Author's response to reviews

Title: Endurance, resistance and resilience in the South African health care system: case studies to demonstrate mechanisms of coping within a dysfunctional system

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Version: 5 Date: 22 September 2015

Author's response to reviews:

Dr Claudia Hanson
Editor
22 September 2015
Dear Dr Hanson, Dr Pfeiffer and Dr Leon,

Revisions to MS: 5880246261502800 - Endurance, resistance and resilience in the South African health care system: case studies to demonstrate mechanisms of coping within a dysfunctional system

Many thanks for your constructive, insightful engagement with our paper, Endurance, resistance and resilience in the South African health care system: case studies to demonstrate mechanisms of coping within a dysfunctional system. We have revised the paper (attached) and provide a point-by-point response to the comments (see below). The reviewers’ comments were knowledgeable and helpful and have made this a better paper. While acknowledging the diligence of Dr. Leon, we find ourselves a little confused. We recognize the interconnections between the concepts used and have tried to make our discussion more nuanced in this regard. But we do feel to adopt the format suggested (for example, to ‘un-label’ the cases in order to first describe the coping mechanisms and then abstract to the coping categories, which would effectively ‘undo’ the cases presented) would result in a very different paper and one we do not feel our data or approach could support. We hope you can accept our disagreement with Dr. Leon on this point. We look forward to seeing the paper in publication.

Kind regards,

The Authors
Editorial request
Please give the full name and affiliation of all committees that ethically approved the study, and add them to the Methods section. If the list is large you may wish to upload the information as an additional file and refer to it from the Methods section.

• Details added as follows:
p.6 (218-225) The data were collected between June 2009 and July 2010. Ethical clearance was granted by the Universities of Cape Town (Health Sciences Faculty Research Ethics Committee: 460/2008) and Witwatersrand (Human Research Ethics Committee (Medical): R14/49/2008); and the Western Cape Health District Health Services and Programme (19/18/RP11/2008), Gauteng Directorate of Policy, Planning and Research (06/06/2008), and Mpumalanga Health Research and Ethics Committee (MP/09/08). Study permission was also received from the Cities of Johannesburg (23/07/2008) and Cape Town (13/12/2008) and verbal approval was granted by district managers in each study site, as well as heads of the health facilities involved. Informed, written consent was obtained from all individuals interviewed. All interviews were anonymized and stored on a secure server available only to the research team. Pseudonyms were assigned to people and facilities to protect confidentiality. But for this commentary, we emphasize a case approach, using four respondents for analysis, supported by some commentary from others in the discussion section.

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Kindly format the abstract section headings according to our Instructions for authors.

• Revisions: made accordingly

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Reviewer 1
The cited Obrist et al. article highlights a framework that refers to the role of cultural (!), social, economic and symbolic capital (and not human capital). The respective sentence in the manuscript should be revised accordingly.

• Revision made:
pp. 4-5: Obrist et al (2010) identify these with respect to mitigation and environmental change but the social, economic, symbolic and cultural (often religious) asset bases shape the possibility and form of resilience.

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Reviewer 2
The Abstract should be revised to reflect more closely the findings of the study (it makes no mention of the key concepts in the title or findings) (ME)
We have explicitly situated endurance, resistance and resilience as mechanisms of coping, thereby ensuring better alignment between the findings presented in the abstract with both the findings in the paper (these engage with the ways in which these mechanisms allow patients and providers to cope within the health system; and are summarized in the abstract), and the title itself, Endurance, resistance and resilience in the South African health care system: case studies to demonstrate mechanisms of coping within a dysfunctional system.

Background and conceptual framework (ME)

There is still a lack of clarity re the use of the terms ‘endurance, resilience and resistance’. For instance, whilst the authors focus on the last two, it touches on ‘endurance’ from time to time, in passing. It is not clear if resistance and resilience are mechanisms or tools for endurance or if endurance is another mechanism/tool for coping, or a state of coping that is achieved. The concept of Resilience is part of a large body of literature and well –theorised, but this is not evident from the way its presented in this study. The authors also speak of coping and agency and at times it seems these terms may be better suited to what they are trying to describe. Also, the way the term ‘resilience’ is used in this study is sometimes confusing. Does it refer to merely responding (line 573) or does it refer also to the outcome achieved by such a response- that is, achieving ‘coping’ and or a state of managing/containment and or endurance?

While recognizing the necessary-interconnectedness of these terms, we have sought to further clarify and differentiate them across the paper according to the following ‘conceptual flow’:

i) Coping is conceptualized as a form of negotiation between individuals within a system, a way of proactively managing and responding to the challenges of the health system, rather than simply ‘making do’ or ‘acquiescing’ (p.4, 132-145)

ii) As negotiation, coping requires agency (p.4, 147).

iii) Agency is defined as ‘life conduct’ (Lebensfuhrung) in which individuals respond to and cope with demands and opportunities in an active way (after Weber) (see Cockerham et al., 1993) (p.4, 149-150)

iv) Agency is not the opposite of passive victimhood but rather, the two concepts work alongside each other to produce and insert autonomous individuals within neo-liberal hierarchies of power. From this understanding, even passive acceptance of the status quo (continuing with life or endurance), also requires agency (pp.4-5, 150-183). We return to this idea in our discussion, where our findings allow us to re-conceptualise endurance itself - p.17 (616-620): “In many ways, we assert, endurance is the bedrock of coping, requiring making do and performing the roles required. Endurance understood in this way is not merely passivity but rather permits emotion and problem-based coping. Like resistance and resilience, it is an expression of agency, negotiated and mediated through
individual expectations, interpersonal engagement and the system itself.”

v) Endurance, resistance and resilience are defined as individualised mechanisms of coping.

vi) These different coping mechanisms shed light on how and why individuals respond within a dysfunctional system (themes we explore and theorize through the cases).

vii) We conclude with an acknowledgement (borne out of the case study findings) that these concepts are necessarily closely intertwined: p. 18 (638-639):

“Furthermore, as told in the four cases, endurance, resistance and resilience, victimhood and adaptation, context and agency are all intertwined.” Yet, rather than locating our analysis at the more abstracted levels of ‘coping’ or ‘agency’, we argue that there is conceptual value in grounding and theorizing these interconnections at the more immediate/concrete level of mechanisms, or “micro-practices”, of coping – the ways that patients and providers cope. As the cases and additional ‘voices’ reveal, it is through unravelling the ways that individuals cope (through mechanisms of endurance, resistance and resilience), and recognizing the role for individual agency (whether passive or active) within these coping mechanisms, that problems and possibilities emerge for potentially transforming individuals and the system itself. Through this conceptual intertwining, a systems’ perspective is made apparent and lessons for policy and intervention can be drawn.

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The Methods section also reads well (though can do with reducing some of the duplication, especially in the last 3 prgs ). (ME)

• Response:

We would like to argue in favour of retaining the detail provided in the methods section, including the last three paragraphs. This section seeks to establish not only ‘what’ we did in terms of the data collected and analysed but ‘how’ and ‘why’ we selected the cases presented. The last three paragraphs are particularly important for setting out the purpose of these cases and locating the methods conceptually. They thereby provide a bridge between the ideas introduced via the literature and the presentation of the cases in the findings. These paragraphs also create a rationale for the ‘individual’ as the unit of analysis, in close resonance with our conceptual framing of coping and agency. Furthermore, they establish a lens that moves us methodologically beyond the individual, to “The Field” itself. This enables us to develop a systems’ perspective in our analysis and to link coping in the individual cases to coping in the health system itself (an important gap in the literature). The methodological and conceptual argument developed through these three paragraphs therefore enables us to move straight into the case presentation under the themes (or ‘labels’, see comments from the reviewer below) in the Findings section. Here, we are able to immediately begin to explore and theorize the ways in which endurance, resilience and resistance manifest within the texts. It is in the presentation of this data – as individual cases - that we are able to both describe and then abstract and theorise their meanings.
The Findings (ME)

The case studies illustrate interesting points in relation to how patients cope and how staff cope in relation to poor treatment (patient) and stressors of working in a ‘dysfunctional’ system (staff). However, the way the findings are presented does not always present a convincing argument: it reads more as a labelling their behaviours as resistance and resilience, than demonstrating through a series of steps and data sources why this behaviour could be considered as resilience and resistance, what purpose these behaviours serve, when and why one or the other is triggered etc. Throughout the case studies, the authors seem to start by providing the label for a particular action before making the case using the data. It often feels that the use of the concepts are premature. The link between the data and the presentation of this data as findings (categorised as ‘resistance and resilience’) needs to tightened. This may require a description of the behaviour/type of coping mechanisms first- and as a second level of abstraction-making the link to why this would be categorised or interpreted as resilience or resistance. For instance, at times, what could be described as someone getting support to cope with their circumstances gets presented as a mechanism for resilience- leaving me wondering what the difference is between the term coping and agency and why the terms resilience and resistance was chosen for this analysis.

• Response and revisions made:

In our methods, we have more clearly noted that our analysis is theory-driven, grounded in our conceptualization of endurance, resistance and resilience as mechanisms of coping (see p. 7). Furthermore, we have used the methods section to create a conceptual ‘bridge’ between the introduction and findings sections. Consistent with a case approach, we have thus constructed the individual cases around the emergent ‘themes’ of endurance, resistance and resilience in order to differentiate and compare the narratives. Hence, each case is presented under a ‘label’—not because we are pre-empting the analytical work of interpretation and theorizing but rather because these themes (headings/labels) represent the starting point for such interpretation and theory-generation (which is carried into the case description and discussion). It is around these themes that each case has been built and can be further abstracted through the discussion itself. Hence, by retaining the detail in the methods section (which is intended to be read in close proximity to the findings) and through extending the conceptual framework into the presentation of the findings, we are able to examine the ways in which endurance, resistance and resilience are expressed across the cases, and to extend this analysis to the capabilities and resources/assets that individuals hold (or don’t).

More generally, through the changes made and ‘conceptual flow’ described in the ‘background and conceptual framework’ section (see above), we hope that there is no longer confusion between the terms and that we have made clear the...
reasons why we theorize endurance, resistance and resilience as coping mechanisms, rather than merely discussing ‘coping’ or ‘agency’ devoid of these details.

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Discussion (M)

The Discussion does well with synthesising the main concepts and with providing additional data to support the data in the case studies. So it satisfies one of the purposes of a Discussion section. However, what is missing, is: reference to the broader literature (some of which was discussed in the Background section); and what this study adds to this literature (compare and contrast), (and referencing the literature); how this study may be supporting or adding a different dimension; what new research questions it may present; what the policy and practice implications may be.

* Revisions made:

We have added key references from the broader literature, including the background section, to the discussion and conclusion in order to explicitly contextualize our findings and relate the themes discussed to the ideas initially introduced (see references included pp.15-18).

As argued in the introductory sections and expanded in the discussion and conclusion, this study contributes knowledge to the little-examined topic of how patients (and, we add, providers) cope with the health care system itself (p. 4, 135). By taking a theory-driven approach (established through the conceptual framework presented in the introduction and methods), the contribution, questions and implications of the research are essentially embedded in the discussion and conclusion as a whole. It is in the discussion and theorization of the issues that the contribution is revealed. Moreover, the conclusion provides the space where we raise the implications of the findings for policy and practice: by moving from individual coping mechanisms to a system-wide perspective, the concepts explored in the paper (agency, coping, resistance, resilience and endurance) allow for possibilities to learn and improve “the practice and receipt of care” (p.19, 653). However, as we note in our final sentence, there is a strong policy message about the need for “provincial and national leadership and will to instigate the admirable reforms set out in policies for the health care system” (p.18, 654-655)

It also requires a more reflective Limitations section.

The single sentence on limitation of a resource poor setting is not clear (line 605). Are you referring to generalisability? The second part of the sentence is also unclear. The authors should for instance reflect on the issue of how difficult it is to understand a complex, interpersonal and intra-personal, psychological phenomena, such as coping behaviour. And they could acknowledge that a once-off interview with one individual would inevitably not be able to provide a thick description of such a complex phenomena... (but that nevertheless they were able to contribute to understanding by identifying interesting coping mechanisms- that helps us understand better why patients sometimes act
against their own health needs)

- Revisions made - Limitations clarified and reflexively contextualized in time and place as follows:

p. 17 (608-612): “Indeed although there are limitations to this study in terms of generalizability, bound as it is to individual stories told at one point of time and within a particular resource-poor setting, there is a contribution to how individuals use their capabilities and assets through shaping and reshaping their life-conduct -within this very time and place - to cope and even more, to deal with demands and opportunities of everyday life.”

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The authors could more clearly acknowledge any work upon which they are building. For instance the use of the term “weapons of the weak” should be referenced, and perhaps explained in terms of how this concept may be illustrated in this study.

- Revisions made:


The term, ‘weapons of the weak’ closely resonates with De Certeau’s (1994) ‘tactics’ as explored in Schneider et al’s (2010) work on patient negotiation of care. In the concluding paragraph (p.18), we have explicitly linked these ideas, relating them to the ways in which individuals cope and make meaning within the health system. Furthermore, we link these concepts to Scott’s (1990) later work on resistance in the back spaces of behaviour (p.18, 643), arguing that such weapons (coping mechanisms) are potentially transformative – not only of ‘the weak’ (here individual patients and providers embedded in the South African health system) but the system itself:

p.18: “As coping mechanisms, endurance, resistance and resilience are responses to context. They are ‘weapons of the weak’ [see Scott, 1985] or ‘tactics’ [see Schneider et al, 2010] for manoeuvring, managing and contesting power in systems They represent ways through which illness and occupation can be made personally meaningful as they make personal identities vivid. Resistance may be in the back spaces of behaviour [see Scott, 1990] but it does have the potential to alter the ways in which the health system works, especially if citizen engagement is taken forward as laid out in the National Development Plan [see NDP, 2012]. These weapons – denial and refusal to behave as expected, recognizing human dignity in the most trying of circumstances – further resilience. […] enable individuals to maybe fight for positive change […] might lead to system improvement as a partial journey to system ‘transformation’.

More generally, the literature introduced in the beginning sections of the paper has been explicitly brought back into the discussion and conclusion in order to
firmly situate our findings, and the ways in which they build on and extend this body of work, within the broader literature.

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The manuscript require further editing, especially for grammar and punctuation:

• Response:

The revised version of the manuscript has undergone a close grammatical edit by an English first-language academic. Every effort has been made to conform to the journal style.