(Dear Friends: This is a draft of a chapter of a book I am writing. Please do not forward or otherwise circulate it to friends or colleagues without first asking my permission. It is far from finished and some of my ideas might change based on our conversation.)

The Moral Intimacies of Care

For the Workshop on Bodies and Bodiliness in Africa, Moshi Tanzania, June 2010

As a cancer epidemic rapidly emerges in Botswana, closely trailing the wake of ARV provision, the fragility of moral sentiment and political efficacy are at issue in ways we can best trace through the intimacies of care. Care-giving in Botswana’s lone cancer ward (a 20-bed unit located in the central referral hospital – PMH) takes on a particular moral urgency for two reasons. First, because of the nature of oncology as a body of practice. This is a domain of medicine where harming continually threatens healing in disorienting ways: oncological therapeutic practices consist of poisoning, burning, and cutting. Second, because in the PMH oncology ward, we see clearly how health instantiates politics. Botswana’s program of universal care is in keeping with a public political narrative in which Botswana’s success is rooted in a enduring, history of participatory democracy stretching back to pre-colonial times, a political philosophy centering around the concept of botho (African humanism), and where the circulation of collective wealth mediates hierarchies of class and status. This narrative is overly nostalgic, yet the existential, social, and political import of such health policy is made
clear in the shadow of the profound AIDS epidemic that has shaken Botswana to its very foundations over the past decade and a half.ii The social and political nature, and thereby the moral stakes of healing are never more evident than in these periods of intense collective vulnerability when the weight of survival threatens to overwhelm the processes of care and the webs of relationships that sustain communities.iii

Policing the critical moral boundary between harming and healing; mediating the relationship that is cancer in this ward, caring for one’s fellow human beings (botho) is the work of a small group of not-quite peasant intellectuals: nurses, and their partners in care – patients.iv Their political philosophy is embodied, heartfelt, and articulated. Like all philosophies its ideals are often subverted amid the ebb and flow of daily life. I introduce the highly contextual nature of nursing as a philosophy of social healing with a brief excerpt from my field notes.

**Death of a Member of the Ward**

Field Notes 20 May 2009

*Mma S arrives for the night shift. It is my first time to see her since returning to PMH oncology this year. We have a nice long chat. Eventually she turns to the bad news she has to tell me. Mosadi is late. [She was a really wonderful young woman with a rare blood cancer, who had been a regular in the ward for several years]. Now Mosadi’s father has colon cancer. I had never known, but turns out that Mma S and Mosadi were relatives. Here is what Mma S told me.*

*Dr P[the oncologist] was in Germany last year visiting his mother, and it must have been shortly after he left. Dr P likes his work too much and he will even call when he is away in Germany and ask about this patient and that one. So Mosadi was here and she started bleeding. The disease converted and took a bad turn. She was critically ill, she was O positive and there was no blood at PMH so we called GPH [the private hospital across town] – also no blood and we were so worried! So Dr M called Dr P in Germany and from there he said no – we MUST get her the blood! So he called South Africa and arranged for blood that side and they drove it to the border and he said no, they will call you when it gets there. And they called and one of the nurses went to the border to get it. Six, we gave her six units of O positive, but still she was bleeding everywhere, and she...*
was asking for Dr P. And we said no, he is at home, but then when the plane landed he came straight here. And she was bleeding everywhere and couldn’t see because of it, but we said no he is here and she started calling out – from right there (she points to the female A cubicle of beds). Mma J I am dying! Mma S I am dying! Calling to us nurses and we came and she called for MmaT, so we ran to male medical ward [where she has been reassigned] to get her and brought her here. And Dr P was crying and she died then with MmaT holding one hand and Dr P the other. And we, all of us, we were crying. When the shift ended we did not leave. Dr M and Dr S and Dr P and the nurses; we just sat here crying. These things, this disease it is too cruel. HIV is better than cancer – you can take those ARVs, you will be fine. But cancer it is too cruel. You tell me, tell me, tell me – when will there be a cure for cancer? When will there be new treatments? This was one of the most heartfelt pleas for scientific progress I think I’ve ever heard.

Cancer is a terrible thing. The patients lying in the beds of PMH oncology are very sick. Some have open necrotic wounds. Others have pressure sores. Still others suffer open sores in their mouth or anus from radiotherapy. Some are hooked up to intravenous drips of cytotoxic chemicals that produce profound nausea and diarrhea. Others can no longer swallow, their throats blocked with esophageal tumors that force them to spit their saliva into a wad of towel every few minutes. Many are in tremendous pain. Some are disfigured by disease and surgery. Some have catheters or tracheostomies or colostomies to manage. All are worried, many are bored, some are depressed or anxious. Some patients have mothers or sisters or aunts who come to care for them in the evenings, helping to bathe and feed them. Some have family, friends, church members, and colleagues who visit them and call their cell phones. Many others are far from home. Some are dying. All of them need care.

The nurses broker this terrible thing, cancer. Their job is an intensely important one, and an extremely difficult one. They do not always succeed. This chapter examines the stakes and processes of their work, tacking back and forth between ethnography and explication. Nursing is a remarkably complicated endeavor right now in PMH– one best
understood by situating nurses fully in the structural, social, moral, and often pressing existential realities of their working lives. I begin by clarifying these features of nursing care in the ward, and then move on to examine the moral significance of the bodily care that nurses provide. I conclude by looking at the relationships between relatives, patients, and nurses and the ways that nurses extend and reshape social healing within the microcosm of the cancer ward.

The stakes of care

Care-giving is a moral endeavor. It is at once deeply personal and deeply social, and it is a vital practical matter; crucial to patient well-being and survival. In the PMH oncology ward, professional care-giving is also an inherently political act. The bodily care Batswana nurses provide is part of a system of universal care in a country that is still in the throes of a widespread and overwhelming epidemic of HIV/AIDS, while also grappling with a rapidly escalating cancer epidemic. Nursing in PMH oncology is an extension of the state’s commitment to care for its people, a manifestation of an explicit national ethos of collective care and compassion, and as such it exposes ongoing tensions between personal and state responsibilities and entitlements. Unlike doctoring, which is often performed by expatriates, professional nursing is a Tswana endeavor; and unlike doctoring which is shielded behind the opacity of scientific expertise, technology, and jargon – nursing work is far more accessible to evaluation by the public.

The past decade and a half has been a fraught period for the nursing profession in Botswana to put it mildly. Once a prestigious job that presented one of the very few opportunities for upward mobility available to Batswana women, over the past 15 years
or so nursing has fallen from grace and into a period of ambiguity, even as a shortage of trained nurses has emerged as a major national crisis.\textsuperscript{vi} In these dynamics, Botswana is far from alone. The “nursing crisis” is a pressing global phenomenon. Yet, the shortage of nurses in wealthier countries in turn draws experienced nurses from poorer countries, part of the infamous African “brain drain.”\textsuperscript{vii}

Concern over the quality of nursing and in particular the attitude of nurses in the country is long-standing. But by the late 1990s as the AIDS epidemic exploded into Botswana’s clinics and hospitals, these concerns took on a powerful import. Nurses were regularly characterized in newspapers, political discussions, and among the general public as callous, rude, uncaring bureaucrats. Such criticisms were matched by equally strong recognition of their importance to the core medical and public health enterprise of the country.\textsuperscript{viii} Over the past decade nurses have organized for better pay, they have gone on strike, they have left for greener pastures, and sadly, they too have become patients and died. Perhaps nowhere is this more evident than at PMH. In 2001 at the very pinnacle of the AIDS epidemic, before ARVS arrived, in the months just before the oncology ward opened, the shortage of nurses was so acute that the hospital superintendent was forced to temporarily close two wards of PMH – an institution that could hardly afford to reduce capacity.\textsuperscript{ix} By 2004, with all wards open, the situation had yet to substantially improve. Though the hospital’s nurse-to-patient ratio was one of the highest in Southern Africa, PMH was operating with only a third of their standard nursing staff. The WHO standard of care is one nurse to a maximum of six patients, but as the Botswana Daily News reported at the time, “nurses at Marina say their average is 10, and can go up to 20 in times of crisis. ‘We are extremely overworked, but underpaid.
It is not easy to attend to patients on the beds, on the floors, on the trolleys and in cubicles. The wards are always flooded with people, yet there are so few of us,’ said a nursing sister.” Yet it is also the centrality of their work – and the seeming clarity of their mission that opens nurses to such strident criticism.

So too nurses have long enjoyed the privileges of gate-keeping, wielding as they do tremendous if quotidian power over the fortunes of those who seek their care and attention, and over allied workers, including doctors who rely on their labor. In short nursing is a dangerous endeavor for all involved, highlighting as it does the vulnerabilities of the ill and the frail, and the pettiness on which all bureaucracies feed. And yet, like many such high stakes endeavors the potential payoffs are tremendous. When done well, nursing – with its touching, feeding, bathing, listening, noticing – concretizes the humanistic promise of medicine. When shirked or performed as just another bureaucratic function – it concretizes the immorality, the coldness of modern institutions.

Perhaps more than doctoring, nursing is understood to require sentimental work – compassion, care, empathy, even love are expected to animate and orient the work of nursing, and this is where it seems the greatest critiques lie. Patients, family members, doctors, and the general public alike do not always see the sentimental work they expect from the nurses in PMH. Oncology is unique in the hospital for the rigor with which Dr P manages bed space in the ward, but also for the ways the disease and its cyclical management produces long-term relationships between patients and the cancer nurses.

Throughout my research I met many patients who praised the oncology nurses for their care and support, patients like Mosadi who called for the nurses by name in
moments of terrible fear and anguish. I also met patients and relatives, who complained bitterly about their needs being ignored or rebuffed by the nurses. It seemed that for every patient or relative who complained about care on the ward there were many others who praised the nurses, who carried the matron’s cell phone number in their pocket and rang her – even in the middle of the night – if there were problems.

Such are the contradictions of oncology nursing in PMH. My point here is neither to valorize nurses nor to condemn them. Many of them are doing extraordinary work under remarkably difficult conditions. It was Mma C from oncology and her nursing colleagues in the surgical wards who of their own initiative, pushing against a thick bureaucracy, began an ostomy clinic to support patients who they saw emerging from surgery disfigured and lacking support for the management of their new bodily state. On the other hand, some nurses are domineering or lazy, like Mma P who in 2007 ran the bookings in gynecology in an abusive and rude manner, intimidating patients and staff alike. Sometimes a nurse in oncology would stay long after his shift had ended, simply to see a patient through a bureaucratic challenge, or to assist in a difficult procedure. Other times a nurse was busy playing solitaire on the ward computer and could not see the patient at the far end of the ward who needed assistance. Sometimes a nurse would advocate for a patient’s humanity, like when Mma C scolded Dr P for exposing Ninki’s cancerous vulva to twelve pairs of eyes during a training round. Other times a nurse would oppose Dr P in an effort to police her own professional autonomy, even when this went against a patient’s interests. I dare say a similar range might be found in any workplace – including my own. Yet the stakes here are extremely high, and the work
extremely difficult, given the charge of nurses to care for very sick and therefore very vulnerable people in an overcrowded and in some ways dysfunctional institution.\textsuperscript{xiii}

For patients and nurses alike, the cancer ward is both a self-contained institutional space, and one that is porous and connected to home in troubling ways. One of the nurses I worked with in 2006, Mma Z, often seemed detached and was desperate to get transferred to a new ward when the rotations came the following May. It turned out that this was because her mother had previously died in the ward and it was very difficult for her to be in this place each day that she hated for its terrible memories of suffering and loss. One cold July day, I watched as another nurse, Rra D had to leave the clinic and stand outside for a moment to collect himself after a difficult prognostic conversation with Jane and her partner Roger. They were close childhood friends of his, and Jane though not yet thirty years old, had just been diagnosed with an extremely aggressive breast cancer. Botswana is a small country, and such moments where home floods into work are not uncommon.

Many nurses, of course are patients themselves. Some have HIV, others have breast cancer, or diabetes or hypertension, their privacy potentially compromised by their work. Some nurses, (particularly women) were not only taking care of dying or profoundly ill patients in the ward – but also of dying or profoundly ill relatives in their homes each day after their shift in PMH ended. They were expected by their families to be the advocate and broker for sick relatives who arrived in Gaborone needing care. Nurses are often the obvious choice for families struggling to provide care for the sick – because of their knowledge and skills, because of their assumed resources (after all they are employed), and when hospitalization or out-patient consultation was a possibility
because of their residential proximity to PMH. Their bureaucratic knowledge of the system, and their sociological knowledge of the various hospital personnel were further recognized as invaluable to patients facing admission to a very challenging institution. But brokering between family and work is far from easy. One nurse from men’s orthopedic ward – a senior and very important nurse -- faced the shame of coming to oncology with her brother, a cancer patient wearing the orange pajamas and shackles that clearly identified him as a prisoner. She looked immensely grateful when Dr P took the opportunity to lecture her brother sternly on how difficult this was for his sister.

Other times, nurses decide not to reveal these connections publicly because they fear this might complicate matters, making others feel they are playing favorites. Mma S, as we saw, was related to her patient, Mosadi, though I did not learn this until after Mosadi’s death. She was not alone. It was not until Boitumelo died on the ward, that I learned she was the matron’s cousin. The following year that same matron lost her brother and returned to the ward after his funeral only to leave the next day in tears and shock over the death of her beloved niece. In other words, in addition to the pressures and responsibilities of balancing family and work, some of the nurses in PMH oncology are grieving – and they are grieving in a world where that fact has lost some of its cache given the overwhelming burden of grief in the country.

Given the difficulty of their job, grief of course is not only for lost kin. Many nurses do develop deep connections to some of their patients, whom they come to care for over the months and years of their illnesses. As Mma D said to me one afternoon exhausted and reflective at the end of a long day,
Eh! This disease - -this cancer is so terrible. The things it does to people. This place is awful. I don’t like working in this ward. You meet patients. You get to know them. You become friends, and then you watch them deteriorate and die. When they die it is your friend. It is too, too, too painful! You see people. They come to the clinic and you see them come there and then eventually you see them start to waste away and enter the agony of it. No it is just too painful. I hate it here. We grow to love our patients only to watch them die. They become like our family. There are days when it is just so painful for us.”

Of course, not every nurse is like Mma D, willing to undergo this pattern of love and loss over and over and over again. There are certainly some nurses in PMH oncology who appear at times to be disconnected from human suffering. I doubt they were always this way. More likely the job, the epidemic, the bureaucracy, finally eroded their emotional commitment, rendered it unsustainable, perhaps replacing it with depression or anger or indifference. Nonetheless we can see the terrible problems this presents for the patients in their care. And not every patient is like Mosadi. Most of the patients in the ward, are gracious, polite, humorous, and kind with the nurses and with one another. But occasionally the ward houses a loathsome character, demanding, self-important, obstinate, and/or lecherous. Yet they too need and deserve care.

**Oncology as a slice of the national cake**

In the PMH oncology ward the promise of citizenship is manifest in access to novel technologies increasingly understood as necessary to collective health and well-being.
Nursing is the moral face of citizenship in Botswana’s system of universal care – one of the critical ways that patients and relatives understand and evaluate the political promise of care, and the ethics of distribution in a new regime of highly technologized medicine.\textsuperscript{xiv}

The vast majority of PMH nurses and patients are Batswana. By contrast, though there is a small but growing group of Batswana clinicians, particularly medical officers (like Dr R) most of the doctors in PMH are expatriates. Nurses by contrast are almost exclusively Batswana. This complicates their relationship to PMH in multiple ways, since they are at once employees, past and future patients, advocates for relatives, cultural brokers, and guardians of a very precious form of medical citizenship, even as they occupy a relatively weak position within the institutional hierarchy. It means that many nurses accept their work as civil servants as necessarily about controlling access to resources often envisioned as a “national cake” that must be shared out equally. And it means that nurses must do a tremendous amount of linguistic and cultural brokering between expatriate doctors and patients.

Botswana is both remarkably hierarchical and also remarkably egalitarian - -and this political, social, and cultural formulation combines with a political and economic structure and discourse that treats the bulk of the nation’s vast diamond wealth as collective property. Batswana envision national resources as much more of an immediate zero-sum enterprise than Americans like myself do. In America we continually defer debt to future generations sustained by a progressive vision of increasing wealth. Even now, when the current economic situation is dire, for many it is assumed to be temporary if painful.
The Botswana government does not incur debt, and so they have spared their citizens the predations of structural adjustment. In Botswana – bordered as they are by Zambia and Zimbabwe both of whose amazingly fertile and promising development trajectories were subject to sudden, and seemingly long-term if not permanent reversals, on a continent where Botswana is very much the exception that proves the rule – there is no reason to assume that wealth continues to grow.\textsuperscript{xv} Borrowing against the national future is recognized to be a foolish game.\textsuperscript{xvi}

While Batswana understand, appreciate, reinforce, and live with all sorts of hierarchies, where the national cake is concerned, if someone receives more than her share, this is extremely problematic. Batswana have long-standing forms of allocation from the doling out of food at weddings, to the sharing out of gifts by returned migrant workers intended to mediate potential tensions between equity and equality.\textsuperscript{xvii} In such situations where equity is meant to hold, individuals in Botswana are perhaps less expected to mediate their own desire not to take too much; instead institutional practices are recognized as necessary to ensure equity. When I bring chocolates to the ward as a gift, two nurses take them and carefully count them out and then divide by the number of staff and then present each staff member with their share. They do not put them out in a bowl and let people help themselves as might happen back in New York where I bought them.

Such habits are both the product of less-relative wealth than in the U.S., but also a collective ethos that provides for the kind of health care rationing and equitable distribution that Americans have been unwilling to commit to in my own country, thus allowing tens of millions of our citizens to be consigned to serious health-care anxieties,
deficiencies, dangers, and crushing health-related personal debt. Batswana will not allow this. These habits too are the product of a context where corruption is the specter that is feared most of all, given the notoriety of corruption on their continent. These sensitivities to equity and corruption combine with the kind of institutional record-keeping that hospitals excel at in their accounting for resources. Within PMH we can see the bureaucracy of the state combining with the bureaucracy of the hospital combining with cultural forms of equity in distribution. All these operate in a place that is intimate enough that collectivity is palpable, and where nurses as citizens are highly invested in that collectivity. And so nurses do see themselves as particularly suited, indeed they are charged, to carefully watch the dispensing of resources in an institution where the pharmacy, the prescription pad, and the admission form (in short the national cake) are all by and large controlled by expatriates. This is bound to produce problems.

Nurses in oncology who take pity on an elderly woman after a push injection of doxorubicin and cisplatin must furtively offer her one of the red biohazard bags to help her contain her vomit while traveling to the bus rank for her journey home, or develop a steely countenance and pretend not to see her predicament. This is a difficult decision, especially after it has been stressed in circulars and meetings that the biohazard bags are scarce and not to be given out. It also means that sometimes a nurse will wield a petty form of power by fetishizing bureaucratic details -- access to supplies, appointments, bed space, and patient queues -- in ways that make little sense in terms of care, but which condense moral judgments over the deserving or undeserving nature of particular patients or their familial care-givers. Such judgments were sometimes wielded at relatively wealthy patients and their relatives, who were often more agentive about their needs and
vocal in their opinions about care, and who nurses might perceive as taking resources they could and should provide themselves. And of course it also means that many nurses are hemmed in by a form of medical citizenship and the realities of expatriate doctoring such that they themselves (their labor and their moral sentiment) are a part of the national cake to be allocated. In other words, patients and their relatives also might complain that they are not getting enough nursing from the state.

These issues are playing themselves out against a shifting epidemiological landscape in PMH that has required nurses to manage crowds on the one hand and to care for very sick people with inadequate resources on the other. The situation is in some way comparable to that of the American teacher in an overcrowded public school who finds herself forced to essentially shift her energies from teaching to policing in her classroom. But in the cancer ward, where bed space is more tightly managed than other wards of the hospital, and where many patients become known to staff over the course of their illnesses, moral sentiment and care, while still hard work, are somewhat more easily achieved.\textsuperscript{xx}

\textbf{Body, Intimacy, Human}

At 7:20 a.m. on an ordinary February day in 2007, the nurses begin their “hand over” meeting. Arriving in their pressed white uniforms, with epaulets and pins marking their rank and training, they crowd into the small anteroom at the back of the ward with its microwave oven, electric kettle, two wooden chairs, calendar and “duty rosta” pinned on the wall, alongside photographs, postcards, and announcements. Greetings are exchanged, jokes cracked, new hairdos admired. Mma R has a new wig. Mma L has a
headache. Mma C makes fun of the rumpled clothing of the visiting ethnographer whose sorry ironing skills are a source of regular amusement.

When everyone is in the office, seated on counter or chairs or leaning against the wall, each patient’s file is read out, the doctor’s notes and the nursing notes from the previous night and this morning, both handwritten on white paper that has been hole-punched and tied into the file with yarn. Unlike the doctors, the nurses make a serious effort to know all their patient’s names, always. Attention is paid to the intravenous lines -- how and what to run or finish, which medications have been stopped, which medications have been ordered, problems with pain, constipation, and nausea. Vital signs are read for each patient. Mma T, a senior nurse in her late 50s, her grey hair in small braids who is just finishing the shift she began at 11 the previous night, points out one patient who was restless with pain, though on codeine phosphate. In the night it would wear off very quickly, so he will need his pain medicine upped she explains.

It is very quiet and peaceful on the ward. The patients are sleeping; morning visitors have left. Mma C, the shift manager, assigns the morning nurses to their duties as the ward begins to come to life – Rra D to the clinic, Mma N to accompany patients to radiotherapy at the private hospital across town. Mma N groans, there are four stretcher cases for her to lift. Mma R is asked which beds she wants. She points to the three empty beds in Male A cubicle, I will take those. Everyone laughs, and then Mma C divides the beds up among the three nurses covering the floor. The nurses fan out to greet each of their patients for the morning, and begin getting vitals on patients who are now getting their motogo (soft sorghum porridge), milk, and sugar from Tiny, the cleaner, who is
rolling a metal cart through the ward serving breakfast. The nurses do some chatting and joking with the patients they know.

At approximately 8 am, their handover completed, Mma T having departed for the bus rank, the nurses come out and stand behind the desk in the center of the ward, facing the waiting benches in the corridor, which are now filling up with patients. They are joined by the nursing assistants who run errands, process clinic paperwork, and do data entry and translation in the clinic. Someone in an act of Christian charity grabs the rumpled, tone-deaf ethnographer from where she is sitting, scribbling into her black notebook. Then lining up in a row they begin to sing to Jesus. The complex harmonies of Tswana choral music are incredibly rich and beautiful and they echo down the corridor. The ethnographer lip-synchs with great enthusiasm. Mma S comes out from behind the nurses station, Setswana Bible in hand and begins to preach. Her voice feverishly rising and falling, she implores Jesu to heal the sick, to help the patients, to bless the doctors in their work.

Mpho is now sitting up in her bed with her bible, as is Christine the 40 year-old woman with breast cancer in the next bed. Patients and relatives sitting on the waiting benches are listening. Mma S offers the bible up and Mariana, another patient, takes it and reads a verse. Then a final hymn with Mma L, a young nurse with a truly gorgeous voice, singing out the cues for the next verse. Prayers over, Dr P and Dr A (the ward medical officer) arrive, greet the nurses with handshakes, and the ward round is underway.

So begins each day in this cancer ward, as the nurses prepare for clinical work and mark their corner of PMH as a moral space, a place of hope, and courage, and faith. It is
hard to stress how important this moment was each morning to clarify the purpose of medicine, to remind very sick patients that God was there; that their nurses prayed for them. Through their joking, and laughter, and gossip, and occasional strife, nurses also create the ward as an intensely social world. This is a world where apathy and depersonalization continually threatens the moral project (more so than the jealousy and competition that threaten the morality of the world beyond the hospital walls), and yet where the potential to rehumanize decomposing bodies also animates the work at hand.

Professional medical work, as many observers have suggested is primarily task oriented. For many nurses in PMH, AIDS has reprioritized the tasks somewhat in the face of a very high volume of patients, many of whom are very sick. Changing diapers, for example, or in the oncology wards emptying the vomitous are perpetual, tedious, and unpleasant tasks. On the occasions when this work is shirked it is horrible for the patients. And yet nurses are not maids, or cleaners, or porters. Tasks need to be embedded in the care they provide for nurses to embrace them professionally.

Take for example, a curious debate that emerged one Friday afternoon in oncology in April of 2007. It was not unique. I was to witness this same dynamic on more than one occasion. On this day the oncology ward was already overcrowded with extra beds packed into the female side. So Naledi, an immobilized breast cancer patient with bone metastases, and a passive fracture who needed palliative radiotherapy, had been admitted to the female orthopedic ward while awaiting transfer to oncology. Naledi needed to go to GPH for radiation, and on that day there were already two stretcher cases in female oncology headed GPH, both large, heavy women. The orthopedic nurses wanted the oncology nurses to come and collect Naledi and bring her to GPH. The
oncology nurses protested this, arguing that she was not their patient, and asking the orthopedic nurses to transport her. The orthopedic nurses replied by asking oncology nurses to come to their ward and administer the drugs for this patient.

A huge struggle ensued, at which point Dr P got involved and made things worse by asking that the orthopedic nurses bring the patient as far as oncology from where the oncology nurses could bring her to GPH. This solution angered everyone. Finally an exasperated Dr P decided, pounding his fist, that space be damned, Naledi would come over to oncology! Transfer Naledi – we will squeeze her in somehow! Then he turned to the nurses and pointed out that they had only added to their own workload by refusing to transport her – now they would need to bathe, medicate, and otherwise care for her as well. Eventually Naledi was brought to oncology, but too late in the day to make it to radiotherapy. She would have to begin the following week.

Afterwards the nurses were very angry at what had happened, but surprisingly enough, they were happy about the transfer, even though it meant more work for them. As Mma D said, trying to explain the situation to me – No we are not donkeys! Bring the patient here and it will be much better! Let her stay here if she is our patient and we won’t mind. In other words, there may be some tasks (like lifting stretcher cases for transport, or changing diapers) which are low status and unpleasant. Once those tasks or any tasks, even the giving of medicine, are separated from the moral responsibility of care for an individual patient, an “identified life” they become merely that – tasks, porterage, cleaning, the work of donkeys. But when they are embedded in the flow of care for a human being, those tasks are subsumed within a professional commitment and
moral ethos of care and humanization. Unfortunately, Naledi had to wait yet longer for
her radiotherapy in order for this point to be made.

If the work of nursing in an overcrowded institution amid simultaneous epidemics
of AIDS and cancer threatens to reduce nurses to donkeys, the threat these diseases pose
to the humanity of patients is even more acute. The grim fact is that some of Botswana’s
advanced cancer patients are rotting. Their tumors have burst the skin, harnessing and
rerouting blood supply for growth in networks that produce tissue death, and the deep
stink of necrotic flesh. Cleaning such wounds at home, especially in compounds without
running water and possessing a limited supply of linens and soap, is extremely difficult.
And relatives often find it hard to approach such wounds without experiencing palpable
fear and disgust, which is understandably troubling to patient and relative alike. It is this
rot, and its accompanying stink and sight that in earlier decades made cancer an obscenity
in the west. One of the most crucial tasks of oncology nursing is to humanize such
patients whose bodies are undergoing profoundly disfiguring processes of decomposition.
Wound and bodily care for the rotting is a site where the combination of technical skill,
professional knowledge, and the sentimental work of cancer nursing concretizes the
humanistic promise of medicine.

Field Notes, Friday 9 March 2007
_Dumisane, the guy with the hole in his head is here._

_His blood is ok – so he will have chemo, but first the wound [from the tumor on his neck] has to be cleaned. The nurse who brought him says at Letlhakeng there were maggots in the wound and they cleaned with hydrogen peroxide. It must not have been today, because the bandage is dirty. The nurse is from the health post, and he hasn’t seen the wound himself. He runs off when Mma T and I go to clean it. Mma T rolls her eyes. We don plastic aprons, masks, and gloves, and get two dressing packs. The trolley is already in use with another patient. We push Dumisane’s gurney into the ward into Male A cubicle, squeezing it next to bed five which we push to the side. We can’t use the chemo room, because we will need
suction for the maggots. Hydrogen peroxide is not good because it just boils the maggots and leaves them in the wound – dead and rotting – better to vacuum them out and then dress it.

We pull the curtain (but still the man in bed 3 can see in since the curtain doesn’t close all the way). Then I hold the bib – wait, actually first we cut the suction tube with a sterile blade and hold it with sterile gauze waiting and pull the patient up to sitting. Peeling off his long navy raincoat and layers, Dumisane is like a skeleton. I am shocked to learn he is only 54 yrs – he looks like he is in his 70s. I hold the bib and the suction while MmaT removes the gauze. She soaks a lot of cotton in saline and then uses them to peel the bandages off because they are all stuck to the wound, so the moisture helps to remove them. She reassures Dumisane, sorry Rra Dumisane, sorry. Sorry Rra, bothoko (pain)! Sorry. But he is a quiet man and does not like to talk so much during the cleaning, unlike some patients with whom the exchange is continuous. The wound is ENORMOUS – open, gaping, and vascular. But there are no maggots. This is good. We can drop the suction and both be on the same side of the patient with an easier set up. MmaT puts on the sterile gloves and begins to clean with saline, scooping out clots of blood and necrotic tissue, then throwing the gauze in the biohazard bag as she goes. She doesn’t like forceps, they are awkward, she explains – but when a wound is so deep you need to use them to get all the way in. After the deepest part, she uses her hands for control. She keeps one sterile and one dirty and passes the gauze between – never letting them touch.

I ask her about cleaning someone else’s wound. How do you know how gentle or hard you can be? She says you learn how to do it, as a student your hand shakes – but as you learn it stops shaking and you can do it with confidence making sure it moves. Dumisane remains completely still, only a few times making an eesh (Setswana: ouch). I am holding his shoulders to keep the back of the bib (fashioned from a sterile pad) closed and then cupping the front to catch the blood. He looks sad. I think it is a lonely situation for him, powerless with this stinking horrible thing. When the wound is cleaned a lot of blood has pooled out onto the bib. MmaT takes it away and begins to pack the wound with gauze that she has soaked in betadine. I hold the soaked pieces of the gauze in place as she adds more layers. The wound is so wide and deep it takes a lot to pack it. Then as I continue to hold the betadine soaked pack in place she starts adding dry clean gauze over it. I try to hold gingerly, but firmly. As the dry, clean gauze is added it somehow feels good to see it looking so clean and fresh. MmaT asks if it is completely covered – if not there is some opening then it is a pathway for new bacteria to enter. It needs one more bit of gauze, here. I’m coming over with it! And then it is all covered. It takes both of my hands spread wide over his throat to hold it all in place. Then MmaT wraps it with a bandage and puts on the clips. Dumisane asks if he can lay down now, he is so tired, and we say yes. So he is resting with his olive green hat back on his head covering the hole, and navy trench coat. He still has chemo left to go. One of the nurses sprays a blast of cinnamon air freshener.

MmaT reports to Dr P that there are no maggots – but that soon the wound will be like Kgosietsile’s. Kgosietsile’s was so big you could see the organs in the neck. This one
you can’t see yet, but soon you will. She has to remind Dr P who Kgosietsile was (nurses in oncology always seem to remember patients by their names, while Dr P remembers each patient by face and condition) then he recalls him. Dr P says I felt SO bad then, because even me I felt such an aversion to that wound. I didn’t want to look at it and that was so awful.

MmaT says yes, there were maggots, he could feel them crawling around in there and call us. I was afraid to clean him the first time, but of course I couldn’t dodge. I just said ok – before you assign me to that I want to come and take a look – to know what to expect under that bandage. So I looked while someone else was cleaning and I said ok now I’ve seen it. No surprises and the next day when it was my turn Mma D assisted me and it was fine. Then I could do it easily and Kgosietsile was very lively –even when you were cleaning the wound.

The care and attention with which oncology nurses clean necrotic wounds and thereby rehumanize patients with disfiguring growths is extraordinary. Each day patients arrive in clinic wrapped in dirty, stinking, often homemade bandages. They leave freshly covered with clean, white cloth. It is a crucial moment of respite on the arduous journey to death. One elderly woman whose entire leg was rotting with malignant melanoma arrived with her daughter painfully trundling in with two mop handles as canes, her foot wrapped in a disposable diaper to catch the blood and tissue. When I told Mma F, a very intimidating senior nurse (who later that year would be diagnosed with breast cancer), how impressed I was with the care she brought to the cleaning of this patient’s leg – such that the patient and her daughter were both able to laugh and joke during the cleaning, her voice actually cracked and tears came to her eyes. She felt this among the most important work she did in PMH oncology and was touched that someone had noticed. I ask Mma E, another senior nurse about this as well. She said,

Yes, that is why nurses of all people must have empathy. Not sympathy, not pity, but empathy. You have to really feel (Setswana: go utlwa – to feel, to understand, to sense, to hear) that you want that patient to get better, to feel ok. With
experience you don’t feel that sickness or disgust or fear from the wounds. You can’t if you are a nurse. You cannot let the patient feel that you are afraid of them or that you are disgusted by them. If nurses do not do this job then who will? Who will? The relatives they will feel that fear, ok they may not want to look. It is ok. But we must. When I was training as a nurse I lost a colleague in the first year that way. We went to learn to dress wounds and that woman couldn’t handle it – she dropped out of the program. In my second year the teacher really made sure we saw a patient with rotting cancer of the breast. Two students vomited and the teacher made them stay for three hours with that vomit. At the time we all thought that she was being cruel but now we know she was teaching us something important.

By contrast on 22 May 2009 a young woman lay dying in the ward with a particularly egregious wound on her neck. Maggots had developed in her wound the previous day and as I wrote in my notes, “The new, young, male nurse Rra K upon being assigned to her bed says in Setswana – no, I haven’t done this before. And the shift manager, Mma J says you need the heart of a man to do this. It is natural, the fear. And so we all discuss. I say, you will get used to it, look for a while, to make it familiar. And Rra D says no, some things you never get used to. Dr R agrees.”

In other words, cancer nursing is an embodied practice. But it is a fine tuned form of embodiment. Effective nurses may not be disgusted or afraid such that it might compromise patient care, such that the patient feels repulsive or shunned or separated from the flow of social experience. And yet, there is a danger if one gets so used to the
wounds and the agony that one experiences no aesthetic reaction at all. Nurses and clinicians, my friends were saying, should be physically and emotionally moved by the obscenity of cancer; moved to compassionate and practical action.

If such wounds are occasions for the enactment of professionalism and positive moral sentiment in the oncology ward, that is in part because they are an upsetting challenge to the material and moral limits of home based nursing care. One young woman accompanied her grandmother each week or two to oncology for blood work and chemotherapy. On several occasions the nurses tried to instruct her on how to clean the wound on her grandmother’s cancerous breast. This included using a syringe to get the saline into a deep pocket of infection in the appallingly large wound. This daughter was greatly affected by the wound and her eyes would widen and then look away as she backed out of the clinic office. She found herself unable to help her grandmother to tend to this wound, a fact which made her extremely uncomfortable. *Ke a tshaba*, I am too afraid, she whispered to me. *Go ferosa sebete?* (does it nauseate you?) I whispered back. Yes, she affirmed nodding her head. She was not alone in this reaction, other relatives struggled with these feelings, though many care givers are able to overcome such aversions.

For the patient, living with this rot and disfigurement is deeply exhausting, among other significant challenges. Flies circle them constantly, and the stink can cause others to distance themselves. Not only do nurses reaffirm the humanity of patients who are decomposing, by addressing their wounds matter-of-factly, but gently, but they also constitute the ward as a site of at least partial respite for patients from the energy required in trying to mediate the effects their bodies may have on others. Lying in PMH
oncology, finally, at last, one need not worry so much about their smell, as nurses move about the ward cleaning wounds and blasting air freshener. Patients too aided in one another’s respite. Indeed on the occasions where a patient had to explain to clinical staff how their nausea was triggered by smells, they took care to clarify loudly that it was the smell of food or chemicals, ensuring their fellow patients did not feel responsible for the odor of their vomit or rot or diarrhea.

The Ad Hoc Therapy Management Group

This is an open ward. It is a neighborhood within the strange village that is PMH, and this fact extends the social work of nursing with its greetings, jokes, prayers, conversation, quarrels, and laughter, as well as the humanizing body work that lies at the core of care. Here the therapy management group that John Janzen first described as a cornerstone of African social healing, is reconfigured temporarily through the distorting prism of the ward.

Last May an elderly man rose in his striped pajamas, and crossed the cubicle to instruct a younger man on how to clean his tracheal tube, just as during clinical rounds I have seen many patients advocate for or explain the circumstances of their neighbor in the next bed in an effort to improve that person’s care. In June 2008 Dr P temporarily commandeered a cubicle in the Eye Ward for five patients (four with cervical cancer and one with breast cancer) all arriving together from the northern referral hospital for radiotherapy at GPH. Four of these women expressed deep concern over the pain and depression of their neighbor, reporting her distress to the oncology team on rounds, and seeking to reassure her as she grappled with the loneliness and fear of being so far from
her children for weeks on end. Hospitalization, like serious illness more generally, is a process of social estrangement. But a temporary, condensed, social world is created within the hospital, one with its own personalities, rhythms, attachments, and politics. For some patients this new neighborhood extends the logics of social healing into the heart of the biomedical institution, mitigating the isolation of illness.

Field Notes 12 March 2007

At lunchtime I go to talk to the man with ca hypopharynx in Male B bed 4. Dr P asked me to talk to him because he is upset and depressed. How have I become a counselor for the dying? I ask Mma D to come with me and she does. This man has been told the other day that it is cancer – so he only wants to know if it can be healed. He is depressed. Mma D and I back him up and explain what cancer is – and also how the chemo works. It is cyclical. You are not being sent away. You will come back in three weeks for more medicine, and then bo-three weeks, three weeks, three weeks, until you have taken the chemo 6 times. It seems he was worried that he was being sent to Palapye and there would be nor more treatment. Is there anyone at home when you get there? He is in his 50s – the wife is late but his mother and kids are there – one is a soldier. He describes how it feels when he tries to talk – the tumor grabs him inside the throat. He is worried about his voice. I use the metaphor “bomb” for chemo. I reassure him that the treatment is powerful and the body needs to rest afterwards. But that he will come back for the next course of treatment. Mma D and I are trying to make him myopic, to limit his temporal horizon of concern. And I explain (as Dr P has to me) how the tumor could shrink quite a bit before he experiences a change in sensation given where it sits. His prognosis is terrible and we don’t tell him this. I think he knows. Words can kill. But we encourage him to focus on each day rather than worrying about a future that only God knows, and to have patience.

We three grope for a pathway out of his existential angst. Then we find it – over there in the opposite bed! He begins gossiping with us about the man with ca esophagus from Mahalapye – the one whose wife is always here helping him. He says with a knowing smile – that man always wants the wife around, near him. Because he is older than her and afraid she will sleep with another man. Then he starts laughing with us about it, going into more detail and is greatly cheered up – but I am so worried that we gave him false hope.

Like all neighborhoods in Botswana, relatives come to visit. They cycle in and out of the ward during prescribed visiting hours, though some patients come from far, and not every
bed is surrounded by family. Several years ago a friend told me the following story. Her brother-in-law, Wabona, had been in PMH oncology with cancer. He required consent for a surgical procedure that his wife, Tshepiso, my friend’s sister, had to sign. While PMH staff called and prodded this woman to hurry down to the hospital from her town 100 kilometers to the north and sign the necessary forms, Tshepiso took her time. She arrived a week into his stay, barely greeted her husband, signed the required paper and left immediately. It would have been easy enough to write her off as a lazy or selfish or callous woman. Perhaps the clinical staff thought so at the time. I don’t know I wasn’t there. And what about this man’s grown children, some of whom lived in Gaborone, yet failed to visit him? But the truth was that Wabona had spent the first fifteen years of his marriage beating Tshepiso senseless each time he came home from the bars in the evening, before she finally moved out. His children loathed him, his wife too. Cancer did not change this. Instead it felt almost like some form of justice.

If a crucial part of effective nursing is performing the proxy work of family, providing care in the context of moral sentiment, humanizing patients, marking the ward as a social and moral space, patients and their family members are critical actors, not passive recipients of these processes. Cancer renders patients vulnerable, it harms them, it hurts them, it worries them, and in this is a great equalizer. But, American narratives of heroic survivors aside, cancer does not redeem them and render them angels unless they began their path towards illness already so constituted. Nor does it undermine the deeply social nature of their personhood. Patients and relatives are fully human in ways both large and small, good and bad, complex and contradictory. They arrive in the cancer
ward already embroiled in complex interactions, and these relationships spill into the clinical space, gathering nurses, doctors, and even fellow patients into their dynamics.

Social patterns, tensions, and values from beyond the clinic door continually spill into the ward, shaping its processes and patterns of care. Like so many hospitals, PMH is a tough institution and so successful care often hinges on the efforts of relatives to monitor the care of their patient, a job made more difficult by the highly regimented visiting hours. Some relatives finesse this by working alongside nurses or befriending them. Others complain to Dr P or the hospital superintendent about the care received, and Dr P might, in turn, take the nurses to task. Unlike the patterns documented in South Africa or Bangladesh, where middle class nurses might look down on their poor patients, in Botswana nurses are in the middle of a class spectrum whose income differentials have expanded greatly in recent years, and this shapes the politics of patient advocacy.\textsuperscript{xxv}

Many nurses make a point of pushing back against claims by elite Batswana relatives for extra resources (bed space, time with the doctor, nursing attention, rubber gloves to take home etc). These relatives are often more effective in advocating than the relatives of poorer patients, and so nurses might take on this role. Sometimes this is because they are pushing back on or bristling at what they see as the excessive demands of the wealthy, who, they feel look upon them as yet another maid. Other times it is because they have sympathy for the plight of someone who is poor and who seems to ask so little of her carers, despite the depth of her needs.

But in many other cases, the therapy management group reconfigures in the ward to a powerful nurse-clinician-kin-neighbor hybrid, as relatives, doctors, and nurses work together to enact care for their patient. Relatives might go into the city or even across the
border to South Africa to purchase medicines or nursing supplies not available in the
ward. While nurses might be enlisted by Dr P to convince distant relatives to pursue a
particular therapeutic strategy. Operating in concert, care proceeds.

On Valentines Day of 2007, at approximately three in the afternoon, the
ambulance brought a group of six acute myeloid leukemia patients, all in the early 20s,
back from South Africa where they had been sent for treatment. One of them, a 21 year
old man from Bobonong, tall, thin, and wearing a track suit arrived with a fever and so
was not discharged along with his friends. When Dr P told him he could not continue on
to his home, but instead would have to stay in PMH and potentially even return to South
Africa he was extremely upset. He was being left behind. No, I just want to go home, I
want to go back to school! I need to get back home. As he got angrier and quieter, Dr P
got angrier and louder, until finally he pounded his fist on the table and yelled, NO – I
ORDER YOU – as your doctor to get into that ward!! Then Dr P performed a
pantomime of what will happen – shaking, convulsions, if the blood infection goes
untreated. Dr P was furious that they sent him from South Africa in this condition. The
patient looked like he might cry as his friends slipped away towards their homes and he
remained behind in PMH.

By the next morning this young man was totally despondent during rounds, but
his temperature was way down. Then it turned out he hadn’t been properly placing the
thermometer in a failed attempt to be discharged. He looked so depressed and Mma M,
the ward matron, counseled him extensively on how important it was to take care of the
blood infection, and how he would be home before he knew it. I offered to give him my
cell phone to call home – but it turns out he did call a friend yesterday. He told me that
the problem is that there is no phone at home, so he could not speak with his family. This led to a longer counseling conversation by Mma M who took on an increasingly maternal tone. And then in the middle of all of this talking, cajoling, and counseling, in walked his mother still smelling like the fire in the cooking enclosure back home! \[^{xxvi}\]

A few minutes later the surgeon arrived to remove the central line that was the most likely portal for the infection. But now the patient was refusing the procedure. Mma M, the surgeon, the student nurse, and Dr A were all trying to convince him to consent the procedure. Dr P arrived and insisted – no he demanded it will be done and done NOW. This pushed the patient a bit closer to passivity, but he was not there yet.

And then his mother turned to him and said in Setswana – I have come all the way from Bobonong to PMH. That is 100 pula [bus fare] and I didn’t come all this way to see you refuse [by which she meant die]. Then she and I laughed. I don’t know why but something about how she referred to the bus fare was terrifically funny and we both realized it at the same time. Suddenly her joking and doubling over in laughter was a way of saying that everything was going to be ok – this was nothing serious, even as her trip down showed how very serious it was, and even as the laughter allowed tears to stream down her face. Dr P was still saying go home for what? Go home and this infection will kill you and you will die. But it no longer mattered, the patient was now busy requesting that his mother might stay with him for the procedure. Sometimes mothers exceed the limits of even the most powerful of doctors and most effective nurses.

**Conclusion**

Through its nurses, its patients, and its practices the PMH oncology ward is a place where a philosophy of social healing animates care giving, offering powerful insights about the
morality of care in our world, and the mutual dynamics of embodiment that shape care. Nurses and their patients do not always succeed in their efforts; a few have days where they appear to have even given up trying. And yet day after day patients arrive in PMH oncology. If they are not in deep bodily distress upon arrival, they may well be upon discharge. Such is the nature of healing via chemotherapy and radiation. And so this is a place where the stakes of moral sentiment and bodily care are high, where ailing human bodies provide the grounds on which politics and sociality are enacted in ways both large and small.

Coda: Death of a Visitor to the Ward
Field Notes: 25 May 2009

When a patient from PMH oncology dies at home, relatives call the ward and tell the nurses, “Your patient has died.” When the patient dies in the ward, the call goes in reverse.

During lunch time the woman in the ward in Female A bed 2 who was paralyzed from the waist down with a possible developing pressure sore – this older woman – has died. Mma O discovers the death and pulls the curtain around her bed. I go to help Mma O and Mma J to process her body. Mma H comes in and says Ao! She didn’t even wait to see her kids. Me, I want to die at home. Mma J says – yes, I also want to die that side. We all agree that we do. Mma O rolls her (a big woman about 60 years) to the side so that Mma J can remove the catheter, I help to hold her on her side. First they inject some water so that the balloon can be pulled out. Then Mma J spreads her legs and Mma O pulls it out. She is all splayed, genitals showing (though of course the curtain is closed tight), and smelling rotten. Now Mma J will work to restore order to her body. Even a dead body can be humanized, must be humanized. Using cotton wool and alcohol they wipe away the bits of feces clinging in her anus, and whatever else is smelling. They remove the cannulas. Then (we are all wearing gloves and plastic aprons) they put her legs lying straight and closed, her arms fixed to her sides, placing her fingers under her buttocks and hips to hold the arms in place. This takes some strength and determination. Mma J takes the top blanket and smooths it and folds it and then uses it as a pillow to put her head in place. She is looking more like a funeral corpse now. Then Mma J keeps trying to close her mouth. It keeps gaping, and so she wraps it with a bandage from chin to the top of her head to set it in place as she stiffens. We pull up the blankets to her chin, making sure they cover her feet. Then we pack her belongings into two black garbage bags. This whole process has taken some muscle, some care, and some respect.
While all of this is going on, Dr Z is poring over her files – trying to figure out what happened. This woman had been in female Ortho – but then came to oncology within the last few days. Was I there for the transfer? She was from Tsabong [a town way out in the Kalahari], but didn’t get to go back and “die that side” because the transport last Friday only had an FWE and she needed to travel with a nurse.

I walk into the clinic office and Dr R says, Hey! I find it so, so sad. Her family, her children back in Tsabong. Just saying to themselves – I hope everything in PMH is going well – and to die so far from home without anyone to talk to...

---


ii See for example, President Festus Mogae’s State of the Nation Address in 2001 when he declared, “HIV/AIDS is the most serious challenge facing our nation, and a threat to our continued existence as a people.”


This is also the case in South Africa, and perhaps the broader region. In South Africa, Jewkes, Abrahams and Mvo describe instances of abuse, humiliation, and neglect of patients accessing midwifery services. Complaints about nursing in Botswana rarely, if ever, rise to this level. While people complain that patients are neglected, and/or that nurses are rude and intimidating, abuse does not seem to be at issue. In further contrast to the midwifery services Jewkes, Abrahams, and Mvo researched, oncology is a unique location where nurses get to know many of their patients over time, and where patients are recognized to be quite ill. This is not to say that there is no complaint in oncology, nor that complaints are never justified. Rachel Jewkes, Naeemah Abrahams, and Zodumo Mvo, “Why Do Nurses Abuse Patients? Reflections from South African Obstetric Services,” *Social Science and Medicine* Vol. 47, No. 11 (1998): 1781-1795.

See for example, Sreekanth Chaguturu and Snigdha Vallabhaneni, “Aiding and Abetting – Nursing Crises at Home and Abroad,” *New England Journal of Medicine* 353(17), October 27, 2005: 1761-1763; the special issue on global nurse migration in *Policy, Politics and Nursing Practice* Volume 7 (3 supplement), 2006;


The nurses in PMH oncology are not “oncology nurses” per se, and they do not have the option to become so trained. Nurses in PMH are rotated every two years to new wards and duties, though some are able to remain in a ward through two rotations. They may have been a surgical scrub nurse in their last rotation, or headed to radiology or to labor and delivery on their next rotation. During most of my time at PMH only Mma M, the ward matron, had specialist training in oncology, though in May 2009 she was joined by Rra T, who had just come from oncology training in South Africa. Nurses in Botswana receive little education about cancer during their training, and so they enter the oncology ward having to learn the theoretical and practical knowledge on the fly. The difficulty of acquiring specialized skills contributes to Batswana nurses’ complaints about compensation. Without the ability to specialize it becomes difficult to both find a pathway for salary advancement, and for developing the kind of expertise and personal advancement that brings satisfaction to professionals.

In this way hospital nursing is similar to the nursing care provided by female relatives in the home, which is also loaded with similar expectations and moral critique. See Julie

xii Again, I have changed the names and some of the distinguishing details of various people here in an attempt to protect their anonymity. I am not describing an actual gynecology nurse!

xiii One of the best in depth discussions of these issues of nursing care is Patricia Benner and Judith Wrubel, *The Primacy of Caring: Stress and Coping in Health and Illness* (Addison Wesley Longman, 1989).

xiv We saw in chapter 2 how the plight of Zimbabwean patients, so in need of care, which is not extended to them free-of-charge reinforce the meanings of citizenship in Botswana as a set of services and opportunities facilitated by moral governance. Expectations of medical care as citizenship in Botswana contrast with the model of urgent and uncertain biological citizenship Adriana Petryna describes for Ukrainians. Adriana Petryna, *Life Exposed: Biological Citizens After Chernobyl* (Princeton University Press, 2002). By contrast see also, Meredeth Turshen, *Privatizing Health Services in Africa* (New Brunswick: Rutgers University Press, 1999); Vinh Kim Nguyen, “Government By Exception: Enrollment and Experimentality in Mass HIV Treatment Programmes in Africa,” *Social Theory and Health*, 7(3), 2009: 196-217. But this does mean that nurses are state actors and as such they wield tremendous power in brokering the benefits of public medical care.


xvi There are certainly some people who argue that the government should spend more on this or that project, but not that the nation should live beyond its means. In contrast to the government, many individuals live with serious debt. See Julie Livingston, “Suicide, Risk, and Investment at the Heart of the African Miracle,” *Cultural Anthropology* 24:4 (2009): 652-680.


xviii Of course nurses everywhere have serious complaints about compensation, which drive them abroad in search of better remuneration, as well as out of the profession entirely. Though pay scales are higher in Botswana than neighboring countries, nurses find it hard to fulfill their responsibilities and desires on their salaries. G. Thupayagale-Tshweneagae, “Migration of nurses: is there any other option?” *International Nursing Review* 54 (2007): 107-109.


xx I am not claiming this is the case in all cancer wards – see by contrast the excellent patient-centered ethnography by anthropologist Benson A Mulemi, “Coping with cancer and adversity: Hospital ethnography in Kenya,” PhD. Dissertation, University of Amsterdam, 2010.

When this patient first came to oncology the previous month Dr P noticed that he had a hole in his skull, which was not noted in his medical cards. With a flashlight we could see straight into the dural matter. Dr P and Dr A were absolutely amazed that someone could be walking around with such a hole, and brought the patient to A and E where seemingly every doctor in the hospital took a turn looking at the hole.


I take this term from Robert Murphy, The Body Silent (New York: Norton, 1987).


Of course what had happened was that the patient’s friend had run to his mother’s home with the news of his condition and mood. She had put her things together as the family pooled funds for her trip (fortunately it was mid-month so there was still cash on hand), and she had departed then and there hurrying toward her son.