population in America (Hunt et al., 1991). However, most other groups exhibit less motivation to modify their behaviours because of perceived lower risk and/or lack of information - this would appear to be the case with general heterosexual communities all over the world. Research in this area has concluded that in order to be effective, education must be geared to specific behaviours, and that broad goals and abstractions are not so easily related to actual behaviour (Kirscht & Joseph, Fishbein & Middlestadt, & Bandura cit. Mays et al., 1989). Self-directed change is often a function of perception of risk; psychological assessment of costs and benefits; underlying beliefs about the efficacy of change, and the network of relations among beliefs, attitudes, intention and behaviour change (Fishbein & Ajzen, 1975). This has strong implications for education within a health prevention programme.

Third world countries have shown a varied response to educative efforts. In Tanzania the popular translation of AIDS is "Adia In'ue Dogedego Siachi", a Kiswaluli phrase meaning "Let it kill me as I will never abandon the young women", and similarly in South Africa it is popularly known as "American Idea to Discourage Sex" (Crewe, 1992). Tribal customs and traditions in the third world support certain behaviours such as circumcision, polygamy, the system of concubines, and other potentially high risk activities. In Africa the use of condoms, previously associated with contraception, carries heavy connotations relating to colonial efforts to control the population growth. The resistance to condoms demonstrated in Rwanda has been examined by C.C. Taylor (1990) who explains that this negative attitude is deeply rooted within a cosmological matrix which emphasises the socially-ordered flow of fertility fluids. These examples show that a concerted, culturally sensitive, and ethically sophisticated worldwide educational effort is required to modify risk behaviours.

However, it is clear that the operationalisation of these goals presents serious difficulties which jeopardise effective design and implementation of prevention programmes. Implicit in both Mann's and Lachman's breakdown of the progress of the disease is the strong social impact and emphasis it has received. Even the

intervention and preventative programmes recently developed show a strong bias in terms of common social perspectives and beliefs with regard to disease in general and HIV/AIDS in particular. Earickson (1990) in his essay "International behavioural responses to a health hazard: AIDS" claims that a so-called concerted global effort to manage this disease resembles the human response to natural and technological disasters. The result is a self-interested, piecemeal and inconsistent approach by various nations to contain or deflect the disease such that it has minimum economic or political impact on these nations. The fact that many countries - contrary to WHO recommendations - have recently begun to consider travel restrictions against infected foreigners, mandatory testing for immigrants, and expulsion of HIV-positive foreign students, supports this view.

1.4.2 Symbolic Interpretations of HIV/AIDS

The study of metaphor, focusing on its role in everyday behaviour and experiences, reveals that it is not merely a linguistic phenomenon but also structures perceptual and conceptual systems and directs individual and group action: the individual understands concepts through metaphor. Symbolic meanings and metaphors are fundamental to society's interpretations, perceptions and definitions of a disease. Cross-cultural studies of illness and health show that the complex processes involved in perceiving, interpreting, defining and reacting to these phenomena are understood within a social framework of metaphorical meaning used by individuals to make sense of these phenomena (Good & Good, cit. Montagne, 1988). An example of this is the societal understanding of HIV/AIDS, with the many myths and metaphors which have arisen to circumscribe and explain the disease. Some of these metaphors have been examined by Susan Sontag in her book *AIDS and its Metaphors* (1988) in which she shows how HIV/AIDS has been interpreted through a variety of metaphors, most of which are pejorative, "AIDS has a dual metaphoric genealogy. As a micro-process, it is described as an invasion. When the focus is transmission of the disease, an older metaphor is invoked: pollution" (p. 17).

The death toll from AIDS, especially in the beginning of the epidemic, was high - at any one stage at least half the number of cases reported had died. The disease therefore caused great fear amongst the public - a fear exacerbated by the media sensationalism. Unlike some other major diseases - for instance, tuberculosis in the 19th Century - HIV/AIDS does not allow for romanticising or sentimentalising, perhaps because its association with death is too strong (Sontag, 1988, p. 24). With no cure, no vaccine, and a rapid rate of infection, HIV/AIDS was seen in terms of a very contagious, very dangerous, indiscriminate

and silent killer. "AIDS is incurable and uniformly fatal, striking in the prime years of life with a lingering illness after a lengthy silent incubation period during which it is insidiously contagious" (Hulley & Hearst, cit. Mays, 1989, p. 54). Diseases of exceptional virulence are frequently given the metaphor of "plague": a term long used for the highest standard of collective calamity, evil and scourge. Sontag points out that the "plague" is the principal metaphor by which the HIV/AIDS epidemic is understood. Typical of the plague is that the disease comes from "somewhere else", or "someone else". This point is exemplified historically through the reactions to the syphilis epidemic that occurred in Europe in the late fifteenth century. The disease was known as the "French pox" to the English, "*Morbus Germanicus*" to the French, the "Naples sickness" to the Florentines, and the "Chinese disease" to the Japanese. A tendency towards ethnocentrism is a phenomenon that is common to most cultural groups, and they accordingly develop metaphors which distance their own vulnerability to and involvement in a disease. HIV/AIDS is generally understood as a tropical disease, yet another infestation from the "Dark Continent". Many African academics, politicians and members of this broader population have constructed their own metaphors, believing that the virus was sent to Africa from the USA as an act of bacteriological warfare. In South Africa this phenomenon of ethnocentricity is evident in the way various cultural groups perceive the disease to be a product of racial aggression: many Black South Africans believe the disease to be an American product of biological warfare. Crewe cites from the *Drum* magazine: "...all of a sudden, here comes this virus with a propensity for Black people...at the very least, you have to be suspicious" (1992, p. 10). Sontag states that much of the speculation about the geographical origin of HIV/AIDS is the product of stereotyped racist beliefs and myths. The subliminal connection made between notions about a primitive past and the many hypotheses that exist about the possible transmission from animals (such as Green monkey Disease, or African swine Fever) all contribute to a familiar set of stereotypes about animality, sexual licence, and blacks (Sontag, 1988). In South Africa the racial and religious stereotypes are clearly displayed: the Whites tend to regard the disease as a form of population control; the Blacks regard it as either a White myth or a product of Biological Warfare from America, and the Muslim community sees it as a judgement from God, condemning immoral behaviour.

Ignorance about the risk involved for each individual and the inability of Medical science to concur over risk factors enhanced the public's fear of the disease. This fear and ignorance, together with governmental lack of interest, and the physical nature of this disease, encouraged the general population to

perceive HIV/AIDS in discriminatory and stigmatising terms. The sociologist Erving Goffman (cit. Brandt, 1985) has outlined these metaphors of stigmatisation. The first type of stigma, an abomination of the body, emerges clearly in the physical disfigurements of AIDS sufferers, highlighted by media pictorial coverage. Sontag echoes this view in stating that commonly the diseases which have aroused most fear are those which are not only fatal but also disfiguring or 'dehumanising'. "Underlying some of the moral judgements attached to disease are aesthetic judgements about the beautiful and the ugly, the clean and the unclean, the familiar and the alien or uncanny" (1988, p. 41). HIV/AIDS was seen as striking at socially aberrant behaviour: the result of deviancy. Deviant behaviour is commonly understood as a lack of control - Goffman's second type of stigma. The public conception of HIV/AIDS emphasises the promiscuous and immoral behaviour of those at most risk - homosexuals or drug abusers especially. The development of HIV/AIDS amongst certain ethnic groups - the Hispanics and the negroes in America, the indigenous populations of third world countries - encouraged public perceptions of HIV/AIDS as a racially and culturally defined disease, giving rise to Goffman's third type of stigmatisation, on racial and religious grounds. In an attempt to "control" the disease and understand the suffering it causes, various metaphors have been developed to explain it. It has been described as God's Judgement on deviant (especially sexually promiscuous) behaviour: the victims "got what they deserved". HIV/AIDS is seen within a moralistic framework based on its transmission through promiscuity. Alternatively it is perceived as a means of thinning out overpopulation. Typically of such metaphors, the disease is understood purely in terms of happening to "them" - third world, or deviant populations.

Goffman's first form of stigma is apparent in the tendency to merge AIDS and HIV as meaning the same thing - a swift and unpleasant death - but as Sontag (1988) points out, HIV positivity is not a disease, and does not lead immediately to AIDS. The fact that an infected individual can live for years is not a concept the general public recognises; infection with the virus immediately creates of the sufferer an "alien", whatever his/her actual health. This view is derived from and exacerbated by the means of contraction and the groups most affected. As Sontag points out, to be diagnosed HIV-positive "is precisely to be revealed, in the majority of cases so far, as a member of a certain 'risk group', a community of pariahs" (1988, p. 25). Western metaphorical meanings are strongly influenced by the perceived history of the disease: where it first occurred, which groups of individuals are most affected, and the general nature of the disease. These social facts can be distorted to concur with pre-existing value-

judgements, and this has happened in the case of HIV/AIDS. HIV/AIDS was first noted in homosexuals and IVDUs, then in the indigenous groups of the third world. The disease has been irredeemably linked to "casual spread" and immoral behaviour, particularly as most of the sufferers are from deviant groups. In America it is typically the Blacks and Hispanics, homosexuals and IVDUs who are most affected. In Africa it is the poor and marginalised sector of the community - again Blacks - who are most at risk.

The lack of concern or action on the part of governments, and the apparently group-limited risk, has confirmed a complacent and judgemental attitude on the part of society, or alternatively an attitude of denial and apathy. Inaccurate knowledge of figures and "Doomsday" prophecies have encouraged the general perception that HIV/AIDS is an insurmountable problem, a view which K. Edelston encouraged in his book *Countdown to Doomsday* (1988). The population at threat - the lowest socio-economic groups - see HIV/AIDS as yet another ploy by colonial or western powers to interfere with their way of life; as yet another form of discrimination. These attitudes, in fact, form part of Mann's "Third Wave" of the progress of HIV/AIDS: the epidemic of economic, social, political and cultural reaction (Earickson, 1990). The emphasis that the media has given to HIV/AIDS as a purely marginalised group problem has encouraged such negative attitudes.

1.4.3 Social & Media Response to HIV/AIDS

Societies in both western and third world countries have reacted to HIV/AIDS through a process of denial, isolation, discrimination and stigmatization, around which responses a strong element of myth and metaphor have been developed (Crewe, 1992). This is reflected in legislative and educational attempts, aiming to control and manage the problem, which often reveal thinly disguised prejudices about race, religion, social class, sexual practises and nationality; in the roles defined for health care workers, and in media and social responses to the disease and its sufferers. Economic and political motives contribute to and support this scenario. In Sontag's words, "A whole politics of 'the will' - of intolerance, of paranoia, of fear of political weakness - has fastened on this disease" (1988, p. 63). These attitudes of denial, stigmatisation and moral judgement on the part of western society in particular derive from the metaphors created to understand disease, HIV/AIDS and deviant behaviours or marginalised groups.

The media has been a powerful force in reflecting and influencing society's perceptions of the HIV/AIDS epidemic. The Sapir-Whorf hypothesis states that words inform meaning: "the nature of the words used to describe events has a powerful influence upon how those events are understood" (DiMatteo & DiNicola, 1982, p. 7). The terminology of the media has aroused a strong response in the general public. Crewe (1992) points out that a common term applied to HIV/AIDS is "killer disease". This term is an anthropomorphism, making the disease into an aggressive actor, not a passive circumstance. Further examples of such a process of animation are cited by Sontag: "'AIDS Virus Found to Hide in Cells, Eluding Detection by Normal Tests' - front page story of the *New York Times*" (1988, p. 19). Terms such as "the gay plague" and "Doomsday forecasts" increase negative public reaction. The disease and its economic consequences have been sensationalised, and the physical conditions of its sufferers frequently depicted. The media has emphasised the deviancies implicit in the sufferers of this disease; as such terms as the "Gay Plague", or the African Plague, indicate.

The number of books which have come out, either refuting or claiming to be based upon medical knowledge, have increased the problem. Recent publications claiming that in America, heterosexual HIV/AIDS is a "myth", have misinformed the public and elicited a dangerously complacent response. Similarly Masters, Kolodny and Johnson in their book *CRISIS: Heterosexual Behaviour in the Age of AIDS*, in which they emphasised the concept of casual spread, caused a major public panic when it appeared in America in 1988.

With the numerous comments on the chances of catching HIV/AIDS through kissing, mosquitoes, tears, and other casual means, the media has increased public paranoia. The invariably fatal nature of the disease is constantly emphasised, and any person HIV-positive was seen as extremely sick and shortly to die. "The fears of the public have been fanned through irresponsible media coverage both written and spoken, on radio and on television" (Lachman, 1991, p. 307). The lack of concrete facts and conflicting and contradictory reports made by various sections of the media has encouraged a "mystical" form of explanation to be adopted: the vagueness with which the disease and its risks are discussed in the media has encouraged religious or naturalistic explanations by the public. The "Doomsday prophecies" have encouraged this metaphorical view of HIV/AIDS as Nature's way of decreasing overpopulation. In fact these figures exaggerate the problem: HIV/AIDS would have to claim 18 million lives a year to neutralise the projected annual growth rate (3%) of the African population (*Africa Institute Bulletin*, 1988).

Such coverage has been described by many critics, including M. Padayachee and R. Schall in *South African Medical Journal* (1990), as "inopportune". These perspectives detract from the real purpose of informing the public about means of prevention of HIV infection that the individual can make use of through a modification of personal behaviour. Overly sensational media coverage has caused disbelief or apathy in general society and amongst the original high risk groups especially. People have been led to see the disease as either a huge hoax or as an act of fate which they cannot avoid.

SECTION TWO: THE BIOMEDICAL MODEL

2.1: The Biomedical Model as a Dominant Symbolic Framework for Interpreting and Managing Disease

A major influence on medical practitioners and their interpretations of their professional identity, in fact the dominant framework in which their activities are undertaken, is the biomedical model. This model explains and delineates the understanding and treatment of disease and illness. It outlines the role of the medical practitioner and of the patient, and determines the means and modes of disease, infection, and treatment. This model itself is based on metaphorical understandings of disease and the individual person.

2.1.1 Historical Overview

Modern medicine as it exists today has evolved out of certain influences which, over time, have emerged to form a dominant philosophy. These influences include medicine as a science, the social and religious orientations of the day, humanity's struggle to master the environment and the biological adaptation of the human body (Wolinsky, 1988).

The earliest western philosophical orientation to health is contained in the mythology surrounding the Greek goddess Hygeia. Hygeian philosophy and its followers believed that, in the natural order of things, health was a positive attribute to which men were entitled, provided they governed their lives wisely. In terms of this understanding the fundamental function of medicine was to discover and then teach the natural laws ensuring a healthy mind and a healthy body (i.e. a preventative and maintenance orientated philosophy). This philosophy recognising the relationship between the mind and body was dominant until the twelfth century B.C. The cult of Asclepius succeeded the Hygeian view of health. According to legend Asclepius was the first Greek physician. In contrast to Hygeia, Asclepius represented mastery in the use of surgery and knowledge of the curative power of plants in restoring the physical body to its original state of health. The primary role of the physician was to treat the physical disease, and by so doing to restore health (i.e. a corrective or interventionist philosophy). The restoration of health was accomplished by correcting the imperfections in the human body that were caused by accidents of birth or life. This orientation became the dominant model and remained in use for centuries. Another important figure with regard to the evolution of modern medicine was Hippocrates, a Greek physician who lived in the fifth century B.C., best known for the Hippocratic oath which exists as the cornerstone of contemporary medical

ethics. Hippocrates was also important for two other contributions. Firstly, he demanded a rational, systematic approach to patient care, rejecting the effects of supernatural phenomena. He encouraged the use of scientific medicine, rather than one that appealed to the supernatural. Secondly, he maintained that the mind and body affect each other and cannot be considered as independent entities. Treatment involved the whole person and it was necessary to consider the effects of the social environment on illness. This understanding of medicine and health was guided by a scientific and holistic medical philosophy, rather than Asclepius's purely physical philosophy (Wolinsky, 1988).

With the collapse of the Roman empire, and the ensuing dark ages, much of what was achieved during Hippocrates's time was lost. The Church assumed responsibility for social and spiritual problems and medicine was relegated to considering only the problems of the physical body. The whole person approach came to an end. The distinction drawn between mind and body increased and became firmly emphasised when Descartes and a group of seventeenth-century rationalist philosophers argued that the mind-body dichotomy did definitely exist. Descartes's philosophy stated that medicine should concentrate its efforts on the physical functioning of the body - the mind was to be the province of God. The influence of Isaac Newton and his scientific philosophies had a large impact on understandings of medical science and disease. The individual was seen as part of a scientifically ordered and rule-governed universe. Human rationality was explained as working on the same mechanical principles: the human body and social existence were seen as explicable and controllable through these same scientific laws. Medicine was defined as a "natural science" (Van Niekerk, 1991), and all problems relating to the human body were seen in purely physical terms. As in Descartes' understanding of man, the religious and ethical domains of existence were relegated to a non-scientific and therefore non-essential sphere. The concept of control was central to the sciences, and the idea that medicine could ultimately "solve" all the body's problems through physical processes arose in this period (Wolinsky, 1988).

During the industrial revolution some advances were made in the direction of public health. A focus on community, rather than purely individual health, was implicit in this development. This influenced regulations on public hygiene, thereby improving the management of many epidemics (Wolinsky, 1988). However, during the 1800s - the Age of Enlightenment - medicine, influenced by the Rationalist approaches of Newton's scientific universe, once again became more concerned with technological advancement rather than with social reform (Van

Niekerk, 1991). The pioneering work of Louis Pasteur, Robert Koch and others, provided a foundation for progress in bacteriological research (Brandt, 1985).

This research resulted in the establishment of a germ theory of disease and was accompanied by significant advances in clinical medicine, especially anaesthesiology, pathology, immunology and surgery. Bernard Dixon in *Beyond the Magic Bullet* (1978) refers to this movement as the development of the theory of specific aetiology - the notion that particular diseases have particular causes. Dixon states that medicine in fact has two tasks: to comfort, and to heal. However, since the influence of Hippocrates there has been a gradual movement towards the notion of specificity in medicine (either internal or external). This involves the idea that particular agents cause particular illnesses. Twentieth century medicine has consequently become distinctly scientifically orientated, placing the emphasis on healing rather than on comfort. The sheer volume of relevant scientific material has created significant rift between the technological aspects of medicine and the actual care of the patient (DiMatteo & DiNicola, 1982). Dixon explains that specific aetiology developed strong credibility with the discovery of germs a century ago.

2.1.2 The Biomedical Model

Modern medicine is committed to a belief that all bodily events have specific physical causes, and that disease is purely a biological phenomenon in which non-material factors play little if any role. This view of medicine has become known as the biomedical model, or simply as biomedicine (Engel, 1977, p. 196).

The basic premise of the germ theory is that for every disease there is a specific pathogenic cause or causes. The most effective way of treating disease was to remove or control its cause within a biomedical framework. A natural consequence of the germ theory model was the concept of reductionism. Medical practitioners adopted a scientific fragmentation approach whereby the patient and the diseased organ were often seen as separate. The metaphorical description of practitioners as mechanics working on an engine has its roots in this era (Wolinsky, 1988).

Deriving from this perception of disease, disease intervention and the ill individual as physical objects, is what has been termed the "military metaphor", which perceives illness as an invasive foreign agent attacking the body. It is through this metaphor that the biomedical model's conceptualization of disease is structured, and the professional identity of practitioners is largely based upon this metaphor. This metaphor regards illness and disease as a function of

physical organisms: the invasive morbidic "germ" which must be countered through physical intervention strategies. This metaphor divorces the individual sufferer of disease from his/her situational context and the influences this context has on his/her wellbeing. Factors such as environment, psychological state, and economic circumstances are not recognised by society or western medicine as having any impact on the individual's health - instead the body alone becomes a combat zone between invading forces and the body's defence system, frequently backed up by interventive strategies such as drugs. (Sontag, 1988).

The germ theory and resultant military metaphor determined a view of medicine, which has come to dominate medical science, involving what Dubos (1959) referred to as "magic bullets" - that is, drug therapy - used to "shoot down and kill" the disease. This view is fundamental to medical practise, as is evident in the extensive use of pharmaceuticals in treatment by modern practitioners. This form of intervention arises out the perception of the patient as a static physical entity whose immune system is not able to cope with the morbidic agent, and who therefore has to be physically helped.

So successful has the effect of various antibiotics been that medical practitioners, patients, scientists and planners alike have failed to recognise the limitations of the theory of specific aetiology and its application. When specific aetiology is applied to such diseases as coronary heart disease, cancer, and much mental illness, however, it loses much of its explanatory power and potency. Dixon points out that it is necessary to look beyond the "magic bullet" and explore the effects on health that derive from external influences such as the geographical environment, diet, and lifestyle. However, as Gerhardt (1989) points out, "The medical model...establishes disease as a seemingly culture-free entity within the individual" (p. 83). The biomedical model views the patient as a biological organism distinct from, and in isolation to, the mind and thus from the universe of meaning that constitutes the whole person. In the context of modern medicine, a disease can only be understood if its mechanisms at a subcellular level have been elucidated. Physiology and cellular pathology thus become the foundation sciences and molecular biology becomes the ultimate level of explanation regarding the body and its diseases.

Biomedicine therefore construes disease as something that is wrong with an organ of the body, assuming that that which has gone wrong can be explained in physical terms. The cause of illness is either the presence of an imbalance in physical substance, or the presence of a harmful physical agent (Foss & Rothenberg, 1988).

Appropriate therapy is therefore also physical intervention (chemical, surgical, radiation and the like). This sort of intervention compensates for a recognised surplus or deficiency, or will counter the action of a harmful agent.

In the early 1900s there was a strong move to return to a conception of medicine and health involving the whole person. The WHO provided strong motivation for the establishment of this view. They identified three major levels on which health should be addressed: these included a physiological, a psychological and a social dimension. Dubos (1959) not only recognises these three dimensions of health, but takes the WHO's argument one step further and proposes that health means constant adaptation to ongoing and ever-changing biological and social environments. This new philosophy of medicine and health maintains that treatment must re-direct its focus from the physiological pathology of a patient more towards the whole person: this may include family members and significant others. Although there is some indication of a move in the direction of a whole-person approach, this new trend is still in its infancy (Wolinsky, 1988).

2.2: Biomedicine & HIV/AIDS

2.2.1 The Medical Practitioner's Role

The biomedical model has very important implications for the role of the patient and of the medical practitioner: it is through the metaphorical framework of this model that these roles are determined. Medical sociology has postulated a number of theories explaining these roles: that of Parsons (1951, 1975) is perhaps the best known. While this theory has definite shortcomings it displays the basic framework delineated by the biomedical model for doctor-patient relationships. The theories of Ivan Illich suggest why the roles have been determined as they have. Illich is one of the major arbiters against the notion of contemporary medicine. In his book *Limits to Medicine* (1977) he outlines the process whereby a passive society has allowed the medical practitioner the exclusive right to determine what constitutes sickness, who is or might be sick, and what shall be done to such people. Health is no longer under the individuals' autonomous control (self-directed), it is governed, managed and maintained by an external heteronomous (other-directed) system - the biomedical model. The social commitment to provide all citizens with unlimited outputs from the medical system, according to Illich threatens to undermine the environmental and cultural conditions needed by people to live a life of constant autonomous healing: the biomedical model with its focus on the physical nature of disease and its strategies of control from within this framework does not concern itself - or

encourage its practitioners or, for that matter, its patients, to concern themselves - with the less scientific factors of psychological, environmental and communal influences on health.

Illness, according to Parsons, is an inability on the part of the individual to fulfil his/her functions in his/her social structure. In terms of society this is seen as involuntary deviant behaviour which the individual is expected to attempt to remedy. The expected means of remedy is for the individual to seek professional help as s/he is not able to remedy him/herself - the medical profession, as Illich points out, fulfils the role of curer and arbiter in this process, "Only doctors 'know' what constitutes sickness, who is sick, and what shall be done to the sick and to those whom they consider *at a special risk*" (1977, p. 55). Complementing the patient's duty to seek professional help is the doctor's obligation to be solely guided by the welfare of the patient. The patient is obliged by social mores to get well: the doctor is expected to apply the highest possible standards of technical competence and scientific knowledge (Gerhardt, 1989).

It is further expected that the sick individual will relegate responsibility to the medical practitioner and adopt a passive-dependant stance. The practitioner is "active" and in a position of authority. The sick role involves total co-operation with the practitioner who is in turn obliged to guide the patient to recovery. DiMatteo & DiNicola (1982) outline the Parsonian model further, "The professional role of practitioner demands technical competence, emotional neutrality, and a commitment to serving people" (p. 30). As most theorists point out, the doctor-patient relationship is based strongly on practitioner dominance (*vide* Gerhardt, 1989). The practitioner typically occupies the superordinate, and the patient the dependent, station. This is as a result of the practitioner's "expert command of an esoteric body of knowledge", creating what Parsons calls "the competence gap". "This 'competence gap' justifies the practitioner's social position as legitimate authority and professional" (DiMatteo & DiNicola, 1982, p. 30).

Freidson, cited in Gerhardt, maintains this point:

Expertise is not mere knowledge. It is the practice of knowledge, organised socially...The [practitioner] develops around his work an ideology and, with the best of intentions, an 'imperialism' that stresses the technical superiority of his work and his capacity to perform it (Gerhardt, 1989, p. 114).

As an individual's sickness is perceived as deviancy which is involuntary, society grants him/her certain privileges while s/he attempts to seek remedy, including a temporary abeyance of his/her ordinary role: it is important

therefore that the individual adopts a very recognizable and definite "sick role". Medicine becomes a social institution existing for the purpose of social control in that it ratifies the sick role and the practitioner's role (Dobraszczyc, 1989). The doctor-patient relationship is not a spontaneous form of social interaction, it is a well defined encounter based upon stable roles defined by the dominant theory of illness - in this case, the biomedical model (Cockerham, 1978). The general principles of the doctor-patient relationship as outlined by Parsons exist in a discernable structure. This structure, encompassing the doctor role and the patient role, is built upon expectations which are determined by the broader social contexts of the medical practitioner and the patient, including the dominant social perspective on illness and disease.

Illich states that "Diagnoses made by the physician can define either temporary or permanent roles for the patient. They add to a biophysical condition a social state created by presumably authoritative evaluation" (p. 97). The role of the practitioner has a great deal of social power implicit in it. The biomedical model, therefore, has had to determine the role of its medical practitioners very clearly and rigidly. This model, as has been indicated, has distinct goals and modes of conduct delineated for the medical practitioner. These guidelines on behaviour and perceptions include certain symbolic definitions and metaphors through which medical practices and concerns are understood. It is these goals and symbols which determine the role of the practitioner. The goal of medical practice originally comprised both interventive treatment for existing disease and prevention of future disease or ill health: the word "doctor" derives from the latin "docere", 'teach'. However, "in modern times the role of the doctor as teacher seems indeed to be almost totally outmoded" (DiMatteo & DiNicola, 1982, p. 38). DiMatteo and DiNicola cite a large number of cases indicating that practitioners spend very little time educating or explaining to their patients the meaning of illnesses and diseases. The reason they give for this is that practitioners are unwilling or unable to expend the necessary effort. This is in part because,

Patients fail to follow medical regimens at rates of 30-40 percent when the regimen is preventative...This 'preventative' noncompliance is the most problematic in terms of adherence because the required regimens extend into virtually every aspect of the patient's life (DiMatteo & DiNicola, 1982, p. 2).

The metaphorical understanding of the patient as a physical disease has emphasised the importance of the goal of cure: prevention has become a goal not of medicine but of other more sociological approaches (Sontag, 1988; DiMatteo & DiNicola, 1982).

The Medical Practitioner's Position in the Context of HIV/AIDS.

Most HIV/AIDS-related problems occur or are emphasised within the context of clinical medical practise. The ramifications of HIV/AIDS encompass the personal, social, legal, political, economic, moral and ethical dimensions of every society (Lachman, 1991). The biomedical model defines the role of the medical practitioner within strict legal and ethical parameters, particularly in the context of HIV/AIDS. The social and ethical issues surrounding the testing, screening, surveillance, control and treatment of persons infected with HIV, or persons with AIDS (PWAs), are becoming increasingly extensive and complex, concurrent to the growth of the epidemic. The social stigma attached to this disease, and its invariably fatal outcome, with the resulting fear and discrimination it has engendered, has affected the definition of the professional role in relation to disease and particularly in relation to patients.

Biomedical models of recommended practise in dealing with the problem of HIV tend to focus on the medical practitioner and his/her relationship to disease. The practitioner is seen in relation to HIV (rather than in relation to his/her patient). Precautionary measures are seen as protecting the practitioner; as many medical procedures involve the risk of body-fluid transmission in either direction, the patient is thus also protected. The patient and the disease are in many regards seen as separate entities. This view is further stressed by the nature of recommendations given to practitioners for handling HIV: the framework is very scientific, using a highly factual approach to precautionary procedures, the rights of the health care worker and various ethical issues such as confidentiality, patient consent, and forms of treatment.

Ethical Issues.

The College of Medicine of South Africa (CMSA) emphasises that all groups are potential high risk: a medical practitioner is neither safe nor justified in labelling only selected parts of the population as being risky. The biomedical approach defines strict procedures with regard to precautionary measures. It is the practitioner's responsibility to adopt suitable precautionary measures in the case of known infection, and all emergency patients whose status is unknown should be treated as high risk. Health care workers have a responsibility to treat all patients: they may not refuse to treat possible HIV-positive patients, and they should ensure that appropriate treatment is given to known HIV-positives and at the same time try to prevent transmission of the virus (Crewe, 1992).

There are a number of ethical concerns facing the practitioner within the context of the biomedical model. The College of Medicine has recently raised the following in a policy statement:

A health care worker's rights in gaining consent for blood tests to be undertaken: a medical practitioner has at present no right to enforce the HIV test on any patient, nor may s/he refuse to treat the patient on the grounds that the patient presents a risk or potential risk. Treatment should be conservative, rather than invasive or surgical, so as to protect the health care worker, and the patient should be treated as high risk.

The practitioner is within his/her rights to divulge the patient's HIV status to members of the patient's family. This may be done with or without the patient's consent, though if consent is not gained, the practitioner must be prepared to accept full responsibility for the disclosure.

It is recommended that the HIV status of all patients be known before surgery or intervention, as this fact has an influence not only on the wellbeing of the practitioner, but also on the kind of treatment to be implemented. Surgical techniques should be modified to minimise the risk of transmission and staff in this situation must also be kept to a minimum. Medicinal treatment will be affected by HIV-positivity, and the practitioner should take this into account in treating an HIV patient and re-assess indications for surgery or other interventional procedures.

Health care workers must be very aware of the risk they are faced with and should have an annual HIV antibody test. If they know they have been exposed to the virus they should immediately take prophylactic precautions (such as AZT) and should have themselves tested at six weeks, 12 weeks and six months (CMSA, 1991).

Precautions.

The Medical institution has defined a set of precautions to minimise the risk of health care workers (it is impossible to ensure total safety). These are:

Wearing protective clothing such as gloves and masks;

Maintaining very high levels of hygiene;

Cautious surgical procedures, with as few staff and instruments as possible;

Sharp instruments and needles should be very carefully handled, and kept to a minimum;

All specimens should be carefully packaged in leakproof containers;

Mouthpieces and other instruments to aid mouth-to-mouth resuscitation should be readily available; and

All instruments and paraphernalia should be thoroughly sterilised with heat treatment and liquid disinfectant.

(CMSA, 1991 and Crewe, 1992).

Treatment.

Current procedures for HIV infection rely upon diagnosis, treatment and, whenever possible, prophylaxis of opportunistic infections. Lange in *Medical Chronicle* (1991) states that in the absence of a vaccine for HIV, the options available to medical practitioners include the prevention of transmission and treatment of HIV-related secondary disease. The emphasis is primarily on the individual who is already infected. In keeping with the curative goal the target therefore is a physical one concerning the immunological and virological status of the patient.

Recent medical literature outlines a number of strategies for the treatment and handling of HIV. As an important starting point to the overall management of HIV infection, medical practitioners are advised to acquire a thorough knowledge of the HIV infected patient's medical history, before making a physical examination of the patient tailored to cover known HIV-related problems. Laboratory tests to establish baseline parameters and immunological status should be carried out at the initial consultation and regularly thereafter. Practitioners are informed that many opportunistic infections and HIV-related symptoms respond to standard treatments and that simple remedies such as emollients for dry skin and adequate nutrition and hydration in patients with diarrhoea can be a part of treatment. Zidovudine (AZT) therapy has been shown to delay disease progression significantly by improving immunological parameters in patients with ARC and AIDS, and reducing the frequency of opportunistic infections. Early detection and treatment of ARC is of particular importance given the improved effectiveness of AZT and its inhibitory effects, and the greater effectiveness of most interventive strategies, in the early stages. Practitioners must therefore be able to diagnose the clinical signs and symptoms of seropositivity in its initial stages.

Medical practitioners are also advised to counsel patients thoroughly prior to initiating drug therapy, explaining the physical process of the treatment. Careful monitoring of the patient's physical and psychological state is necessary once treatment has begun and practitioners should be alert at all times for the signs and symptoms of major medical problems. An overall assessment of the patient should include, in addition to an evaluation of past or current psychiatric disorders and neurological disorders, a determination of psychological distress level, available coping strategies, suicide potential, and a brief mental status examination. A permanent record of useful information and facts must be supplied to the patient with regard to tests, symptoms and

treatments. Advice about safe sex should not be overlooked and patients should be given easy access to or supplied with condoms to encourage safe-sex practises. HIV management is seen as a collaborative approach calling upon the skills of several different members of the health care team. Practitioners must be prepared to handle a range of AIDS emergencies in the future ranging from medical problems such as respiratory distress to psychological problems.

2.2.2 The Biomedical Model and its Influence on Society

The biomedical position has been widely criticised in recent years; the basic principles of this orientation are, however, so firmly entrenched in western culture that it remains the dominant model for illness. Society has become conditioned to believe that the medical practitioner alone knows the cause for their illness, and that some form of technological intervention is the only solution (Capra, 1982). The biomedical model determines society's perceptions on what constitutes and causes illness and disease, and how disease should be treated and controlled. In accordance with these understandings, biomedicine has determined the roles for medical practitioners and for patients and defined distinct boundaries and conditions of behaviour and action within these roles.

As Kleinman states, "The health care system includes people's beliefs (largely tacit and unaware of the system as a whole) and patterns of behaviour. Those beliefs and patterns are governed by cultural rules" (1980, p. 27). Medicine is therefore a cultural system of symbolic meanings based on patterns of social institutions and interpersonal interactions. These symbolic meanings are evolved by the society and relate to beliefs about illness, health, treatment, and interpersonal roles and power relations. The tenets of the biomedical model are themselves cultural beliefs about illness and intervention (*ibid*). This symbolic system gives a great deal of power to its metaphors.

With regard to HIV/AIDS, the cause of this disease is seen exclusively within a biological framework, the physical causative agent being HIV. Consequently most research to date has aimed at elucidating the physical mechanisms of infection and disease causation, thereby placing the emphasis on the biological aspects of prevention and cure. In the medical setting the means of transmission are regarded purely in physical terms; the social aspects of risk behaviours are irrelevant. These behaviours are understood as risk factors and are not considered to be part of the disease itself. Medical science has a very specific understanding of the term "disease", deriving from the biomedical model: this understanding directly influences both the professional medical response to

disease, and social perceptions of disease and its causes. Because disease is generally understood in terms of a contemporary medical scientific definition, the correct response towards the HIV/AIDS epidemic is seen as a medical response. Society regards HIV/AIDS, therefore, as being under the jurisdiction of the medical profession: the opinions and attitudes of this profession in the context of the disease guide the perceptions and beliefs of the general public, in terms of both contagion, and treatment and prognosis (Sontag, 1988; Illich, 1977).

2.2.3 Limitations of the Biomedical Model

Medical Science as it exists today is a result of the interplay amongst various historical influences. Carlson (1975) states that because of these influences there exist four dualities in modern medicine. The first duality concerns the simultaneous reliance on "magic" and science. This is a duality that has always existed in medicine, as is evident through various practises in the past that were based on the assumption that illness is caused by the presence of supernatural elements in the body. This mixture of scientific techniques and the supernatural or inexplicable still exists today, as is clear from strongly idiosyncratic reactions from different patients to the same disease. The second duality in modern medicine is the distinction drawn between individual-orientated medicine and population-orientated medicine. A focus on the former has existed in medical schools for some time. This focus carries with it an emphasis on cure and restoration. Population-orientated medicine has been the domain of public health, and the focus here has been preventative. McKinlay and McKinlay (1977) claim that although a preventative approach has greater impact on health levels, it is the individual-orientated, curative approach that generally receives most financial support. The third duality relates to those in support of the distinction between mind and body and those who criticise it. On the one hand modern medicine continues to treat both dimensions as separate, on the other there is a substantial amount of research data linking psychological and social stress factors to physiological conditions (Kaplan, 1983). The fourth duality derives further from the perceived split between mind and body. Technological advances in modern medicine have given rise to a technical treatment of disease rather than the anthropological or holistic treatment of the whole person (Carlson, 1975). This approach is an extension of the scientific fragmentation method, in which the disease itself assumes importance over the patient: although the whole person presents himself to the medical practitioner, it is only the identifiable disease process that is considered. All of the above dualities represent a significant internal dilemma for modern medicine (Wolinsky, 1988).

Illich (1977) is one of the major critics of the biomedical model. He refers to the "Iatrogenic epidemic" (p. 11), which he defines as the process whereby the medical profession has assumed all forms of social "deviancy" into the field of medicine and taken away the onus of self-determination from the individual. This increases the degree of illness deviancy in the general public. "With increasing zeal, physicians and especially psychiatrists began to call 'illness'...anything and everything in which they could detect any sign of malfunctioning" (Freidson cit. Gerhardt, 1989, p. 97). Symbolic Interactionist theorists have postulated a view of medical care known as the "Crisis Model". In this they point out that medicine is in fact "the application of medical ideologies. Therapy is no more than the practical use of treatment doctrines" (Gerhardt, 1989, p. 111). Treatment in terms of the crisis model is a moral event, in that labelling (diagnosing) patients is done as a means of social control (*ibid*). Such theories have emphasised the power of the biomedical model as determiner of social attitudes and actions. As this model is primarily - almost purely - scientific, the environmental and psychological context in which illness occurs is ignored or discounted. However, psychological and social factors are perceived as irrelevant to modern medical understanding. As a result the social sciences play little role in the training of medicine, and biomedicine considers the solution of social problems to lie outside medicine's boundaries. Further, "cultural attitudes interfere with objective perception and evaluation of symptoms" (Gerhardt, 1989, p. 99): the medical profession chooses to suppress the cultural factors inherent in illness and disease, as these are perceived to adversely affect the practitioner's curative decisions. As Illich, however, states, "For more than a century, analysis of disease trends has shown that the environment is the primary determinant of the state of general health of any population" (1977, p. 25).

HIV/AIDS management, as the medical profession is beginning to recognise, needs a whole-person approach. However, a number of forces in the biomedical institution militate against an holistic approach. These same forces make the implementation of the biomedical doctor-patient role particularly problematic in third world situation. Kleinman (1980) discusses three of these:

1. The ingrained ethnocentrism and scientism that dominates the modern medical profession...follows the paradigm of biomedical science to emphasise in research only those variables compatible with biological reductionism and technological solutions, even if the problems are social ones.
2. The bias of many health care professionals in developing countries is to restructure health care delivery in their countries by copying an idealised model of professional care in technologically advanced societies.
3. The longstanding tendency of clinicians is to treat healing as if it were a totally independent, timeless, culture free process. (p. 31).

These attitudes are inappropriate to the situation of HIV/AIDS, in both developed and undeveloped countries. A number of problems arise within the roles defined for the medical practitioner and the patient in this context. Firstly the practitioner's role of authority and knowledge based upon the biomedical goals of cure is undermined by the terminal nature of this disease. Secondly, as the practitioner's role is determined in a curative framework, there is little attempt to engage in preventative education strategies. Thirdly, problems will arise in cross-cultural situations where practitioners have been unable to adapt their expectations of the patient role to the broader context. The denial of cultural and environmental factors is particularly problematic in third world contexts, where these factors are of primary importance in determining the epidemiological trends of a disease, and especially in determining the reaction of the various societies in terms of seeking treatment and responding to preventative strategies (Crewe, 1992).

Kleinman points out that health care systems are social entities, defined around social beliefs. He uses the phrase "clinical reality" to describe the process whereby clinical phenomena are socially constructed and the social world can be clinically constructed (1980, p. 37). The biomedical model has in part defined the society in which it operates; part of the process through which this is done is the biomedical model's readiness to define as disease all forms of social 'deviancy' which previously were located in other cultural institutions. It is through this process that HIV and its associated behaviours have become a medical issue, rather than a psychosocial matter. The biomedical model is not able to adapt itself to differing social context readily. Other problems in third world situations include the imbalance between the number of practitioners and patients, different cultural understandings of illness, medicine and expectations of the practitioner. Many societies perceive the practitioners purely as pill dispensers and nothing more (Gumede, 1990). With HIV/AIDS requiring a community rather than individual emphasis, the traditional doctor-patient paradigm requires considerable modification.

SECTION THREE: THE MEDICAL PRACTITIONER IN THE CONTEXT OF HIV/AIDS

Medical practitioners are at the forefront of the efforts to control and alleviate the impact of the HIV/AIDS disease. The biomedical model defines and orders their professional perceptions and activities in this regard: there are clearly delineated modes of conduct and goals for the practitioner. Western society re-enforces these perspectives in that it accords to the practitioner a high degree of knowledge and authority, the ability to cure and control, and an unjudgemental, unbiased approach in which ethical considerations such as confidentiality are strictly maintained. Society's perspectives on the practitioner's professional stance influence the individual practitioner: it is also true that society's perspectives on HIV and AIDS sufferers, and the metaphors used by society to explain the disease, will influence the practitioner in a personal capacity. The practitioner is therefore in a situation where there are two major influences at least on his/her perspectives: the biomedical model and the role this determines for the practitioner; and the social metaphors derived from society's understandings of this disease.

The position of the medical practitioner in the context of HIV/AIDS is particularly intricate in that the biomedical model itself has recognised the limitations and inadequacies of its conventional approach, especially with regard to this disease. Much of the literature (*vide* Lachman, 1991) reflects attempts on the part of the biomedical approach to contextualise the role of the practitioner within the new dimensions highlighted by this disease. These include the need for a more long-term counselling approach and a greater awareness of the social and psychological needs of patients, as well a recognition of the needs of the "worried well" and communal and preventative (educative) involvement. These issues are not new concerns - pre-HIV/AIDS literature discusses these same limitations - but the disease has clearly highlighted the inadequacies of biomedicine and its narrow goals. The role of the medical practitioner, therefore, is in a state of conflict and change, in that the determining framework itself is undergoing adaptation.

The meaning of HIV/AIDS within this context is likely to be complex and perhaps problematic for medical practitioners. The symbolic understandings and metaphors which determine the meaning of this disease for them are both derived from and influence their professional and personal identities. The symbols and the identities are influenced by the flux in social and medical perceptions of the disease and the role of practitioner in relation to it.

3.1: The Professional Role & HIV/AIDS

3.1.1 Doctor-Patient Role Relationships

This study aims to elucidate the meaning of HIV/AIDS for selected general practitioners through a consideration of the experience of an encounter with an HIV infected person. It also aims to interpret this experience by way of the symbolic meanings and definitions that these individuals use to understand the HIV/AIDS concept in relation to their personal and professional roles and situational context. The medical encounter between a practitioner and his/her patient takes place within the interpersonal framework of the doctor-patient relationship. It is from an interpretation of the experience occurring in this situation that an understanding of the subjects' symbolic meanings will emerge. In order to structure the understanding of this experience for these subjects, it is necessary to establish the context - medical, psychological and social - in which it occurs. This relationship needs to be examined closely for a number of reasons, such as the way it may influence the practitioner's subjective understanding of HIV/AIDS through perceptions of his/her professional role. Further reason for focusing on this relationship derives from the need to establish the influence of external factors that may contribute to these subjects' personal understanding. The doctor-patient relationship is not an encapsulated event, but is an interpersonal process drawing on the wider external contexts of the participants. This relationship comprises a clearly defined medical practitioner and patient role including medical, psychological and social dimensions. Within these roles both individuals have expectations of each other's and their own behaviour. These expectations are determined by the context surrounding the doctor-patient relationship. This context will differ in third world and first world situations, therefore the nature of the doctor-patient relationship will differ (Kleinman, 1980). This relationship has strong implications for the management and treatment of HIV infected patients.

The doctor-patient relationship, as Parsons (1975) suggests, comprises expectations of role and consequent behaviour on the part of both individuals. These expectations are dependent upon the broader context of each individual. It is evident that the expectations of the third world individual will therefore be very different from those of the first world individual. While Parsons has only considered the social dimension of illness, it must be recognised that the broader context includes a psychological, a social and a biological domain. Social changes over time and different cultural contexts create a need for ongoing modification of the doctor-patient relationship. In American society the rise of consumerism and increased competition has diminished medical practitioner

authority and patient dependency. Similarly in Africa the increasing number of people seeking medical attention is causing further change in the doctor-patient relationship. Different cultures have different understandings of illness, consequently their expectations of their own and the practitioner's role do not concur with Parsons' model. Another criticism of this theory is that it focuses on acute illness and therefore is unable to encompass chronic or terminal illnesses such as AIDS. These illnesses are by definition not temporary or curable and the patient cannot be expected to get well, no matter how willing and co-operative s/he may be. Likewise, the practitioner cannot be expected to fulfil the curative goal. This undermines normal role expectations and therefore causes a modification of the relationship to take place.

3.1.2 Ethical & Legal Concerns of the Medical Practitioner in the context of HIV/AIDS

Medical ethics delineate a certain code of behaviour for medical professionals. Practitioners are obliged by oath and law to uphold certain standards of practise. By taking the Hippocratic oath graduate medical students swear to the following: a) to help the sick; b) to refrain from intentional wrongdoing or harm to the patient; c) to keep sacred the patient-practitioner relationship (Dixon, 1978). This oath summarises the professional concerns and modes of conduct for medical practitioners: the particular case of HIV/AIDS, with its strong social and personal implications, has brought new issues and dimensions to light in the role of the practitioner.

In the context of HIV/AIDS a number of problems have emerged for practitioners, who are in a position whereby they are expected to place the needs of the patient above their own. It is necessary to maintain a balance between the welfare of the individual, the interests of society and public health, and the safety of the health care worker. An ethical concern arising out of this issue relates to "contact tracing". This is a situation whereby an infected individual becomes a potential risk to others, either through sexual contact or through other means of transmission. Under these circumstances should it be the duty of the practitioner to advise those at risk. The practitioner has a legal and professional obligation to maintain the confidentiality of the doctor-patient relationship, and is not required by law to divulge any details of a patient's illness to employers, employees or the like (Strauss, 1984), even in the case of a potentially dangerous illness such as HIV/AIDS. This is especially the case where the disclosure of the nature of the disease will be detrimental to the patient: the discriminatory attitude held towards HIV infected or AIDS persons

means that such information will be greatly detrimental. One result of the fear and stigmatization felt by society towards HIV and AIDS infected persons is that test results and HIV status are kept very confidential. The legal question of whether HIV status should be notifiable; whether practitioners should be allowed to conduct automatic HIV tests, and the question of HIV confidentiality in terms of other people at possible risk, is a major issue for the medical practitioner and the health care professions, particularly as this has implications for their own risk in treating patients whose HIV status is unknown. With a social context that maintains a strong negative perception towards sufferers, the issues of confidentiality and anonymity become very significant, especially in the testing and reporting of results.

In South Africa there has been some discussion about making HIV/AIDS a notifiable disease: up to the present this has not happened. On the issue of "contact tracing" it is generally accepted that a medical practitioner may notify the spouse or the other sexual partners as to the condition of an AIDS sufferer. Legally the practitioner is not obliged to supply medical details to spouses, but a failure to do so might be seen as a failure to act in the best interests of the spouse (Strauss, 1984). Whether under these circumstances s/he becomes obliged to do so is a contentious matter, nor is it clear how far a practitioner may go in this regard (Van Niekerk, 1991). Another dilemma with regard to confidentiality arises when for epidemiological reasons information relating to the seroprevalence of a population is important. Formal notification of all infected persons is an option that has been considered and adopted in many western and third world countries. However, legislation that insists on "contact tracing" and "formal notification" runs the risk of driving infected individuals underground (Lachman, 1991). Such strategies will run counter to recent acknowledgements of the importance of early diagnosis as a means to controlling the spread of this disease. The new ruling of the South African Medical & Dental Council (SAMDC), undertaken in August 1992, stipulates that medical practitioners are not at liberty to reveal the HIV status of any patient to persons only indirectly affected - this includes health care professionals. This issue has been recently highlighted in South Africa with a legal case being brought against a Johannesburg practitioner who informed two other Health Care Workers of a patient's HIV-positive status without that patient's permission (*E.P.Herald*, 17 October, 1991). The point of safety versus confidentiality has been tested in this case, and the outcome - which found for the practitioner - is likely to set a precedent for future legal and ethical procedures (Crewe, 1992).

The lack of notification of HIV/AIDS creates further problems in the issue of risk to health care workers in emergency situations. In South Africa a medical practitioner or other health care worker is not obliged by law to render all assistance possible in the case of accident or other emergency, but the Appellate Ruling of 1975 stipulates that a failure on the part of an informed and capable individual to render assistance in an emergency situation makes the capable person legally culpable (Strauss, 1984). This means that practitioners are confronted with an unknown risk every time they engage in a "rescue", as HIV-positive individuals are not required to carry notification of their condition on them.

Because of the social and personal implications for an individual testing positive for HIV, practitioners have to be particularly sensitive to the issue of testing and also "false positive" results. Practitioners need to be extremely cautious and must not always assume that a positive test is actually correct, especially when the clinical features are negative. Even the Western Blot Test, considered to be a standard measuring technique, is open to error. HIV-1 testing has been used amongst other things to deny or prevent access to: certain institutions; insurance cover; various countries for holiday or immigration purposes; medical and dental care, and to certain professions. In 1986 the United States Justice Department passed a ruling that employers were at liberty to bar employees testing HIV-positive from working, even in circumstances where there was no chance of spreading the infection (Lachman, 1991). The practitioner has to be aware of such issues when diagnosing a patient. While within the medical context a test result is a purely clinical feature necessary for determining treatment procedures, for the individual in a social context the test carries distinct connotations and difficulties. Mandatory testing, while safeguarding the health care worker, must be viewed within the context of the individual's rights. A group has in principle the right to know what is happening within it, but this right carries with it an accompanying responsibility towards each individual within the group (Kielau, 1989).

In South Africa this disease has as yet not confronted the legal system with totally new problems, unlike, for example, artificial insemination or *in vitro* fertilisation. Instead it has served to test the flexibility and applicability of existing legal rules, especially those concerning health care workers and associated institutions. The judiciary system will in the future be placed under strong pressure to maintain the fine balance among the interests of various parties (Van Niekerk, 1991). The HIV/AIDS disease raises many sensitive and emotional issues, many of which concern practitioners. Increasingly practitioners

and other health care professionals are being legally challenged with various HIV/AIDS-related issues. In terms of the practitioner's professional role, the legal and ethical dimensions have become emphasised, with resulting implications for this role (Lachman, 1991).

3.2: The Biomedical Model and the Medical Practitioner

3.2.1 Biomedical Influences on the Medical Practitioner

The central tenets of the biomedical model (outlined in Section 2) have a great influence on medical practitioners in that it is through this model that they develop their professional identity. The goals and metaphors of the biomedical model define the actions and perceptions of these practitioners. The military metaphor discussed in the preceding section has a large impact on practitioners in encouraging them to think in terms of cure and physical intervention (Ostrow, 1990). B. Schaffner (cit. Ostrow, 1990) discusses these influences when he points out that the biomedical training encourages practitioners to suppress and ignore their own emotional feelings. The legal and ethical parameters within which practitioners carry out their professional duties exacerbate the scientifically neutral stance which forms a strong part of the doctor-patient relationship (DiMatteo & DiNicola, 1982). This is itself informed by the Hippocratic oath. These parameters are made necessary by the nature of the power relations within the medical context, in which practitioners are frequently given a large insight into the personal and intimate facts of their patients' life (Gerhardt, 1989). This is particularly an issue in the context of such a socially stigmatising disease as AIDS, with its implication on the patient's lifestyle (Sontag, 1988). The role of medicine within the community and the care of the sick are also the concern of the practitioner, derived from the biomedical model.

3.2.2 Innovations in the Role Defined for the Medical Practitioner in the Context of HIV/AIDS

Medical practitioners are having to prepare for the ever-increasing number of HIV/AIDS patients that are presenting for surveillance and treatment. The needs and requirements of these patients are diverse and are constantly changing in accordance with the progression of the disease. In response to the new demands presented by this epidemic, an increasing number of publications have emerged which aim to define the role of the practitioner within the context of HIV/AIDS. Suggestions for the management of HIV/AIDS vary from a very traditional impersonal approach to disease management, with the emphasis on precautions for practitioners, towards more innovative strategies such as primary prevention and counselling. All these suggestions derive from the biomedical paradigm.

Practitioners are being urged to educate themselves with regard to modifying and adapting their existing skills in order to meet the demands of this disease. The presence of the HIV/AIDS epidemic has thrown into relief some of the inadequacies and limitations of the western biomedical model and those trained within this orientation. As this paradigm is not well-suited to the management of HIV/AIDS, the position of the practitioner within this context is often ambiguous.

Medicinal treatment and precautionary procedures are the priority of most guidelines for general practitioners. Health care professionals are in effect being urged to adopt a defensive position with regard to HIV and HIV-positive individuals. Precautionary measures against contraction of HIV, whilst necessary, threaten to become destructive to the doctor-patient relationship. From a biomedical perspective, practitioners may be inclined to perceive patients as a threatening disease and take precautionary measures against this disease, without realizing that these precautions are complicating their relation with the patient. In the context of HIV/AIDS, where the relationship is particularly sensitive, fastidious precautions may be perceived to create not only physical but also psychological barriers between patient and practitioner. Professionals need to engage patients in an understanding of the need for universal precautions which are designed to protect both patient and practitioner. A study in England has shown that despite extensive precautionary programmes targeted at health care professionals, many surgeons fail to comply with these suggested measures. This raises the point as to how much attention medical practitioners do in fact place on so-called guidelines. Many of the precautionary procedures advocated for the health care professions rely on first world resources such as availability of disinfecting agents, the accessibility of sterile equipment, and standards of cleanliness and hygiene which are possible to maintain only under first world conditions.

According to Lachman (1991), drawing on Soloway and Hecht (1990) and Higginson, Wade, and McCarthy (1990) the role of the general practitioner within the context of HIV/AIDS should include the following dimensions.

In diagnosing someone HIV-positive the practitioner must be aware of the implications this has for the mental and social life of the patient, including relationships with family and significant others, employment difficulties, and possible stigmatization by the community. The patient is in great need of counselling, education, support and reassurance. A close and trusting relationship with good communication between practitioner and patient is very necessary. In eliciting medical histories and risk behaviours, the practitioner must not show any bias or judgement towards the patient. S/he must recognise the

acute emotional state of the patient in learning of a positive diagnosis: counselling from this point on is necessary. Counselling must include a recognition of the needs of the caregivers for the HIV-positive person, and others at possible risk from the patient. It is especially important to find out with whom the diagnosis is to be shared, and to maintain confidentiality. Education on the nature of HIV disease and risk behaviours is also necessary. Patients must be advised on safe-sex procedures and other factors and counselled on how to prevent transmission to others.

Counselling and education are recent innovations in the practitioners' role: these factors, aimed at preventative rather than curative goals, have not hitherto formed part of the medical practitioner's role. B. Hedge (in *Medical Chronicle*, 1991) states that "For many HIV infected persons, medical management alone is not sufficient. The need for thorough counselling for all infected persons and even for those taking a blood test is now well recognised" (p. 4). Counselling must be directed at: HIV seropositive patients (symptomatic or asymptomatic); partners, relatives and friends of infected patients; and persons affected by the existence of HIV, such as the worried well. Practitioners are urged to keep abreast with HIV/AIDS-related medical knowledge and to consult frequently with their colleagues. Counselling is directed towards assisting the patient to make informed decisions which maximise the quality of life and minimise adverse psychological reactions. The ultimate aim of counselling is to reduce the development of psychosocial problems and to help people to deal with those that do emerge. Practitioners are required to adjust counselling techniques through the progression of the disease. Types of counselling include pre- and post-test counselling, crisis intervention, long-term adjustment support, terminally ill support, and support in dealing with complications. Long-term coping strategies include behaviour therapy techniques such as cognitive behavioural intervention.

Primary care professionals are becoming more involved in the care of HIV infected patients in the community. Medical practitioners are not inclined to offer this level of care, seeing it as incompatible with the usual running of a daily practise. This system involves the administration and monitoring of AZT and other forms of drug therapy, psychological care and nutritional advice within the developed structures of home care facilities. A high standard of care and support is possible, with other members of the community health care system also being involved. As the burden continues to grow, and medical practitioners will need to work closely with other members of the health professions. The medical practitioner must also be available to deal with the wider concerns and problems

facing the individual: a recognition of the social context of the patient therefore forms part of the new requirements of the professional role.

3.2.3 A Critical Perspective of the Role of the Medical Practitioner within the Context of HIV/AIDS

The role of the medical practitioner is defined and limited by the extent of his/her professional medical knowledge. HIV/AIDS is a disease manifesting much uncertainty, with consequent implications for the practitioner. Because HIV/AIDS is manifested by secondary infections it is difficult to diagnose, especially in the early stages. This has contributed to the difficulties for the practitioner in handling possible HIV/AIDS cases. Furthermore, this disease is incurable and fatal, defeating the main goal of the practitioner - to heal.

Medical practitioners, being trained within a curative framework, are having to re-adjust their professional stance because of the failure to fulfil this curative role. An awareness of this inability to fulfil the public's role expectations in countering this epidemic has strong implications for professional identity.

Most articles in giving advice to medical practitioners on how to manage HIV draw on examples from situations external to the third world. Examples of this sort often contain valuable insight and input, but need to be greatly modified before they can be of use to the third world. The role of counselling as suggested for the practitioner, for example, is inappropriate to a third world situation, in that cultural, language, time and personnel constraints do not allow for effective communication (Crewe, 1992). Counselling is a luxury of the first world, and a luxury, what is more, which practitioners are not equipped to assume. They are implicitly being encouraged to adopt the functions of clinical psychologists. Counselling and psychotherapy for chronically and terminally ill patients demands very specific skills which a traditional medical training does not provide for. The very fact that present literature is emphasising this new role indicates that practitioners as yet are not equipped with and do not practise these skills. While counselling is a very important component of interaction with HIV/AIDS patients, practitioners should not be urged into a role for which they will not be equipped. The medical practitioner's role needs to incorporate a counselling approach that has as its aim a preventative focus, reaching individuals before they become infected, rather than focusing only on those who are already infected. Most of the counselling techniques outlined for medical practitioners are directed towards helping, advising and informing an individual already infected with HIV. These techniques are an extension of the

curative model that at present strongly defines a practitioner's role. Counselling in this context replaces cure and therefore is cast in a curative framework.

The western orientation and urban bias in the medical training of medical practitioners in South Africa and most other African countries may actually render them inexperienced to deal with medical conditions commonly found in rural areas. This is particularly true of conditions relating to dietary customs and practise (Van Niekerk, 1991) Training received by these practitioners also excludes a knowledge of certain cultural, social and other circumstantial factors which may directly influence the health of a community. In addition, the curricula in the medical schools of most of these countries have tended to be medically "traditional" with an emphasis on curative aspects and practises in hospitals, devoting less attention to prevention, public health, community medicine, rural health and other aspects of medicine that relate to primary health care (*ibid*). Dixon (1978) states that virtually all medical schools use as admission criteria high educational standards in science and follow this by a rigidly scientific training, and therefore many of their products lack broader sensitivities that, in normal practice, are in greater demand than detailed anatomical and physiological knowledge.

3.3: Social Influences on the Medical Practitioner

The medical practitioner's understanding of his/her role is influenced strongly by the perceptions the general public has of this same role. The practitioner is seen as an arbiter and 'labeller'; a diagnosis confirms a patient in a particular social status. Symbolic Interactionist theory explains the process through which an individual, labelled by the medical practitioner, will be re-interpreted in terms of this label; the act of diagnosis is therefore a very significant one in the social context (Gerhardt, 1989).

The symbolic meanings of HIV/AIDS for medical practitioners is formulated in part around personal factors, including perceived high risk status. The risk practitioners face affects them not only to their professional role, but also in their personal role. In the personal roles practitioners are subject to the same influences that the rest of society is subject to: the social metaphors defining moral behaviour and attitudes - attitudes and judgements which their own risk could well exacerbate. Their perceptions are influenced by their social context such as media hysteria, the negative responses from the public, "Doomsday" predictions, and governmental inaction. These influences are likely

to affect their personal views, although in their professional role they are required to interact with the very people they may be influenced against.

The common understanding of medical practitioners as a high risk group is not necessarily the attitude expressed by the biomedical institution. Practitioners are receiving two conflicting influences in that the social perceptions of practitioners comprises a strong awareness of potential risk, both to them and from them. The level of risk to practitioners from HIV is unknown, but first world studies have shown that the risk appears to be inconsiderable. The risk to surgeons of becoming infected with HIV as a result of a sharps injury is not large: seroconversion after a needlestick injury has been estimated at 0 - 5% (Higginson et al., 1990). The fear and emotional response engendered amongst health care workers is out of proportion to the risks (Gerbert, Maguire, Badenaar, Altman, & Stone, 1989). From 14 prospective studies the transmission rate of HIV after inoculation with infected blood through an occupational percutaneous injury was 0.5% (Higginson et al., 1990).

Similarly, a study in the USA of 2000 health care workers who sustained needlestick injuries recorded five seroconversions (Levin, 1989). Another study in Holland reports five cases of seroconversion occurring, after massive exposure of the skin or mucous membranes to blood (Leentvar-Kuijpers, Keeman, Dekker, J., Dekker, M.M., Ansink-Schipper, & Coutinho, 1989). While low, these figures do indicate some level of risk, and in third world countries where the medical facilities are under a far greater patient load than in the West, and lacking in resources, the risk could well be higher. The controversy and problems surrounding the use and usefulness of precautionary measures and the actual risk-status of doctors has caused confusion. A study in the UK reported that although most surgeons took some precautions when operating, most still exposed themselves to considerable risk from patients whose HIV or Hepatitis B virus status was unknown (Porteous, 1990). The Head of surgery at the University of Cape Town and Groote Schuur, Professor J. Terblanche, recently observed that medical staff could not afford to take every single possible precaution against HIV/AIDS. This was largely due to financial cutbacks, staff reductions and an ever-increasing patient load. Another problem was that doctors and nurses - particularly in trauma surgery - were having to move more quickly than precautionary measures would allow in order to save the life of a person (*E.P.Herald*, 16 October, 1991). The likely outcome of such controversies is that doctors will be uncertain of how to deal with HIV or possible HIV situations, and this will influence both their behaviours and relationships to their patients and their perception of their role.

Lachman (1991) states that the risk of transmission of HIV from health care workers to patients is considered to be low. However, the issue of patients being infected by doctors and other health care workers has aroused a strong social response. In the USA there has been a call for the mandatory testing of all health care workers. This follows a highly publicised incident whereby a Florida dentist infected a 23 year old woman with the HIV virus. The dentist, who was aware of his HIV status, was shielded by Florida law and was therefore not obliged to reveal this information to his patients (Hansen, 1991). Recent incidences of this nature indicate that transmission from practitioners to patient is a real possibility. Despite such incidences, practitioners seem oblivious to this issue, possibly because they are educated into an authoritative, curative role. Transmission from doctor to patient or vice versa is a controversial point. In South Africa a doctor, as a so-called 'independent contractor', has the option of refusing to treat patients (Strauss, 1984), and this fact has implications for the position of patients presenting with HIV infection, in that a doctor is legally free to refuse to treat them. The SAMDC has in fact recently found it necessary to stipulate that doctors may not refuse to treat HIV-positive patients on medical grounds.

The practitioner is exposed to these difficulties and conflicts arising from the differing opinions of the public and the biomedical model. While the model stipulates purely physical means of protection which are not fail-safe, the public follows a view which emphasises the considerable risk of practitioners to HIV infection.

Scheff, cited in Gerhardt (1989), claims that "everyone in a society learns the symptoms of [medical deviance] vicariously, through the imagery that is conveyed, unintentionally, in everyday life" (p. 92). This includes medical practitioners in their personal capacity, who are as much exposed as other members of society to the stereotypes and metaphors portrayed in the media and other non-professional sources. Three sources of 'popular' imagery have been determined, "during socialisation in childhood typifications are learned; another [source] is folklore and smalltalk in everyday encounters that re-inforce the stereotype; and a third is public communication media" (*ibid*). Practitioners therefore have numerous influences apart from the biomedical model to determine their attitude to HIV/AIDS. In the context of the biomedical model, however, personal feelings and attitudes are not considered appropriate.

The beliefs and attitudes of individuals towards disease, illness, modern medical treatment, and drugs have been shown by M. Montagne (1988) to be associated with

societal symbolic and metaphorical conceptualisations. These metaphors may influence health care professionals in their provision of care in that they describe and order certain experiences into a symbolic understanding. For practitioners as well as most other individuals, personal metaphors are to some extent determined by the conceptualizations of general society, while their professional metaphors are ordered in accordance with the biomedical model of their training. The total understanding of HIV/AIDS for these professionals will be based upon both personal and professional sets of metaphorical meaning. Personal metaphors are constructed through a process whereby the individual interprets for him/herself, through personal experiences, the symbolic meanings already laid down by society (Mead in Collins, 1985). The medical practitioner's understanding of HIV/AIDS will therefore be partly based on his/her personal interpretation of society's symbolic conceptualizations of this disease.

The media and governmental policy has greatly affected the general perceptions of the significance of this disease. Government policy has been to try to ignore it as much as possible, as it appeared to be limited to unimportant "problem" sections of the population, and this exacerbated the judgemental views of the media and the public. The apparent lack of urgency in dealing with the disease also influenced practitioners into underestimating the impact of this epidemic. The inability to control the disease, along with health care professionals' gaps in knowledge with regard to management, has caused a modification in the view of practitioners as authority figures. This is exacerbated by the media's indiscriminate use of the medical institution and its practitioners as authoritative sources. Further the media has developed a stereotypical notion of medical practitioners as cold, excessively brisk, brusque, inaccessible and unfeeling. The medical system is portrayed in the media as decidedly impersonal. (DiMatteo & DiNicola, 1982). Practitioners are placed in a situation where they are at once perceived as semi-omnipotent authority figures, and also as distant, unemotional manipulators of the individual's wellbeing (*ibid*). These perceptions have consequences for the practitioner's actions and perceptions of him/herself. This, together with the fact that practitioners in their personal role as members of society are influenced by public perceptions of the disease, is likely to result in an increasing complexity of the practitioners' symbolic understanding of HIV/AIDS and their position within this context.

SECTION FOUR: METHODOLOGY

4.1: Theoretical Orientation

The present study aims to **describe** and **interpret** the lived experience of six medical practitioners in their respective encounters with HIV infected patients. It therefore aims to elucidate for each subject the changing symbolic meanings and definitions of HIV/AIDS which this encounter introduces into their personal and professional roles. These understandings comprise the subjective perceptions of each individual. The researcher aims to describe the essence of the subjects' thoughts, feelings, attitudes and beliefs pertaining to the encounter. It is for this reason that the study requires a methodology which will facilitate the interpretation of these understandings. A qualitative research paradigm is most suited to elucidating the essence of such experiences. In particular, the existential-phenomenological approach provides an appropriate and flexible framework in which to examine this encounter. Having investigated this experience through these parameters, the resulting emergent psychological structure of the experience will be further interpreted within the framework of Symbolic Interactionism.

The researcher has chosen to use qualitative rather than quantitative methods of investigation as the latter are ill-suited to explicating human phenomena. Traditional quantitative approaches are based on positivistic principles drawn from natural scientific premises. Central to such approaches is the verification of a pre-established hypothesis. Unlike qualitative procedures, the quantitative approach uses methods of data collection and analysis that impose upon the research process a pre-determined structure delineated by the requirements of the initial hypothesis (Taylor, S., 1984). Quantitative research is by nature objective, deductive and is directed towards a means-ends analysis. In this paradigm the ends of the research must be amenable to testing, verification or refutation (Wood, 1977). The qualitative approach, however, regards research as an end in itself. This approach is characteristically based on the tenets of induction, holism, and subjectivism (Ferreira in Mouton & Marais, 1988). Inductive research extrapolates directly from the data rather than imposing pre-existing expectations. It aims to establish generalised patterns from specific experiences. These patterns comprise themes and categories of understanding and interpretation. In the present study the researcher focused on the subjects' lived experience of a specific encounter in their professional capacity with an HIV infected person. From the description of this experience emerged general patterns, interpersonal themes and categories of meaning.

A qualitative approach is thus orientated towards elucidating the subjective meaning of human phenomena. This approach affords an insight into feelings, thoughts, attitudes, beliefs and the interactional consequences pertaining to the individuals' perspectives on a particular experience (Taylor, S., 1984). Qualitative methodologies are designed to incorporate the individual in his/her interactional reality: a feature which quantitative methodology is unable to accommodate. The nature of the medical encounter with an HIV infected person is essentially interactional and therefore requires a qualitative approach.

4.2: Methodological Strategy

This study uses as its methodological foundation the approaches of Existential-Phenomenology and Symbolic Interactionism. Existential Phenomenological procedures will be used to enter into the experiential world of six medical practitioners and describe the psychological structure of the symbolic meanings and definitions they use to understand their encounter with an HIV infected person and their situation within the context of HIV/AIDS. Symbolic Interactionism thereafter will be used to interpret these emergent psychological structures through examining the symbolic and interactional themes incorporated in this structure.

4.2.1 Existential Phenomenology

Existential Phenomenology views human existence as having a constant interactional relationship with the world. Reality and meaning is not encapsulated purely within the individual mind, nor is it understood as being located entirely in the outside world, but is an intrinsic process of interaction between the self and the world. Husserl states that consciousness intends an object, it does not exist in and for itself but always intends an object beyond itself. That is, the individual's thoughts, feelings, attitudes and beliefs are always directed towards an object (concrete, social or abstract) within the world. "Existential Phenomenology therefore departs from the traditional [dualistic] understandings of human existence in that its focus is neither one of Idealism (with its emphasis on the encapsulated mental event), nor one of Positivism (with the emphasis on observable and measurable behaviour), but rather on the issue of being-in-the-world [*Dasein*]" (Stones in Fisher, 1981, p. 24). Phenomenology sees the human being as in dialogue with a system of meanings: rather than responding directly to stimuli in his/her environment, s/he responds to the meanings s/he attaches to these stimuli. A view of the human being from

this perspective - an understanding of individuals through their phenomena - allows for an insight into the unique metaphorical meanings of each individual's *Lebenswelt* (lived world). In the present study the subjects are seen as having defined for themselves a system of meanings and definitions relating to the concept of HIV/AIDS and their professional and personal roles, in response to their encounter with an HIV infected person.

The medical encounter between a practitioner and patient is a complex interpersonal experience which can only be understood through inductive methods of inquiry. This relationship is delineated by professional norms and expectations, and influenced by personal factors. Because of the intimate nature of this relationship the medical profession ascribes to it a set of clearly defined ethical standards which constitute part of the practitioners' professional identity. The complexities of the doctor-patient relationship have become exacerbated by the presence of HIV/AIDS. This disease more so than any other in recent times has introduced strong moral, social, legal and ethical implications into the *Lebenswelt* of the medical practitioner. Practitioners, who are at the forefront of the AIDS epidemic and society, are, because of the extra dimensions of this new disease, having to define for themselves a clear identity and framework of understanding enabling them to comprehend effectively their personal and professional position in relation to the phenomenon. In order to understand the complexities of these identities the researcher must gain a clear insight into the individual's system of meanings. These psychological meanings arise spontaneously in the individual through his/her experience, and are accessible only through a technique of flexible exploration. Phenomenological principles provide such a method of eliciting this system of meanings.

To comprehensively understand the specific experience of encountering an HIV infected person, the researcher needs to remain within the subject's perspective. The first phase of this study does not aim to *explain why* these subjects ascribe certain meanings and definitions to this phenomenon, but rather to *describe what* these meanings and definitions are. Phenomenology is primarily a means of description and is therefore useful for the requirements of the study. It is through description that the pre-reflective life-world of the subject is brought to a level of reflective awareness where it manifests itself as psychological meaning (Valle & King, 1978, p. 17).

The descriptive procedures used in this study are drawn from the strategies developed by L. Binswanger (in Needleman, 1963), A. Giorgi, (1975), and F.J.

Wertz (in Giorgi, 1985). The methods of description proposed by these theorists have been integrated and adapted to meet the requirements of this research.

In the first phase of this study phenomenological methods have been used to **elucidate** and **describe** the encounter between a medical practitioner and an HIV infected person. The second goal of this study, which constitutes the second phase, aims to **interpret** this experience by way of the symbolic meanings and definitions that constitute these practitioners' understanding of their personal and professional identities in relation to their conceptualisation of HIV/AIDS. The approach chosen as being most suitable for this interpretation is that of Symbolic Interactionism.

4.2.2 Symbolic Interactionism

The medical encounter is a social event defined by social parameters. For this reason the Symbolic Interactionist approach, which incorporates an understanding of the individual within a social event, is appropriate to the encounter under study.

Symbolic Interactionism takes a social psychological perspective of human experience and behaviour, and has contributed much to sociological understandings of the individual within his/her society. Symbolic Interactionism maintains that the individual comes to identify and classify his/her world - including self and his/her own actions - according to what s/he learns from others in social interaction (Charon, 1979). This perspective derives primarily from the sociological theories of George Herbert Mead (1934) and Herbert Blumer (1969). The present study extrapolates from the approach outlined by Blumer (1969), who draws his own interpretation of Symbolic Interactionism from the work of Mead and other significant social philosophers such as Charles Cooley (1909); John Dewey (1930); William James (1890); Georg Simmel (1950); William Thomas (1937), and Max Weber (1947).

Symbolic Interactionism, in order to understand human experience and behaviour, focuses neither on the internal personality characteristics of each individual, nor on the external environment, as a static cause of individual behaviour. Rather, the nature of the process of interaction and the dynamic social activities between individuals is its primary focus. "Interaction implies human beings acting in relation to each other: taking each other into account, acting, perceiving, interpreting, acting again" (Charon, 1979, p. 23). Interaction takes on its symbolic dimension in that the social activities which comprise it have little intrinsic meaning, rather they are symbolically defined and understood

by participants within their interpretive context. According to this perspective the individual is viewed as a conscious actor in his/her world who perceives situations and events in terms of his/her own meanings and definitions, which in turn arise from and are modified by social interaction with others. Individuals are seen as interpreting and defining each others' actions and as responding to the meanings they attach to these actions. Interaction is assumed to be mediated by the use of symbols, by imputing meaning to social actions, and by interpretation. This perspective approaches society from the viewpoint of the individual's system of meanings as it is formed through interaction with his/her social environment (Ferreira in Mouton & Marais, 1988).

Blumer's understanding of Symbolic Interactionism has provided a basis for the model of interpretation used in this study. This perspective is useful because it integrates many important concepts from a number of prominent social philosophers in such a way as to place more emphasis on the individual, rather than on society. This focus on the individual allows for a psychosocial understanding of a particular event - such as the encounter between a practitioner and patient - rather than the more social understandings proposed by other Symbolic Interactionist theorists such as Manford Kuhn (1954).

According to Blumer's approach, Symbolic Interactionism is founded upon three premises (Collins, 1985):

- a) Individuals act towards objects in terms of the meanings that these objects hold for them. These objects include everything incorporated in the world of the individual. These are categorised as physical objects within the environment, such as surgical instruments and diseases; social objects - the world of other individuals and their roles, including practitioners, patients, friends, family; and abstract objects, such as moral principles, ethical standards, personal (rather than conventional) attitudes to and perceptions of others.¹
- b) The meanings ascribed to these objects arise out of social interaction amongst individuals.
- c) These meanings are constructed and subsequently modified through an ongoing interpretive process of definition, assessment and re-definition within the social context.

¹ It should be noted that Blumer's three classes of objects - Physical, Social, Abstract - are very closely related to Binswanger's three modes of being: Umwelt, Mitwelt, Eigenwelt.

For human beings all **objects** in nature are not fixed stimuli, but are social objects constantly changing as they are defined and redefined in interaction. "The meaning" says Blumer, "is not intrinsic to the object" (Blumer, 1969, p., 68). Social objects are defined according to their use for the individuals involved, "The object changes as its use for us changes, as we change the meaning it has for us" (Charon, 1979, p. 39). Most physical objects, because of the potential diversity of uses they have, constitute a variety of social meanings.

Attitudes are constructs of the individual in relation to a specific object or class of objects; **perspectives** are a framework of symbols belonging to a certain **reference group** or **generalised other** (as described by Mead, 1934). This reference group or generalised other comprises a culture, with a set of norms and perspectives belonging to this culture (Woods, 1983). This framework derives from interaction and identification with the reference groups and orders the individual's perceptions of reality. One's perspectives therefore influence one in what one notices, how one interprets, and what one overlooks.

Symbols are a class of objects. A symbol is any object, mode of conduct, or word towards which individuals act as if it were something else (Charon, 1979). The meaning of a symbol is that something stands for something else. Symbols are conventional; their meaning is socially determined and recognised. What is essential to communication is that the symbol should arouse in one's self the meaning it arouses in the other individual. **Language** is a symbolic system, defined in interaction, and used to describe to others and to the self what one observes, thinks and imagines. Language is therefore used to refer to or represent a part of reality.

The **self** is a social object like all the other social objects the individual shares with others in interaction. An individual comes to define "self" in interaction with others. It takes others in interaction to point out to the individual that s/he is a separate object and to give to him/her some sort of understanding of self. This self is defined and redefined through interaction. How the individual views the self, how s/he defines this self, the judgement s/he has of the self, all depend on the social definitions s/he encounters during the course of his/her life. This process depends largely on taking the role of others to see the self from their perspective. The essence of selfhood is that one can communicate with one's self, and this fact makes possible the ability to analyze self, to control and direct self, to judge self and to name or identify self. The analysis of self as the individual interacts with others is central to

understanding social situations. The ability of the individual to influence his/her own action makes possible both individuality and co-operative behaviour. It makes possible goals, morals, values, and ideas that the individual may use to guide interaction with others: to agree or refuse to conform.

The self does not have the unity implied in the generalised other, but changes as the individual interacts with family, friends, colleagues, various professionals, etc. In each case the view of self is somewhat different, and it is always undergoing change. William James (cit. Charon, 1979, p. 68) indicates that "A man has as many social selves as there are individuals who recognise him and carry an image of him in their minds". As the individuals who carry these images fall naturally into classes, it can be said that the individual has as many social selves as there are distinct groups of persons with whom s/he interacts. S/he generally shows a different side of the self to each different group.

The self is a social object which one names, classifies or identifies in a world of social objects. The act of defining and labelling these aspects of self through the process of self-judgement is an act of identification. The individual develops a series of **identities** for different reference groups and for the aspects of his/her self associated with these reference groups. Gregory Stone (1962) describes identity as where the individual is situated in relation to others, "what one announces" to others that one is. Identities are "socially bestowed, socially maintained and socially transformed" (Stone cit. Charon, 1979, p. 76). Self judgement is related to both what one does (one's actions) and who one "is" (one's identity). That is, one learns from others who one is, announces to the self in communication this identity, and announces to those with whom one interacts who one is. This interaction is a two way process by which others identify the individual and by which s/he influences others to identify him/her in certain ways desired.

Mind is the means of guiding and determining the actions of the self. The mind comprises the processes of indication, interpretation, definition and action. "The mind is symbolic interaction with the self" states Blumer (cit. Charon, 1979, p. 86). It is the conscious manipulation of symbols, made possible through the learning of those symbols and the development of the self in interaction, that makes mind able to communicate. It is through mind that the individual is an actor. Objects in the world take on meaning through "minded activity". Action is response, not to objects, but to the individual's active interpretation of

these objects. When one indicates an object to oneself, "one can withhold action towards it, inspect it, judge it, ascertain its meaning, determine its possibilities and [thereafter] direct one's action with regard to it" (Blumer, 1969, p. 8).

All human action is imbued with meaning. Human action comprises **lines of action**, action which is directed by the mind towards a certain goal or understanding. All these lines of action - goal directed action - are together referred to as **streams of action** - the ongoing process of the individual's life. These series of acts that make up the stream of action begin with situations and defined goals and end with goals achieved, altered or forgotten through the progression of the situation. The objects in the situation become part of the goal, part of the plan of action. Objects - including other people - in the situation are interpreted as social objects, influencing social action. The individual is engaged in a continuous stream of action towards an innumerable list of social objects that are defined around a great number of goals, changing lines of action as s/he acts, altering directions, re-defining goals and re-directing action as objects in the environment act back. Individuals determine lines of action based upon their understanding of their self and their situation and upon their established goals. Developing a line of action towards something involves a rehearsal of acts before they are carried out. Mind makes possible this rehearsal of acts. The consideration of strategies or lines of action, delayed response and the active definition and re-definition of the world of objects are basic activities of the mind. Having determined the line of action it might - though not necessarily - be acted out overtly. As Blumer states, "Given lines of action may be started or stopped...confined to mere planning or if initiated they may be transformed" (cit. Charon, 1979, p. 85).

It is by **taking the role** of the other that the individual can understand the meaning other people's words and actions have. Taking the role of the other is taking the perspective of the other, understanding how their meanings operate, and directing the self and interaction in accordance with this. The individual infers perspectives from the actions of the other - the mind interprets these actions in a symbolic understanding of what these actions mean to the other, and through this minded activity comes to share in the meanings or perspectives of the other. The individual attempts to see him/her self from the perspective of the other. Symbol is the basis of all human interaction and it is only through role-taking that the meaning of a symbol can be mutually understood. The individual, through role-taking, attempts to determine what understanding the other will have of the symbol in different contexts.

4.2.3 Phenomenology & Symbolic Interactionism as Complementary Approaches

In order to interpret the changing symbolic meanings and definitions of HIV/AIDS through the experience of encountering an HIV infected person it is necessary, to elucidate the psychological structure of this experience. Phenomenological procedures drawn from Binswanger (in Needleman, 1963), Giorgi (1975), and Wertz (in Giorgi, 1985) provided the most effective means of explicating the psychological structure of this phenomenon for each subject in terms of its temporal sequence and in terms of "the three modes of being - self, world and others - that constitute every psychological reality" (Wertz in Giorgi, 1985, p. 177). These procedures constituting the first phase of the study were also useful in terms of ordering and thus preparing the data for the second phase of the study - the phase of interpretation through Symbolic Interactionism.

The nature of the encounter between a practitioner and an HIV infected patient is characterised by strong interpersonal dynamics. Symbolic Interaction as a theory of social interaction was a very appropriate framework for interpreting the changing symbolic meanings and definitions of HIV/AIDS comprising this interpersonal encounter. The extended thematic description which constituted the final stage of the first phase of this study comprised a highly organised text in terms of modes of being, themes and temporal sequence. The transition from this phase to the second phase of interpretation was made easier in that the themes of the extended description accorded well with the central concepts of Symbolic Interactionism; the three modes of being related closely to the three dimensions of object - physical, social and abstract - incorporated in the theory, and the temporal sequence of the text made it possible to illustrate how the symbolic meanings and definitions of HIV/AIDS for general practitioners were modified and adjusted through the encounter.

The fundamental theoretical orientations of this study - existential phenomenology and Symbolic Interactionism - were not only complementary on the level of methodological procedure but were also well suited in terms of their philosophical underpinnings. Both approaches see the individual as being in a process of constant dialogue with the world. Phenomenology views the individual as Being-in-the-world. The world and its meanings are revealed through three modes of being - *umwelt* (the "world around"), *mitwelt* (the "with world") and *eigenwelt* (the "own world"). In Symbolic Interactionism the world is understood in terms of socially derived meanings acquired through a dialectical process of interaction with the three dimensions of this world - the physical, social and abstract. Both approaches oppose traditional dualistic understandings of human

existence in that reality and meaning are understood as being located neither in the mind nor in the material world, but are defined through a complex process of interaction between the self and the world. The language of Symbolic Interactionism theory is often misleading in that terms such as "object", "self", "mind" and "others" may suggest that it conforms to traditional dualistic understandings of human existence. In fact this is not the case: this terminology suggests divisions that are in many respects artificial - Symbolic Interactionism views the individual's relationship to his/her world as an unsegmented dynamic process. Terminology suggesting compartmentalisation provides a manageable way of discussing this process.

Symbolic Interactionism is an integrated understanding that views human existence as a dynamic process of interaction between the individual and the social, physical and abstract aspects of his/her world. According to Symbolic Interactionism individuals see the world through "perspectives" (Charon, 1979). These perspectives are developed socially whereby individuals come to identify, classify and interpret their world according to what they learn from others in interaction. (Like phenomenology this approach does not deny the presence of an intrinsically natural world). Social definitions do respond to something real or physical, however the nature of reality is a social construction and human action involves responding to this social definition of the natural world (*ibid*). Social objects are defined according to their use for the people involved. Meaning "arises from how the person is initially prepared to act toward it" (Blumer cit. Charon, 1979, p. 39), Symbols have meaning for people, whatever the symbol stands for constitutes its meaning. Social reality therefore grows out of social process (Glassner, 1980).

Husserl investigated consciousness as "Intentionality", that is consciousness always intends an object - "I do not just see, I see something" (Kruger, 1979, p. 23). If consciousness is an act of revealing the world and this act is always directed towards an object then an encapsulated view of humanity such as that of "Idealism" must fall away. The world is not a system of bare facts but rather "the world is a system, a cosmic totality, of meanings" (*ibid*, p. 28). These meanings are developed in dialogue with the world and fellow men. Through intercourse between body and world; body and significant others, the individual builds up a pre-reflective world comprising a system of meanings. These meanings are strongly influenced by the presence of other beings in the individual's world. As Kruger indicates: the individual is from the very first conscious of other beings who are in the world in the same way as him/her. We can say that

the world we live in is Mitwelt, a world which we share with others, that we can know and understand the experience of others is a premise basic to the operation of our whole social world. These meanings that exist for individuals are to a large extent developed through consensus. Phenomenology and Symbolic Interactionism therefore both see meaning in terms of a social derivation.

These theories, therefore, recognise the importance of social interaction in terms of establishing meaning. Through Phenomenology the structure of the phenomenon of encountering an HIV infected patient can be explicated in terms of the system of meanings the individual derives through the process of this encounter. It is the task of the researcher to create an atmosphere in which the subject is free to explicate his/her experiences of specific phenomena and the meanings implicit in these experiences (Kruger, 1979). Phenomenology describes and elucidates the structure of the individuals' meanings with regard to the phenomenon of encountering an HIV infected patient. Symbolic Interactionism then proceeds to interpret the description of this experience in terms of explaining where the meanings derive from, why they take the form they do, and how such meanings evolve over time.

4.3: Procedure

Phenomenological psychology has no specific method of data collection or analysis. As Wertz (in Giorgi, 1985) states, "Part of the very meaning of Phenomenology [is] not to seize upon a particular method and impose it everywhere, but rather to develop appropriate methods precisely in contact with each unique phenomenon" (p. 160). Different investigators such as Giorgi (1975) and Von Eckartsberg (1979) have developed different methods of collection and analysis in accordance with the needs and style of their research. The present research procedure incorporates aspects of the perspectives of Wertz and Giorgi, although the techniques used in this study have largely been developed in accordance with the requirements of the phenomenon being examined. This study therefore, as does those of Giorgi and Wertz, provides its own variation on phenomenological research procedure.

Phenomenological procedures aimed at qualitatively describing the essential structure of specific human phenomena were pioneered by Giorgi (1970). The operative word in phenomenological research is **describe** (Giorgi, 1985). According to Van den Berg (1972), a fundamental imperative of phenomenological praxis is

that the researcher should begin by describing phenomena as they are. The researcher should aim to describe as accurately as possible the phenomenon as it occurs, rather than indulging in attempts to explain it within a pre-given framework (Stones in Kruger, 1988). In order to reach a definitive explication of particular psychological structures Giorgi proposed a method of collection and analysis that required focusing on a specific human event. This analysis involves a rigorous systematic ordering and analysis of the data pertaining to a specific experience. Wertz (1985) elaborates upon Giorgi's initial proposals by indicating that phenomenological procedures need not be confined to the instance of a specific event, but are rigorous enough to research complex life events, particularly in terms of their genesis through time. Wertz has as his aim an extended description of the psychological structure pertaining to a complex life event, rather than the more focused definitive goal of Giorgi. These respective goals are reflected in their different methodological procedures, in that Wertz is intent upon examining the broader context surrounding a complex event, whereas Giorgi is intent upon defining the specific structure of an isolated event. The present study aims to elucidate and **describe** the psychological structure of a medical practitioner's encounter with an HIV infected patient. This description - the extended thematic description, which constitutes the final stage of the first phase of this study - will comprise the meanings these individuals develop through the interactive process of this encounter. In terms of this aim, Wertz's technique of an extended focus was seen as being both useful and appropriate. The second phase of the study is the **interpretation** of the extended thematic description through a Symbolic Interactionist model.

4.3.1 Data Collection

The data collection procedures in this study involved contacting 13 practising medical practitioners, explaining the goals of the study to them, and establishing whether they met the criterion of having encountered and subsequently attended to an HIV infected person in their professional capacity. Of these 13 subjects, eight met the criterion. These eight subjects were provided with a detailed statement on the intent of the research (see Appendix I). The researcher arranged for a pre-interview meeting with each subject to discuss the statement of intent and to obtain their consent to participate. Seven of these subjects gave their consent. These pre-interview meetings also served to establish rapport with the subjects, as well as provide an opportunity to discuss issues such as anonymity and confidentiality. Having gained the consent of the chosen subjects, the researcher arranged for an interview with each subject.

At the beginning of each interview the subjects were presented with the research question (see Appendix II). The subjects were asked to read this broad question thoroughly and were then guided through it by the researcher during the course of the interview. Each interview was tape-recorded, and these recordings later transcribed verbatim. The researcher briefly assessed each interview in terms of their suitability for analysis. One interview was discarded, as the interviewee had misunderstood the criteria for participation in this study, and in fact had not encountered an HIV infected patient. The transcriptions of the six suitable interviews were returned to the subjects with a covering letter (see Appendix III), asking them to indicate any amendments and deletions they felt were necessary in order to protect their identity. All six subjects declared themselves satisfied with the transcriptions.

Sample.

The researcher chose to use all six transcriptions for the study. This number was seen as adequate in terms of providing a generalised core of themes and constants representative of a certain phenomenon as experienced by medical practitioners in a subregion of the Eastern Cape. The sample size conforms to accepted phenomenological research practise for higher degrees in South Africa, there being no conventional sample size for Phenomenological procedures. Phenomenological research, unlike certain quantitative procedures, is not intent upon establishing the sample as representative of a certain population so much as describing the general constructs typical of a certain phenomenon. Phenomenological praxis in psychology is concerned with the rigorous description of phenomena contextualised in the *Lebenswelt*. While the researcher strives to achieve "a consistency of meaning that is trans-situational" (Giorgi cit. Stones in Kruger, 1988, p. 331), his primary mandate is "to listen to what the incidents, the phenomenon, tell him" (Van den Berg cit. Stones in Kruger, 1988, p. 77). However, although phenomenology is not a natural science, it also strives for intersubjectivity and general laws (Kruger, 1979). This intersubjectivity is not achieved through the same procedures as natural science whereby exact experiments are replicated, rather "it should suffice if the same or similar themes can be explicated in the same field by different researchers" (Kruger, 1979, p. 183). Validity is therefore indicated by the extent to which there is consensual validation with regard to the outcome of the research. External validity is achieved through intersubjective congruence rather than sample representation.

The subjects comprising the sample were assessed according to the following criteria, as outlined by Stones (cit. Kruger, 1988):

- 1) Having experienced the phenomenon under study.
- 2) Verbal fluency and the ability to express themselves well in the researcher's first language.
- 3) Willingness to participate.

The main criterion in selecting the sample was that each subject should have had an encounter with an HIV infected individual. It was decided to use this phenomenon as a central criterion for selection for the following reasons:

- 1) Phenomenology focuses on the experience of a particular phenomenon.
- 2) It is through the experience of a particular phenomenon that the meaning of HIV/AIDS becomes concretised for the subjects. These subjects' thoughts, feelings, attitudes, beliefs, and symbolic understandings of HIV/AIDS have become defined through the interactive process of an encounter. The subjects chosen were verbally articulate and able to express their thoughts, feelings, attitudes, beliefs and understandings in relation to the phenomenon they experienced. As noted earlier, seven subjects stated they conformed to these initial criteria. Through the technique of spoken interviews the lived experience of encountering an HIV infected patient was reported retrospectively. Because of the flexibility of the methodological procedures used, it was possible to accommodate the complexity of this event incorporating the before, during and after of the experience. Subjects were able to relate their thoughts, feelings, attitudes and understandings retrospectively to the encounter, regardless of the exact point in the experience at which the patient's HIV status became clear to them.

Interview.

There being no collection procedure specific to a phenomenological approach, the techniques used in this study conformed to a standard qualitative interviewing method. This strategy was chosen above the written descriptive method used in some research studies, as this method, whilst being applicable to certain phenomena, was not appropriate to the present study in that it is unable to examine a complex interactive event over time. The researcher also felt the written descriptive method to be limited in that it would not allow for a dynamic exploration of the subjects' thoughts and feelings. The semi-structured non-directed interview (Stones in Kruger, 1988) was used because it promotes the uninhibited spontaneous emergence of these thoughts and feelings and allows for the subjects to be as near as possible to their lived experience. The structure of the interview involved an encompassing question. This broad question comprised a number of sub-questions, incorporating structural themes relating to before,

during and after the encounter; and content themes dealing with interpersonal issues. The researcher made use of structural and content sub-questions to ensure that all issues in the broad question were adequately pursued. Throughout the interview the researcher drew upon these themes, thereby guiding the process. The interview was conducted in an informal, flexible and non-directive manner, the interviewer attempting to influence the subjects' responses as little as possible (*ibid*). Subjects were encouraged to determine the sequence as well as to introduce new themes. In doing so the constructs were able to emerge through a thematic explorative technique within the interview, rather than being pre-determined by the researcher. Owing to the comprehensive nature of the data obtained, no follow-up interviews were necessary. After the interviews had been transcribed and re-affirmed by the subjects, the phase of formal explication began.

4.3.2 Data Analysis

The following provides a detailed outline of the stages involved in the two phases of this research. These phases are designed in accordance with the two aims of the study:

a) This study aims to elucidate and **describe** the symbolic meaning and definitions of six medical practitioners from a subregion of the Eastern Cape, relating specifically to the phenomenon: The experience of encountering professionally an HIV infected individual.

b) The second goal of this study is to move beyond pure description so as to **interpret** this experience by way of the symbolic meanings and definitions that these individuals use to understand the HIV/AIDS concept in relation to their role and situational context. As mentioned earlier, the latter aim will be achieved through using constructs derived from Symbolic Interactionism.

The researcher used the theories of Phenomenology to achieve the first goal - that of elucidation and description.

Elucidation & description phase through Phenomenological procedures.

The transcribed data was initially prepared in accordance with the sequence outlined by Wertz (in Giorgi, 1985). In Wertz's procedure, the means by which the researcher arrives at the individual psychological structure is through the adoption of a particular psychological stance, and the implementation of 11 active operations. This stance is the way in which the researcher familiarises himself with and identifies with the subject's lived reality. The researcher moves into this psychological state as he initially addresses the data, and sustains this attitude throughout the study (Wertz in Giorgi, 1985, pp. 174-177).

The stance is inductive and comprises five basic components:

- 1) *Empathic immersement in the world of description.* The researcher needs to place himself in the subject's lived world, making it his own and viewing the description from this perspective.
- 2) *Slowing down and dwelling.* The researcher needs to reflect upon each detail of the description independently, moving beyond the sequence of situations as outlined by the subject and slowing down and dwelling on the distinct significances of each situation.
- 3) *Magnification and amplification of the situation.* This follows from the preceding stage: each detail's significance is amplified and its underlying importance is exposed to the researcher. What may appear insignificant to the subject becomes magnified in importance to the researcher.
- 4) *Suspension of belief and employment of intense interest.* In stage 1 the researcher enters the subject's world with straightforward empathy, in this stage, whilst maintaining empathy, the researcher must not accept the situation precisely as reported. Rather than being at all concerned with the truth or falsity of the description, the researcher adopts a stance of intense interest towards the genesis, relations and overall structure of the situation as lived by the subject.
- 5) *The turn from objects to their meanings.* The researcher is concerned with the subject's lived reality, that is, the meanings of objects and facts for the subject arising out of various situations. This is uncovered through a focus on the meanings implicit in the subject's reported descriptions. "[The researcher] turns his attention from these facts to their meanings for the subject...This is in part what makes the research psychological, namely, a study of man's participation in the immanent significations of lived experience" (Wertz in Giorgi, 1985, p. 175). The psychologist must attend to the exact sense of the situation as the particular mode of the subject's participation regards it.

This stance is sustained by the researcher throughout the process of explication and description. The 11 active operations derive from this stance, and are the active means of preparing the data for the interpretation phase. This stance and the active operations inform the researcher's decisions and actions at each stage of the first phase.

The operations used in this study, based loosely on those suggested by Wertz (in Giorgi, 1985) are:

- 1) *Making distinctions.* The researcher differentiates the NMUs within the data by asking each successive statement what it expresses that is different from the

other statements, in terms of the subject's psychological reality. By differentiating between statements, the researcher can distinguish the NMUs. It is at this stage that all irrelevant data can be excluded.

2) *Interrogation of opacity.* In order to demarcate NMUs effectively, the researcher should be able to understand the implicit meanings within each statement. When the meaning of statements is not clearly apparent, the researcher should interrogate such statements in terms of their broader context.

3) *Penetration of implicit horizons.* Reflection must focus on the immanent significance of the subject's lived reality, penetrating into the implicit horizons of the subject's world. Once firmly in contact with the this world, the researcher is able to reflect upon the implicit meanings of the account, even if these not actively stated by the subject.

4) *Seeing relations of constituents.* Each NMU is evaluated and ordered coherently in terms of its relations to each and to the whole. This allows for levels of priority to be developed: in this research the temporal relation was seen as the most important. The NMUs were placed in temporal sequence in terms of the evolution of the experience of this phenomenon.

5) *Thematization of recurrent meanings or motifs.* The NMUs are further examined in terms of recurrent themes and meanings and regrouped accordingly, within the structure of temporal relation. These themes form patterns of meaning emerging out of the data.

6) *Reflection on judgement.* The researcher has already excluded all irrelevant data. He now assesses his understanding of the re-organised text and asks of each NMU what it contributes to his overall understanding of the experience, and also what this understanding is, such that the NMU is relevant to it. This operation is fundamental to the transformation of the NMUs into psychological language.

7) *Imaginative variation and seeing the essence of the case.* In order to fully understand the contribution each NMU makes to the meaning of the subject's world, the researcher uses a process of imaginative variation and deletion of individual NMUs: if the understanding of the whole is modified by the variation or deletion of a NMU, then this NMU is significant and cannot be discarded. The researcher can determine through this method "precisely what must be involved for the peculiar character of the individual understanding to be as it is" (Wertz in Giorgi, 1985, 177).

8) *Languaging.* Throughout the analysis the researcher expresses the sense he is finding. Themes, phases, distinctions are all named: given significance through languaging. When the NMUs are transformed into psychological language the researcher retains as much as possible the subject's own words and metaphors. The goal of this stage is to achieve psychologically revelatory description.

Whilst it is recognised that the terms used are in part defined by the researcher, every effort is made to ensure that his frame of reference remains fundamentally "psychological" and reflective of the data.

9) *Verification, modification and reformulation.* Every decision the researcher makes regarding languaging and categorisations must be checked against the original data and preceding operations to avoid losing contact with the subject's lived reality. The researcher must ensure that everything he states is verifiable from the original data and that nothing from the original data is excluded. He must be prepared to modify constantly and reformulate his decisions.

10) *Use of a Symbolic Interactionist baseline.* This operation replaced Wertz's use of an existential baseline. Implicit in the researcher's frame of reference through out the first phase of elucidation and description was the understanding that this phase was preparatory to the final phase of interpretation through Symbolic Interactionism. The researcher therefore kept in mind at each stage the explanations used by Symbolic Interactionism to interpret psychological processes.

11) *Use of existential-phenomenological concepts to guide reflection.* According to Wertz, it is necessary for the researcher to use a general theoretical concept to guide reflection when analysing the data. One such concept suggested by Wertz is that of the self-world-others structure (in Giorgi, 1985, p. 177). This conceptual framework is central to existential-phenomenological understandings of individuals in their world. The present study uses L. Binswanger's interpretation of this structure. Binswanger (in Needleman, 1963) proposed three core modes of being which are involved in every psychological phenomenon: Umwelt (world), Mitwelt (others), and Eigenwelt (self). These modes of being cohered well with the central concepts of Symbolic Interactionism used for the interpretation phase of this study (see Section 4.2.3).

Organization of data (see Section 5.1).

- 1) The first step the researcher took was to familiarise himself with the verbatim interviews, reading without bias or special attitude.
- 2) The data was then demarcated into natural meaning units (NMUs).
- 3) All irrelevant NMUs not related to the phenomenon under study were removed.
- 4) The NMUs were placed in temporal order and re-arranged into groups expressing the same thematic concerns.
- 5) The researcher drew upon the methods proposed by Giorgi (1975) and transformed each meaning unit into psychological language.
- 6) Transformed NMUs were each designated a mode of being. This was done on the assumption that for any one NMU there is one mode of being that is primary; it

is recognised, however, that as each mode is emanating from the holistic self, there are clearly times when this primary mode is being fed into by the other modes. The primary mode was decided upon according to the categorisations Umwelt, Mitwelt and Eigenwelt stated below.

As has been discussed, existential-phenomenological understandings of humanity view the individual as interrelated with his/her world. The individual and the world are considered to co-constitute one another. It is through this interrelation to the world that the very meaning of the individual's existence emerges both for him/herself and for others (Kruger, 1979). "Being" is therefore being-in-the-world. This "world" has traditionally been differentiated into three modes of being, that is, three simultaneous aspects of the world which characterise the existence of each individual as being-in-the-world (May cit. Valle & King, 1978). These three modes are: Umwelt, literally meaning "world around" - the biological world including the physical environment; Mitwelt - the "with-world" - the world of one's fellow men; and Eigenwelt - the "own-world" - the mode of relationship to the self (May, Angel, & Ellenberger, 1958).

The researcher's understanding of the concepts of Umwelt, Mitwelt and Eigenwelt were formed from the following references: Binswanger (in Needleman, 1963); May et al., (1958); Misiak & Sexton, (1973); Spinelli, (1989), and Valle & King, (1978). This understanding as it pertains to the present study is as follows:

Umwelt This involves the identification of:

- Emotions engendered by the presence of HIV/AIDS.
- The meaning for the subject of the body and its parts in the context of HIV/AIDS
- Precautionary behaviour in the physical presence of HIV/AIDS.
- Experiencing patients as manifestations of physical disease.
- Objective facts concerning the non-human environment.
- Spatial dimensions including where the subject was, where the patient came from.
- Statistical understandings in the context of HIV/AIDS.
- Emotions engendered through the concept of personal HIV tests.
- The changing meaning for subjects of HIV/AIDS through the experience of a concrete encounter.
- Subjects' experience of patients as HIV infected.
- The meaning of personal risk in the context of HIV/AIDS.
- Understandings of groups and behaviours constituting high risk in the context of HIV/AIDS.
- Facts relating to the immediate and historical context of the encounter.

Mitwelt This involves the identification of:

- Subjects' relationship to people as individuals. This includes colleagues, family patients and groups.
- Subjects' perception of his/her role as educator.
- Subjects' relationship to society, the media and the medical institution. Under this category are included education and information from sources outside the experience of the encounter, such as literature, courses, conferences, colleagues, journals and policy rulings.
- Subjects' experience of their professional role and the impact of future trends on this role.
- Modification of perceptions towards significant others.
- Communication with HIV patients.
- Subjects' perceptions of others' thoughts, attitudes, beliefs or feelings (which constitute the other person's Umwelt, Mitwelt, or Eigenwelt mode of being).
- Subjects' perceptions of social and cultural understandings.
- Understanding in relation to high risk groups and high risk behaviour.

Eigenwelt This involves the identification of:

- Subjects' relation to their personal reflections, thoughts, feelings, judgements, attitudes and opinions.
- Subjects' personal understanding of roles. This includes personal understandings of duties, motivations and opinions.
- Subjects' moral, ethical beliefs and reflections pertaining to their personal role.
- Personal judgements on professional role and future trends in the disease.
- Personal feelings about various issues such as religion, the HIV/AIDS disease and commonly held views towards issues surrounding the disease.
- Reference to the generic class of medical practitioners rather than to a specific colleague.
- Considerations relating to the knowledge of a patient's HIV status.
- Personal attitudes to high risk groups and behaviour
- Self-reflection on relationship to HIV infected patient.
- Personal concerns relating to family and significant others.

7) Each NMU, having previously been assigned a mode of being, was grouped under this mode and then arranged in temporal sequence - Umwelt: before, during, after; Mitwelt: before, during, after; and Eigenwelt: before, during, after.

Individual thematic description (see Section 5.2).

8) An individual thematic description of the psychological reality of encountering an HIV infected person was compiled for each subject. The individual

thematic description is based upon and drawn from the transformed and re-organised NMUs. This phase of data analysis was based loosely on and corresponds to Giorgi's (1975) situated structure and Wertz's (in Giorgi, 1985) individual psychological structure. The individual thematic description comprises a description of the essential psychological meanings of this phenomenon: that is, it seeks to characterise this phenomenon in terms of the interrelated situational, experiential, interpersonal, bodily and actional themes constituting the subjects' psychological reality pertaining to the event (Valle & King, 1978). These themes evolve out of the data itself. Each mode of being dictates its own set of themes, appropriate to the mode; themes across the modes relating to similar issues are given a single general superordinate theme-heading: for instance under the superordinate theme of "Precautions" was "Precautionary behaviour in the presence of HIV/AIDS" (Umwelt), "Precautionary techniques in relation to professional procedures" (Mitwelt), and "Self reflection regarding precautionary behaviour" (Eigenwelt). Individual thematic descriptions for each subject comprised a re-organisation of NMUs under these thematic headings. The structure of Umwelt, Mitwelt, Eigenwelt and Before, During, After was maintained during this phase.

Extended thematic description (see Section 5.3).

9) The extended thematic description of the psychological structure of encountering an HIV infected patient comprised a synthesis of all the themes general to the six individual thematic descriptions. The structure of before, during, after, rather than being kept separate as in the individual thematic descriptions, was incorporated into each theme. Similarly the structure of Umwelt, Mitwelt, Eigenwelt was incorporated into each superordinate theme through the use of sub-categories. The individual thematic descriptions and the consequent extended thematic description in this design are preparatory to the final hermeneutic process. The individual thematic description is a synthesised summary where individual transformed NMUs are categorised and organised thematically into a manageable coherent sequence. These themes are derived with an awareness of the hermeneutic focus on symbolic and interactive meanings in mind. The extended thematic description is the final stage of the phenomenological procedures and comprises the text which the hermeneutic procedure uses for analysis. For the purpose of a smooth transition to the hermeneutic phase the extended thematic description has been highly organised and codified.

Deviations from Wertz's procedures.

Stages 1 to 4 in this study (see p. 75 above) followed the procedures outlined by Wertz in his article "Methods and findings in a phenomenological-psychological study of a complex life event: being criminally victimized" (in Giorgi, 1985, chap. 5). At stage 5 the study deviated from Wertz in the following ways. Instead of writing an individual phenomenal description, structured temporally in the subject's own words, relating to the event under study (see Wertz in Giorgi, 1985, p. 169), the researcher transformed each NMU into psychological language, as suggested by Giorgi (1975). The researcher then proceeded to ascribe to each transformed NMU a mode of being (see p. 76) as proposed by Binswanger (in Needleman, 1963). The data was ordered temporally in terms of these modes of being. From the "organisation of data" the researcher developed an individual thematic description - the counterpart of Wertz's individual psychological structure of the phenomenon. However, the individual thematic description pertaining to this study differed from Wertz's individual psychological structure in that it was organised thematically. Wertz used an existential baseline in this stage (see Wertz in Giorgi, 1985, p. 176); the present study replaced this operation with another operation using an implicit awareness of a Symbolic Interactionist baseline (see p. 75).

From this stage Wertz moves to a general psychological structure of the phenomenon (see Wertz in Giorgi, 1985, p. 193) comprising an extended description of the event - a narrative synthesis of all the individual psychological structures. This study followed a similar procedure, however, it is different in that the extended thematic description of this study was highly organised and codified through the use of thematic categories. Wertz's general psychological structure was the conclusive stage of his study; in this study the extended thematic description concluded only the first phase of the research and was in fact preparatory to the final phase of interpretation through Symbolic Interactionism.

The extended thematic description of this study, like Wertz's general psychological structure, was more exploratory and descriptive than Giorgi's proposed "general structure", which comprised a more definitive rather than an extended description. Although both types of findings differ, they are none-the-less arrived at through similar techniques: as Giorgi states "It is the intent of the method...to arrive at the general by going *through* the concrete and not by abstraction or formalisation" (1985, p. 54).

After the extended thematic description the first phase of this study was completed. The researcher then went on to the interpretive phase, using Symbolic Interactionism.

Interpretive phase through symbolic interactionism (see Section 5.4).

10) The extended thematic description was codified into themes emerging out of the data. This codification included situations, interactions, perceptions, actions, retrospection, interpretations and forecasts of future HIV/AIDS related contexts, and therefore prepared the data for interpretation using Symbolic Interactionism. These concepts were discussed in a narrative form in this phase, using the constructs and concepts proposed by Blumer (1969).

The discussion situates the results emerging out of the interpretative phase within the broader context of the general practitioners' conceptualisation of and relation to HIV/AIDS and related issues.

SECTION FIVE: RESULTS

Because of space constraints, only one example of the analysis procedure could be included in the main body of this study. The researcher has chosen Interview 3. As the subjects' own words are present in the left hand column of the organisation of data, it was not felt necessary to include the verbatim interviews.

This section includes:

5.1: Table One: Subject Three: Organisation of Data.

For the organisations of data pertaining to Subjects One, Two, Four, Five and Six see Appendix IV.

5.2: Table Two: Subject Three: Individual Thematic Description.

For the individual thematic descriptions of Subjects One, Two, Four, Five and Six see Appendix V.

5.3: Table Three: Extended Thematic Description for All Subjects.

5.4: Interpretation of Extended Thematic Description through Symbolic Interactionism.

5.1: Table One: Subject Three: Organisation of Data

UMWELT

Before

Perhaps you can start describing the context of this specific incident. A Alright, I was phoned from another hospital where the superintendent asked us if we had a bed available for this patient, because the patient came from here. And he informed me that this patient had AIDS and also had skin cancer as a result of AIDS and needed nursing care and so on.

So that was the basic...but in fact checking back on the records we knew that she'd got AIDS here, she had been in to us, last year, with a skin infection and had been tested for AIDS but had been discharged before the result came back. And then we lost track of her, we couldn't track her down, and in the meantime she'd gone to school in another town.

UMWELT

Before

U S describes the context of his first encounter with an HIV infected person. After being contacted by the superintendent of another hospital, S agreed to admit the patient, who came from this area. The patient had developed AIDS with a skin-related opportunistic infection.

U S points out that when the records were checked it was discovered that this patient had previously been at the hospital and was recorded as suffering from a skin complaint. The patient had been tested for HIV but had been discharged before the test result was received; thereafter the hospital lost contact with the patient as she had gone to school in a nearby town.

So that was the situation, so I knew she had AIDS before she came in and then we arranged a bed for her and I spoke to the nursing staff about it,

Q Was there any of that fear in you before seeing this patient. A I think initially, when the disease first came to note, yes there was,

Our first AIDS patient in fact we handled a year-and-a-half ago and didn't know that we had handled it. It was a case where the patient was referred to another town and it was after the person had died there, the diagnosis that it was AIDS came through

this was one of the first cases in the area, then the Transvaal and Natal...

this was of the heterosexual type.

Q Was this one of your first cases. A This was the first that we knowingly admitted.

Q It was simply like accepting another patient. A Yes, that's right.

This person arrived at night and so was kept in Outpatients overnight, because uh...and then was admitted to the ward the next day. Um...and then I went across to see what the story was.

During

Q Physically how did this person appear to you, can you describe her. A Physically she looked well, a little bit drawn, but reasonably well, she wasn't rag and bones or anything like that.

U S reiterates that they knew the patient was HIV-positive before she arrived. A bed was arranged for the patient and the nursing staff were informed.

U S experienced fear towards AIDS patients initially, especially in the early stages of the disease's emergence.

U The first HIV/AIDS patient in the hospital had been handled a year and a half before. The hospital was unaware at the time that the patient had been HIV positive. This fact was only discovered once the patient died after being transferred to another hospital.

U The first case of HIV/AIDS at the hospital was one of the first cases in the province: up until then cases had been confined to other provinces.

U The first HIV/AIDS case was of the heterosexual type.

U This was the first case of HIV/AIDS admitted to the hospital knowingly.

U Receiving this HIV-positive person into the hospital was, according to S, the same as accepting any patient.

U S explains that the patient arrived at night, was admitted to Outpatients, and then transferred to a ward the following day. S then went across to the ward to ascertain the situation himself.

During

U S describes the patient as looking physically well. She was a little drawn, but not emaciated.

Um...myself, I was not scared or anything like that, it was a case of, I know that if you take proper precautions and you are careful, then you have got no problem, basically, so that was my situation.

Q How did you prepare yourself before you saw her. A Had I been examining her physically and touched her I would have put gloves on. Gloves were available but I decided not to use them because of the nature of my contact with her.

Q To what extent did you feel that you could be at risk in that situation. A I knew I could be at risk, ja...but then I know that there are precautions that you take to try and minimize the risk as much as possible. And I wasn't using any instruments on her so... .

Q What were the opportunistic infections in this case. A She had *Kaposi's sarcoma*. Q *Kaposi's* is an opportunistic infection seen more often in the West. A No, *Kaposi's sarcoma* is a cancer which uh...is - can occur in any population, but it has been found to be very prominent with homosexuals. It was initially seen in homosexuals when they were linked together with AIDS. There was a sudden increase in *Kaposi's sarcoma* in gay communities in the States.

Uh...in Africa it is quite a common presentation of *Kaposi's sarcoma* as being a manifestation of AIDS and certainly it is more common now in heterosexual AIDS, and it is being noticed up North now as quite a common manifestation.

This person had been diagnosed with K.S. at another hospital.

U S was not scared of the patient, this was because he was aware that if he took the correct precautionary measures he would be safe.

U S did not examine the patient physically, therefore he decided there was no need to wear gloves even though these were available.

U S knew that he was at risk when he encountered the HIV-positive patient. However, he was aware of the precautions he could take to minimise the risk. S was not physically examining the patient, which had strong implications for the precautionary measures he took.

U S observed the patient was suffering from *Kaposi's sarcoma*. This opportunistic infection can occur in any population though it is common among homosexuals. Initially it was observed in homosexuals when AIDS was first identified: at this point there was a sudden increase in *Kaposi's sarcoma* in homosexual communities in the United States.

U In Africa *Kaposi's sarcoma* is a common opportunistic manifestation of AIDS, and recently its incidence has increased in heterosexual AIDS. S states that it is now being noticed in the Transvaal as a common manifestation of AIDS.

U S reiterates that this patient had been diagnosed with *Kaposi's sarcoma* at the hospital where she had been previously treated.

After

Q Has your understanding of AIDS as a disease altered in any way. **A** No.

Q Has your attitude towards preparation and the use of precautionary measures when dealing with HIV-infected individuals been changed by this experience. **A** No, I would do what I intended to do in any case where infectivity is expected, whether it was Hepatitis B, AIDS, typhoid or meningitis.

Q As a result of this experience has your technique in dealing with patients changed. **A** It's emphasised that...as I said before, when body fluid is involved, yes I will take precautions to make sure I don't get exposed.

Q Do you take these precautionary measures at all times with every person you treat. **A** The same for any highly infectious disease, generally, I take full precautions if I am stitching some-one, dealing with an open wound, or dealing where there are body fluids involved, then I will make sure I'm wearing gloves.

Q Have you always done that. **A** Not until AIDS came into being.

Q So this has changed since the advent of AIDS. **A** Yes, not just as a result of this experience, my views changed before that.

Q Most changes took place before this experience. **A** It didn't really change anything, it just emphasised they were the right things to do. What we decided on doing and what we were doing was correct.

After

U S's understanding of AIDS as a disease has not altered in any way on account of his experience with an infected person.

U S's attitude towards the adoption of precautionary measures when dealing with patients has not undergone any change as a result of this experience. S continues to take the same precautions for all highly infectious diseases such as typhoid, meningitis or AIDS.

U S feels that his experience has served to emphasise that when body fluids are involved he must take precautions in order to minimise the risk of exposure.

U S takes the same precautionary procedures with all highly infectious diseases. He takes full precautions if he is stitching some-one, dealing with open wounds, or just generally when he is in contact with body fluids. In these cases, S wears gloves.

U S has taken strict precautions only since the advent of AIDS.

U S's attitude towards precautionary strategies has changed since the advent of AIDS. His views changed before his first encounter with an HIV-positive patient.

U Most of S's modifications in terms of precautions took place before his first encounter with an infected patient. This encounter merely served to emphasize that these techniques that had been decided upon were in fact necessary and correct.

Q Can we pick up what you were saying about a lot of diseases coming out of Africa. **A** Well, a lot of the major viral diseases over the last decades have come out of Central Africa.

Why it should have suddenly manifested itself in gay populations before it became a noticeably heterosexual disease I don't know, but I think it has quite possibly been incubated in Central Africa before it broke out. Most highly infectious diseases come from Central Africa, the major viral diseases.

But I think that Uh...as a general overview that is certainly my feelings on this. It is now a general disease as opposed to a narrow spectrum disease with a certain sort of community and a certain sort of behaviour which I disapprove of.

Um...look, there is fear amongst my medical staff about the possibilities of infection, without any doubt at all, there is probably some in my mind. But you've just got to be very careful when you are operating now. When using instruments you must be as careful as possible.

Q This concern over precautionary measures, did this come into your thinking before you saw this patient. **A** Not at that instance, because I knew if I was going to examine her I was going to use gloves.

This is standard practice now, with any patient where bodily fluids are involved you wear gloves. So that was really now habit rather than special precautions taken, the fact that it was in my mind was because I knew she had AIDS,

U S states that a lot of the major viral diseases over the last decades have originated in Central Africa

U S is uncertain as to why AIDS appeared in the homosexual community before it did in the heterosexual community. He is, however, quite sure that the disease was incubated in Central Africa, because this area has always been a source of major viral diseases.

U HIV/AIDS is now a general disease as opposed to a narrow-spectrum disease. It is no longer confined to a specific community and form of behaviour that S disapproves of.

U S states that with regard to infection both he and his medical staff feel some fear. However, one must just be careful now when operating and when using certain instruments.

U When encountering the patient that was admitted to the hospital, S was not concerned about precautionary measures because he knew that he would not examine the patient.

U S states that certain precautionary procedures are now standard practise. Thoughts concerning precautionary procedures were in his mind when he encountered the infected patient because these have now become part of the process.

Q How do you feel towards the notion of high-risk groups that AIDS is supposed to be contained within. A Most cases do not exist within those groups, not according to local statistics.

Q What do you feel about that. A Well I think probably deep down there is a little bit of apprehension, but basically if you're doing what you're meant to be doing then there is no real major problem.

Q Do you ever think about the fact you may contract AIDS yourself in your profession. A It has crossed my mind.

Q What do you feel about this. A I don't want to get it - apprehension.

Before I knew about AIDS, if some-one was bleeding and I was busy I would be quite happy to get my hands full of blood, if some-one needed instant care I would be quite happy to stick my thumb in the hole to stop the bleeding; now I'd make sure I had gloves on first

it has made a difference.

MITWELT

Before

Q What level of knowledge about the AIDS disease did you have before this experience, did you feel adequately informed. A Oh yes. Yes.

there was quite a lot of fear amongst the nursing staff about this.

Uh...then uh...we sorted that out by talking to the nursing staff and explaining to them how they must handle it, and that was the situation basically.

U S believes that most of the AIDS cases are not contained within the so-called high-risk groups: local statistics endorse his statement.

U With regard to having to treat all patients, S states that deep down there is some apprehension. However, if one takes the necessary precautionary steps then there is no real problem.

U It has crossed S's mind that as a doctor having to deal with HIV/AIDS patients, he may contract AIDS himself.

U S feels apprehension over the possibility that he may contract AIDS.

U Before the advent of HIV/AIDS S would not have been concerned about being exposed to large quantities of blood in emergency situations. However, his attitude has changed significantly; now he would wear gloves.

U According to S, the presence of HIV/AIDS has made a big difference.

MITWELT

Before

M S felt adequately informed with regard to the HIV/AIDS disease before his initial encounter with an HIV infected person.

M S recalls there was a lot of fear amongst the nursing staff with regard to the patient.

M S states that the fears of the nursing staff were alleviated through discussions about precautionary measures.

Q So on the whole people were quite prepared for this. **A** Well, let me put it this way, we have had discussions amongst the doctors on AIDS often, I have lectured to the Public on AIDS, uh...I... . In this instance because we knew the patient was coming in, the sister in charge of the ward lectured her nurses and went through the whole story with her nurses beforehand and um...report-back sessions with them as well, and any new nurse that comes onto that ward uh...goes through the whole procedure and certainly this has helped them in, in...

we have some who are dead scared of it because of the publicity and this sort of thing, but now they treat her as another patient except they take precautions when necessary.

Q Was there a lot of anticipation on behalf of yourself and your colleagues before this patient arrived. **A** That wasn't the first AIDS patient here - it was the first one that I knew...that I had personally been involved with.

And then we went back and this is when we started proper education, until that stage we had done very little.

Q When you were asked by the other hospital to make a bed available for this person, how did you respond to this request. **A** Uh...basically my response was that if we had a bed available in this section we were going to put her into, we must give her a bed - that we must try and facilitate her life to be as close to her family as possible;

M S explains that the professional staff of the hospital were adequately informed and prepared for this incident, through discussion, lectures and report-back sessions. New staff on the wards undergo a programme of education. S feels this has assisted individuals greatly.

M Some of the staff in the hospital are still anxious about dealing with AIDS patients: this is largely a fear generated through publicity. However, according to S these individuals now treat this particular patient in the same way as they would any terminally ill patient, though they do take the necessary precautions.

M This patient, according to S, was not the first HIV/AIDS case in the hospital. There had been other cases; this, however, was the first that S had been personally involved with.

M Formal education on HIV/AIDS was started in the hospital shortly after the first incident took place.

M When S was requested by the other hospital to make provision for the infected person, he responded by recognising the need for his patient to be looked after in a place which was as close as possible to her own family.

During

Q Can you describe to me your experience when you first came into contact with this person. What were your thoughts, feelings, and attitudes during this encounter. A I felt sorry for her, alright, she's 18 years' old, she's got AIDS, she's now got a death sentence.

Um...she didn't know why she had got AIDS - well, it had been explained to her at the other hospital, but she hadn't understood until that stage.

Q Did you relate to this person in the same way that you would relate to a normal terminally-ill patient. A No, I don't think so.

Q What were your feelings when confronted with this patient. A Sorrow and pity for her situation more than anything else but no revulsion on my part or anything like that - certainly not.

Q Do you see it as important to maintain this veneer in front of your colleagues, especially with reference to this experience. A Yes, I think there was that aspect to it. I think it is very important. The nursing staff must see that what we are saying is true, if you take precautions there is no need to be scared.

Q Were there any other feelings that came to the fore during this experience. A No undue feelings, certainly any young person who is facing terminal illness, I feel more for them than I do for older people who are more towards the end of their life-span and it's part of life-expectancy as far as they're concerned. Um...this person was 18.

During

M When S first encountered the HIV patient, he felt sorry for her because he saw her as a 18 year-old girl who has AIDS, and therefore has a death sentence.

M S states that the patient was not aware of why she had AIDS. It had been explained to her at the previous hospital, but initially she had not understood.

M S states he did not relate to this patient in the same way that he would to other terminally ill patients.

M When S confronted this patient he felt sorrow and pity for her condition. There was certainly no feeling of revulsion on his part.

M S sees it as important to maintain a professional facade above personal feelings, especially with regard to setting an example in front of the hospital staff. S refers to the incident where the first HIV case presented herself in the hospital.

M S felt sorry for the patient on account of the fact that she was a young person with a terminal illness. S feels more pity for cases of this sort, who are young, than he does for elderly people in the same position. For elderly people S sees this in terms of life-expectancy.

Certainly this is something I've noticed in my professional life, I feel more for young people. You know I... I...have more empathy for young people in terminal illness than I have for older people. It's part of their life-story at that stage whereas with young people it's totally unfair.

Q How did you communicate with her.
A Through an interpreter partly, she can speak a little English...but through an interpreter.

Q What was the nature of your interaction with her. **A** I asked her how she was feeling, I asked her if she knew what was wrong with her,

she said yes, she had been told she's got AIDS; I asked her if she knew what that meant. Um...and she said yes, she had been counselled, that her parents had been counselled but she didn't think her mother really understood.

Um...then we started questioning her a little bit and we found that she had a very superficial knowledge, that it hadn't really penetrated, she knew that she had got something she wasn't going to get better from.

Um...there was a sort of...what's the word I want...a certain placidity, she had come to terms with the situation with herself as far as I could see, within the means of her intellect, I think that's the way to put it. There was a feeling of fatalism.

After

Q Have your perceptions of HIV-infected persons changed as a result of your experience. **A** No, I don't think so.

Q Has your perception of AIDS sufferers undergone any modification on

M S has noticed in his professional life that he feels more compassion for young people who are terminally ill than he does for older people. Death is part of the elderly person's life-story, whereas with young people it is totally unfair.

M S communicated with the patient mostly through an interpreter, although the patient could speak a little English.

M S asked the patient how she was feeling and whether she knew what was wrong with her.

M The patient stated she had been told she had AIDS. The patient said she had been counselled along with her parents as to the nature of the disease. However, she felt that her mother did not really understand.

M S states that the patient revealed after some questioning that her own understanding of the disease was very superficial. She had not grasped a full understanding though she was aware she would not get better.

M S observed a certain placidity in the patient: she had, within the means of her intellect, reached an understanding of her condition. There was a sense of fatalism in her perception.

After

M S does not feel his perceptions of HIV infected individuals have changed on account of his experience with this patient.

M Since his experience with an HIV infected person, S's perception of AIDS

account of your experience. **A** I think having seen people with AIDS I am a lot more sympathetic towards them than when this was just a general topic for discussion on this sort of thing. Yes.

Q So you feel more sympathy and compassion. **A** I think so, I think so, when you actually see how people suffer from it.

You know when you see a...I will quote another case to you - I wasn't involved in it, but we picked up one girl who was positive, she was pregnant and her consort was positive and the baby was born positive and the baby is now dead. I mean that...you feel a lot of sympathy in that situation, I mean the poor little mite had no chance. That's the only one we've had that we know of.

Q Has the experience of the AIDS patient caused any adjustment in your behaviour towards patients, your colleagues, or other people. **A** No.

Q Your relationship towards those that work with you - has this changed. **A** No, I don't think so. They are doing what I would expect them to do.

Q Have your interactions with your colleagues and other health-care workers had any bearings on your own experience. **A** Yes,

because I've, I've had to Uh...talk to my colleagues about the disease and what they must do about it and some of them have been quite fearful about it. And I've had to sort of explain the situation to them.

It's helped me in that...because I've had to educate my-self as much as possible in order to be able to pass on the information to them and make sure

sufferers has changed in that he is now more sympathetic towards them than when AIDS was merely an abstract topic for general discussion.

M S believes that he feels more sympathy and compassion now that he has actually seen how people suffer from HIV/AIDS.

M S relates another recent case involving a girl who was HIV-positive; her consort was also positive and she was pregnant. When the baby was born it was also positive. In this recent case S felt strong sympathy especially for the child who had been given no chance in S's view. This is the only case of this nature recorded by the hospital.

M S's experience with an infected person has not caused any adjustment in his behaviour towards his patients, colleagues or other people in general.

M S's relationship towards his colleagues has not changed since the experience.

M S's understanding of HIV/AIDS has been influenced by his relations with his colleagues and other health-care workers.

M S has had to talk to his colleagues about the disease, in terms of the measures they need to adopt. S has also had to try to alleviate fears when they have arisen.

M S's dealing with his colleagues on the topic of HIV/AIDS has been beneficial to him - this is because, in order to effectively discuss and

that they understand the situation and they take the adequate precautions and that sort of thing when they handle the patients themselves.

Q Did your relationship between yourself and your colleagues undergo any change after you or they had this experience. A No.

Q Is your view of this disease similar to that of your colleagues. A A couple of my colleagues are a lot more vociferous about it than I am, and less accepting of it than I am certainly,

and I think this is a general feeling throughout the medical profession. There are some people who are totally against anybody with AIDS but they are just in a situation where they have just got to grin and bear it.

Q You have been running AIDS education programmes with these people. A We have been running AIDS education.

Q How do you feel about the negative aspects of Society's perception of AIDS. A My role as a doctor is to try and make the public understand that basically this is an infectious disease like any other infectious disease;

to educate the public that certainly certain behavioural patterns will increase the risk of contracting AIDS and other behavioural patterns will not.

Um...and to allay the fears and fallacies, that I think is a big role, education.

Q You see yourself as playing an educative role. A Oh yes, I think so.

transmit information to these persons, he has had to be very well informed himself.

M S's relationship with his colleagues has not undergone any change on account of this first experience.

M Some of S's colleagues are more vociferous and less accepting than himself with regard to HIV/AIDS.

M S sees the medical profession as incorporating a number of people who are very opposed to dealing with PWA's. However, these individuals are in a position where they have no choice and have to do so.

M S has been running AIDS education programmes with the hospital nursing staff.

M S separates his role and duty from the influence of Society's negative perceptions of HIV/AIDS.

M S explains that his role as a doctor is to educate the public into an awareness of the highly infectious nature of HIV/AIDS, and to draw the public's attention to the various risk activities that give rise to infection.

M As a part of his role S perceives his duty to include the allaying of fears and fallacies through educating people.

M S perceives himself as fulfilling an educative role.

Q How do you see yourself as transmitting this. **A** Well, I have been asked to speak to groups and I have done, and friends ask me questions and I discuss it with them.

Q Do your friends see you in this role as educator. **A** It comes up in conversation, they see me as a doctor with medical knowledge. People have come to me to seek knowledge on this.

Q When you deal with your patients do you attempt to educate them. **A** Not unless they ask me questions, I don't push the knowledge. No I lie: there was one young lady who worked on a fishing boat off the coast, she was fairly promiscuous and she fell pregnant and I suggested to her and her family doctor that she be checked out for AIDS. Um...apart from that, no.

Q If people are promiscuous then you feel it is necessary to educate them and have them tested. **A** Yes.

Q Most people that come into your rooms you feel do not need education from yourself about this topic. **A** No, not on a general basis.

Q Do you see yourself as playing an important role in educating your staff. **A** What we've done here is that we have had directives and policies sent to us from Head Office to be disseminated amongst staff, we've made ourselves available to answer questions, to discuss it if necessary.

Q Do you see yourself as a doctor being in a position whereby your perception and knowledge of the AIDS phenomenon may influence and contribute to the general understanding of AIDS held by Society. **A** I think that one of the roles the doctor has to plan is to educate their patients and indirectly the public as a result of that.

M S enacts his perceived duty as educator by speaking to groups and friends when they request information.

M S's friends perceive him as fulfilling an educative role by virtue of the fact that he is a medical professional and is therefore knowledgeable on the topic of HIV/AIDS.

M S does occasionally attempt to educate his patients with regard to HIV/AIDS, when he thinks it is necessary. S relates a case where a patient with a high degree of promiscuity fell pregnant. S suggested to the patient and her family doctor that she be tested for HIV.

M If people are promiscuous S feels it is necessary to educate them about AIDS and encourage them to take a test.

M S does not generally perceive it as necessary to educate most of his day-to-day patients.

M With regard to educating the hospital staff S explains that directives and policies concerning staff education are sent from Head Office. The senior staff in the hospital have made themselves available to explain and discuss this material with the staff if necessary.

M S perceives his role as a doctor as including the need to educate patients and indirectly the public. In this sense S sees the general practitioner as being in a position whereby his perception and knowledge of the AIDS phenomenon may influence and contribute to the general understanding of AIDS held by Society.

To let people come to an understanding and be able to handle their own feelings; and make the best they can of the information given to them.

Q Can we talk about the negative views that form part of the general perception of Society. **A** I have often wondered in my own mind if this might not be a new plague - a different plague, it's one way of dealing with over-population, though it is a very drastic way it's one way.

It's interesting that most of these fancy diseases that you get which we have no medicine for and which present problems to medicine come out of Central Africa and uh...yes, I do wonder why the possible reasons for...

I don't think it's an indictment of gay behaviour, I mean gay behaviour has been here since time immemorial, a way of life for certain people, it means nothing to me...but if somebody wants to live that way it's their prerogative as long as it doesn't affect me.

Q How do you feel the negative view towards AIDS sufferers may affect those that are infected. **A** I think the fact that Society has always been antagonistic towards gay behaviour, and the fact that AIDS first manifested itself among gays certainly has a hell of a lot to do with Society's attitude towards AIDS sufferers as a whole.

Um...that, of course, I think is basically the general Public's idea.

Now I think basically there is more fear amongst the Public because there is much more of an understanding.

M S sees himself as in a position where he can assist people to a personal understanding of HIV/AIDS on an intellectual and emotional level based on the information they are given.

M S has at times adopted the negative view towards HIV/AIDS sufferers held by Society. In this sense he has perceived the disease as a new plague, a drastic way of dealing with over-population.

M S finds it interesting that most of the diseases that present problems to medicine originate in Central Africa. S mentions these thoughts in relation to the negative views surrounding the origins of these diseases sometimes held by Society.

M S does not see HIV/AIDS as an indictment of gay behaviour. According to S homosexuality has existed since time immemorial. It is a way of life for certain people and it is their prerogative to live this way so long as it does not affect S.

M S is certain that a large part of the negative social perception of HIV/AIDS is built around the fact that Society has always been antagonistic towards homosexuality. Presently Society associates AIDS with homosexuality and this accounts for their attitude towards AIDS sufferers.

M S sees his view as representative of the general public's view.

M S believes there is now a greater fear in the public, because they are aware the disease is no longer confined to specific communities. They understand the issue better now.

Q Do you think people are fully aware of this disease and its implications. A No, Society is becoming more aware, Society is becoming more aware,

certainly the only way this disease can be dealt with at the moment is through Society and the education of Society.

It is very difficult to get through to the population at risk, a lot of them just won't change their attitudes, take the students, some of them say come and test me for AIDS but they will still go and be promiscuous.

Then you have cultural problems where promiscuity becomes a way of life; lack of understanding; politics, there are a lot of different aspects.

Q What are your observations with regard to the future incidence of the disease in this area. A Well basically with the extrapolations put forward - the scenarios of the potential cases of AIDS - it has worried me that if all potential cases require hospitalization at the same time for various reasons, then the Health Authorities in this country will not be able to cope with the demand and there are going to be no beds for sick patients,

this is one of the things that worries me, the effects of the disease on the economy if it spreads as it is expected to.

We would have to rely to a great extent on the Public, through Hospice and the AIDS counselling programme - which is in its infancy - but it is there to - um to try and help us as much as possible so that we could keep beds available for people that are ill.

M S believes that Society is becoming more and more aware of this disease and its implications.

M In S's opinion the only way to deal with HIV/AIDS at the moment is through educating Society.

M S states it is very difficult for educational strategies to make an impression upon those at risk. Many persons are very reluctant to change - S cites the examples of students who visit him for tests but continue to be promiscuous.

M Other problems militating against effective education include cultural factors such as promiscuity as a way of life and factors such as ignorance and the politico-economic scenario.

M With regard to the future incidence of HIV/AIDS in the local region, S is concerned about the fact that if the predicted scenarios materialise, then the Health Care systems, not only locally, but throughout the country, will not be able to cope.

M S is very concerned about the effects of the disease upon the economy if it spreads as it is expected to.

M If the disease reaches the proportions it is expected to, S states it will be necessary to rely to a great extent upon the public and various non-governmental organizations.

Q In your capacity as a medical practitioner, what do you perceive as constituting your role in this situation. A My role as a doctor is to provide help where I can.

Personal feelings, if it was purely a homosexual disease I think probably my feelings might differ slightly, the fact is that it is basically a promiscuity basis.

but if I didn't know she had AIDS I probably would have worn gloves to examine her anyway.

Um...but other precautions: if she had needed surgery or anything like that then we would have taken full precautions.

She has responded very well to the care and treatment that she is getting. And she's come out, she's part of the Ward community, she's not shunned, she joins in on the games and that sort of thing that they do: she's in the chronic section, they organize bingo sessions and togetherness things. And she joins in on those things

and this is what happens, she goes home to her family and comes in for dressings and so on and we keep the bed available for her.

and the patients, if they know what her illness is, it doesn't make any difference. I don't know whether some of them know.

Q On the part of your nurses this response would have been fostered through education techniques. A Definitely yes, the degree of acceptability -

M S's role in the future with regard to HIV/AIDS will be to provide help wherever possible.

M S states that were HIV/AIDS purely a homosexual disease, his feelings towards the disease might differ slightly. However, whether it is homosexual or heterosexual, S recognises it as being based essentially on promiscuity.

M S states that had he not known this patient was HIV-positive, he would probably have worn gloves anyway.

M If this patient had required surgery then the surgical staff would have taken full precautions.

M According to S, the infected patient in their care has responded very well to treatment; she has been accepted by the ward community and she has been encouraged to participate in group activities.

M S states that this is what happens: the patient visits her family, returns for medical care when necessary, and the hospital keeps a bed for her.

M The patients in the ward have accepted the HIV infected patient without reserve. S is unsure whether the other patients are aware of the exact nature of her illness.

M The degree of acceptance shown by the nursing staff is related to the education they have received.

there has been one nurse who has found it very difficult but even she has mellowed, Um...she's still not a hundred percent happy but she's fairly new on the ward, but even she has settled down and is much better than at first. At first she was terrified when she had to talk to the patient, she would stand just inside the door and talk from the other side of the room.

This is wrong, but you have to convince them so it's a matter of educating them to get over cultural feelings and that sort of thing, which is difficult, unless you can communicate effectively. The sister in charge fortunately has been very helpful.

Q So far you have indicated that you tend to see the disease purely in medical terms rather than in any other way. Do you feel you may be influenced in any way at all by external perceptions. **A** Not as far as the heterosexual AIDS is concerned, but with the homosexual variety I would have some feelings for that.

Q Could you elaborate on that - do you feel differently towards those that have contracted the disease heterosexually as opposed to homosexually. **A** No, possibly I would because I had an experience as a child with a homosexual, certainly -

but since then I have treated homosexuals and had them as patients and established a good relationship with them when they have said, you know, that they have felt I have empathy for their feelings uh... . But no, there certainly is deep down a thing about homosexuality as far as I'm concerned so...but that is a personal thing as opposed to a professional thing, I don't think it would affect my judgement on a medical basis.

M S explains that one of the new nurses who was initially very resistant to dealing with AIDS patients has relaxed her attitude. Initially this nurse would have refused to have physical or verbal contact with the patient.

M S believes it is wrong for staff to be resistant towards infected patients. Education aimed at overcoming cultural beliefs held by the staff is necessary, even though it is difficult to implement. Other members of staff have been very helpful with regard to education of the staff.

M S tends to see the disease purely in medical terms, however, he feels his perception may to a certain extent be influenced by the general perception held by Society in so far as the homosexual aspect of the disease is concerned.

M S's negative childhood experiences with a homosexual may, he acknowledges, influence his perception of infected individuals when it has been contracted through this form of behaviour.

M S's recent dealings with homosexuals have been characterised by good relations and empathy on his part. However, he acknowledges he has very deep feelings towards this lifestyle that derive from personal experience. He states that this attitude is personal and he does not think it will affect his professional judgement.

Q To a certain extent you say you are affected by external perceptions towards this disease, do you think these perceptions may influence your relationship with and goal towards caring for these individuals. **A** I don't think that would affect me, based on my experience of treating homosexuals in the past as an ordinary medical attendant or G.P..

Q So what you are saying is that your reservations about certain groups that show a high incidence of AIDS derives from personal experience rather than an external perspective. **A** That's right.

Q It is this that inspires you then to be more cautious. **A** It has certainly made me conscious of the fact that I should take more precautions.

Q You are married and have children, what are your feelings towards them, taking AIDS into the context. **A** Well, the worry is that if I get AIDS and am unable to support them, um...then what's going to happen. Yes, you can take out insurance but you have to be able to afford it in the first place.

Q Your main concern here then is not yourself but the effect on your family. **A** Yes.

Q What about your interaction with your family - do you see yourself as infecting them at any point in time. **A** No, that hasn't crossed my mind.

Q Do you perceive your old patients in a new light; or perceive new patients in a different way. **A** No, just the same as before.

Q Have any of your patients shown any reaction to your being a possible high-risk person. **A** No, not to my knowledge.

M S is aware that his conception of HIV/AIDS is to a certain extent influenced by external perceptions. However, in terms of his relationship to patients, he feels these influences will not affect him. S has had plenty of past experience with homosexual patients and has consequently established his professional stance in this regard.

M S's reservations about certain risk groups that exhibit a high incidence of HIV/AIDS derive from personal experience, rather than from external societal perceptions.

M S's principal concern with regard to contracting HIV relates to his family. This issue is a far more serious issue than his attitude to his profession.

M With regard to his wife and children, S is worried that if he were to contract the disease he would be unable to support them. It is possible to take out insurance but it is very expensive.

M S's main concern with regard to HIV/AIDS is not orientated to himself, but rather to his family.

M S does not see himself as possibly transmitting HIV to his family.

M S does not perceive his old patients in a new light, nor new patients in a different way, on account of his experience with an HIV infected person.

M None of S's patients have given any indication of the fact that they may perceive S as a possible high-risk individual.

Q Do you anticipate this happening.
A If it would mean less work I would be quite happy! [laughs].

Q Do you think this disease complicates the fundamental goals that underlie the medical profession such as giving care. A I suppose it's possible, certainly for some individuals it will.

Q Do you see yourself as a doctor being given enough opportunity to learn about AIDS. A Oh yes, there is a lot of opportunity. There is literature, conferences - the opportunities are there, it's up to you to take it. If I pick up anything my staff will know about it, so it's an in-service education.

EIGENWELT

Before

but then as more information was made available and having attended a couple of congresses where AIDS was the main topic, and dealing with cross-infection and this sort of thing and speaking to people who've been involved in nursing AIDS cases and handling AIDS cases, I felt that I was well prepared to cope with the situation when it did arise.

And this is what I've found with time, I've become...I've been through enough pre-discussion etc etc to sort my attitude out so that I can cope with it as opposed to suddenly being confronted.

Q So mentally you felt you had prepared yourself very well. A Yes.

Um, personal feelings - nothing really of note, there was no apprehension or anything like that.

M S does not seriously consider this happening.

M S believes that for some health care workers it is possible that the HIV/AIDS epidemic may in fact complicate certain fundamental goals of medicine.

M S feels that he has been given enough opportunity as a doctor to learn about HIV/AIDS: education is available in the form of literature and conferences. Information is available; it is, however, up to the doctors themselves to make use of this and in turn educate their colleagues.

EIGENWELT

Before

E S became more confident in his ability to cope with the concept of AIDS once he became more familiar with the disease through various forms of information, such as attending congresses; and speaking to people involved in treating Persons With AIDS. S felt well prepared to cope with the situation when it did arise.

E S feels that his exposure to discussion and other forms of information has over time helped him to define a coping attitude towards the disease. This attitude equipped and prepared S for his first encounter.

E S feels that he was psychologically well-prepared for his first meeting with a PWA.

E Regarding S's personal feelings relating to this first encounter, there was nothing of note, and no apprehension.

During

During

After

Q The changes largely came about through dealing with the issue previously, rather than facing the experience itself. A Yes, that's it.

It worries me, contracting AIDS, if I should: what about my family, the effect on my family, what do I do about that. That is a more serious thing rather than my working attitude.

Q Your attitude then is less severe. A No not much, but in some cases.

Q What do you feel about these extreme views. A They are entitled to their views, but certainly we doctors take on the Hippocratic Oath and the WHO Oath and we have to basically stick to this.

Q Do you feel this means doctors are bound to a sense of duty. A If possible.

Q Do you do that yourself. A I try to.

um...the fact that I'm a Government employee doesn't give me any choice in the matter. If a patient comes it doesn't matter what they've got - you've got to treat them. It's not like private practice where you have that choice.

Q Society has a particular perception of AIDS, do you feel influenced by this perception in your professional capacity. A Uh...yes, probably I am influenced by it, but at the same time um...professional training and working

After

E Most changes that took place in S's attitude and practise with regard to precautions happened long before his encounter with an infected person.

E S's fear relating to what his family will do if he contracts AIDS is one of the factors which has encouraged him consciously to take heed of precautionary measures.

E S sees his attitude as being in some cases less severe relative to the more radical views of others in the medical profession.

E S feels that his colleagues are entitled to their own views concerning HIV/AIDS, however, all doctors are bound to the Hippocratic Oath and the World Health Organization Oath and must adhere to this.

E S feels that wherever possible doctors must fulfil their duty.

E S tries to fulfil his sense of duty as a doctor.

E S explains that as a Government employee he is obliged to treat all patients regardless of their disease or its origin. Unlike those who are in private practise, Government doctors do not have any choice.

E S feels that even in his professional capacity his perception of HIV/AIDS is to some extent influenced by Society's attitude towards this phenomenon. However, his years of professional training and work has given him the

for a long time, there is a veneer over the top and I don't worry about that, I deal with what's going on at the time.

Um...I don't brood over it or anything like that, or I haven't.

Q This "veneer over the top" - is it a veneer over your personal feelings. **A** Yes, personal feelings never come to the fore, personally.

Q Do you see it as important to keep the two separate. **A** Yes... Oh yes.

Q Is it easy to do this. **A** Yes...there is tension at times, but...yes, personal feelings don't come to the fore.

The fact that it has now become a heterosexual disease and it's a wide spectrum of the population rather than a very narrow spectrum Uh...certainly has changed my basic attitude towards it being a gay disease. When it's a gay disease I think if you want to be that way then you take the risks but when it's a general thing then you look at it with a different mind - I may have contradicted something I said earlier.

Ja, I think it's damned unfair.

Q Did the meaning of being a doctor have to be re-evaluated or re-assessed in any way. **A** No,

I wouldn't change my profession, I am totally committed, if I had the choice to live again I would choose the same profession. I might not end up in the same field of medicine but I would be in medicine.

ability to block out such perceptions and deal with each incident in a non-judgemental, professional manner.

E S has not been up to this point unduly pre-occupied with the social aspect of HIV/AIDS.

E S never allows his personal feelings to come to the fore when he is working in a professional capacity.

E S sees it as important to keep his personal feelings separate from his professional role.

E S finds it relatively easy to keep his personal feelings out of his professional role. At times there is tension but generally personal feelings do not come to the fore.

E S's view of HIV/AIDS has altered since it became a heterosexual disease which covers a relatively wide-spectrum of the population. As a homosexual disease S felt that if a person chose this lifestyle then they must take the risks. However, as it is now a heterosexual disease he views things differently. S acknowledges he may have contradicted himself.

E S feels that it is extremely unfair that people contract the disease through no fault of their own.

E S has not had to re-evaluate or re-assess his role as a doctor in any way, on account of his experience with an infected person.

E Despite the risk involved in his work, S would not give up his profession: he is totally committed to medicine. If he were able to have his life over again he would choose again to work in the field of medicine.

Q Do you see yourself as having to work harder in the future because of the AIDS epidemic. **A** If the work's there to be done it will be done. That's the way it is, we have got so many medical officers and if the work has to be done we will do it, that's what we're here for: that's my philosophy.

Q And for yourself. **A** Not so far, not so far.

E If S has to work harder in the future because of the way the HIV/AIDS epidemic is progressing, then he will do so. S sees this as his duty.

E So far the HIV/AIDS epidemic has not interfered with any of the fundamental principles of medicine which S works by.

5.2: Table Two: Subject Three: Individual Thematic Description

UMWELT

Before

Historical context

U The first HIV/AIDS patient in the hospital had been handled a year and a half before. The hospital was unaware at the time that the patient had been HIV-positive. This fact was only discovered once the patient died after being transferred to another hospital.

U The first case of HIV/AIDS at the hospital was one of the first cases in the province: up until then cases had been confined to other provinces.

Immediate context

U S describes the context of his first encounter with an HIV infected person. After being contacted by the superintendent of another hospital, S agreed to admit the patient, who came from this area. The patient had developed AIDS with a skin-related opportunistic infection.

U This was the first case of HIV/AIDS admitted to the hospital knowingly.

U S explains that the patient arrived at night, was admitted to Outpatients, and then transferred to a ward the following day. S then went across to the ward to ascertain the situation himself.

Meaning of behavioural practices in the context of potential HIV transmission

U The first HIV/AIDS case was of the heterosexual type.

Emotions engendered through the presence of HIV/AIDS in Subject's experienced world

U S experienced fear towards AIDS patients initially, especially in the early stages of the disease's emergence.

Physical preparation prior to encounter

U S reiterates that they knew the patient was HIV-positive before she arrived. A bed was arranged for the patient and the nursing staff were informed.

Subject's statistical understandings within the context of the HIV/AIDS disease

U S points out that when the records were checked it was discovered that this patient had previously been at the hospital and was recorded as suffering from a skin complaint. The patient had been tested for HIV/AIDS but had been discharged before the test result was received; thereafter the hospital lost contact with the patient as she had gone to school in a nearby town.

Subject's experience of a patient as HIV infected

U Receiving this HIV-positive person into the hospital was, according to S, the same as accepting any patient.

During

Considerations engendered by physical presence of HIV infected patient

U S describes the patient as looking physically well. She was a little drawn, but not emaciated.

Immediate context

U S reiterates that this patient had been diagnosed with *Kaposi's sarcoma* at the hospital where she had been previously treated.

Subject's experience of the patient as physical disease

U S observed the patient was suffering from *Kaposi's sarcoma*. This opportunistic infection can occur in any population though it is common among homosexuals. Initially it was observed in homosexuals when AIDS was first identified: at this point there was a sudden increase in *Kaposi's sarcoma* in homosexual communities in the United States.

Precautionary behaviour within the context of HIV/AIDS

U S was not scared of the patient, this was because he was aware that if he took the correct precautionary measures he would be safe.

U S did not examine the patient physically, therefore he decided there was no need to wear gloves even though these were available.

U S knew that he was at risk when he encountered the HIV-positive patient. However, he was aware of the precautions he could take to minimise the risk. S was not physically examining the patient, which had strong implications for the precautionary measures he took.

Subject's statistical understandings within the context of the HIV/AIDS disease

U In Africa *Kaposi's sarcoma* is a common opportunistic manifestation of AIDS, and recently its incidence has increased in heterosexual AIDS. S states that it is now being noticed in the Transvaal as a common manifestation of AIDS.

After

Changing meaning of HIV/AIDS through the experience of a concrete encounter

U S's understanding of AIDS as a disease has not altered in any way on account of his experience with an infected person.

U According to S, the presence of HIV/AIDS has made a big difference.

Meaning of behavioural practices in the context of potential HIV transmission

U HIV/AIDS is now a general disease as opposed to a narrow-spectrum disease. It is no longer confined to a specific community and form of behaviour that S disapproves of.

Personal emotion

U S states that with regard to infection both he and his medical staff feel some fear. However, one must just be careful now when operating and when using certain instruments.

U With regard to having to treat all patients, S states that deep down there is some apprehension. However, if one takes the necessary precautionary steps then there is no real problem.

U It has crossed S's mind that as a doctor having to deal with HIV/AIDS patients, he may contract AIDS himself.

U S feels apprehension over the possibility that he may contract AIDS.

Precautionary behaviour within the context of HIV/AIDS

U S's attitude towards the adoption of precautionary measures when dealing with patients has not undergone any change as a result of this experience. S continues to take the same precautions for all highly infectious diseases such as typhoid, meningitis or AIDS.

U S feels that his experience has served to emphasise that when body fluids are involved he must take precautions in order to minimise the risk of exposure.

U S takes the same precautionary procedures with all highly infectious diseases. He takes full precautions if he is stitching some-one, dealing with open wounds, or just generally when he is in contact with body fluids. In these cases, S wears gloves.

U S has taken strict precautions only since the advent of AIDS.

U S's attitude towards precautionary strategies has changed since the advent of AIDS. His views changed before his first encounter with an HIV-positive patient.

U Most of S's modifications in terms of precautions took place before his first encounter with an infected patient. This encounter merely served to emphasize that these techniques that had been decided upon were in fact necessary and correct.

U When encountering the patient that was admitted to the hospital, S was not concerned about precautionary measures because he knew that he would not examine the patient.

U S states that certain precautionary procedures are now standard practise. Thoughts concerning precautionary procedures were in his mind when he encountered the infected patient because these have now become part of the process.

Subject's statistical understandings within the context of the HIV/AIDS disease

U S believes that most of the AIDS cases are not contained within the so-called high-risk groups: local statistics endorse his statement.

U S states that a lot of the major viral diseases over the last decades have originated in Central Africa

U S is uncertain as to why AIDS appeared in the homosexual community before it did in the heterosexual community. He is, however, quite sure that the disease was incubated in Central Africa, because this area has always been a source of major viral diseases.

The meaning for the subject of the body and its parts in the context of HIV/AIDS

U Before the advent of HIV/AIDS S would not have been concerned about being exposed to large quantities of blood in emergency situations. However, his attitude has changed significantly; now he would wear gloves.

MITWELT

Before

Education of colleagues

M S states that the fears of the nursing staff were alleviated through discussions about precautionary measures.

M S explains that the professional staff of the hospital were adequately informed and prepared for this incident, through discussion, lectures and report-back sessions. New staff on the wards undergo a programme of education. S feels this has assisted individuals greatly.

M Formal education on HIV/AIDS was started in the hospital shortly after the first incident took place.

Influence of others/professional

M S felt adequately informed with regard to the HIV/AIDS disease before his initial encounter with an HIV infected person.

Relationship between subject and patient in 1st encounter

M This patient, according to S, was not the first HIV/AIDS case in the hospital. There had been other cases; this, however, was the first that S had been personally involved with.

Subject's perception of colleagues' response to HIV/AIDS

M S recalls there was a lot of fear amongst the nursing staff with regard to the patient.

M Some of the staff in the hospital are still anxious about dealing with AIDS patients: this is largely a fear generated through publicity. However, according to S these individuals now treat this particular patient in the same way as they would any terminally ill patient, though they do take the necessary precautions.

Subject's relationship to known HIV infected patient

M When S was requested by the other hospital to make provision for the infected person, he responded by recognising the need for his patient to be looked after in a place which was as close as possible to her own family.

During

Assessment of known HIV infected patient

M S observed a certain placidity in the patient: she had, within the means of her intellect, reached an understanding of her condition. There was a sense of fatalism in her perception.

Subject's relationship to terminally ill patients

M S felt sorry for the patient on account of the fact that she was a young person with a terminal illness. S feels more pity for cases of this sort, who are young, than he does for elderly people in the same position. For elderly people S sees this in terms of life-expectancy.

M S has noticed in his professional life that he feels more compassion for young people who are terminally ill than he does for older people. Death is part of the elderly person's life-story, whereas with young people it is totally unfair.

Subject's relationship to known HIV infected patient

M When S first encountered the HIV patient, he felt sorry for her because he saw her as a 18 year-old girl who has AIDS, and therefore has a death sentence.

M S states he did not relate to this patient in the same way that he would to other terminally ill patients.

M When S confronted this patient he felt sorrow and pity for her condition. There was certainly no feeling of revulsion on his part.

Subject's perception of patient's understanding of his/her condition

M S states that the patient was not aware of why she had AIDS. It had been explained to her at the previous hospital, but initially she had not understood.

M The patient replied to S, stating she had been told she had AIDS. The patient said she had been counselled along with her parents as to the nature of the disease. However, she felt that her mother did not really understand.

M S states that the patient revealed after some questioning that her own understanding of the disease was very superficial. She had not grasped a full understanding though she was aware she would not get better.

Perception of professional role in relation to others

M S sees it as important to maintain a professional facade above personal feelings, especially with regard to setting an example in front of the hospital staff. *S* refers to the incident where the first HIV case presented herself in the hospital.

Verbal communication with known HIV infected patient

M S communicated with the patient mostly through an interpreter, although the patient could speak a little english.

M S asked the patient how she was feeling and whether she knew what was wrong with her.

After

Education of Public

M S explains that his role as a doctor is to educate the public into an awareness of the highly infectious nature of HIV/AIDS, and to draw the public's attention to the various risk activities that give rise to infection.

M S enacts his perceived duty as educator by speaking to groups and friends when they request information.

M In *S*'s opinion the only way to deal with HIV/AIDS at the moment is through educating society.

M S states it is very difficult for educational strategies to make an impression upon those at risk. Many persons are very reluctant to change - *S* cites the examples of students who visit him for tests but continue to be promiscuous.

M Other problems militating against effective education include cultural factors such as promiscuity being a way of life and other factors such as ignorance and the politico-economic scenario.

Education of colleagues

M S has had to talk to his colleagues about the disease, in terms of the measures they need to adopt. *S* has also had to try to alleviate fears when they have arisen.

M S has been running AIDS education programmes with the hospital nursing staff.

M With regard to educating the hospital staff *S* explains that directives and policies concerning staff education are sent from Head Office. The senior staff in the hospital have made themselves available to explain and discuss this material with the staff if necessary.

M The degree of acceptance shown by the nursing staff is related to the education they have received.

M *S* believes it is wrong for staff to be resistant towards infected patients. Education aimed at overcoming cultural beliefs held by the staff is necessary, even though it is difficult to implement. Other members of staff have been very helpful with regard to education of the staff.

Education of patients

M *S* does occasionally attempt to educate his patients with regard to HIV/AIDS, when he thinks it is necessary. *S* relates a case where a patient with a high degree of promiscuity fell pregnant. *S* suggested to the patient and her family doctor that she be tested for HIV.

M If people are promiscuous *S* feels it is necessary to educate them about AIDS and encourage them to take a test.

M *S* does not generally perceive it as necessary to educate most of his day-to-day patients.

Influence of others/Media

M *S* has at times adopted the negative view towards HIV/AIDS sufferers held by society. In this sense he has perceived the disease as a new plague, a drastic way of dealing with over-population.

Influence of others/personal

M *S*'s negative childhood experiences with a homosexual may, he acknowledges, influence his perception of infected individuals when it has been contracted through this form of behaviour.

M *S*'s recent dealings with homosexuals have been characterised by good relations and empathy on his part. However, he acknowledges he has very deep feelings towards this lifestyle that derive from personal experience. He states that this attitude is personal and he does not think it will affect his professional judgement.

M *S*'s reservations about certain risk groups that exhibit a high incidence of HIV/AIDS derive from personal experience, rather than from external societal perceptions.

Influence of others/Society

M S tends to see the disease purely in medical terms, however, he feels his perception may to a certain extent be influenced by the general perception held by society in so far as the homosexual aspect of the disease is concerned.

M S is aware that his conception of HIV/AIDS is to a certain extent influenced by external perceptions. However, in terms of his relationship to patients, he feels these influences will not affect him. S has had plenty of past experience with homosexual patients and has consequently established his professional stance in this regard.

Influence of others/colleagues

M S's understanding of HIV/AIDS has been influenced by his relations with his colleagues and other health-care workers.

M S's dealing with his colleagues on the topic of HIV/AIDS has been beneficial to him - this is because, in order to effectively discuss and transmit information to these persons, he has had to be very well informed himself.

Influence of others/Professional

M S feels that he has been given enough opportunity as a doctor to learn about HIV/AIDS: education is available in the form of literature and conferences. Information is available; it is, however, up to the doctors themselves to make use of this and in turn educate their colleagues.

Management of known HIV infected patient

M According to S, the infected patient in their care has responded very well to treatment; she has been accepted by the ward community and she has been encouraged to participate in group activities.

M S states that what happens is the patient visits her family, returns for medical care when necessary, and the hospital keeps a bed for her.

Modification of interaction with others subsequent to encounter

M S's experience with an infected person has not caused any adjustment in his behaviour towards his patients, colleagues or other people in general.

M S's relationship towards his colleagues has not changed since the experience.

M S's relationship with his colleagues has not undergone any change on account of this first experience.

Modification of relationship to patients in general subsequent to encounter

M S does not perceive his old patients in a new light, nor new patients in a different way, on account of his experience with an HIV infected person.

Modification of relationship to HIV/AIDS patients subsequent to encounter

M S does not feel his perceptions of HIV infected individuals have changed on account of his experience with this patient.

M Since his experience with an HIV infected person, S's perception of AIDS sufferers has changed in that he is now more sympathetic towards them than when AIDS was merely an abstract topic for general discussion.

M S believes that he feels more sympathy and compassion now that he has actually seen how people suffer from HIV/AIDS.

M S relates another recent case involving a girl who was HIV-positive; her consort was also positive and she was pregnant. When the baby was born it was also positive. In this recent case S felt strong sympathy especially for the child who had been given no chance in S's view. This is the only case of this nature recorded by the hospital.

Perception of professional role in relation to others

M S sees the medical profession as incorporating a number of people who are very opposed to dealing with PWAs. However, these individuals are in a position where they have no choice and have to do so.

M S separates his role and duty from the influence of society's negative perceptions of HIV/AIDS.

M As a part of his role S perceives his duty to include the allaying of fallacies and fears through educating people.

M S perceives himself as fulfilling an educative role.

M S perceives his role as a doctor as including the need to educate patients and indirectly the public. In this sense S sees the general practitioner as being in a position whereby his perception and knowledge of the AIDS phenomenon may influence and contribute to the general understanding of AIDS held by society.

M S sees himself as being in a position where he can assist people to a personal understanding of HIV/AIDS on an intellectual and emotional level based on the information they are given.

M S believes that for some health care workers it is possible that the HIV/AIDS epidemic may in fact complicate certain fundamental goals of medicine.

Perception of changing role in relation to others

M If the disease reaches the proportions it is expected to, S states it will be necessary to rely to a great extent upon the public and various non-governmental organizations.

M S's role in the future with regard to HIV/AIDS will be to provide help wherever possible.

Precautionary techniques in relation to professional procedures

M S states that had he not known this patient was HIV-positive, he would probably have worn gloves anyway.

M If this patient had required surgery then the surgical staff would have taken full precautions.

Relationship to family in the context of HIV/AIDS

M S's principal concern with regard to contracting HIV/AIDS relates to his family. This issue is a far more serious issue than his attitude to his profession.

M With regard to his wife and children, S is worried that if he were to contract the disease he would be unable to support them. It is possible to take out insurance but it is very expensive.

M S's main concern with regard to HIV/AIDS is not orientated to himself, but rather to his family.

M S does not see himself as possibly transmitting HIV to his family.

Subject's knowledge of HIV/AIDS drawn from research findings

M S finds it interesting that most of the diseases that present problems to medicine originate in Central Africa. S mentions these thoughts in relation to the negative views surrounding the origins of these diseases sometimes held by society.

Subject's perception of individuals in terms of high risk activities

M S states that were HIV/AIDS purely a homosexual disease, his feelings towards the disease might differ slightly. However, whether it is homosexual or heterosexual, S recognises it as being based essentially on promiscuity.

Subject's perception of colleagues' response to HIV/AIDS

M Some of S's colleagues are more vociferous and less accepting than himself with regard to HIV/AIDS.

M S explains that one of the new nurses who was initially very resistant to dealing with AIDS patients has relaxed her attitude. Initially this nurse would have refused to have physical or verbal contact with the patient.

Subject's perception of patients' understanding of G.P.s as high risk

M None of S's patients have given any indication of the fact that they may perceive S as a possible high-risk individual.

M S does not seriously consider this happening.

Subject's perception of friends' understanding of doctor's role

M S's friends perceive him as fulfilling an educative role by virtue of the fact that he is a medical professional and is therefore knowledgeable on the topic of HIV/AIDS.

Subject's perception of social attitude to HIV/AIDS

M The patients in the ward have accepted the HIV infected patient without reserve. S is unsure whether the other patients are aware of the exact nature of her illness.

M S does not see HIV/AIDS as an indictment of gay behaviour. According to S homosexuality has existed since time immemorial. It is a way of life for certain people and it is their prerogative to live this way so long as it does not affect S.

M S is certain that a large part of the negative social perception of HIV/AIDS is built around the fact that society has always been antagonistic towards homosexuality. Presently society associates AIDS with homosexuality and this accounts for their attitude towards AIDS sufferers.

M S sees his view as being representative of the general public's view.

M S believes there is now a greater fear in the public, because they are aware the disease is no longer confined to specific communities. They understand the issue better now.

M S believes that society is becoming more and more aware of this disease and its implications.

Subject's perception of future trends in the disease

M With regard to the future incidence of HIV/AIDS in the local region, S is concerned about the fact that if the predicted scenarios materialise, then the Health Care systems, not only locally, but throughout the country, will not be able to cope.

M S is very concerned about the effects of the disease upon the economy if it spreads as it is expected to.

EIGENWELT

Before

Cognitive preparation for the situation of encountering an HIV infected patient

E S feels that his exposure to discussion and other forms of information has over time helped him to define a coping attitude towards the disease. This attitude equipped and prepared S for his first encounter.

E S feels that he was psychologically well-prepared for his first meeting with a PWA.

Personal feelings

E Regarding *S*'s personal feelings relating to this first encounter, there was nothing of note, and no apprehension.

Subject's self-reflections in relation to professional influences

E S became more confident in his ability to cope with the concept of AIDS once he became more familiar with the disease through various forms of information, such as attending congresses; and speaking to people involved in treating PWAs. *S* felt well prepared to cope with the situation when it did arise.

During

After

Modification of personal judgement of role subsequent to encounter

E S has not had to re-evaluate or re-assess his role as a doctor in any way, on account of his experience with an infected person.

Personal judgement of professional role

E S feels that his colleagues are entitled to their own views concerning HIV/AIDS, however, all doctors are bound to the Hippocratic Oath and the World Health Organization Oath and must adhere to this.

E S feels that wherever possible doctors must fulfil their duty.

E S tries to fulfil his sense of duty as a doctor.

E S explains that as a Government employee he is obliged to treat all patients regardless of their disease or its origin. Unlike those who are in private practise, Government doctors do not have any choice.

E S sees it as important to keep his personal feelings separate from his professional role.

Personal concerns relating to potential effect of HIV/AIDS on family

E S's fear relating to what his family will do if he contracts AIDS is one of the factors which has encouraged him consciously to take heed of precautionary measures.

Personal feelings

E S sees his attitude as being in some cases less severe relative to the more radical views of others in the medical profession.

E S has not been up to this point unduly pre-occupied with the social aspect of HIV/AIDS.

E S never allows his personal feelings to come to the fore when he is working in a professional capacity.

E S finds it relatively easy to keep his personal feelings out of his professional role. At times there is tension but generally personal feelings do not come to the fore.

E Despite the risk involved in his work, S would not give up his profession: he is totally committed to medicine. If he were able to have his life over again he would choose again to work in the field of medicine.

Subject's self-reflections regarding precautionary behaviour

E Most changes that took place in S's attitude and practise with regard to precautions happened long before his first encounter with an infected person.

Perception of high risk behaviour

E S's view of HIV/AIDS has altered since it became a heterosexual disease which covers a relatively wide-spectrum of the population. As a homosexual disease S felt that if a person chose this lifestyle then they must take the risks. However, as it is now a heterosexual disease he views things differently. S acknowledges he may have contradicted himself.

E S feels that it is extremely unfair that people contract the disease through no fault of their own.

Subject's self-reflections on changing role

E If S has to work harder in the future because of the way the HIV/AIDS epidemic is progressing, then he will do so. S sees this as his duty.

E So far the HIV/AIDS epidemic has not interfered with any of the fundamental principles of medicine which S works by.

Subject's self-reflections in relation to Society

E S feels that even in his professional capacity his perception of HIV/AIDS is to a certain extent influenced by society's attitude towards this phenomenon. However, his years of professional training and work has given him the ability to block out such perceptions and deal with each incident in a non-judgemental, professional manner.

5.3: Table Three: Extended Thematic Description for All Subjects

The extended thematic description of the psychological structure of encountering an HIV infected patient general to six subjects. This description seeks to examine the themes pertaining to each mode of being through their temporal development. These themes exist as concepts to guide reflection; they are not an explanatory framework within themselves, but comprise a preparatory organisational framework for the stage of hermeneutic analysis to follow. This stage, as the final goal of the first phase, comprises an illustrated descriptive text of all six subjects' lived reality of the experience of encountering an HIV infected person. The second goal of this study - the interpretation of the symbolic and interactive meanings of this experience - will be done using this text as a basis for interpretation.

Changing meaning of HIV/AIDS

Changing meaning of HIV/AIDS for subjects through the experience of a concrete encounter. Subjects indicate that through their encounter with an HIV infected person the HIV/AIDS disease has become more real to them, subsequently they are more cautious.

Modification of perception of HIV/AIDS subsequent to the encounter. The encounter - for the subjects - gave rise to a strong emotional recognition of the disease and its consequences. Subsequent to the encounter the problems associated with HIV/AIDS became more real for the subjects.

Changing meaning of HIV infected patients

Modification of relationship to HIV infected patients. Subjects indicated that their perception of and subsequent relationship to HIV-positive patients had undergone a significant change. There was a strong increase in sympathy towards patients together with a marked decrease in fear and its related attitudes. Subjects began to relate to the patient as a whole person rather than a disease.

Changing meaning of patients in general

The changing meaning of patients in general through the experience of a concrete encounter. The encounter has made subjects more aware of the possibility of HIV in patients they treat generally. Subjects are especially cautious with those presenting with sexually transmitted diseases and persistent infections.

Modification of relationship to patients in general subsequent to encounter. Subjects indicated that their relationship to their patients in general has not undergone any significant change subsequent to the encounter.

Colleagues' response to HIV/AIDS

Subjects' perception of colleagues' response to HIV/AIDS. Subjects felt that their colleagues were likely to hold similar views to themselves with regard to HIV/AIDS. They felt that interaction with their colleagues was important, however the degree of interaction was low. Subjects also felt that their colleagues - particularly their junior colleagues - were afraid of dealing with HIV infected patients, this had implications for their interaction with these HIV patients. During their first encounter subjects perceived their junior colleagues to be afraid of the patient. Subsequent to the encounter subjects have witnessed a change in this respect.

Self-reflection regarding perception of colleagues' response to HIV/AIDS. Subjects acknowledge that their colleagues are individuals and that they may hold different attitudes to HIV/AIDS and the precautions against this disease.

Context of First Encounter

Immediate context. Prior to the encounter the subjects were concerned with the physical location of the patient and the reasons for their respective encounters. The encounter was explicitly understood as the first meaningful interaction the subjects had had with an HIV-positive patient. During the encounter the subjects were concerned over the degree of physical contact they had with the patient. The purpose of the encounter was a confirmation of a diagnosis.

Relationship between doctor and patient in first encounter. The subjects assessed their relationship to the patients in terms of the degree of personal interaction in the encounter. The subjects perceived their patients as individuals for whom they had some understanding of responsibility. During the encounter the subjects took note of the physical condition of the patient as it related to their professional attention of the patient.

Education/colleagues

Education of colleagues. Subjects felt that their colleagues were adequately informed - through discussion and in-house education - before encountering an HIV infected person. Subjects indicated a need for education directed at health-care workers, in particular nursing staff. They believed that by their own actions and attitudes they should set an example to their staff. Subjects were active in educating their own staff. Education of colleagues was seen as a means of alleviating fears relating to the disease.

Education/family

Education of family. The subjects perceived a need to educate their families with regard to HIV/AIDS contraction.

Education/patients

Education of patients. Subjects perceived a need for preventative education for their patients with regard to HIV/AIDS. Education messages are directed generally to those patients who belong to specific groups or engage in specific activities that the subjects perceive as high risk. The subjects felt that the encounter had augmented their educative abilities in that they could base their information on concrete examples. Subjects indicated an awareness of the difficulties associated with education aimed at behavioural change.

Education/public

Education of public. All subjects perceive themselves as active educators in the community with regard to HIV/AIDS. Subjects perceive education as part of their role, the best means of combatting the disease. Subjects also believed the burden of education should be shared by various community structures. Subjects were aware of the difficulties of educating the public through the use of a moral framework. Subjects indicated that they are approached by various groups in the community to perform educative functions.

Familial concerns in the context of HIV/AIDS

Relationship to family regarding HIV/AIDS. The subjects' principal concern with regard to contracting HIV/AIDS relates to their family. This concern centred on two major issues: The financial status of the family in the event of the subject contracting HIV; The risk the subject presented to the family, in particular to the spouse by virtue of his/her high-risk status. Subjects expressed a concern relating to their children's possible contraction of HIV/AIDS from external sources.

Personal concerns deriving from the perceived potential effect on family from HIV/AIDS. Subjects showed a strong emotional reaction when considering their high-risk status in relation to their family. The implications of contracting HIV/AIDS - when seen in the context of the family - strongly influenced the subjects' professional precautionary procedures. After their encounter with an HIV infected person the subjects did not perceive this incident as presenting any risk to their family.

Family's response to HIV/AIDS

Subjects' perception of Family's response to HIV/AIDS. Subjects stated that their spouses had expressed their concern with regard to their high-risk status. Spouses had also actively displayed their concerns.

Friends' understanding of Doctor's role

Subjects' perception of friends' understanding of Doctor's role. Subjects perceive their friends as recognising their high-risk status, although their friends do not react negatively on this account. Friends also perceive the subjects as fulfilling an educative role.

High risk behaviour

The meaning for the subjects of behavioural practises in the context of potential HIV transmission. Subjects identify certain behavioural practises as high risk. These practises include homosexuality and sexual promiscuity as evidenced by sexually transmitted diseases.

Subjects' perception of individuals in terms of high risk activities. When subjects identify high-risk activities in their patients they perceive a need to educate these patients in terms of behaviour change.

Perception of high-risk behaviour. Subjects perceive there to be a moral choice in practising high-risk activities. Individuals contracting HIV/AIDS who do not engage in perceived high-risk activity are seen as innocent and others are seen as accountable.

High risk groups

Subjects' understanding of groups constituting high risk in the context of HIV/AIDS. Subjects understand high risk groups in terms of their experience with an HIV infected patient. Subsequent physical precautionary behaviour is dependent upon this perception.

Subjects' perception of social groupings in terms of HIV risk. Despite their recognition of the fact that the entire community is at risk to HIV, subjects still maintain a traditional perception of distinct high risk groups comprising blacks, male homosexuals, migrant workers and students.

HIV/AIDS/Future trends

The future context of the HIV/AIDS disease. Subjects foresee a significant increase in the future in the number of HIV infected persons seeking medical treatment for opportunistic infections. Subjects perceive a need for routine tests on all patients presenting to Health Care institutions to establish HIV status.

Subjects' perception of future trends in HIV/AIDS. Subjects believe they will increasingly become directly involved with HIV infected patients. Subjects see the local incidence of HIV increasing sharply and creating problems in local health care facilities. Subjects believe that because of the economic strain

placed on present health care systems, a shift to alternate community-based structures will be necessary.

Subjects' self reflections regarding future trends in the HIV/AIDS disease.

Subjects indicate deep concern with the future impact of HIV/AIDS on their profession.

Influence/colleagues

Influence of others/colleagues. Subjects state that their concept of HIV/AIDS has been affected by the views of their colleagues. They feel that the influence of their colleagues has been beneficial to them in that they have learnt more about HIV/AIDS from their colleagues.

Influence/media

Influence of others/Media. Subjects are influenced by the perspective of HIV/AIDS portrayed in the Media in that they adopt - to a greater or lesser extent - these views. Subjects are well informed with regard to the Media perspective on HIV/AIDS.

Subjects' self-reflections in relation to Media. Subjects gauge their own experience against the Media's depiction of the HIV/AIDS disease and HIV infected persons. Subjects indicate a general lack of confidence in this depiction and are inclined rather to form their own expectations and predictions based on their experience.

Influence/medical institution

Influence of others/medical. Subjects were all well prepared academically for the experience of encountering an HIV infected person. Since the encounter subjects see it as important to maintain their knowledge of trends in the disease. Subjects have always had sufficient information at their disposal on the topic of HIV/AIDS.

Subjects' self-reflections in relation to medical influences. Subjects believe that they are responsible for their own education and that this education helps them in their dealings with their patients. Education of this nature has helped subjects to develop a sophisticated awareness of issues relating to HIV/AIDS such as high risk groups and behaviour.

Influence of encounter on professional role

Modification of personal judgement of role subsequent to encounter. Subjects have experienced their encounter with an HIV infected patient as significant with regard to their perception of their role. They have re-evaluated and re-assessed their role as doctor within the context of HIV/AIDS.

Influence/personal

Influence of others/personal. Subjects have been influenced in their attitude to HIV/AIDS and its high risk groups by significant others.

Influence/society

Influence of others/society. Subjects are influenced by society's perspective on HIV/AIDS both in terms of high-risk groups and moral stance. Subjects have a recognition

of the negative aspect of this perspective and the way it influences them. Subjects do not however feel that their relations to their patients are influenced by society's perspective.

Self-reflection in relation to society. Subjects indicate that in their professional capacity they are critical of society's perceptions of HIV/AIDS. These perceptions with their moral views, attitudes and explanatory frameworks are carefully assessed by all subjects. Subjects recognised that they did internalise certain aspects of society's explanatory frameworks and metaphors for understanding the disease.

Management of HIV infected patients

Professional action and management within the context of known HIV infected patients. The management of known HIV infected patients involved physical medical procedures such as chemotherapy and AZT treatment.

Management of known HIV infected patients. Subjects were concerned with the whereabouts of their patients. They also showed concern for the ongoing treatment of the patient and how these patients were responding to their condition and situation.

Modification of interaction with others

Modification of interaction with others subsequent to encounter. Subjects stated that their relationship to others, colleagues, friends, family and patients has not undergone any change as a result of their encounter with an HIV infected person.

Patient's understanding of General Practitioners as high risk

Subjects' perception of patient's understanding of general practitioners as high risk. Subjects have received little reaction from their patients concerning their possible HIV high-risk status. However, subjects anticipate this reaction increasing greatly in the future. Subjects anticipate that were they HIV-positive their practises would diminish greatly.

Patient's understanding of his/her condition

Subjects' perception of patient's understanding of his/her condition. Subjects felt it was important to assess the extent to which the patients were aware of their condition. Their level of awareness influenced the subjects' relationship to the patient.

Personal feelings

Emotions engendered by the presence of HIV/AIDS. Subjects indicated a strong initial fear prior to the encounter with a known HIV infected patient. Subjects' emotional response to their first encounter differed according to the nature of their interaction - verbal, physical, or other. After the encounter the subjects still felt a strong fear towards the disease and fear of dealing with unknown patients. However, their feelings towards known HIV infected patients had transformed to pity and compassion. The subjects felt the outcome of the HIV/AIDS disease to be worrying and serious. Despite the fear of contracting the disease, the subjects' respective encounters did not worry them unduly in this regard. Subjects indicate that the precautions allay their apprehensions, however, they acknowledge there is still an element of risk. Within this framework, subjects see the contraction of HIV/AIDS in fatalistic terms.

Personal feelings evoked in relation to others. During the encounter the subjects felt strong pity for their HIV infected patients. The subjects are able to recognize and identify with the personal feelings of their colleagues and patients in relation to this disease.

Personal feelings. Subjects showed a marked development with regard to coming to terms with and understanding their position in relation to certain issues concerning HIV/AIDS, such as stigmatized views and attitudes to homosexuality. Subjects organised these understandings into either a personal or a professional code of beliefs. Moral views were not seen as part of the professional stance, but were contained at the level of personal attitude. Subjects found it very important to separate their personal feelings from their professional activities with patients and staff. Subjects declared they enjoyed working in medicine and that it was very important to them; ultimately, despite the perceived risk, they were not willing to change their profession. Subjects perceived HIV/AIDS differently to other terminal illnesses. HIV/AIDS was seen as more serious. Subjects indicated that their fearful attitude to the disease over and above other terminal diseases was founded largely upon the social stigma attached to this disease, rather than the physical consequences. Subjects indicated some degree of denial when considering the possibility of contracting HIV/AIDS. For this reason subjects found it hard to articulate their emotional perception of

this disease. Subjects also indicated a need to work through the issues relating to personal contraction of HIV. Subjects expressed their understanding of HIV/AIDS in various metaphorical frameworks, such as "divine intervention" or "natural selection".

Personal HIV tests

Emotions engendered through the concept of personal HIV tests. None of the subjects felt it necessary to have a test consequent upon their encounter. However, they perceived testing to be necessary after being directly exposed to HIV through such incidences as needle stick injuries.

Considerations regarding personal HIV tests. Subjects were not seriously concerned with personal testing for HIV on a regular basis. Subjects perceived the test to be a duty, to their patients. Subjects showed a strong reluctance to consider the consequences of their tests being positive.

Personal risk

The meaning of personal risk in the context of HIV/AIDS transmission. Up until the encounter the subjects maintained a relatively unfocused awareness of the concept of risk. They did not see their own encounters involving HIV-positive patients as comprising a high level of personal risk. After the encounter all subjects showed an increased awareness of their personal risk relating particularly to emergency surgery. Subjects gauged their own level of risk through reference to other health-care occupations they felt to be of greater risk. Subjects put the risk of HIV/AIDS into perspective by referring to the contraction of other diseases such as hepatitis B.

Subjects' assessment of personal risk through professional activity. Subjects' understandings of personal risk did not greatly affect their attitude to or relations with other individuals.

Assessment of personal risk. The subjects identify themselves as being part of a high-risk group, and all show concern towards the fact that they are obliged to treat patients with no knowledge of their HIV status. All the subjects have tentatively considered moving to alternate positions in medicine that present lower risk.

Physical presence of HIV infected patient

Considerations engendered by the physical presence of an HIV infected patient. The subjects used the patient's physical appearance as a means of assessing the patient. The subjects found that their conventional expectations relating to the physical condition of HIV infected persons were not met by the actual appearance of their patients.

Assessment of known HIV infected patient. Subjects assessed their patients in terms of how they were responding to their illness. The subjects' relationship to their patients was influenced by their physical condition and physical circumstances such as their home background.

Precautions

Precautionary behaviour in the presence of HIV/AIDS. During the encounter subjects were not worried about exposure to HIV as they had taken adequate precautionary measures. Subjects indicated that their changes with regard to standard precautionary tactics took place before their first encounter with an HIV infected patient. Subjects were using similar precautions for other diseases prior to HIV/AIDS. However, the encounter served to emphasise the need for these precautions. Precautionary measures were dependent upon the nature of the interaction between the subject and patient: subjects felt relatively safe with daily procedures but were more concerned with surgical procedures. Subjects were becoming increasingly aware of the need to take precautions with every patient, although at the moment they are not doing so. Subjects saw recent precautionary techniques as necessary yet obstructive. Subjects were not convinced of the degree of safety in surgical precautionary procedures.

Precautionary techniques in relation to professional procedures. The act of adopting precautionary measures was perceived by the subjects as making a definite statement with regard to their perception of the patient. Subjects showed concern for the access to and use of precautionary procedures by their colleagues. The subjects' attitude to precautions involved not only an understanding of their own protection but also that of their patients.

Self reflection regarding precautionary behaviour. Subjects indicate their encounter with an HIV infected patient has influenced their personal understanding of precautionary measures. They felt that while precautionary measures were important they should not be over-emphasised as there is no means of removing all risk from their lives.

Preparation

Physical preparation prior to encounter. Subjects took steps to be physically prepared for the possibility of encountering an HIV/AIDS patient.

Cognitive preparation for the situation of encountering an HIV infected patient. All the subjects felt a need to prepare themselves psychologically for the encounter with a known HIV-positive person. Subjects felt a need to keep themselves informed on the issue of HIV/AIDS. This they did through discussion with colleagues and professional reading. After the encounter all the subjects expressed satisfaction with the way they had prepared themselves.

Previous experience

Historical context. Subjects indicated that they had not previously had a professional encounter with a known HIV infected patient prior to the encounter related to this study. Subjects were aware, however, that many of the patients they had interacted with in the past may have been HIV-positive. Subjects are aware of a number of individuals in the local area who are HIV-positive although these individuals are not their patients.

Professional relationship to colleagues

Professional interaction with colleagues. Subjects felt a need to discuss the incident with an HIV infected patient with their colleagues for the purpose of exchanging factual information and receiving emotional support. Discussions based on general concerns relating to HIV/AIDS such as risk, precautions and treatment were felt to be very important. Subjects felt that the discussions up to this point had not fulfilled their emotional needs.

Professional role

Professional action and interpretation of role in the context of HIV/AIDS. Subjects indicate a part of their professional role involves dealing with life-threatening diseases.

Perception of professional role in relation to others. During the encounter the subjects felt that their actions were important in terms of setting an example to junior colleagues. This encounter intensified the subjects' belief that they should set an example to their colleagues. Part of the subjects' professional role also included influencing the Public's way of understanding HIV/AIDS and its sufferers. Subjects perceived their professional stance as containing no moralistic element but instead they emphasised the basic goals of care-giving and comforting, and perceived it as important in terms of the relationship between doctor and patient to express feelings of empathy and solidarity to HIV infected patients. They perceived the patient's needs should be placed above the needs of the doctor, and therefore felt the need to maintain a clear distinction between their personal feelings and their professional attitude. Subjects also felt a need for ongoing professional education involving factual and ethical information. They perceive part of their role to incorporate a strong emphasis on preventative education.

Personal judgement of professional role. Subjects are acutely aware of a strict code of ethics defining their practice; this involves a strong sense of duty and responsibility. Prior to the encounter subjects showed a personal reluctance to attend to HIV infected patients, however, they saw it as their duty to do so.

Subjects were very concerned with fulfilling their duties thoroughly and professionally. At the same time subjects felt a strong need to prevent their personal feelings from impinging on their professional activities. Subjects experienced tension between their personal feelings and the expectations of their role. Despite the perceived high risk of their situation and their professed doubt with regard to remaining in the profession, subjects ultimately saw it as their duty to maintain their present professional role. The tension between personal feelings and professional role was most apparent with regard to hospital work. Subjects perceived the hospital as an environment where they had less control over high risk situations.

Professional role/changing meaning

Perception of changing role in relation to others. Subjects indicate it will be necessary to reevaluate seriously their roles as general practitioners in the light of future trends in HIV/AIDS. Subjects understand their future role in terms of risk of HIV/AIDS, and foresee necessary adaptations in their professional role, such as greater caution in dealing with unknown patients; taking on an educative function; developing support structures for all health care workers. Subjects perceive their future role in terms of treatment - they do not perceive their role to be front-line educators or care-givers. Subjects see their future role as being threatened by HIV and foresee this as influencing their choices in terms of their future careers.

Subjects' reflections on changing role. Subjects all considered some move away from high risk positions in their future professional role. These considerations are motivated by a fear of HIV.

Relationship to an HIV infected patient

Subjects' experience of a patient as HIV infected. Subjects did not perceive HIV patients as presenting any significant threat in a professional context. After the encounter there was, however, some awareness of possible physical contamination.

Subjects' relationship to known HIV infected patient. Subjects perceived their patients as terminally ill. They felt pity for the patients and exhibited a strong awareness for the patients' emotional needs. These perceptions did not change after the encounter.

Self-reflection on relationship to HIV infected patient. Subjects' self-reflections indicated that they perceived their HIV patients as terminally ill. Consequent professional attention was dependent upon this perception. Having been through the encounter subjects affirmed their understanding of these patients

as terminally ill. They reflected that these patients should be treated as terminally ill, not in any way stigmatised or different.

Social attitude to HIV/AIDS

Subjects' perception of Social attitude to HIV/AIDS. Subjects perceived the social attitude towards HIV/AIDS to be fearful. They perceived society as being ignorant and moralistic with regard to HIV/AIDS.

Statistics

Subjects' statistical understandings within the context of HIV/AIDS. Subjects recognised a need for maintaining statistical records relating to local HIV/AIDS incidence. All the subjects showed concern for the epidemiological patterns of the disease. They showed an awareness of this patterning in terms of common opportunistic diseases and high-risk groups. Subjects were aware of the statistical impact of HIV/AIDS on their profession and more specifically on their local region. Subjects viewed the origin of HIV/AIDS in terms of the conventional understanding of HIV/AIDS as a tropical disease emanating from Central Africa.

Subject-patient verbal communication

Verbal communication with known HIV infected patient. Verbal communication was seen as an important step in establishing a relationship with the patient. Subjects attempted to offer reassurance through verbal communication as well as establish the details of the patient's disease. Difficulties arose with regard to the language.

Subjects' understanding of patient's HIV status

Concrete presence of HIV-positivity in the subjects' known-about world. Subjects expressed concern about conducting invasive procedures on patients who have not been tested for HIV. Subjects believe larger numbers of people should be tested, thereby reducing the risk for Doctors.

Knowledge of patient's HIV status. Knowledge of patient's HIV status derived from external sources of information: none of the subjects diagnosed the HIV patients they encountered themselves. Subjects indicated they very rarely resorted to HIV testing unless requested by a patient. Subjects indicated that the knowledge of a patient's HIV status affects the nature of interaction between the doctor and patient.

Considerations relating to knowledge of patient's HIV status. Subjects experienced a degree of personal concern upon learning of their respective patient's HIV status either before, during or after the encounter.

Terminally ill patients

Subjects' relationship to terminally ill patients. Subjects feel strong compassion for terminally ill patients, particularly if they are young patients. Subjects indicate that the relationship to terminally ill patients is very different to that of other patients. Subjects did not feel that AIDS patients were any different to other terminally ill patients. These feelings and perceptions were evoked during the encounter.

Self-reflection on relationship to terminally ill patients. Subjects experienced tension between their own feelings of withdrawal and the expectations of their curative role when dealing with terminally ill patients.

The meaning of the body and its parts

The meaning for the subjects of the body and its parts in the context of HIV/AIDS. Body fluids, specifically blood, now carry a threat to subjects on account of their experience with an HIV infected person. Before this experience subjects indicated that they were not overly concerned with procedures exposing them to body fluids: Since the encounter these procedures have taken on a new significance. Subjects show that they have confidence in current blood taking paraphernalia such as needle packs and gloves.

Understanding of the patient as physical disease

Subjects' experience of the patient as the manifestation of a physical disease. During the encounter subjects used disease as a label of categorisation, seeing the patient as a manifestation of this disease. Subjects indicated that the disease intruded between themselves and the patient as an individual. Subjects felt that the disease strongly influenced the nature of the relationship with the patient.

5.4: Interpretation of Extended Thematic Description through Symbolic Interactionism

5.4.1 Reading Guide

Symbolic Interactionism provides a useful model for the second goal of this study - the interpretation of the *experience* of encountering an HIV infected person. This theory of human interaction is able to explain how the individual's meanings, perceptions, attitudes and actions develop and change over time. It is also possible through this theory to understand the dynamic interplay of symbolic and metaphorical meanings that comprise the interactive process. This model is able therefore to accommodate the process through which the general practitioner defines and re-interprets the meaning of HIV/AIDS through the experience of encountering an HIV infected person. As the focus of Symbolic Interactionism is the integration of all aspects of human action into a single unit of interactive processes, it is not possible to discuss specific events in isolation from one another. For this reason the following interpretation is presented in a narrative form incorporating a full integration of all the processes in temporal sequence. The researcher has not attempted to give prominence to the theory, rather the theory is merely an instrument for interpretation of the data.

The following reading guide explains the central concepts incorporated in the theory of Symbolic Interactionism as they pertain to this study. The extended thematic description was interpreted by reading for these concepts:

Reading Guide.

(These terms are drawn from: Charon, 1979; Collins, 1985; Woods, 1983)

Self: The Self is a social object defined in interaction with other social objects. The self is developed and interpreted through the perceptions of and interactions with other individuals and reference groups. The individual can judge, analyze and direct the self as an object like any other object.

Mind: Mind is the means of guiding and determining the actions of the self, and of interpreting and re-interpreting the self in relation to others.

Identity: Identity is how the individual understands who s/he is and how s/he labels the self in relation to others. Identity is perceived in relation to specific reference groups - the individual has more than one identity (such as mother, doctor, etc).

Perspectives: Perspectives are a symbolic, ordered view of one's world. Reference groups are those groups whose perspectives the individual adopts and identifies with. The perspectives of each reference group forms a culture (such as the medical culture).

Attitudes: Attitudes are constructs of the individual (as opposed to the reference group) based on personal experience and feelings.

Significant others: Significant others are other persons, from any reference group, who are meaningful to the individual.

Generalized Other/Society: The generalized other forms the dominant cultural perspectives of all individuals, and is superordinate to the reference groups which comprise it. The generalized other stipulates the moral and social codes of each individual.

Objects: No object has a fixed meaning, but are defined by the individual in interaction as an object having physical (pertaining to the spatial environment), social (pertaining to the human environment) or abstract (pertaining to the mental environment) meaning. All objects are social in that they are understood through the social context: this understanding may be physical, social or abstract. Objects have meaning according to their perceived use; as the use changes, the meaning changes. Meaning arises from how the individual is initially prepared to act towards the object.

Lines of Action: Lines of action comprise actions directed by the mind towards a certain goal or understanding. They are defined in relation to interpretations of and perspectives towards objects in the situation. A group of lines of action directed towards the same situation comprises a stream of action.

Interaction: Interaction involves the active relationship between individuals and other social objects (not necessarily human). Interaction implies taking other social objects into account, acting, perceiving, interpreting, and acting again. the individual is dynamically active in relation to his own meanings, rather than responding to external meanings.

Symbols: Symbols are a conventional means of referring to something else. These symbols are created, understood and modified through interaction. A symbol is any object, action or word towards which individuals act as if it were something else.

Role-Taking: Individuals in interaction attempt to understand how their own actions will be interpreted by the other; that is, they attempt to understand the other's perspective and view themselves as objects from that perspective. Taking the role of the other is an important mind activity. The process of role-taking gives rise to shared meanings: meanings and symbols which are not shared are relegated.

5.4.2 Results of the Interpretation

Subjects had no previous professional interaction with an HIV infected individual prior to the researched encounter. Because of this subjects had not re-interpreted the conventional perspective towards HIV infected individuals. Their understanding of HIV/AIDS derived from their social and medical cultures rather than from personal interpretations and reflections, and the disease existed for them as an abstract object.

The subjects' professional identity is located within the medical culture: their role, incorporating specific codes of conduct, is defined by this paradigm. They interpret, judge and delineate their professional actions, and the situations in which they find themselves, in accordance with the perspectives comprising this medical culture. The subjects' professional identity defines the lines of action and perspectives, including ethical concerns and responsibilities, appropriate to the professional role: perspectives deriving from reference groups other than the medical are deliberately excluded from the professional context as they form no part of the professional identity. For example, personal fears, judgements, moral attitudes, personal opinions and feelings are understood by the subjects as inappropriate to their professional role. The meaning of their professional role is defined by and directed towards the patient's needs as dominant object in the situation. The intrusion of the subject's (doctor's) personal needs into this stream of action sets up an alternative goal which is not appropriate to the standards of the medical culture. The professional identity of the subjects and thus the professional role is informed and strengthened by scientifically validated sources of information relating to new ethical and medical developments in the context of HIV/AIDS. Subjects interpreted the situations in which they found themselves through their professional perspectives. In the interaction between the subject and HIV infected patient the professional goals of care-giving and comforting were dominant. Subjects understood their actions in the situation of encountering an HIV infected patient as making a symbolic statement to other health care workers. This statement had as part of its meaning an attempt to influence and educate the perspectives and subsequent actions of junior colleagues towards HIV infected patients. Subjects recognized the medical culture's perspective on HIV/AIDS as an authoritative standpoint with the capacity to influence the "generalised other's" perspective on the disease, thereby changing established negative perspectives in this regard.

However, subjects found themselves in a situation where the codes of conduct relating to their professional identity were in conflict with the lines of action suggested by their personal interpretations of and reservations about the disease as threatening object. Where this threat was greatest - in surgery - the tension between personal understandings and professional duties was most emphasised. This tension was further complicated by the fact that subjects adhered very strictly to the medical culture's perspectives on their professional role. In this, subjects were aligning themselves very strongly with the ethics and duties defined by their reference group.

The subjects adopted a stream of action towards professional involvement with HIV/AIDS in accordance with the meaning of the disease for them prior to the encounter, derived from their social and medical perspectives. Part of this stream of action involved physical and cognitive preparation for the likelihood of encountering an HIV infected patient. HIV/AIDS was at this point perceived as an intangible threat, which subjects attempted to concretize and control through their preparations. This included interaction with colleagues, the reading of medical journals and familiarization with precautionary techniques. Through this "minded activity" centring on engagement with professional reference groups, subjects were informing their "self" as they assessed and formalised their perspectives on the disease, thereby giving the self more control over the situation. This line of action guided the subjects into the encounter: it proved adequate and helpful as a means of controlling the subject's initial fears relating to the situation.

Another line of action the subjects have adopted centres on their use of precautionary measures. Precautionary measures had always been an institutionalised part of the subject's professional role prior to the advent of HIV/AIDS. The meaning of precautionary behaviour was determined by the understanding of the self as being directly threatened by the concrete presence of a physical contagious disease (such as Hepatitis B, Meningitis, Congo fever, etc). With the advent of HIV/AIDS the subjects re-interpreted their precautionary behaviour. Disease was no longer a concrete presence but rather an abstract possibility, as the subjects were having no direct contact with an infected person: the perceived usefulness of precautionary techniques therefore changed. They were no longer a direct physical response to a present physical disease (Hepatitis, etc), but a potential physical protection against an unlocated threat, as the subjects had not yet encountered an HIV infected patient.

Prior to the advent of HIV/AIDS precautions had been used in direct physical relation to the physical presence of disease. The perceived usefulness of precautionary techniques was defined and confirmed by interaction with the object (of disease). Before the subjects had had direct interaction with HIV/AIDS or an HIV infected patient the usefulness of precautions was not verified in this manner, and therefore they did not initially practise these precautions seriously. However, through the physical encounter with an HIV infected patient the meaning of precautionary behaviour changed again in that its perceived usefulness became far more focused. Precautions became a symbol of protection against not only a physical disease but also disfigurement and social stigma. The change in meaning of precautions derives in part through role-taking, whereby the subjects through minded activity placed themselves in the position of the patient and attempted to interpret the situation within this framework: in the encounter subjects understood the situation, and the full range of consequences of the disease to the individual, from the patient's perspective.

Academic understandings of the disease, redefined and concretized through physical experience, served to clarify perspectives on the usefulness of precautions as this usefulness became far more meaningful and focused. After the encounter precautions became a symbol of protection against a possible HIV infected patient, whereas before they had been a symbol of protection against an unlocatable disease. With this re-interpretation the risk of HIV was more concretized and controllable. Precautions were focused on the patients as the concrete presence of risk. The use of precautions became for the subjects a symbolic representation of their categorization of a patient as a threat; precautionary measures therefore made a strong interactive statement between doctor and patient.

Subjects categorised patients into groups of "threat" or "non-threat" according to their perspectives of high risk groups and high risk behaviour. These perspectives were once again drawn from the dominant medical and social cultures of the subjects. While this categorization was applicable to day-to-day consultation procedures, the surgical environment made these categorizations ineffective. In the surgical situation with an unknown patient the meaning of precautions was once more interpreted in the context of their use as protecting the subject against a potential threat of disease as the object. Subjects had no means of assessing the patients' likely risk status and could not modify their actions accordingly; they were at highest risk and least control in this situation. Precautions were symbolically perceived as the means of control: subjects perceived full precautions were necessary as a means of physical

protection and cognitive control in that the perceived level of risk was very high. The subjects judged their selves in relation to a perceived duty to be as efficient as possible in surgery, balanced against the personal need to protect themselves. Through self-judgement of their perceptions and actions involving their personal needs, set against their professional duties, precautions become a metaphor for these personal needs or wants obstructing the doctor's professional duties. While the subjects therefore understood precautionary techniques as useful in protecting them from the disease they also saw these techniques as obstructing their duty to the well-being of the patient and the outcome of surgery.

The precautionary line of action, therefore, was modified in accordance with the changing meaning of the risk to the subject. This risk was initially understood as disease (Hepatitis B, etc) located in the patient, then became disease (HIV/AIDS) as an unlocated abstract object, and then once more, after the encounter, physical disease located in the patient. Subjects incorporated a symbolic understanding of risk of HIV to self into the perspective of other life risks (motor car accidents, etc). Precautionary lines of action were interpreted through analogy to these other risks, and were understood as necessary but not failsafe. Subjects did not allow precautionary lines of action to dominate other professional lines of action in doctor-patient interaction, for instance, they continued to use surgical techniques which were risky but more efficient than those involving greater precautions.

Prior to the encounter the meaning of the body and parts of the body had no special significance for the subjects. As a result of the encounter subjects understood the disease as located in the physical body. The body and parts of the body (such as blood and other body fluids) are thereafter re-interpreted and take on new meaning, including that of threat. Lines of action (such as precautions) towards these body parts have been modified in accordance with their change in meaning. Day-to-day precautionary techniques are understood as a symbol for personal safety, their use ensuring subjects' peace of mind.

Before their encounter subjects took a line of action towards patients in terms of understanding a patient as a manifestation of physical disease. This line of action arises out of the subjects' medical culture which defines disease in physical terms independent of the individual sufferer. Subjects approached the encounter with a symbolic understanding of HIV/AIDS derived from the generalised other's perspective of the disease as a "deforming terminal illness". The

appearance of the patient was interpreted, in relation to this social understanding, as "diseased physical object", the disease, because of its seriousness and social implications, taking precedence over the patient as person. This symbolic understanding was used by the subjects in their lines of action towards the encounter. During the encounter this understanding of the patient had to be re-defined as the meaning of this symbol was not shared by the patient. This symbol obtruded between the subject and the patient in that it obstructed effective interaction. The subjects' understanding of the patient was modified therefore from "patient as physical object" to "patient as social object". The subjects developed a new conceptualisation of the patient as an individual human being rather than simply the disease. Subjects had based professional lines of action, such as the extent of precautions to be taken, and relating to the patient as a diseased object, on their conventional understanding of the patient's assumed physical condition. These lines of action had to be re-interpreted through the encounter as the concrete experience of the HIV infected patient's physical condition did not conform to conventional understandings of AIDS sufferers. New lines of action were developed in accordance with the subjects' interpretation of the patient's actual appearance, with the focus on physical details replaced by more interpersonal goals.

Immediately prior to the encounter temporal and spatial details and the location of patient as object within these two dimensions became meaningful to the subjects, as they used these details to define and control the situation. At this point the meaning of the situation involving the relationship between doctor and patient was defined in terms of the subjects' appraisal of their professional role. The objects and events in the initial stages of the encounter had meaning as they pertained to this role.

Through role-taking during the encounter the subjects came to understand the patient's perspective towards their situation. Through the process of role-taking the subjects indicated to their selves how their actions would be understood by the patient. This allowed for an increased sensitivity to the patient's needs and perspectives. Subjects thereafter modified their own actions in accordance this developed understanding. The act of physically touching the patient was an symbolic gesture used to express acceptance and compassion for the patient. The meaning of the patient became that of another individual with desires and perspectives to be understood, rather than a physical disease with its implications of stigma, disfigurement and suffering to be feared.

Once within the encounter the subjects' understanding of HIV infected patients was that such patients should not be stigmatized or treated differently to other terminally ill patients. Through the course of the encounter and subsequently subjects adopted lines of action towards their HIV infected patients based on the perceived medical needs. These lines of action were drawn from a curative framework aimed at physical intervention, such as AZT treatment and chemotherapy. Because of the strength of the medical culture and the orientation of their professional role within this culture, subjects had difficulty in developing lines of action directed more towards the patient's emotional state and needs. In the context of dealing with terminally ill patients subjects were in a situation where their professional duties as "curers" were inapplicable. Subjects had therefore to redefine their perspectives and lines of action towards terminally ill patients. The re-interpretation of the subjects' role in relation to a terminally ill patient creates a relationship different to relationships with other patients. As the standard professional duties become less useful in this context they become less meaningful. Other perspectives become more useful, such as being sensitive to the patient's emotional state. Subjects appraised their selves in relation to the inadequacy of their professional role in this context together with their own confrontation, through role-taking, with death. The reference group of terminally ill patients involves perspectives, relating to death and the inadequacy of treatment and drug intervention, which conflict with the perspectives of the subjects. Subjects experienced a desire to withdraw from the situation because of these factors; they found themselves helpless in this situation to fulfil their professional goals of curing, however, they were constrained by the demands of their professional duty.

Subjects' medical and professional perspectives were at the fore during the encounter, and the perspectives of the generalised other, including stigmatization, were diminished. Subjects perceived HIV infected patients from the medical perspective of terminal illness in which the goals of care-giving and compassion were most important. They modified their professional lines of action around these understandings, thereby showing empathy and sensitivity to the patient's emotional and physical needs. Within the encounter the subjects perceived the generalised other's perspectives towards HIV infected persons as inappropriate. As subjects began to perceive their patients as individuals with whom they were interacting they found it necessary to develop a framework of shared symbols through verbal communication. The quality of the interaction between subject and patient was determined by the extent of verbal communication during the encounter. Where subjects used language frameworks different to the patient's they had difficulty in establishing shared symbols. As the patient's

condition was central to the interaction, subjects attempted to assess the patient's understanding of his/her condition and thereby define what symbols were appropriate for interaction. Subjects modified their lines of action towards the patient in accordance with this understanding.

After the encounter the concept of personal risk was more meaningful to the subjects on account of their direct contact with the disease. This was because the disease had become a significant object in their immediate environment. Subjects understood the medical profession as comprising a high risk group with regard to HIV contraction. Various professional activities (such as nursing, surgery, obstetrics, etc) within this group were perceived as of higher or lower risk to the subjects' own activities. Subjects interpreted their own risk in relation to these perceptions.

The encounter with an HIV infected patient modified the subjects' initial perspectives on their role and duties within the situation of HIV/AIDS and their own risk. They have, however, been unable to fully re-define their perspectives through a single encounter. Because the meaning of their future situation is not clear for them they have difficulty in defining appropriate lines of action. For instance, subjects considered changing occupation in the face of the threat of HIV/AIDS, yet showed no real intention of taking this step.

The subjects' awareness of their risk status was concretised in their perception of personal HIV tests. The meaning for the subjects of personal HIV tests was defined in terms of the consequences of a positive test result. The usefulness of the test for the subjects was interpreted as minimal, as subjects believed themselves to be HIV negative, and did not perceive a need for a reassurance of this negativity. The test would therefore only impart unwanted information. Subjects indicated to themselves a need of routine HIV testing: this line of action derived from their understanding of their professional duty to their patients. Within the perspectives of the professional role the test was a routine matter, however, the test was ultimately understood as a symbol of the subjects' own risk status. This symbolic understanding engendered strong personal emotions which subjects found difficult to deal with from the perspectives of their professional role.

With the changing meaning of disease as object from abstract to social, the subjects recognised the disease as located in the individual person. This recognition, as well of the recognition of their own risk, gave rise to a strong

emotional response. Personally-directed emotions are not acknowledged by the subjects as part of the medical professional identity, consequently they experienced difficulty in accepting these emotions. These emotional difficulties were ameliorated to some extent through interaction with colleagues, but the constraints of the professional role obtruded into this interaction. Interaction between subjects and their colleagues was largely confined to the exchange of factual information within the professional situation, rather than emotional support.

Subjects initially accepted the generalised other's perspective of HIV infected individuals being part of specific subgroups in society, who by their behaviour and perceived moral norms were at particular risk to HIV. These subgroups constituted for the subjects deviant "cultures" with which the subjects did not identify. These groups were perceived as having their own perspectives and standards comprising reference groups different to those of the dominant social ideologies with which the subjects identified. These high risk groups included male homosexuals, blacks, migrant workers and students. Individuals were categorised into these groups on the basis of their behavioural practises and perceived moral norms. The subjects' understanding of high risk behaviour in the context of HIV/AIDS was informed by the social and medical perspectives towards the disease. Through the process of the actual encounter, however, subjects re-interpreted their perspectives on high risk groups and activities. This was because the patients encountered by the subjects did not contract HIV/AIDS through the subjects' pre-conceived notions of high risk activity. In the process of personal interaction with their patients, subjects found themselves in a situation where, through indications to themselves within the situation, they re-defined the meaning of high risk activities. This new definition, brought about through self-appraisal of their conventional perspectives, comprised an understanding of all individuals (not only subgroups) being at potential risk to HIV. It also involved a move away from social stigmatising perspectives towards high risk groups. Despite this significant re-definition through the course of the encounter, subjects continued to assess their patients in terms of the social definition of high risk groups and activities, with STDs being a symbol for high risk to HIV. After the encounter, although some modification had taken place on a personal level, subjects showed a tendency to regress to the standard social perspectives, for instance they still perceived HIV/AIDS sufferers as accountable or innocent for their condition depending upon their means of contraction. Subjects, in appraising their perspectives, felt they would need more experiences with HIV infected persons before these modifications could

become entrenched. One of the lines of action subjects took towards patients they perceived to be at high risk was that of education.

The dominant medical culture in which the subjects were trained designates their role as curative rather than preventative. For this reason subjects tended to be hesitant with regard to direct preventative education towards their patients. As the disease became less abstract through the encounters, subjects re-assessed their professional role in terms of incorporating a preventative educative focus. As a result of the encounter the use of educational strategies became more meaningful to the subjects. Through self-appraisal in the context of the encounter, subjects felt more confident in their ability to impart knowledge to, and influence the activities of, certain patients. The educative line of action was therefore taken towards perceived high risk patients. Subjects did not perceive a need to educate all patients. With regard to this educative line of action subjects were aware that patients would be reluctant to change their perspectives on high risk sexual activity until the meaning of such behaviour changed for them. This would involve their conceptualisation of the disease being concretized through personal experience rather than existing as an abstract notion.

Subjects interpret others' perspectives in interaction through a process of role-taking. They understand the others' words and actions as being symbolically indicative of their perspectives. Through this process subjects make assumptions about the perspectives of significant others, including family members, patients and colleagues. As a result of such minded activity, subjects understood their interaction with their spouses as having changed as a result of HIV/AIDS. Spouses now understood the subjects as members of a high risk group and indicated to the subjects this understanding through action and speech. Subjects did not understand their friends' actions as indicative of a negative perception towards them on account of their high risk to HIV/AIDS. Patients occasionally took lines of action which subjects interpreted symbolically as being a reaction to the subject as high risk. Subjects expected that this would occur more often in the future. Subjects interpreted their colleagues' response to HIV/AIDS within the perspectives of the medical culture. Subjects expected their colleagues to hold similar perspectives to their own as they belonged to the same medical culture.

Subjects identify with a number of reference groups. The perspectives of these reference groups are adopted by the subjects and influence their understanding of various issues. One of the dominant groups guiding the subjects is the culture of the "generalised other" (society). This culture stipulates moral

understandings and general codes of conduct to all individuals within this culture. Through their identification with the culture of the generalised other subjects initially used stigmatising perspectives to understand HIV infected persons and high risk groups. These stigmatising perspectives were projected and re-inforced by the Media, particularly in regard to the physical appearance of HIV infected persons and the future incidence of HIV/AIDS. In the context of the encounter subjects critically re-interpreted the perspectives and in doing so were reformulating their self-identity in that they distanced themselves to a certain extent from the perspectives of the generalised other. Subjects interpreted these perspectives as being ignorant, moralistic and fearful, and as being inappropriate to their personal understandings and their professional role.

Through epidemiological knowledge and the influence of the Media perspective subjects understood the incidence of HIV/AIDS as increasing greatly in the future. On account of this anticipated incidence subjects will be increasingly exposed to risk. The meaning of HIV/AIDS as threatening object becomes more concretised as subjects perceive its incidence as increasing in the local area. Because of this meaning subjects interpret their future role as influenced by the risk of HIV/AIDS. Knowledge of the patient's HIV status has become an important symbol of the subjects' own safety. This knowledge strongly influences the subjects' subsequent lines of action. Because of their understanding of this influence, subjects perceived it as desirable that all patients undergo routine testing. This testing is used by the subjects as a means of controlling their situation. Subjects have re-interpreted their role and their actions within this role in the context of future trends in HIV/AIDS. They understood epidemiological facts and statistics as part of the factual knowledge pertaining to their professional role. The subjects' concern with regard to epidemiological statistics, particularly in the local area, related to their perceptions of their future role and the impact HIV/AIDS would have on this in terms of intervention strategies and personal risk. Statistics became a symbol for the understanding of the spread of the disease.

Influenced by this understanding, subjects are now cautious of emergency surgery, and have contemplated other occupations. They understand the disease as having a large influence on their future careers.

Subjects understand their professional role and the professional health-care structures as being unable to deal with the increase in HIV infected patients. They interpret their future role as comprising lines of action, such as drug intervention, within a curative framework. The meaning of HIV infected patients

in terms of future management includes the need for long term care rather than short term curative intervention. For this reason subjects perceived a need for an alternative to present health care structures. These structures must arise from the community as economic constraints and the restraints relating to the established role of medical practitioners prevent such structures developing from the present health care system.

Through the advent of HIV/AIDS, education has become a part of the subjects' professional role. Subjects understand this as part of their role as they are identified as educators by the general public and their junior colleagues. As subjects understood their curative lines of action as limited in relation to HIV/AIDS, they established alternative lines of action. Preventative lines of action became more meaningful in their interpretation of their role, as they understood these to be of most use in the context of an incurable disease. Prevention was understood as the best means of controlling the future incidence of HIV/AIDS. Deriving from their professional access to knowledge and their neutral stance within the professional role, subjects chose the educative line of preventative action as most appropriate to their role. The professional identity of the subjects does not include the moral framework of the generalised other, thus education which is drawn from professional perspectives cannot be implemented through this moral framework. Subjects interpreted the duties of their reference group in the context of other reference groups (such as teachers, the clergy, etc) and understood these other groups as having an equal duty to educate the general public. Because of this understanding, and the primarily curative goals of the professional role, based on drug intervention and direct treatment, subjects did not perceive themselves as front-line educators.

Through role-taking subjects understood their colleagues, particularly their junior colleagues, as being fearful of HIV/AIDS. Education was a means of overcoming this fear.

The subject's relationship to their families was influenced by their understanding of HIV/AIDS. Part of the meaning of the subjects' role as family member is to care for and protect their spouse and children. The most effective line of action in terms of these goals they perceive themselves as being able to adopt is education. The threat of HIV/AIDS in the context of the family had two major meanings for the subjects, deriving from their role as carer: the financial impact on the family if the subject were to contract the disease, and the possibility of the subject infecting the spouse in this context. Subjects perceived themselves as the object of threat to their families; this perception

engendered a strong emotional response in the subjects. This subsequently influenced their lines of action in their professional role, with their being more cautious. As the meaning of the subjects' first encounters did not entail an understanding of acute risk to themselves, the encounter did affect their role as family members.

The meaning of significant others has not changed for the subjects as a result of their experience. A single encounter of this nature did not appear to be influential enough to significantly change deeply entrenched perspectives in this regard.

Subjects identified very strongly with the medical culture and its perspectives. This identification influenced their lines of actions in a number of contexts. The meaning of HIV/AIDS as object subsequent to the encounter entailed a strong realisation of social stigma. In this it was understood as different to other terminal illnesses, such as cancer which was understood in purely physical terms devoid of social stigma.

A strong fear towards HIV/AIDS as object, together with the knowledge of their risk status in terms of the professional interaction with this object, gave rise to denial whereby subjects were reluctant to appraise their personal position in regard to this object and the possible consequences for this position.

Subjects interpreted the meaning of HIV/AIDS through various metaphorical symbols. These were frequently derived from, though did not necessarily adhere to, conventional symbols. For example, all subjects rejected the generalised other's perspective of "divine retribution", however, they re-interpreted this symbol through their own attitudes and the perspectives of their professional role in terms of "divine intervention" - that is, circumstances being determined by God as a means, not of punishment, but of ameliorating behaviour: Subject 4 understood the disease in terms of re-emphasising the virtues of monogamy; Subject 3 understood its impact as influencing the behaviour of high risk groups. The Doomsday perspectives of HIV/AIDS as a major and catastrophic epidemic subjects interpreted in terms of the "intervention of nature": Subject 6 understood the disease as a curb on over-population; Subject 5 as a process of natural selection. All subjects understood the disease in terms of its origins in Central Africa. This understanding included a perspective on Central African diseases as being incurable and virulent, thereby distanced from the curative framework of Western Medicine, and their own professional control of the disease.

SECTION SIX: DISCUSSION

6.1: Discussion of Findings

As of January 1993 there were ± 45000 confirmed HIV positive cases in South Africa (ATIC, personal communication, 7 January, 1993). Medical practitioners in all parts of the country are having to attend to increasing numbers of HIV infected patients. As J. Mann (Mann & Chin, 1988) and S. Lachman (1991) have outlined (see sec 1.4), this disease - more so than any other in recent times - incorporates far-reaching social, legal, ethical and medical dimensions, which in turn have very strong implications for the identity of the practitioner and his/her future role in this context.

Medical practitioners are in a process of defining for themselves a clear identity and framework of understanding to enable them to comprehend effectively their personal and professional position in relation to the phenomenon of HIV/AIDS. This identity is the means through which the general practitioners attempt to understand and control their situation within the context of this disease. This identity has important implications for the practitioners themselves, society in general, and HIV infected individuals. For this reason it is important to determine the symbolic understandings practitioners are using to define their identity in this context. The actions and interactions practitioners use towards HIV/AIDS and related issues are determined by and derive from the symbolic meanings they attach to these issues. The situation of the general practitioner in relation to HIV/AIDS is captured in the symbolic meanings which are developed through the process of the encounter.

6.1.1 Metaphorical Influences

According to Symbolic Interactionist theory individuals base their actions upon the symbolic meanings they ascribe to objects and circumstances within a situation. As subjects modified their understandings through the process of the encounter, their actions changed accordingly.

This study has confirmed that the subjects initially formulated their symbolic understandings of HIV/AIDS issues through a process of assimilating the values, beliefs and attitudes of society in general on the one hand, and the perspectives of the biomedical model on the other. The encounter with an HIV infected patient was significant in that these pre-conceived conceptualizations of the HIV/AIDS disease and related issues were re-assessed, re-interpreted and modified as a result of this encounter. The disease changed in meaning for the subjects from

an abstract notion to a concrete experience, therefore the subjects' actions and perceptions relating to the disease also changed.

In Symbolic Interactionist terms, subjects underwent a process of "acting, perceiving, interpreting, acting again" (Charon, 1979, p. 23) as their perceptions were modified through ongoing experience and interaction with others - in particular the encounter and interaction with an HIV infected patient. Once in the encounter subjects found their pre-conceived medical and social perspectives to be largely inappropriate and in many cases obtrusive. This study has revealed how these perceptions and symbols have been developed and adjusted over time through the process of the encounter as subjects have found them obstructive or attempted to make them more constructive.

After the encounter the perceptions of the subjects became highly complex as they re-defined and developed their original symbolic understandings. These new understandings comprised a combination of perceptions drawn from a variety of sources, including a re-interpretation of the social and medical perspectives; a recognition of the implications of the social attitude to HIV sufferers; a strong awareness of personal risk and a personal understanding of the threat (financial, social and physical) of the disease to themselves and their families; personal influences such as family, friends and colleagues, media and patients; a perception of their changing role and the future trends in the disease, and the expectations and goals of their professional role.

The **professional role** outlined for general practitioners defines the professional identity within certain parameters. This identity was derived largely from and upheld by medical journals. Subject 5 stated that when HIV first appeared there was a tremendous volume of information available in medical journals. A lot of this information was misleading for instance the impression given was that a person could only contract the disease if he were an active homosexual. These journals had a strong western bias which significantly influenced subjects' perceptions. In terms of this identity subjects perceived their role within the scientific parameters of drug intervention, physical treatment and cure. These perceptions were derived in part from the dominant medical metaphor towards disease, the military metaphor (Sontag, 1978). This metaphor understands disease in terms of an invasive morbid agent which is countered by the body's immune system, supplemented by "magic bullets" - drug therapy (Dixon, 1978). Subjects indicated that this identity was kept deliberately separate from any personal feelings or beliefs: Subject 3 stated that he never allowed his personal feelings

to come to the fore when he was working in a professional capacity. Instead they saw their role as authoritative and objective and related to their patients from this perspective. Subjects were constrained by the parameters of their professional role in interpersonal situations such as providing and receiving emotional support from colleagues, discussion of the emotional implications of this disease for themselves and significant others, and counselling infected patients. The metaphorical understandings with which the medical perspective provided the subjects in terms of dealing with an infected patient included: perceiving the patient as a physical disease; taking precautions against the patient as a manifestation of this physical disease; understanding the patient's condition in terms of germ aetiology, modes of transmission and behavioural practises; understanding the incidence of the disease in statistical terms; and management of the patient in terms of drug intervention, testing procedures, hospitalization and other physical strategies. These metaphors proved largely inappropriate for the subjects: for instance, precautions were seen as a means of defending the subjects against their fear of the disease. In situations where this fear was intense, however - in high risk surgery - the physical guidelines outlined by the biomedical institution did not adequately alleviate the subjects' fear. These metaphors also obtruded between the practitioners and their patients in the interpersonal situation and militated against the development of effective and meaningful interaction. Subject 6's desire to take photographs of an HIV infected patient for medical or educational purposes derived from his perception of the patient as a physical disease. Because of this he did not interact with the patient in a meaningful way. The biomedical perspectives and its metaphors did not allow for the emotional needs of the patient or of the practitioner, nor did they equip the practitioner with viable guidelines for dealing with the social aspect of the disease and its stigmatising viewpoint - a finding supported by Ostrow (1990). These practitioners were further constrained by the curative goal of their profession in dealing with a disease that has no prospect of a cure.

Jonathan Mann (Mann & Chin, 1988) indicates that HIV/AIDS has engendered a very strong social response: this he refers to as the "Third Wave" of the disease. Susan Sontag shows how societies construct social metaphors to understand the phenomenon of HIV/AIDS and control and distance their own fears. These social metaphors are often based on denial, isolation, discrimination and stigmatisation (see sec 1.4). It was found in this study that the **social perspectives** towards HIV/AIDS did strongly influence the subjects' personal understandings and judgements towards the phenomenon. Symbolic Interactionism states that meanings

are socially derived from the reference groups with which the subjects identify; with regard to the meaning of HIV/AIDS for the subjects, the dominant and most influential reference group in their personal identity was society.

The social metaphors through which subjects initially understood the phenomenon were drawn from the western culture's perspective on medicine and on moral behaviour. The subjects' understanding of the disease was strongly influenced by their perception of its origin. All the subjects saw HIV/AIDS in the conventional way as emanating from Central Africa - a metaphor suggested by Sontag (1988). A further metaphor discussed by Sontag of the disease being contained in specific deviant subgroups whose sexual behaviours made them personally responsible for contracting the disease was also adopted by the subjects. Subjects understood HIV infection as synonymous with Full Blown AIDS and therefore rapidly terminal. They expected HIV persons to be greatly disfigured by the disease, as Goffman predicts in his first level of "stigma" (see Section 1.4, p. 27). For instance when Subject 5 first saw his HIV infected family he expected them to be physically a lot worse than they were, he thought they would "look thinner and have sores". Society perceives the disease to be a major catastrophe, similarly subjects were strongly influenced by Doomsday predictions. HIV/AIDS as divine retribution was a metaphor that subjects were aware of, however, this metaphor was re-interpreted in accordance with their personal beliefs: they saw HIV/AIDS as divine intervention rather than direct punishment. As discussed by Sontag (1988), another metaphor subjects assimilated from society was that of HIV/AIDS as a population curb. Subjects understood themselves through the social perspective of medical practitioners as a high risk group. The social attitude to the disease comprises an affective component of "fear". This fear was the basis from which socially stigmatising and negative attitudes derived: subjects also incorporated this aspect of social metaphor into their perceptions. This understanding underwent considerable change during the course of the encounter. For example Subjects 2, 3 and 6 initially held strong views towards homosexuality, however, these views underwent significant change. Subject 3 explicitly stated that he had at times adopted the negative perception towards HIV/AIDS sufferers held by society, he had originally perceived the disease as a new "plague". Subjects realised that they themselves would be ostracised through the same stigmas were they to contract the disease, and this had considerable implications for their professional and precautionary behaviour, as well as for their personal role. It must be noted that while the encounter served to decrease their fear of HIV infected patients, it exacerbated their fear of the consequences of the disease. Through interaction with society the subjects

became aware of the social attitude towards themselves as authorities on the topic of HIV/AIDS. For this reason they felt it was important to educate themselves in this field; however, this education focused on highly specific physiological details in keeping with the biomedical role, neglecting the sociological dimension, and did not meet these social expectations.

As indicated above subjects' actions were based largely on their assimilation and interpretation of symbolic meanings deriving from their social and medical cultures. The medical culture was especially significant in terms of the subjects' professional identity, whereas the social culture strongly influenced their personal identity. Although subjects did modify their understanding of the social and medical attitudes towards the HIV/AIDS disease on account of their interaction with an infected patient, they showed little evidence of consciously integrating these social and medical understandings towards the disease. For this reason a considerable degree of psychological tension, or "role conflict" as Stryker (1980) terms this phenomenon, existed between what the subjects believed through social and media influences and what they were informed of through interaction with their medical culture. For instance, although the medical literature has informed the subjects that the incidence of contraction through needlestick injuries is extremely low, because of the social understanding of medical practitioners as a high risk group they were extremely concerned about and attempted to avoid invasive surgical procedures.

Although the subjects were most influenced by their social and medical cultures they also assimilated and consequently re-interpreted understandings from other groupings with which they identified. These understandings were influential with regard to their personal and professional identities. These references groups included: **friends; family; colleagues; patients, and media.**

The influences on the subjects from **familial interaction** included the metaphorical understanding of themselves as protectors and providers. Subject 3 stated that were he to contract the disease he would be unable to support his family and this worried him greatly. Subjects also saw themselves in the role of educator, especially with regard to their children whom they perceived may contract the disease through external sources. Subjects were aware that their spouses perceived them as belonging to a high risk category: this influenced them into understanding themselves as a source of threat to their families, which in turn affected their use of professional precautionary strategies.

Understandings developed through interaction with **friends** included an awareness that friends perceived the subjects in terms of fulfilling an educative and advisory role. Subjects were also aware that their friends understood that medical practitioners constituted a high risk group.

Metaphors relating to interaction with **colleagues** and staff included perceiving relationships in terms of hierarchies. Subjects felt it was their duty to educate their junior staff in a formal way as well as informally through setting examples and professional standards. Subject 2 stated that she felt it was very important to set examples in front of her patients and nursing staff. Interaction between senior colleagues was perceived as important, however, interaction on this level was low both in terms of exchanging factual information and receiving emotional support. Subjects felt strongly compelled to separate their personal feelings from their professional interaction with both junior and senior colleagues.

Despite the subjects' critical attitudes towards popular **media** reports, particularly concerning sensationalised Domsday scenarios, they were in fact influenced by these reports. Subject 1 indicated that he read the reports in the media on HIV/AIDS but did not allow these opinions to alter his own views. However, this subject later stated that he agreed with the pessimists who predicted an enormous increase of HIV/AIDS in South Africa. Subjects' interpretations of these reports, whilst modified, still reflected certain aspects of the media portrayal. All the subjects forecast a major upsurge in infected patients in the future, causing economic strain and overcrowding in health care systems. Media reports in South Africa have vacillated between citing medical practitioners as the ultimate authority on HIV/AIDS and depicting these same professionals as transgressing ethical boundaries and not meeting the needs of the society (Crewe, 1992; *E.P. Herald*, October 17, 1991). Subjects made no explicit reference to this two-fold dimension, however, they gave evidence of a strong defensive attitude. For example subjects expressed anger at the fact that it was demanded of them to treat all members of society, despite this putting themselves at risk. In this regard Subject 6 claimed that he was not a "martyr".

The concrete presence of **HIV infected patients** in the subjects' world significantly influenced their understanding of the patient as object, and subsequently their understanding of HIV/AIDS in general. This study has revealed that the patient, through the course of an encounter, has been the central

influence on these practitioners in formulating and adapting their perceptions. Their original understanding changed considerably through the course of the encounter. Metaphors provided by the social culture were largely negative, based on fear and denial; metaphors from the medical culture were equally inappropriate. Through their interaction with an HIV infected patient the subjects re-organised their understanding of these metaphors. Patients were no longer seen in purely medical terms but rather as individuals who were unfortunate victims of circumstance. The changing perception towards the patient through active "role taking" (Charon, 1979) had important implications for the subjects' overall understanding of their position in relation to this disease. The interaction with the patient influenced them into recognising the social implications of contracting HIV/AIDS, and their own vulnerabilities. As Sontag states, "AIDS... is a disease that is a marker of both individual and social vulnerabilities" (1988, p. 65).

6.1.2 Metaphorical Re-Interpretations

The meaning of HIV/AIDS has changed for the subjects as a result of their encounter with an HIV infected patient. This changing meaning has affected their perception of issues relating to the disease, such as **precautionary techniques, attitude and relationship to HIV infected patients; understanding of social attitudes; interpretation of professional role; relations to significant others; understanding of body and body parts, high risk groups and high risk behaviour.** The meaning of HIV/AIDS before the encounter, as previously stated, was "disfiguring terminal disease". This perspective was strongly influenced by the social attitude to HIV/AIDS and the medical understanding of disease.

Subjects felt a need to prepare themselves before entering into the encounter. This preparation was in accordance with their professional role, derived from medical literature and discussion with colleagues. Subjects were underprepared emotionally for this encounter. Prior to the encounter the disease did not seem real to the subjects. They needed to go through the process of the encounter in order to comprehend fully the medical, social, and personal ramifications of the disease.

During the encounter subjects were compelled to re-assess both their socially and medically derived understandings of the disease and HIV infected persons. This was because subjects entered the encounter with strongly preconceived expectations which were not met by the reality of the situation.

The following provides a consolidation of the changing symbolic meanings of HIV/AIDS for the practitioners in this study. These metaphorical understandings display the processes through which these practitioners have gone since they encountered an HIV positive patient. It also displays the means by which these practitioners attempt to understand and control their professional and personal positions in the face of HIV/AIDS and its related issues.

The meaning of precautions.

Subjects have an extensive knowledge of precautionary procedures, particularly those relating to HIV/AIDS. Despite this knowledge, subjects did not appear to put these procedures into practice very seriously prior to the encounter. They did not see the encounter as directly threatening, but it did change their attitude to precautions. Subjects do now take precautionary procedures more seriously, though they feel these procedures should not be over-emphasised in day-to-day consultation. However, a major change has taken place within the context of surgery in that subjects perceive themselves to be at high risk in such situations and perceive precautions as very important in these circumstances, although they do not perceive precautions as a fail-safe guarantee in surgical situations. Subjects perceived the use of precautions to be a strong interactive statement with regard to the doctor-patient relationship in that they emphasise the practitioner's perception of the patient as high risk.

Body/body parts.

Prior to the encounter subjects attached no significance to their patients' physical bodies - or parts thereof - in terms of threat. However, after the encounter parts of the body such as blood and other body fluids were seen as threatening. Subjects began to understand the disease as located within the physical body of the patient. It was against the body as a manifestation of disease that they took precautions. A change in conceptualisation took place therefore from understanding the disease as an abstract, unlocated threat to locating this threat in the body of the patient.

Social attitudes.

Having gone through the encounter subjects re-assessed their social attitudes, perceiving these attitudes to be ignorant, moralistic and fearful, as well as stigmatising. Subjects were fearful of the potential attitude to themselves as individuals and doctors should they contract HIV/AIDS. Although subjects intellectually understood these attitudes to be inappropriate to their

professional role they in fact remained influenced by these attitudes, particularly with regard to high risk groups and high risk behaviour.

High risk groups & high risk behaviour.

Subjects understood HIV/AIDS transmission in terms of high risk groups and high risk behaviour. In their understanding of high risk groups and behaviour subjects appeared to be influenced by two major sources: the social perspectives and the medical literature. Groups which were marginalised or perceived of as deviant in terms of the understood moral and cultural norms of society were equated by the subjects with high risk. These included Blacks, migrant workers, homosexuals and students. The medical perspective influenced subjects towards identifying male homosexuals as the highest risk group (despite the fact that this belief is not borne out by statistics in South Africa). This attitude is most probably derived from the fact that these subjects' professional sources of information are largely western orientated. It must be noted, however, that the other major western high risk group, IVDUs, are not mentioned by the subjects. Because of the media portrayal of HIV infected persons as highly disfigured by a terminal illness, subjects expected their patients to reflect this image. However, after the encounter subjects modified their understanding, recognising that a person with HIV was not necessarily going to die in the near future and would not necessarily be greatly disfigured.

While all the subjects' patients were black, none of them fitted the conventional definition of high risk behaviour. Subjects therefore modified their perception of high risk groups towards an intellectual understanding of each individual in the community being at potential risk to the disease. This understanding was, however, tenuous. Subjects still maintained to a strong degree the social perceptions of high risk groups and behaviours. The extent to which these perceptions remained entrenched is shown by the subjects determining the need for precautions through an assessment of each patient's likely risk status in terms of belonging to a high risk group or pattern of behaviour.

Relationship to HIV infected patients.

The subjects' relationship to their HIV infected patients changed through the process of the encounter. As subjects interacted with their patients they developed a far more personalised understanding, seeing the patient as an individual rather than as a physical disease. The act of touching the patient was a symbolic gesture used by the subjects to express compassion and acceptance.

The greater the extent of interaction, the more this understanding developed. Subjects were able to control their fear towards these patients as well as transcend the limitations of their professional role, in that they were able to empathise strongly with their patients. Despite their recognition of the HIV infected patient's emotional needs, subjects had great difficulty reacting to these patients on this level. Subjects stated they perceived HIV patients in the same light as any terminally ill patient. This statement was in accordance with their professional role. However, it was evident that on a personal level subjects did discriminate between HIV and other terminally ill patients. This was probably due to the added dimension of fear and stigma attached to HIV infection.

Subjects saw it as important to establish to what extent the patient understood his/her situation, and modified their interaction with the patient accordingly. They chose not to explain the concepts of the illness if the patient appeared to be ignorant.

Interaction with significant others.

Subjects, in their family role of carer and protector, were principally concerned about the financial impact on their families should they contract HIV/AIDS. Subjects also perceived of themselves as a threat to their families. This understanding aroused strong emotions in them. The subjects' perception of possible infection to their families influenced them to take greater care in their professional activities. While the female subjects were concerned over possibly infecting their husbands, the male subjects showed no such concern regarding their wives.

Subjects found it necessary to re-inforce their understanding of their role through talking to their colleagues. They also felt a need for emotional support from their colleagues, which they did not feel they were receiving.

Perception of professional role.

In terms of their professional role, subjects maintained a strong sense of loyalty to the duties of their profession. They had fully internalised a strict code of ethics defining their practice. Even in circumstances where they felt personally compromised - for instance, their perception that hospital work comprised an environment where they had least control over high risk situations -

they felt compelled by their professional role to continue their duties within these situations. While subjects constructed for themselves scenarios in which they would choose to leave the profession, they nevertheless showed no signs of taking such steps. It was especially significant that even in the event of their contracting HIV/AIDS they felt they would remain within the medical profession. They saw their professional role as excluding any personal attitudes; their professional stance therefore should exclude any moralistic or personal opinions. Attitudes expressed through the professional stance included the basic goals of care-giving and comforting, whereby the patient's needs were seen as more important than those of the practitioner.

Subjects indicated that part of their professional role has always involved dealing with life-threatening diseases, and they were not especially worried about HIV/AIDS on this account. However, it was evident through their personal perceptions that HIV/AIDS with its related social stigma was in fact very different.

In the light of the perceived future trends of HIV/AIDS, subjects indicated it would be necessary to re-define seriously their professional role. This role was perceived very much in terms of personal risk; they foresaw adaptations as necessary to avoid this risk. These adaptations included greater caution in dealing with unknown patients, taking on an educative function, developing support structures for all health care workers. However, they indicated that they perceived their future role to be orientated around treatment rather than frontline preventative education strategies. They felt that alternative community-based structures would have to carry the burden of education and care-giving. They also saw HIV/AIDS as having a significant effect on the choices they made in their future careers and on the profession as a whole.

As seen above the changing symbolic meaning of HIV/AIDSs which encountering an HIV-positive patient has introduced into the personal and professional identities of selected health care professionals is extensive and complex. Subjects as "conscious actors" in their world have re-interpreted and re-defined incoming information from their reference groups to accord with their own experience.

These new metaphorical understandings generated by the subjects through their experience have generally been positive in that subjects have a far better understanding of the disease, its implications for the sufferer and their role

within this context. They also showed a greater recognition of their professional needs and duties with regard to this disease, including preventative education, a sensitive awareness of patients' emotional needs, an awareness of their own vulnerabilities and an overall amelioration in their attitude towards HIV/AIDS-related issues. Despite these positive changes subjects still had great difficulty in feeling at ease in their situation. A marked division was evident between the subjects' interpretations of metaphors deriving from social perspectives on the one hand and biomedical perspectives on the other. Subjects understood these perspectives to be in opposition, consequently influences from these dimensions were not allowed to inform each other. Through the process of the encounter, while these two sets of perspectives did in fact affect one another implicitly subjects still perceived them as necessarily kept separate. This unwillingness to integrate these two perspectives limited and constrained the subjects in that they were unable to construct a unified identity in relation to the issues HIV/AIDS raised for them. This division between these two opposing perspectives gave rise to a fundamental dichotomy which was revealed through this research study. This involved a split between the subjects' personal attitudes, feelings and thoughts on the one hand and their perception of their professional duties on the other. These two dimensions were frequently at variance and subjects gave little evidence of perceiving a need to reconcile them. This distinction is especially significant and has serious implications for the medical practitioner in the context of HIV/AIDS.

6.2: Constraints on the Medical Practitioner in the Context of HIV/AIDS

6.2.1 Constraints Imposed by Social Perspectives of HIV/AIDS

Subjects were constrained in their relationships to HIV infected patients and in their methods of treatment by the dominant social metaphors (see p.***) on the disease. In this study subjects did not clearly differentiate between living with HIV infection and the syndrome of Full Blown AIDS. Only Subject 5 developed a clearer perspective in this regard through his encounter. Mostly the subjects saw the contraction of HIV as correlated with death. This understanding was derived from the social perspective on the disease as a "disfiguring terminal illness". This perspective had strong implications for their professional activities, particularly in the context of the curative goals of the biomedical model.

A further metaphor which influenced the subjects was the perception of the disease as a process of Nature: this implicitly encouraged them to be fatalistic about allowing the disease to run its course, both in terms of patients and high risk groups, and in terms of their own possible contraction. Subject 5 saw HIV/AIDS as a process of natural selection, Subject 6 as a mechanism for controlling population. Other subjects viewed the disease as a form of divine intervention. This again had implications for their professional roles in that these individuals ultimately saw themselves as making little impact on the course of the disease.

Sontag (1988) states that sufferers of STDs have been traditionally viewed as "wilful" and deserving of their condition. Subjects displayed this understanding in their personal attitudes to HIV sufferers, by their understanding of their particular HIV patients as "innocent" victims (none of the subjects' patients had contracted the disease through sexual promiscuity or other so-called "deviant" behaviour). Subjects expressed a hope that HIV/AIDS would encourage a return to "traditional" moral values and a decrease in "wilful" sexual behaviour.

As has been shown in the preceding paragraphs, social metaphors on HIV/AIDS did affect subjects in their professional activities. As these metaphors were largely negative, so too was their effect on the practitioners.

6.2.2 Constraints Imposed by Biomedical Practise in the Context of HIV/AIDS

This study has revealed that by explicitly formulating their professional identity purely in terms of the biomedical culture and by not integrating their identity with the wider context, subjects are disadvantaged and constrained in their professional activities in the context of HIV/AIDS by the limitations of this culture.

The dominant metaphor through which the biomedical model understands the process of disease is that of the military metaphor (Sontag, 1978). This understands causative factors in terms of specific aetiology (Dixon, 1978), whereby the individual is "invaded" by a foreign pathogenic agent. This assumes a one-to-one correlation between a specific disease and a specific agent. For example, Subject 4 treated her patient for TB alone and discovered only later that the HIV virus was also a contributing factor to the patient's condition. This example shows that with many opportunistic infections practitioners are not orientated to move beyond this one-to-one correlation: this presents difficulties for diagnosis of

HIV/AIDS. This metaphor directs practitioners towards viewing the process of disease as a conflict between a morbidic agent and the body's defence systems. The sociological context of disease is neglected, that is the factors influencing the patterns of transmission and environmental and psychological factors compromising immune system functioning are not taken into account (Van Niekerk, 1991). Medical practitioners see disease intervention as purely physical, involving scientifically based drug therapy, surgery, or chemotherapy (DiMatteo & DiNicola, 1982) - the metaphor of the "magic bullet" as a means of supplementing the body's own defences (Dubos, 1959). In the context of HIV/AIDS there is no "magic bullet": Subject 1 stated that had he realised initially his patient had AIDS he would probably have discarded all effort towards treatment. Subject 1, therefore, saw his role in physical interventionist terms. In the absence of a cure subjects felt the care of the patient as inappropriate to their professional role. This physical focus emphasises the role of cure - subjects were constrained in establishing preventative goals. The inadequacy of the Military metaphor, curative intervention and a purely physical focus towards the patient (Illich, 1977) has been highlighted significantly by the presence of HIV/AIDS. Through the course of the encounter the practitioners became particularly aware of the need for preventative strategies such as education. All subjects understood it as their duty to attempt to educate high risk patients (those exhibiting STDs). This education, however, was initiated and took place within the biomedical framework. They understood their high risk patients in terms of physical vulnerability - STDs - rather than social, cultural or environmental vulnerability - they made no attempt to educate their patients who were placed in immune compromising positions by such factors as poor diet, environmental stress, substance abuse and other factors relating to poverty.

Further constraints relating to education included the subjects' reluctance to involve themselves in their patients' non-physical world. With disease confined to a physiological dimension it is easier for practitioners to relate to patients as a manifestation of disease, rather than in a more holistic way encompassing the patient's beliefs, feelings, cultural values and lifestyles (DiMatteo & DiNicola, 1982). This was evident through the fact that the subjects were reluctant to comment on the risk implicit in lifestyles such as promiscuity or homosexuality, and cultural practises such as circumcision.

In accordance with the dualistic philosophies of the human condition, biomedicine separates the individual into body and mind (Wolinsky, 1988). With the medical emphasis being on the body, practitioners adopt a natural scientific stance

towards the functionings of the body in which scientific knowledge, neutrality and objectivity are paramount (DiMatteo & DiNicola, 1982). This attitude of objectivity and neutrality is evident not only in practitioners' relations to their patients, but in every sphere of their medical activities. Emotions both on their own part and on the part of the patient are seen to detract from effective implementation of medical treatment (Kleinman, 1980). Subjects also showed a reservation with regard to exposing their emotions to patients, staff and colleagues. Subject 3 stated explicitly that he maintained a "veneer" over his personal feelings in the medical context. Subject 4 indicated a difficulty in communicating her emotions to her colleagues. The biomedical model, by emphasising this stance of neutrality, gave these practitioners little room for personal emotions in the medical context. This presented a problem for these practitioners in the context of HIV/AIDS in that this disease in particular engendered a strong fear response which was not suitably accommodated by this model. The only structure available to the subjects as a means of alleviating this fear was through standard precautionary measures outlined by the model. These physical strategies were largely ineffective in dealing with these emotional issues. Subjects had the same difficulties relating to their fears for their families. Again they saw precautions as the only means at their disposal for controlling their concern over possibly infecting their own families. Subjects were also considerably influenced by social and media perspectives towards the disease and its sufferers which were at variance with the biomedical ethos and subsequently gave rise to psychological tensions (Stryker, 1980). Practitioners were required to treat sensitively those very persons whom they feared or personally disapproved of. For example, those subjects who indicated a moralistic stance towards certain types of behaviour were compelled to treat individuals practising such behaviours. Similarly, practitioners were adverse to treating patients whose HIV status they did not know, yet they were required to do so.

With the emphasis on the physical aspects of the patient, psychological issues are frequently overlooked (Kleinman, 1980). With regard to HIV/AIDS the psychological implications are immense for the infected individual. Although it was recognised by the subjects that their duties included pre- and post-test counselling, they had no clear framework in which to implement this focus. While the biomedical model stipulates that practitioners must be sensitively aware of their HIV infected patients' psychological and emotional needs (Lachman, 1991; Ostrow, 1990), neither their training nor the entire focus of the model have given them the necessary skills. The psychological needs of the patient extend

beyond the issue of testing and physical treatment; individuals need to be informed, guided, assisted and supported throughout the disease process and need to be counselled on how to manage their lives healthily as well as contending with social stigma.

The biomedical model is defined and upheld by certain ethical and legal parameters. Medical practitioners are expected by duty, enforced by oath, to conform to these parameters. An issue of concern for subjects in this study was the legal and ethical constraints placed on practitioners in relation to the management and treatment of HIV/AIDS patients. Subjects all felt to some extent disempowered by the stipulation that they were required to treat patients without an awareness of their HIV status. Subjects believed that they were being placed in potentially high risk situations without recourse to effective means of safeguarding themselves. Out of this arose the issue of mandatory testing. Subjects felt that testing should be the choice of the practitioner and not of the patient, and considered the patient's autonomy in this regard to be inappropriate. Regulations involving doctor-patient confidentiality were also felt by the subjects to be constraining in that they were not able to openly discuss their HIV-positive patients with other health care workers.

Biomedicine is a phenomenon of the western culture. As Kleinman (1980) points out, all health care systems are symbolic constructs of a specific society, arising out of the needs, beliefs and values of that society. Biomedicine, like all other health care systems, is a cultural system which both informs and is informed by symbolic meanings:

The health care system integrates the health-related components of society. These include patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially legitimated statuses, roles, power relationships, interaction settings, and institutions (Kleinman, 1980, 24).

The goals and interpersonal relationships of this system are therefore specific to the society from which they derive. When such a system is translocated into a differing society with different goals and expectations, conflicts arise. In South Africa there exist a number of societies with differing symbolic understandings of illness. Practitioners in South Africa, especially in the context of the AIDS pandemic, are confronted with a series of problems, particularly with regard to prevention strategies, treatment of and management of HIV/AIDS. The most obvious difficulty experienced by the subjects in this study related to language and communicative constraints. They were unable to communicate meaningfully with their patients; this had implications for diagnosis and counselling. None of the subjects were of the same culture as their patients,

furthermore they were all trained in the biomedical model. Their expectations with regard to effective education methods; patient compliancy; practitioner authority and disease management were largely inappropriate. Subject 4 encountered a patient whose family resisted the authority of the practitioner in refusing to allow the patient in question to be directly hospitalised. Subjects 2 and 3 both indicated that their patients, while having received counselling, did not appear to have fully understood the issue of their illness. Subject 6 attempted to educate the Public through lectures but found attendance poor and was not able to reach those most at risk through this strategy.

Because of the strong influence of the biomedical approach most preventative-educative programmes have adopted a physiological orientation as is evident through the subjects recommending their patients to adopt safe-sex procedures such as the use of condoms, as well as urging people to limit their number of sexual partners. It is also evident through their provision of information to their staff, which relates specifically to transmission.

The focus of education strategies should be extensive, moving beyond programmes aimed at primary prevention of HIV infection towards educating HIV-positive individuals on how to maintain healthy lifestyles and how to prevent themselves from developing full blown AIDS. The subjects all indicated that they educated patients in terms of contraction, but made no provision for educating patients already infected. Biomedical education programmes focus specifically on the physical pathways of the germ and the ways in which an individual is able, or not able, to contract it: HIV can be contracted through sexual intercourse, blood transfusion, intravenous drug abuse, surgical practises, and so on. It is not contracted through mosquitoes, sharing cups, toilet seats, kissing or shaking hands. Preventative measures against contracting HIV are also seen in moralistically biological terms. For instance the individual must practise safe sex, limit his/her number of partners, use condoms and spermicides, and live a monogamous lifestyle (Kriel in Van Niekerk, 1991). Subjects 2, 3 and 4 indicated a very strong understanding of this.

Kriel states that HIV/AIDS is not a "medical" disease. This response is inappropriate in that it is based on the specific understanding of HIV/AIDS as a biological disease, consequently it neglects to address the fundamental issue at stake in the HIV/AIDS epidemic: the behaviour patterns that maintain the epidemic. Kriel further states that education programmes based on a biomedical approach incorrectly assume that by simply knowing the facts about HIV/AIDS people will change their sexual behaviour. This view does not take into account

the socio-political factors (including apartheid legislation and labour practises) that have severely disturbed the family relationships of most black communities in South Africa, thereby creating the material conditions that form the basis for the behaviours that maintain the HIV/AIDS epidemic. These education programmes therefore ignore the psychological, anthropological and social context of the behaviour. According to Kriel the discovery of a cure for HIV/AIDS or the development of a vaccine against HIV will not reduce the impact of HIV/AIDS without concomitant behavioural change.

Information relating to safe-sex procedures and the use of precautionary measures is vital, but this on its own does not meet the full challenge of the disease. Such programmes are based on the belief that supplying knowledge of the biological facts of HIV transmission will be sufficient to motivate individuals to change their behaviour. Apart from the fact that the link between knowledge, beliefs, attitude and behaviour is now generally accepted to be very tenuous (Ajzen et al., 1980), this view also ignores the pressures placed on the individual by customs, taboos, social rituals, sexual values and peer group pressure. Furthermore, these programmes are designed and directed towards the individual, seeing the modification of high risk behaviour as lying entirely within the individual's choice. Patterns of sexual behaviour in most cultures are often integrated into gender stereotypes and other complex issues. Consequently, the individual's so-called free choice is often very limited, especially for women.

The biomedical model sees the management and treatment of HIV/AIDS as a function of the medical practitioner within the medical institution. In South Africa the large majority of the population has traditionally perceived the management of disease as located in the community. The long-term management of HIV/AIDS within the hospital setting is ineffective and stressful to the patient, and given the increasing numbers of HIV/AIDS sufferers, almost impossible (Gerhardt, 1989; Crewe, 1992). Subjects indicated an awareness of this and emphasised a strong need for community based care. They were, however, unsure as to how future community care structures could be implemented, nor did they see their own role in this context (with the exception of Subject 4). Co-operation with and referral to other health care and community workers, as well as traditional healers, was also an issue on which the subjects had not clearly defined their stance. The "prestige" of scientific approaches over all other methods of action also influenced the subjects, in that alternative understandings of AIDS and HIV and alternative treatments or therapies were seen as subordinate and frequently dismissed as counterproductive.

6.3: Limitations of Research and Suggestions for Further Study

One of the major limitations of this research was the difficulty in eliciting spontaneous personal emotions from the subjects. This was due to a number of factors. Subjects were interviewed in their professional setting about a professional event, and were influenced by this to maintain a professional attitude. Furthermore, medical practitioners in recent years have been greatly criticised from psychological and sociological perspectives and have also been subject to adverse reporting by the media in relation to their actions in the context of HIV/AIDS. As a result they have adopted a defensive attitude and appeared reluctant to express their real feelings.

A further limitation was the lack of data referring to subjects' perceptions and feelings before the encounter took place. Although information in this regard was implicit in the stages during and after the encounter, a more explicit focus on this temporal stage would have made the position of the study stronger.

The methods employed in this research gave rise to a rich and extensive description of the phenomenon under study. Space constraints, however, limited a full exposition of this data.

A number of further needs and suggestions have arisen out of the process of this study. The research examined practitioners whose background was located in a predominantly western culture. Further research could profitably focus on biomedical practitioners whose background is more representative of the larger population groups within this country. These individuals would have a different set of understandings about health care systems and the nature of illness and HIV/AIDS. Further research also needs to be conducted into developing effective models of HIV/AIDS management and the medical practitioner's role within this.

As Kleinman (1980) states, disease and illness are culturally defined and understood. This understanding is not a static process but is always undergoing change. It is important for further research to be directed at determining and monitoring these changing symbolic understandings of HIV/AIDS in all groups of society. Education prevention strategies must be based on such understandings in order to be effective.

6.4: Conclusion

It has become clear through the course of this study that the symbolic meanings subjects have evolved to understand HIV/AIDS are highly complex and influential with regard to their personal and professional identities. Symbolic meanings were initially derived from the biomedical and social perspectives. The subjects encounter with an HIV infected patient provided a catalyst through which their symbolic meanings were redefined. These understandings of HIV/AIDS were, however, still constrained. These constraints have their genesis not only in the social metaphors of stigmatisation fear and denial, but more so in the limitations of the biomedical model in relation to HIV/AIDS. The deficiencies of this model in terms of training, treatment and overall understanding of disease become very apparant when HIV/AIDS is treated purely within this framework. Practitioners within this model are severely limited and constrained by these deficiencies, both in that the goals of their professional role are largely inappropriate and in that they are unable to form a unified identity in terms of understanding both the personal and professional implications of the disease to themselves. The future role of practitioners in the context of HIV/AIDS needs to include the psychosocial dimensions hitherto neglected.

SECTION SEVEN: APPENDICES & REFERENCES

7.1: Appendices

Appendix I Statement of Intent

G F H READ
JUNE 1991

PSYCHOLOGY DEPARTMENT
RHODES UNIVERSITY

Statement of Intent for proposed Research

Introduction

This document aims to provide participants with a comprehensive understanding of the exact nature of the proposed research study and their role within this process. It is hoped that this document will also promote discussion between the researcher and the participant with regard to any issues that may require clarification.

Topic

A qualitative study aimed at describing and interpreting the changing symbolic meanings of HIV/AIDS which encountering HIV-positive patients introduces into the personal and professional identity of selected Health Care professionals.

Context

This study arises out of the prediction that AIDS in South Africa threatens to become an unprecedented public health crisis with large economic and social implications, and consequent psychological implications. Although AIDS in South Africa is still in the early stages and has not yet reached serious epidemic proportions, there is no reason to suggest that the natural history of the disease in this country should follow a course any different from that of neighbouring countries. Reports indicate that 446 000 South Africans are expected to be HIV positive by the end of this year (ANC spokesman, *CIT. Sunday Times*, 1991). In the Cape Province 907 people to date have tested positive for the HIV virus. This figure continues to rise and a recent report indicates that the incidence of infection for the first three months of 1991 in this region showed a twofold increase in comparison to the same period in 1990 (Dept of National Health, *CIT. E P Herald*, 1991).

Health Care professionals are at the forefront of the encounter between the AIDS epidemic and Society. Consequently, these individuals are faced with a unique situation. This situation is highly complex, having intricate psychological ramifications. Little research has been undertaken in this regard. The needs and concerns of health care professionals have been brought to the fore by the advent of this disease. The complex psychological structures surrounding these needs and concerns require close analysis.

Aims

This research study arises out of the above scenario and it aims principally to elucidate and interpret the symbolic meanings of HIV/AIDS which an encounter with an HIV infected patient introduces into the general practitioner's personal and professional identity. By doing so it will be possible to achieve a detailed understanding of the meaning of HIV/AIDS and related issues for these individuals. It is only once a baseline of information has been obtained in this regard that discussion relating to the needs of these individuals can be initiated.

Data Collection Methods

The method of data collection employed in this study comprises one in-depth interview. A second interview will be conducted if the researcher feels it is necessary to clarify certain points raised in the first interview. All interviews will be tape-recorded and later transcribed. The initial interview with each participant will focus specifically on the phenomenon: **The experience of having encountered an HIV infected patient.** The interview procedure will follow a semi-structured design, beginning with an encompassing question which will be followed by a set of thematic questions. The themes raised by the interviewer will be interpersonally based and will be content-free in that they will centre around the feelings, thoughts, attitudes and perceptions experienced before, during and after their first encounter with an HIV infected person.

Role of the Participants

The participation of the persons in this study will be entirely dependent upon their own consent. The researcher recognises that during the course of the interview he may be asking intrusive questions: these are designed to gain an understanding of the psychological issues involved in the meaning of AIDS for these individuals, and the way it affects their lives. The participants will be required to articulate clearly their thoughts, feelings, attitudes, emotions and behaviours in relation to the specific event of having attended to an HIV infected individual. The questions will refer to: a) The subjective experiences that took place before, during and after this encounter; b) HIV/AIDS-related feelings that extend beyond this event into the various roles that constitute these persons' lives.

The interviewee will be free to decline from answering any question which may cause him/her discomfort. It must be made clear, however, that the focus of this research study is not on the individual but rather on the composite picture of the meaning of HIV/AIDS for Health Care professionals as a group.

Ethical Considerations

Owing to the sensitivity of the topic and the nature of the participants' professions, the issues of confidentiality and anonymity are of particular importance. For this reason the participants in this study will not be identified by name. With regard to data which may threaten to disclose the identity of the participants, the following procedure will be taken. Once the interviews have been transcribed by the researcher, they will be returned to the participants for review. The participants will be free to determine sensitive areas and discuss these with the researcher, eliminating such areas if necessary.

Throughout the process of the relationship between the researcher and the participants, an atmosphere of complete openness will be maintained whereby any concerns, reservations or misgivings arising out of the process can be openly discussed and subsequently attended to.

The findings of this project will be made available to those persons who participated.

Appendix II Interview Questionnaire

Interview Schedule

Can you describe to me how you felt when as a doctor you were faced for the first time with the situation where you were required to attend to an HIV infected person. Can you recall the actions, thoughts, feelings and attitudes you experienced and expressed in this situation. Could you also include a description of how you felt in the time leading up to this first experience, in other words how you anticipated handling an HIV infected person, and how you felt after this process. Did you experience any changes in perception, was it necessary for you to resolve or work through anything, if so, how did you do this. Did this experience affect your interaction with colleagues, family, patients and others.

The above will generate thematic interpersonal categories apart from those already determined. The researcher will ensure that all sub-questions comprising the above encompassing question will be adequately pursued. The interviewees' response to the encompassing question in terms of their perceptions before, during and after the experience will be accommodated in the structural categories (see below); Their response in terms of interpersonal themes, also drawn from the encompassing question, will be accommodated in content categories, comprising roles (see below).

The following questions in both structural and content categories will form a standard framework, the researcher will ensure that each of these questions is asked of each subject. These questions are designed to generate open responses from the subjects in whichever areas interest them most. The order of the questions will be dependant on the sequence of response from the interviewee. The researcher will adopt a flexible attitude with regard to all the questions asked in this interview. However, a certain degree of control will be maintained throughout the process to ensure that the goals of this interview are adequately met. These sub-questions operate as a guide to the researcher and will not be seen by the subjects.

Structural categories

Thematic questions relating to before, during and after the experience

Before:

- What were your thoughts, feelings and attitudes in knowing that at some time you would in your professional capacity be required to deal with an HIV infected person.
- Before your actual encounter with your HIV patient, did you find it necessary to prepare yourself in any way, either physically, mentally or otherwise.
- To what extent do you feel your preparations may have been influenced by other people's perceptions towards HIV/AIDS.
- What level of knowledge about the HIV/AIDS disease did you have before this experience.

During:

- During this experience do you recall feeling any strong emotions, having certain thoughts, behaving in a particular way, or holding a particular attitude.
- What was the nature of your interaction with this person.
- Did you feel that all your initial preparations taken before treating this patient were necessary, adequate and appropriate.

After:

- Have your perceptions of HIV infected individuals changed as a result of your experience.
- Has your understanding of HIV/AIDS as a disease altered in any way.
- Has this experience caused any adjustment in your behaviour towards patients, your colleagues or other people.
- Has your attitude towards preparation and the use of precautionary measures when dealing with HIV infected people been changed by this experience.

Content Categories

Thematic questions extending beyond the immediate experience.

Various roles

- Did the meaning of being a doctor have to be re-evaluated or re-assessed in any way.
- Did this experience have any effect on your interaction with members of your family.
- Did this experience have any more impact on you because of your role as a family person: Husband/wife, father/mother etc.
- Did your interaction with other colleagues or health care workers have any bearings on your own experience.
- Did the relationship between yourself and your colleagues undergo any change after you or they had had this experience.
- Did you perceive your old patients in a new light; Did you perceive new patients in a different way.
- As a result of this experience has your technique in dealing with patients changed.
- Have any of your patients shown any reaction to your being a possible high-risk person.
- Has your perception of HIV/AIDS sufferers undergone any modification on account of this experience.
- Has your perception of what constitutes high-risk groups undergone any change on account of this experience.
- Has your interaction with people in general undergone any change as a result of your professional knowledge and experience of HIV/AIDS.
- Do you see yourself, as a general practitioner, being given enough opportunity to learn about HIV/AIDS and HIV/AIDS precautions.
- How do you perceive your role as a doctor in relation to the attitudes that Society holds towards AIDS sufferers.
- Do you see yourself, as a general practitioner, being in a position whereby your perception and knowledge of the HIV/AIDS phenomenon may influence and contribute to the general understanding of HIV/AIDS held by Society.

Appendix III: Letter to Subjects

G F H READ
Department of Psychology
Rhodes University
1.10.1991.

Dear Dr.....

Attached is a transcribed copy of the tape-recorded interview undertaken for the purpose of my research study. I would be grateful if you would read through this document and eliminate any information that you find disagreeable, or that you feel may disclose your identity.

I will collect this document from your receptionist on Thursday 10 Oct and will proceed to make a time to briefly discuss any changes that you may have made.

Yours faithfully

G.F.H. READ

Appendix IV: Organisation of Data

Subject 1.

UMWELT

Before

Q Was this your first concrete AIDS related experience. A Yes.

During

Um... in the meantime, during the resuscitation - mouth-to-mouth resuscitation - the child had vomited and the contents went into my nose and mouth.

Q Does this often happen during resuscitation. A No, not really and one does use suction, suction apparatus to try and take stuff out of the mouth... and oxygen,

I do very little operations. I am less exposed than him.

After

Q If you were to contract the disease how do you think you would react. A I'm sure I will get a normal reaction of denial, repression and so on, but then,

I think during that time there was some fear, there still is that fear.

I thought of it at night but it wasn't long-lasting,

I felt whatever comes has to come you know, I don't think one has to worry unduly.

It was just once, one day that I had that little doubt, it wasn't really something that I felt for a long time.

Q What will you do in order to prepare yourself. A I think the use of gloves...

or... without any examination, I wouldn't be over-reactive, but just ordinary,

the body fluids... I would try to avoid contact with the body fluids, especially with blood... and injections, be extra careful too. If there are any medical procedures you know, one must be extra careful.

Q When in surgery there is a lot of blood, do you feel that you may react differently to that now, than before. A No, I don't believe that...

UMWELT

Before

U This was S's first concrete AIDS-related experience.

During

U During the mouth-to-mouth resuscitation procedure, the child vomited into S's nose and mouth.

U S explains that under normal circumstances, resuscitation equipment with suction apparatus and oxygen would be used to avoid an incident such as he experienced.

U S does few operations, so is less at risk than his colleague.

After

U Were S to contract AIDS, his reaction would probably follow the classic stages of denial and repression.

U During this period S felt some fear, and part of this fear is still with him.

U S thought of this incident at night, but this phase did not last for long.

U S believes that whatever comes has to come, it is no use worrying unduly.

U S explains that it was only for the one day that he felt doubt; this feeling did not last for long.

U S will use gloves when examining a patient.

U If S was not doing a physical examination, he would not be over-reactive.

U S would try to avoid contact with the body fluids, especially blood. With regard to injections and other risky procedures, S would be extra cautious.

U S does not feel that during surgery he will respond differently to large quantities of blood, on account of this experience.

I've had that experience of a lot of blood you know when dealing with an incomplete abortion, or when people come in here and some of the blood gets onto me. Or a delivery that suddenly happens here, when they come in and it's too late I have to deliver, in fact I use gloves of course but some of the blood gets onto you,

of course I'm not afraid of having blood on my skin as long as there is no cut on my skin.

Q If you have a cut on your skin would you be more cautious. **A** I would definitely... Yes... . If I had a cut in my skin and I had contact with blood with some-one who I thought had AIDS... if it were some-one who...

a person without AIDS I wouldn't even bother. If I knew, I wouldn't even bother having an AIDS test, I would just clean it myself, make sure I washed myself thoroughly.

You do use gloves for every examination.

Except with examinations like vaginal examinations, rectal examinations when there is a lot of blood one does use gloves, that is routine and has been for years.

It's not that I would be antagonistic or anything, or that I would be afraid...but I will just make sure that I am extra careful as far as possible to avoid infection.

Q Has your perception of AIDS as a disease changed at all since this experience. **A** I don't really think so, probably more cautious now than before...

Q Do you take precautions with every patient. **A** One does, I think... after examination of the patient I wash my hands with disinfectant. One uses gloves and that routine you know, even before the AIDS scare.

But I think where an AIDS patient... where one knows the patient has AIDS, then I think one becomes extra careful, probably wash your hands twice or whatever. **Q** What would you do. **A** I think it would probably come to that.

Q With yourself, what sort of emotion comes to the fore when you think of the disease. **A** Well AIDS... anyone who knows something about it it will naturally instil a lot of fear or dread. **Q** Does it do that for you. **A** Absolutely.

Q How do you differentiate between those at risk and those not at risk. **A** At the moment the ones who have sexually-transmitted diseases, it's usually those.

U S explains how during everyday procedures he does come into contact with lots of blood. In these cases - such as incomplete abortions or deliveries - he uses gloves. However, he still comes into contact with some blood.

U S is not afraid of coming into contact with blood so long as his skin surface is intact.

U Were S's skin surface broken and he came into contact with a person he thought was HIV-positive, he would be very cautious.

U If S came into contact with some-one's body fluids whom S knew to be free of HIV then S would maintain ordinary hygiene procedures and not worry.

U S uses gloves for every examination.

U S explains that for vaginal, rectal and similar examinations involving a lot of blood, the wearing of gloves has always been routine procedure.

U S would not be antagonistic towards an HIV-positive patient and would not be afraid: he would just make sure to take precautions.

U S is more cautious now as a result of his experience; apart from this things have not changed much.

U S takes precautions with every patient. After examinations he washes his hands with disinfectant, and uses gloves, which has always been part of his routine.

U When S knows the patient is HIV-positive, then he is extra careful - he may wash his hands twice.

U When S considers the concept of AIDS it instills fear and dread in him, in the same way it would anyone who is informed about the disease.

U S uses the presence of a sexually transmitted disease as an indicator of whether a patient is at risk to HIV or not.

Q What is the incidence of this. **A** It's rife, and uh it's part of over-population, poor socio-economic conditions, overcrowding and so on.

MITWELT

Before

A In this patient initially, the child I did not know had AIDS.

Um... Ja... this little child was brought to me with gastro-enteritis, severe dehydration and Um... I took the child up myself up to the hospital, but then she was quite seriously ill and I didn't want to wait for an ambulance.

At the hospital she stopped breathing and then I applied mouth-to-mouth resuscitation, and asked the nurses to bring me the resuscitation equipment.

During

but then I... while waiting for this equipment to come I applied mouth-to-mouth resuscitation. **Q** Was the child unconscious. **A** Yes, so we tried to resuscitate, but then gave up because there was no hope.

Q How did you feel once you found out that the child and mother were HIV-positive. **A** There was no anger at all, in fact I really took pity on this child and the mother, because...

in fact I even stopped the nurse or sister for talking harshly with the mother of the child for not telling.

I understood the reason for her not telling me her child was dying and in her mind it would have been possible, if she came to my surgery and told me the child has AIDS and is dying, it is possible in her mind that I could have told her there is nothing I can do. And she wanted help.

But she still wanted some help. I think any mother would want her child to survive and Uh... so I understand her.

Q With the HIV mother and child, you felt pity for both of them and you don't blame the mother. **A** Absolutely, yes.

After

Thereafter I heard the nurse had seen the child and the mother and she tells me the child had AIDS and the mother had AIDS.

U S states that the incidence of sexually transmitted diseases is rife and this is due to over-population, overcrowding and poor socio-economic conditions.

MITWELT

Before

M S did not know that his patient - a child - had AIDS.

M S relates the circumstances surrounding his first encounter with an AIDS sufferer. The child was seriously ill, to the extent where S felt it necessary to take the child up to the hospital himself.

M When S arrived at the hospital the child stopped breathing. He called for resuscitation equipment and in the meantime applied physical mouth-to-mouth resuscitation.

During

M S applied mouth-to-mouth resuscitation whilst waiting for the resuscitation equipment to arrive. However, the child was unconscious and S's efforts were in vain.

M When S learnt that the child and mother were HIV-positive he did not feel anger, but rather pity for them both.

M S recalls stopping his assistant from reprimanding the mother for not revealing her child's HIV status to S.

M S completely understands why the mother did not reveal the fact that she and her child were HIV-positive. S understands that the mother was desperate to save her child and by informing the doctor of the child's condition she may have suspected the doctor would then not help her.

M S reiterates that he can understand the mother's behaviour concerning her child: most mothers would react in the same way.

M S felt pity for the mother and her child and he does not blame the mother for her behaviour.

After

M After S had administered the resuscitation procedure to the child he was informed that the mother and child were HIV-positive.

Q Can you tell me how you felt waiting for that result. **A** Um..I think about a week after I had..after this episode - incident, I had spoken to one or two colleagues and Uh.. they seemed to have, most of them, in fact all of them seemed to have a more worried or serious approach to it.

I think that it, later on it did affect me,

I didn't tell my family, I didn't mention it, but... .

later on when I discussed this with them they felt Uh... I should have taken medication soon after this, you know, whatever the results were I should have taken some AZT.

Q Are you saying that your colleagues inspired a certain reaction in you. **A** Some fear

and Uh... and one of them mentioned that they would with the AIDS thing coming up, you know, one... medicine is a bit of a dangerous... he didn't use those words but he sounded his feelings that compared to other types of jobs medicine is... because we are so highly exposed.

he said he would rather do another job than risk his life every day.

Q How do you feel about that, do you see yourself as at risk every day. **A** No, I don't think so, he probably does more surgery, more ops than myself, being in the hospital. Maybe he is at greater risk, probably one could give him credit for that, that he is at a greater risk than myself.

In this case the reaction of your colleagues is going to be another thing.

Q Your reaction to AIDS seems to include certain influences from your colleagues. **A** I think so, yes.

One thing we discussed right at the beginning Uh... one of the colleagues I spoke to suggested that he wouldn't even bother to do the test, that is the thing he said...

Q You mentioned that you had not told your family about this incident, could we talk about that. **A** No... I didn't think that it was serious enough to discuss it with them.

Q Do you have children. **A** Yes I am married and I have three children... .

Um... but I did discuss this with one of my colleagues in my home, I discussed it with him

M After the incident S discussed the matter with his colleagues. They held a more serious attitude towards the incident than S.

M S agrees his colleagues' views did affect him later on.

M S did not mention the incident to his family.

M When S discussed the incident with his colleagues later, they indicated that they felt that he should have taken medication soon after this incident: he should have started a course of AZT.

M S states that his colleagues instilled a certain amount of fear in him.

M One of S's colleagues suggested to him that with the presence of HIV/AIDS, medicine was now a very high-risk occupation compared to other sorts of work.

M S recalls his colleague saying that he would rather do another job than risk his life every day.

M S states that his colleague may be more at risk with regard to HIV/AIDS than S because this colleague is in the hospital and involved in more surgery than S. This may be why his colleague holds such a strong view.

M S predicts in the event of his contracting AIDS and having to work in another area of medicine, it would be no longer be the public's but rather his colleagues' attitudes that he would have to contend with.

M S agrees that his reactions towards HIV/AIDS are influenced by his colleagues' views.

M One of S's colleagues told him that he would not bother to test himself for the HIV virus, given the potential consequences for doctors who test positive.

M S did not discuss the incident with his family because he felt that it was not serious enough to warrant discussion. S is married, with three children.

M S discussed the incident with one of his colleagues at his home.

and Um... and the colleague at that time wasn't very... he also agreed with me that the chances of infection is very very unlikely, very remote.

And Uh... but he did suggest that I do take, I do the AIDS test on a regular basis and Uh...

and then the wife came to know about it eventually, ... the wife did have some fear that... but I did manage to convince her that it was unlikely that I would have AIDS.

Q She was very worried, has she expressed her fears to you often with regard to your belonging to a high risk group. **A** No... at that time she did,

and she knows that I love kids also that I play with them, that I kiss them, and she says that I must stop that

but I don't... of course I still play with them now you know,

I don't think that... but maybe. **Q** Are these children that come through the surgery. **A** Yes, I love those kids actually.

Q How do you feel about being a father who is in a potentially high-risk group with regard to AIDS. **A** That's a frightening thing.

and Uh... I think after, as I mentioned before, after I had spoken to a few colleagues who had taken a more serious attitude in their discussion with me, there was some fear in me then,

but it wasn't strong enough for me to have any guilt feelings or any worry, or any undue worry or any sleepless nights about it.

But that thought did strike me, that my kids, my wife might get AIDS at some stage from me.

Q When you discuss AIDS with your friends are there any issues that arise. **A** I did tell them that the risk is almost non-existent with this particular incident I've mentioned,

but they do know that we are at high risk.

Q What is their reaction to this. **A** Nothing negative, no negative reactions.

Q How do you feel about belonging to this high-risk group with regard to your family. **A** No, there was at one stage... the thought did come up.

M At the time of discussion, S's colleague agreed that the chances of infection were very slim.

M S's colleague did, however, suggest that S have an AIDS test on a regular basis.

M S's wife eventually came to know about the incident. She expressed her fear over the incident. However, S managed to convince her that it was unlikely that he would have contracted the disease.

M S's wife does not usually express her fears with regard to S's high-risk status, but she did after this incident.

M S's wife knows that S is fond of children and is often very physical with them. S's wife has asked S to curb this physical expression of affection.

M S has not stopped playing with the children that come into his surgery.

M S does not think that he is at risk with this behaviour involving children, but he is not sure. S loves the children that he sees in his surgery.

M S finds the concept of being a father who is in a potentially high-risk group very frightening.

M S developed a certain amount of fear concerning his exposure to the HIV virus after he had spoken to a few colleagues who took a more serious view of the incident.

M Although S felt some fear after talking to his colleagues, it was not significant enough to cause him to have sleepless nights.

M The thought did occur to S that because of his high-risk position, his children and his wife were vulnerable.

M S has told his friends that regarding this incident the risk of his having contracted AIDS is almost non-existent.

M S's friends are aware that doctors constitute a high-risk group.

M S feels no negative reaction to the fact that his friends recognise him as part of a high-risk group.

M S has considered his relationship to his family with regard to the fact that he is part of a high-risk group.

Q Can we talk about that. **A** After I had been discussing with my colleagues, after this incident, you know they felt that although it was minimal the risk was there, that I do have a test -

Q Would you say that your relationship with your colleagues has undergone some kind of change as a result of this experience. **A** No - I don't think so. I think their concern was for me,

I think...one of the colleagues I spoke to on that day I was exposed to this AIDS child was terribly angry with the mother and child. Um...I felt it was unfair on his part.

He probably, might have felt some guilt in that he had looked after the mother and the child, he was the doctor...

he kept on telling me that he told the mother several times that she must, any doctor she goes to she must tell them that they have got AIDS. He said he couldn't understand how or why they do this - in angry terms.

Q What did you feel. **A** I felt, I didn't tell him but I felt that his reaction was harsh, in that he should understand the reason for the mother not having told anyone.

Q Do you think your colleagues would hold the same view. **A** I think so, they would take the same view. They would use the normal procedure and use gloves for examination.

Q So you don't really take any extra precautions with normal patients. **A** No - just the normal procedure, I use gloves and I've always done this.

They have even advised that during taking blood from patients that we use gloves.

The advice when there was the AIDS scare... then the hospital doctors gave the advice that when ever they pull blood, for any investigation when they draw blood from a patient that they use a glove and even when they put up a drip on a patient that they use a glove to do that -

I don't use gloves when I put up a drip, I don't think any of the doctors do that.

Q Because of AIDS you then don't relate differently on the whole to your patients. **A** No.

Q The only changes you would make would be to take more precautions if you knew the patient was HIV-positive. Psychologically is there any difference

M After discussing the incident with his colleagues, S was advised by them to have a test even though the perceived risk was small.

M S does not see his relationship with his colleagues as having undergone significant changes as a result of this experience. Their concern during this period was for S himself.

M One of S's colleagues was extremely angry with the mother during the incident where S was exposed to HIV. S felt that this was unfair of his colleague.

M S surmised that his colleague may have felt responsible for the event as he was the hospital doctor originally treating the case.

M S relates how his colleague persistently explained that he had frequently informed the patient to reveal her HIV status to every doctor she saw. The colleague was angry and unable to understand why anybody should act in such a way.

M S felt that his colleague's reaction was harsh: the colleague should have understood the reason for the mother's not wanting to reveal her or her child's condition.

M S feels that his colleagues would behave in much the same way as himself: they would take the normal procedures and use gloves for examinations.

M S continues to treat his normal patients in the same way as he did before the advent of HIV/AIDS. He uses gloves where necessary.

M S states that standard precautionary procedures advise doctors to use gloves when they are taking blood.

M S refers to a time when there was an AIDS scare at the local hospital. All the hospital doctors advised the other doctors to wear gloves for taking blood and putting up drips.

M S does not use gloves to set up a drip. Furthermore, he is sure most doctors do not.

M S does not relate differently on the whole to his patients because of the presence of HIV/AIDS.

M On a psychological level S finds that his attitude towards his patients as a result of his experience has not changed.

in your attitude to the patient. A My attitude towards that patient - no,

I think Uh one has to try - your basic... one mustn't keep away from your basic goals to try and comfort a person and Uh... OK medicine is commercialised to a certain extent but one mustn't think of your own safety so much as to compromise your patient.

Q You see the needs of the patient as being more important than your own. A I don't know, people might not - people's views might differ, doctors are human beings,

the ones I have spoken to they have, they probably have different views on this.

There was one case where there was a lady with AIDS to deliver, I think the nursing staff apparently wouldn't want to touch the patient and they called for the doctor and the doctor did go and deliver the child. I got the impression that there was some reluctance but the doctor had gone to deliver, there must have been some fear because I felt there was some reluctance.

Q Do you think you will relate differently to those patients who are HIV-positive to those who are not. A I think so, I think I would, after having this first experience I would.

Q Working with the patients that you see here, do you see yourself as being at increased risk to HIV compared to other doctors. A Uh... I don't think so. But.. I don't think there is an increased risk.

But I have sent very few, very very few who I thought had AIDS to the hospital. I don't get many positive responses.

but I don't think... you know, that generally... you know, that I am extra cautious, or even very much more cautious and that every patient I see that I have... I don't think that I have become paranoid.

Q How do you see the AIDS problem in this town. A It's an absolutely serious problem, definitely a worrying problem.

Uh... I totally agree with the pessimists that there is going to be a tremendous increase in AIDS in South Africa

and I would really go for education as much as possible, planned education, because uh... the problem of sexually transmitted diseases is as high as ever and one can use that as a gauge on sexual practises. It is a problem, yes.

M S feels that although medicine is commercialised to a certain extent, the basic goal of caring and comforting the patient must not be compromised and doctors must not put their own safety above the care of the patient.

M S understands that doctors are human, their views are different and therefore they may hold different views with regard to the concept of the patient's needs having priority above those of the doctor's.

M S's colleagues will probably all hold different views on the topic of patient's versus doctor's needs.

M S refers to a case where an HIV-positive woman was due to give birth. The hospital staff were reluctant to be involved, consequently a doctor was called upon to perform the duty. S got the impression that in this case his colleague was reluctant to perform the duty; S attributes this to fear on the part of his colleague.

M S will relate differently to patients in his care who are HIV-positive, than to those who are not: this attitude is directly related to his experience with the HIV baby.

M S does not perceive himself to be at an increased risk to HIV above other general practitioners by virtue of his position.

M S states that he has sent very few patients to the hospital who he suspected had AIDS. He has had few responses.

M Although S has become more cautious with his patients he has not changed radically and has not become paranoid.

M S perceives the HIV/AIDS problem in his local area to be serious.

M S agrees with the pessimists who predict an enormous increase of HIV/AIDS in South Africa.

M S feels that a strong emphasis needs to be placed on education which is aimed at sexually transmitted diseases. The incidence of sexually transmitted diseases is high and this is a reflection upon sexual practises.

Q How do you see your role in the future. **A** I would expect it to be more of an issue in the future,

one tries to educate patients and one does notice concern in these patients, but I don't... I'm not convinced that that concern is a permanent thing.

It might just be a temporary thing during my conversation with the patient who has a sexually transmitted disease or who has a recurrent pubic infection. But uh... I don't think... I think something more has to be done.

Q Would you deal with that person differently to how you deal with a normal patient. **A** Ja maybe, not so much... but then I would definitely be much more careful on precautions, though I would treat the patient as an ordinary patient.

Q Since this incident then little change has taken place in terms of how you perceive and deal with patients. **A** The same, I think it is much the same.

Q How do you feel about the fact that this sort of behaviour increases the risk for doctors. **A** Yes...it's, in future a way in which to communicate and discuss the AIDS patients, you know one of the possible... therefore in future one could have regular meetings and discuss the AIDS patients so that one knows who is HIV-positive, so that doctors will know the backgrounds of the patients.

I don't think we have any such thing at the moment. Even with other medical conditions besides AIDS, not anything for your protection but just for information.

Q Society holds a certain attitude towards AIDS. Do you feel this may influence the way you relate to your patients. **A** No, I don't think so.

Q Stigmatizing views or other views - how do you feel about these. **A** Well, I really feel people should be adult enough, they should be able to make up their own minds or their own decisions,

but one must try and educate them on these high-risk behaviours and the dangers of sexually-transmitted diseases including AIDS and Uh... one must try to get through to them, try and make them understand the seriousness of AIDS.

I think that not has happened yet

let the patient decide, let the people decide, let Society decide what they want, yet one must try and make it as clear cut as possible - complications of the risk.

M In terms of his role as a doctor, S sees HIV/AIDS as being more of an issue in the future.

M S attempts to educate his patients. However, although he recognises a degree of concern in these individuals, he sees this concern as temporary.

M S believes that his patients' concern for HIV may be very brief and temporary. S feels that something more in terms of education needs to be done.

M S states that he may deal with an HIV-positive person differently from an ordinary patient, though the difference would be slight. However, he would definitely be much more cautious, while at the same time treating the patient as an ordinary patient.

M S states that the way he perceives and deals with patients has changed very little as a result of his experience.

M S would like to see some sort of system whereby doctors could meet to communicate, and discuss their patients who are HIV-positive. This would be an attempt to avoid a similar event such as that which S experienced.

M S does not think that there is any system working at the moment which has as its aim the safety of the general practitioner. Most systems are aimed at information.

M S does not think that the general perception held by Society towards AIDS sufferers will affect the way he relates to his patients.

M S feels that people should be adult enough to hold their own views and make up their own minds, rather than follow the general view of Society.

M Education aimed at teaching people about high-risk behaviour and sexually transmitted diseases, including AIDS, must have first priority according to S. People need to know the seriousness of AIDS.

M People have not yet been reached - and subsequently influenced - by standard education programmes.

M People, patients and Society as a whole are free to make their own decisions. However, S feels that these people must be informed of what they are facing.

I think the overall general fear for AIDS is there but I don't think that fear is so much so that one knows really what AIDS is.

Q The Media presents a certain perspective on the AIDS issue: are you influenced by this perspective. **A** I read the reports but I always assess the gist of the Media reports because it may be the attitude of a particular person who is expressing his opinion and Uh, it might not coincide with mine,

one of the papers pushing it as a male problem, probably they are looking at homosexual males and Uh, but then the heterosexual male could easily have AIDS

I think AIDS is a fear in male and female and I think almost the same proportions.

Q You say then that there are a number of influences on doctors: Media, family, friends. Do you think these affect the role of a doctor. **A** I think people have different personalities and with some their self-interest is more forthcoming than their role as a doctor.

and I think even at Medical School level one must impress, the educators must impress on the students the, the importance of treating an AIDS patient as a normal human being, taking the special precautions, taking the normal precautions but with the same compassion as you would treat a person with cancer, not as somebody you should try and keep away from.

Q Do you feel that you are adequately informed on the topic. **A** Oh yes.

Q Has your perception of what constitutes high-risk groups undergone any change on account of this experience. **A** I would see AIDS as crossing the whole spectrum.

Q Have any of your patients shown any reaction to the fact that you are part of a high-risk group. **A** I have spoken to some of the patients,

but No.

If they do, I have spoken to some good friends of mine who are also patients of mine and I told them that, I think they did understand my point-of-view and they didn't see any fear in me so they had no worry.

but I think members of the community in different areas must become more aware and become part of the education.

M S believes that a general fear of HIV/AIDS exists in Society. S doubts, however, whether people have a very realistic notion of what the disease actually is.

M S reads the Media reports on HIV/AIDS. However, he does not allow the opinions expressed in these reports to alter his own views.

M S is sceptical of Media reports that see AIDS as a male problem; he understands that this may stem from the high incidence in male homosexuals, but states that heterosexual males can also contract the disease.

M S sees AIDS as instilling fear in males and females proportionally.

M S perceives doctors as individuals who have different personalities. They are therefore influenced differently by the Media, family, and friends. Some doctors place their own self-interest above their expected role as a doctor.

M S believes that medical students must be educated to deal with AIDS patients as normal human beings. While students must take the necessary precautions, they must show the same amount of compassion they would to any terminally-ill patient. They should not see an AIDS patient as a pariah.

M S feels that he is adequately informed with regard to the AIDS disease.

M As a result of S's experience with an HIV infected person he perceives AIDS not to be confined to certain groups, but rather it covers the whole spectrum of the population.

M S has spoken to some of his patients about their perception of the fact that he represents a part of a high risk group.

M No patients have yet reacted to his high-risk potential.

M S has spoken to various friends who are also his patients about his high-risk potential. They understand his point-of-view and are at ease.

M S thinks that various members of the community must become aware of HIV/AIDS and become involved in education.

most of the information coming to him from his medical journals, maybe from - maybe the media itself but more from the medical aspect.

Q Do you see yourself in a position whereby you can educate people. **A** Yes, I do that with every patient who is at risk.

Q When these cases present themselves then you attempt to educate them. **A** Yes I do as much as possible, I mention AIDS, use of condoms, abstention or having one partner.

Q Are they responsive to this. **A** Yes,

but as I said before, that fear is there with your interaction with them now, you know, how long it lasts or whether it fizzles out when they leave the consulting room, maybe a month or two later.

And if I do get the same patient coming several times then I discuss this with them.

EIGENWELT

Before

During

Q Do you think that you could have turned her away. **A** It is possible, it is possible I could have, when she came up here and said the child has AIDS, the child was admitted in the hospital a few days back, discharged and is still not better. I would have seen that nothing ... that the child was seriously ill, I would have known that the defences are so low that there is nothing one could do.

After

And when I was told the child had AIDS, my immediate reaction was not of any worry at all, because I know from my teaching one has to have several episodes of this type of exposure to have any significant effect at all, and as the chance of getting AIDS from this type of source is remote...so I wasn't really, wasn't worried or anything of that sort

and Um...the superintendent suggested when he came to hear of this, that I do administer an AIDS test on myself, which I wasn't really keen on doing,

but eventually after about two weeks on his insistence I did, he actually took the blood himself.

M According to S, HIV/AIDS information for doctors in the future will derive principally from formal medical journals and perhaps even the Media itself.

M S states he attempts to educate every patient he perceives to be potentially at risk.

M When S is confronted with patients suffering from sexually transmitted diseases, he attempts to educate these patients, mentioning various preventative options.

M S's patients do respond to his educative procedures.

M S reiterates his concern over the fact that his educative efforts with his patients are often very short lived.

M If S treats a patient regularly for sexually transmitted diseases, he will discuss the risks of HIV with this person.

EIGENWELT

Before

During

E S agrees that had he known the child had AIDS he may have given up trying, knowing that with the defences so low the prognosis of recovery would be very bad.

After

E S was not worried when he learnt that he had been exposed to the HIV virus because his knowledge of the disease was such that he believed the chance of contracting AIDS from such limited exposure through this particular route was minimal.

E S explains that when the hospital superintendent heard of the incident he immediately advised S to have a blood-test. S was reluctant to do so.

E After two weeks of insistence from the superintendent, S eventually agreed to have the test done. This was performed by the superintendent.

Q Do you feel it is up to you to have these tests on a regular basis in that you have a responsibility to your patients. A No... Uh... I don't look at it in that light,

It is possible that to be fair on my patients I should take it. Um...although that one episode with vomitus - with very little vomitus you know Uh...I'm almost convinced it is insignificant.

Q Can you tell me why you weren't keen to have the test. A I wasn't really you know, I didn't really feel that this was a significant enough exposure for myself to worry about this. Um...but eventually we had the test done and Uh - it was negative of course - and that was about two weeks later.

Q Has the meaning of being a G.P. had to be re-evaluated or re-assessed in any way since the advent of AIDS. A I get that impression. As I said one of the doctors mentioned that he would gladly change his occupation.

But I disagree with that. I feel that whatever job one is doing, one must accept the hazards that come with it.

Q Would you do the same. A No, I'd disagree with him,

But I feel if I have had contact with AIDS from a patient then that is an occupational hazard that I must accept. You know I must accept the consequences,

I wouldn't feel that I must change my occupation so that I can avoid AIDS.

I don't have it now, but I would bravely say that I would continue working in the medical profession.

Q Have you considered not being allowed to practise in that case. A That is an issue, that one won't be allowed to practise. That will be a blow, definitely a great blow.

Though, I think even then there might be other branches of medicine one could work in.

in fact I am convinced I don't have it - I won't be infected - that I'm not even keen on taking more blood.

I think it is a bother taking blood and I will have to go and get some-one to take the blood from me. I think it would be an inconvenience, I have to go up to the Medical Centre at some stage, Uh... .

E S does not see a need for regular testing: he does not perceive testing in terms of a responsibility towards his patients.

E S agrees that from the point of view of his patients' safety it is possible that he should test himself regularly. However, he feels that his one exposure, to vomitus, is insignificant.

E S was not eager to have the test done because he felt the incident was not significant enough to warrant a test. Eventually, however, it was done, and the results were negative.

E S agrees that the meaning of being a general practitioner has had to be re-evaluated and re-assessed since the advent of AIDS. This is apparent to S through the fact that some doctors are willing to change their profession.

E S disagrees with his colleague and feels that whatever job one is doing, one must accept the consequent hazards.

E S disagrees with his colleague: he does not wish to change occupation.

E S feels that the possible risk of contracting HIV/AIDS is part of his job, something which he must accept.

E S does not feel he must to change occupation, so as to avoid AIDS.

E S is not presently HIV-positive; but if he contracted AIDS he would continue working in the medical profession.

E It would be a great blow to S if, as a result of contracting HIV/AIDS, he was no longer allowed to practise his profession.

E Were S to contract AIDS he feels that there would be some aspect of medicine that would still require his expertise.

E S is so sure that he does not have the HIV virus that he is not even keen on having further tests done.

E S sees the HIV test as bothersome and inconveniencing.

Maybe I would do the test in another year's time or so just as a routine but I don't really see it as necessary.

The...of course I have done repeat tests four months from this first incidence, that wasn't for the purpose of checking, but rather for insurance purposes. I am not even keen on doing any further tests.

Q You are aware that there is always that risk factor. Does it worry you. **A** No, not at all,

but I would probably do another test in a year's time.

Q Did you think about this after the incident. **A** I didn't really, I was quite convinced that it wouldn't affect me at all,

I don't think it was something that I should worry about so seriously to take precautions.

Q What do you think your reaction will be in the future towards patients coming to you for treatment who you know are HIV positive. **A** I would try to be as careful as possible, you know, as far as examination is concerned or any procedure is concerned.

Uh... I don't... I don't see the rationale for that.

I don't do that, I don't see a need because I don't see what a glove is going to do if a needle is going to prick you. A needle is sharp enough to go through that glove.

Q How do you feel about that. **A** I think it is one's duty and you must deliver the child,

if the sister who normally does normal deliveries, if she feels unhappy then the doctor must do it.

A basic goal for us is to comfort a patient, to relieve him of his disability as much as you can, of his discomfort.

Q Do you see AIDS as having any influence on this goal. **A** I would think so

I feel that is wrong, I feel one should spend more time with them, probably time is a problem.

Q So you say you should treat an AIDS patient like any other terminally-ill patient. **A** As any other patient with a serious illness... .

E S may do the test in another year or so, though he does not perceive this to be necessary.

E S had an HIV test four months after the incident. This, however, was purely for insurance purposes. *S* is not keen on doing any further tests.

E S is not worried about the fact that his work constitutes a high risk factor.

E S will probably have another test done in about a year.

E S did not consider his position in relation to his children after the incident, because he was certain that he was not infected.

E S feels that the incident was not serious enough to warrant his taking precautions.

E In the future *S* will try to be as careful as possible with patients who are HIV-positive, especially with regard to physical examinations and procedures.

E S does not use gloves when taking blood; he does not see the rationale behind this.

E S does not wear gloves: he feels that if a needle is going to prick him, then it will pass through a glove anyway.

E S believes that it is a doctor's duty, and this duty must be performed.

E S feels that if the sister-in-charge feels unhappy about delivering a child from an HIV-positive person, then the doctor must perform the task.

E S sees the basic role of the doctor as comforting the patient and relieving him of his disability and discomfort as much as possible.

E S sees AIDS as having an influence on the goal that constitutes the role of the doctor.

E S feels doctors should spend more time with terminal patients, though he realises that time is often limited.

E S reiterates the need for doctors to treat AIDS patients in the same way as any terminally ill patient.

I know even some patients with cancer, I have had experience, even in hospital that the doctor would try to shy away from a patient with cancer, maybe not shy away but give up hope on the patient, not show much enthusiasm in the treatment, just try to give them pain relievers,

Q Has the presence of AIDS any bearing on your perception of your role as a doctor in the future. **A** I think the medical group has a role to play

Q And the role of the doctor. **A** It will be quite an important role, one who has contact with patients, who has information,

E S explains how he has encountered various colleagues in the past who have given up on patients who are terminally ill.

E S feels the medical profession has a very important future role to play regarding the AIDS epidemic.

E The role of the doctor, according to S, will be very important with regard to the HIV/AIDS epidemic; it will constitute a clinical and an educative dimension.

Subject 2.

UMWELT

Before

So it means that it's not that frightening

During

She was a little girl who has got very extensive *Kaposi's sarcoma* which is infiltrating her legs and her abdomen and is all over her body and it's really totally horrible.

there had been others which were blood positive but not sick, so you know there is a difference between the actual full-blown disease and HIV-positive, there have been a couple subsequently that we have seen but again they have died very quickly more of septicaemia and lung problems than actually of *Kaposi's*. Q Is it quite unusual to find a *Kaposi's* patient. A Very unusual, ja.

we've had others, we've had a woman who had T.B. who just delivered a baby which was found to be positive and we've had a young girl who died of septicaemia and we've had two staff members who died of accelerated T.B. who we thought were probably HIV-positive, so we dealt with it, but I must say this little girl was the worst.

Q Can you detail for me exactly what happened when you first saw her. A OK. What happened when I first saw her, I walked into the room and I had been told the diagnosis

The other doctors that had seen her had actually not looked under the bandages, they had merely come in, written up the treatment and gone away. I felt I had to - but I knew that I had to take those bandages off and I had to look at them and it was just Uh... the two sisters in the ward and the staff nurse, and uh... we had to do that together, which is what we did

Um... you don't want to touch the person I mean really it's too difficult to touch them and you don't want to stand close to them and you don't want to smell it.

Q When you said you were hesitant to touch the person as an initial reaction, was this based on a fear of contracting the disease. A Well it's just unpleasant to look at it.

UMWELT

Before

U Owing to thorough preparation the concept of HIV/AIDS was less frightening.

During

U S explains that the HIV-infected patient is a little girl with extensive *Kaposi's sarcoma*. The infection is spreading over her legs, abdomen and all over her body. S perceives this as "totally horrible".

U S explains that there have been a number of positive cases in the hospital, and more recently there have been some deaths relating to lung infections. It is unusual to find a *Kaposi's sarcoma* sufferer.

U A cluster of other HIV/AIDS cases have occurred in the hospital; this includes a woman who recently gave birth and was found to be HIV-positive, a young girl who died of septicaemia and two members of staff who died of accelerated TB. This particular incident, however, has been the worst.

U S describes her first encounter with an HIV infected individual. She knew the patient's diagnosis and went to visit her in her room.

U S explains that the other doctors who had examined the patient had not done a thorough physical examination, but had merely prescribed treatment. S felt compelled to take off the patient's bandages despite her repulsion. S was assisted by two sisters in the ward and the staff nurse.

U S found it difficult to touch the person with *Kaposi's*. She did not want to stand close by and did not want to smell the infection.

U S's hesitation to touch the patient with *Kaposi's sarcoma* was based on the fact that it was simply unpleasant to look at and not necessarily because she was afraid of contracting the disease.

Ja, no, I don't really think that I am all that afraid, I suppose there is that attitude, but I mean we were all wearing gloves so it wasn't as if you could actually get it, it's just sort of...

I'm not particularly nervous about getting it, I'm terribly, obsessively careful about hygiene, washing hands and gloves.

Q Did you at any point feel that you were exposing yourself to HIV. A Oh yes, I think if we are honest we are always at risk.

Q What sort of preparation did you take. A We had gloves and we had discussed it and we opened up a dressing pack which was sterile and we used a... sterile instruments, so that everything was clean and we weren't contaminating her, but by using that in fact you are screening yourself as well, because the same sterile precautions work two ways, so we were careful about that.

I think we did use masks, not that AIDS is going to be transmitted orally, but because of the smell, I think we did do that, ja. And then I think the nurse who was doing the most work, we all had plastic aprons and gloves and she had a gown as well so I mean all of us were reasonably protected.

I don't think that we really thought that we were going to catch it, not really, not from *Kaposi's* you know, you catch it from blood.

and I was aware of a terrible smell. I mean the smell radiated for a good 10 or 15 yards around the room. She had old bandages on which had been on for a couple of days.

and it was very much worse than I anticipated. The smell was unbelievable and the actual appearance of the tumour was actually horrifying. Q Was it a single tumour. A No it's multiple tumours all over her thighs and lower abdomen which had kind of coalesced into a huge sort of fungated mess which smelt, at that stage it was about five inches by five inches on the top of her thighs, but with little satellite tumours all down her legs and black spots on her chest and in her mouth and in her ears.

Q When you say the final phase did the person show signs of dementia. A No

Q Was she not responding to treatment. A She was put on chemotherapy which is the treatment for cancer and that was continued here for about four months.

U S reiterates that she was not afraid of catching the HIV virus: though this thought did exist, by taking precautions, the risk of contraction was eliminated.

U S states that she is not nervous of contracting HIV, this is because she takes very strict precautions with herself and is very fastidious about hygiene.

U S states that if she is honest with herself she must accept that all health care workers are involved in risky procedures.

U Before examining the infected patient S and her colleagues had discussed the procedures they would take; consequently they wore gloves, opened up a sterile dressing and used sterile instruments. These procedures served the dual purpose of reducing contamination from the point of view of the patient as well as reducing the risk of infection in relation to the hospital staff.

U S explains that when first attending to the patient she and her colleagues were well protected. This was to secure themselves against HIV infection. They all wore masks because of the smell of the infection and the nurse most involved wore an apron and a gown.

U S believes that neither herself nor her colleagues really thought they would contract HIV during this procedure. HIV according to S is more likely to be contractible through blood rather than a skin disease.

U When S initially encountered the infected patient she was aware of a terrible smell radiating for at least 10 - 15 yards around the room. The patient's dressing had not been changed for a couple of days.

U The experience of unbandaging the patient was a lot worse than S had anticipated. S found the smell overpowering and the appearance of the tumour horrifying. The tumour consisted of multiple tumours spreading over the patient's thighs and lower abdomen. The tumour had coalesced into a fungated mass which smelt. The main tumour had a radius of five inches and was situated at the top of the thigh, satellite tumours and black spots covered the patient extensively.

U S explains that the patient was in the final phase of the disease, though she had not yet exhibited signs of dementia.

U With regard to treatment the patient had been given chemotherapy for her skin cancer; this was continued for approximately four months.

but to get back to that first thing, well it was just shattering, I felt shattered,

Q You must have been confronted with these extreme situations before in your experience. **A** Ja, oh yes, I remember the last time I felt that shattered was when they asked me to certify a man who had committed suicide by jumping in front of a train and he was in pieces in a big waste-paper bag, dreadful,

you know there are some things that humans can't actually handle all that well.

After

and I'm still disturbed by the figures that are coming out. I mean currently we know that there are at least a quarter of a million people HIV-positive in South Africa and people are still saying that it is not going to have any impact on population growth, but I mean quarter of a million people in 16 months' time is a million and I think it's quite a problem.

People are expecting there is going to be a big explosion and it's, you aren't suddenly going to see people around you dropping dead - but the reality is there are simply going to be more people coming into hospital and more people dying, getting unusual illnesses

and many of these illnesses are never going to be reflected on the Admission books as being due to AIDS. It is simply going to be reflected as T.B., septicaemia, pneumonia and so on. I mean we may not see for many years a recognition of the fact that there is a general increase in the number of illnesses.

I mean we are not testing anything like adequate numbers,

also I mean for - in a sense I'm... in a kind of backward way, it's a funny way to say it but in a way I'm glad they've got patients because you can actually point and say this is what is going to happen, instead of trying to say to people there is an invisible threat.

I think that I'm extremely lucky because I'm not in a high-risk category in terms of what's going to happen in the next few years.

Q You see it as being a major problem. **A** I see it as being very catastrophic.

this is in fact the biggest argument in the profession against this whole issue of getting consent. As far as the medical profession is concerned if a patient comes in and they request treatment and they offer themselves to be investigated we shouldn't have to say to them can I do an AIDS test.

U S reiterates that the experience of unbandaging the HIV infected patient was shattering.

U S has confronted similar emotionally overwhelming experiences in the past. On one occasion she felt the same way when she was required to certify dead a man who had committed suicide by jumping in front of a train.

U S states that there are some things which humans cannot handle well.

After

U S is disturbed by the increasing number of HIV/AIDS cases. She points out that currently there are a quarter of a million HIV cases in South Africa. **S** is sceptical as to whether this will not affect population growth.

U S states that people are expecting an explosion of cases with large numbers of deaths. However, she perceives that there are simply going to be more people coming into hospital, more people dying and more people presenting with unusual illnesses.

U Many of the illnesses in the future, according to **S**, will not be registered in hospitals as being due to HIV/AIDS. They will be documented as Tuberculosis, septicaemia, pneumonia, and so on. This may distort the "actual" rise in the number of cases.

U S believes larger numbers of people should be tested.

U S feels that the presence of patients with HIV in the hospital acts as tangible evidence of the risks and future threat of HIV/AIDS.

U S perceives herself as being extremely lucky in the light of what is to come in that her job as a diagnostician does not carry a high risk status.

U S sees the HIV/AIDS epidemic as catastrophic.

U S points out that a major concern in the medical profession involves the notion of consent. Doctors should not have to ask patients to offer themselves for an HIV test, this should be part of the over-all process.

and also the attitude of the fact that the patient has a right to say no to having tests if they have voluntarily come to the doctor and said please find out what's wrong. Then they should not be able to say no, they should be able to say either you accept it all *in toto* or you don't, you have that right to walk away, but having done that you are not in a position to selectively choose what you will and won't have done.

Q Has your attitude towards preparation and the use of precautionary measures changed. **A** No I just talk louder and harder to everybody, but then I have been talking loud and hard for a very long time.

I'm, I'm a bit cautious in certain groups, but then I always was because Hepatitis is as much of a risk as AIDS except that you don't die so much, but I mean one has always been very cautious about Hepatitis so it hasn't changed that much.

I am more interested in the whole person. I mean there's not much good treating for pneumonia unless you know about where he's getting it from or what the environment is, you know that's what has always interested me. Ja, I don't think things have changed that much.

Q So you prefer to see the disease purely as a disease. **A** Oh yes, I think it is a disease, ja, I think that it really unrealistic to start trying to separate it from other diseases,

It should be part of a whole spectrum of illnesses, it's not worse than syphilis or gonorrhoea or other venereal diseases, I mean we don't have to ask for permission and

And that I think is much more realistic, that treats illness as illness and this is just another illness, it's much worse but I mean cancer of the lungs - people are going to die much quicker from cancer of the lungs,

well I usually ask something in fact why they got certain diseases - we try and follow them up.

but I think I'm lucky because I have already, I don't have that contact with trauma and emergency medicine that the others do, so I have already moved away from it.

Q Have you tested yourself for HIV. **A** We've all had AIDS tests.

Q Do you do this on a regular basis. **A** No, no, we have to by law do it if we've had a finger-prick

U According to S, if a patient voluntarily presents for investigation to a doctor then that patient must agree to all testing procedures including the HIV test which forms part of this process. Individuals must accept the whole testing battery or nothing at all. If individuals exercise their right to disagree they are responsible for the consequences.

U S's attitude towards preparation and the use of precautionary measures has not changed recently. She has always emphasised the importance of these strategies and now she is even more emphatic.

U S explains that she is cautious when dealing with certain high risk groups: she has, however, always been cautious with these groups because of the risk of Hepatitis.

U S is more interested in the whole person than simply focusing on the disease alone. S has always taken a primary health care approach including the individual and his/her social environment.

U S sees HIV/AIDS as a disease and believes it is unrealistic to separate this disease from other diseases.

U S believes that HIV/AIDS should be seen as part of the whole spectrum of illnesses, it should not be separated from other sexually transmitted diseases, and doctors should not have to ask permission to test.

U S believes her approach to be realistic as it ascribes the same status to all illness in that illness needs to be treated. S agrees that HIV/AIDS is a more serious disease - however, there are other illnesses such as lung cancer which are just as serious.

U S usually asks for some information relating to the individual's disease for epidemiological reasons.

U In connection with the risk of contracting HIV/AIDS, S perceives herself as being fortunate in that she does not have contact with trauma and emergency medicine. In this sense S has already moved away from contact with HIV.

U S and her colleagues all have had HIV tests.

U S and her colleagues do not have HIV tests on a regular basis. However, if a staff member has a needle

injury, but that was... we started doing them a long time before there was any real risk. So I think pretty well everyone has had one by now.

Q So you use all the standard precautions with all your patients. **A** Well, Uh... we don't always put on gloves for everybody because we have got the barrel system of taking blood which is where you use a vacuum needle in an evacuated blood tube, so you don't always need to wear gloves, but certainly if I am stitching or examining a patient with blood, I would have been inclined to take precautions for many years but perhaps they are a little accentuated now than they were,

Q So your technique has changed slightly. **A** Slightly, yes.

A You know I think if you're being practical and reasonably careful, I mean we face that issue every time we get into a motor car and drive to P.E.. So we say might get run over, I mean it's how you face death and whether you are prepared for it.

it's the unknown that is frightening.

Q Does that inspire you to be more cautious. **A** I think all of us should be very cautious, we should be driving around with gloves for if we get caught up in an accident. I have gloves in my car.

Q Has blood taken on a different meaning for you, or is your perception of it still the same. **A** Well yes, I've always been worried about Hepatitis, but yes, it's become more dangerous with this...

people losing blood inexplicably is also a very big issue.

MITWELT

Before

Q Could you recall your first experience whereby you were confronted with an HIV-infected person. **A** Well, you know I've been prepared for it because you know I've done a lot of reading and had a pretty good idea as to what the possibilities were.

Q Could you perhaps outline the context for me. **A** She was diagnosed, she's seventeen years old, she's a black girl who was diagnosed about a year before, she'd gone off to a local town to school, she was very bright she was doing very well at school, passed Std.8 top of her class and Uh... was diagnosed at Livingstone, didn't get very much support or counselling. The boyfriend of course disappeared, the family as she deteriorated brought her home and

stick injury then they are obliged by law to have a test. **S** explains that all the hospital staff started having tests long before there was any risk. Most of the hospital staff have had a test.

U **S** does not put on gloves for every examination procedure. New improved methods of taking blood do not warrant the use of gloves. If **S** is stitching or is she comes into contact with blood in any way then she takes precautions. **S** has always been inclined to use precautionary techniques. However, these strategies have become slightly accentuated recently because of HIV/AIDS.

U **S**'s technique with regard to precautions has changed slightly now that HIV/AIDS is present.

U **S** draws an analogy between the dangers of HIV/AIDS and the dangers that face an individual every day, such as getting into a motor car. The issue at stake relates to the person's attitude towards death and whether they are prepared for it.

U For **S** the unknown element of risk is frightening.

U **S** believes all health care professionals should be very cautious, and should carry gloves in their cars in the event of encountering an accident. **S** has gloves in her car.

U **S**'s perception of blood has taken on a slightly new meaning in that it is now more dangerous with the presence of HIV/AIDS. However, **S** has always been careful of blood because of Hepatitis.

U People losing blood inexplicably is also a big issue according to **S**.

MITWELT

Before

M **S** was well prepared for her first encounter with an HIV-infected person. She had done a lot of reading and knew what to expect.

M **S** explains that the patient is seventeen, a young black girl who was diagnosed about a year ago. At this point the patient was at school in another city. She was intelligent and was progressing well. When she was diagnosed she didn't get much support or counselling and her boyfriend disappeared. Her family subsequently brought her back to this area which is her home. The patient was admitted to the local hospital on the request of the superintendent of the provincial hospital.

asked if we could help look after her, and the superintendent from the provincial hospital actually asked if we could accept her, which we did.

Q Before this experience what were your thoughts and concerns with dealing with this AIDS patient. **A** Well I read extensively which means that pretty well from the early Eighties I knew this disease was looming and was - I was following it in the press long before it was generally recognised that it was something that South Africa was going to be involved in.

So I mean I had a working idea about it

and I mean I really have kept up to date with the literature, I pretty well know most of the stuff that has been printed in the medical journals, there is a lot in other journals but pretty much everything that has come out of any significance in the major journals I've got some idea about.

Though in all that time I've been saying that we should be getting involved and we should be taking precautions and by and large people have said that's ridiculous.

And then when the big scare started to happen which was about 1987/88 when you started to see things in the newspapers, there was a bit of excitement for a while and then people's reaction was well if it hasn't come now that means it doesn't exist and it's not going to be a problem.

That I found upsetting because I think people weren't taking it seriously.

and I have sat down and talked about terminal illness because we run the big radio-therapy group here as well. So we have actually sat round the table and talked it out. So we have some idea of how to handle it, and I think having one or two people able to handle it helps.

During

Q Was that here in this town. **A** Yes

but I think that if we are honest, I mean all of us find dealing with terminal illness is very distressing and it doesn't really matter, the age, but it is much worse in young people, when you know you can't help.

Q So you were all very well prepared and informed. **A** Oh yes, and I think anyone who isn't well-informed in this hospital has got to be half-blind or deaf. There has been so much attention to detail - no, I think we knew.

M S reads extensively with the result that she has been well informed with regard to HIV/AIDS since the early 1980s. S had been following the development of this disease in the Press long before it became a South African concern.

M S had a working idea about the disease before her first encounter.

M S has kept up to date with the development of the HIV/AIDS disease by reading the major medical journals on a regular basis.

M Since the early 1980s S has been motivating for the use of precautions and for the local medical community to become involved: this was met with resistance.

M S recalls the "big scare" began in South Africa in 1987/1988 with newspapers reporting incidents. However, the general feeling was one of excitement for a while, but this quickly developed into complacency.

M S found the initial complacency towards AIDS upsetting, as it indicated people were not taking it seriously.

M S had previously discussed the issue of terminal illness in groups with other members of staff. Various aspects of the AIDS disease had been thoroughly covered prior to the first incident. The presence of one or two staff who have some knowledge about AIDS has been beneficial.

During

M S states the person is presently in the local hospital.

M S states that she must honestly admit that terminal illness in every age group is distressing for her, though she finds it particularly difficult to deal with terminal illness in young people.

M S and her colleagues were well informed before this incident took place, with the strong emphasis on HIV/AIDS education in the hospital. S finds it difficult to believe that anyone could be misinformed.

In fact I wasn't that enthusiastic about it, because I felt she didn't have that much time and I was sure it wasn't going to make any difference and was merely going to make her last few months very unpleasant, so it was eventually stopped.

She's in fact a very sweet little girl, her family are wonderful, they come back and they look after her and she took it you know without too much complaints and the family brought her back regularly but it obviously didn't make any difference,

and then the recognition of really feeling desperately sorry for her because I mean she is intelligent, I mean she too - presumably she had often seen these lesions, so she had some idea,

but for her to see reflected in our faces what our attitude was.

I mean I think if we are honest, we all let off steam to each other and we come back and discuss it with each other to kind of relieve the pressure

and being in that situation you absolutely have to be in control, there is no way you can exhibit to anyone else your own attitude because whatever attitude I follow the others are going to follow.

but I mean to the patients and to the nursing staff - I mean you know be prepared to go in first, you can't ask other people to walk in and do it if you aren't prepared to do it. So, I think that is very important,

After

Q So you have been quite exposed emotionally in this case. A Yes, but it's much better now, because she's stopped being a patient who's got a terrible lesion and she has become a person, she's become a person who's suffering. And as soon as some-one becomes a person and not just a lesion or a thing in the bed it's different.

Q Is she still alive. A Oh yes she's still alive, well she is gradually fading away

but we develop a very - all of us have developed a very close attachment to her, she comes up regularly and when she comes up - her family are very good, and as soon as that happens you... the revulsion disappears because then it's merely compassion, it's compassion and it's recognition that you've got to do whatever you can to make her life easier.

M S was not enthusiastic about the patient receiving chemotherapy because she felt that the patient would not live for very long and this form of therapy would merely make her uncomfortable. Chemotherapy was eventually terminated.

M S explains that the patient was a very young sweet girl and her family was very supportive. The patient accepted her condition without much complaint; she has returned to the hospital on a regular basis but this has not made much difference to the disease progress.

M The second reason for S's overwhelming emotional response to her first encounter with the patient involved the fact that S felt desperately sorry for the patient because she was aware the patient knew the nature of her condition and its fatal implications.

M S was sensitive to the fact that the patient would be able to recognise her own attitude and that of the other staff towards her condition.

M S states that if they are honest with themselves all doctors air their frustrations and reveal their emotions at times; subsequent discussion with one another helps to relieve the pressure.

M S states that being in a situation where you are setting an example to others, it is not possible to show your attitudes and feelings.

M S feels that it is very important to set an example in front of her patients and nursing staff. She feels she cannot expect from her staff what she is not willing to do herself. In this case S finds it important to present a certain attitude to those around her.

After

M S has undergone significant emotional concern with regard to her HIV infected patient. However, things have changed with time, and S now perceives the patient as a whole person rather than as a terrible lesion. Now that the patient has become a person who is suffering, rather than an object, things are different.

M S explains that the patient is still alive, though she is gradually fading away.

M S and her colleagues developed a close attachment to this patient. The patient visits regularly with her family. Revulsion has transformed into compassion and a recognition for S that she must do whatever she can to make the patient's life easier.

Q Do you find that you consciously have to try and rid yourself of these emotions at times. **A** Oh yes, I think everybody needs a release valve you know, and I think you talk it out with other people,

but I must say I think this is where for people who are going to have to counsel or look after these patients extensively, it is going to be very important for them to have some sort of programme to support them. Talking to the sister who ran the AIDS clinic at Somerset Hospital, she said the nursing staff could only handle it for about two or three months, the junior nurses; they had to be counselled by the senior sisters and then they had to be transferred away, because that was about as long as they could handle it, the senior sisters being more experienced did better. But this girl herself only stayed there for about eight to nine months, she too found there is a limited period of time one can do it.

And I feel that time could be extended and people could have less trouble if there was some sort of service which involved counselling the others and this is the good thing about Hospice, is that half of Hospice is that they counsel the carers and this is often forgotten, we are lucky we have got that. I think this is why people get burn-out you know, because there isn't enough back-up,

and I think psychologists of course are at particular risk with this, by being so emotionally involved with the patients.

There's a lot of light relief in medicine, patients get better... or they die you know, but they change, it's not that you - the thing doesn't continue.

And we are lucky because we have got colleagues to work with.

I think it is interesting how the nurses have overcome their initial fears Um... by the fact that she has been in there and they have been looking after her and got involved with her and you know doctors and sisters and all the rest of it have been prepared to go in there and touch her, look at her and talk to her, has dispelled a lot of the anxiety for the nursing staff who now recognize that you can actually handle this patient without dropping dead on the spot.

I went to a conference in - at the end of last year, a congress and one serious physician said that it really wasn't a problem and that we shouldn't be worrying about it and that sort of thing I find disturbing: that if the Medical profession can't get on top of it

M S explains that everyone becomes emotionally overwhelmed at times; in these cases it is necessary to find a release. One way of doing this is to talk it out with other people.

M S believes that for those individuals who in the future will be counselling and dealing with HIV/AIDS patients, it will be important to have some form of support programme. S uses the example of the staff at Somerset HIV/AIDS Hospital where she was personally informed that nursing staff were in fact unable to cope effectively for more than two to three months. The junior nurses had to be counselled and transferred, and although the senior nurses were able to cope for longer periods, S's contact at this hospital stayed for only eight to nine months.

M S believes that nursing staff would be able to cope better if they were given more support. According to S this need has been recognised by Hospice. Unfortunately the perspective of the carer is often overlooked and S believes this accounts for burn-out.

M S perceives psychologists as being particularly vulnerable to burn-out due to the fact that they are so emotionally involved with their patients.

M S draws a distinction between the outcome of the relationship between the doctor and his patient and the psychologist and his patient. The doctor's relationship with his patient is more transient.

M S believes doctors are better off than psychologists because they are able to work more closely with their colleagues and thus support one another.

M S has observed how the nurses have gradually overcome their initial fears towards the infected patient. This has come about through general interaction with the patient, as well as through doctors and sisters setting an example by touching the patient, looking at and talking to her. Nursing staff have grown to recognise that normal interaction with the patient is not risky.

M S attended a congress on AIDS last year and was surprised to hear one person state that HIV/AIDS was not a real problem and it did not warrant much concern. S found this attitude very disturbing, especially as it came from the medical profession.

and recognise their role in terms of education and in terms of involvement in Society, I take it much beyond the point of just treating people when they are ill, but in a preventative sense, if they can't do that then there is not very much hope for anyone else,

You... it's very difficult to educate the public unless they have seen a case or heard of a case or know some-one, and as soon as there are one or two cases it's easier to get the message across, so in a sense I am glad that it has actually evolved.

Q Do you see yourself as playing a very important role. **A** Well, just in a very small environment, which is our environment, what I would like to do is simply to motivate other people to get involved because I don't think the medical profession is going to have time to do it, we are going to be so busy trying to stem the tide that we aren't going to have time to educate

so for the moment we only have the medical profession, but I think all professions should be ready to give a lead and I mean it's going to impinge on everybody.

and I think that we should be educating the children. The only group that should be focused on at the moment is young to very young children to try and protect them against their nature.

Q Well we know the problems there. **A** Oh yes - very difficult.

Q When patients come to you for consultation or as out-patients do you think that you relate to them slightly differently now. **A** Not really, you know I don't think one should be condemnatory. I think that one must just accept mankind for his realities and the realities are that a lot of people aren't doing what they should be doing and they get illnesses. I have always believed that the medical profession should avoid being condemnatory or having very narrow attitudes.

Q Has your perception of what constitutes a high-risk group undergone any change in account of this experience. **A** No, it's the same groups that were at risk all the time. It's all people, all races, all socio-economic groups.

Q Are you saying that you try not to take a moralistic view towards illness and the patients who are ill. **A** No I'm - I think once a person has got AIDS it's irrelevant to be moralistic. I think the only attitude where morality comes into it is it comes in with the process of education and educating children

M S is disturbed by the fact that the medical profession is unable to recognise its role as educationalists who need to be involved beyond pure treatment. Doctors need to take a preventative approach. According to S, if they cannot assume this role, then the consequences for the rest of Society in terms of dealing with this disease are serious.

M S states that she is in a sense glad that there is concrete evidence of HIV/AIDS in the form of patients, in that these individuals act as educational examples and make the concept of the disease more real and concrete to the public.

M S sees herself as playing an important role in her immediate environment with regard to the HIV/AIDS scenario. S would like to motivate the community to get involved because she believes the medical profession will be very busy with the medical aspect of the disease. They will not have the time to focus on education.

M HIV/AIDS will impinge on everybody and all professions, according to S, should be ready to take a leading responsibility.

M S sees education which is aimed at young and very young children as the main priority. These individuals need to be taught to protect themselves against their own nature.

M S acknowledges the problems associated with education targeted towards young age groups.

M S does not relate to her patients differently because of the presence of HIV/AIDS in Society. S believes that the medical profession should not be morally judgemental towards people, they need to accept the reality that a lot of individuals become ill because they are doing what they should not be doing. Mankind must be accepted for his realities and narrow or condemnatory attitudes in medicine should not exist.

M On account of her recent experience S's understanding of high risk groups has not changed. These groups, according to S, remain the same, and include all people, all races and all socio-economic groups.

M S believes that once a person is diagnosed as having AIDS it is irrelevant to be moralistic. The issue of morality according to S is only relevant to the process of education, especially the education of children.

but it is not my job to tell people they are doing the wrong thing. I mean they - it's not even that it's not a job, it's just that it's quite an invasion of privacy to say to people that they've done something...

I mean things like smoking where if the person is going to give it up they are going to save their lives, that's another matter, I think one can lay it out you know that if they don't do this... but where it's a matter of a person who has picked up a terminal illness from whatever role or method, I mean there's no point.

Q How do you feel towards so-called high-risk groups. **A** I feel sorry for them,

I think one should be educating them, I don't particularly feel that, you know, one should be condemnatory, rather than be condemnatory one should be giving out as much information as possible.

I think that we should get far away from the moralistic attitude

Q Yes, can I pick up on what you've just said, "... people seem to regard it as". Society has a particular view of the AIDS disease, does this view influence your perception and do you feel it influences the way you relate to your patients. **A** Well you know, in a personal sense one has an attitude towards Society, but I try not to let it spill over into my work, certainly not to the point of verbalizing it. So whatever I as a person may think about morality it's not - I very seldom allow it to spread over and it certainly wouldn't have made any difference in my attitude towards that little girl, you know: she was just unlucky.

I don't mind if a person comes and tells me they're homosexual and they've had 50 consorts if that's going to make it easier to make the guy better and give a diagnosis, that's fine, that's his business, and it has got nothing to do with me whether he is right or wrong. If he asks me what I think then I'll offer an opinion but in terms of the actual doctor/patient relationship I don't think that's all that important.

Q Do you agree that doctors to a certain extent influence the broader perception of AIDS held by Society. **A** Well, doctors are going to give a lead in attitudes,

they shouldn't be the only ones giving a lead, I think your religious leaders and your teachers and other leaders in the community should be giving a lead but at the moment none of these seem to have established where they are in the field,

M S does not perceive it as part of her role to inform individuals of correct moral conduct, she also sees this as an invasion of an individual's right to privacy.

M With regard to prevention S sees it as her duty to inform individuals of the danger of certain behavioural patterns. However, once a person has contracted a terminal illness there is no point in taking a moralistic stance.

M S feels sorry for those individuals who form part of high risk groups.

M S thinks that individuals belonging to high risk groups should be given information, they should not be condemned.

M S thinks that the medical profession should move away from a moralistic stance concerning HIV/AIDS.

M S explains that on a personal level she has a particular attitude towards Society. She makes an effort not to allow this particular attitude to influence her professional conduct, especially in terms of verbalizing this attitude. For example S explains that she does not allow her personal views on morality to affect her professional role. With regard to the young HIV patient these views did not affect S's interaction, S simply saw this individual as unlucky.

M If an individual reveals to S that he is homosexual and has had 50 consorts S does not mind. If this information assists her diagnosis and makes it easier for the individual then S believes that this is the patient's business and nothing to do with S's personal moral views. If the patient appeals to S on a personal level then she may offer her opinion, but on a professional level this is irrelevant.

M S sees doctors as providing a lead with regard to the general attitude held by Society towards HIV/AIDS.

M S states that doctors should not be the only professional group providing a lead in attitudes in Society. Other people such as religious leaders, teachers, and community leaders should follow suit. S feels, however, that these groups have not defined their position on HIV/AIDS as yet.

Q When people come through your rooms do you provide any educative messages at all. **A** Not really, not unless they -

I tell people about AIDS no problem with that but you know by the time they get to me they're pretty sophisticated and they pretty much know what's going on. Patients who don't have venereal diseases you know one brings up the issues occasionally and certainly in young girls and people with heart disease and those things one often discusses issues like contraception and along with that comes AIDS.

Q If you adopted a very fearful approach towards AIDS would this have any effect on those around you. **A** Not so much on the patients but more so with the staff. The patients are going to be frightened, I mean there's no doubt about that, but that's not what I'm worried about particularly, because I would be surprised if they weren't frightened.

I think the staff are the important people at the moment to protect and educate.

but then I do much less trauma now, but certainly now-days with putting up a drip, I would - standardly I would wear gloves and make sure the sister wears gloves.

I think AIDS would have brought it to a head

but I mean it tends to be something that people think about periodically and you go through that mid-life crisis which I experience so often in my colleagues where they start thinking about what they are doing. I think AIDS will bring it to a head, I think it is that much more dangerous,

Q Do you perceive your old patients in a new light or your new patients in any different way. **A** No, no, I have always been careful, you know I've worked in three Liver Units and never got Hepatitis working with patients with Hepatitis all the time, and you only do that by being very very careful.

Q Have any of your patients shown any reaction to your being a possible high-risk person. **A** No, I haven't noticed it, I mean I've said to people I'm putting on gloves to protect me and you in case I've got it and they actually just laugh, so they obviously aren't particularly anxious.

Q Do you see yourself as a doctor as being given enough opportunity to learn about AIDS and AIDS precautions. **A** I think that the GPs are not being educated sufficiently well and I think that comes from above with the seniors in the C.P.A. system not having been doing as much as they should.

M S does not always provide direct education messages to people she deals with in a professional capacity.

M S informs people about HIV/AIDS, although by the time S sees her patients they are generally well informed anyway. For those patients who do not suffer from venereal diseases S occasionally brings up the topic, especially with young girls, patients with cardiac problems and others. With these individuals S often discusses contraception and the threat of HIV/AIDS.

M Were S to show her anxiety with regard to HIV/AIDS this would have more of an effect on her staff than on her patients. S expects her patients to be frightened anyway, for this reason she is more concerned about her staff.

M S believes the staff to be the important individuals to educate and protect.

M S does much less trauma work now than before, however, if she is putting up a drip she wears gloves and would make sure her colleagues were doing the same.

M S believes that HIV/AIDS would have brought to a head her colleagues' reservations regarding their profession.

M According to S, she and her colleagues experience misgivings about their profession regularly. S has often observed her colleagues experience a mid-life re-evaluation of their profession. S believes that HIV/AIDS will have a significant effect on this period in the lives of her colleagues.

M S does not perceive her old patients in a new light nor her new patients in a different way due to the presence of HIV. S has always taken precautions and continues in the same way. S has worked in three liver units and has never contracted Hepatitis, because of the precautions she takes.

M None of S's patients have shown any reaction to her as a possible high risk person. S has mentioned this issue to her patients in a light-hearted way and their response has generally been a lack of anxiety.

M S does not think that general practitioners are educated sufficiently with regard to HIV/AIDS and she believes the reason for this problem to derive from the Government system in that it has not provided enough education opportunities for doctors.

GPs are a bit out on a limb because they do a lot of self-educating and nobody takes responsibility,

I think the district surgeons are being well educated and the Medical Officer of Health is obviously very clued up about it. So in that field it has been actually better. The regional services are being better educated than the C.P.A.. And there isn't enough being done in the C.P.A., far too little being done for GPs, I'm quite sure they are not getting much.

Q Government doctors cannot refuse to treat a patient. A Ja, that's a very difficult one, that's of course one of the things that is going to drive people out.

It's not so much that they can't treat them but that the guys at the top are not going to make it obligatory for HIV patients to have HIV testing before surgery and before obstetrics, and it's that - refusal, of the people at the top that is going to be the problem because it means you are going to be treating people without being aware

If you know what you are doing, that's a much healthier attitude.

I think it will influence people's decision on those sorts of issues.

Q Has your relationship to your colleagues changed in any way. A No,

I think in a sense closer, because we're talked about it more and discussed it more and in a sense it has been good.

Q Did your interaction with other colleagues or Health-care workers have any bearings on your own experience. A Sure, whenever they are frightened they come rushing to me and say what do we do now. And we've had a couple that had to go and have treatment to protect them against it while waiting for the blood tests and they came straight to me and talked it all out.

Q They see you as an authority on this. A The other thing is that I'm a specialist so they tend to ask my advice for everything, so when it comes to their own personal life they carry on in that field as well.

So yes, I think it draws colleagues closer together, I mean I think you've got to be more united and you have to remind each other about the dangers and the risks and I think that's actually quite good.

M S sees general practitioners in private practice as being out on a limb in that they are required to educate themselves and often they are not doing so.

M S believes the District Surgeon and the MOH to be very well informed about HIV/AIDS. The Regional Services are better educated than the Provincial Services. The Cape Provincial Service according to S needs to do more in the way of education, they are not doing enough and they are not focusing on general practitioners.

M Because Government doctors cannot refuse to treat a patient this, S feels, will drive a lot of doctors out of Government services. The issue is a very difficult one.

M An important issue for Government doctors which has given rise to much concern relates not so much to the fact that doctors have to treat all patients but more to the fact that they are not authorised to administer compulsory HIV testing on patients before surgery. Doctors may therefore treat infected individuals without being aware.

M If doctors were aware of their patients' HIV status then this would promote a much healthier attitude.

M S believes her colleagues will be influenced by HIV/AIDS on issues such as whether they remain employed by the Government or not.

M S's relationship with her colleagues has not changed in any way because of the presence of HIV/AIDS.

M S's relationship with her colleagues is in a sense closer now through discussion around the topic of HIV/AIDS. S sees this as very positive.

M S's colleagues and other health care workers depend on S for information and advice. On two occasions S has had to counsel health care workers who had been exposed to HIV and were waiting for their test results.

M S's colleagues see her as an authority on HIV/AIDS. S is a senior practitioner so her colleagues tend to ask her advice extensively, not only regarding their working lives, but also on issues relating to their personal lives.

M Working with HIV patients draws colleagues closer together, according to S. Individuals need to be united and they need to communicate the dangers and risks of HIV/AIDS to one another. S sees this as very positive.

Q What is your relationship with the other doctors in the same position as yourself. **A** Very careful, they're very careful, now all of us agree in our attitudes and how we should handle a patient.

Q Your colleagues in town. **A** Well I haven't really discussed it much with them. The ones I have I've found were basically in agreement but they probably don't take it as seriously because they aren't doing it so much,

but I expect in times to come it's going to influence their impact on the hospital.

Q Can we go back to that point when you covered this. **A** About two years before, well my children are too young to discuss it with but with my husband, about at least two years before that we had actually talked it out you know, and discussed you know that we would have to at least know about it. I don't think I had problems with it.

Q What are your feelings about being in this high-risk group in relation to your family. **A** Well, I have a big insurance policy against that which covers me for treatment, Um, so that if I do get it it won't devastate my family to have the treatment.

Q Did your family, husband ever express their views about your being in a high-risk group. **A** Oh yes, ja how... I think that we covered that ground and worked through it - discussed whether I was taking the right precautions and should I take out an insurance policy. He's very well versed on this issue.

Q What about your friends. **A** Oh well every one around says you're the one that says everyone is going to die of AIDS [laugh]. **Q** How do you feel about that. **A** Well if they want to know they will ask, if they don't want to know that's OK too.

They are not... I mean, I think everybody has the right to know.

Q Do these people then relate to you differently. **A** No, not particularly.

You know I think that where you are so involved with the public and we are so involved with the people around us at such a deep and intense level, I mean there is nothing more intense than going through a death experience with some-one and being the person who's looking after your mother who is dying, I mean sexuality doesn't come near that in terms of the close relationship.

M S's colleagues are very careful about HIV/AIDS precautions. S and her colleagues hold similar attitudes towards dealing with HIV patients.

M S has not discussed the topic of HIV/AIDS very much with other doctors in private practice. The ones she has spoken to hold similar views to her own. S states that private practitioners probably don't take the issue of HIV/AIDS as seriously as Government doctors because they are not as directly involved.

M S sees the HIV/AIDS issue as having some influence on the private practitioners' involvement and duties at the hospital.

M Two years before this experience S discussed the HIV/AIDS issue with her husband and together they reached an understanding. S's children are as yet too young to discuss the topic with.

M With regard to S's role as a family person, she has a large insurance policy against possible contraction, a policy that will safeguard her family financially in the event of her contracting HIV and requiring treatment.

M S's husband has expressed his views about S being in a high risk group. However, this issue has been discussed extensively and topics such as precautions and insurance have been dealt with. S's husband is well informed on the HIV/AIDS problem.

M With regard to S's friends, these people point out to S that she is the one that says that everybody will die of AIDS - S finds this amusing. However, if individuals are seriously in need of information S feels they will ask; if they choose not to know anything about the disease, S is unperturbed.

M S thinks everyone has the right to know about HIV/AIDS.

M When S discusses the notion of HIV/AIDS with people they do not relate to her differently thereafter.

M S explains that her relationship with the people she deals with is often very intense. Issues such as sexuality do not compare with issues such as death experiences in families which give rise to a very close relationship between S and her patients.

Q Towards AIDS patients what emotion comes to the fore when you think of it. **A** Well, I can tell you what upset me, there was a story that I heard from a chap that came into Casualty in a major local centre that no-one knew and this guy had fallen down and broken - no, he started coughing up blood, he started coughing up blood and there were two doctors there, one who was on duty and one who had just come in because he had grazed his arm while he was working. And this patient collapsed and they started treating him and the relative of the guy that collapsed was standing next to the door and a third doctor walked in and said just as a matter of interest has this guy got AIDS, and he said yes but he told me not to tell you. So the patient was dying of AIDS and they did not tell the doctors, thereby exposing the doctors and I think that is a wicked thing to do.

And I think in that sense all of us are going to be more cautious about people that we don't know and whether they are putting us at risk and perhaps who have been in the past. It is going to create a sense of unease when you are called in to treat people as an emergency that you don't know. People that you know who develop AIDS and you then have to treat it, it is not the same thing at all because you are never going to be exposed to unknown risk,

EIGENWELT

Before

Q Did you feel that the preparations that you took before examining this person were adequate. You obviously knew that she would be arriving here and that you would have to attend to her. **A** Well I think we have prepared ourselves in a sense because we have actually sat down and discussed attitudes and interactions. **Q** Was this with all the staff. **A** Yes, with the staff and some of the doctors and the sister who runs the clinic you know,

During

and then because we had accepted her into the terminal ward and I was sort of nominally looking after the ward, I felt bound to go and just see what the situation was.

Q Was it one of the first cases that came into the hospital. **A** It was one of the first which was so horrifying,

Q Can you recall some of your actions, thoughts and feelings when faced with this person. **A** Well you know one has got a training which tells you, you actually can't run away, though one sort of... your immediate reaction is to actually go away and not actually face this and also to...

M S relates an incident where two doctors working in a casualty department were very nearly exposed to HIV because a patient had chosen not to reveal his status. S perceives this as a very wicked thing to do because it endangered the lives of the practitioners.

M S believes that all doctors will now be more cautious of dealing with people they don't know. The risks involved will have a significant effect upon doctors' attitudes towards emergency work on people they are not acquainted with. If a doctor knows his patient is HIV-positive it is very different because the risk is known.

EIGENWELT

Before

E Before her first encounter with an HIV-infected person S felt quite well prepared. This was because the medical staff had previously discussed attitudes and interactions in this regard before the patient arrived.

During

E Because S was nominally in charge of this ward into which this patient had been admitted, she felt it necessary to visit the patient.

E This case, according to S, was one of the first cases in the hospital which was so horrifying.

E When S was initially confronted with this AIDS patient her first impulse was to leave. However, S states that her training demands the opposite. It is not possible to run away.

Q Was your interaction with this person different to the way you would interact with a terminally-ill person who didn't have AIDS. A Um... you know there is always that matter you know, there is always that feeling you know when you see people who are terminally ill, which we all experience, which is you know kind of with slight withdrawal to it and kind of Um... almost a wish not to be too involved, but you over-ride that because of training and also being able to think about the other person so. I mean one... I don't think that some-one looking at it from outside would even realize that that was your attitude

you know some things are just quite difficult, even certifying death, people who have been badly mutilated it's actually quite difficult to do. But I think it was more revulsion, not that I would actually let the patient ever know that... .

I felt shattered for two things: one is that because of course, you know one recognises one's own inability to be perfect, it would be fantastic if you could be perfect and you wouldn't be nervous and you wouldn't feel revulsion,

but if you did, if you were that perfect you would not have any compassion. So compassion is part of undergoing some of the suffering that the patient has

Q You mentioned earlier that you have to present a certain attitude to those around you. Is this because of your position. A Oh yes, you have to - you can't panic and you can't walk away, mostly in front of the patients.

that's how the whole hierarchical structure of medicine works, the guys at the top sort of take, carry the can, emotionally as well.

After

but I must say it was actually horrifying, it was really very much worse than one even anticipates, you know on paper something looks as if it is sort of handleable, but when you actually see the reality of the terminal phase in a person who's young and who's got an extremely disfiguring disease and is very upset because she knew.

You know the revulsion, being revolted is actually very selfish isn't it, it's very ego-centric. As soon as you can displace it out to other emotions it's better.

Q Are you saying you have a moral code which is independent of the way you conduct yourself professionally. A Oh yes, but those are personal and they are not - actually, I don't usually publicise my personal opinions because the point is that actually

E S explains that most doctors find it difficult to deal with terminally ill patients. There is a slight withdrawal from it, almost a wish not to be involved. However, doctors are trained to overcome these feelings; this they manage to do to the extent where they do not betray their true feelings to patients or outsiders.

E S explains that some duties which constitute the doctor's role are difficult, particularly certifying death, attending to badly mutilated individuals. With regard to this patient S felt a sense of revulsion. However, she would never reveal these feelings to the patient.

E S felt shattered for two reasons. She outlines the first reason as her inability to be perfect in terms of not being nervous and not feeling revulsion. S is referring to her professional role and what is expected of her in this role.

E S believes that if she were perfect she would not have any compassion. S sees compassion as the ability to undergo some of the patient's own suffering.

E S explains that because of her professional position she is not allowed to show any signs of panic or resistance, especially in front of patients.

E S perceives the whole structure of medicine in hierarchical terms; the people at the top must take control in every way, including emotionally.

After

E S reiterates that the experience was horrifying and worse than she had anticipated. The reality of confronting a young terminally ill patient with an extremely disfiguring disease, a patient who understands her condition and is very upset, was very different to S's academic conception of the disease. S was not fully prepared for this experience; on paper it had appeared to be handleable.

E S sees revulsion as a very selfish emotion, an egocentric one that needs to be transformed into another emotion as soon as it is possible.

E S has a moral code which is independent of the way she conducts herself professionally. This code is personal and S does not usually publicise her personal opinions because this would threaten her neutrality which forms part of her professional role.

takes you away from that position of being relatively neutral.

It's the same with doctors, I don't believe they should shove their politics down anyone's face, or their religion. It doesn't matter to me what a person's politics or his religion or his skin colour is, or his morality. It's got nothing to do with my role or his role as the patient.

And I think that it is important to try and get away from condemnation on any score. The interaction between you and the patient depends on the patient believing that they can tell you things and if they feel that by telling you things you are going to be condemnatory they aren't going to tell you things and in fact it makes the job easier to maintain a relative neutrality.

Well - you know, one keeps one's own code of ethics, you don't alter your own code of ethics. Q Do you ever feel this code of ethics has to be compromised. A No I think that they are pretty well... by now you have either survived or you have had a breakdown or gone into something else. You know, I mean you've got a... it's a very tough code you know, so I mean you either live by it and survive or if you don't get on too well with the code you had better adapt yourself.

Q Are you saying you have adapted your personal code. A No, I think there are various -

I think I brought the personal code into the medical world. To a certain extent we are taught the ethics as part of our training, we are faced with issues and told to work them out at Medical school, which I think is very important and it's not done in all Medical schools, it's done in some Medical schools and not in others and I think that... you know presenting people with an attitude and an ethical attitude at an early phase in their medical career is quite important because it demands the highest in ethics.

Q Has the meaning of being a doctor had to be re-evaluated or re-assessed in any way on account of your experience. A No. Q Since the advent of AIDS. A No, we've already been through it with other illnesses: - meningitis, terribly frightening condition, - there's a very frightening type of meningitis often transmitted to staff; and Um, T.B.; Hepatitis; very difficult to handle even patients with cancer, but certainly there are quite a lot of conditions that you can pick up from patients, Um, I was involved in Jo'burg at the time they had the Congo fever outbreak and fortunately not in Casualty at the time, but you know one's faced that a long time now.

E S believes that doctors should not impose their own values on their patients. As far as S is concerned, she adopts an entirely neutral stance towards her patients. Personal judgments are out of place in terms of S's role and the role of the patient.

E S believes that judgemental attitudes in the medical profession are destructive, since the interaction between the doctor and patient is dependent upon trust. This relationship cannot be achieved if the patient perceives the doctor as condemnatory and judgemental. For this reason S believes a doctor's work is made easier if a relative neutrality is maintained on the part of the professional.

E S explains that as a doctor she keeps a code of ethics and does not alter them. This code has become firmly established through experience. It is a tough code that is necessary for survival. An individual either lives by it or adapts accordingly.

E S has not adapted her personal code of ethics.

E S brought her personal code of ethics into the medical world. At medical school S was trained in ethical issues. S saw this training as very important. Some medical schools do not offer this training; however, S believes that for individuals to be faced with and have to decide upon certain ethical issues for themselves is very important and useful because it cultivates a high level of ethical awareness.

E The meaning of being a doctor since S's recent experience, or since the advent of HIV/AIDS, has not had to be re-evaluated or re-assessed in any way for S. According to S, she and her colleagues have had to learn how to deal with similar life-threatening diseases in the past, such as types of meningitis, Tuberculosis, and Hepatitis. Hospital staff have had to deal with terminally ill cancer patients and S herself was once involved with a Congo Fever outbreak.

Q Would you say then that things haven't changed to the extent where you are having to rethink your entire role as a doctor. A No.

Q What about in future. A Well it may lead one to move out of hospital practice more into private practice where you have more control over the situation, but it probably won't be the only factor.

Q Have you ever had reservations about your profession. A Oh I think all of us have done that. If we say we haven't we aren't telling the truth.

I think the medical profession in a few years' time, I will be surprised if people want to do medicine, if they've got any sense.

The argument's always being made that you shouldn't change your treatment at all. But I don't think there is a place for elective surgery in patients who are HIV-positive these days and I think those patients should not be operated on.

And I think it should be known if you've got it. I'm a consultant so I don't have to operate or deliver babies, but if I did it might well influence my decision as to whether I stay in the C.P.A.. I think it will do so,

and that's frightening.

Q You are married and have children. After this experience with an AIDS patient in the terminal phase, did this experience have any more impact on you because of your role as a family person, wife, mother. A No, I covered that a long time before, a long long time before.

Q On an emotional level. A I don't think I can work through that with you [laugh]. Ja, I have thought about it but that's a little private. Q A very sensitive issue.

I think that's something people should have worked out by now.

I mean you either practise that kind of medicine or you practise the type where you just write out a slip and give them a plaster and send them on their way. Q So you see two types of behaviour in this role. A Oh yes, I think there are two types of medical practitioners.

I mean it's not that devastation that people seem to regard it as.

E S has not had to rethink her entire role as a doctor on account of the HIV/AIDS epidemic.

E S suggests it may be necessary to move out of hospital practice in the future, into practice where a doctor has more control. However, HIV/AIDS may not be the only factor necessitating this move.

E S feels that all individuals involved with medicine would have to have some reservations about the profession. If these individuals deny this then they are not telling the truth.

E S would be surprised if in a few years' time people still want to do medicine. According to *S* if they have any sense they won't.

E S rejects the argument that a patient's HIV status should have no influence on the treatment. She feels that there is no longer any place for elective surgery in patients who are HIV positive, and these patients should not be operated upon.

E S believes that if a patient is HIV-positive the doctor should know. *S* is a consultant so she does not have to operate or deliver babies: is she were involved on this level she believes it would strongly influence her decision as to whether she would continue in her present position.

E S sees it as frightening that Government doctors are obliged to operate on individuals who may be HIV positive without knowing beforehand.

E S's experience with an HIV infected person did not have any impact on *S* and her role as a family member. *S* had come to terms with this issue long before the experience.

E On an emotional level *S* chooses not to discuss these issues though she has considered her position on this level with regard to her family and finds the topic very sensitive.

E S believes the issue of death is something people should have worked through by the time they reach her age.

E S believes a doctor either practices the type of medicine which requires a close compassionate relationship between doctor and patient or the type where the practitioner remains emotionally detached. In this light *S* identifies two types of medical practitioner.

E HIV/AIDS is not as devastating, according to *S*, as some people believe.

Subject 4.

UMWELT

Before

A I saw one girl who came through our clinic who I didn't know was HIV-positive until afterwards, in fact she was very badly - a case responding very poorly to TB treatment,

she had come from a farm; but I didn't know she was HIV-positive until she had been through the whole process.

During

I didn't think why she actually wasn't responding to treatment as a TB patient, she was just poorly nourished and perhaps not even taking her treatment properly. Um... that's the situation.

And about two weeks later I had a reply from the hospital saying that she had actually been transferred to P.E. because she was so ill and they had done a test, and after she had died the result had come back saying she was positive.

I didn't feel contaminated;

Q Did you find yourself thinking back to the precautions that you had taken when you examined the patient: whether these precautions were appropriate and sufficient. A No, I don't think there was any risk, there was no contact with body fluids.

Q What precautions were you taking at that time when treating and examining terminally-ill - or all your patients, for that matter. A Well no, I didn't really, there wasn't anything specific to do then -

but I didn't have to take blood from her, I just listened to her chest and touched her. She didn't have a lot of swollen glands, she was very wasted - coughing a lot, but I mean one normally avoids sputum and that sort of thing so that you don't pick up an infection if possible.

But I mean I wasn't wearing gloves and I don't unless I'm taking blood or doing something specific. I still don't.

one doesn't really want to think about it and consider it but I think just to be safe

and I suppose one's possibly exposed to high... you know, other things like Congo fever and other infections, various severe infections that have killed doctors in a matter of days:

UMWELT

Before

U S explains that she saw a patient at her clinic who she later discovered was HIV-positive. At the time of examination the patient was responding very poorly to TB treatment.

U S explains that the patient came from a farm. S was unaware of the patient's HIV status until this patient had been through the whole medical process.

During

U When S first encountered this person she did not think of why the patient was not responding to treatment, she merely saw her as poorly nourished and perhaps not taking her treatment properly.

U Two weeks after this incident, S had a reply from the hospital saying that the patient had been transferred to P.E. because of the seriousness of her condition. The patient died in P.E. and shortly after this her test was returned confirming that she was HIV-positive.

U S did not feel contaminated after she learnt that the patient was HIV-positive.

U S did not come into contact with any body fluids during her examination of this patient; there was, therefore, no risk involved.

U At the time S encountered this patient she was not using specific precautions for terminally ill or other patients. These were not available at this point.

U None of S's procedures with this patient were invasive. The patient was coughing a lot; S states, however, that one normally avoids sputum anyway so as not to pick up infection.

U S was not wearing gloves when she examined the patient: now, as then, she only wears gloves when taking blood or doing something specific.

U S explains that she doesn't really want to think about the issue of risk. However, she feels one must take precautions.

U S acknowledges the possibility of being exposed to other life-threatening diseases, such as Congo Fever and other severe infections, in her profession.

After

I mean when the goggles were eventually found they had been lying in the stockroom for six months and no-one had known what they were for [laugh]. Some of these guys came back from the conferences saying we should be wearing goggles and double masks and they actually had goggles there in the stockroom [laugh].

OK, a needle prick can happen, and one does worry sometimes about needle pricks and one has to be extra... we have taken more precautions lately. We are doing things differently, we are watching how we sheath needles and have a special disposable needle and so on. We are actually being more cautious,

Um... but I use gloves when I examine patients.

Q Do you deal with each one of those patients as a potential AIDS carrier. **A** Yes - in a sense.

In general I think this is a virus that has undergone change, there have been other plagues, um... in past history,

Yes, in a sense people have to change their behaviour in the same way basic hygiene had to change years ago for other plagues and other infections. Because this one is linked to a sexually-transmitted um... mechanism,

Q What do you see as a solution to this. **A** All sorts of diseases have social links, TB for example. In this country it is an apartheid disease, apartheid linked.

but then I see people who come to me after an affair and say "Please test me for HIV", because the patient has been unfaithful and I think, if you are actually not in a monogamous relationship with a second partner, what's to stop that other person from having another partner and so it goes on.

Q Before you saw this person you were told he was in a dementia phase: with your knowledge of dementia what did you feel about this. **A** I was frightened, I didn't quite know: she said dementia and confusion more than anything - I didn't anticipate any aggression as such.

She had already organized for the blood to be taken and so on, so I was in no physical danger and yet when I was just able to touch him and say hello it didn't take long to see that he was catatonic. So that was a tricky one:

After

U S recalls that when the need arose for goggles at the local hospital, it was discovered that they had been in storage for six months and no-one had known what they were for. S views this incident humorously.

U S acknowledges that needle stick injuries can take place and that this is worrying. It is therefore necessary to be extra careful and consequently S takes more stringent precautions. S states that they are doing things differently now. This involves more careful procedures with regard to using syringes.

U S uses gloves when she examines patients.

U S deals with each patient presenting with a sexually transmitted disease as a potential HIV carrier.

U S believes HIV/AIDS to be a virus that has undergone change. S sees this as similar to other plagues. S prefers to see the disease in virological epidemiological terms.

U S believes individuals need to change their behaviour in order to control this disease. Behaviour change in the past was linked to basic hygiene, whereas now it is linked to a sexually transmitted mechanism.

U S explains that disease has always had a social link. In South Africa TB is linked to Apartheid policy.

U S has experienced situations whereby individuals who have had an affair then want an HIV test. In such cases S speculates that this sort of unfaithful behaviour may form an entire web of relationships which has strong implications for the transmission of HIV.

U When S heard the [catatonic] patient was an AIDS dementia patient she was frightened though she did not anticipate aggression.

U S explains that her colleague had already organized a blood sample from the patient, therefore she was in no danger in this regard. S realised very quickly that the patient was catatonic.

and we are having to face the issue, and I think you know, we might have one now and two in six months' time and 22 in the next couple of years in an 18-bedded ward.

Ja, if I had nursed I would have been more at risk in many ways, more contact,

Certainly in the middle of the night when one is operating on an unprepared, unbooked Caesar patient who has just walked in and could be infected. Then if one is slightly careless, nicking a finger, or being nicked - in fact that's more likely to be the case if there is a needle lying around on the side - in fact you can probably nick yourself whilst operating. Ja, one realizes it could be there: the person may have AIDS.

there are the sort of stories: the fact that the doubling is eight months. In this area I am aware that AIDS is around,

There are so many factors involved, including the change and the nature of the disease; one can't predict these things. I don't think I've answered your question.

Q Has this incident changed your perception towards taking precautions. A I think in general terms one is more aware.

It put me more on the lookout for future patients and uh... one has to have a higher index of suspicion now, I think, because there are many patients.

Q I think you have mentioned that your techniques of physically dealing with people have changed. A Yes - yes, safety precautions.

I tend to say... is the patient going to be high-risk and should I wear gloves.

Ja, there are a lot of people I know very well, I wouldn't dream of putting on gloves [laugh] to take their blood, OK I'm very careful at taking blood and I try not to get any on me, but I think... .

Q You are saying then that you would make an assessment of each person in terms of whether you consider them to be a potential risk or not, and deal with them accordingly. A Yes.

Q Would you deal with a person who came in with a non-sexually related problem in the same way. A No, I probably wouldn't.

US explains that the number of AIDS cases is increasing rapidly and soon it will be beyond the holding capacity of many wards.

U S states had she been a nurse she would have been more at risk to HIV/AIDS through more contact with body fluids.

U The possibility of contracting HIV/AIDS becomes very real when in the middle of the night S may be called out to perform an emergency caesarian on an unprepared, unbooked patient. Under these circumstances it is possible to incur an injury during the operating procedures without knowing the HIV status of the patient.

U S is aware of the predictions and estimations regarding HIV/AIDS - for instance that the doubling time is eight months. S is aware that HIV/AIDS exists in the local area.

US states that when making predictions there are many variables to consider, such as the nature and the changes of the disease.

U S's incident with an HIV infected person has inspired her generally to be more aware of taking precautions.

U S's experience has put her more on the look-out for future patients manifesting conditions that may indicate HIV. A higher index of suspicion is now necessary because of the large numbers of potential cases.

U S's precautionary techniques when physically dealing with people have changed.

U When confronted with a patient, S assesses this person in terms of whether she perceives him/her as high-risk or not.

US states that she knows a lot of people with whom she would never consider wearing gloves when taking blood. S is always very careful when she takes blood.

US would make an assessment of each case before she performed invasive procedures, considering whether they are a potential risk or not, and proceed accordingly.

U S would deal with a person who had come to her surgery with a non-sexual-related problem differently to some one who had a sexually transmitted disease.

of course now one thinks of it every time, if you see a patient who is not doing well on TB treatment, it just makes me think perhaps one should test a little further or send them for testing.

Q Do you feel relaxed with this procedure. A No, not necessarily, because the person that comes in with bronchitis might not be worrying about the vaginal discharge or relationship problem. So there is always potential, anybody...

But I counsel them in the same way, but generally I try to treat everybody, I try to look at the person as a person rather than try to label them.

Ok, I have had myself immunized a couple of years ago against hepatitis B, because I've realized that is a thing I am at risk for. In fact we've still got to realize it is more risk than AIDS number-wise.

MITWELT

Before

During

Q Can we start off with the general context. A Ja. Well, firstly, I remember it was a Saturday morning and she was brought in by her family, two family members who said she was a TB patient and she was doing very badly and she was losing weight, not at all well;

and they wanted a doctor to have a look at her because she had been going to the clinic regularly for the pills.

She was living on a farm and her husband was living in Johannesburg and he had visited her in recent months. I don't know whether she had picked up the infection at that stage or how, she was just very thin and wasted and I realized she was seriously ill

and I think - I suppose that I felt as though I did with any other seriously ill patient, she had to be referred to Hospital for better attention than I could give her just as an Outpatient. Um... and I suppose I felt more compassion than anything, she was possibly a dying patient at that stage.

Q How long afterwards did you discover she was HIV-positive. A It was about two weeks later.

Actually I wanted her to go to hospital at the time and they refused, they said they would have to go back and discuss it with the family.

U S is now very conscious of the possibility of HIV if a patient exhibits poor progress on TB treatment. In such cases S considers further testing.

U S is not entirely relaxed with the way she assesses patients because she is aware that although many patients may present with mild symptoms they may in fact be HIV carriers.

U S counsels all patients in the same way; she tries to treat everyone and see each patient as an individual, and avoid labelling them.

U S has had herself immunised against Hepatitis B because she sees herself as at risk. S states that we must not lose sight of the fact that Hepatitis B is still statistically more of a risk than HIV/AIDS.

MITWELT

Before

During

M S recalls when she was first confronted by the infected person. It was a Saturday morning. The patient was brought in by her family. The family members explained she was a TB patient doing very badly - she was losing weight and was not well.

M S explains that the patient's family members wanted a doctor to look at her because she had been receiving treatment and had shown no improvement.

M The patient had been living on a farm; her husband, who was living in Johannesburg, had visited her some months before this. S was unsure as to whether the patient contracted the disease at this point or not, nevertheless she was wasted and thin. S realised she was seriously ill.

M When S first encountered the patient she felt the same as she would with any other seriously ill patient. S felt compassion for this person because she was possibly dying at that stage. She had to refer the patient to a hospital in order for her to receive better attention.

M S discovered two weeks later that this patient was HIV-positive.

M During her encounter with the patient, S requested the patient to be admitted to hospital immediately. The family members refused, saying that they would have to discuss it with the rest of the family first.

Then the farmer's wife phoned me on the Monday. This was the Saturday, they had gone home and she was very worried because the woman was so ill and she phoned and said what should she do and I said well I had already referred her, I had given her a note for the hospital, and this woman said alright she would make sure she went in.

I had touched the patient and examined her fully and I felt good that I had done that because I felt I had actually done my bit, I hadn't sort of rejected her or kept her at arms' length or anything like that.

Q How did you actually find out the information.
A It was through one of the doctors at the hospital, it was just a reply, they said "Oh that patient you sent up actually turned out to have HIV-infection", the result was only back after she had died so the message had come back along the chain.

I just felt sad for the patient and for the mis-diagnosis and... it wasn't missed in the end - and um... the fact that I hadn't counselled the people with her,

that was quite a thing for me, wondering how much counselling they had got at the hospital, whether they had gone back,

whether the farmer's wife knew I wasn't in a position to tell her. Um... you know,

and I didn't know what contact this person had had with the family, with her own family and with the farming family and I wondered about that, maybe if I had known there might have been a lot more I could have done.

After

Q Has this experience caused any adjustment in your behaviour towards those patients that you see every day in your rooms. **A** No, not really, I think before that stage I had already been counselling people with sexually-transmitted diseases about AIDS and the possibility of AIDS.

Now I can actually say to them we have actually had some-one with AIDS in this room and there are cases with AIDS in the district.

Um... and I can say this with authority because I have actually seen one AIDS patient and I am aware of others as well.

M Shortly after S's patient had returned to the farm, S received a call from the farmer's wife. This person was anxious about the health of the young woman and when S told her that she had given her a note to go to the hospital, this person said that she would make sure the patient went.

M S recalls she had touched the patient and examined her fully. S was pleased she had done so because she felt she had performed her duty and had not distanced herself from that patient in any way.

M S became aware of her patient's HIV status through her colleagues at the hospital. S was informally told that the patient she had sent to the hospital was HIV-positive. The test result had been received only after the death of the patient, so the message had been returned along the chain.

M With regard to her patient, S felt sad for the individual and for the fact that she had not counselled the patient's relatives, and also sad on account of her mis-diagnosis.

M The extent to which the patient's relatives had been counselled was a strong issue for S. S was left wondering how much counselling these persons had received at the hospital, and whether they had returned to the hospital.

M S was also worried about whether the farmer's wife realised that S had not known the patient was HIV-positive.

M S was unaware of the degree of contact the patient had had with her own family and with the farming family. S feels she may have been able to do a lot more in this regard if she had known the patient was HIV-positive.

After

M S's recent experience has not caused any adjustment in her behaviour towards the patients she sees daily. This is because S had been counselling people with sexually transmitted diseases for some time before this incident.

M S is now able to say to those patients with STDs that HIV/AIDS is a real possibility, she has seen a case in her rooms and there are cases in the district.

M S is able to impart local information about HIV/AIDS to her patients with authority because she has seen one patient and knows of others.

So I feel it has given me more sort of authority and this sort of pre-AIDS era when there was a lot of talk and preparation which has been going on for a couple of years, um... . It has now arrived, it is now in this town, one can possibly respond to that and hopefully use it in educating patients.

Q Do you then hold this image in your mind of this person when you speak to these people. **A** Yes, as with any case especially with a rare disease, I think one often remembers specific cases that you have seen.

I mean I had a leprosy patient in a township hospital and I will never forget that guy because it is the only one I have diagnosed and one of the very few that I have seen.

So you do remember these patients, you might not remember the names or all the details but you often remember the circumstances.

Q Did you discuss this with your colleagues. **A** Yes. **Q** What was the nature of your interaction with them with regard to this experience. **A** Well, amongst my partners there are fairly similar views on this, we are going to have to treat it and be careful to avoid risk to oneself.

Ja, they were interested to know that there was a case,

and not long afterwards - two or three weeks later - one of my colleagues got a report from the hospital that somebody he had sent up for testing for a sexually-transmitted disease, I don't know if it was because he was suspicious of AIDS specifically or whether it was for some other reason, he sent him up for tests. I think the patient had started losing weight and he got a message back saying this chap was HIV-positive and could we call him in because they had no address for him, and our interpreter had written down "Passing through from Cape Town" which was all we had, so if he passes through again we have got it on his file and in fact he hasn't been back and that is even more worrying.

Q So this partner was in much the same situation as you and his reaction would have been similar to yours. **A** Yes, I suppose so, one doesn't always discuss one's feelings and... you can with certain colleagues, otherwise one just discusses matters of interest from the diagnostic point-of-view.

M S feels her experience with an HIV infected person has provided her with some sort of authority. She also feels that as this incident has occurred in a time when there was much preparation and speculation about HIV/AIDS in the area, it has served as a turning point which can be used advantageously from the point of view of education.

M When S discusses the topic of HIV/AIDS with patients she does so with the image of her recent experience in mind. S does this with most cases, especially with rare diseases: she recalls similar clinical incidents.

M S once treated a leprosy patient in a township hospital. S will never forget this patient because it was the first leprosy case she diagnosed and one of the few she has seen.

M S states that she does remember specific patients with specific diseases. She may not remember the patient's name or other details but she does remember the circumstances.

M S discussed her recent experience with her colleagues. When she discussed this experience with her colleagues their views were similar to her own in that there is an understanding they will have to treat HIV/AIDS patients, while at the same time avoiding personal risk as much as possible.

M S's colleagues were interested to know that S had dealt with an HIV/AIDS case.

M Shortly after S's own experience one of her colleagues was advised by the hospital that a patient referred by him had tested positive. S is unsure of the reason her colleague referred this patient, however, the hospital needed information from S's colleague as to the whereabouts of this patient. Unfortunately it was not possible to provide this as the surgery had no information other than that the patient was passing through town. His test result is now on his file against his return. S states that this patient has not returned and this is very worrying.

M S's partner experienced a similar encounter to that of her own with an infected person. S states, however, that it is not always possible to discuss feelings and emotions with colleagues. It is possible with some colleagues but generally discussion relates to diagnostic matters of interest.

Q Has your interaction with your colleagues and other health care professionals had any bearing on how you are going to approach the whole problem.
A Oh definitely yes, I think there is a reaction, I often get quite uptight when I hear some of my colleagues talking, because they get so very angry about the whole thing - situation,

they get very defensive, and wanting to move out and avoid... which I feel... . They are not doing their duty,

Some people react differently, but then maybe they are being wiser in terms of safety precautions or making a fuss about getting goggles in the hospital for this sort of thing.

Q You said you treat all terminally-ill patients in a similar way. A Yes.

in my own background I have been very involved with terminal patients, I have been very aware that we will be dealing with AIDS as well as with cancer.

In fact our policy at the moment is to treat specifically AIDS, or look after AIDS patients who have cancer as we are doing at the moment, well in fact I'm not directly involved but one or two of our people are actually involved with a patient.

Um... and I was thinking, yes I think of them more as terminally-ill than infected and risky because I know in fact you've got to be closely sort of involved with body fluids etc.

I think yes, I am handling them as terminally-ill patients rather than as stigmatized. And I know that they are going to be traumatized enough by family, friends and rejected and possibly also by nursing staff and they don't need a doctor to reject them as well

and I don't feel rejecting, of them.

And possibly of the fact that I have also seen heterosexual patients who have been infected by family or in the case of this other chap travelling through here, prostitutes, because he did have girlfriends all round.

It was about the third or fourth time he had come in for a sexually-transmitted disease for his injection, that's why we thought we would see him again, and he hasn't been back.

M S's interaction with her colleagues and other health-care professionals has had some bearing on her attitude towards the HIV/AIDS problem. S is often very emotionally affected by the views and attitudes of some people: these individuals often show a lot of anger towards the whole situation.

M S states some of her colleagues are very defensive with regard to the HIV/AIDS problem. They want to move out of the profession and not face the problem. S feels these individuals are not doing their duty.

M S acknowledges that other doctors react differently to diseases such as HIV/AIDS. S states that maybe they are being wiser by taking strict precautions such as including goggles as a part of precautionary paraphernalia.

M S treats all terminally ill patients in a similar way.

M S states that in her own endeavours she has been involved with terminally ill patients. This has increased her awareness of the fact that AIDS patients will eventually form a significant part of all terminally ill individuals.

M S states that the organization she works for focuses on treating AIDS patients in the same way as other terminally ill patients. Presently, the local branch of this organization is dealing with such a case.

M S perceives HIV/AIDS patients as terminally ill rather than as risky. S is aware that risk involves being in close contact with body fluids.

M S feels she regards HIV/AIDS patients more as terminally ill rather than as stigmatized. S feels these individuals have experienced enough emotional trauma already from family and friends and possibly nursing staff. S feels these patients do not need a doctor to reject them as well.

M S does not feel rejecting of HIV/AIDS patients.

M S's attitude towards HIV/AIDS patients is possibly influenced by her involvement with a heterosexual patient who had contracted the disease from family and with another who had contracted the disease from a prostitute.

M The patient who was passing through the town and was later discovered to be HIV-positive had sought treatment a number of times in the past for sexually transmitted diseases. This is why he was expected to return.

You know there has been no stigma of homosexuality or anything like that attached.

Q If it was a turning point, do you relate to people who come in here any different to the way you have related to them before this incident. **A** Not to the people... to those who have sexually-transmitted diseases, I explain to them that they are more at risk than the average person, I mean some-one with a sexually-transmitted disease has got mucosal damage and is more likely to pick up the infection.

So I'm seeing it as a preventative thing, knowing that in fact some of them probably have already contracted it

I don't think I label the next time round a patient comes in... . An STD patient, especially if you see them more than once on a regular basis, are more likely to be at higher risk.

Q In your assessment of these people: do you think that the general conception of AIDS as it is perceived by Society may influence your assessment. **A** I don't think so actually... there might have been one or two instances where say I have seen a young woman who is particularly well dressed, unemployed and has a vaginal discharge and so on and might be a prostitute, and ja, I am aware that they might have a problem with AIDS.

Q The general perception towards AIDS held by Society: does this influence your perception and subsequent treatment in any way. **A** I think so,

and possibly in the very early days Um... . I know that one of my colleagues was totally adamant and anti homosexuality and so on. I mean I discussed this and knew her attitude

sure there are other taboos and things at play, sexual taboos, I suppose people... ja, I see it as a safety thing and the monogamous relationship is important for this reason.

Q Do you see these negative views as destructive towards individuals then. **A** Yes definitely, I think so, just from the isolated cases that one reads about,

when a family has withdrawn from a patient who is HIV-positive, because not only is he now presented with a life-threatening terminal illness, it might be the first time that the family has discovered he is gay. That's a sort of double blow for the family so they have had to take two big sort of shocks and are not able to cope with both.

M S's view of HIV/AIDS patients bears no relation to stigmatization, such as that relating to homosexuality.

M As a result of her recent experience, S does not relate differently to her patients in general. However, with those patients who are suffering from sexually transmitted diseases she explains that they are more at risk than the average person. These patients generally have mucosal damage and are more liable to pick up infection.

M S imparts HIV/AIDS information to individuals with sexually transmitted diseases as a preventative strategy. At the same time S is aware that some of these individuals have already contracted the disease.

M S does not immediately label a patient a potential HIV carrier if he/she presents with an STD: however, according to S, if an individual presents on a regular basis then they are more likely to be at a higher risk.

M S agrees that in some instances her assessment of certain individuals may be influenced by the general perception held by Society towards HIV infected persons. S explains that in one or two instances she has found herself stereotyping certain women into the category of prostitute. This assumption has generally been based on certain physical, social, medical and economic factors.

M S believes that her perception and subsequent treatment of certain individuals may be influenced by the general perception held by Society towards HIV infected persons.

M In the first stages of the HIV/AIDS epidemic S had a colleague who was homophobic. S discussed this with the individual.

M With HIV/AIDS there are other issues at play, such as sexual taboos. For this reason S believes that the monogamous relationship is very important.

M S believes that the negative views towards HIV/AIDS sufferers can be destructive. She refers to inflated account of cases which she has read.

M S explains that in some cases a family is presented with too many threatening issues. Firstly they may learn that a family member is HIV-positive; secondly, that this family member is homosexual. Often families are unable to cope with two shocks of this nature.

That's quite devastating for a family and they have withdrawn and that patient has been left unsupported from the usual and expected support.

So there is definitely a link with Society but I think, whereas in the States it has been a white male homosexual disease which has its connotations, in Africa it is seen as a black-promiscuity type thing and that is a problem.

but on the other hand I have a friend who is a scientist who is actually working on figures, and he says that things are not going to be that horrendous - wiping out of vast numbers of people. It is not going to be like that in the next few years, and various research seems to back that up.

I don't really say it is a way of controlling over-population.

I have a friend who is a doctor and a priest four years ago and he preached about AIDS and he was attacked on the phone half an hour after the service by a black priest who said you know "You say it's a black disease", um... maybe he wasn't tactful in his actual wording, but the black guy was definitely reacting to what he saw as a political statement, but it wasn't.

Q What you are saying is that there is a lot of misunderstanding, misinterpretation and offloading on various groups, giving rise to stigma. A Absolutely, that's right, no-one really wants to accept this,

it is very much a personal thing, person-to-person. It actually can be prevented by early education. So it is linked, ja.

Q Can we discuss the notion of stereotypical views. A I know with a lot of these patients that I've seen, I've seen gays with Afrails but I haven't seen gays with AIDS, OK, and I have seen um... patients who are just affected by the migrant labour system. Um... you know, who have AIDS. This woman had AIDS through no fault of her own, her husband was a miner in Johannesburg and he came to visit her and brought it home.

Q You don't see the disease as being confined to the high-risk groups that have been defined generally. A Yes, I was talking to my husband last night and he has just met somebody from the States who was actually at a seminar in Africa. This chap has written a foreword on a book about AIDS, on Pastoral counselling and so on which looks very good, he's reading it at the moment, and he was saying that AIDS really affects the marginalized, you

M Families are often devastated and withdraw, consequently the patient is left without the usual expected support.

M S explains that disease is linked to the Society. In the United States HIV/AIDS has been a homosexual disease - which has its connotations. In Africa it is seen as a black disease related to promiscuity.

M S is also aware that the Doomsday forecasts stating that vast numbers of people with the disease will die are not altogether correct. S has a friend who works in this field and he maintains that this will not be the case.

M S does not see HIV/AIDS as a way of controlling over-population.

M S relates an incident whereby a colleague of hers who is also a priest was severely criticised by a member of his congregation because he referred to HIV/AIDS as a black disease. In this case this statement was seen in a political light.

M S feels generally that there is much misunderstanding, misinterpretation and offloading on various groups in Society such as blacks and homosexuals. This has created much stigma. The reason according to S is that no-one really wants to accept this disease.

M S believes that HIV/AIDS is a person-to-person transmitted disease which can therefore be prevented by early education.

M S has encountered a variety of scenarios relating to HIV contraction. S has seen 'gays-with-Afrails', but has not seen any gays with AIDS. S's recent incident relates to a person contracting the disease from her husband who is a migrant worker. In this case it was not the woman's fault.

M S was recently discussing the issue of high risk groups with her husband. He had recently met a person from the United States who had written a foreword to a book on HIV/AIDS. This book concludes that HIV/AIDS affects marginalised groups, groups who are marginalised in Society such as homosexuals.

know, whether it's marginalized through poverty and marginalized in Society you know, homosexuals and so on,

but certainly that there has been the most change in behaviour in the high-risk homosexual male group, which has been a good thing, it's actually... they have changed behaviour in forming certain constant relationships and practising safe sex,

so I am aware in general - yes, marginalized groups I do agree with that, but it could be anybody, absolutely anybody.

Q What are your feelings and thoughts with relation to the moral views that form part of Society's response to this disease. **A** I do talk about it, I think it's very important to be aware,

I'm not saying it's judgement, I think a lot of it is ignorance,

but um... I think the more people one can educate in order to sort of whittle down the numbers of cases as far as possible and to practise safe sex until they are married

um... I think that's important because it is a very severe and serious illness, a type of illness that is spread around

I try to explain that to patients, you know I say, here is a little diagram and I say there you are, here's your girlfriend, and you've got two girlfriends so they might have two boyfriends, so we eventually land up with 26 people on the page in no time.

Q How do you feel about being in a high-risk group with regard to your family, children. **A** Ja, I think - I know in a sense I can't pass it on to my children but I could pass it on to my husband, so that will affect things;

it will affect our sex-life, we would have to practise safe sex for his sake,

OK. So I understand that and know that and must work through it, we haven't really talked about it that much as a family, how it would affect us;

we've talked a lot about Society in general and the effects in general and how we would feel about dealing with other people who might have AIDS, I don't think that we've really talked it through as a family

M S explains that there has been a witnessed change in life-style practices of the male homosexual population. S sees this as positive. Individuals have formed single-partner relationships and are practising safe sex.

M S believes that mostly marginalised groups are affected, but states that absolutely anyone is able to contract HIV/AIDS.

M S is aware of the moral views that constitute Society's response to HIV/AIDS. She feels it is important to discuss this and to be aware.

M S feels that Society's views are derived more from ignorance than a truly judgemental stance.

M S feels it is important for individuals to be educated into practising safe sex before marriage so as to reduce the number of cases as far as possible.

M HIV/AIDS is a very severe and serious illness according to S, therefore education is very important.

M S often attempts to explain to patients diagrammatically how through unfaithful relationships it is possible to construct a web of associations which have implications for the spread of HIV/AIDS.

M As a member of a high-risk group, S is aware in relation to her family that she would be unable to affect her children, but she could pass the disease on to her husband. In this sense it does impinge on her family.

M S states that her high risk status has potential implications for her sex life: she and her husband would have to practise safe sex for her husband's sake if she contracted the virus.

M S is aware of the family implications of her high risk status, and needs to work through this. S states her family has not discussed how this would affect them as a group.

M S's family has discussed the effects of HIV/AIDS on Society in general; however, they have not really talked it through as a family.

and I don't know that I've really talked it through or felt it through for myself.

Q When you discussed this particular incident with your husband, was there anything significant in his reaction. **A** No, he was interested to hear that, you know, one of the first cases in this town, there is now actually a case.

And for him it's more of an intellectual type of thing you know. An understanding that it's there and that he should be enlightening others a bit more about it through discussion. He is very aware that his profession hasn't got involved in a in a big way, I mean having a positive approach... .

But you know, I don't think it affected him in that he thought I was bringing home any contamination.

I hope I've educated my family well enough to be able to cope with it.

Yes, I think I would fear giving it to my husband.

Q What sort of precautions and preparations do you take now with regard to those patients that you deal with who are HIV-positive. **A** Well, what happened yesterday, a colleague phoned me, she had gone to a conference Um... She said would I go and see a patient in the hospital and look after him over the weekend. He has been demented, he is about 19, has dropped out of school a few months ago, he has swollen glands, lost weight, and he's suffering from a dementia and she's pretty sure he is going to be HIV-positive, and if he's HIV-negative she would take him as terminal AIDS rather than HIV-positive: his immunity might strike to negative.

She had said that she felt he has the neurological form of AIDS and that is why he has got a dementia. In actual fact I am inclined to disagree with the diagnosis and two other hospital doctors have seen him because they didn't realize he was a private patient so Um... they had had a look at him, and I quite agree with them that he is a catatonic schizophrenic.

So I was able to walk in, put my hand on his shoulder and say "Good Morning, how are you?" and so and so on.

In fact he is in such a world of his own, he is totally introverted and catatonic - he just sat there, so I developed no form of relationship whatsoever.

M S is uncertain whether she has come to terms with the issue of her high risk status in relation to her family.

M S discussed with her husband her recent experience with the HIV infected person. S's husband's reaction centred on an interest with regard to the objective, statistical implications of this case.

M S's husband approaches the concept of HIV/AIDS within an intellectual framework. He sees it in terms of his occupation and the need for continuous education by this profession.

M S states that she does not think her husband has been affected in any way by S's high risk status and the fact that she could bring home contamination.

M S hopes she has educated her family adequately in order for them to cope in the event of her contracting HIV/AIDS.

M S would fear transmitting HIV to her husband.

M S explains that recently a colleague of hers asked her to take over a patient for the weekend. The patient was hospitalised: he was a nineteen year-old boy who recently dropped out of school. He exhibited swollen glands, weight loss, and dementia. S's colleague diagnosed him as AIDS terminal phase, and would regard even a negative test as the immunity reverting to negative at that stage of the illness.

M S's colleague had diagnosed this patient as having the neurological form of HIV/AIDS. S disagreed with this diagnosis. She and two other doctors concluded that the patient is a catatonic schizophrenic.

M By preparing herself beforehand, S was able to show compassion to the patient by putting her hand on his shoulder.

M S explains she was unable to make contact with the patient because he was catatonic.

So I don't really know, I don't think he has got AIDS. And I don't know whether I felt relief... it wasn't relief, I actually felt quite sad in a sense in that OK, we are now going to have to go through a whole lot more diagnostic procedures. Because here was just a frightened young boy.

He probably couldn't understand all of what was going on, the idea was to try and get through to him, he's still a person with which one has got to make contact.

Q What do you perceive the prognosis of this to be. **A** From the point-of-view of economics, we know that Government hospitals and services are not going to be able to support the number of cases that are expected, and we know that there must be another form of dealing with it and that's why I think it is very important for Hospice to be involved

because in fact um... already our black patients and black care-givers are involved with a black AIDS patient who has *Kaposi's sarcoma* um... this has been in the last couple of weeks. They are going to be visiting her at home and she has been in hospital, she is not going to be there all the time,

Um... we can't fill them all up with AIDS patients, so to get in now on the ground floor and educate and educate and talk about it and be aware of it in terms of our care-givers who are very few and far between in terms of the black population here.

Um... that, and talking to our professional people, our nurses, people who are really involved with patients.

I think our next step is to get into that community - now I am stereotyping - OK, but I mean, because of the numbers, to be able to get into the community and have some sort of support system going when the cases start popping up in large numbers.

It is going to be important and I think education is important and as a doctor I think my role is in educating staff and patients.

So I can do it on an individual level, but I can also give talks on a broader level, within Hospice and anywhere else it might be appropriate.

Q Do you think you have a good knowledge of AIDS and that you have access to information. **A** Yes, oh yes.

M S states that she did not believe this patient had AIDS. She explains that her feelings were ambivalent at this stage because the patient would now have to undergo a great many more diagnostic procedures. In this regard S felt sorry for the patient. S refers to the [catatonic] patient as a frightened young boy.

M S saw the patient as confused; however, he is still a person whom one has to make contact with.

M S foresees in the future a shift in emphasis from the hospital towards other forms of care for Persons with AIDS. This will largely be because of the economic strain placed on health care systems in the future as a result of HIV/AIDS. For this reason S sees it as important for Hospice to be involved.

M At the local hospice there are black PWAs as well as black care-givers. Presently, these persons are attending to a patient with *Kaposi's sarcoma*. This patient is being visited at home.

M The hospitals according to S will not be able to accommodate all the AIDS patients. There are many other patients also needing attention. For this reason education at a grass-roots level is necessary and an emphasis must be placed on educating and training care-givers.

M S states that education must extend to professionals and other health care workers.

M S indicates a need for the development of a support system in the black community to accommodate the increasing HIV/AIDS cases. S is aware of her stereotyped view of HIV/AIDS being coupled to this community, but is making this statement on the basis of numbers of reported cases.

M S sees community work as important. She sees education as important and believes her role as a doctor incorporates a component of educating staff and patients.

M S states that she can educate people on an individual as well as on a community level.

M S believes she has a good knowledge of HIV/AIDS and has access to information on the topic.

Q Do you see yourself, as a general practitioner, being in a position whereby your perception and knowledge of the AIDS phenomenon may influence and contribute to the general understanding of AIDS held by Society. **A** Yes, in a small way,

and I think at some stage we are going to have to involve the traditional practitioners, because they must also have some sort of understanding of AIDS and we must be able to work with them.

Q Do you see yourself as playing an important role in terms of educating people who come through here. **A** Ja, I think it's very important, OK you don't talk about it to everybody, but if there is a vaginal discharge or penile discharge and you talk about it, you know - are you sexually active, and if you are, are you - are you using proper precautions, are you... do you have more than one partner and if not you really should be sleeping with one partner.

For some people though, a monogamous relationship is a three-month relationship. So I think one has to see it in terms of long-term effects.

So I see it as important to be an educator, I see myself as an educator

and I've always felt... again, I've had an interest in community health and preventative medicine, [more] than in a lot of other areas in medicine, that's part of what I've been trained to do

Q How are doctors going to fare in this context. **A** It's difficult and I don't blame people for pulling out, doctors through the ages have changed their careers; people do tend to go for the less life-threatening situations and I can't blame them, and yet there are always people who will want to be surgeons [laugh].

because I actually feel - we've discussed this, a couple of us, time and time again - that there is so much stress one can take. I mean you can only take a certain amount of stress as a general practitioner. Perhaps in ten years a lot of GPs would like to be retiring, around 50, and going into part-time work

and certainly the options are there for one to specialize and do something which is not going to expose you to a lot of risk

From the point-of-view of my children I am not encouraging them to do medicine at all, the one definitely would not be interested and the other who might be inclined to do something like that also has no interest. Certainly I will not push my children and say you should at least try and be a doctor.

M S sees her perception and knowledge of the HIV/AIDS phenomenon as contributing to and influencing the general understanding of HIV/AIDS held by society.

M According to S the knowledge of HIV/AIDS held by traditional practitioners must be acknowledged and incorporated into the Western medical understanding of the disease.

M S believes it is very important for her to educate her patients about HIV/AIDS. S targets her education on selected individuals, those particularly who show evidence of a sexually transmitted disease. S asks these people if they are sexually active, if so, are they taking precautions; do they have more than one partner - if not she indicates they should have only one partner.

M S explains that the perception of monogamy varies - for some it is a three-month relationship. S feels it is important to have a long-term perspective when educating.

M S sees education as important and sees herself as an educator.

M S has always been interested in preventative community-based medicine and has some training in this field.

M S sees the doctor's future role in the context of HIV/AIDS as difficult. S does not blame individuals for leaving the profession. Throughout history doctors have changed careers for less life-threatening situations. According to S there will always be people who want to be surgeons.

M In terms of her future role within the context of HIV/AIDS S states she has discussed the issue regularly with her colleagues. S explains that a general practitioner can take only a certain amount of stress in his/her profession. At the age of 50, many general practitioners may be retiring and working on a part-time basis.

M S explains that within the medical profession the option exists for practitioners to specialize and to involve themselves in some non-risk activity.

M S is not encouraging her children to do medicine. One of S's children is not interested in medicine, the other who potentially might follow this career is also not interested. S would not push them in this direction.

Q Is that directly based on the AIDS issue and risk. **A** I think so, I think it has something to do with it.

I thought, well it's quite appropriate, today I am going to see some-one with AIDS and ... [laugh] I'm sure the time will come when I see many patients.

Q And here in town. **A** Oh yes, definitely, we are - I know of another G.P. who has a case, a family in fact, a family situation, and there must be others that are cropping up, one has had a death.

Anyway, yes it's something we can't hide away from, push aside or isolate.

Q You see it as very important to be able to be a care-giver and show honest compassion. **A** Yes, that's right.

Q Do you see AIDS as threatening this role and contact. **A** Well, I've seen in fact as leader of the team at Hospice, within Hospice it is important to be able to set the tone and to let people know that there is nothing really to be afraid of.

Q Has your interaction with people in general undergone any change. **A** I wouldn't say so... that's quite a hard one,

Q Have any of your patients shown any reaction to you as a possible high-risk person. **A** No, I don't think so. One nurse or teacher, I'm not sure - I don't think it's that important - came down to our clinic and said "Do you do pap smears" and I said yes. She said "Well, can I have it done at your other surgery because I don't think I will be at risk to AIDS there".

And to be quite honest we do have a sterilizer here at this surgery and things down there are not as sterile. But the storage space is not as sterile, the walls are damp - we are looking for other premises and part of it's been, we would have looked anyway but the whole concept of hygiene really was... to provoke reproach and I really felt reproved [laugh].

She was a black lady and she said, "Well, I might get AIDS if you use the same instrument as on some-one else, even if it is cleaned. I would rather have my pap-smear at the other surgery".

Q This wasn't directed at you as such. **A** No, no, I suppose not, nor at the patients, but on the other hand she was perhaps acknowledging something that I perhaps hadn't really thought much about at that stage - this was about a year ago.

M The fact that S does not encourage her children to take up medicine is based on her perception of the HIV/AIDS risk.

M S saw this incident as appropriate seeing as she was also scheduled to be interviewed this day. S is sure the time will come when she sees many patients who are HIV.

M S states that locally HIV/AIDS will definitely present a big problem in the future. Already a colleague of hers treats an HIV infected family, another has experienced an AIDS-related death, and S expects other cases are occurring.

M S states that HIV/AIDS is not something that general practitioners can deny, push aside, or isolate.

M S sees it as very important to be a care-giver and to show honest compassion.

M As a member of the Hospice team S believes that it is important for her to set an example and to let people know that there is nothing to be afraid of when dealing with HIV infected persons.

M S does not feel her interaction with people in general has changed at all, though she is not sure about this.

M S's patients have not shown any reaction to her as a possible high-risk person. One person, however, who was requesting a pap-smear, informed S that she would prefer to have it done in a more hygienic environment than the clinic S was working in at the time. This was because the patient feared contracting HIV.

M S agreed with this patient's demands because she is aware that the conditions of hygiene at the one clinic are far below the standards of the other.

M S explains that this patient was a black woman who felt she might contract HIV if the necessary instruments were not sterilised properly.

M This patient's statements were not directed at S or at the other patients. She was merely pointing out something to S that S herself had not given enough attention to - the standard of hygiene in the light of HIV transmission.

Q How would you feel if somebody directed this towards you personally. **A** Well that's fine,

Q Does putting on a pair of gloves make quite a statement in this context which is AIDS-related. **A** I suppose it might do, but my dentist has worn gloves for years and I've never thought of it in terms of AIDS, he wears gloves for everybody and it's routine, he's always wearing gloves and that's fine.

It says things about his precautions in general in terms of hygiene, not just AIDS you know... . Hepatitis,

EIGENWELT

Before

During

I don't really think I felt any differently from, say a cancer patient or a TB patient who was dying.

I don't think I acted any differently than I would've -

it made me realize of course with a bit of a jolt that I had actually seen my first AIDS patient without even realizing it.

I mean ja, maybe we weren't being as cautious with other patients,

Q What did you feel when you received this information - can you recall your feelings at this point. **A** I think mostly disappointment that I hadn't actually thought of HIV, that I was treating it as a pure TB patient. Just the fact that it hadn't gone through my mind,

I suppose there is a sense of pride if you make a diagnosis first.

Q So your first reaction was related to your diagnostic abilities rather than anything else. **A** Yes, it's important for me to make a correct diagnosis, to at least be suspicious;

Q You felt annoyed with your own diagnostic ability. At this point when you reflected back on the way you dealt with the patient, were there any other prominent thoughts or feelings. **A** Um... with regard to being exposed to the virus, I think there is quite a high element of denial [laugh],

M If a patient directed a fear of HIV contraction towards S as a high-risk person, S would be able to accept this.

M S agrees that by putting on gloves she is making some form of AIDS-related statement. However, her dentist has worn gloves for many years and she has never associated this with HIV/AIDS, she accepts this as a matter of routine.

M S feels her dentist's use of gloves says something about his precautionary standards generally, not only HIV/AIDS.

EIGENWELT

Before

During

E S's reaction to the death of this patient and her HIV status was no different from her reaction to the death of a cancer or TB patient.

E S thinks her reaction to this incident was not different from other terminal incidents.

E This incident did make S realize with some force that she had actually encountered her first AIDS patient without even realizing it.

E S states that at this point they were perhaps not being very cautious.

E When S heard this news she felt disappointed that she had not considered the possibility of HIV. She had been treating the person as a TB patient.

E S states that there is a sense of pride involved in making an accurate diagnosis.

E S's first reaction related to her diagnostic abilities; it is important for S to make a correct diagnosis, or at least to be suspicious of possible factors.

E With regard to S's reaction when she first heard of her patient's HIV status, S recalls that her thoughts and feelings relating to exposure were linked to a high element of denial.

and to accept that if it does happen, well, you know, hopefully through no fault of my own, it will be an accidental thing

at least with AIDS one has a period of time to work through things like a terminal illness, but the actual thinking about the final illness could be quite difficult because it could be a painful, very lonely experience

Q Would you say that these thoughts were initiated through this experience. A Yes, I think in a sense yes. I had already for some time been thinking about these things

but certainly at that stage I don't know if I made any new decisions or felt different,

After

Q It seems that in your professional capacity you were concerned about the patient and the way you dealt with her, what of your thoughts about yourself in this situation. A Not a lot, ja, I think I tend to intellectualize and try and push it away - a lot of denial.

Q Because of this experience you are now more sensitive to this. A Oh yes, definitely, yes, I think it has.

Q Would you say that this experience made it a bit more concrete or real for you. A Yes, that's right.

but I also think they are perfectly entitled to it. And there is a sort of dichotomy of feeling there, [laugh] I really can see both sides.

Q Getting back to what you said about duty and personal feelings and the dichotomy that exists between them. Is that the case for yourself. A Ja, possibly, I think I am more accepting of the situation. Maybe fatalistic: if it's going to happen it's going to happen but then so could cancer.

Q After this incident - I gather this incident was very significant for you. A It was a turning point, yes.

and I actually felt yes it was some sort of judgement - punishment or whatever - but in terms of my own understanding of homosexuality or bisexuality or whatever in the last couple of years in fact I've changed from that point-of-view,

so AIDS Um... hasn't changed my, I don't think it's affected my perspective of say the AIDS patient so I could still accept whether they are homo- or bisexual; for me, there is no stigma attached anymore

E If S contracts the virus she hopes it will be accidental, through no fault of her own.

E S states that HIV infection is different to other fatal infections in that it allows time to work through the issue of terminal illness. However, she acknowledges that accepting the nature of this illness could be very difficult as it could be a lonely and painful experience.

E S states that her thoughts relating to infection and its fatal outcome were in some ways initiated by her recent experience, although S had been thinking about these issues for some time.

E Although this incident further provoked S's thoughts about infection S did not form any new conclusions.

After

E S states that her personal thoughts and feelings relating to her encounter with this patient were largely non-existent. S states that she tends to intellectualise these experiences: there is a lot of denial.

E On account of this experience S is now more sensitive to issues relating to the diagnosis of HIV/AIDS.

E S's experience with this patient has made the notion of HIV/AIDS more concrete and real for her.

E S also feels that her colleagues are entitled to their views. S can appreciate why individuals react the way they do. S's own feelings reflect this dichotomy.

E S experiences some tension between her personal feelings and her duties as a professional. She is, however, more inclined to accept her situation and its related duties. In some ways S perceives her attitude to disease as fatalistic, if it is going to happen then it will happen.

E The incident with an HIV infected individual was a turning point for S.

E At one point S felt that perhaps HIV/AIDS was some form of judgement against homosexuality. However, her understanding of homosexuality and bi-sexuality has changed in the last couple of years.

E S's view towards AIDS patients involves an accepting, non-stigmatising attitude. S's perspective of homo- or bisexuality has not been influenced by HIV/AIDS.

but I've read a lot and talked about it and thought about it and I've seen changes in myself and have come to realize that in fact so many people are man and woman in one. You know what I mean, the psychological as well as anything else. And I think mainly through reading and partly through personal experiences and getting to know patients, Um... you know, it has just grown.

Q Have you consciously made an effort to try and come to terms with this. **A** Yes, possibly, I don't think I did it consciously, it is something that has happened in the process over the last couple of years.

Q How do you feel about the Media stereotypes that pervade Society with regard to AIDS. **A** No, I think... as I say, deep down in my own sort of basic religious understanding there might be a feeling that this is a form of punishment.

But on the other hand, we are all sinners, Christians are sinners, everybody is a sinner in a sense, drawing away from God in a free world leading one into temptation, and doing things that aren't right, so it could happen to anybody. So ja, I don't think God's punishing Society as a whole.

I have never felt... This is like the mini-skirt drought story, I remember reading about that in Johannesburg. A priest who used to say we are having this awful drought because people are wearing mini-skirts to church. You know, they can stand at the pulpit and say that and well, God doesn't punish people in that way.

- and perhaps somewhere at the back of my mind or in my intellect or my religious feeling, I do feel, well in a sense there is a reason why God said you should stick to your wife and become one flesh, why a monogamous relationship is important.

Um... not so much a judgement, but that it is a sensible thing to do, a reasonable thing.

Um... yes, I have worked through it and thought it through, I am just very fortunate that I am in a monogamous situation and always have been and always will be

and Um... ja, I can understand, I can see why people do these things, people are tempted,

I have thought, well I must be more careful in the future and I must be more suspicious of the possibility that the patient might have AIDS. Um... and careful from the point-of-view of finger pricks.

E S states that her personal perspective towards HIV/AIDS and its sufferers has been developed through reading, discussion, reflection, personal experience and contact with patients. With regard to homosexuality S has come to realise that man and woman psychologically and otherwise are incorporated into one entity. S has experienced growth with regard to her views on this matter.

E Over the last couple of years S has experienced a process whereby she has unconsciously developed a more comprehensive understanding of issues relating to AIDS.

E S declares that fundamentally she may hold a personal belief - based on a religious understanding - that HIV/AIDS is a form of punishment.

E S clarifies her understanding of HIV/AIDS as punishment by stating that all humans are sinners drawing away from God by temptation and sin, so we are all vulnerable. S does not see God as punishing Society as a whole.

E S extrapolates from the mini-skirt drought story whereby a priest was alleged to have told a congregation that the cause of drought derived from women wearing mini-skirts to church. S does not believe that God punishes people in the way that the priest in the mini-skirt story believed.

E S states that essentially in her intellect or religious feelings, she believes there is some reason why God indicated the importance of a monogamous relationship.

E S clarifies her views on monogamy: she is not making a judgement, just sees it as a sensible, reasonable practice.

E S has considered the concept of monogamy very seriously. She sees herself as fortunate that she is presently, always has been and always will be in a monogamous relationship.

E S can understand why people behave in certain ways: they are tempted.

E S has deliberated to herself in relation to her family that she must be more cautious and suspicious in the future, especially with regard to needle-stick injuries.

Q Would you say then that your family plays an important role in terms of your understanding of AIDS and these precautions you take. **A** Yes, Um... I agree with that.

Um... so I actually had to go up this morning at about 9 a.m. to see this patient so I knew I might be in touch with some-one who has AIDS or is HIV-positive.

But I think before going along I actually had to say to myself, right now this is a possible HIV-positive patient and I did say to myself he is - he might be terminally ill, he might actually be some-one who is going to be needing Hospice care, I might be involved with him long-term, it is important for me to develop some sort of relationship with him and to show him my care.

He has had all the blood sent off, he might come back HIV-positive but I actually thought, no, this isn't an AIDS patient, and therefore I still don't really know how I feel about it.

I actually felt almost cheated because I had steeled myself up to this and thought here we are, here we go - this is the test of how compassionate I am; in a sense, how I am going to handle it.

Q So AIDS in the future will be a big problem for people like yourself. **A** Yes, I think so.

and that's what I would like more and more doctors to do, you know, we should be promoters of health rather than just cure givers.

Q Has the meaning of being a doctor had to be re-assessed or re-evaluated in any way on account of your experience. **A** Yes, I think in a sense I do say to myself, what if I had done something else, you know, not in terms of hankering after it,

I don't know what else I would have done.

Um... but ja, I am also here to fulfil a role, that's why I'm part of it and I'm, you know... if I'm negligent about education then I could also be negligent about my role as a doctor;

Ja, I think it's important to be thoroughly involved; Ja, I think it has in a way made me affirm things a bit more as well as saying whatever - there is always that whatever, things could have been different.

Q How do you perceive your role in the future, within the context of AIDS. **A** Well I mean that's very complex,

E S agrees that her family plays an important role in terms of her understanding of HIV/AIDS and the precautions she must take.

E S was due to see the supposed HIV patient on this day. S experienced the anticipation of encountering an HIV-positive person.

E Before S was due to see the patient she had to prepare herself. S anticipated a terminally ill patient needing Hospice care. She thought she may be involved with this person for a long time and therefore it was necessary to develop a good relationship and show her care.

E S explains that the [catatonic] patient was tested for HIV. The result as yet is not confirmed. Until the result returns S is unable to clarify how she feels about this incident.

E S feels almost deceived because she had thoroughly prepared herself for an encounter with an infected person. S had felt that this would be the test for her of her capability and compassion.

E S sees HIV/AIDS as presenting a big problem for her profession in the future.

E S would like more doctors to become involved in the preventative aspect of health, rather than just being care-givers.

E The meaning of being a doctor has had to be re-assessed and re-evaluated to some extent for S on account of HIV/AIDS. S asks herself what it would have been like to follow another profession, though she does not yearn for change.

E S is unsure of what profession she would have chosen apart from being a doctor.

E S claims she is fulfilling a role. Education of others is a part of this role, therefore if S does not educate she sees herself as not correctly fulfilling this role.

E S believes it is important to be thoroughly involved as a doctor. This involvement has made S affirm things for herself; at the same time it has made her question how things may have been were she not a doctor.

E S perceives her future role within the context of HIV/AIDS as very complex.

and my interest might be - if we left town to go to a bigger centre - might be to specialize in psychiatry, or community psychiatry might be of interest to me.

And so in the long term I can see myself perhaps getting out of a risk situation and um... taking another area.

Q Going back then, as a doctor you are required to abide by a certain set of rules. **A** Yes, even though legally I am not obliged to, I can refuse to treat patients, though I actually feel as a doctor I can't and I don't really want to.

Q Would this incident itself have changed this. **A** Ja, I would say that it is contributory.

E In the future, if S were to go to a larger centre, she may choose to specialise in psychiatry or community psychiatry.

E In the long term S sees herself as moving out of her present field and taking up a less risky aspect of medicine with regard to HIV/AIDS.

E S explains that even though legally she is not obliged to perform certain duties - for instance she can refuse to treat patients - as a doctor she feels ethically bound to her duty and does not want to change this.

E S believes that her encounter with an infected person has contributed to her new attitude towards precautions.

Subject 5.

UMWELT

Before

but one always hoped one wouldn't,

So one day when some-one came in and said they would like to introduce a family that had all got AIDS, I thought well, I knew - here it is and I did have a fear in my heart because you know one had heard about it and... I was the first doctor in town to have to deal with it.

A Ja, my first thought was that I must try and get out of this situation. You know - I am going to have to say I can't take them, it was easy just to say "Sorry, I won't treat you".

Q So your initial reaction was to feel a certain amount of fear. A Yeah.

I just felt a personal threat. It's like before you are going to arrest a robber or something, ... you have to be aware of that personal threat or... .

Q So it was your own safety. A My own safety, my own safety.

Q Did you feel that you were adequately informed with regard to the procedures you must take to secure your own safety. A I think so, I... *think* so... .

A Um...how I felt, well I had looked up about AIDS again, you know, refreshed my mind. Q Just before you were due to meet them. A Just before that day, ja, because I was given about two days before the appointment. They came in... .

Q What specifically had you looked up on. A Well, the medical journals that are constantly telling you how you can get AIDS, the approach towards the AIDS patient, you know this is constantly coming through, no current journal hasn't got at least a quarter of it [laugh] about AIDS or how you can get it and so on.

During

They were diagnosed up country and they have come down here and been transferred.

Q What precautions did you take. A I've taken none, except when I examined that family I told them that I am examining them and before I take blood from them I will take great precautions, I will wear more gloves -

UMWELT

Before

U S states that one always hoped one wouldn't have to encounter this disease.

U When S encountered his first HIV/AIDS patients he initially felt some fear. S was the first doctor in town to deal with a patient infected by this disease.

U When S was confronted with the prospect of treating infected individuals his first reaction was to withdraw from engaging in any form of relationship.

U S's initial reaction towards the prospect of treating HIV infected individuals was fear.

U S's initial fear reaction was personal. This fear was like that experienced before arresting a dangerous person - the fear of approaching something dangerous.

U S's fear related to his own safety in relation to contracting this disease.

U Before treating his patients S felt that he was adequately informed on precautionary techniques to secure his safety.

U S explains that before he was due to meet his first HIV/AIDS patients he refreshed his memory on HIV/AIDS by doing some reading on the topic.

U S's readings prior to his appointment with his HIV/AIDS patients centred on ways of contracting the disease and the approach one should adopt towards HIV/AIDS patients. S points out that most medical journals have extensive coverage of HIV/AIDS.

During

U S did not know the history of these patients because they had been diagnosed elsewhere.

U S has taken no precautions. However, when he examined this family he explained to them that he will take extra physical precautions with them.

fortunately I've had no blood-taking, I haven't had to invade their bodies at all. They've come for sore throats and odd things, you know, they come quickly because they know their immune system is weak.

OK, look, sorry - you said AIDS cases, I have no AIDS cases, these are HIV-positive. A I haven't treated an AIDS case, these are HIV-positive

but most of the time I stick a spatula in their throat and I know that way I'm not going to get... . I listen through the stethoscope and it's totally... you know.

Q You feel no need to wear gloves in these procedures. A No.

But I... I - the fact that they are HIV-positive does affect me, definitely.

Q AIDS is a terminal illness, so is cancer: what would be the difference. A Well, HIV-positive, a person can live for ten years, so I don't call that a terminal illness

After

Q After a good intellectual understanding of the disease and then a real-life experience you say you are still not totally certain of your response to this disease. Are there any other changes that have taken place. A Oh. OK, can I just say, I and the other doctors in town - from now onwards we are on call for emergencies in the hospital, for hospital patients and that means the millions of disenfranchised Blacks, the poor people, who have a much higher incidence of AIDS.

Q How do you feel about the fact that there have always been potentially dangerous diseases around. A You know they have all been relatively curable, nothing has been so dramatic as AIDS.

We treat meningitis all the time. I worked at the children's Red Cross Hospital in Cape Town where I used to run the meningitis ward and there were bugs around there like mad. I used to wear gloves and every day I used to take two anti-biotic tablets to prevent myself from getting it. And it seems as if - like meningitis and these kinds of diseases... if - you know, I also worked in the hepatitis ward and I never got hepatitis and I never got meningitis, but meningitis is curable and hepatitis in 99% of incidence you recover.

But AIDS is a different story. It's a totally different ball game, totally different, like nothing else, like nothing else: far more serious.

U Up to this point S has not had to use invasive procedures on these patients. They have presented with minor ailments and they do so regularly and early because they are aware they have weak immune systems.

U S qualifies the distinction between AIDS cases and HIV cases. His patients are HIV carriers - he has not dealt with any AIDS cases.

U Most of the time S's procedures with these patients have been confined to using instruments such as a spatula or a stethoscope. S sees these strategies as totally safe.

U S does not see it as necessary to wear gloves when he examines these patients.

U S states that the nature of his relationship with the HIV infected family is greatly influenced by the fact that they are HIV-positive.

U S does not see the HIV-positive condition as a terminal illness because a person can still live for 10 years. In this sense, according to S, it is different to cancer.

After

U With regard to the changes that have occurred for S as a result of HIV/AIDS, S explains that he and his colleagues are on call for emergencies at the hospital. They are expected to deal with those groups who show a comparatively higher incidence of HIV/AIDS, such as disenfranchised blacks and poor people.

U S states that despite the fact that potentially dangerous diseases have always existed, none of these has ever been as dramatic as HIV/AIDS: they have all been relatively curable.

U S has been exposed to life-threatening diseases in the past: when he worked in a Meningitis ward he wore gloves and took two antibiotics every day to prevent contraction, and he has also worked in a Hepatitis ward. He did not contract any of these diseases. S explains, however, that Meningitis is curable and that Hepatitis has a 99% recovery rate.

U S sees HIV/AIDS as being vastly different to any of the other life-threatening diseases. HIV/AIDS in unprecedented and far more serious.

We get called sometimes, anytime during the night, to do an operation because the hospital doctors often are inexperienced chaps, younger and inexperienced. So we get called in to do difficult operations or just to do standby on motor-car accidents, stabs and gunshot wounds, you know these things. We must have operated on many AIDS cases, we must have,

and of course I get very resentful at times if I have to get up at night out of the blue and you go in there and there's a drunk who's pranged a car and killed somebody else and he's got AIDS and I've got to save his life.

In that way, from the AIDS point-of-view, I don't blame him because he has got AIDS, I blame my circumstances, that why do I have to now sit in this dangerous situation, where I don't get danger pay, I don't get anything like that,

and from that point-of-view... but these aren't my patients, I go in as a mechanic to do my job and then go through;

but there we wear gloves, we wear plastic covers, you know it's a whole ritual. Q Has this ritual emerged recently. A It's been there for about two years because of the AIDS virus.

And we often operate on cases where we don't know whether they have got AIDS or not. And... . Q Do you think these precautions are adequate. A They are probably adequate,

but if I am operating in a field where there are bits of bone chips, for instance a bullet wound, or a motor accident through the pelvis, and you are going in there and you are trying to nip off arteries, to patch up that person. You've got an assistant and your hands are in there and you've got a needle, artery-holder here, which has got a viciously hooked needle, and you're in there trying to get through. The patient is breathing so you're moving through there [illustrates], you put your needle through and you have to feel, in the dark, or in there and it's often not clear like it is in an anatomy book: it's full of junk and shit and all kinds of things in there. And that is when I say to myself, am I saving this person's life so I can get AIDS, or I can just stand back and let him die.

all our operations, we are operating slower now and sometimes speed is vital in saving a person's life.

delivering babies, if you go really hard for it and you put local anaesthetic in there, but you feel where

U S and his colleagues are often asked late at night to work on complex operations, or standby on emergency operations: this is because the hospital doctors are often young and inexperienced. S's point is that he and his colleagues must have unwittingly operated on many HIV/AIDS cases.

U S explains that on some occasions when he is called out to operate late at night he becomes very angry. This pertains to cases where S exposes himself to HIV/AIDS, whilst trying to save the life of - for instance - a drunk who has had a car accident and killed somebody else.

U S is not angry at this person because he has AIDS, rather S blames his own circumstances - for instance, why must he threaten his own life, he does not get danger pay or any form of compensation.

U With regard to emergency surgery S sees himself as a mechanic doing a job: these are not S's patients.

U S explains that during emergency surgery precautionary measures have become ritualised. This has happened in the last two years and is because of HIV/AIDS.

U S reiterates that he and his colleagues may often operate on cases that are HIV-positive; he believes, however, that the precautionary measures are probably adequate.

U S explains that when he is involved in a complex operation such as that caused by a car accident or a bullet wound, it is often very difficult, despite the precautionary procedures. In these procedures the instruments are sharp and the operator relies strongly on a sense of touch to guide his instruments. At times such as these, S asks himself if he is actually saving the person's life at the risk of his own, or could he just let the person die.

U S states that he and his colleagues are operating more slowly now because of the risks of exposure: this may be detrimental as speed is often vital in saving lives.

U When delivering babies and giving an anaesthetic, sometimes it is necessary to direct the needle by holding

the local goes by putting your finger in there, you have to feel with the tip of the needle, now with AIDS am I going to put local in, you know... what am I actually doing.

And these are the things that go through your mind and you've got to say OK, now operate slowly; do it accurately; keep your fingers away; use a sucker, you know, don't operate with the tip of your finger anymore - now you operate with forceps all the time.

Q The presence of AIDS then is influencing the quality of the operation. A It must,

these are the real *real* problems, and it's based purely on fear, fear of death, you know and fear of quality,

But if, to... actually wilfully go in and be exposed to this all the time.

OK, a car might run me over but at least, you know - and there's a much higher chance of being killed in a motor accident at the moment. Um... .

and with AIDS it might come to that, so it has a terrifying thing to it if one gets it.

Like now, before I have to do a caesarian section on a case that I don't know about, I haven't done the AIDS test, I query that.

So I am still very pleased, I'm being introduced very slowly into this whole thing.

Q Did you expect what you saw. A No, I expected that possibly they would look a bit worse and look a bit thinner, and have sores and things,

and then I would have had to have worn gloves when I shook their hands.

Q Do you have AZT available if it is needed. A Yes, well it has a relatively short expiry time but if one needs it one orders it and then uh... I think it has, one has to try and use it as fresh as possible.

Q The way you deal with patients generally now in terms of taking precautions with body fluids: is this different now. A Yes. Well, it's different since AIDS started coming into South Africa.

Well I mean for instance, taking blood. Now it gets taken in a syringe that has vacuum-packed tubes like this [illustrates this]. So we don't have to touch the blood. Here it's sealed, I haven't touched it.

the tip with a finger: with the presence of HIV/AIDS this poses an enormous risk to a surgeon.

U Precautions and risks are issues which concern S. During operations it is now necessary to consciously attempt to be accurate, use correct instruments, and take sensible precautions.

U According to S, the presence of HIV/AIDS is influencing the quality of the surgery.

U The problems which S has outlined are based on fear; the fear of death and the quality of life.

U S is concerned about wilfully exposing himself to the risk of HIV all the time.

U S accepts that everyday life has its dangers - in fact at the moment there is a higher chance of being knocked down by a car than there is of contracting HIV/AIDS.

U HIV/AIDS may give rise to a similar scenario as S experienced with Congo Fever. This gives HIV/AIDS a terrifying dimension.

U Before S does a Caesarian section on a case involving someone he does not know and who has not had an HIV/AIDS test, he is very wary.

U S is pleased that he is being introduced slowly to the AIDS disease.

U When S first saw this HIV infected family he expected them to be physically a lot worse than they were: he thought they would look thinner and have sores.

U S would have felt it necessary to wear gloves when he shook their hands.

U S explains that AZT is available; however, it has a relatively short expiry date and must therefore be ordered and used as quickly as possible.

U The way S deals with patients generally now, as regards taking precautions, is different since HIV/AIDS started coming into South Africa.

U S explains and illustrates the latest precautionary procedures with regard to taking blood. With these procedures the practitioner does not come into contact with any blood.

The only place where the error comes, where human error comes in is when you resheathe it. This is where an accident can occur. So this is purely, only and totally a precaution against AIDS. And we take blood from everybody like this now. And once you have got into the habit you do it all the time.

Q So a whole new set of precautionary measures and procedures have been developed specifically for prevention of HIV. A Rubber gloves - we used to have old plastic ones, now we have boxes and boxes: we buy these in vast quantities. Companies have opened that just make gloves. Now drug companies are actually giving them to us - boxes and boxes, we go through vast quantities, the hospitals, everyone, every ward, everywhere you see these gloves. In an operating theatre, when we give an anaesthetic [illustrates putting gloves on]. Theoretically - you put on two pairs - theoretically if the needle goes through the first rubber it takes off the blood, the next one hopefully there is no blood on the end. So you're less likely to get blood in you if you prick yourself.

You always wear two gloves, you operate with two gloves, especially with suspect cases.

Q Are you happy with this procedure. A I just have to make... ideally if you put a layer of Jik between the gloves it should give you an even better chance. It depends how badly you jab yourself or how you cut yourself, which happens *all* the time, especially if you are in a hurry and often you are in a hurry, that case is an accident and you have to operate quickly, and operating quickly you stick yourself.

Q Is this still happening. A Yes, it's still happening, still happening, and if that patient's got AIDS... it's still happening,

and OK, we say we are never going to prick ourselves again, just when you think you're safe, there you go again.

But fortunately a needle prick positive - you know, conversion from a positive needle prick is about 1 in 215, so the chances are small. So that is a back-up,

we take precautions, but you have got a higher incidence of getting AIDS through blood spraying into your eyes. Through the eyes it's easier than getting it through a needle prick.

Q Do you wear goggles. A With blood it's amazing: you operate with [them] for six months and you don't get it and you think how can blood get sprayed into my eyes and you look again and the guy who has been assisting has got blood on his face.

U The resheathing of the needle is the only aspect of the blood-taking process that is potentially dangerous. S explains that these new precautionary procedures relating to blood-taking, developed in response to HIV/AIDS, are now regular practice.

U S outlines other precautionary techniques developed specifically for the prevention of HIV/AIDS. These include plastic gloves which are now an ubiquitous part of the hospital and surgery environment. Whilst operating two pairs of gloves are used. S explains that theoretically, when a needle passes through both layers of glove it should leave the blood on the first layer, thereby preventing the virus from entering the skin.

U S repeats it is now common practice when operating to use two pairs of gloves, especially with cases arousing suspicion.

U S has to make the most of these procedures. Another way of minimising virus transmission is to place a layer of *Jik* [Hydrochloric acid] between the layers of glove. However, the margin of safety depends on the depth of a needle stick injury. Deep injuries are, according to S, common, especially under hurried conditions such as emergency operations.

U Deep needle-stick injuries are happening regularly in S's experience. If an individual is HIV-positive, this has strong implications for the doctor.

U S states that after a needle-stick accident, the doctor tries to ensure it does not happen again. However, it is unavoidable.

U S explains that fortunately the risk of contracting HIV/AIDS from a needle-stick injury is about a 1 in 215 chance. This ratio provides a back-up at least.

U S explains that, despite taking all precautions, there is more chance of contracting HIV/AIDS through blood spraying into the practitioner's eyes, than there is through a needle stick injury.

U S describes that a practitioner can operate with goggles for six months without any sign of blood-spray, which leads to complacency - then suddenly it will happen. Blood-spray may occur through drilling, or when the practitioner attempts to close off a bleeding vessel.

And you hardly knew that he had it, and it's either from a drill or just from a little bleeder and as you grab it like that you think you've stopped it and just a couple of drops spray out.

So therefore we also operate with goggles, sort of wrap-around goggles with holes here.

Q So you are doing that with every operation now.
A Yes.

Q Do you use these precautionary instruments with every patient - gloves, goggles, and so forth. A No, only with high-risk patients

- but then, what is a high-risk patient, I don't know.

you see if I treat a patient with leukaemia or cancer; or epilepsy or a manic depressive psychotic, who I don't know how he is going to react - I think with each person I have a different type of relationship. I mean I can't say I have exactly the same relationship with every patient

so each person - I will have a specific relationship with them which is different from other patients again.

And I think with each disease one has sort of a different relationship again.

You see, you come in here and I don't think you are wearing an earring and I think you are a low-risk patient, you are a low-risk patient in my assessment, but I could be terribly wrong.

So you come in here and reckon, Ag doctor, shit I'm feeling terrible, take some blood, so I take some blood. And then you say, by the way can you do an AIDS test.

but... I still think certain people do have a higher risk and... I mean the Black people definitely have a higher incidence of HIV-positive. Just like the Black people have a higher incidence of T.B. and it's a fact - you know;

so I am much more careful with Black people. So when it comes to Black people or potential homosexuals, or chaps that look like homosexuals, OK gays.

But... Um, we should do it with everyone and none of us do it with everyone yet. The epidemic hasn't got big enough yet.

U S explains that operating procedure now includes goggles as part of the precautionary paraphernalia.

U Goggles are now used in every operation.

U Precautionary instruments according to s are only used with high-risk patients, not with all patients.

U S is unsure of the criteria which defines a high risk person.

U S explains that he has a different relationship with every patient. This depends largely on the disease of each individual. S does not have the same relationship with every patient.

U S reiterates that he will have a different relationship with each person he treats.

U S will have a different relationship with each person depending on their disease.

U S refers to the researcher as an example of a low risk person: he illustrates the criteria he uses by stating that because the researcher is not wearing an earring, he would classify him as low risk although he could be wrong.

U S refers to the researcher again as a low risk person to illustrate how such a person may request a blood test: after s has taken the blood this person may then ask for an HIV test.

U Certain people according to S are a higher risk to doctors than others. The black people have a higher incidence of HIV-positivity, just as they also exhibit a higher incidence of T.B..

U S is more careful with black people, homosexuals, or those he perceives to be potential homosexuals.

U S states that all doctors should take precautions with everybody; as yet this is not happening, largely because the epidemic has not become widespread enough.

Q When you talk about these high-risk groups, you are saying certain groups are prone to having a higher incidence of HIV. **A** Yes.

I mean the vagina is one of the toughest organs on the planet because the woman has been so abused over the centuries, you know, and those that survive have got vaginas that even resist AIDS.

You know the vagina is an unbelievable organ and only the toughest of the tough... and in my opinion a white woman is the toughest of the tough, she has been through most hell. And she's got the toughest vagina, and I think to get AIDS through a white woman's vagina is almost impossible [laugh].

and one does make a sort of certain risk assessment, one does it subconsciously, especially when you are operating on some-one.

Q Do you have that done on a regular basis. **A** I've had three tests done in two years, so it's maybe not regular enough.

A I will probably go on having it done once every six months or so.

Because [laugh] you get AIDS sufferers, the men, bisexual men, who have got AIDS through a homosexual relationship, whose wives don't have AIDS. Because their wife... I'm also on slightly tricky ground here... but whose wife will only allow them to have normal sex in the vagina, and the wife won't get AIDS even with un-condomed sex.

Lots of the men who are bisexual also don't use the vagina as a sexual route with their wives and those wives also get it up the backside. And so those wives will get AIDS, but those wives who stay with normal vaginal sex don't.

A It is an interesting view because you know why white people don't get T.B. in Africa. Because it killed all the white people, Keats and Shelley and those fellows died of galloping consumption. It went through the white population of Europe... like masses... and those people who survived have an inbuilt resistance and they just happen to be the white people.

Black Africa never had T.B. until the whites came and brought it with them. The Blacks are now going through what the whites went through. So they are also being weeded out just like the whites were.

So it just happens to be a quirk of circumstances. So that's why we get lots of Blacks with TB, because they are more prone to it. Similarly with AIDS... .

U S states that certain groups are prone to having a higher incidence of HIV than others.

U S explains that the vagina is resilient to even the HIV virus. This is because over the centuries women have been so abused sexually that those who have survived have developed a resistance to disease.

U S believes that a white woman's vagina is an incredibly tough organ. This is because of the abuse she has received over the centuries. S believes the transmission of the HIV virus through the vagina is almost impossible.

U S states that he does make a sort of subconscious risk assessment of a person's HIV status, especially when operating.

U S has had three HIV tests in two years; he questions whether this is regular enough or not.

U S will probably continue to have an HIV test once every six months.

U S explains that bi-sexual men who have contracted HIV homosexually can still have a normal sexual relationship with their wives and even though this is unprotected vaginal rather than anal sex the wife does not contract the virus. S qualifies that he is open to correction on this statement.

U Bi-sexual men according to S who prefer anal sex with their wives are likely to pass the virus to them. Those who have sex via the normal route do not.

U S supports his theory by explaining that white people are resistant to T.B. in Africa because historically this community was badly affected by this disease, consequently those who survived have an inbuilt resistance.

U In Africa the black population was not exposed to the disease until the arrival of white settlers. The blacks are now experiencing what the whites experienced a long time before. The weaker ones are being weeded out.

U Diseases such as T.B. and AIDS take over because of circumstances.

AIDS hasn't really struck me so closely, I mean except I have three healthy HIV carriers and I must have often operated on HIV carriers.

Q Have you operated on a person whom you knew beforehand to be HIV-positive. **A** No.

Q Do you see yourself in the future having to do this. **A** Ja, all the time, because about two years ago there were two HIV-positive people. Now there... in the last six months they have delivered 40 HIV-positive cases, so obviously, we are obviously...

and they are not testing everyone either, so it's coming in all the time and I must have operated on positive individuals, positive AIDS cases.

MITWELT

Before

A Well, I mean at the various refresher courses we had always heard about AIDS and that we would start seeing them; and we had spoken to quite a lot of people that had already treated AIDS, so we knew it was coming. **Q** Was this in the last couple of years. **A** Yes, and we knew we had to start seeing cases,

but we were prepared.

Q How many people are there in this family. **A** Two parents and a child. So it's three all in all.

A A spokesperson for this family came first. Because it was a Black family and they wanted to find out firstly what my attitude to a Black family was, you know... and secondly what my attitude to AIDS was.

So I said "Well of course I will see them".

Q What was the nature of this fear. **A** You know, my future as a doctor isn't really threatened, even if I am perceived as a doctor who has... deals with AIDS patients. I didn't feel about that... I didn't feel frightened of losing patients,

Although there was so much - when AIDS started there was so much information, disinformation, not active disinformation but you know when AIDS started with only the homosexual community and all the first AIDS cases were all homosexuals who had had more than 120 different sexual partners a year.

U Apart from his relationship with three HIV infected individuals and the strong possibility that he may have often operated on infected persons, S believes that HIV/AIDS has not really affected him closely.

U S has not operated on a person whom he knew beforehand to be HIV-positive.

U In the future S sees himself as having to operate on people who he knows are HIV-positive; this is because the number of cases is increasing dramatically: two years ago there were two cases in the community, now there are forty. It is therefore inevitable that S will become more involved.

U S states that patients are not being tested. Infected patients are coming into the hospital all the time: S believes that he must have operated on AIDS cases and HIV-positive individuals.

MITWELT

Before

M S explains that in the last couple of years he and his colleagues were made aware of HIV/AIDS through various refresher courses and through discussing the topic with other colleagues who had already dealt with cases. S and his colleagues were therefore expecting to encounter cases in the near future.

M S and his colleagues were prepared for the arrival of HIV/AIDS.

M S's HIV infected patients constitute three individuals: two parents and their child.

M Before S met his patients he was approached by a spokesman for this family. This person came to assess S's suitability by questioning his attitudes towards blacks and HIV/AIDS. S's prospective patients were all black.

M S assured the spokesman that he would see this family.

M S does not believe that his future as a doctor would be jeopardised if people perceived him as a doctor who deals with HIV/AIDS patients. S's initial fear did therefore not contain a fear of losing patients.

M According to S, when HIV/AIDS first appeared there was a tremendous volume of information available. A lot of this information was misleading, for instance initially the impression given was that a person could only contract the disease if he were an active homosexual. As the virus has spread to other risk groups, more

So our first information came and said, you will only get AIDS if you are an active homosexual, a promiscuous homosexual who has had more than 120 cases a year. So as the AIDS virus spread and as more information came, so more... we know more about it, I don't think we know everything about it yet, but I still think we are reasonably, reasonably well informed, at least as far as our personal safety is concerned.

A We had prepared ourselves for this and as a practice we had talked about it. Every journal, medical journal, they tell you about what to do you know, we were all prepared for it, we had been waiting for it for a long time.

Q So there is a lot of information available. A There is a hang of a lot of information, a hang of a lot.

During

A They were a bit nervous coming to a new doctor in a new town. But they seemed quite relaxed. You know, once I had sort of said to them I am also frightened of this disease and you might find me sometimes saying No, or let me look it up, you know, let me get some information before I do something.

And they seemed quite - I think they relaxed when I at least told them the truth rather than a shady sort of cloak and dagger stuff.

And uh... I did shake their hands as it was, because they are now people in distress.

And I said I would take them on, so I take them on, shake their hands and sit them down and make them comfortable and then they tell their story.

A young couple and they told me the story and they were well informed.

Q They had been counselled. A Ja, they had been counselled, they had been counselled. And um... so I said I would see them

and then it's usually the baby that is sick, you know - the kid, and the mother just comes with the child, and once or twice the father comes.

And they just say Hi, and I say Hi and... .

and they have been told what to look out for, so they come often,

information has become available, consequently we have learnt more about the disease. However, S believes that although we are well informed about precautions, there is still a lot we do not know about the disease.

M S and his colleagues had discussed and prepared themselves for the day when they would receive HIV patients. This preparation had been facilitated by the extensive amount of literature on the topic. S and his colleagues had been waiting for a long time.

M According to S there is an extensive amount of information available on the topic of HIV/AIDS.

During

M S states that these patients were nervous of coming to a new doctor in a new town. However, S felt that they had relaxed once he explained to them his own fear and uncertainty about HIV/AIDS.

M S felt that his patients became more relaxed because he was frank and open with them.

M S shook his patients' hands because he perceived them as people in distress.

M S told the patients that he would be willing to be their doctor; he then shook their hands and sat them down, making them comfortable whilst they related their story.

M S explains that his patients were a young couple. They related their circumstances to S and S perceived them to be well-informed.

M S states that these individuals had previously been counselled. S reiterates the point that he told them he would accept them as his patients.

M S's subsequent dealings with these infected patients has focused mainly on the mother and child. It is normally the child who is ill: the mother accompanies the child and the father comes only occasionally.

M When S sees his patients they greet one another informally.

M S explains that his patients have been made aware of the early signs and symptoms of this disease. Consequently they see him on a regular basis.

Q Do you think that the way you interact with them is any different to the way you would react with a normal patient. **A** No, I don't think so,

I interact absolutely honestly, my reaction is totally honest and I have told them that I am frightened

and I can feel their own fear - you know, their own fear of this disease and that I am also frightened

and they understand that I am also another person that can get an infection, but I said I'll do my best to help them. Um...

so they come in and I say well look - and I said, every time you come in I am going to examine you very carefully and there's going to be a relative standoffishness.

But at the same time I say, when you go to a supermarket and stand in a queue, other people who don't know that you are HIV-positive are standing right up against you, and taking your money and chatting to you and all that, so it's only because I know that you've got it that I seem to be frightened.

Q Do you feel that this may get in the way of the normal doctor/patient relationship. **A** I think initially, the first... once or twice there was something that would stop me. But once I get to know the person it becomes a relationship and um... .

So it becomes an interaction and the more they trust you, rely on you, the more you have...have not to - the more one tends to produce the goods and the more one becomes sympathetic towards them.

Q During the time that you have treated this family, the quality of your interaction has improved, is that what you are saying. **A** I hope,

and I think we have worked out a working relationship with these people.

Uh... I can't possibly say I have the same relationship with them as I would with an anti-natal, with a lady I know - maybe I have delivered two of her babies, now I am delivering a third one - she's got total trust and it's a fun situation and there is more of a sort of camaraderie.

But this is not like that,

Like with terminal illnesses you have a different kind of relationship and with um... family drug abuse... and so each one has different relationships I think,

M S does not think that his manner of interaction with these patients is different in any way to his interaction with so-called "normal" patients.

M S interacts in an honest and open way with these individuals - he has disclosed his feelings of fear to them.

M S states that apart from his own fear of this disease he can feel the anxiety experienced by these individuals.

M S's patients understand that by treating them he is putting himself at risk. However, s has explained to these patients that he will do his best to help them.

M S has explained to these patients that when they present for treatment he will examine them very carefully but that there will always be a relative standoffishness on his part.

M S explains his standoffishness by using the example of how individuals relate to one another in a supermarket queue. When people are unaware of the fact that someone else is HIV-positive their interactions are normally relaxed and uncomplicated. S explains that it is only because he is aware, that he will behave differently. This difference will derive from his fear.

M S agrees that initially his attitude and fear may have obstructed the establishment of the normal doctor-patient relationship. Once s started to get to know these people a relationship did begin to develop.

M Through interaction S explains that a trust develops and as patients become more dependent, the more he becomes inclined to help and the more sympathetic he becomes towards those patients.

M S hopes that the quality of his interaction with this family has improved during the time he has been treating them.

M S believes he has developed a working relationship with this family of HIV infected persons.

M S states he cannot for example have the same relationship with this family as would have for instance with a person expecting a child, having perhaps previously delivered two of this person's children. This relationship would contain trust, humour and comraderie.

M S's relationship with this family is not like his relationship with an expecting mother.

M S's relationship with someone suffering from terminal illness will be different to that of someone involved in drug abuse.

You see I have only got this one family, but I might have a different relationship with another family.

Q Has this experience caused any adjustment in your behaviour to patients in general, colleagues, others. **A** No.

Q Do you treat these patients in the same way you treat other people that come in here. **A** Absolutely identical,

except that I have said to them - I mean I say, that I treat them identical to any other patient, but no two patients do I treat the same. You know because people are different,

as I said earlier, a terminal leukaemia, a mother with a terminal leukaemia child will possibly be treated in a different way to a guy who rocks in and has twisted his ankle at the rugby game, you know.

So, but... if I had five different families with AIDS - as carriers, I might treat them all differently

because some might be more clinging, some might be more demanding, some might need more support, whereas this family is totally independent. They're amazingly independent. Ja.

but as one sees the family more and more, it becomes a genuine relationship.

After

Q Did you speak to your colleagues about this experience. **A** Yes.

A Well, there are a number of us in the practice and because one of us - I might go on holiday; I'm not on call every night, we have a rotation system and I've told the other partners this is the situation.

And when they phoned I told them we as a practice will look after them.

My partners have said, "Oh you prick!" and all kinds of things, but of course they will do the same as I would.

But none of them have had to treat them as yet. They have always sort of waited for that.

Q Do you think then that your views are similar not only to your partners', but also to your other colleagues' in town. **A** I don't know, I know that for my partners it will be the same.

M S only has one family of infected persons; if he were to have others his relationship with them may be different.

M S's experience with these HIV infected patients has not caused any adjustment in his behaviour in general to other patients, colleagues, or the general public.

M S treats his HIV infected patients in an identical way to how he treats his other patients.

M S qualifies what he means by "identical", he states that although he treats people in the same way, everyone is different and therefore his relationship to each person will be different.

M S reiterates his point that a mother with a terminal leukaemia child will be treated differently by him to someone who has twisted his ankle in a Rugby game.

M If S had five different families who were HIV-positive he would treat them all differently.

M S shows how people may be different in that some are more dependent, more demanding or in need of more support. s states that the HIV family is amazingly independent.

M As S's encounters with this family have become more frequent a genuine relationship has begun to develop.

After

M S has spoken to his colleagues about his experience with an HIV infected family.

M Because the practice that S belongs to works on a rotation system - where his colleagues will stand in for him - it has been necessary for S to explain the situation concerning his HIV patients to his colleagues.

M When the HIV infected family first contacted S by phone he emphasised that they would be cared for by the entire practice.

M S's partners have lightheartedly chastised him for involving them with HIV infected persons. However, S is certain they will maintain the same standards as himself.

M None of S's colleagues have had to treat his HIV infected family yet. They are all expecting the day they have to do so.

M S believes that his own views towards HIV/AIDS are the same as those of his partners. However, he is unsure whether his colleagues in town hold similar views.

They would also not be frightened unless they had to take a guy to operate, you know if it was in blood contact, basically that's all; and presumably they wouldn't have sex with their patients [laugh], you know that's the only real way to spread it.

Q Has your relationship with your colleagues undergone any change as a result of this experience.
A No.

Q Has anything changed in your view of AIDS patients since you started seeing this family. **A** Uh... I'm not quite sure... .

Q Has your perception of HIV-infectees undergone any modification as a result of this experience. **A** Yes, one doesn't actually expect to see healthy people walking around. It's not what I had pictured in my mind.

And these are realities which we are discussing all the time, because we are all aware of this, you know-

if you think of one of those big Black hospitals, the surgeons have all resigned; the specialist surgeons are resigning and those that are left are registrars who want to become surgeons, and these are the ones who are doing all the operations. And those guys are resigning because of the fear of AIDS, nothing else,

because if I get AIDS I won't be able to work because it has to get out that I have got it.

The patients won't come to me if I've got AIDS, or if I'm a carrier, you know, as a doctor. I will see AIDS patients and that is it. And um... these are real things that we have to look at.

Q How do you feel in relation to your family and friends, in the context of the fact that you constitute a high-risk category. **A** Ja, once I've got the disease I would be like anybody else that is dying.

Because my wife is terrified, you know,

and OK my kids are big enough now, they can look after themselves.

But the wife says, "Look, we haven't now brought up the kids; we haven't now got ourselves relatively stable; we haven't worked, we haven't pissed it all against the wall or whatever it is, for you to now go and get AIDS from some guy.

M S states that his colleagues would only be anxious when dealing with an infected person if they were operating and coming into contact with blood. S humorously presumes that they would not have sex with their patients: this is the only way to contract HIV/AIDS.

M S's relationship with his colleagues has not undergone any change as a result of his experience.

M S is not sure whether anything has changed in his view towards HIV/AIDS patients since he began to see this family.

M S's perception of HIV infectees has undergone modification as a result of this experience. Previously S had not expected to see healthy individuals who were infected.

M Issues relating to the risks involved in surgery are a regular topic for discussion amongst S and his colleagues.

M S explains that at some of the big Black hospitals, the surgeons and specialist surgeons have all resigned because of the fear of HIV/AIDS. The people doing the operations now are the registrars who want to become surgeons.

M S states that if he were to contract HIV, he would not be able to work because people would find out.

M S believes that if he were HIV-positive his patients would not come to him: his range of patients would be restricted instead to those who were HIV-positive themselves. These are the real concerns which need attention.

M S feels, with regard to his family and friends, that if he contracted the disease he would be like anybody else who was dying.

M S's wife is terrified of the fact he is in a high risk group.

M S feels his children are old enough to care for themselves, were he to contract HIV.

M S's wife points out to S that they have not brought up a family, developed a degree of stability and worked hard, for S to throw it all away by contracting HIV/AIDS from someone.

OK, it's not his fault he has got AIDS, that's just the system

A Your wife has voiced her concern about your position in relation to AIDS. A Yes very. Very, very.

Q And the rest of your family. A Well, my sons are all adults now - I've got three sons;

my own family, ja my mother occasionally says, "I hope you don't get AIDS", and I say, so do I,

but you know it's not a direct effect with my uncles and aunts and cousins. Two cousins and a nephew are doctors, ja, so it's not a direct impingement,

my wife just keeps on saying she hopes I don't get it. During a Congo Fever scare I had to sit in the hospital the whole night until they could prove we didn't have it - my wife says she doesn't want to go through that again, neither do I, really;

as a G.P. not so high, but as a friend of mine who is a surgeon, he says; "Ah shit man what can I do, what can I do" - you know, he also thinks about it often.

A You know, we have often spoken to people about this, you know, socially everybody asks, "Have you got AIDS cases; how do you deal with it?", and one just tells them, and I've never found anybody who is unsympathetic, you know: everybody understands.

Q With regard to your friends, the feeling which comes to the fore in your interaction with them is sympathy. A Yes, oh yes.

Or a doctor asks me to do a caesarian because he hasn't got enough experience. I'll say make bloody sure that the patient doesn't need an operation [rather] than you delivering it normally [laugh], you know.

Um... but I haven't got any, I haven't had any... no person who I might have come across is unsympathetic to my situation. Many people say, "Thank goodness I'm a tractor driver"; or thank goodness I'm an estate agent or whatever it is, you know, because they haven't got that contact.

Q And this is in relation to your position as a doctor and what is expected of you as a doctor. A Yes, in the community; ja, ja.

M S would not blame the person who gives him AIDS for having the disease: this is merely a part of the social system.

M S's wife is very concerned about his position in relation to HIV/AIDS.

M S's concern about HIV/AIDS is different in relation to his three sons because they are all adults.

M S's mother occasionally voices her concern about S contracting HIV/AIDS.

M S's concerns about HIV/AIDS relate more to his direct family than they do to his distant family. Some members of S's distant family are also doctors.

M S's wife expresses her concern constantly about S belonging to a high risk group. S was once quarantined during a Congo Fever scare, and his wife states that she does not want to have to go through such an experience again; neither does S.

M S believes that surgeons are a higher risk category than general practitioners. S has a surgeon friend who has thought about that issue at length and finds it difficult.

M S has discussed the topic of HIV/AIDS with people, he is asked many questions and he answers them. He has never found people to be unsympathetic: they all understand his position.

M S's friends feel sympathy for him because of the nature of his work.

M If S is asked by an inexperienced doctor to perform a Caesarian section on his behalf, S encourages his colleague to make sure the birth cannot be performed normally, before he operates.

M S has not come across anyone who is unsympathetic to his situation. Many people mention to S that they are pleased that their professions do not involve contact with HIV-carriers and possible risk.

M The sympathetic view of others towards S is directed at his position as a doctor in the community.

um... because they are so healthy, you know, they are AIDS carriers and they are not AIDS patients, so they don't need the regular nursing, they just know that if they get any illness they must come for treatment quickly before the resistances break down, and that type of thing.

yet um... one can, whereas with certain cancers - I reckon a guy with cancer will probably not live longer than six months [laugh], it's unusual. Of course there are some but not many, OK I am generalizing. OK there are some cancers, you diagnose the first time, you cut it out, the guy is cured. If he lives for five years you call it cured.

Except for the hospital cases: they are a separate entity.

and then I wouldn't have known how to go about it,

But they were well, they looked just like you and me; they were perfectly normal people.

But there are millions of guys who are gays who don't look like gays or have just had one or two homosexual experiences just because of circumstances.

Um, I think in this town, I can only speak from a specific community. I have lived here now for a long time. I've delivered kids, I know who the risk guys are

But I don't know any of the Black people - or very few of them.

Whether they are more prone to it, or whether it's just malnutrition like in T.B.. Or whether they live together or whether they don't have the same sexual norms or whether... you know, I don't know. But the fact remains that the Black people have a high incidence.

Q You use this as your criteria for your assessment. A Ja, and also because the Black people, you know, in my opinion and the statistics that I have seen, they seem to have a higher incidence.

Shit, I didn't take precautions, ja OK high risk time, OK [laugh]. So we should be taking precautions with every patient, we should be, we should be absolutely,

Q Do you perceive your old patients in a new light, or your new patients in a different way. A No.

M S's HIV-positive patients are perceived by him as being healthy. S explains that these patients are HIV carriers, rather than AIDS patients. They do not need regular attention. If, however, they become ill, they know to seek treatment immediately.

M S explains that cancer is different to the HIV condition because individuals seldom live longer than six months after diagnosis with cancer - although there are exceptions: if a person lives for five years after operating then he has been cured.

M S distinguishes between his patients and hospital patients.

M Had S's patients been in an advanced stage when he first saw them, he would not have known how to deal with them.

M When S first met his patients they appeared to be perfectly normal.

M S explains that there are many people who are gay who do not look as if they are. Many individuals may have had one or two homosexual experiences because of circumstances.

M With regard to risk groups S states that he can only speak in terms of his own community. S has lived in one community for a long time, he is aware of those persons that are at risk and put others at risk to HIV/AIDS.

M S states that his knowledge of risk types does not extend to the black community.

M S states that it is a fact that the black population has the highest incidence of HIV/AIDS. This may be due to a number of reasons, such as malnutrition; whether they live together, and their sexual norms.

M S uses certain criteria to assess a person's risk status; he also reaches his understanding that blacks constitute a high risk group through statistics he has seen, as well as his own opinion.

M S may perceive someone as low risk, take no precautions, and then realise he was wrong. For this reason S states precautions should be taken with everyone.

M S does not perceive his old patients in a new light or his new patients in a different way on account of his experience.

Q Have any of your patients shown any reaction to your being a possible high-risk person. **A** Yes, definitely, I often get patients asking, "I hope you're using a new needle and I hope that syringe is clean and I hope... why aren't you wearing gloves with me?" you know, that kind of thing. Oh yes, one gets that, that's coming more and more.

Q How do you feel about that. **A** I say "Uh oh, I didn't know you were an AIDS risk, I will put on my gloves" - you know, that type of thing depending on what type of relationship I have.

But I mean some people are genuine and I say fine, I will wear gloves if you want me to. But I say I haven't got AIDS and you haven't got AIDS: we're not at any risk.

But I have my AIDS blood test negative here, so if anybody really wants to know I can show them.

Q Do you find that the general perception of AIDS held by Society affects you in any way. **A** Yes, definitely, because I'm also prone to advertising and I think it's the same type of thing; I must be affected by the Media.

Q Do you think this influences the way you perceive your patients. **A** I'm sure it does.

A I think for instance every time I see this family I am actually surprised at how healthy they are and how normal they are, you know, and that I am actually only treating the Tonsillitis or the cold or whatever. Because every time I say to myself, they're not thin and they don't look like the pictures you see.

Q What about the moral views held by Society towards groups. **A** Well you know, from the point-of-view of spreading it: the low-intellectual, the lower social strata always live shorter than the higher strata. They have a higher incidence of heart disease, they smoke more, they drink more, they eat the wrong food more, they beat each other - they have a shorter life duration and by the same thing, they are also probably more prone to AIDS. So they are more likely to catch it, just like T.B., just like any disease tends to be more in the lower socio-economic groups: so they live shorter lives.

Oh, they carry all kinds of diseases...

Q Has your interaction with people in general undergone any change as a result of your professional knowledge and experience with AIDS.

M S's patients have shown a reaction to S being a possible high-risk person. Patients have enquired as to whether S is using new needles and clean syringes; others have asked S why he isn't wearing gloves. These questions are occurring more and more often.

M S's reaction towards the individuals who demand precautionary paraphernalia differs depending upon his relationship with the person. S may react in a humorous way, informing the individual that he was unaware that this person was an HIV/AIDS risk.

M If a patient is genuinely concerned about the risk of HIV/AIDS, then S will comply accordingly. He will, however, discuss the issue of risk with the person.

M S has his blood test available to show individuals that his HIV status is negative.

M S states that the general perception towards HIV/AIDS held by Society does affect him. This is because - like everybody else - he is influenced by the effects of advertising and the Media in general.

M S is certain that the influence of advertising and the Media affects the way he perceives his patients.

M The effects of advertising and the Media on S's perception of HIV/AIDS are apparent to him through the way he is constantly surprised at how healthy his patients look. They are not thin and emaciated as is the impression he has developed through observing Media pictures.

M With regard to the moral views held by Society towards various groups, S believes that there is a truth in the fact that lower socio-economic groups are more prone to HIV/AIDS than other groups. S explains that these groups also have a higher incidence of heart disease: they smoke more, they drink more, eat the wrong foods, they beat each other they have a shorter life span. These groups are more likely to contract HIV/AIDS and T.B..

M According to S homosexuals carry all kinds of diseases.

M S's interaction with people in general has not undergone any change as a result of his professional knowledge and experience with HIV/AIDS. S delivers

A No. I mean I give talks on AIDS all over the place, but I also give talks on contraception and VD and drug abuse, you know, whatever.

Q Do people come to you and request that you deliver such talks. A Ja, school groups, University reses, Farmers' associations, you know... but they also ask me to talk on any kind of illness... but at the moment it is AIDS. I walk around giving AIDS - spewing forth AIDS to farmers all over the country [laugh] you know, because they also want to be informed.

Q Do you mention AIDS to your patients. A Yes, oh yes, I mean as soon as a person... . As soon as a person is ill, his first fear is that he has got cancer, I mean whatever, because that is natural thing. However, nowadays a guy is scared of two things: he's either got cancer or AIDS.

He might say it in a laughing way, a jovial way, because he might have had an affair outside of the marriage or he might as a youngster slept with a maid or whatever it was, or slept with somebody... a prostitute, and now he is suddenly thinking now he might have AIDS. Although he talks about it jovially there is often a serious undertone.

So I do mention it a lot. I used to say, "Oh, you haven't got cancer", now I say, "Oh you haven't got cancer or AIDS, ha ha ha ha".

He says "Are you sure I haven't got AIDS", I say "Well we can do a test just to prove it". So that kind of conversation comes up a lot.

Q Since this incident and the advent of AIDS, has your relationship with others changed. A Constantly, constantly.

The interests people show at social functions - or at when I'm playing tennis, cricket, golf, hockey or even at parties - I don't think one day goes by when some guy asks you, "Aren't you afraid of AIDS", this AIDS subject comes up: "How many cases have you treated", "How does one get it", you know people are amazingly interested. Or there has been discussion about AIDS on the radio and people say, "What do you think about it", constantly, and when you start talking to one, the next thing is that there are three or four people sitting around, you know, wanting some advice, as much advice as possible: what does it look like; who's going to get it... .

Q So you are an advice giver. A Ja, socially.

many public lectures on HIV/AIDS but he also talks on contraception, V.D., drug abuse and other topics.

M S is generally approached by various institutions such as schools, University residences, Farmers' Associations and the like to give lectures on various illnesses. At the moment the main issue is HIV/AIDS. S talks extensively on this topic to farmers who want to be informed.

M S does mention the topic of HIV/AIDS to his patients. According to S, in the past, when a person felt ill, his first fear was cancer. Today he fears cancer and AIDS.

M When a patient refers to the possibility of his having HIV/AIDS it is normally done in a lighthearted way. However, according to S there generally exists a more serious undertone to such statements. In the past many of these patients may have been involved in high-risk sexual activities such as having sex with a prostitute, sleeping with a maid, or having an affair.

M S mentions HIV/AIDS regularly to his patients. In the past he may have reassured a person by saying "You do not have cancer"; today he states, "You haven't got cancer or AIDS".

M If a patient is overly concerned about his HIV status S will encourage a test in order to alleviate these fears. According to S, conversations centring on such issues are common.

M Since the advent of HIV/AIDS, and S's recent experience, his relationship with others is constantly changing.

M Whenever S is in a public place - a social function, sports meeting or party - he is confronted by individuals who seek information and advice relating to HIV/AIDS. Questions relate to his own fear; the number of cases; transmission, and signs. S states that people are amazingly interested in the topic, and want as much advice as possible.

M S gives a lot of advice socially to the public.

Q Do you see part of your role is to be an educator. A I think so, yes, yes.

Q And in the future. A I think so, I think the Media - you know one does get a lot through the Media and there are big organizations who are trying to educate, so I don't think I'm a frontline educator.

Q And is that for GPs in general. A I think yes,

I... they should be educated, they should be kept up to date; they should also be educating.

Q Do you see yourself as a GP being given enough opportunity to learn about AIDS and AIDS precautions. A Oh yes,

So we go to the various teaching hospitals to keep up -

EIGENWELT

Before

But I had to get my mind clear, and I had to know now that I am dealing with a hand grenade as far as my own danger is concerned. But all the time we had been aware.

Q You are not obliged to as a G.P. - is that right. A I don't even know, but morally I am obliged to,

legally I don't know how I stand. I think I could get away with it. I could just say, look I can't see them, my practice is too full; I've got no time for this kind of thing; I could give a lot of excuses, but uh.

During

I play different roles and I hope I play the correct one every time.

But if a person with AIDS... you will see I am still a bit wobbly with my opinions on AIDS because I haven't quite cleared it in my mind, we don't treat many cases... yet.

Q In spite of your experience, the concept is still quite academic - is that what you mean. A Academic,

After

Q Has anything significant changed in your general perception as a result of your experience with this family. A Yes, because these are the first AIDS cases that I have got and AIDS is here. It is here, we've got to start coping with it.

M S sees part of his role as comprising an educative component.

M S does see his role in the future as containing an educative component. However, he does not see himself as a front-line educator because the Media and various large organizations are taking on this role.

M S does not see G.P.s in general as having a front-line educative role in the future.

M S believes general practitioners should be educated themselves and kept up to date; they should also be educating.

M S sees himself as a general practitioner being given enough opportunity to learn about HIV/AIDS and precautionary measures.

M S and his partners visit the various teaching hospitals regularly for education purposes.

EIGENWELT

Before

E Before S was due to meet his first HIV/AIDS patients he needed to think very seriously about his position in relation to this disease and the danger it presented, even though he had been aware of this beforehand.

E As a general practitioner S is unsure if he is legally within his rights to deny treating an HIV infected person. Morally, however, S feels he is obliged to.

E S believes that legally he could possibly get away with his decision not to treat HIV patients. He could do this by stating that his practice is full and he has no time for this type of disease, or a number of other excuses.

During

E S plays different roles according to the circumstances and he hopes that he plays the correct roles each time.

E A person with AIDS is different; however, S is not entirely sure of this difference: his opinions in this regard are not entirely clear because he has not had much experience.

E Despite S's recent experiences with HIV/AIDS, his understanding of the disease is still largely academic.

After

E On account of his experience with an HIV infected family S's general perception has been changed to the extent where he is now certain that HIV/AIDS is here and that it needs to be dealt with.

Q Do you feel that all your initial preparations taken before treating these patients were necessary, adequate and appropriate. **A** I think so, I think so, I think so.

They might say different things you know, just like different people have different opinions, but they would treat them, they are also well informed, they also know what to do.

Q Since the advent of AIDS has the meaning of being a doctor had to be re-evaluated or re-assessed in any way. **A** Yes, oh yes, oh yes, I've never had a reason to resign, now I might.

Q So you have re-evaluated quite seriously. **A** Yes, oh yes.

It's making it difficult for us. It's making it difficult. I'm sure I'm affected - because I've only got one family to treat, I can't really talk like from experience.

But if there were masses of AIDS cases and they all needed treatment and they all were incurable and uh...if it got to the proportions that some prophets of doom have predicted, I might have to consider it, consider resigning or retiring as a doctor,

because I don't want to kill myself for something that cannot be cured. I'm not a martyr. I'm not a martyr,

but I will see as many...OK I'm not a martyr... however... . But those people with AIDS, even with full blown AIDS - if I had a patient in my practice and he was a genuine patient of mine, I would carry on seeing him and doing the best I could for him.

But if I had to be pushed into a situation where they said, "Look, there are only ten doctors in town and there are 10 000 AIDS cases lying around" - which certain scenarios can put to us - "You've got to work in an AIDS hospital for six days in a month because that's your allotment", and then I might start saying I will become a small-business man and start making pizza pies [laugh].

I have to go away and work it out in my mind. It's, it's... am I committing suicide, has this patient really got a chance -

And why does a chap who drives a dynamite bus get paid danger money, and I've got to go out there at night and do this over and over and over and my chances of getting AIDS must be getting better, you know, the risk is higher.

E S feels that all his initial preparations taken before treating his first HIV-positive patients were appropriate, necessary and adequate.

E S believes that his colleagues, like most people, have differing views. However, they are competent, well informed and they would treat his patients.

E Since the advent of HIV/AIDS the meaning of being a doctor has had to be reevaluated for S. S has never had a reason to resign, now he feels he has.

E S has seriously reevaluated the meaning of being a doctor in the light of HIV/AIDS.

E HIV/AIDS is making it very difficult for doctors. S is sure that he is affected, but as he has only one family to treat, he cannot really speak from experience.

E S surmises upon his position if there were masses of HIV/AIDS cases who all required treatment and were incurable. He states that were HIV/AIDS to reach the proportions that various prophets of doom predict, he may have to consider retiring or resigning as a doctor.

E S does not want to kill himself for something that cannot be cured. S states that he is not a martyr.

E S states that he is not a martyr; he will, however, continue to see and treat, to the best of his ability, those individuals who are genuine patients of his who contract HIV/AIDS.

E If S had to be coerced into a situation where for instance there were only ten doctors in town and 10 000 cases of AIDS, and where he has been told to work for six days a month in an AIDS hospital - scenarios which have been outlined to the local doctors - then S will consider changing his profession.

E S feels he needs to work with these issues very thoroughly, and ask himself whether in fact he isn't committing suicide in such situations, and does the patient actually have a chance.

E S does not understand why he should continue operating - thereby increasing his chances of contracting HIV/AIDS - when, unlike the driver of a dynamite bus, for instance, he receives no danger pay.

Because why do I have to work in Africa where there is AIDS, as a doctor, if I can go to Canada and work there, or to America and England where it is all cushy and fine.

Am I just going to resign and say, look, I'm not a doctor anymore, I'm resigning and I am going to become a drug rep., or I am going to open a small business and then I've got a chance of living until I'm 60. What am I trying to do now,

You know, if I've got cancer OK that's nothing, I will try and have it cured and if... there's lots of people I've seen and there is nothing they can do.

- but why you, why don't you just resign this whole thing, just pack up; resign as a doctor, become a business man, become a hobo". Sell your house and become a hobo. Put that in the stock exchange, live at the seaside, your conscience will be clear.

Q You perceive yourself as being in an extremely high-risk category. A Very high risk,

Because they've got a choice to sleep with potential AIDS cases, homosexual activity or whatever it is, whereas we haven't.

Q So you don't really see it as a moral issue, but rather as a result of circumstances. A No no no, the homosexuals for instance just happened to be - it just happened to be one of the ways of introducing an infection, through an area, through the anus where there is a lot of venus flexos, and uh, sticking a penis into an anus invariably causes bleeding.

Q Has your understanding of AIDS as a disease altered in any way. A Yes, no - not because of this,

Q And is this because you feel you have a responsibility to your patients. A I think so, yes,

and also for my own, actually, ja. It probably won't make any difference, I would... no, I would, if I found I were HIV-positive, I would sell everything and travel around the world and stop working, enjoy life... not knowing might be better.

Q So in a way Society has presented this view. A Ja, but I think it is only because of the small amounts that I have seen so far.

Q What about the stereotypes held by Society: what do you feel about these - for instance, "Divine retribution" and so on. A Heap of garbage, heap of garbage.

E S asks the question why he should work in Africa where there is HIV/AIDS when he could go to Canada, America, or England where conditions are less threatening.

E S hypothetically outlines the possibility of resigning from his profession and becoming a drug representative, or opening a small business. In this way S sees himself as having the chance of living until he is 60, contrary to his present expectations.

E S states that if he were to develop cancer he could handle it: he would try to have it cured, though in his experience this is improbable.

E S reiterates his feelings and thoughts about resigning as a doctor and becoming a businessman or a dropout: selling his house, putting the money on the Stock Exchange, and living at the seaside. In doing this his conscience would be clear.

E S perceives himself as belonging to an extremely high risk category.

E S explains that other people have a choice; if they contract HIV/AIDS it is because they have chosen certain behaviours; S on the other hand has no choice.

E S does not see HIV/AIDS as a moral issue. He sees this phenomenon within a framework of circumstance. For instance, with homosexuals their lifestyle and associated sexual behaviours happened to provide a means through which the transmission of this disease could take place.

E S's understanding of the HIV/AIDS disease has altered, but not on account of his experience with this family.

E S will be tested regularly for HIV because he feels this as his responsibility to his patients.

E S has a regular HIV test both for his own and his patients' benefit. He feels that even were he HIV-positive, it probably wouldn't make a difference. S then changes his mind and states that he would sell everything, stop working, travel and enjoy life. Again, S suggests not knowing his status may be better.

E S has not been exposed to large numbers of HIV/AIDS patients and this may account for the fact that he has not yet formed a strong impression of his own but is influenced by the Media.

E S refers to the stereotypes held by Society towards AIDS sufferers - such as "divine retribution" - as so much rubbish.

I mean Black Death and Polio then - every disease is brought on by God. I mean then God can give you the lucky number in the casino too, you know. No no, my God plays a different role, He's not a magician, He's not a guy there sitting with a magic wand.

but then there are a lot of GPs that don't, one has to make an effort, because... like two of the members of our practice have just been on an anaesthetic revision course, but one doesn't have to go; and the week before, two other partners went on an AIDS update, to jack themselves up; and the week before that another chap went on a general accident refresher course.

but it is an effort that one has to make, you can fall behind, you know it is an individual thing but I think generally the GPs have to keep up.

E S states that if the view is adopted that every disease is brought on by God, such as the Black Death and Polio, then God appears as some sort of magician who can also give a person a lucky number in a casino. *S's* God plays a different role: he is not a magician with a magic wand.

E S points out that there are many general practitioners who do not take the opportunities available to them for their own education. In *S's* practice his partners have been on a number of refresher and revision courses recently. They are not compelled to go but they do.

E S states that it is necessary for doctors to make this effort; however, it is easy to fall behind. *S* feels it is up to each person to keep up.

Subject 6.

UMWELT

Before

Q Is this the only person that you have seen personally. A Ja,

I'm keen to take pictures.

I have had a lot of blood tests that are positive, but I haven't physically, personally had to deal with them.

Q Have you examined anyone else who you knew to be HIV-positive. A Well, when I was in another African country, I saw them walking around with these very thin faces - presumably this is what they have. At the hotel there was a guy who helped us with the boats and I looked at this guy's neck. It was obviously hot, he had a tee-shirt on and there were very big glands. I said "Let me feel", and Jesus -

but you know the language wasn't - communication wasn't all that hot, but what I did establish was that he had lost a hell of a lot of weight. So he has got AIDS Related Complex, he has got these huge glands,

During

Q Under what circumstances did you first come into contact with an HIV/AIDS infected person. A It was out of curiosity: there was a woman in the maternity hospital who had just had a baby - it was purely out of curiosity that I went to see her;

Q You knew that she was positive before you saw her. A Yes.

Q Was she on treatment. A No, they don't have any of the fancy stuff here. Q AZT. A They have AZT, but it's only for the doctors: if you prick yourself you can ask for AZT. Q So they don't normally give it to patients. A I doubt it.

So I popped in there with the sister... I didn't physically let her lie down so that I could examine her.

I went and looked at her in hospital and there was this very thin anaemic-looking woman, glands in the neck swollen, um...

Q The baby hadn't been tested positive. A No, not at that stage, because they were still waiting, the woman had just had the baby but the blood test was positive later on.

UMWELT

Before

U This was the only HIV-positive person seen by S.

U S was eager to take photographs of this case.

U In his professional capacity S has encountered HIV-positive blood samples without attending to infected individuals as such.

U During a visit to another African country, S encountered various individuals who showed classic signs of HIV infection.

U Despite the language barrier S was able to conclude that a particular individual exhibited signs of ARC.

During

U S went to see the HIV-positive person.

U S was aware of the patient's HIV status before the event.

U According to S, AZT therapy is not normally readily available for infected patients, though it is available to doctors who are exposed to the virus.

U S's visit to the patient was brief and did not involve a physical examination.

U S visited the patient and observed a thin and anaemic woman with swollen glands.

U S states that the patient's child later tested HIV-positive.

Q Clinically were the symptoms much the same as you expected. A Yes. Q Was she in the final stages. A I don't think final, she didn't have any of these funny infections at that stage, she was just very thin with glands, so she really has the AIDS Related Complex, not the fully... she hasn't got the immune disease deficiency part yet.

Q When you say you wanted to satisfy your curiosity, what was it that you were curious about. A Well, you know, we do treat a lot of STDs and AIDS is one of them, so you know I felt it was part of an ongoing education process

and I am quite keen to go and see the other girl who is going to be back in West Wing in about a week, I believe. I would like to take some slides you know, it is part of an education process.

Q You feel it is important for you to keep abreast of this, would you say, especially in this region. A Yes.

Q You went into this situation knowing that you weren't going to touch this person. A No, I don't feel strongly about not touching. Q If you knew that you were going to examine her physically. A I might have even touched her - I can't remember.

After

and well, it doesn't worry me touching them as long as I know that my skin is intact. I don't have a problem with that.

Q You don't do surgery. A I do, that is the worrying part.

Q During surgery do you take all the necessary precautions. A We do, but you know, is it enough - I mean if you pierce your finger with a needle.

So... I must say, if one thinks about it...

I normally try and arrange my time so I get there first and get the anaesthetic. I'm not keen to operate anymore.

You know, that is where this comes in: you have to operate on people you've never known before, you've never met before, emergency situations, mostly Caesareans. You might be dealing with HIV positives,

Um... you've got to wear those bloody plastics - you look like a space-invader [laugh]. Plastic goggles, two pairs of gloves, and plastic aprons and so on.

U S diagnosed the patient to be in the AIDS Related Complex (ARC) stage of the disease process.

U S's curiosity with regard to the patient's disease related to his educative interests in the field of sexually transmitted diseases.

U From an educational point-of-view S is eager to take slides of another HIV-positive case who is a patient in the hospital.

U S feels that it is important to record the local incidence of the disease.

U S declares that he is not concerned about touching an HIV infected person and in fact - he cannot actually remember - he might have touched this patient.

After

U S is not concerned about physically examining a person for HIV infection, so long as the surface of his skin is intact.

U S is a surgeon and with regard to AIDS this worries him.

U S takes precautions during surgery but is doubtful as to whether these are sufficiently effective.

U S considers his high-risk position.

U When involved in surgery S arranges his time so as to take on anaesthetic duties rather than surgical duties.

U S reiterates his concern over his high-risk status with regard to emergency surgery or patients who are HIV-positive.

U For S the extra precautionary paraphernalia due to HIV/AIDS that is now a part of surgical procedure is annoying.

Q Do you find the quality of your operations is impaired by all these precautionary paraphernalia. **A** No, no. The gloves are very thin, very easy for a needle to go through.

Q Has that happened. **A** I pricked myself, last week when I was doing a Caesar. That was on a private patient. Now the chances are that she can also have HIV but they are very small.

The time will come when routine HIV testing is done before surgery. If you know that you are going to be operating on some-one for some or other thing in the future, you are going to test them.

It has already changed: you don't touch the patient where before you weren't really... I mean, I'm not scared of blood... but before you weren't very worried, but now I put bloody gloves on before I do anything.

Q Do you carry gloves in your car. **A** No... I must [laugh]. I've also got one of these things for giving mouth-to-mouth ventilation without coming into contact with blood or saliva, but since I've bought it, it's being lying in the surgery, I haven't put it into my car... it's important that I do.

Q How do you feel about having to deal with AIDS on a very large scale in future. **A** Ja, I thought about it yesterday actually, we're going to have to be speaking to guys in our surgery, sitting in the waiting rooms, lying on our beds, sitting in our clinics.

We are just going to have to be really sharp about the way we deal with disposing of our needles, linen and that sort of stuff. It's going to be a hell of a thing if it ever gets to that extent.

But now, as well as the patient, this also threatens me.

It's bloody frightening man.

so really if you start getting technical about it, it really is frightening.

Q When you take blood do you take full precautions. **A** No, I really don't think it is necessary, you know, you don't touch... This whole new system with a vacuum, you just stick the needle in and attach the tube. You don't come close to the blood, you just put the thing on the back, it's all sealed. There's no blood on your or anywhere near you.

So I think that's overdoing it. **Q** You don't wear gloves in those situations. **A** No, sometimes I might but I think it's overdoing it.

U S is sceptical of the effectiveness of HIV/AIDS precautionary paraphernalia.

U Recently whilst performing a Caesarian section on a private patient S incurred a needle-stick injury; although S acknowledges the patient could be HIV-positive, he perceives the risk to be small.

U S predicts routine testing for all before surgery, in the future.

U From a personal point-of-view the presence of HIV/AIDS has caused changes in S's medical procedures. He now uses gloves where he would not have in the past.

U S does have access to precautionary paraphernalia; he acknowledges the importance of carrying these items such as gloves and ventilators with him, but does not do so at present.

U S recently considered the future scenario that will arise as a result of HIV/AIDS. S sees an influx of patients into the health care structures.

U If HIV/AIDS reaches major epidemic proportions S foresees a lot of problems. However, he proposes that very stringent precautionary measures will be necessary if this is the case.

U S feels threatened by both an increase in AIDS cases and having to attend to AIDS patients.

U HIV/AIDS is an extremely frightening disease for S.

U A close look at the potentially disastrous effects of this disease creates in S a strong fear.

U S does not wear gloves when taking blood. This is because he feels that the new blood-taking procedures are safe enough and do not warrant further precautions.

U Generally S feels that the wearing of gloves during the blood-taking procedure is an unnecessary precaution.

Q Do you use gloves for those physical examinations where you come into contact with body fluids. **A** Ja, I use obviously... I don't think it's because of AIDS... I've always used gloves any of the internal examinations, even if I am feeling inside someone's mouth. I've always worn gloves for that sort of thing, I don't know, that's how I feel about it, especially when feeling someone's gums or whatever. That hasn't changed at all.

For other things like cutting an abscess open, before I wouldn't have worn gloves but now I will put gloves on. So if I do incisions, cut into someone or do stitches, whereas before I wouldn't use gloves, I do now.

Q Do you see the prevalence of AIDS to be proportionally higher in blacks than in whites. **A** We have had no cases in the white group to date, they have all been black, about 30 or so HIV positives.

It's terrible, I mean, when you see somebody with a terminal illness like AIDS, who is dying or is going to die, when you see the individual it is terrible.

I probably won't take precautions with a cancer patient but talking to them would be the same, I'm not scared or anything like that.

MITWELT

Before

Q Had you examined this patient at some stage prior to this incident. **A** No.

in this case I was not personally responsible for the person.

Q The incident with the mother and child, could you explain to me what happened in that case. **A** I don't know if she is still alive - she was quite sick at the time. I went out of curiosity to see her because I haven't personally had contact with an AIDS patient before.

there was a girl at the West Wing now at the moment which I also haven't seen but I have asked the sisters to get hold of her. You see she comes to West Wing periodically and then goes home again. I've asked them to bring her to the clinic or I will visit her at the hospital,

During

Q Could you describe to me physically what happened that day. **A** I had known she was HIV because of the ante-natal clinic, the guys told me that there was a woman with very strong positive HIV who was going to have a baby.

U S has always used gloves for internal physical examinations even before the advent of AIDS. in this regard, the presence of HIV/AIDS has not changed anything.

U For other procedures, such as various types of incisions, S now uses gloves whereas before he would not have. This is due to the presence of HIV/AIDS.

U According to S the local district has not recorded any HIV/AIDS cases in the White population group. The 30 or so cases reported have all been from the Black population group.

U On an individual level S perceives HIV/AIDS as a terrible terminal illness.

U S would deal with cancer and HIV/AIDS patients in the same way although he would not take the same precautions with a cancer patient as he would with an HIV/AIDS patient.

MITWELT

Before

M S had not examined the patient before this encounter.

M S was not responsible for this person.

M During S's first encounter with an HIV infected person, which was motivated by curiosity, he perceived the patient as being unwell.

M S requested the hospital staff to assist in co-ordinating a meeting between himself and an HIV-positive person who is currently being treated.

During

M S's awareness of the patient's HIV status derived from his relation with the ante-natal clinic staff.

I was in the hospital, in the ward one day - I don't know what I was doing there - one of the sisters asked me who was going to deliver this baby, can they refuse, I said "No you can't, you must do it", whoever is on duty that night, or whatever time. There was a bit of an argument: they were going to refuse or run away when this baby was due.

Then one morning I was just there and somebody said to me she delivered last night, this woman, and a certain sister delivered her, so out of curiosity I went around and asked the sister how she was, she said it went OK, there was no blood spilt or anything like that. I said "Do you mind if I have a look at the patient" so we just popped in and we weren't there for long.

Q The patient was looking sickly. **A** Yes... she was OK, but she was very thin.

I didn't want her to feel awkward, I didn't want her to wonder why there are such a lot of people all of a sudden visiting her. **Q** She knew that you were a doctor. **A** She must have, I must have had a stethoscope around my neck.

I didn't know if she knew what the implications were of this disease, I didn't know whether she even knew that she had it.

Q Did you speak to her. **A** No.

Q Why was that. **A** Well, for one, I don't speak the language all that well, I can speak some basic stuff;

and also I didn't want to make it a big deal for her that I am popping in to see her. Because I didn't know how much she actually knew about it, I mean the whole hospital was humming with this patient, but I didn't know how much she actually knew.

It does go through your mind that this person is not going to live for very much longer.

Q Did you perceive her differently from any other terminally-ill patient. **A** No.

The tragedy was that she was a young patient first of all; and she had a baby, which in my guess could have been infected as well and might be without a mother very shortly.

It was just like I said, it was tragic to know that this was a young case with a terminal disease and she had a baby.

M S explains the reluctant attitude of the hospital staff towards the impending delivery of a potentially infected child from an HIV positive mother.

M S was informed of the birth of the child. S visited the patient briefly after she had experienced a relatively straightforward delivery.

M S observed that the patient was looking unwell.

M S did not want to cause the patient any undue worry or alarm. S declares that the patient must have been aware of his status as a doctor.

M S was unsure of the extent of the patient's knowledge of her condition.

M S did not speak to the patient.

M One reason for S not communicating with the patient was his limited knowledge of the language.

M Because S did not know how well the patient understood her condition, he was careful not to make an issue of his visit.

M During this encounter S had thoughts relating to the fact that the patient would die soon.

M S perceived this patient in the same way he would any terminally ill patient.

M Because of the young age of this patient, together with the fact that she had recently given birth, S perceives this case as tragic.

M S reiterates the fact that he perceived this case as tragic because the patient was terminally ill and had recently had a child.

After

Q In those cases where the individual's blood test is positive, have you spoken to any of these people. **A** No, you see in my situation the hospital lets me know, this patient is positive, and then I inform my sisters.

there is normally a doctor at the hospital, a hospital doctor on call and then us GPs provide a second and a third doctor. A second doing an anaesthetic and a third assisting.

Q Do people ever show any awareness of the fact that you are in a high-risk group. **A** No.

Q Do you think this may happen one day. **A** Yes, I'm bloody well sure.

So I will happily carry on with medicine the way I am doing it, if I can stop surgery, I will do anaesthetics but surgery and of course obstetrics, delivering babies, I can also do without.

Q Has the meaning for you of being a doctor had to be re-evaluated or re-assessed in any way. **A** Well you know, in America the guys don't stop at an accident, a road-side accident, anymore, especially when there is a lot of blood about. One doesn't stop, or those guys don't, and I must say that's what has changed.

Q How do you feel about all this in relation to your family. **A** I've often thought about it, I've often thought about it. You know it's going to be difficult, or it's going to be different rather.

Q Has your wife expressed any concern about the fact that you constitute a high-risk group and that your work is potentially very risky. **A** My wife often helps me and often gives me hell when I am handling things I shouldn't be handling, and she says, "Please, your gloves, your gloves!". I wouldn't say it's pressure, but obviously concern about it.

You know my daughter is fifteen and I think she's a very beautiful girl. She is coming to the stage now where she is going to be sexually active in the next couple of years... and one doesn't know how much, you know, that is going to affect people's sexual relationships.

I've often... I've sent her some brochures and stuff on AIDS you know... so that at least she is completely - the choice is hers but I mean I would like her to be completely informed about this disease... ja... .

After

M S has no direct contact with infected individuals; positive results are directed to S through official channels, S in turn informs his staff.

M S explains that the role of the general practitioner during surgical procedures at the hospital is to attend and assist a full-time hospital doctor.

M People have not shown an awareness of the fact that S is part of a high-risk group.

M S strongly believes that in the future people will become aware that he is part of a high-risk group.

M In the face of AIDS, S is content to continue consulting in his rooms but is not enthusiastic about surgery or obstetrics.

M S uses the example of how American doctors no longer stop at road-side accidents, to make the point that HIV/AIDS has influenced and changed the medical profession.

M S has thought about the influence that the AIDS epidemic will have on his family.

M S explains how when his wife assists him in his clinic she frequently admonishes him for not taking precautions. To S this is a show of her concern for him and the risk involved in his work.

M S expresses his concern for the safety of his daughter whom he perceives as being close to the sexually active age and therefore at risk of contracting HIV/AIDS.

M S has attempted to educate his daughter as far as possible about the risks of HIV infection.

My other daughter is eleven and the youngest is still too small to discuss anything like this.

Q And with regard to yourself contracting this disease in relation to your family. **A** One of my colleagues said that, you know, if you get HIV through a needle stick, your practice will be gone if people find out, you might not die for another ten years, keep yourself going with AZT and all this fancy stuff, but the point is your practice will be gone, people... I don't think people would come of course. You would have to stop right there and then where you are at,

Q Has this experience caused any adjustment to your relationship with patients, colleagues, or other people. **A** No.

Q When you saw the mother and her child did anything change for you. What I mean is has your perception of HIV infected individuals changed as a result of this experience. **A** No. This incident was just confirmation of what I already knew.

Q Do you think that your experience of people with AIDS has in any way affected your interaction with people in general. **A** Ag, you might be asked about it often and you weren't before, yes, ja one might have questions about it socially, it doesn't happen daily. People often ask me, how many cases there are in this town.

Q You have obviously discussed these AIDS-related issues with your colleagues: has anything significant come out of this. **A** No. Our views are much the same.

Q Have you discussed the issue with any other Health Care workers. **A** We often have discussions and meetings about it. The purpose being to educate, to talk about AIDS and to help the workers protect themselves.

Q So these discussions attempt to educate with regard to staff taking precautions. **A** We've always given them Hepatitis B injections, all our sisters,

but I would hate one of my sisters to contract AIDS through dealing with a patient and then sue us for half-a-million, or something like that, which is possible.

So when certain things like journals, circulars and so on come through from State Health, I make them read it and make them sign it so at least they have known. They know what to do, which precautions to take and if they don't it is through their own negligence.

M S has another two daughters. One of these is too young for discussion on the topic of AIDS.

M Through a discussion with one of his colleagues S is aware that if he becomes HIV infected he may live for ten years, but his practise will collapse because people would no longer use his service for fear of contracting HIV from him.

M S states that his encounter with an HIV positive person has not caused any adjustment in his relations with patients, colleagues and other people.

M S states that his encounter with the HIV infected individual and her child has merely confirmed what he already knew.

M For S the increased presence of HIV/AIDS has given rise to more questions from the public being directed to S. In this way, S's interaction with people in general has changed.

M S claims that his views on AIDS-related issues are similar to those of his colleagues.

M S often attends formal meetings and discussions with other health-care workers on the topic of AIDS education.

M S indicates that his nursing staff have always had access to Hepatitis injections.

M With regard to education about precautionary measures, S states that he would not like one of his staff to become infected and consequently sue him for not providing a satisfactory education programme.

M To ensure that his staff are adequately informed, S makes a considerable amount of literature available for their perusal. S ensures the staff sign their name after they have read the literature: this way they are responsible for their own safety.

Q Do you discuss AIDS with your patients at all.
A I do actually, I often talk about it to younger guys, I don't know whether they listen.

Often in the clinics we see the same people with the same STD time and time again, then I feel it is important they should be told and spoken to about AIDS, especially when they attend the clinics for venereal diseases often.

Q Only when patients show signs of STDs do you talk to them about AIDS.
A No, the door is open; if anyone wants to ask any questions then they can. We have had meetings in the Town Hall; I've had the guy who is big on AIDS come and speak for us, but that public lecture wasn't very well attended; there have been one or two articles in the papers, so you know we try to tell the people about it.

I am also supposed to be an advisor in my position, so if a school or a church comes to me, I don't want to look like a bloody fool if somebody asks me a question. We are supposed to be able to assist and answer questions for these organizations.

Q So part of your role includes giving informative talks, the role of an educator.
A Yes.

Q Has your relationship with your patients changed in any way as a result of AIDS.
A No, not yet. If I practised in San Francisco or Los Angeles then maybe ja.

Q Do you see AIDS as belonging to certain high-risk groups. Has your experience with this woman and her child influenced this perception at all.
A She was probably a prostitute,

these groups are a reality. However, the majority of black people with HIV are heterosexual, so it covers the full range, the whole lot.

Q Do you find that of the people that come into your surgery you perceive some of them to be more high-risk than others.
A We often are requested by patients to do HIV tests.

Q When you think of AIDS sufferers what sort of attitude or feelings come to the fore.
A I feel neutral, I don't have any negative things about it.

I don't particularly ask a person if they come to me, whether they are gay or whatever. I have a lot of patients who I am quite convinced are gay. I don't condemn them but I also don't necessarily agree either, they don't know what they are missing.

M S does attempt to inform his younger patients, especially the men, about the risks of HIV infection

M S attempts to educate those patients who repeatedly return with sexually transmitted diseases about HIV/AIDS.

M S is available to answer questions about HIV/AIDS at any time. S has organised meetings, public lectures and newspaper articles in an attempt to increase awareness about HIV/AIDS. The public lecture was not well attended.

M Part of the reason S has endeavoured to educate himself on the topic is because he is often expected to play the role of advisor in the community and is asked to speak at schools and churches. For this reason he needs to know the facts.

M S perceives himself in the role of an educator in the community.

M S states that his relationship to his patients has not changed as yet. If he were working in San Francisco where the numbers are greater then perhaps his relationship would have changed.

M S surmises that the patient he saw was probably a prostitute.

M S sees high-risk groups as a reality. However, HIV/AIDS according to S extends beyond these risk groups into the whole population, especially in the Black population.

M S is often requested by his patients to do HIV tests.

M When S thinks of AIDS sufferers his attitude is neutral and he has no negative feelings.

M S does not openly ask those patients whom he suspects to be gay whether they are or not; furthermore S neither condemns nor condones their behaviour, he just feels that they don't know what they are missing.

But you are often asked, the guys come in and they want HIV tests.

Q Do you become suspicious that they are gay. A Yes, that's right.

We have all got a lot softer about this in our attitudes, well I certainly have. I've never been intolerant, but maybe intolerant in my own mind about it or condemned them in my own mind,

I do think uh... this guy might be homosexual, because those are the guys that normally ask, but we have a number of other guys asking too.

The one guy, some-one wrote him a note on his windscreen in lipstick, "I have AIDS"... . It was a joke but the guy got such a bloody fright he came to my house on a Saturday afternoon, he was pale, I said it was a joke and it turned out to be a joke in the end... but it was a sick joke. I had to take blood from [him] on Monday morning early so that it could go to the lab. The fact that there is a window period didn't worry him, he didn't know about it. As soon as the blood test came back negative he was fine.

Q How do you perceive your role as a doctor in relation to the negative attitude that Society holds towards AIDS sufferers. A I haven't thought about it much.

EIGENWELT

Before

During

Q Could you describe that situation in more detail. A It was no big deal really,

we've seen terrible things in our lives so... .

Q Can you describe to me your feelings during this encounter. A It wasn't a shock, it wasn't a shock, I've seen many pictures of AIDS, films and slides and stuff. It wasn't a shock.

Q You said that you went into this experience with a certain understanding of the AIDS disease built up through photographs, reading and so on. Did this experience present anything different to what you expected. A No.

After

Q Do you deal with all terminally ill patients in the same way. A Ja, I would do the same,

M S is often asked by men to test them for HIV/AIDS.

M When men ask S for HIV tests S suspects they might be gay.

M S states that most people, and especially himself, have grown more tolerant of homosexuality. He states that he has never been explicitly intolerant of others, though he has perhaps held certain prejudices in his own mind.

M If a person requests an HIV test S may suspect that he is homosexual because these are the people that normally ask. However, heterosexual males also request tests.

M S relates an incident to make his point about the fear that AIDS instils in people. In this case a person's partner wrote "I have AIDS" on his car windscreen in lipstick. The person's reaction was of intense fear and S had to allay this fear by taking an immediate blood test. The test recorded negative.

M S has not considered his role as a doctor in relation to the negative attitude held by Society towards AIDS sufferers.

EIGENWELT

Before

During

E For S this encounter was straightforward.

E S indicates that doctors are used to witnessing extreme medical cases.

E S states that this first experience with an HIV-positive person did not shock him. He knew what to expect.

E S's encounter with an HIV person did not present anything different to that which he had expected.

After

E S is used to, and not afraid of, dealing with terminally ill patients.

I will happily consult at my surgery which is something I enjoy. I don't - not all that surgically inclined in any case, for other reasons as well, it's always in the bloody middle of the night and I work on my own so the next day is even longer when you're half-tired, having operated in the middle of the night.

Q How do you deal with the fact that you constitute a high-risk group and that you are having to perform surgery. **A** I am in private practice because I enjoy it and I don't want to be a hospital doctor, but that is part of our part-time duties as a doctor: we have to be on call for the hospital.

I must say that is something that I don't enjoy all that much anymore. When I was younger and so on I did a lot of surgery, but I'm not keen on operating any more, for that reason - well, one of the reasons.

Q Generally how do you understand the impact of AIDS. **A** There are going to be a hell of a lot of people dying from AIDS in the next ten years. Um... this might be a way of controlling... I really believe that us medical people have disturbed the balance of nature by treating - don't quote me out of context here - by treating measles infections, re-feeding malnourished children and educating people about the re-hydration of gastro, which is wonderful - but we didn't at the same time do something about the other area which is population explosion, it is completely out of balance;

if you look at curves, population growth curves, it's frightening.

This might restore the balance, if you read old Edelson's book, *Countdown to Doomsday*, it's going to... If that's going to be true or not I don't know, I think we're going to see a lot of AIDS. In Malawi 30% of people who are sexually active appear to have AIDS.

When you see it in the broader context - call it God, call it Nature - Nature might be using AIDS to keep the figures of our population down, back into a balance. **Q** So you see this as a way of balancing things out. **A** Yes.

Q How do you see this scenario affecting your and your family in the future. **A** You know, I've often thought about it and one doesn't know... .

I enjoy medicine and I will continue practising, I might change the profile of the work I do, I might... if AIDS becomes more and more prevalent and I get put off by what's happening at the hospital, I might get out of hospital work and just do consulting work. I think I will be around for a long time still.

E S is content with consulting at his surgery and prefers this to surgical work which involves long hours and increased risk.

E S enjoys private work above hospital work, though he acknowledges his duty to the local hospital.

E As S grows older his enthusiasm for surgery has declined. The presence of HIV/AIDS has contributed to this attitude.

E S believes that modern medicine and its practitioners have disturbed the natural balance of the human population. By attending to only one aspect - saving lives - they have exacerbated the high population growth rate.

E S is alarmed by the population growth rate.

E S refers to the source *Countdown to Doomsday* to support his theory that AIDS may restore the population balance. Although he is not certain that this book's predictions are correct, he foresees a considerable increase in the incidence of AIDS in the future.

E S reiterates his belief that some greater force may be responsible for the introduction of AIDS in an attempt to control population growth.

E S has often considered his own and his family's position with regard to future doomsday predictions of the incidence of AIDS. S is uncertain of the outcome.

E The increased risk which is presented to S by the presence of HIV/AIDS may influence S to stop working in the hospital. However, S would still remain within the medical profession and would focus on consulting duties alone.

Q So you would try to move away from direct surgical work. A Yes.

Q What are your own feelings about being in a high-risk group. A Not a nice thing to think about, but yes, I am very aware of this, very aware.

Ja, you know it's always the inevitable thing, you think ja, it won't happen to me, it will happen to the other guy - that's human nature... . Yes, I have thought about that but I can't, I haven't particularly thought...

but I am always saying to myself be bloody careful because you might get it. That means that I have thought about it but that's all that I can say. There is not much you can do apart from take precautions or get out into another job.

Q Would you do that. A No, I enjoy medicine.

Q So what you are actually saying is that you see yourself as having to re-define your role as a doctor in the future. A Yes.

Q Psychologically, having to face this every day, will this have any influence on you. A It won't worry me, well I wouldn't say it won't worry me, I'm used to it.

I think sensible people are going to have to be extremely careful. I don't quite know, but I have often thought about it,

Q Do you see yourself as a GP being given enough opportunity to learn about AIDS and AIDS precautions. A It's up to you. I had to get to know the disease and read books and so on because of my position.

Q So certain things have changed as a result of AIDS. A Yes.

but I've become accepting of the whole thing now so I don't... .

Q What do you feel about Society's view of AIDS that sees AIDS sufferers in a stigmatized way. A All I can say... . I don't think AIDS is sent by God but I think, I don't think that everything pertaining to the so-called massive epidemic that we are going to see is necessarily negative, because it might... .

E In the future, S would try to move away from direct surgical work.

E S himself is very aware that he is part of a high-risk group. This reality is not pleasant to confront.

E S explains that like any human being he believes that he will never contract HIV/AIDS. For this reason he has been unable to realise the full implications of the disease as it pertains to him.

E S has thought about his high-risk position and acknowledges the seriousness of it to himself. However, apart from taking the necessary precautions or leaving his job, there is little he can do.

E S enjoys his profession and would not leave it.

E S sees himself as having to redefine his role as a doctor in the near future.

E S acknowledges that the AIDS epidemic will affect him psychologically but feels that he will be able to deal with it as he is used to it.

E S is not entirely sure of the risk posed by the disease. However, he feels that sensible people are going to have to be very careful in the future.

E S feels that it is up to the individual to educate himself about HIV/AIDS. S felt obliged to educate himself because of his profession.

E Certain things have changed for S as a result of HIV/AIDS.

E S is now more accepting of homosexuality.

E S does not perceive HIV/AIDS as divine retribution; he does not see the epidemic as totally negative because it may restore the population balance.

Subject 1.

UMWELT

Before

Immediate context

U This was S's first concrete AIDS-related experience.

During

Immediate context

U During the mouth-to-mouth resuscitation procedure, the child vomited into S's nose and mouth.

Precautionary behaviour within the context of HIV/AIDS

U S states that standard precautionary procedures advise doctors to use gloves when they are taking blood.

U S does not use gloves to set up a drip. Furthermore, he is sure most doctors do not.

U S explains that under normal circumstances, resuscitation equipment with suction apparatus and oxygen would be used to avoid an incident such as he experienced.

The meaning of personal risk in the context of HIV/AIDS transmission

U S does few operations, so is less at risk than his colleague.

After

Changing meaning of HIV/AIDS through the experience of a concrete encounter

U S is more cautious now as a result of his experience; apart from this things have not changed much.

Meaning of behavioural practices in the context of potential HIV transmission

U S uses the presence of a sexually transmitted disease as an indicator of whether a patient is at risk to HIV or not.

Emotions engendered by the presence of HIV/AIDS in Subject's experienced world

U Were S to contract AIDS, his reaction would probably follow the classic stages of denial and repression.

U During this period S felt some fear, and part of this fear is still with him.

U S thought of this incident at night, but this phase did not last for long.

U S believes that whatever comes has to come, it is no use worrying unduly.

U S explains that it was only for the one day that he felt doubt; this feeling did not last for long.

U When S considers the concept of AIDS it instills fear and dread in him, in the same way it would anyone who is informed about the disease.

U S perceives the HIV/AIDS problem in his local area to be serious.

Precautionary behaviour within the context of HIV/AIDS

U S will use gloves when examining a patient.

U If S was not doing a physical examination, he would not be over-reactive.

U If S came into contact with some-one's body fluids whom S knew to be free of HIV then S would maintain ordinary hygiene procedures and not worry.

U S uses gloves for every examination.

U S takes precautions with every patient. After examinations he washes his hands with disinfectant, and uses gloves, which has always been part of his routine.

Subject's statistical understandings within the context of the HIV/AIDS disease

U S states that the incidence of sexually transmitted diseases is rife and this is due to over-population, over-crowding and poor socio-economic conditions.

Subject's experience of a patient as HIV infected

U S would not be antagonistic towards an HIV-positive patient and would not be afraid: he would just make sure to take precautions.

U When S knows the patient is HIV-positive, then he is extra careful - he may wash his hands twice.

The meaning for the subject of the body and its parts in the context of HIV/AIDS

U S would try to avoid contact with the body fluids, especially blood. With regard to injections and other risky procedures, S would be extra cautious.

U S does not feel that during surgery he will respond differently to large quantities of blood, on account of this experience.

U S explains how during everyday procedures he does come into contact with lots of blood. In these cases - such as incomplete abortions or deliveries - he uses gloves. However, he still comes into contact with some blood.

U S is not afraid of coming into contact with blood so long as his skin surface is intact.

U S explains that for vaginal, rectal and similar examinations involving a lot of blood, the wearing of gloves has always been routine procedure.

MITWELT

Before

Knowledge of patient's HIV status

M S did not know that his patient - a child - had AIDS.

Relationship between subject and patient in 1st encounter

M S relates the circumstances surrounding his first encounter with an AIDS sufferer. The child was seriously ill, to the extent where S felt it necessary to take the child up to the hospital himself.

M When S arrived at the hospital the child stopped breathing. He called for resuscitation equipment and in the meantime applied physical mouth-to-mouth resuscitation.

During

Feelings evoked in relation to others

M When S learnt that the child and mother were HIV-positive he did not feel anger, but rather pity for them both.

Relationship between subject and patient in 1st encounter

M S applied mouth-to-mouth resuscitation whilst waiting for the resuscitation equipment to arrive. However, the child was unconscious and S's efforts were in vain.

Subject's perception of colleagues' response to HIV/AIDS

M S recalls stopping his assistant from reprimanding the mother for not revealing her child's HIV status to S.

Subject's relationship to known HIV infected patient

M S completely understands why the mother did not reveal the fact that she and her child were HIV-positive. S understands that the mother was desperate to save her child and by informing the doctor of the child's condition she may have suspected the doctor would then not help her.

M S reiterates that he can understand the mother's behaviour concerning her child: most mothers would react in the same way.

M S felt pity for the mother and her child and he does not blame the mother for her behaviour.

After

Concrete presence of HIV-positivity in subject's known-about world

U After S had administered the resuscitation procedure to the child he was informed that the mother and child were HIV-positive.

U S states that he has sent very few patients to the hospital who he suspected had AIDS. He has had few responses.

Education of patients

M S attempts to educate his patients. However, although he recognises a degree of concern in these individuals, he sees this concern as temporary.

M S believes that his patients' concern for HIV may be very brief and temporary. *S* feels that something more in terms of education needs to be done.

M S states he attempts to educate every patient he perceives to be potentially at risk.

M S's patients do respond to his educative procedures.

M S reiterates his concern over the fact that his educative efforts with his patients are often very short lived.

Education of public

M S feels that a strong emphasis needs to be placed on education which is aimed at sexually transmitted diseases. The incidence of sexually transmitted diseases is high and this is a reflection upon sexual practises.

M Education aimed at teaching people about high-risk behaviour and sexually transmitted diseases, including AIDS, must have first priority according to *S*. People need to know the seriousness of AIDS.

M People have not as yet been reached - and subsequently influenced - by standard education programmes.

M People, patients and society as a whole are free to make their own decisions. However, *S* feels that these people must be informed of what they are facing.

M S thinks that various members of the community must become aware of HIV/AIDS and become involved in education.

Feelings evoked in relation to others

M Although *S* felt some fear after talking to his colleagues, it was not significant enough to cause him to have sleepless nights.

Influence of others/Professional

M S feels that he is adequately informed with regard to the AIDS disease.

M According to *S*, HIV/AIDS information for doctors in the future will derive principally from formal medical journals and perhaps even the media itself.

Influence of others/Society

M S does not think that the general perception held by society towards AIDS sufferers will affect the way he relates to his patients.

M S feels that people should be adult enough to hold their own views and make up their own minds, rather than follow the general view of society.

Influence of others/Media

M S agrees with the pessimists who predict an enormous increase of HIV/AIDS in South Africa.

M S reads the media reports on HIV/AIDS. However, he does not allow the opinions expressed in these reports to alter his own views.

M S is sceptical of media reports that see AIDS as a male problem; he understands that this may stem from the high incidence in male homosexuals, but states that heterosexual males can also contract the disease.

Influence of others/Colleagues

M S agrees his colleagues' views did affect him later on.

M S states that his colleagues instilled a certain amount of fear in him.

M S agrees that his reactions towards HIV/AIDS are influenced by his colleagues' views.

M One of *S*'s colleagues told him that he would not bother to test himself for the HIV virus, given the potential consequences for doctors who test positive.

M S developed a certain amount of fear concerning his exposure to the HIV virus after he had spoken to a few colleagues who took a more serious view of the incident.

M After discussing the incident with his colleagues, *S* was advised by them to have a test even though the perceived risk was small.

M S refers to a time when there was an AIDS scare at the local hospital. All the hospital doctors advised the other doctors to wear gloves for taking blood and putting up drips.

Modification of relationship to HIV infected patients subsequent to encounter

M S will relate differently to patients in his care who are HIV-positive, than to those who are not: this attitude is directly related to his experience with the HIV baby.

Modification of relationship to patients in general subsequent to encounter

M S has not stopped playing with the children that come into his surgery.

M S continues to treat his normal patients in the same way as he did before the advent of HIV/AIDS. He uses gloves where necessary.

M S does not relate differently on the whole to his patients because of the presence of HIV/AIDS.

M On a psychological level S finds that his attitude towards his patients as a result of his experience has not changed.

M Although S has become more cautious with his patients he has not changed radically and has not become paranoid.

M S states that the way he perceives and deals with patients has changed very little as a result of his experience.

Modification of interaction with others subsequent to encounter

M S does not see his relationship with his colleagues as having undergone significant changes as a result of this experience. Their concern during this period was for S himself.

Perception of professional role in relation to others

M S feels that although medicine is commercialised to a certain extent, the basic goal of caring and comforting the patient must not be compromised and doctors must not put their own safety above the care of the patient.

M S understands that doctors are human, their views are different and therefore they may hold different views with regard to the concept of the patient's needs having priority above those of the doctor's.

M S's colleagues will probably all hold different views on the topic of patient's versus doctor's needs.

M S perceives doctors as individuals who have different personalities. They are therefore influenced differently by the media, family, and friends. Some doctors place their own self-interest above their expected role as a doctor.

M S believes that medical students must be educated to deal with AIDS patients as normal human beings. While students must take the necessary precautions, they must show the same amount of compassion they would to any terminally-ill patient. They should not see an AIDS patient as a pariah.

Perception of changing role in relation to others

M In terms of his role as a doctor, S sees HIV/AIDS as being more of an issue in the future.

Precautionary techniques in relation to professional procedures

M Were S's skin surface broken and he came into contact with a person he thought was HIV-positive, he would be very cautious.

Professional interaction with colleagues

M When S discussed the incident with his colleagues later, they indicated that they felt that he should have taken medication soon after this incident: he should have started a course of AZT.

M S discussed the incident with one of his colleagues at his home.

M S would like to see some sort of system whereby doctors could meet to communicate, and discuss their patients who are HIV-positive. This would be an attempt to avoid a similar event such as that which S experienced.

M S does not think that there is any system working at the moment which has as its aim the safety of the general practitioner. Most systems are aimed at information.

Relationship to family in the context of HIV/AIDS

M S finds the concept of being a father who is in a potentially high-risk group very frightening.

M The thought did occur to S that because of his high-risk position, his children and his wife were vulnerable.

M S has considered his relationship to his family with regard to the fact that he is part of a high-risk group.

Subject's perception of colleagues' response to HIV/AIDS

M After the incident S discussed the matter with his colleagues. They held a more serious attitude towards the incident than S.

M One of S's colleagues suggested to him that with the presence of HIV/AIDS, medicine was now a very high-risk occupation compared to other sorts of work.

M S recalls his colleague saying that he would rather do another job than risk his life every day.

M S states that his colleague may be more at risk with regard to HIV/AIDS than S because this colleague is in the hospital and involved in more surgery than S. This may be why his colleague holds such a strong view.

M S predicts in the event of his contracting AIDS and having to work in another area of medicine, it would be no longer be the public's but rather his colleagues' attitudes that he would have to contend with.

M At the time of discussion, S's colleague agreed that the chances of infection were very slim.

M S's colleague did, however, suggest that S have an AIDS test on a regular basis.

M One of S's colleagues was extremely angry with the mother during the incident where S was exposed to HIV. S felt that this was unfair of his colleague.

M S surmised that his colleague may have felt responsible for the event as he was the hospital doctor originally treating the case.

M S relates how his colleague persistently explained that he had frequently informed the patient to reveal her HIV status to every doctor she saw. The colleague was angry and unable to understand why anybody should act in such a way.

M S feels that his colleagues would behave in much the same way as himself: they would take the normal procedures and use gloves for examinations.

M S refers to a case where an HIV-positive woman was due to give birth. The hospital staff were reluctant to be involved, consequently a doctor was called upon to perform the duty. S got the impression that in this case his colleague was reluctant to perform the duty; S attributes this to fear on the part of his colleague.

Subject's perception of family's response to HIV/AIDS

M S did not mention the incident to his family.

M S did not discuss the incident with his family because he felt that it was not serious enough to warrant discussion. He is married, with three children.

M S's wife eventually came to know about the incident. She expressed her fear over the incident. However, S managed to convince her that it was unlikely that he would have contracted the disease.

M S's wife does not usually express her fears with regard to S's high-risk status, but she did after this incident.

M S's wife knows that S is fond of children and is often very physical with them. S's wife has asked S to curb this physical expression of affection.

Subject's perception of social attitude to HIV/AIDS

M S believes that a general fear of HIV/AIDS exists in society. S doubts, however, whether people have a very realistic notion of what the disease actually is.

M S sees AIDS as instilling fear in males and females proportionally.

Subject's perception of friends' understanding of doctor's role

M S's friends are aware that doctors constitute a high-risk group.

M S feels no negative reaction to the fact that his friends recognise him as part of a high-risk group.

Subject's assessment of personal risk through professional activity

M S does not think that he is at risk with this behaviour involving children, but he is not sure. S loves the children that he sees in his surgery.

M S has told his friends that regarding this incident the risk of his having contracted AIDS is almost non-existent.

M S does not perceive himself to be at an increased risk to HIV above other general practitioners by virtue of his position.

Subject's relationship to known HIV infected patient

M S felt that his colleague's reaction was harsh: the colleague should have understood the reason for the mother's not wanting to reveal her or her child's condition.

M S states that he may deal with an HIV-positive person differently from an ordinary patient, though the difference would be slight. However, he would definitely be much more cautious, while at the same time treating the patient as an ordinary patient.

Subject's perception of social groupings in terms of HIV risk

M As a result of S's experience with an HIV infected person he perceives AIDS not to be confined to certain groups, but rather it covers the whole spectrum of the population.

Subject's perception of individuals in terms of high risk activities

M When S is confronted with patients suffering from sexually transmitted diseases, he attempts to educate these patients, mentioning various preventative options.

M If *S* treats a patient regularly for sexually transmitted diseases, he will discuss the risks of HIV with this person.

Subject's perception of patients' understanding of GPs as high risk

M *S* has spoken to some of his patients about their perception of the fact that he represents a part of a high risk group.

M No patients have yet reacted to his high-risk potential.

M *S* has spoken to various friends who are also his patients about his high-risk potential. They understand his point-of-view and are at ease.

EIGENWELT

Before

During

Considerations regarding personal HIV tests

E *S* explains that when the hospital superintendent heard of the incident he immediately advised *S* to have a blood-test. *S* was reluctant to do so.

E After two weeks of insistence from the superintendent, *S* eventually agreed to have the test done. This was performed by the superintendent.

Subject's self-reflections in relation to known HIV infected patient

E *S* agrees that had he known the child had AIDS he may have given up trying, knowing that with the defences so low the prognosis of recovery would be very bad.

After

Assessment of personal risk

E *S* was not worried when he learnt that he had been exposed to the HIV virus because his knowledge of the disease was such that he believed the chance of contracting AIDS from such limited exposure through this particular route was minimal.

E *S* is not worried about the fact that his work constitutes a high risk factor.

Considerations regarding personal HIV tests

E *S* was not eager to have the test done because he felt the incident was not significant enough to warrant a test. Eventually, however, it was done, and the results were negative.

E *S* is so sure that he does not have the HIV virus that he is not even keen on having further tests done.

E *S* sees the HIV test as bothersome and inconveniencing.

E *S* may do the test in another year or so, though he does not perceive this to be necessary.

E *S* had an HIV test four months after the incident. This, however, was purely for insurance purposes. *S* is not keen on doing any further tests.

E *S* will probably have another test done in about a year.

E *S* does not see a need for regular testing; he does not perceive testing in terms of a responsibility towards his patients.

E *S* agrees that from the point of view of his patients' safety it is possible that he should test himself regularly. However, he feels that his one exposure, to vomitus, is insignificant.

Modification of personal judgement of role subsequent to encounter

E *S* agrees that the meaning of being a general practitioner has had to be re-evaluated and re-assessed since the advent of AIDS. This is apparent to *S* through the fact that some doctors are willing to change their profession.

Personal feelings

E *S* is not presently HIV-positive; but if he contracted AIDS he would continue working in the medical profession.

E It would be a great blow to S if, as a result of contracting HIV/AIDS, he was no longer allowed to practise his profession.

Personal judgement of professional role

E S feels that the possible risk of contracting HIV/AIDS is part of his job, something which he must accept.

E S disagrees with his colleague and feels that whatever job one is doing, one must accept the consequent hazards.

E S disagrees with his colleague: he does not wish to change occupation.

E S does not feel he must change occupation, so as to avoid AIDS.

E S believes that it is a doctor's duty, and this duty must be performed.

E S feels that if the sister-in-charge feels unhappy about delivering a child from an HIV-positive person, then the doctor must perform the task.

E S sees the basic role of the doctor as comforting the patient and relieving him of his disability and discomfort as much as possible.

Personal concerns relating to potential effect of HIV/AIDS on family

E S did not consider his position in relation to his children after the incident, because he was certain that he was not infected.

Subject's self-reflections regarding precautionary behaviour

E S feels that the incident was not serious enough to warrant his taking precautions.

E In the future S will try to be as careful as possible with patients who are HIV-positive, especially with regard to physical examinations and procedures.

E S does not use gloves when taking blood; he does not see the rationale behind this.

E S does not wear gloves: he feels that if a needle is going to prick him, then it will pass through a glove anyway.

Subject's self-reflections in relation to known HIV infected patient

E S reiterates the need for doctors to treat AIDS patients in the same way as any terminally ill patient.

Subject's self-reflections on relation to terminally ill patients

E S explains how he has encountered various colleagues in the past who have given up on patients who are terminally ill.

E S feels doctors should spend more time with terminal patients, though he realises that time is often limited.

Subject's self-reflections on changing role

E Were S to contract AIDS he feels that there would be some aspect of medicine that would still require his expertise.

E S sees AIDS as having an influence on the goal that constitutes the role of the doctor.

E S feels the medical profession has a very important future role to play regarding the AIDS epidemic.

E The role of the doctor, according to S, will be very important with regard to the HIV/AIDS epidemic; it will constitute a clinical and an educative dimension.

Subject 2.

UMWELT

Before

Physical preparation prior to encounter

U Owing to thorough preparation the concept of HIV/AIDS was less frightening.

During

Considerations engendered by physical presence of HIV infected patient

U S explains that the patient was in the final phase of the disease, though she had not yet exhibited signs of dementia.

U S explains that the HIV-infected patient is a little girl with extensive *Kaposi's sarcoma*. The infection is spreading over her legs, abdomen and all over her body. *S* perceives this as "totally horrible".

Emotions engendered by the presence of HIV/AIDS in Subject's experienced world

U S reiterates that the experience of unbandaging the HIV infected patient was shattering.

U S has confronted similar emotionally overwhelming experiences in the past. On one occasion she felt the same way when she was required to certify dead a man who had committed suicide by jumping in front of a train.

U S states that there are some things which humans cannot handle well.

Historical context

U S explains that there have been a number of positive cases in the hospital, and more recently there have been some deaths relating to lung infections. It is unusual to find a *Kaposi's sarcoma* sufferer.

U A cluster of other HIV/AIDS cases have occurred in the hospital; this includes a woman who recently gave birth and was found to be HIV-positive, a young girl who died of septicaemia and two members of staff who died of accelerated TB. This particular incident, however, has been the worst.

Immediate context

U S describes her first encounter with an HIV infected individual. She knew the patient's diagnosis and went to visit her in her room.

U S explains that the other doctors who had examined the patient had not done a thorough physical examination, but had merely prescribed treatment. *S* felt compelled to take off the patient's bandages despite her repulsion. *S* was assisted by two sisters in the ward and the staff nurse.

Precautionary behaviour within the context of HIV/AIDS

U S states that she is not nervous of contracting HIV, this is because she takes very strict precautions with herself and is very fastidious about hygiene.

U Before examining the infected patient *S* and her colleagues had discussed the procedures they would take; consequently they wore gloves, opened up a sterile dressing and used sterile instruments. These procedures served the dual purpose of reducing contamination from the point of view of the patient as well as reducing the risk of infection in relation to the hospital staff.

U S explains that when first attending to the patient she and her colleagues were well protected. This was to secure themselves against HIV infection. They all wore masks because of the smell of the infection and the nurse most involved wore an apron and a gown.

Professional action and management within the context of HIV infected patients

U With regard to treatment the patient had been given chemotherapy for her skin cancer; this was continued for approximately four months.

Subject's experience of the patient as physical disease

U S found it difficult to touch the person with *Kaposi's*. She did not want to stand close by and did not want to smell the infection.

U S's hesitation to touch the patient with *Kaposi's sarcoma* was based on the fact that it was simply unpleasant to look at and not necessarily because she was afraid of contracting the disease.

U When S initially encountered the infected patient she was aware of a terrible smell radiating for at least 10 - 15 yards around the room. The patient's dressing had not been changed for a couple of days.

U The experience of unbandaging the patient was a lot worse than S had anticipated. S found the smell overpowering and the appearance of the tumour horrifying. The tumour consisted of multiple tumours spreading over the patient's thighs and lower abdomen. The tumour had coalesced into a fungated mass which smelt. The main tumour had a radius of five inches and was situated at the top of the thigh, satellite tumours and black spots covered the patient extensively.

The meaning of personal risk in the context of HIV/AIDS transmission

U S reiterates that she was not afraid of catching the HIV virus: though this thought did exist, by taking precautions, the risk of contraction was eliminated.

U S states that if she is honest with herself she must accept that all health care workers are involved in risky procedures.

U S believes that neither herself nor her colleagues really thought they would contract HIV during this procedure. HIV according to S is more likely to be contractible through blood rather than a skin disease.

After

Concrete presence of HIV positivity in subject's known-about world

U S believes larger numbers of people should be tested.

U S points out that a major concern in the medical profession involves the notion of consent. Doctors should not have to ask patients to offer themselves for an HIV test, this should be part of the over-all process.

U According to S, if a patient voluntarily presents for investigation to a doctor then that patient must agree to all testing procedures including the HIV test which forms part of this process. Individuals must accept the whole testing battery or nothing at all. If individuals exercise their right to disagree they are responsible for the consequences.

Emotions engendered by the presence of HIV/AIDS in Subject's experienced world

U S sees the HIV/AIDS epidemic as catastrophic.

U For S the unknown element of risk is frightening.

Emotions engendered through the concept of personal HIV tests

U S and her colleagues all have had HIV tests.

U S and her colleagues do not have HIV tests on a regular basis. However, if a staff member has a needle stick injury then they are obliged by law to have a test. S explains that all the hospital staff started having tests long before there was any risk. Most of the hospital staff have had a test.

Precautionary behaviour within the context of HIV/AIDS

U S's attitude towards preparation and the use of precautionary measures has not changed recently. She has always emphasised the importance of these strategies and now she is even more emphatic.

U S's technique with regard to precautions has changed slightly now that HIV/AIDS is present.

Subject's experience of the patient as physical disease

U S sees HIV/AIDS as a disease and believes it is unrealistic to separate this disease from other diseases.

U S believes that HIV/AIDS should be seen as part of the whole spectrum of illnesses, it should not be separated from other sexually transmitted diseases, and doctors should not have to ask permission to test.

U S believes her approach to be realistic as it ascribes the same status to all illness in that illness needs to be treated. S agrees that HIV/AIDS is a more serious disease - however, there are other illnesses such as lung cancer which are just as serious.

U S is more interested in the whole person than simply focusing on the disease alone. S has always taken a primary health care approach including the individual and his/her social environment.

Subject's statistical understandings within the context of the HIV/AIDS disease

U S usually asks for some information relating to the individual's disease for epidemiological reasons.

U S is disturbed by the increasing number of HIV/AIDS cases. She points out that currently there are a quarter of a million HIV cases in South Africa. S is sceptical as to whether this will not affect population growth.

Subject's understanding of groups constituting high risk in the context of HIV/AIDS

U S explains that she is cautious when dealing with certain high risk groups: she has, however, always been cautious with these groups because of the risk of Hepatitis.

The meaning of personal risk in the context of HIV/AIDS transmission

U S perceives herself as being extremely lucky in the light of what is to come in that her job as a diagnostician does not carry a high risk status.

U In connection with the risk of contracting HIV/AIDS, S perceives herself as being fortunate in that she does not have contact with trauma and emergency medicine. In this sense S has already moved away from contact with HIV.

U S draws an analogy between the dangers of HIV/AIDS and the dangers that face an individual every day, such as getting into a motor car. The issue at stake relates to the person's attitude towards death and whether they are prepared for it.

U S believes all health care professionals should be very cautious, and should carry gloves in their cars in the event of encountering an accident. S has gloves in her car.

The future context of the HIV/AIDS disease

U S states that people are expecting an explosion of cases with large numbers of deaths. However, she perceives that there are simply going to be more people coming into hospital, more people dying and more people presenting with unusual illnesses.

U Many of the illnesses in the future, according to S, will not be registered in hospitals as being due to HIV/AIDS. They will be documented as Tuberculosis, septicaemia, pneumonia, and so on. This may distort the "actual" rise in the number of cases.

U S feels that the presence of patients with HIV in the hospital acts as tangible evidence of the risks and future threat of HIV/AIDS.

The meaning for the subject of the body and its parts in the context of HIV/AIDS

U S does not put on gloves for every examination procedure. New improved methods of taking blood do not warrant the use of gloves. If S is stitching or is she comes into contact with blood in any way then she takes precautions. S has always been inclined to use precautionary techniques. However, these strategies have become slightly accentuated recently because of HIV/AIDS.

U S's perception of blood has taken on a slightly new meaning in that it is now more dangerous with the presence of HIV/AIDS. However, S has always been careful of blood because of Hepatitis.

U People losing blood inexplicably is also a big issue according to S.

MITWELT

Before

Education of colleagues

M Since the early 1980s S has been motivating for the use of precautions and for the local medical community to become involved: this was met with resistance.

M S had previously discussed the issue of terminal illness in groups with other members of staff. Various aspects of the AIDS disease had been thoroughly covered prior to the first incident. The presence of one or two staff who have some knowledge about AIDS has been beneficial.

Influence of others/Media

M S recalls the "big scare" began in South Africa in 1987/1988 with newspapers reporting incidents. However, the general feeling was one of excitement for a while, but this quickly developed into complacency.

Influence of others/professional

M S was well prepared for her first encounter with an HIV-infected person. She had done a lot of reading and knew what to expect.

M S had a working idea about the disease before her first encounter.

M S reads extensively with the result that she has been well informed with regard to HIV/AIDS since the early 1980s. S had been following the development of this disease in the Press long before it became a South African concern.

M S has kept up to date with the development of the HIV/AIDS disease by reading the major medical journals on a regular basis.

Relationship between subject and patient in 1st encounter

M S explains that the patient is seventeen, a young black girl who was diagnosed about a year ago. At this point the patient was at school in another city. She was intelligent and was progressing well. When she was diagnosed she didn't get much support or counselling and her boyfriend disappeared. Her family subsequently brought her back to this area which is her home. The patient was admitted to the local hospital on the request of the superintendent of the provincial hospital.

Subject's perception of social attitude to HIV/AIDS

M S found the initial complacency towards AIDS upsetting, as this indicated people were not taking it seriously.

During

Assessment of known HIV infected patient

M S explains that the patient was a very young sweet girl and her family was very supportive. The patient accepted her condition without much complaint; she has returned to the hospital on a regular basis but this has not made much difference to the disease progress.

Education of colleagues

M S and her colleagues were well informed before this incident took place, with the strong emphasis on HIV/AIDS education in the hospital. *S* finds it difficult to believe that anyone could be misinformed.

Management of known HIV infected patient

M S states the person is presently in the local hospital.

M S was not enthusiastic about the patient receiving chemotherapy because she felt that the patient would not live for very long and this form of therapy would merely make her uncomfortable. Chemotherapy was eventually terminated.

Perception of professional role in relation to others

M S states that being in a situation where you are setting an example to others, it is not possible to show your attitudes and feelings.

M S feels that it is very important to set an example in front of her patients and nursing staff. She feels she cannot expect from her staff what she is not willing to do herself. In this case *S* finds it important to present a certain attitude to those around her.

Professional interaction with colleagues

M S states that if they are honest with themselves all doctors air their frustrations and reveal their emotions at times; subsequent discussion with one another helps to relieve the pressure.

Subject's perception of patient's understanding of his/her condition

M The second reason for *S*'s overwhelming emotional response to her first encounter with the patient involved the fact that *S* felt desperately sorry for the patient because she was aware the patient knew the nature of her condition and its fatal implications.

Subject's relationship to known HIV infected patient

M S was sensitive to the fact that the patient would be able to recognise her own attitude and that of the other staff towards her condition.

Subject's relationship to terminally ill patients

M S states that she must honestly admit that terminal illness in every age group is distressing for her, though she finds it particularly difficult to deal with terminal illness in young people.

After

Assessment of known HIV infected patients

M S explains that the patient is still alive, though she is gradually fading away.

Education of colleagues

M S believes the staff to be the important individuals to educate and protect.

M S's colleagues and other health care workers depend on *S* for information and advice. On two occasions *S* has had to counsel health care workers who had been exposed to HIV and were waiting for their test results. *M S*'s colleagues see her as an authority on HIV/AIDS. *S* is a senior practitioner so her colleagues tend to ask her advice extensively, not only with regard to their working lives, but also on issues relating to their personal lives.

Education of public

M S states that she is in a sense glad that there is concrete evidence of HIV/AIDS in the form of patients, in that these individuals act as educational examples and make the concept of the disease more real and concrete to the public.

M S sees education which is aimed at young and very young children as the main priority. These individuals need to be taught to protect themselves against their own nature.

M S acknowledges the problems associated with education targeted towards young age groups.

M S does not perceive it as part of her role to inform individuals of correct moral conduct, she also sees this as an invasion of an individual's right to privacy.

M S thinks everyone has the right to know about HIV/AIDS.

Education of patients

M S does not always provide direct education messages to people whom she deals with in a professional capacity.

Feelings evoked in relation to others

M If an individual reveals to *S* that he is homosexual and has had 50 consorts *S* does not mind. If this information assists her diagnosis and makes it easier for the individual then *S* believes that this is the patient's business and nothing to do with *S*'s personal moral views. If the patient appeals to *S* on a personal level then she may offer her opinion, but on a professional level this is irrelevant.

M S relates an incident where two doctors working in a casualty department were very nearly exposed to HIV because a patient had chosen not to reveal his status. *S* perceives this as a very wicked thing to do because it endangered the lives of the practitioners.

Influence of others/Professional

M S does not think that general practitioners are educated sufficiently with regard to HIV/AIDS and she believes the reason for this problem to derive from the Government system in that it has not provided enough education opportunities for doctors.

M S sees general practitioners in private practice as being out on a limb in that they are required to educate themselves and often they are not doing so.

M S believes the District Surgeon and the MOH to be very well informed about HIV/AIDS. The Regional Services are better educated than the Provincial Services. The Cape Provincial Service according to *S* needs to do more in the way of education, they are not doing enough and they are not focusing on general practitioners.

Influence of others/Society

M S thinks that the medical profession should move away from a moralistic stance concerning HIV/AIDS.

Knowledge of patient's HIV status

M If doctors were aware of their patients' HIV status then this would promote a much healthier attitude.

Modification of relationship to patients in general subsequent to encounter

M S does not relate to her patients differently because of the presence of HIV/AIDS in society. *S* believes that the medical profession should not be morally judgemental towards people, they need to accept the reality that a lot of individuals become ill because they are doing what they should not be doing. Mankind must be accepted for his realities and narrow or condemnatory attitudes in medicine should not exist.

M S does not perceive her old patients in a new light nor her new patients in a different way due to the presence of HIV. *S* has always taken precautions and continues in the same way. *S* has worked in three liver units and has never contracted Hepatitis, because of the precautions she takes.

M S explains that her relationship with the people she deals with is often very intense. Issues such as sexuality do not compare with issues such as death experiences in families which give rise to a very close relationship between S and her patients.

Modification of interaction with others subsequent to encounter

M S's relationship with her colleagues has not changed in any way because of the presence of HIV/AIDS.

M When S discusses the notion of HIV/AIDS with people they do not relate to her differently thereafter.

Modification of relationship to HIV infected patients subsequent to encounter

M S has undergone significant emotional concern with regard to her HIV infected patient. However, things have changed with time, and S now perceives the patient as a whole person rather than as a terrible lesion. Now that the patient has become a person who is suffering, rather than an object, things are different.

M S and her colleagues developed a close attachment to this patient. The patient visits regularly with her family. Revulsion has transformed into compassion and a recognition for S that she must do whatever she can to make the patient's life easier.

Perception of professional role in relation to others

M S draws a distinction between the outcome of the relationship between the doctor and his patient and the psychologist and his patient. The doctor's relationship with his patient is more transient.

M S is disturbed by the fact that the medical profession is unable to recognise its role as educationalists who need to be involved beyond pure treatment. Doctors need to take a preventative approach. According to S, if they cannot assume this role, then the consequences for the rest of society in terms of dealing with this disease are serious.

M S sees herself as playing an important role in her immediate environment with regard to the HIV/AIDS scenario. S would like to motivate the community to get involved because she believes the medical profession will be very busy with the medical aspect of the disease. They will not have the time to focus on education.

M S explains that on a personal level she has a particular attitude towards society. She makes an effort not to allow this particular attitude to influence her professional conduct, especially in terms of verbalizing this attitude. For example S explains that she does not allow her personal views on morality to affect her professional role. With regard to the young HIV patient these views did not affect S's interaction, S simply saw this individual as unlucky.

M S sees doctors as providing a lead with regard to the general attitude held by society towards HIV/AIDS.

M Were S to show her anxiety with regard to HIV/AIDS this would have more of an effect on her staff than on her patients. S expects her patients to be frightened anyway, for this reason she is more concerned about her staff.

M S sees the HIV/AIDS issue as having some influence on the private practitioners' involvement and duties at the hospital.

Perception of changing role in relation to others

M S believes that for those individuals who in the future will be counselling and dealing with HIV/AIDS patients, it will be important to have some form of support programme. S uses the example of the staff at Somerset HIV/AIDS Hospital where she was personally informed that nursing staff were in fact unable to cope effectively for more than two to three months. The junior nurses had to be counselled and transferred, and although the senior nurses were able to cope for longer periods, S's contact at this hospital stayed for only eight to nine months.

M S believes that nursing staff would be able to cope better if they were given more support. According to S this need has been recognised by Hospice. Unfortunately the perspective of the carer is often overlooked and S believes this accounts for burn-out.

M According to S, she and her colleagues experience misgivings about their profession regularly. S has often observed her colleagues experience a mid-life re-evaluation of their profession. S believes that HIV/AIDS will have a significant effect on this period in the lives of her colleagues.

M S believes her colleagues will be influenced by HIV/AIDS on issues such as whether they remain employed by the Government or not.

M S believes that all doctors will now be more cautious of dealing with people they don't know. The risks involved will have a significant effect upon doctors' attitudes towards emergency work on people they are not acquainted with. If a doctor knows his patient is HIV-positive it is very different because the risk is known.

Precautionary techniques in relation to professional procedures

M S does much less trauma work now than before, however, if she is putting up a drip she wears gloves and would make sure her colleagues were doing the same.

Professional interaction with colleagues

M S explains that everyone becomes emotionally overwhelmed at times; in these cases it is necessary to find a release. One way of doing this is to talk it out with other people.

M S believes doctors are better off than psychologists because they are able to work more closely with their colleagues and thus support one another.

M S's relationship with her colleagues is in a sense closer now through discussion around the topic of HIV/AIDS. S sees this as very positive.

M Working with HIV patients draws colleagues closer together, according to S. Individuals need to be united and they need to communicate the dangers and risks of HIV/AIDS to one another. S sees this as very positive.

Relationship to family in the context of HIV/AIDS

M With regard to S's role as a family person, she has a large insurance policy against possible contraction, a policy that will safeguard her family financially in the event of her contracting HIV and requiring treatment.

Subject's perception of family's response to HIV/AIDS

M Two years before this experience S discussed the HIV/AIDS issue with her husband and together they reached an understanding. S's children are as yet too young to discuss the topic with.

M S's husband has expressed his views about S being in a high risk group. However, this issue has been discussed extensively and topics such as precautions and insurance have been dealt with. S's husband is well informed on the HIV/AIDS problem.

Subject's perception of colleagues' response to HIV/AIDS

M S has observed how the nurses have gradually overcome their initial fears towards the infected patient. This has come about through general interaction with the patient, as well as through doctors and sisters setting an example by touching the patient, looking at and talking to her. Nursing staff have grown to recognise that normal interaction with the patient is not risky.

M S attended a congress on AIDS last year and was surprised to hear one person state that HIV/AIDS was not a real problem and it did not warrant much concern. S found this attitude very disturbing, especially as it came from the medical profession.

M S believes that HIV/AIDS would have brought to a head her colleagues' reservations regarding their profession.

M S's colleagues are very careful about HIV/AIDS precautions. S and her colleagues hold similar attitudes towards dealing with HIV patients.

M S has not discussed the topic of HIV/AIDS very much with other doctors in private practice. The ones she has spoken to hold similar views to her own. S states that private practitioners probably don't take the issue of HIV/AIDS as seriously as Government doctors because they are not as directly involved.

Subject's perception of friends' understanding of doctor's role

M With regard to S's friends, these people point out to S that she is the one that says that everybody will die of AIDS - S finds this amusing. However, if individuals are seriously in need of information S feels they will ask; if they choose not to know anything about the disease, S is unperturbed.

Subject's perception of patients' understanding of GPs as high risk

M None of S's patients have shown any reaction to her as a possible high risk person. S has mentioned this issue to her patients in a light-hearted way and their response has generally been a lack of anxiety.

Subject's perception of future trends in HIV/AIDS

M HIV/AIDS will impinge on everybody and all professions, according to S, should be ready to take a leading responsibility.

Subject's assessment of personal risk through professional activity

M Because Government doctors cannot refuse to treat a patient this, S feels, will drive a lot of doctors out of Government services. The issue is a very difficult one.

M An important issue for Government doctors which has given rise to much concern relates not so much to the fact that doctors have to treat all patients but more to the fact that they are not authorised to administer compulsory HIV testing on patients before surgery. Doctors may therefore treat infected individuals without being aware.

Subject's perception of social groupings in terms of HIV risk

M On account of her recent experience S's understanding of high risk groups has not changed. These groups, according to S, remain the same, and include all people, all races and all socio-economic groups.

M S feels sorry for those individuals who form part of high risk groups.

M S thinks that individuals belonging to high risk groups should be given information, they should not be condemned.

Subject's perception of individuals in terms of high risk activities

M With regard to prevention S sees it as her duty to inform individuals of the danger of certain behavioural patterns. However, once a person has contracted a terminal illness there is no point in taking a moralistic stance.

M S informs people about HIV/AIDS, although by the time S sees her patients they are generally well informed anyway. For those patients who do not suffer from venereal diseases S occasionally brings up the topic, especially with young girls, patients with cardiac problems and others. With these individuals S often discusses contraception and the threat of HIV/AIDS.

Subject's perception of social attitude to HIV/AIDS

M S believes that once a person is diagnosed as having AIDS it is irrelevant to be moralistic. The issue of morality according to S is only relevant to the process of education, especially the education of children.

M S states that doctors should not be the only professional group providing a lead in attitudes in society. Other people such as religious leaders, teachers, and community leaders should follow suit. S feels, however, that these groups have not defined their position on HIV/AIDS as yet.

EIGENWELT

Before

Cognitive preparation for the situation of encountering an HIV infected patient

E Before her first encounter with an HIV-infected person S felt quite well prepared. This was because the medical staff had previously discussed attitudes and interactions in this regard before the patient arrived.

During

Personal feelings

E This case, according to S, was one of the first cases in the hospital which was so horrifying.

E S felt shattered for two reasons. She outlines the first reason as her inability to be perfect in terms of not being nervous and not feeling revulsion. S is referring to her professional role and what is expected of her in this role.

Personal judgement of professional role

E Because S was nominally in charge of this ward into which this patient had been admitted, she felt it necessary to visit the patient.

E When S was initially confronted with this AIDS patient her first impulse was to leave. However, S states that her training demands the opposite. It is not possible to run away.

E S explains that some duties which constitute the doctor's role are difficult, particularly certifying death, attending to badly mutilated individuals. With regard to this patient S felt a sense of revulsion. However, she would never reveal these feelings to the patient.

E S believes that if she were perfect she would not have any compassion. S sees compassion as the ability to undergo some of the patient's own suffering.

E S explains that because of her professional position she is not allowed to show any signs of panic or resistance, especially in front of patients.

E S perceives the whole structure of medicine in hierarchical terms; the people at the top must take control in every way, including emotionally.

Subject's self-reflections on relation to terminally ill patients

E S explains that most doctors find it difficult to deal with terminally ill patients. There is a slight withdrawal from it, almost a wish not to be involved. However, doctors are trained to overcome these feelings; this they manage to do to the extent where they do not betray their true feelings to patients or outsiders.

After

Assessment of personal risk

E S sees it as frightening that Government doctors are obliged to operate on individuals who may be HIV positive without knowing beforehand.

E S believes that if a patient is HIV-positive the doctor should know. *S* is a consultant so she does not have to operate or deliver babies: is she were involved on this level she believes it would strongly influence her decision as to whether she would continue in her present position.

Modification of perception of HIV/AIDS subsequent to encounter

E S reiterates that the experience was horrifying and worse than she had anticipated. The reality of confronting a young terminally ill patient with an extremely disfiguring disease, a patient who understands her condition and is very upset, was very different to *S*'s academic conception of the disease. *S* was not fully prepared for this experience; on paper it had appeared to be handleable.

Modification of personal judgement of role subsequent to encounter

E The meaning of being a doctor since *S*'s recent experience, or since the advent of HIV/AIDS, has not had to be re-evaluated or re-assessed in any way for *S*. According to *S*, she and her colleagues have had to learn how to deal with similar life-threatening diseases in the past, such as types of meningitis, Tuberculosis, and Hepatitis. Hospital staff have had to deal with terminally ill cancer patients and *S* herself was once involved with a Congo Fever outbreak.

E S has not had to rethink her entire role as a doctor on account of the HIV/AIDS epidemic.

Personal feelings

E S sees revulsion as a very selfish emotion, an egocentric one that needs to be transformed into another emotion as soon as it is possible.

E S has not adapted her personal code of ethics.

E S believes the issue of death is something people should have worked through by the time they reach her age.

Personal judgement of professional role

E S has a moral code which is independent of the way she conducts herself professionally. This code is personal and *S* does not usually publicise her personal opinions because this would threaten her neutrality which forms part of her professional role.

E S believes that doctors should not impose their own values on their patients. As far as *S* is concerned, she adopts an entirely neutral stance towards her patients. Personal judgments are out of place in terms of *S*'s role and the role of the patient.

E S believes that judgemental attitudes in the medical profession are destructive, since the interaction between the doctor and patient is dependent upon trust. This relationship cannot be achieved if the patient perceives the doctor as condemnatory and judgemental. For this reason *S* believes a doctor's work is made easier if a relative neutrality is maintained on the part of the professional.

E S explains that as a doctor she keeps a code of ethics and does not alter them. This code has become firmly established through experience. It is a tough code that is necessary for survival. An individual either lives by it or adapts accordingly.

E S believes a doctor either practices the type of medicine which requires a close compassionate relationship between doctor and patient or the type where the practitioner remains emotionally detached. In this light *S* identifies two types of medical practitioner.

Personal concerns relating to potential effect of HIV/AIDS on family

E S's experience with an HIV infected person did not have any impact on *S* and her role as a family member. *S* had come to terms with this issue long before the experience.

E On an emotional level *S* chooses not to discuss these issues though she has considered her position on this level with regard to her family and finds the topic very sensitive.

Subject's self-reflections regarding future trends in HIV/AIDS

E S would be surprised if in a few years' time people still want to do medicine. According to *S* if they have any sense they won't.

Subject's self-reflections on changing role

E S suggests it may be necessary to move out of hospital practice in the future, into practice where a doctor has more control. However, HIV/AIDS may not be the only factor necessitating this move.

Subject's self-reflections regarding perceptions of colleagues' response to HIV/AIDS

E S feels that all individuals involved with medicine would have to have some reservations about the profession. If these individuals deny this then they are not telling the truth.

Subject's self-reflections in relation to known HIV infected patient

E S rejects the argument that a patient's HIV status should have no influence on the treatment. She feels that there is no longer any place for elective surgery in patients who are HIV positive, and these patients should not be operated upon.

Subjects' self-reflections in relation to media

E HIV/AIDS is not as devastating, according to *S*, as some people believe.

Subjects' self-reflections in relation to Professional

E S brought her personal code of ethics into the medical world. At medical school *S* was trained in ethical issues. *S* saw this training as very important. Some medical schools do not offer this training; however, *S* believes that for individuals to be faced with and have to decide upon certain ethical issues for themselves is very important and useful because it cultivates a high level of ethical awareness.

Subject 4.

UMWELT

Before

Immediate context

U S explains that she saw a patient at her clinic who she later discovered was HIV-positive. At the time of examination the patient was responding very poorly to TB treatment.

U S explains that the patient came from a farm. S was unaware of the patient's HIV status until this patient had been through the whole medical process.

During

Subject's experience of a patient as HIV infected

U S did not feel contaminated after she learnt that the patient was HIV-positive.

The meaning for the subject of the body and its parts in the context of HIV/AIDS

U S did not come into contact with any body fluids during her examination of this patient; there was, therefore, no risk involved.

U None of S's procedures with this patient were invasive. The patient was coughing a lot; S states, however, that one normally avoids sputum anyway so as not to pick up infection.

Immediate context

U Two weeks after this incident, S had a reply from the hospital saying that the patient had been transferred to P.E. because of the seriousness of her condition. The patient died in P.E. and shortly after this her test was returned confirming that she was HIV-positive.

Changing meaning of patients in general through experience of a concrete encounter

U When S first encountered this person she did not think of why the patient was not responding to treatment, she merely saw her as poorly nourished and perhaps not taking her treatment properly.

Professional action and interpretation of role in the context of HIV/AIDS

U S acknowledges the possibility of being exposed to other life-threatening diseases, such as Congo Fever and other severe infections, in her profession.

Precautionary behaviour within the context of HIV/AIDS

U At the time S encountered this patient she was not using specific precautions for terminally ill or other patients. These were not available at this point.

U S was not wearing gloves when she examined the patient: now, as then, she only wears gloves when taking blood or doing something specific.

U S explains that she doesn't really want to think about the issue of risk. However, she feels one must take precautions.

After

Changing meaning of patients in general through experience of a concrete encounter

U S deals with each patient presenting with a sexually transmitted disease as a potential HIV carrier.

U When confronted with a patient, S assesses this person in terms of whether she perceives him/her as high-risk or not.

U S is now very conscious of the possibility of HIV if a patient exhibits poor progress on TB treatment. In such cases S considers further testing.

U S's experience has put her more on the look-out for future patients manifesting conditions that may indicate the presence of HIV. A higher index of suspicion is now necessary because of the large numbers of potential cases.

Changing meaning of HIV/AIDS through the experience of a concrete encounter

U S's incident with an HIV infected person has inspired her generally to be more aware of taking precautions.

Emotions engendered by the presence of HIV/AIDS in Subject's experienced world

U When S heard the [catatonic] patient was an AIDS dementia patient she was frightened though she did not anticipate aggression.

Meaning of behavioural practices in the context of potential HIV transmission

U S believes individuals need to change their behaviour in order to control this disease. Behaviour change in the past was linked to basic hygiene, whereas now it is linked to a sexually transmitted mechanism.

U S has experienced situations whereby individuals who have had an affair then want an HIV test. In such cases S speculates that this sort of unfaithful behaviour may form an entire web of relationships which has strong implications for the transmission of HIV.

U S states that she knows a lot of people with whom she would never consider wearing gloves when taking blood. S is always very careful when she takes blood.

U S would make an assessment of each case before she performed invasive procedures, considering whether they are a potential risk or not, and proceed accordingly.

U S is not entirely relaxed with the way she assesses patients because she is aware that although many patients may present with mild symptoms they may in fact be HIV carriers.

Precautionary behaviour within the context of HIV/AIDS

U S recalls that when the need arose for goggles at the local hospital, it was discovered that they had been in storage for six months and no-one had known what they were for. S views this incident humorously.

U S acknowledges that needle stick injuries can take place and that this is worrying. It is therefore necessary to be extra careful and consequently S takes more stringent precautions. S states that they are doing things differently now. This involves more careful procedures with regard to using syringes.

U S uses gloves when she examines patients.

U S's precautionary techniques when physically dealing with people have changed.

Subject's experience of the patient as physical disease

U S counsels all patients in the same way; she tries to treat everyone and see each patient as an individual, and avoid labelling them.

Subject's statistical understandings within the context of the HIV/AIDS disease

U S believes HIV/AIDS to be a virus that has undergone change. S sees this as similar to other plagues. S prefers to see the disease in virological epidemiological terms.

U S explains that the number of AIDS cases is increasing rapidly and soon it will be beyond the holding capacity of many wards.

U S is aware of the predictions and estimations regarding HIV/AIDS - for instance that the doubling time is eight months. S is aware that HIV/AIDS exists in the local area.

Subject's understanding of groups constituting high risk in the context of HIV/AIDS

U S would deal with a person who had come to her surgery with a non-sexual-related problem differently to some one who had a sexually transmitted disease.

The meaning of personal risk in the context of HIV/AIDS transmission

U S states had she been a nurse she would have been more at risk to HIV/AIDS through more contact with body fluids.

U The possibility of contracting HIV/AIDS becomes very real when in the middle of the night S may be called out to perform an emergency caesarian on an unprepared, unbooked patient. Under these circumstances it is possible to incur an injury during the operating procedures without knowing the HIV status of the patient.

U S has had herself immunised against Hepatitis B because she sees herself as at risk. S states that we must not lose sight of the fact that Hepatitis B is still statistically more of a risk than HIV/AIDS.

The future context of the HIV/AIDS disease

U S states that when making predictions there are many variables to consider, such as the nature and the changes of the disease.

The meaning for the subject of the body and its parts in the context of HIV/AIDS

U S explains that her colleague had already organized a blood sample from the patient, therefore she was in no danger in this regard. *S* realised very quickly that the patient was catatonic.

MITWELT

Before

During

Assessment of known HIV infected patient

M The patient had been living on a farm; her husband, who was living in Johannesburg, had visited her some months before this. *S* was unsure as to whether the patient contracted the disease at this point or not, nevertheless she was wasted and thin. *S* realised she was seriously ill.

Knowledge of patient's HIV status

M *S* discovered two weeks later that this patient was HIV-positive.

M *S* became aware of her patient's HIV status through her colleagues at the hospital. *S* was informally told that the patient she had sent to the hospital was HIV-positive. The test result had been received only after the death of the patient, so the message had been returned along the chain.

Perception of professional role in relation to others

M *S* recalls she had touched the patient and examined her fully. *S* was pleased she had done so because she felt she had performed her duty and had not distanced herself from that patient in any way.

M The extent to which the patient's relatives had been counselled was a strong issue for *S*. *S* was left wondering how much counselling these persons had received at the hospital, and whether they had returned to the hospital.

M *S* was also worried about whether the farmer's wife realised that *S* had not known the patient was HIV-positive.

M *S* was unaware of the degree of contact the patient had had with her own family and with the farming family. *S* feels she may have been able to do a lot more in this regard if she had known the patient was HIV-positive.

Relationship between subject and patient in 1st encounter

M *S* recalls when she was first confronted by the infected person. It was a Saturday morning. The patient was brought in by her family. The family members explained she was a TB patient doing very badly - she was losing weight and was not well.

M *S* explains that the patient's family members wanted a doctor to look at her because she had been receiving treatment and had shown no improvement.

M During her first encounter with the patient, *S* had requested the patient to be admitted to hospital immediately. The family members refused, saying that they would have to discuss it with the rest of the family first.

M Shortly after *S*'s patient had returned to the farm, *S* received a call from the farmer's wife. This person was anxious about the health of the young woman and when *S* told her that she had given her a note to go to the hospital, this person said that she would make sure the patient went.

Subject's relationship to terminally ill patients

M When *S* first encountered the patient she felt the same as she would with any other seriously ill patient. *S* felt compassion for this person because she was possibly dying at that stage. She had to refer the patient to a hospital in order for her to receive better attention.

Subject's relationship to known HIV infected patient

M With regard to her patient, *S* felt sad for the individual and for the fact that she had not counselled the patient's relatives, and also sad on account of her mis-diagnosis.

After

Education of patients

M S is now able to say to those patients with STDs that HIV/AIDS is a real possibility, she has seen a case in her rooms and there are cases in the district.

M S imparts HIV/AIDS information to individuals with sexually transmitted diseases as a preventative strategy. At the same time S is aware that some of these individuals have already contracted the disease.

M S often attempts to explain to patients diagrammatically how through unfaithful relationships it is possible to construct a web of associations which have implications for the spread of HIV/AIDS.

M S believes it is very important for her to educate her patients about HIV/AIDS. S targets her education on selected individuals, those particularly who show evidence of a sexually transmitted disease. S asks these people if they are sexually active, if so, are they taking precautions; do they have more than one partner - if not she indicates they should have only one partner.

M S explains that the perception of monogamy varies - for some it is a three-month relationship. S feels it is important to have a long-term perspective when educating.

M S is able to impart local information about HIV/AIDS to her patients with authority because she has seen one patient and knows of others.

M S feels her experience with an HIV infected person has provided her with some sort of authority. She also feels that as this incident has occurred in a time when there was much preparation and speculation about HIV/AIDS in the area, it has served as a turning point which can be used advantageously from the point of view of education.

M When S discusses the topic of HIV/AIDS with patients she does so with the image of her recent experience in mind. S does this with most cases, especially with rare diseases: she recalls similar clinical incidents.

M S once treated a leprosy patient in a township hospital. S will never forget this patient because it was the first leprosy case she diagnosed and one of the few she has seen.

M S states that she does remember specific patients with specific diseases. She may not remember the patient's name or other details but she does remember the circumstances.

Education of colleagues

M In the first stages of the HIV/AIDS epidemic S had a colleague who was homophobic. S discussed this with the individual.

M The hospitals according to S will not be able to accommodate all the AIDS patients. There are many other patients also needing attention. For this reason education at a grass-roots level is necessary and an emphasis must be placed on educating and training care-givers.

M S states that education must extend to professionals and other health care workers.

M As a member of the Hospice team S believes that it is important for her to set an example and to let people know that there is nothing to be afraid of when dealing with HIV infected persons.

Education of family

M S hopes she has educated her family adequately in order for them to cope in the event of her contracting HIV/AIDS.

Education of public

M S believes that HIV/AIDS is a person-to-person transmitted disease which can therefore be prevented by early education.

M S feels it is important for individuals to be educated into practising safe sex before marriage so as to reduce the number of cases as far as possible.

M HIV/AIDS is a very severe and serious illness according to S, therefore education is very important.

M S states that she can educate people on an individual as well as on a community level.

Feelings evoked in relation to others

M S does not feel rejecting of HIV/AIDS patients.

M With HIV/AIDS there are other issues at play, such as sexual taboos. For this reason S believes that the monogamous relationship is very important.

M S believes that the negative views towards HIV/AIDS sufferers can be destructive. She refers to inflated account of cases which she has read.

M S feels that society's views are derived more from ignorance than a truly judgemental stance.

M S states that she did not believe this patient had AIDS. She explains that her feelings were ambivalent at this stage because the patient would now have to undergo a great many more diagnostic procedures. In this regard *S* felt sorry for the patient. *S* refers to the [catatonic] patient as a frightened young boy.

Influence of others/Professional

M S believes she has a good knowledge of HIV/AIDS and has access to information on the topic.

Influence of others/Personal

M S was recently discussing the issue of high risk groups with her husband. He had recently met a person from the United States who had written a foreword to a book on HIV/AIDS. This book concludes that HIV/AIDS affects marginalised groups, groups who are marginalised in society such as homosexuals.

Influence of others/colleagues

M S's interaction with her colleagues and other health-care professionals has had some bearing on her attitude towards the HIV/AIDS problem. *S* is often very emotionally affected by the views and attitudes of some people: these individuals often show a lot of anger towards the whole situation.

Influence of others/Society

M S's view of HIV/AIDS patients bears no relation to stigmatization, such as that relating to homosexuality.

M S agrees that in some instances her assessment of certain individuals may be influenced by the general perception held by society towards HIV infected persons. *S* explains that in one or two instances she has found herself stereotyping certain women into the category of prostitute. This assumption has generally been based on certain physical, social, medical and economic factors.

M S believes that her perception and subsequent treatment of certain individuals may be influenced by the general perception held by society towards HIV infected persons.

M S explains that disease is linked to the society. In the United States HIV/AIDS has been a homosexual disease - which has its connotations. In Africa it is seen as a black disease related to promiscuity.

M S relates an incident whereby a colleague of hers who is also a priest was severely criticised by a member of his congregation because he referred to HIV/AIDS as a black disease. In this case this statement was seen in a political light.

M S feels generally that there is much misunderstanding, misinterpretation and offloading on various groups in society such as blacks and homosexuals. This has created much stigma. The reason according to *S* is that no-one really wants to accept this disease.

M S is aware of the moral views that constitute society's response to HIV/AIDS. She feels it is important to discuss this and to be aware.

M S does not see HIV/AIDS as a way of controlling over-population.

M S explains that disease has always had a social link. In South Africa TB is linked to Apartheid policy.

Management of known HIV infected patient

M Shortly after *S's* own experience one of her colleagues was advised by the hospital that a patient referred by him had tested positive. *S* is unsure of the reason her colleague referred this patient, however, the hospital needed information from *S's* colleague as to the whereabouts of this patient. Unfortunately it was not possible to provide this as the surgery had no information other than that the patient was passing through town. His test result is now on his file against his return. *S* states that this patient has not returned and this is very worrying.

M The patient who was passing through the town and was later discovered to be HIV-positive had sought treatment a number of times in the past for sexually transmitted diseases. This is why he was expected to return.

M S explains that recently a colleague of hers asked her to take over a patient for the weekend. The patient was hospitalised: he was a nineteen year-old boy who had recently dropped out of school. He exhibited swollen glands, weight loss, and dementia. *S's* colleague diagnosed the patient as AIDS terminal phase, and would regard even a negative test result as the immunity reverting to negative at that stage of the illness.

M S's colleague had diagnosed this patient as having the neurological form of HIV/AIDS. *S* disagreed with this diagnosis. She and two other doctors concluded that the patient is a catatonic schizophrenic.

M At the local hospice there are black PWAs as well as black care-givers. Presently, these persons are attending to a patient with *Kaposi's sarcoma*. This patient is being visited at home.

Modification of relationship to patients in general subsequent to encounter

M S's recent experience has not caused any adjustment in her behaviour towards the patients she sees daily. This is because *S* had been counselling people with sexually transmitted diseases for some time before this incident.

M As a result of her recent experience, S does not relate differently to her patients in general. However, with those patients who are suffering from sexually transmitted diseases she explains that they are more at risk than the average person. These patients generally have mucosal damage and are more liable to pick up infection.

Modification of interaction with others subsequent to encounter

M S does not feel her interaction with people in general has changed at all, though she is not sure about this.

Perception of professional role in relation to others

M S sees community work as important. She sees education as important and believes her role as a doctor incorporates a component of educating staff and patients.

M S sees education as important and sees herself as an educator.

M S has always been interested in preventative community-based medicine and has some training in this field.

M S states that HIV/AIDS is not something that general practitioners can deny, push aside, or isolate.

M S sees it as very important to be a care-giver and to show honest compassion.

M S sees her perception and knowledge of the HIV/AIDS phenomenon as contributing to and influencing the general understanding of HIV/AIDS held by society.

Perception of changing role in relation to others

M S sees the doctor's future role in the context of HIV/AIDS as difficult. S does not blame individuals for leaving the profession. Throughout history doctors have changed careers for less life-threatening situations. According to S there will always be people who want to be surgeons.

M In terms of her future role within the context of HIV/AIDS S states she has discussed the issue regularly with her colleagues. S explains that a general practitioner can take only a certain amount of stress in his/her profession. At the age of 50, many general practitioners may be retiring and working on a part-time basis.

Precautionary techniques in relation to professional procedures

M S agrees that by putting on gloves she is making some form of AIDS-related statement. However, her dentist has worn gloves for many years and she has never associated this with HIV/AIDS, she accepts this as a matter of routine.

M S feels her dentist's use of gloves says something about his precautionary standards generally, not only HIV/AIDS.

Professional interaction with colleagues

M S discussed her recent experience with her colleagues. When she discussed this experience with her colleagues their views were similar to her own in that there is an understanding they will have to treat HIV/AIDS patients, while at the same time avoiding personal risk as much as possible.

M S's colleagues were interested to know that S had dealt with an HIV/AIDS case.

M S's partner experienced a similar encounter to that of her own with an infected person. S states, however, that it is not always possible to discuss feelings and emotions with colleagues. It is possible with some colleagues but generally discussion relates to diagnostic matters of interest.

Relationship to family in the context of HIV/AIDS

M S states that her high risk status has potential implications for her sex life: she and her husband would have to practise safe sex for her husband's sake if she contracted the virus.

M S is aware of the family implications of her high risk status, and needs to work through this. S states her family has not discussed how this would affect them as a group.

M S's family has discussed the effects of HIV/AIDS on society in general; however, they have not really talked it through as a family.

M S is uncertain whether she has come to terms with the issue of her high risk status in relation to her family.

M S would fear transmitting HIV to her husband.

M S is not encouraging her children to do medicine. One of S's children is not interested in medicine, the other who potentially might follow this career is also not interested. S would not push them in this direction.

M The fact that S does not encourage her children to take up medicine is based on her perception of the HIV/AIDS risk.

Subject's perception of patient's understanding of his/her condition

M S saw the [catatonic] patient as confused; however, he is still a person whom one has to make contact with.

Subject's perception of colleagues' response to HIV/AIDS

M S states that some of her colleagues are very defensive with regard to the HIV/AIDS problem. They want to move out of the profession and not face the problem. S feels these individuals are not doing their duty.

M S acknowledges that other doctors react differently to diseases such as HIV/AIDS. S states that maybe they are being wiser by taking strict precautions such as including goggles as a part of precautionary paraphernalia.

Subject's perception of family's response to HIV/AIDS

M S explains that in some cases a family is presented with too many threatening issues. Firstly they may learn that a family member is HIV-positive; secondly, that this family member is homosexual. Often families are unable to cope with two shocks of this nature.

M Families are often devastated and withdraw, consequently the patient is left without the usual expected support.

M S discussed with her husband her recent experience with the HIV infected person. S's husband's reaction centred on an interest with regard to the objective, statistical implications of this case.

M S's husband approaches the concept of HIV/AIDS within an intellectual framework. He sees it in terms of his occupation and the need for continuous education by this profession.

M S states that she does not think her husband has been affected in any way by S's high risk status and the fact that she could bring home contamination.

Subject's perception of patients' understanding of GPs as high risk

M S's patients have not shown any reaction to her as a possible high-risk person. One person, however, who was requesting a pap-smear, informed S that she would prefer to have it done in a more hygienic environment than the clinic S was working in at the time. This was because the patient feared contracting HIV.

M S agreed with this patient's demands because she is aware that the conditions of hygiene at the one clinic are far below the standards of the other.

M S explains that this patient was a black woman who felt she might contract HIV if the necessary instruments were not sterilised properly.

M This patient's statements were not directed at S or at the other patients. She was merely pointing out something to S that S herself had not given enough attention to - the standard of hygiene in the light of HIV transmission.

M If a patient directed a fear of HIV contraction towards S as a high-risk person, S would be able to accept this.

Subject's assessment of personal risk through professional activity

M As a member of a high-risk group, S is aware in relation to her family that she would be unable to affect her children, but she could pass the disease on to her husband. In this sense it does impinge on her family.

M S explains that within the medical profession the option exists for practitioners to specialize and to involve themselves in some non-risk activity.

Subject's relationship to known HIV infected patients

M S states that in her own endeavours she has been involved with terminally ill patients. This has increased her awareness of the fact that AIDS patients will eventually form a significant part of all terminally ill individuals.

M S states that the organization she works for focuses on treating AIDS patients in the same way as other terminally ill patients. Presently, the local branch of this organization is dealing with such a case.

M S perceives HIV/AIDS patients as terminally ill rather than as risky. S is aware that risk involves being in close contact with body fluids.

M S feels she regards HIV/AIDS patients more as terminally ill rather than as stigmatised. S feels these individuals have experienced enough emotional trauma already from family and friends and possibly nursing staff. S feels these patients do not need a doctor to reject them as well.

M S's attitude towards HIV/AIDS patients is possibly influenced by her involvement with a heterosexual patient who had contracted the disease from family and with another who had contracted the disease from a prostitute.

M By preparing herself beforehand, S was able to show compassion to the patient by putting her hand on his shoulder.

Subject's relationship to terminally ill patients

M S treats all terminally ill patients in a similar way.

Subject's perception of social groupings in terms of HIV risk

M S does not immediately label a patient a potential HIV carrier if he/she presents with an STD: however, according to *S*, if an individual presents on a regular basis then they are more likely to be at a higher risk.

M S has encountered a variety of scenarios relating to HIV contraction. *S* has seen 'gays-with-Afraid's', but has not seen any gays with AIDS. *S*'s recent incident relates to a person contracting the disease from her husband who is a migrant worker. In this case it was not the woman's fault.

M S believes that mostly marginalised groups are affected, but states that absolutely anyone is able to contract HIV/AIDS.

Subject's perception of individuals in terms of high risk activities

M S explains that there has been a witnessed change in life-style practices of the male homosexual population. *S* sees this as positive. Individuals have formed single-partner relationships and are practising safe sex.

Subject's perception of future trends in HIV/AIDS

M S foresees in the future a shift in emphasis from the hospital towards other forms of care for Persons with AIDS. This will largely be because of the economic strain placed on health care systems in the future as a result of HIV/AIDS. For this reason *S* sees it as important for Hospice to be involved.

M S indicates a need for the development of a support system in the black community to accommodate the increasing HIV/AIDS cases. *S* is aware of her stereotyped view of HIV/AIDS being coupled to this community, but is making this statement on the basis of numbers of reported cases.

M According to *S* the knowledge of HIV/AIDS held by traditional practitioners must be acknowledged and incorporated into the Western medical understanding of the disease.

M S saw this incident as appropriate seeing as she was also scheduled to be interviewed this day. *S* is sure the time will come when she sees many patients who are HIV.

M S states that locally HIV/AIDS will definitely present a big problem in the future. Already a colleague of hers treats an HIV infected family, another has experienced an AIDS-related death, and *S* expects other cases are occurring.

M S is also aware that the Doomsday forecasts stating that vast numbers of people with the disease will die are not altogether correct. *S* has a friend who works in this field and he maintains that this will not be the case.

Verbal communication with known HIV infected patient

M S explains she was unable to make contact with the patient because he was catatonic.

EIGENWELT

Before

During

Considerations relating to knowledge of patient's HIV status

E This incident did make *S* realize with some force that she had actually encountered her first AIDS patient without even realizing it.

Modification of perception of HIV/AIDS subsequent to encounter

E *S* states that her thoughts relating to infection and its fatal outcome were in some ways initiated by her recent experience, although *S* had been thinking about these issues for some time.

E Although this incident further provoked *S*'s thoughts about infection *S* did not form any new conclusions.

Personal judgement of professional role

E When *S* heard this news she felt disappointed that she had not considered the possibility of HIV. She had been treating the person as a TB patient.

E *S*'s first reaction related to her diagnostic abilities; it is important for *S* to make a correct diagnosis, or at least to be suspicious of possible factors.

Personal feelings

E S states that there is a sense of pride involved in making an accurate diagnosis.

E With regard to S's reaction when she first heard of her patient's HIV status, S recalls that her thoughts and feelings relating to exposure were linked to a high element of denial.

E If S contracts the virus she hopes it will be accidental, through no fault of her own.

E S states that HIV infection is different to other fatal infections in that it allows time to work through the issue of terminal illness. However, she acknowledges that accepting the nature of this illness could be very difficult as it could be a lonely and painful experience.

Subject's self reflection regarding precautionary behaviour

E S states that at this point [before S's first encounter] they were perhaps not being very cautious.

Subject's self reflection in relation to known HIV infected patients

E S's reaction to the death of this patient and her HIV status was no different from her reaction to the death of a cancer or TB patient.

E S thinks her reaction to this incident was not different from other terminal incidents.

After

Cognitive preparation for the situation of encountering an HIV infected patient

E S was due to see the supposed HIV patient on this day. S experienced the anticipation of encountering an HIV-positive person.

E Before S was due to see the patient she had to prepare herself. S anticipated a terminally ill patient needing Hospice care. She thought she may be involved with this person for a long time and therefore it was necessary to develop a good relationship and show her care.

Modification of personal judgement of role subsequent to encounter

E The incident with an HIV infected individual was a turning point for S.

Modification of perception of HIV/AIDS subsequent to encounter

E On account of this experience S is now more sensitive to issues relating to the diagnosis of HIV/AIDS.

E S's experience with this patient has made the notion of HIV/AIDS more concrete and real for her.

Personal judgement of professional role

E S experiences some tension between her personal feelings and her duties as a professional. She is, however, more inclined to accept her situation and its related duties. In some ways S perceives her attitude to disease as fatalistic, if it is going to happen then it will happen.

E S would like more doctors to become involved in the preventative aspect of health, rather than just being care-givers.

E The meaning of being a doctor has had to be re-assessed and re-evaluated to some extent for S on account of HIV/AIDS. S asks herself what it would have been like to follow another profession, though she does not yearn for change.

E S is unsure of what profession she would have chosen apart from being a doctor.

E S claims she is fulfilling a role. Education of others is a part of this role, therefore if S does not educate she sees herself as not correctly fulfilling this role.

E S believes it is important to be thoroughly involved as a doctor. This involvement has made S affirm things for herself; at the same time it has made her question how things may have been were she not a doctor.

E S explains that even though legally she is not obliged to perform certain duties - for instance she can refuse to treat patients - as a doctor she feels ethically bound to her duty and does not want to change this.

Personal feelings

E S states that her personal thoughts and feelings relating to her encounter with this patient were largely non-existent. S states that she tends to intellectualise these experiences: there is a lot of denial.

E At one point S felt that perhaps HIV/AIDS was some form of judgement against homosexuality. However, her understanding of homosexuality and bi-sexuality has changed in the last couple of years.

E S declares that fundamentally she may hold a personal belief - based on a religious understanding - that HIV/AIDS is a form of punishment.

E S clarifies her understanding of HIV/AIDS as punishment by stating that all humans are sinners drawing away from God by temptation and sin, so we are all vulnerable. *S* does not see God as punishing society as a whole. *E S* extrapolates from the mini-skirt drought story whereby a priest was alleged to have told a congregation that the cause of drought derived from women wearing mini-skirts to church. *S* does not believe that God punishes people in the way that the priest in the mini-skirt story believed.

E S states that essentially in her intellect or religious feelings, she believes there is some reason why God indicated the importance of a monogamous relationship.

E S clarifies her views on monogamy: she is not making a judgement, just sees it as a sensible, reasonable practice.

E S has considered the concept of monogamy very seriously. She sees herself as fortunate that she is presently, always has been and always will be in a monogamous relationship.

E S can understand why people behave in certain ways: they are tempted.

E S feels almost deceived because she had thoroughly prepared herself for an encounter with an infected person. *S* had felt that this would be the test for her of her capability and compassion.

E S explains that the [catatonic] patient was tested for HIV. The result as yet is not confirmed. Until the result returns *S* is unable to clarify how she feels about this incident.

Personal concerns relating to potential effect of HIV/AIDS on family

E S has deliberated to herself in relation to her family that she must be more cautious and suspicious in the future, especially with regard to needle-stick injuries.

E S agrees that her family plays an important role in terms of her understanding of HIV/AIDS and the precautions she must take.

Subject's self reflection regarding precautionary behaviour

E S believes that her encounter with an infected person has contributed to her new attitude towards precautions.

Subject's self reflection regarding perceptions of colleagues' response to HIV/AIDS

E S also feels that her colleagues are entitled to their views. *S* can appreciate why individuals react the way they do. *S*'s own feelings reflect this dichotomy [between duty and personal feelings].

Subject's self reflections in relation to known HIV infected patients

E S's view towards AIDS patients involves an accepting, non-stigmatising attitude. *S*'s perspective of homo- or bi-sexuality has not been influenced by HIV/AIDS.

Subject's self reflections in relation to Professional influences

E S states that her personal perspective towards HIV/AIDS and its sufferers has been developed through reading, discussion, reflection, personal experience and contact with patients. With regard to homosexuality *S* has come to realise that man and woman psychologically and otherwise are incorporated into one entity. *S* has experienced growth with regard to her views on this matter.

E Over the last couple of years *S* has experienced a process whereby she has unconsciously developed a more comprehensive understanding of issues relating to AIDS.

Subject's self reflections regarding future trends in HIV/AIDS

E S sees HIV/AIDS as presenting a big problem for her profession in the future.

Subject's self reflections on changing role

E S perceives her future role within the context of HIV/AIDS as very complex.

E In the future, if *S* were to go to a larger centre, she may choose to specialise in psychiatry or community psychiatry.

E In the long term *S* sees herself as moving out of her present field and taking up a less risky aspect of medicine with regard to HIV/AIDS.

Subject 5.

UMWELT

Before

The meaning of personal risk in the context of HIV/AIDS transmission

U S's fear related to his own safety in relation to contracting this disease.

Physical preparation prior to encounter

U Before treating his patients S felt that he was adequately informed on precautionary techniques to secure his
U S explains that before he was due to meet his first HIV/AIDS patients he refreshed his memory on HIV/AIDS by doing some reading on the topic.

U S's readings prior to his appointment with his HIV/AIDS patients centred on ways of contracting the disease and the approach one should adopt towards HIV/AIDS patients. S points out that most medical journals have extensive coverage of HIV/AIDS.
safety.

Personal emotion

U S states that one always hoped one wouldn't have to encounter this disease.

U When S encountered his first HIV/AIDS patients he initially felt some fear. S was the first doctor in town to deal with a patient infected by this disease.

U When S was confronted with the prospect of treating infected individuals his first reaction was to withdraw from engaging in any form of relationship.

U S's initial reaction towards the prospect of treating HIV infected individuals was fear.

U S's initial fear reaction was personal. This fear was similar to a fear that would be experienced before arresting a dangerous person - the fear of approaching something dangerous.

During

Subject's experience of a patient as HIV infected

U S does not see the HIV-positive condition as a terminal illness because a person can still live for 10 years. In this sense, according to S, it is different to cancer.

Immediate context

U S did not know the history of these patients because they had been diagnosed elsewhere.

U S qualifies the distinction between AIDS cases and HIV cases. His patients are HIV carriers - he has not dealt with any AIDS cases.

Subject's experience of patient as physical disease

U S states that the nature of his relationship with the HIV infected family is greatly influenced by the fact that they are HIV-positive.

Precautionary behaviour within the context of HIV/AIDS

U S has taken no precautions. However, when he examined this family he explained to them that he will take extra physical precautions with them.

U Up to this point S has not had to use invasive procedures on these patients. They have presented with minor ailments and they do so regularly and early because they are aware that they have weak immune systems.

U Most of the time S's procedures with these patients have been confined to using instruments such as a spatula or a stethoscope. S sees these strategies as totally safe.

U S does not see it as necessary to wear gloves when he examines these patients.

After

Changing meaning of patients in general through experience of a concrete encounter

U Before S does a Caesarian section on a case involving someone he does not know and who has not had an HIV/AIDS test, he is very wary.

Concrete presence of HIV positivity in subject's known-about world

U S and his colleagues are often asked late at night to work on complex operations, or standby on emergency operations: this is because the hospital doctors are often young and inexperienced. S's point is that he and his colleagues must have unwittingly operated on many HIV/AIDS cases.

U S has not operated on a person whom he knew beforehand to be HIV-positive.

U S states that patients are not being tested. Infected patients are coming into the hospital all the time: S believes that he must have operated on AIDS cases and HIV-positive individuals.

Considerations engendered by physical presence of HIV infected patient

U When S first saw this HIV infected family he expected them to be physically a lot worse than they were: he thought they would look thinner and have sores.

U S would have felt it necessary to wear gloves when he shook their hands.

Emotions engendered by the presence of HIV/AIDS in Subject's experienced world

U S explains that on some occasions when he is called out to operate late at night he becomes very angry. This pertains to cases where S exposes himself to HIV/AIDS, whilst trying to save the life of - for instance - a drunk who has had a car accident and killed somebody else.

U S is pleased that he is being introduced slowly to the AIDS disease.

Emotions engendered through the concept of personal HIV tests

U S has had three HIV tests in two years; he questions whether this is regular enough or not.

U S will probably continue to have an HIV test once every six months.

Meaning of behavioural practices in the context of potential HIV transmission

U S explains that bi-sexual men who have contracted HIV homosexually can still have a normal sexual relationship with their wives and even though this is unprotected vaginal rather than anal sex the wife does not contract the virus. S qualifies that he is open to correction on this statement.

U Bi-sexual men according to S who prefer anal sex with their wives are likely to pass the virus to them. Those who have sex via the normal route do not.

U S supports his theory by explaining that white people are resistant to TB in Africa because historically this community was badly affected by this disease, consequently those who survived have an inbuilt resistance.

U In Africa the black population was not exposed to the disease until the arrival of white settlers. The blacks are now experiencing what the whites experienced a long time before. The weaker ones are being weeded out.

U Diseases such as TB and AIDS take over because of circumstances.

Modification of perception of disease subsequent to encounter

U Apart from his relationship with three HIV infected individuals and the strong possibility that he may have often operated on infected persons, S believes that HIV/AIDS has not really affected him closely.

Precautionary behaviour within the context of HIV/AIDS

U S explains that during emergency surgery precautionary measures have become ritualised. This has happened in the last two years and is because of HIV/AIDS.

U S reiterates that he and his colleagues may often operate on cases that are HIV-positive; he believes, however, that the precautionary measures are probably adequate.

U S states that he and his colleagues are operating more slowly now because of the risks of exposure: this may be detrimental as speed is often vital in saving lives.

U Precautions and risks are issues which concern S. During operations it is now necessary to consciously attempt to be accurate, use correct instruments, and take sensible precautions.

U According to S, the presence of HIV/AIDS is influencing the quality of the surgery.

U The problems of precautions affecting surgery which S has outlined are based on the fear of death and the quality of life.

U The way S deals with patients generally now, as regards taking precautions, is different since HIV/AIDS started coming into South Africa.

U The resheathing of the needle is the only aspect of the blood-taking process that is potentially dangerous. S explains that these new precautionary procedures relating to blood-taking, developed in response to HIV/AIDS, are now regular practice.

U S outlines other precautionary techniques developed specifically for the prevention of HIV/AIDS. These include plastic gloves which are now an ubiquitous part of the hospital and surgery environment. Whilst operating two pairs of gloves are used. *S* explains that theoretically, when a needle passes through both layers of glove it should leave the blood on the first layer, thereby preventing the virus from entering the skin.

U S repeats it is now common practice when operating to use two pairs of gloves, especially with cases arousing suspicion.

U S has to make the most of these procedures. Another way of minimising virus transmission is to place a layer of *Jik* [Hydrochloric acid] between the layers of glove. However, the margin of safety depends on the depth of a needle stick injury. Deep injuries are, according to *S*, common, especially under hurried conditions such as emergency operations.

U S states that after a needle-stick accident, the doctor tries to ensure it does not happen again. However, it is unavoidable.

U S explains that operating procedure now includes goggles as part of the precautionary paraphernalia.

U Goggles are now used in every operation.

U S states that all doctors should take precautions with everybody; as yet this is not happening, largely because the epidemic has not become widespread enough.

Professional action and management within the context of HIV infected patients

U S explains that AZT is available; however, it has a relatively short expiry date and must therefore be ordered and used as quickly as possible.

Professional action and interpretation of role in the context of HIV/AIDS

U S is not angry at this person because he has AIDS, rather *S* blames his own circumstances - for instance, why must he threaten his own life, he does not get danger pay or any form of compensation.

U With regard to emergency surgery *S* sees himself as a mechanic doing a job: these are not *S*'s patients.

Subject's statistical understandings within the context of the HIV/AIDS disease

U S explains that fortunately the risk of contracting HIV/AIDS from a needle-stick injury is about a 1 in 215 chance. This ratio provides a back-up at least.

Subject's experience of patient as physical disease

U S explains that he has a different relationship with every patient. This depends largely on the disease of each individual. *S* does not have the same relationship with every patient.

U S reiterates that he will have a different relationship with each person he treats.

U S will have a different relationship with each person depending on their disease.

Subject's understanding of groups constituting high risk in the context of HIV/AIDS

U Precautionary instruments according to *S* are only used with high-risk patients, not with all patients.

U S is unsure of the criteria which defines a high risk person.

U S refers to the researcher as an example of a low risk person: he illustrates the criteria he uses by stating that because the researcher is not wearing an earring, he would classify him as low risk although he could be wrong.

U S refers to the researcher again as a low risk person to illustrate how such a person may request a blood test: after *S* has taken the blood this person may then ask for an HIV test.

U Certain people according to *S* are a higher risk to doctors than others. The black people have a higher incidence of HIV-positivity, just as they also exhibit a higher incidence of TB.

U S is more careful with black people, homosexuals, or those he perceives to be potential homosexuals.

U S states that certain groups are prone to having a higher incidence of HIV than others.

U S states that he does make a sort of subconscious risk assessment of a person's HIV status, especially when operating.

U S explains that the female vagina is resilient to even the HIV virus. This is because over the centuries women have been so abused sexually that those who have survived have developed a resistance to disease.

U S believes that a white woman's vagina is an incredibly tough organ. This is because of the abuse she has received over the centuries. *S* believes the transmission of the HIV virus through the vagina is almost impossible.

The meaning for the subject of the body and its parts in the context of HIV/AIDS

U S explains and illustrates the latest precautionary procedures with regard to taking blood. With these procedures the practitioner does not come into contact with any blood.

The meaning of personal risk in the context of HIV/AIDS transmission

U With regard to the changes that have occurred for S as a result of HIV/AIDS, S explains that he and his colleagues are on call for emergencies at the hospital. They are expected to deal with those groups who show a comparatively higher incidence of HIV/AIDS, such as disenfranchised blacks and poor people.

U S states that despite the fact that potentially dangerous diseases have always existed, none of these has ever been as dramatic as HIV/AIDS: they have all been relatively curable.

U S has been exposed to life-threatening diseases in the past: when he worked in a Meningitis ward he wore gloves and took two antibiotics every day to prevent contraction, and he has also worked in a Hepatitis ward. He did not contract any of these diseases. S explains, however, that Meningitis is curable and that Hepatitis has a 99% recovery rate.

U S sees HIV/AIDS as being vastly different to any of the other life-threatening diseases. HIV/AIDS is unprecedented and far more serious.

U S explains that when he is involved in a complex operation such as that caused by a car accident or a bullet wound, it is often very difficult, despite the precautionary procedures. In these procedures the instruments are sharp and the operator relies strongly on a sense of touch to guide his instruments. At times such as these, S asks himself if he is actually saving the person's life at the risk of his own, or could he just let the person die.

U When delivering babies and giving an anaesthetic, sometimes it is necessary to direct the needle by holding the tip with a finger: with the presence of HIV/AIDS this poses an enormous risk to a surgeon.

U S is concerned about wilfully exposing himself to the risk of HIV all the time.

U S accepts that everyday life has its dangers - in fact at the moment there is a higher chance of being knocked down by a car than there is of contracting HIV/AIDS.

U HIV/AIDS may give rise to a similar scenario as S experienced with Congo Fever. This gives HIV/AIDS a terrifying dimension.

U Deep needle-stick injuries are happening regularly in S's experience. If an individual is HIV-positive, this has strong implications for the doctor.

U S explains that, despite taking all precautions, there is more chance of contracting HIV/AIDS through blood spraying into the practitioner's eyes, than there is through a needle stick injury.

U S describes that a practitioner can operate with goggles for six months without any sign of blood-spray, which leads to complacency - then suddenly it will happen. Blood-spray may occur through drilling, or when the practitioner attempts to close off a bleeding vessel.

The future context of the HIV/AIDS disease

U In the future S sees himself as having to operate on people who he knows are HIV-positive; this is because the number of cases is increasing dramatically: two years ago there were two cases in the community, now there are forty. It is therefore inevitable that S will become more involved.

MITWELT

Before

Influence of others/Professional

M S explains that in the last couple of years he and his colleagues were made aware of HIV/AIDS through various refresher courses and through discussing the topic with other colleagues who had already dealt with cases. S and his colleagues were therefore expecting to encounter cases in the near future.

M S and his colleagues were prepared for the arrival of HIV/AIDS.

M According to S, when HIV/AIDS first appeared there was a tremendous volume of information available. A lot of this information was misleading, for instance initially the impression given was that a person could only contract the disease if he were an active homosexual. As the virus has spread to other risk groups, more information has become available, consequently we have learnt more about the disease. However, S believes that although we are well informed about precautions, there is still a lot we do not know about the disease.

M S and his colleagues had discussed and prepared themselves for the day when they would receive HIV/AIDS patients. This preparation had been facilitated by the extensive amount of literature on the topic. S and his colleagues had been waiting for a long time.

M According to S there is an extensive amount of information available on the topic of HIV/AIDS.

Knowledge of patient's HIV status

M Before S met his patients he was approached by a spokesman for this family. This person came to assess S's suitability by questioning his attitudes towards blacks and HIV/AIDS. S's prospective patients were all black.

Precautionary techniques in relation to professional procedures

M S may perceive someone as low risk, take no precautions, and then realise he was wrong. For this reason *S* states precautions should be taken with everyone.

Relationship between subject and patient in 1st encounter

M S's HIV infected patients constitute three individuals: two parents and their child.
M S assured the spokesman that he would see this family.

Subject's perception of patient's understanding of GPs as high risk

M S does not believe that his future as a doctor would be jeopardised if people perceived him as a doctor who deals with HIV/AIDS patients. *S*'s initial fear did therefore not contain a fear of losing patients.

During

Feelings evoked in relation to others

M S states that apart from his own fear of this disease he can feel the anxiety experienced by these individuals.

Management of known HIV infected patient

M S's subsequent dealings with these infected patients has focused mainly on the mother and child. It is normally the child who is ill: the mother accompanies the child and the father comes only occasionally.
M S explains that his patients have been made aware of the early signs and symptoms of this disease. Consequently they see him on a regular basis.

Modification of relationship to HIV/AIDS patients subsequent to encounter

M S agrees that initially his attitude and fear may have obstructed the establishment of the normal doctor-patient relationship. Once *S* started to get to know these people a relationship did begin to develop.
M Through interaction *S* explains that a trust develops and as patients become more dependent, the more he becomes inclined to help and the more sympathetic he becomes towards those patients.
M S hopes that the quality of his interaction with this family has improved during the time he has been treating them.
M As *S*'s encounters with this family have become more frequent a genuine relationship has begun to develop.

Modification of interaction with others subsequent to encounter

M S's experience with these HIV infected patients has not caused any adjustment in his behaviour in general to other patients, colleagues, or the general public.

Relationship between subject and patient in 1st encounter

M S states that these patients were nervous of coming to a new doctor in a new town. However, *S* felt that they had relaxed once he explained to them his own fear and uncertainty about HIV/AIDS.
M S felt that his patients became more relaxed because he was frank and open with them.
M S shook his patients' hands because he perceived them as people in distress.
M S states that these individuals had previously been counselled. *S* reiterates the point that he told them he would accept them as his patients.

Subject's perception of patient's understanding of his/her condition

M S explains that his patients were a young couple. They related their circumstances to *S* and *S* perceived them to be well-informed.

Subject's relationship to known HIV infected patient

M S does not think that his manner of interaction with these patients is different in any way to his interaction with so-called "normal" patients.
M S explains his standoffishness by using the example of how individuals relate to one another in a supermarket queue. When people are unaware of the fact that someone else is HIV-positive their interactions are normally relaxed and uncomplicated. *S* explains that it is only because he is aware, that he will behave differently. This difference will derive from his fear.
M S believes he has developed a working relationship with this family of HIV infected persons.
M S states he cannot for example have the same relationship with this family as would have for instance with a person expecting a child, having perhaps previously delivered two of this person's children. This relationship would contain trust, humour and comradeship.

M S's relationship with this family is not like his relationship with an expecting mother.

M S only has one family of infected persons; if he were to have others his relationship with them may be different.

M S treats his HIV infected patients in an identical way to how he treats his other patients.

M S qualifies what he means by "identical", he states that although he treats people in the same way, everyone is different and therefore his relationship to each person will be different.

M If S had five different families who were HIV-positive he would treat them all differently.

M S shows how people may be different in that some are more dependent, more demanding or in need of more support. S states that the HIV family is amazingly independent.

Subject's relationship to terminally ill patient

M S's relationship with someone suffering from terminal illness will be different to that of someone involved in drug abuse.

M S reiterates his point that a mother with a terminal leukaemia child will be treated differently by him to someone who has twisted his ankle in a Rugby game.

Verbal communication with known HIV infected patient

M S told the patients that he would be willing to be their doctor; he then shook their hands and sat them down, making them comfortable whilst they related their story.

M When S sees his patients they greet one another informally.

M S interacts in an honest and open way with these individuals - he has disclosed his feelings of fear to them.

M S's patients understand that by treating them he is putting himself at risk. However, S has explained to these patients that he will do his best to help them.

M S has explained to these patients that when they present for treatment he will examine them very carefully but that there will always be a relative standoffishness on his part.

After

Assessment of known HIV infected patients

M S's HIV-positive patients are perceived by him as being healthy. S explains that these patients are HIV carriers, rather than AIDS patients. They do not need regular attention. If, however, they become ill, they know to seek treatment immediately.

M S distinguishes between his patients and hospital patients.

M Had S's patients been in an advanced stage when he first saw them, he would not have known how to deal with them.

M When S first met his patients they appeared to be perfectly normal.

Education of patients

M S does mention the topic of HIV/AIDS to his patients. According to S, in the past, when a person felt ill, his first fear was cancer. Today he fears cancer and AIDS.

M S mentions HIV/AIDS regularly to his patients. In the past he may have reassured a person by saying "You do not have cancer"; today he states, "You haven't got cancer or AIDS".

M If a patient is overly concerned about his HIV status S will encourage a test in order to alleviate these fears. According to S, conversations centring on such issues are common.

Education of public

M S is generally approached by various institutions such as schools, University residences, Farmers' Associations and the like to give lectures on various illnesses. At the moment the main issue is HIV/AIDS. S talks extensively on this topic to farmers who want to be informed.

M Whenever S is in a public place - a social function, sports meeting or party - he is confronted by individuals who seek information and advice relating to HIV/AIDS. Questions relate to his own fear; the number of cases; transmission, and signs. S states that people are amazingly interested in the topic, and want as much advice as possible.

M S gives a lot of advice socially to the public.

Influence of others/Professional

M S sees himself as a general practitioner being given enough opportunity to learn about HIV/AIDS and precautionary measures.

M S and his partners visit the various teaching hospitals regularly for education purposes.

M S uses certain criteria to assess a person's risk status; he also reaches his understanding that blacks constitute a high risk group through statistics he has seen, as well as his own opinion.

Influence of others/Society

M With regard to the moral views held by society towards various groups, S believes that there is a truth in the fact that lower socio-economic groups are more prone to HIV/AIDS than other groups. S explains that these groups also have a higher incidence of heart disease: they smoke more, they drink more, eat the wrong foods, they beat each other they have a shorter life span. These groups are more likely to contract HIV/AIDS and TB.

Influence of others/Media

M S states that the general perception towards HIV/AIDS held by society does affect him. This is because - like everybody else - he is influenced by the effects of advertising and the media in general.

M S is certain that the influence of advertising and the media affects the way he perceives his patients.

M The effects of advertising and the media on S's perception of HIV/AIDS are apparent to him through the way he is constantly surprised at how healthy his patients look. They are not thin and emaciated as is the impression he has developed through observing media pictures.

Modification of relationship to HIV infected patients subsequent to encounter

M S is not sure whether anything has changed in his view towards HIV/AIDS patients since he began to see this family.

M S's perception of HIV infected persons has undergone modification as a result of this experience. Previously S had not expected to see healthy individuals who were infected.

Modification of interaction with others subsequent to encounter

M S's relationship with his colleagues has not undergone any change as a result of his experience.

M S's interaction with people in general has not undergone any change as a result of his professional knowledge and experience with HIV/AIDS. S delivers many public lectures on HIV/AIDS but he also talks on contraception, V.D., drug abuse and other topics.

M Since the advent of HIV/AIDS, and S's recent experience, his relationship with others is constantly changing.

Modification of relationship to patients in general subsequent to encounter

M S does not perceive his old patients in a new light or his new patients in a different way on account of his experience.

Perception of changing role in relation to others

M S does see his role in the future as containing an educative component. However, he does not see himself as a front-line educator because the media and various large organizations are taking on this role.

M S does not see GPs in general as having a front-line educative role in the future.

Perception of professional role in relation to others

M S sees part of his role as comprising an educative component.

M S believes general practitioners should be educated themselves and kept up to date; they should also be educating.

Professional interaction with colleagues

M S has spoken to his colleagues about his experience with an HIV infected family.

M Because the practice that S belongs to works on a rotation system - where his colleagues will stand in for him - it has been necessary for S to explain the situation concerning his HIV patients to his colleagues.

M When the HIV infected family first contacted S by phone he emphasised that they would be cared for by the entire practice.

M Issues relating to the risks involved in surgery are a regular topic for discussion amongst S and his colleagues.

Relationship to family in the context of HIV/AIDS

M S feels his children are old enough to care for themselves, were he to contract HIV.

M S's concern about HIV/AIDS is different in relation to his three sons because they are all adults.

M S's concerns about HIV/AIDS relate more to his direct family than they do to his distant family. Some members of S's distant family are also doctors.

Subject's perception of family response to HIV/AIDS

M S's wife is terrified of the fact he is in a high risk group.

M S's wife points out to S that they have not brought up a family, developed a degree of stability and worked hard, for S to throw it all away by contracting HIV/AIDS from someone.

M S's wife is very concerned about his position in relation to HIV/AIDS.

M S's mother occasionally voices her concern about S contracting HIV/AIDS.

M S's wife expresses her concern constantly about S belonging to a high risk group. S was once quarantined during a Congo Fever scare, and his wife states that she does not want to have to go through such an experience again; neither does S.

Subject's perception of colleagues' response to HIV/AIDS

M S's partners have lightheartedly chastised him for involving them with HIV infected persons. However, S is certain that they will maintain the same standards as himself.

M None of S's colleagues have had to treat his HIV infected family yet. They are all expecting the day they have to do so.

M S believes that his own views towards HIV/AIDS are the same as those of his partners. However, he is unsure whether his colleagues in town hold similar views.

M S states that his colleagues would only be anxious when dealing with an infected person if they were operating and coming into contact with blood. S humorously presumes that they would not have sex with their patients: this is the only way to contract HIV/AIDS.

Subject's perception of friend's understanding of doctor's role

M S has discussed the topic of HIV/AIDS with people, he is asked many questions and he answers them. He has never found people to be unsympathetic: they all understand his position.

M S's friends feel sympathy for him because of the nature of his work.

M S has not come across anyone who is unsympathetic to his situation. Many people mention to S that they are pleased that their professions do not involve contact with HIV-carriers and possible risk.

M The sympathetic view of others towards S is directed at his position as a doctor in the community.

Subject's perception of patients' understanding of GPs as high risk

M S states that if he were to contract HIV, he would not be able to work because people would find out.

M S believes that if he were HIV-positive his patients would not come to him: his range of patients would be restricted instead to those who were HIV-positive themselves. These are the real concerns which need attention.

M S's patients have shown a reaction to S being a possible high-risk person. Patients have enquired as to whether S is using new needles and clean syringes; others have asked S why he isn't wearing gloves. These questions are occurring more and more often.

M S's reaction towards the individuals who demand precautionary paraphernalia differs depending upon his relationship with the person. S may react in a humorous way, informing the individual that he was unaware that this person was an HIV/AIDS risk.

M If a patient is genuinely concerned about the risk of HIV/AIDS, then S will comply accordingly. He will, however, discuss the issue of risk with the person.

M S has his blood test available to show individuals that his HIV status is negative.

Subject's perception of social groupings in terms of HIV risk

M S explains that there are many people who are gay who do not look as if they are. Many individuals may have had one or two homosexual experiences because of circumstances.

M With regard to risk groups S states that he can only speak in terms of his own community. S has lived in one community for a long time, he is aware of those persons that are at risk and put others at risk to HIV/AIDS.

M S states that his knowledge of risk types does not extend to the black community.

M S states that it is a fact that the black population has the highest incidence of HIV/AIDS. This may be due to a number of reasons, such as malnutrition; whether they live together, and their sexual norms.

Subject's perception of individuals in terms of high risk activities

M According to S homosexuals carry all kinds of diseases.

M When a patient refers to the possibility of his having HIV/AIDS it is normally done in a lighthearted way. However, according to S there generally exists a more serious undertone to such statements. In the past many of these patients may have been involved in high-risk sexual activities such as having sex with a prostitute, sleeping with a maid, or having an affair.

Subject's relationship to known HIV infected patient

M S feels, with regard to his family and friends, that if he contracted the disease he would be like anybody else who was dying.

Subject's relationship to terminally ill patient

M S explains that cancer is different to the HIV condition because individuals seldom live longer than six months after diagnosis with cancer - although there are exceptions: if a person lives for five years after operating then he has been cured.

Subject's assessment of personal risk through professional activity

M S would not blame the person who gives him AIDS for having the disease: this is merely a part of the social system.

M S believes that surgeons are a higher risk category than general practitioners. S has a surgeon friend who has thought about that issue at length and finds it difficult.

M If S is asked by an inexperienced doctor to perform a Caesarian section on his behalf, S encourages his colleague to make sure the birth cannot be performed normally, before he operates.

M S explains that at some of the big Black hospitals, the surgeons and specialist surgeons have all resigned because of the fear of HIV/AIDS. The people doing the operations now are the registrars who want to become surgeons.

EIGENWELT

Before

Cognitive preparation for the situation of encountering an HIV infected patient

E Before S was due to meet his first HIV/AIDS patients he needed to think very seriously about his position in relation to this disease and the danger it presented, even though he had been aware of this beforehand.

Personal judgement of professional role

E As a general practitioner S is unsure if he is legally within his rights to deny treating an HIV infected person. Morally, however, S feels he is obliged to.

E S believes that legally he could possibly get away with his decision not to treat HIV infected patients. He could do this by stating that his practice is full and he has no time for this type of disease, or a number of other excuses.

During

Subject's self-reflections in relation to known HIV infected patient

E A person with AIDS is different; however, S is not entirely sure of this difference: his opinions in this regard are not entirely clear because he has not had much experience.

Modification of perception of HIV/AIDS subsequent to encounter

E Despite S's recent experiences with HIV/AIDS, his understanding of the disease is still largely academic.

Personal judgement of professional role

E S plays different roles according to the circumstances and he hopes that he plays the correct roles each time.

After

Assessment of personal risk

E S perceives himself as belonging to an extremely high risk category.

Cognitive preparation for the situation of encountering an HIV infected patient

E S feels that all his initial preparations taken before treating his first HIV-positive patients were appropriate, necessary and adequate.

Considerations regarding personal HIV tests

E S will be tested regularly for HIV because he feels this as his responsibility to his patients.

E S has a regular HIV test both for his own and his patients' benefit. He feels that even were he HIV-positive, it probably wouldn't make a difference. S then changes his mind and states that he would sell everything, stop working, travel and enjoy life. Again, S suggests not knowing his status may be better.

Modification of perception of HIV/AIDS subsequent to encounter

E On account of his experience with an HIV infected family S's general perception has been changed to the extent where he is now certain that HIV/AIDS is here and that it needs to be dealt with.

E S's understanding of the HIV/AIDS disease has altered, but not on account of his experience with this family.

Perception of high risk behaviour

E S explains that other people have a choice; if they contract HIV/AIDS it is because they have chosen certain behaviours; S on the other hand has no choice.

E S does not see HIV/AIDS as a moral issue. He sees this phenomenon within a framework of circumstance. For instance, with homosexuals their lifestyle and associated sexual behaviours happened to provide a means through which the transmission of this disease could take place.

Personal judgement of professional role

E S states that he is not a martyr; he will, however, continue to see and treat, to the best of his ability, those individuals who are genuine patients of his who contract HIV/AIDS.

E S does not understand why he should continue operating - thereby increasing his chances of contracting HIV/AIDS - when, unlike the driver of a dynamite bus, for instance, he receives no danger pay.

Personal feelings

E S does not want to kill himself for something that cannot be cured. S states that he is not a martyr.

E S feels he needs to work with these issues very thoroughly, and ask himself whether in fact he isn't committing suicide in such situations, and does the patient actually have a chance.

E S states that if he were to develop cancer he could handle it: he would try to have it cured, though in his experience this is improbable.

Subject's self-reflections on changing role

E S surmises upon his position if there were masses of HIV/AIDS cases who all required treatment and were incurable. He states that were HIV/AIDS to reach the proportions that various prophets of doom predict, he may have to consider retiring or resigning as a doctor.

E If S had to be coerced into a situation where for instance there were only ten doctors in town and 10 000 cases of AIDS, and where he has been told to work for six days a month in an AIDS hospital - scenarios which have been outlined to the local doctors - then S will consider changing his profession.

Subject's self-reflections regarding perceptions of colleagues' response to HIV/AIDS

E S believes that his colleagues, like most people, have differing views. However, they are competent, well informed and they would treat his patients.

Subject's self-reflections in relation to Professional influences

E S points out that there are many general practitioners who do not take the opportunities available to them for their own education. In S's practice his partners have been on a number of refresher and revision courses recently. They are not compelled to go but they do.

E S states that it is necessary for doctors to make this effort; however, it is easy to fall behind. S feels it is up to each person to keep up.

Modification of personal judgement of role subsequent to encounter

E Since the advent of HIV/AIDS the meaning of being a doctor has had to be reevaluated for S. S has never had a reason to resign, now he feels he has.

E S has seriously reevaluated the meaning of being a doctor in the light of HIV/AIDS.

E HIV/AIDS is making it very difficult for doctors. S is sure that he is affected, but as he has only one family to treat, he cannot really speak from experience.

M S asks the question why he should work in Africa where there is HIV/AIDS when he could go to Canada, America, or England where conditions are less threatening.

E S hypothetically outlines the possibility of resigning from his profession and becoming a drug representative, or opening a small business. In this way *S* sees himself as having the chance of living until he is 60, contrary to his present expectations.

E S reiterates his feelings and thoughts about resigning as a doctor and becoming a businessman or a dropout: selling his house, putting the money on the Stock Exchange, and living at the seaside. In doing this his conscience would be clear.

Subject's self-reflections in relation to society

E S refers to the stereotypes held by society towards AIDS sufferers - such as "divine retribution" - as so much rubbish.

E S states that if the view is adopted that every disease is brought on by God, such as the Black Death and Polio, then God appears as some sort of magician who can also give a person a lucky number in a casino. *S*'s God plays a different role: he is not a magician with a magic wand.

Subject's self-reflections in relation to media

E S has not been exposed to large numbers of HIV/AIDS patients and this may account for the fact that he has not yet formed a strong impression of his own but is influenced by the media.

Subject 6.

UMWELT

Before

Historical context

U In his professional capacity S has encountered HIV-positive blood samples without attending to infected individuals as such.

U During a visit to another African country, S encountered various individuals who showed classic signs of HIV infection.

U Despite the language barrier S was able to conclude that a particular individual exhibited signs of ARC.

Immediate context

U This was the only HIV-positive person seen by S.

Subject's experience of the patient as physical disease

U S was eager to take photographs of this case.

During

Assessment of known HIV infected patient

M S visited the patient and observed a thin and anaemic woman with swollen glands.

Immediate context

U S went to see an HIV-positive person.

U S was aware of the patient's HIV status before the event.

U S's visit to the patient was brief and did not involve a physical examination.

U S states that the patient's child later tested HIV-positive.

U S diagnosed the patient to be in the AIDS Related Complex (ARC) stage of the disease process.

Professional action and management within the context of HIV infected patients

U According to S, AZT therapy is not normally readily available for infected patients, though it is available to doctors who are exposed to the virus.

Emotions engendered by presence of HIV/AIDS in Subject's experienced world

U S states that this first experience with an HIV-positive person did not shock him. He knew what to expect.

Subject's experience of the patient as physical disease

U From an educational point-of-view S is eager to take slides of another HIV-positive case who is a patient in the hospital.

U S's curiosity with regard to the patient's disease related to his educative interests in the field of sexually transmitted diseases.

Subject's statistical understandings within the context of the HIV/AIDS disease

U S feels that it is important to record the local incidence of the disease.

The meaning of personal risk in the context of HIV/AIDS transmission

U S declares that he is not concerned about touching an HIV infected person and in fact - he cannot actually remember - he might have touched this patient.

After

The meaning of personal risk in the context of HIV/AIDS transmission

U S is not concerned about physically examining a person for HIV infection, so long as the surface of his skin is intact.

U S is a surgeon and with regard to AIDS this worries him.

U S considers his high-risk position.

U When involved in surgery S arranges his time so as to take on anaesthetic duties rather than surgical duties. *U* S reiterates his concern over his high-risk status with regard to emergency surgery or patients who are HIV-positive.

U Recently whilst performing a Caesarian section on a private patient S incurred a needle-stick injury; although S acknowledges the patient could be HIV-positive, he perceives the risk to be small.

Emotions engendered by the presence of HIV/AIDS in Subject's experienced world

U HIV/AIDS is an extremely frightening disease for S.

U A close look at the potentially disastrous effects of this disease creates in S a strong fear.

U On an individual level S perceives HIV/AIDS as a terrible terminal illness.

Precautionary behaviour within the context of HIV/AIDS

U S takes precautions during surgery but is doubtful as to whether these are sufficiently effective.

U For S the extra precautionary paraphernalia due to HIV/AIDS that is now a part of surgical procedure is annoying.

U S is sceptical of the effectiveness of HIV/AIDS precautionary paraphernalia.

U From a personal point-of-view the presence of HIV/AIDS has caused changes in S's medical procedures. He now uses gloves where he would not have in the past.

U S does have access to precautionary paraphernalia; he acknowledges the importance of carrying these items such as gloves and ventilators with him, but does not do so at present.

U S does not wear gloves when taking blood. This is because he feels that the new blood-taking procedures are safe enough and do not warrant further precautions.

U Generally S feels that the wearing of gloves during the blood-taking procedure is an unnecessary precaution.

U S has always used gloves for internal physical examinations even before the advent of AIDS. In this regard, the presence of HIV/AIDS has not changed anything.

U For other procedures, such as various types of incisions, S now uses gloves whereas before he would not have. This is due to the presence of HIV/AIDS.

Subject's statistical understandings within the context of the HIV/AIDS disease

U According to S the local district has not recorded any HIV/AIDS cases in the White population group. The 30 or so cases reported have all been from the Black population group.

Subject's experience of a patient as HIV infected

U S would deal with cancer and HIV/AIDS patients in the same way although he would not take the same precautions with a cancer patient as he would with an HIV/AIDS patient.

The future context of the HIV/AIDS disease

U S predicts routine testing for all before surgery, in the future.

U S recently considered the future scenario that will arise as a result of HIV/AIDS. S sees an influx of patients into the health care structures.

U If HIV/AIDS reaches major epidemic proportions S foresees a lot of problems. However, he proposes that very stringent precautionary measures will be necessary if this is the case.

U S feels threatened by both an increase in AIDS cases and having to attend to AIDS patients.

MITWELT

Before

Assessment of known HIV infected patient

M During S's first encounter with an HIV infected person, which was motivated by curiosity, he perceived the patient as being unwell.

Professional interaction with colleagues

M S requested the hospital staff to assist in co-ordinating a meeting between himself and an HIV-positive person who is currently being treated.

Relationship between subject and patient in 1st encounter

M S was not responsible for this person.

M S had not examined the patient before this encounter.

During

Assessment of known HIV infected patient

M S observed that the patient was looking unwell.

Feelings evoked in relation to others

M Because of the young age of this patient, together with the fact that she had recently given birth, S perceives this case as tragic.

Knowledge of patient's HIV status

M S's awareness of the patient's HIV status derived from his relation with the ante-natal clinic staff.

Relationship between subject and patient in 1st encounter

M S was informed of the birth of the child. S visited the patient briefly after she had experienced a relatively straightforward delivery.

Subject's perception of patient's understanding of his/her condition

M S was unsure of the extent of the patient's knowledge of her condition.

M Because S did not know how well the patient understood her condition, he was careful not to make an issue of his visit.

Subject's perception of colleagues' response to HIV/AIDS

M S explains the reluctant attitude of the hospital staff towards the impending delivery of a potentially infected child from an HIV positive mother.

Subject's relationship to terminally ill patients

M S reiterates the fact that he perceived this case as tragic because the patient was terminally ill and had recently had a child.

Subject's relationship to known HIV infected patient

M S did not want to cause the patient any undue worry or alarm. S declares that the patient must have been aware of his status as a doctor.

M During this encounter S had thoughts relating to the fact that the patient would die soon.

M S perceived this patient in the same way he would any terminally ill patient.

Verbal communication with known HIV infected patient

M S did not speak to the patient.

M One reason for S not communicating with the patient was his limited knowledge of the language.

After

Education of family

M S has attempted to educate his daughter as far as possible about the risks of HIV infection.

M S has another two daughters. One of these is too young for discussion on the topic of AIDS.

Education of colleagues

M With regard to education about precautionary measures, S states that he would not like one of his staff to become infected and consequently sue him for not providing a satisfactory education programme.

M To ensure that his staff are adequately informed, S makes a considerable amount of literature available for their perusal. S ensures the staff sign their name after they have read the literature: this way they are responsible for their own safety.

Education of patients

M S does attempt to inform his younger patients, especially the men, about the risks of HIV infection

Education of public

M S is available to answer questions about HIV/AIDS at any time. S has organised meetings, public lectures and newspaper articles in an attempt to increase awareness about HIV/AIDS. The public lecture was not well attended.

M Part of the reason S has endeavoured to educate himself on the topic is because he is often expected to play the role of advisor in the community and is asked to speak at schools and churches. For this reason he needs to know the facts.

Influence of others/Society

M S states that most people, and especially himself, have grown more tolerant of homosexuality. He states that he has never been explicitly intolerant of others, though he has perhaps held certain prejudices in his own mind.

M S has not considered his role as a doctor in relation to the negative attitude held by society towards AIDS sufferers.

Influence of others/Professional

M S often attends formal meetings and discussions with other health-care workers on the topic of AIDS education.

Management of known HIV infected patient

M S has no direct contact with infected individuals; positive results are directed to S through official channels, S in turn informs his staff.

Modification of relationship to HIV infected patients subsequent to encounter

M S states that his encounter with the HIV infected individual and her child has merely confirmed what he already knew.

Modification of interaction with others subsequent to encounter

M S states that his encounter with an HIV positive person has not caused any adjustment in his relations with patients, colleagues and other people.

M For S the increased presence of HIV/AIDS has given rise to more questions from the public being directed to S. In this way, S's interaction with people in general has changed.

Modification of relationship to patients in general subsequent to encounter

M S states that his relationship to his patients has not changed as yet. If he were working in San Francisco where the numbers are greater then perhaps his relationship would have changed.

Perception of changing role in relation to others

M S uses the example of how American doctors no longer stop at road-side accidents, to make the point that HIV/AIDS has influenced and changed the medical profession.

M In the face of AIDS, S is content to continue consulting in his rooms but is not enthusiastic about surgery or obstetrics.

Perception of professional role in relation to others

M S explains that the role of the general practitioner during surgical procedures at the hospital is to attend and assist a full-time hospital doctor.

M S perceives himself in the role of an educator in the community.

Precautionary techniques in relation to professional procedures

M S indicates that his nursing staff have always had access to Hepatitis injections.

Relationship to family in the context of HIV/AIDS

M S has thought about the influence that the AIDS epidemic will have on his family.

M S expresses his concern for the safety of his daughter whom he perceives as being close to the sexually active age and therefore at risk of contracting HIV/AIDS.

Subject's perception of social attitude to HIV/AIDS

M S relates an incident to make his point about the fear that AIDS instils in people. In this case a person's partner wrote "I have AIDS" on his car windscreen in lipstick. The person's reaction was of intense fear and S had to allay this fear by taking an immediate blood test. The test recorded negative.

Subject's perception of patients' understanding of GPs as high risk

M People have not shown an awareness of the fact that S is part of a high-risk group.

M S strongly believes that in the future people will become aware that he is part of a high-risk group.

M Through a discussion with one of his colleagues S is aware that if he becomes HIV infected he may live for ten years, but his practise will collapse because people would no longer use his service for fear of contracting HIV from him.

Subject's perception of colleagues' response to HIV/AIDS

M S claims that his views on AIDS-related issues are similar to those of his colleagues.

Subject's relationship to known HIV infected patient

M When S thinks of AIDS sufferers his attitude is neutral and he has no negative feelings.

Subject's perception of social groupings in terms of HIV risk

M S surmises that the patient he saw was probably a prostitute.

M S sees high-risk groups as a reality. However, HIV/AIDS according to S extends beyond these risk groups into the whole population, especially in the Black population.

M S is often requested by his patients to do HIV tests.

M S does not openly ask those patients whom he suspects to be gay whether they are or not; furthermore S neither condemns nor condones their behaviour, he just feels that they don't know what they are missing.

M S is often asked by men to test them for HIV/AIDS.

M When men ask S for HIV tests S suspects they might be gay.

M If a person requests an HIV test S may suspect that he is homosexual because these are the people that normally ask. However, heterosexual males also request tests.

Subject's perception of individuals in terms of high risk activities

M S attempts to educate those patients who repeatedly return with sexually transmitted diseases about HIV/AIDS.

Subject's perception of family's response to HIV/AIDS

M S explains how when his wife assists him in his clinic she frequently admonishes him for not taking precautions. To S this is a show of her concern for him and the risk involved in his work.

EIGENWELT

Before

During

Personal judgement of professional role

E S indicates that doctors are used to witnessing extreme medical cases.

Personal feelings

E For S this encounter was straightforward.

Preparation

E S's encounter with an HIV person did not present anything different to that which he had expected.

After

Assessment of personal risk

E S is content with consulting at his surgery and prefers this to surgical work which involves long hours and increased risk.

E As S grows older his enthusiasm for surgery has declined. The presence of HIV/AIDS has contributed to this attitude.

E S himself is very aware that he is part of a high-risk group. This reality is not pleasant to confront.

Modification of personal judgement of role subsequent to encounter

E Certain things have changed for S as a result of HIV/AIDS.

Personal feelings

E S believes that modern medicine and its practitioners have disturbed the natural balance of the human population. By attending to only one aspect - saving lives - they have exacerbated the high population growth rate.

E S is alarmed by the population growth rate.

E S reiterates his belief that some greater force may be responsible for the introduction of AIDS in an attempt to control population growth.

E S explains that like any human being he believes that he will never contract HIV/AIDS. For this reason he has been unable to realise the full implications of the disease as it pertains to him.

E S enjoys his profession and would not leave it.

E S acknowledges that the AIDS epidemic will affect him psychologically but feels that he will be able to deal with it as he is used to it.

E S is now more accepting of homosexuality.

Personal judgement of professional role

E S enjoys private work above hospital work, though he acknowledges his duty to the local hospital.

E S has thought about his high-risk position and acknowledges the seriousness of it to himself. However, apart from taking the necessary precautions or leaving his job, there is little he can do.

Subject's self-reflections on changing role

E The increased risk which is presented to S by the presence of HIV/AIDS may influence S to stop working in the hospital. However, S would still remain within the medical profession and would focus on consulting duties alone.

E In the future, S would try to move away from direct surgical work.

E S sees himself as having to redefine his role as a doctor in the near future.

Subject's perception of future trends in HIV/AIDS

E S has often considered his own and his family's position with regard to future doomsday predictions of the incidence of AIDS. S is uncertain of the outcome.

E S is not entirely sure of the risk posed by the disease. However, he feels that sensible people are going to have to be very careful in the future.

Subject's self-reflections on relation to terminally ill patients

E S is used to, and not afraid of, dealing with terminally ill patients.

Subject's self-reflections in relation to media

E S refers to the source *Countdown to Doomsday* to support his theory that AIDS may restore the population balance. Although he is not certain that this book's predictions are correct, he foresees a considerable increase in the incidence of AIDS in the future.

Subject's self-reflections in relation to Professional influences

E S feels that it is up to the individual to educate himself about HIV/AIDS. S felt obliged to educate himself because of his profession.

Subject's self-reflections in relation to society

E S does not perceive HIV/AIDS as divine retribution; he does not see the epidemic as totally negative because it may restore the population balance.

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