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Coping with cancer and adversity : Hospital ethnography in Kenya

Mulemi, B.A.

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The cancer ward: Hope and endurance

Most people out there know that if you turn out to have cancer ‘then you are gone’. When I was told I had cancer, those notions came to my mind, but the surgeon encouraged us. He told us: ‘no, this thing can be dealt with. We can treat it if only you are courageous to accept. Do not just accept that you are going to die. You just have to know that cancer is a disease like any other’. My faith helped me a lot. I believe that any thing is possible ... When I came to this hospital, I knew that I would be fine since the doctor told me that it is possible to be cured. Because of the facilities available in Kenyatta (hospital); my expectations are that after treatment, I will go home a fully- healed person to continue with normal life. That is my highest anticipation; that I will not continue (being) ‘sickly’ time after time. I hope I will be healed and continue with normal work, to serve my family. Church and community ... And continue even with work until I reach the retirement age in good health. (Mr Jabari)

Patients came to the hospital with renewed confidence and hope. The national referral hospital represented the space for long-awaited, superior medical and patient care resources. The reality in the hospital in general and the cancer ward in particular, however, was one of emotional disruption, calling for emotional coping resources to improve patients’ endurance of cancer and hospitalisation hardships. Most of the patients who participated in this study turned to religious beliefs for comfort, and to cope with the realities in their treatment setting. Another patient emphasised this when he said:

When I came here, everyone said; ‘if you go there, you will be cured’. They said: ‘you are going to a high-status hospital. The good doctors are there. You will be cured’. I saw the way the machines are and believed that God will help me ... (Mr Kassi)

Admission to the cancer ward signified renewed hope of better rehabilitation. The reputation of the National Hospital as a place for better healthcare strengthened patients’ hope. Hospital staff reassured patients constantly and this rein-

forced their confidence. Religious faith sustained hope for the hospital's potential to restore physical well-being. The National Hospital is at the apex of the public healthcare sector, and most low-income people viewed it as the source of superior treatment and care. However, the hardships of cancer treatment and emotional distress caused by the hospital environment undermined patients' confidence and hope.

This chapter describes the physical and emotional space of the cancer ward. It highlights the implications of this setting for in-patients' well-being and quality of life. This includes patients' expectations of the hospital space and its significance to them. The chapter also underscores the hospital staff's perceptions, showing that as patients and their families enter the ward with great expectations, hospital staff conceal their reservations about the ward's potential to meet those expectations. The chapter then describes the physical layout of the ward and the human and non-human resources available to in-patients. The second part of the chapter deals with patients' experiences of treatment in the prevailing ward circumstances. It points out aspects of the ward that challenge patients' emotional resilience and endurance of cancer and the hospitalisation experience.

'District hospital'

The cancer ward, also known as Ward GFD (Ground Floor 'D') is part of the 'old hospital' complex. The old hospital was established in 1968, five years after Kenya gained independence from British rule. The building is distinct from others which are part of the hospital's new phase. The ward was among the few that remained in the old hospital premises; similar ground floor wards closed in mid 1990s in response to the World Bank's recommendation for a reduction of wards in the National Hospital. The main aim of the World Bank recommendation was to restore the hospital's referral status and reduce the hospital's funding burden. The adult cancer ward was briefly in the current renal clinic adjacent to it. The present-day ward was initially meant to serve as a female cancer ward following the changes in the hospital, but recurrent blockages of the sewage system led to the transfer of both female and male patients, and the absence of a separate ward for teenage cancer patients. The hospital complex's tower block is its landmark and houses the majority of wards, but the cancer ward was not one of them. Nurses said that their colleagues in the rest of the hospital seemed not to know about the adult cancer ward. Viewed this way, the cancer ward seemed to be quite isolated, like a semi-autonomous little hospital. One nurse remarked:

When you tell colleagues that you work in the cancer ward they ask; "and where is this ward?" Is it part of this hospital?

The cancer ward is adjacent to a renal surgery clinic and close to the main hospital entrance to the East. This entrance leads to different hospital depart-

ments and wards in the ‘tower block’. Nurses were concerned about the apparent ‘seclusion of the ward from the rest of the hospital system’. They described themselves as working in a ‘District Hospital’ rather than within a National Hospital. A nurse remarked:

We work in a District Hospital, not in the tower building ... Many people do not know that this ward exists. Our nurse told a visiting doctor at night that she did not know where the blood bank is. The doctor did not believe it ... She said disgustedly, “then this ward is not part of the hospital ... It is not a ward. You should have it closed!”

The public healthcare sector in Kenya caters to most of the population and especially low-income people. The official health sector operates on at least four levels. At the community level, there are ill-equipped health centres, clinics, dispensaries and maternity homes. The next level of health services is the primary or district hospitals, followed by secondary or provincial hospitals, which cover wider areas. The national referral hospital is at the top of the healthcare system and it is expected that all its units have a higher profile compared to those in lower-level hospitals. Primary and secondary hospitals face varying degrees of staff and facility shortages. Healthcare providers at the National Hospital enjoy a higher status and better working conditions than their counterparts in the lower-level hospitals and healthcare facilities.

Key informants indicated that the cancer clinic used to be an operation theatre, whereas the adult ward was a paediatric observation ward. From the 1960s until the late 1980s, adult cancer patients were treated in ‘ward 45’. This was much closer to the present-day radiotherapy clinic on the first floor of the old hospital complex. The ward moved to its current location in early 1990s, when Ward 45 became an emergency ward dedicated to treating accident or assault victims mostly from the city of Nairobi. Thus the cancer ward and treatment centre were not a result of deliberate planning to cater to the needs of the patients and their carers. The staff complained about their workplace environment, which they found stressful. They made efforts to disguise the real conditions of the patient care environment on special occasions, trying to paint a rosier picture during main ward rounds or at times when the hospital or cancer unit expected special visitors, for example. During such times, cleaning and tidying were more prompt and thorough. Both patients and staff noted this momentary attempt to protect the ward’s image to visitors and senior hospital staff. Some staff in the cancer ward attributed the cancer ward’s perceived low status and poor condition to the lack of attention to the disease not only in the hospital but also in the country. Doctor Bedohai, for instance, observed:

People believe that once you have cancer, you are dead. Most of them even today do not know that we can do something about cancer ... The same attitude exists in this hospital. The management does not give us what we are supposed have ... Work facilities are scarce. ... We are just seen as a *ka-peripheral* (minute peripheral) unit compared to departments like

surgery, obstetrics, and gynaecology. The main problem is that most people think that once you have cancer the prognosis is already determined ... They give more priority to other departments, like the medical department ... and diseases like HIV/AIDS.

As aforementioned, poor prognosis and low survival rates of cancer patients partly shaped opinions of the ward. Respondents said that their colleagues in other departments often described the cancer ward as 'less busy', 'a resting' or 'light' ward. Its physical location away from other units reinforced feelings about its perceived isolation from other units. The staff likened the ward to a district hospital as the ward experienced inadequate staffing and supply of patient care resources. (Many district hospitals in Kenya are also relatively remote from central health sector organisation and the staff are often dissatisfied.)

In fact, the ward did seem distinctly separate from the rest in the hospital. It was geographically the last, located near the entrance leading to the main wards in the modern 'tower block'. During visiting hours, crowds of people filed by on their way to and from the other wards and units. As for those who did come to the ward, apart from relatives who had come by several times, visitors seemed lost at first. The cancer ward appeared to be hidden, at the margin of the hospital. According to the staff, the location of the ward isolated them and the patients from the rest of the hospital. This was a significant aspect in the staff's perception of the cancer ward's low status. Some considered their redeployment to the cancer ward and treatment centre to be a demotion. A nurse observed:

When people are posted here, they think they are being misused. It is like being thrown out of the (hospital) system. When new nurses are sent here they feel that they are being punished. Doctors have been posted here, but at the end of the day they tell you; "I cannot nurse patients who are not going to survive. What will the outcome be? People will see me as someone who nurses the dead ones." Everyone wants take care of patients who will survive.

The location and structure of the ward appeared as a metaphor for the reality of cancer. Nurses and medical staff had reservations about the cancer ward's contribution to the overall healthcare outcomes in the hospital. Poor treatment and patient care results conflicted with the conventional association of the hospital with curative medicine. However, patients retained their confidence and hope in the cancer ward. This was the only accessible source of treatment for them after peripheral hospitals and health centres failed to relieve their suffering.

Ward layout

The ward has five rooms with a bed capacity of 32. The first two rooms, with seven and eight beds, and a third smaller room with three beds are reserved for female patients. The ward arrangement facilitated limited separation between male and female patients. The remaining two rooms with a capacity of seven beds each were designated for male patients. The ward management occasionally added two beds in each of the room's corridors and one in the smaller room when

the number of patients exceeded bed capacity. The smaller room was supposed to be reserved for either very sick patients or for those with infectious ailments; however it accommodated female patients instead as they always outnumbered the males. A corridor with front and back doors separates patients' rooms from the other spaces (see Appendix 2). The main entrance, matron's office, nutritionist's room and patient's rooms are on the same side. A treatment room where drugs are prepared and a staff room are located near the back, by the emergency door. The staff room was mainly used by nurses and ward assistants as a tea and social room. The other side of the corridor houses the medical records room, a staff toilet and two bathrooms, one for female and the other for male patients.

Near the staff-changing room is a room labelled 'private', where bodies of the deceased lie before a porter can take them to the morgue. A curtain screen partially shields the room from curious passers-by. Patients went past the private room and attempted to peep in on their way to their shared toilet and the nurses' desk. The curtain screen was occasionally drawn after cleaning the room or the removal of a body. The private room opened and closed as frequently as deaths on the ward occurred. Patients and some staff estimated that at least two deaths occurred per week, an estimation that was close to ward statistics (Appendix 3). Patients said that they were always frightened to go to the toilet at night since it is adjacent to the 'private room'. Mukuru, for instance, noted:

People had told me that this might be the disease that will kill me ... I see people dying here and I become very afraid. I start feeling that if I was not here I would not have seen a person die ... So I thought it would be better to be at home than here. We frequently see people taken out to that room ... We are always aware of what nurses carry in and out of that room. We know when they carry away the deceased. If it is from this side, you imagine that when it comes to this other side, I will be the next to go ... You will be happy when morning comes ... When darkness falls we are even afraid to go to the toilet. You think maybe it is me who will be taken to the room tomorrow.

The location of the private room worsened patients' anxiety about death in the ward. The room was the focal point of the cycle of death I describe later. The nurse's desk was almost in the middle of the ward past the private room and the patients' toilet. After the nurses' desk, there were a drug store and sluice room, where dirty linen, used items such as bed pans, vomit-bowls and urinals are soaked and kept. Next to the sluice room is a minor storage space for used and recycled items, and a bigger storage space for supplies from the main hospital store. Nurses and ward assistants prepared tea and kept utensils in a pantry room near the emergency door.

A television set that staff and patients watched was above the nurses' desk. Patients sat on two benches in front of the nurses' desk as they either watched television or waited for nurses to assist them. The television set, like the radio cassette player below the nurses' desk, was secured with metal enclosures. Ad-

joining the cancer ward were the busy renal surgery wards, where distraught children are often heard crying. Patients came to ward with confidence that its medical care facilities and expertise were superior to the ones available elsewhere.

Care services and facilities

The ward admitted patients with head and neck, breast, cervical, colorectal, prostate, and gastric cancers. The majority of them were on chemotherapy while others were on radiotherapy and 'supportive management'. This included intravenous feeding, treatment of wounds and general palliative care. A few of the patients were treated by a combination of radiotherapy and chemotherapy. The Haematology, Obstetrics and Gynaecology units and amenity wards managed other types of cancer. While the cancer ward was different from other general wards due to the special needs of patients, it was not as high quality and comfortable as the amenity wards. These are part of the hospital's project to provide services equivalent to those in private hospitals. The amenity wards were located in the 'private wing' of the hospital in the tower block. Patients pay more for their care in this wing, which was initiated to enable the doctors to combine private practice and public service within the National Hospital. A few cancer patients are referred to the cancer ward when they no longer afford the higher charges in the amenity wards. These wards were less congested and had more patient-centred services compared to other wards.

Duration of therapies and hospital stay varied with the cancer type and its stage. Apart from long-term cases, patients stayed in the ward for either three or six days of each chemotherapy session. Others underwent eight to 25 radiotherapy sessions, which were often followed by chemotherapy. A maximum of six chemotherapy courses with an interval of three weeks were administered before further reviews. A combination of radiotherapy and chemotherapy entailed a relatively shorter duration of each therapy. The drawbacks to the hospital treatment in general included bad side effects from the drugs, holiday and weekend pauses, poor responses to therapy, low blood count, and some of the patients' irregular attendance at hospital appointments. Shortage of subsidised drugs for poor patients also interrupted the treatment process. Patients had to buy drugs from expensive private pharmacies and dispensing chemists when they were not available in the hospital. Treatment plans were in principal based on medical records. However, some records from referring health facilities were insufficient. Several patients, for instance, reached the referral hospital after numerous unspecified treatments elsewhere.

Cancer in-patients had access to required services from both the ward and other related units. They went for radiation therapy and clinical reviews at the

Radiotherapy Clinic. They also relied on the personnel and services in medical laboratories, X-ray, and scanning rooms. Due to the heavy workload at the radiotherapy department, treatment of in-patients was often postponed to the evening hours. High turnover of both outpatients and in-patients increased the treatment waiting time at this unit. Each day approximately 130 patients would turn up for treatment at the radiotherapy clinic, for a total of about 800 patients each month. With only one radiation oncologist working at a time at the clinic, patients' treatment planning (simulation) did not take place on time and this contributed to backlog in the waiting queue. New cancer cases reporting to the radiotherapy department were increasing. Unpublished figures at the radiotherapy department showed that there were 659 new and 3,890 re-attendant cancer cases in 1995. This totalled to 4,549 cases. Of the 10,809 cases in 2003, 1,135 were new, while 9,374 were re-attendant. The number of patients needing radiotherapy (cobalt) was 23,190, and 1,139 were on chemotherapy. In 2004, there were 1,499 new and 9,761 re-attendant cases, all requiring radiotherapy, whereas 1,164 also needed chemotherapy. (In-patients require radiotherapy in addition to chemotherapy at some point.)

The hospital had two Cobalt-60 units, which were the only ones accessible to the public countrywide. One of these machines was installed in 1983 and the other in 1993. The former machine required replacement, which is usually due after 15 years. A similar machine was available at a private hospital, but was accessible to only those few people who could afford the higher fee charged. The other functioning equipment at the radiotherapy clinic included one treatment planning unit and mould room facility. Immobilisation devices, breast boards, head and neck unit and masking devices were functional. Frequent breakdown of the machines increased treatment waiting time and the backlog of unattended patients. Technical experts and spare parts for indispensable machines came from abroad, especially Canada and Germany. Mr Abeid, a senior radiologist remarked:

We had a machine called the superficial X-ray machine ... When it stopped working we *searched internationally* (emphasis added). We went to Germany to the manufacturers and they said they were no longer manufacturing it!

Political commitment to raising the profile of cancer in Kenya could resolve the insufficiency of essential treatment facilities in the hospital. The purchase, installation and maintenance of the main equipment require large amounts of money. Moreover, safe and accurate operation of cancer treatment equipment requires highly trained personnel. A treatment simulator installed in 1993 was not functional during my fieldwork. It would cost 10 million shillings to repair it (one Euro bought about 100 Kenya shillings). Mr. Abeid reported that experts from the International Atomic Energy Agency (I.AEA.) advised the repair would

be uneconomical. They instead recommended the purchase of C-am X-ray equipment which serves a similar function. The Radiotherapy department was meanwhile using a C-am X-ray machine which they had borrowed from the X-ray department.

Replacement or repair of cancer treatment machines is expensive and takes a long time. For the duration of my fieldwork, a brachytherapy machine was not functioning. Doctors referred cervical and prostate cancer patients to other hospitals abroad if they could afford it. Others, such as Ms. Souda, received only palliative care and pain relief when they returned to the ward. Ms. Souda had tried to gather funds for over one year for brachytherapy in Uganda but she did not succeed. She was eventually discharged through the Nairobi Hospice for weekly palliative care sessions. Both the High Dose Rate (HDR) and the Low Dose Rate (LDR) brachytherapy machines were not functioning. Mr. Abeid said that the hospital was waiting for an engineer contracted from Europe to come and repair the LDR. It had been broken for about three years. The HDR machine had been removed because it was emitting dangerous radiation to the surroundings. Barely one year after its installation the machine could no longer be used, and had not been functional for two years. The cancer treatment centre required a new or reconditioned room if the machine was to be re-installed for safe use. Doctors tried to improvise in order to give patients some help in spite of the insufficiency of such essential machines and facilities. Doctor Martina for instance remarked:

We have been trying our best since the brachytherapy machine has been unavailable ... We try to improvise with whatever machines we have to treat patients. We refer those who can afford it to clinics out of the country. Some go to Uganda; some to South Africa, Tanzania or other overseas countries depending on their financial abilities.

Poor condition or lack of cancer treatment machines affected the well-being of both in-patients and outpatients. Delayed treatment and complaints about missing or inaccurate laboratory results were common. Doctors occasionally recommended repeats of tests and examinations done in the hospital facilities. They preferred diagnostic tests from outside the hospital when diagnostic results were missing from the patients' files. Similarly, they often found it necessary 'to confirm' the reliability of diagnostic results from the hospital's laboratories. Patients interpreted this as conflicting with the high expectations with which they came to the hospital. They initially hoped to find a self-sufficient hospital since they regarded it as the ultimate source of medical care among public and some private hospitals. The condition of treatment facilities accessible to patients shaped their experiences of and attitude towards technical care. The ward topography on the other hand had implications for in-patients emotional stability. The patients' ex-

perience of hospital treatment was an outcome of the psychological impact of the ward layout and effectiveness of available human resources.

Human resources

Nineteen nurses of different training backgrounds and levels in the hierarchy worked in the cancer ward. Two of them opted for early retirement, while two more were on study leave. Others combined work with part-time certificate or diploma courses in palliative care or counselling. The hospital administration had posted about half of the nurses to the cancer ward on 'medical grounds', meaning the nurses were considered to be frail and unable to work well in 'busy' or 'heavy' wards. For this reason, about half of them could not manage night shifts. Two to four nurses worked together during each shift, depending on the current workload.

A typical day for patients generally followed the routine of the nurses and medical staff, beginning around 4 am when the shift nurses took vital signs. After this, at around 5 am they helped patients to their baths, and assisted those patients who were not able to bathe. A kitchen assistant served breakfast between 7:30 and 8 am before nurses made the beds. Treatment, dressing and patient observation followed between 8:30 am and 12:30 pm. Lunch was served between 11 am and 12:30 pm. Nursing and treatment procedures resumed during the 5:30 pm to 7:30 am night shift.

A physician with the designation of Medical Officer of Health was in charge of the ward. He or she handled admissions and chemotherapy. The physician also tended to patients in other units, such as the 'amenity' (private wing) wards, who needed chemotherapy. Patient care demands challenged the ward doctor and nurses many times. The perceived low status of the cancer ward as aforementioned, partly contributed to its understaffing problem. The general attitude that there was 'no work' in the cancer ward apparently justified the inadequate staff posting. The ward doctor was not able to cope with the workload and was not available for patient care at night. Mrs Nedi, a nurse who was often in charge of the ward observed:

We operate without a doctor at night. They say we do not have emergencies. In case we have anything requiring his attention we call him on his mobile phone. He often tells us that will come the following day. So we just do our work and wait for the doctors to come the following day. We know the doctor is on call but he is over-worked.

In the words of Mrs Nedi, the main ward physician was 'a general practitioner familiarising himself with cancer treatment.' Doctors who were in charge of the ward during my fieldwork were not trained in oncology; they were apprentices, 'learning on the job'. Dr. Martina attributed the shortage of cancer treatment specialists to medical students' general lack of interest in oncology. On the other

hand, lack of policy on oncology training in Kenya was apparent from the small number of practicing cancer management specialists. Similarly, informants noted that there was scant focus on cancer in existing medical training programmes. Consider the comments of Mr Darius, a radiographer and Dr. Martina below:

... We need to restructure the training ... None of the doctors at the undergraduate level gets more than ten hours of teaching on cancer. Not even training, teaching ... I have also talked to the nurses. They indicate that the reality of cancer confronts them only after their posting to the radiotherapy clinic or cancer ward ... (Mr Darius)

... Very minimal time is dedicated to oncology in medical training. It only comes up during clinical years from the third year ... We have big rotations such as obstetrics-gynaecology, surgical and paediatric rotations ... There is no oncology rotation per se. This is just put out for students in their extra time ... You 'pass by' Oncology. Maybe students will see a cancer patient during the general rotations. I should say that teaching on cancer gets only an eighth of the total time of medical training ... It is much less. There is a lot of emphasis on the other specialities (Dr Martina)

There were only four qualified oncologists who served in the cancer treatment centre. One oncologist left the hospital to go work abroad at the beginning of the present study. The remaining doctors provided expert services to the ward and other units as consultants. They led the major weekly ward rounds in turns. Consultants are doctors with specialised training in their field, as will be further explained in Chapter 4. They attain the title of consultant after several years of service as specialist registrars and earning a master's degree in their field of specialisation. Ideally, registrars are experts with basic qualification in their specialities. They serve in wards for at least two years as they wait for the training that can lead to their qualification as consultants. However, adult oncology training is not available in Kenya. The four adult oncology consultants at the cancer treatment centre included one who had just completed specialisation training abroad. Their specialisation focused on radiation oncology and one of them was a nuclear medicine physician. They were also involved in part-time work and consultancy in private hospitals.

Only five qualified therapy radiographers served both inpatients and outpatients. Two more radiographers were on study leave. An additional seven untrained radiographers worked in the department. Three oncology nurses and three medical physicists worked at the Radiotherapy Clinic. A full-time nutritionist facilitated patients' diet and feeding needs on the ward. Trainee dieticians from university and mid-level colleges frequently worked in the ward. The nutrition office was handy for counselling sessions with a few patients and their relatives. Counselling sessions addressed eating and diet issues and some questions about cancer and its treatment in general.

A porter, records clerk and three housekeepers or cleaners worked in the ward in shifts. Other personnel attached to the ward included a laboratory technician, a physiotherapist, an occupational therapist and a social worker. Chapter 4 will

further examine the roles and interactions of all these and other actors. Patients' kin and friends complemented the care-giving roles of the hospital personnel. Their presence and roles were more noticeable during official visiting hours, between 12:30 pm and 2:00 pm; and 4:30 pm and 6:30 pm. Patients' social networks and the hospital staff constitute important sociability space in the hospital. Artefacts of medical technology and the physical ward environment contribute to the comprehensive context of patients' hospitalisation experience. These aspects had further implications for patients' endurance and emotional space. Physical conditions of the ward, daily occurrences and shortage of human and medical resources portrayed the hospital as a place in which patients experienced increased uncertainty, anxiety and desperation. The hospital and the ward emerged as a setting in which cancer in-patients gradually felt less attended to. It was a setting in which they experienced prolonged or recurrent states of limbo characterised by distress. Waiting for treatment, examination results and responses to daily physical and emotional needs became part of patients' daily life in the ward. Being an in-patient in the cancer ward also entailed a sense of physical and emotional vulnerability. The ward aggravated this situation by increasingly exposing its patients to threatening conditions and the reality of death.

Bed scarcity, waiting and care delays

Patients linked their narratives of experience in the referral hospital to previous help-seeking events. They had been through many tests in community health centres, private and peripheral public hospitals. They took various paths to the cancer ward. Many of them were referred there at different levels of public health care. Most patients had sought help from either private facilities or public hospitals before their current admission. Others came directly to the cancer treatment centre and ward through the hospital's casualty unit. It gradually dawned on them that the national referral hospital did not guarantee the prompt and reliable treatment they expected. Rather, admission to this hospital implied continuity in waiting for treatment and appropriate care. As pointed out earlier, this resulted from inadequate hospital resources, patient's financial constraints and the unpredictability cancer treatment outcomes. Being in the hospital and the ward was therefore an extension of the period of waiting and delayed relief.

Arrival at the cancer treatment centre did not mean outright access to treatment. Availability of hospital resources determined when patients could be admitted to the ward and their treatment begun. Out of over 100 patients who turned up every Monday for regular admission, only 20 or fewer secured beds. The admission of patients who needed urgent attention on other days further limited the number of beds that would be available on Mondays. Patients and /or their relatives had to be at the clinic by 5 am in order take the first 30 positions in

the queue. This increased the possibility of securing beds from 8:30 am when doctors began their work. Mr. Hassan commented on what he described the ‘scramble for beds’ in the words below:

It is a matter of ‘first-come-first-served.’ One must come here by 5 am to be sure of a bed. There may be only two beds against over 10 patients ... You find people have already arrived very early in the morning, by 5 am ... The person who arrives first collects the cards from others and files them in the order of arrival. He or she then presents the appointment cards to the doctors when they arrive ... Once the beds are filled up, they tell you, “there is no bed, go home and come back next Monday ...” When you go back home you postpone your problem. It has happened to me before three times ...

The range of bed occupancy was 50% to 83%. Between January 2005 and July 2006 in-patients statistics in the ward showed a higher rate of female admissions compared to the males. Therefore, the turnover and death rates among the female patients was more visible in the ward and in the statistics (See Appendix 3). Fewer men turned up or ‘qualified’ for admission. Patients ‘qualify’ for admission if they fulfill several conditions: their blood count should be sufficiently high; the urine analysis should be normal; and they should be able to buy drugs that are not available and pay hospital admission fees. Some patients were not eligible for admission because they failed to meet only one of the criteria. Others who qualified would still fail to be admitted due to the scarcity of beds. Fluctuations between under- and over-admission were also apparent in the ward. Low bed occupancy was related to low turnout for appointments, lack of eligibility among patients who reported for admission and the effects of holidays. Many patients missed the chance for prompt treatment due to bed scarcity. Lack of available space also meant the impossibility of adding beds from elsewhere. Nevertheless, at times the ward very few patients were admitted, and the few who were present were on short chemotherapy sessions of two days each. On such occasions the ward was virtually empty by Wednesday.

Delays in treatment and care persisted even after patients’ admission and during their stay in the ward. This constitutes a significant aspect of suffering that being in the hospital engenders for cancer patients. The delay was often related to a shortage of patient care resources which included drugs, treatment equipment and personnel. Respondents complained of the inadequate attention they received late in the night due to staff shortages and the non-functional calling system. (The bell system was not functioning for the duration of my fieldwork.) Patients therefore relied on shouting for help from nurses, physicians and other available staff. Responses to their calls were not prompt, and this symbolised the general delay in meeting in-patients’ emotional and physical needs. The hospital and ward environment was seen as a barrier to expected treatment and care by both patients and other actors; regardless, most cancer patients who participated in this study regarded the chance for admission to the hospital as a

blessing in disguise. The ward and the hospital constituted their final physical and emotional spaces that they felt obliged to face up to. Most of the respondents cited a need to tolerate their treatment setting in order to maximise the potential medical benefits of being there.

Enduring the ward situation

The hospital environment and specifically the ward is a physical space with emotional implications for cancer patients. Patients engaged in rationalisation in order to ease the distress that this treatment space caused. Some respondents viewed the cancer ward as the climax of hospital treatment. They did not anticipate finding any alternative hospital treatment setting with higher expertise and medical technology they could easily access. They considered the present treatment setting better or more promising than the other places they had previously been. An important aspect of this consideration was that treatment and care encounters prior to the present hospitalisation did not restore their well-being. The cancer ward also seemed better because once patients secured admission; they did not share beds as in other wards in the study hospital and other public hospitals. They also perceived the diet and nursing care in the cancer ward to be generally better than what they found or observed elsewhere. Some respondents noted that the condition of the cancer ward did not necessarily confirm the bleak picture that popular discourse about the hospital often portrayed. Echoing Ms. Nadia's view cited in Chapter 1, Mr. Jabari remarked:

... People out there say that this hospital is filthy. They say service has declined, but what I have seen is contrary to this view. I have had quite good service during the days I have been here ... The nursing care is quite in order and very good. ... It is better than many other hospitals ... It makes our healing process a little bit quicker because we can see that the treatment is good. They give us medicine on time. The doctor who gives chemo is very punctual ... This is very encouraging ...

Patients focused on the positive aspects of the ward in order to anticipate positive results from their stay. Low congestion in the ward and availability of curtain screens for some privacy were additional aspects that encouraged them to persevere. They tended to explain away ward inadequacies and any related anxieties. The view that their 'main interest was to get cured and go back home' offered more consolation. Patients restrained their critical evaluation of the quality of ward amenities. They instead focused more on either their need for more subsidised drugs or for compassionate care, as shown in Chapter 6. They desired more emotional consolation and prompt response to their physical needs. The fact that they did not share beds and that none of them was sleeping on the floor as in other wards was comforting. Others praised the relatively unique diet, staff approach, and somewhat cheap treatment and services. They tried to find the

positive attributes of the ward that made life there bearable. The ward was generally 'not a bad place' for most of them, as it was the only exclusive cancer ward they had been to. Positive experiences enriched their resources for psychological adaptation to anxiety and uncertainty in the ward environment. However, the ward constantly exposed them to threatening conditions and anxiety about death. In this sense the ward environment worsened patients' emotional vulnerability.

Threatening and unpleasant circumstances

The ward atmosphere unfolded the ominous reality of cancer. A poster at the nurses' desk had a positive message: "chances are that you do not have cancer." However, it reminded the reader to confirm this through appropriate medical examination. In the nutrition counselling office, there was another placard on how to cope with cancer through balanced diet. Subtle discourse about the risk of cancer and visible events in the ward often punctuated the hope for restoration of well-being. Patients witnessed the suffering of others in the open ward rooms. Beds were too close to each other and curtain partitions did not adequately screen undesirable treatment side effects such as diarrhoea, vomiting and constipation. Patients with different types of cancer and on diverse treatment regimes and courses lay next to each other. Those who could not stand the suffering of others pestered nurses and doctors to discharge them earlier than scheduled. Some feared that they would contract other illnesses on the ward. A respondent commented:

There might be some infections here. Patients have other problems, such as bronchitis or similar to the one I have. Somebody may have throat cancer and all the time will be spitting here and there. You may be lying near him and you can contract the disease ... Some patients have wounds and flies can transmit sickness from those wounds. (Mr. Mati)

Some patients indeed stayed in the ward longer in order to treat other illnesses such as chest infections. There were a few cases of malaria and additional sicknesses that required further investigation. The ward management did not separate patients according to their conditions as some desired. The small room meant to accommodate patients whose conditions would put the well-being of others at risk was rarely used for this purpose. Patients also wished the hospital would provide them rooms according to the nature and level of their treatment. Treatment side effects and especially vomiting and diarrhoea were more prominent patients in undergoing the first three courses of chemotherapy. This caused discomfort among patients who were not experiencing similar symptoms. Others were anxious that probably some cancers were contagious.

Shortage of cleaning detergents, the nature of cancer illness, blockage of ward drainage system and poor patients' hygiene on occasion caused the ward to stink. This increased discomfort and fear of transmission of illness among both patients and ward workers. The squalid atmosphere also triggered nausea, vomiting and

poor appetite among the patients. Some patients complained about the effect deodorants that some hospital workers and ward participants used. These also increased their vulnerability to nausea and vomiting, especially during chemotherapy. Many patients also found the smell of ward cleaning detergents to be too strong and unpleasant. Frequent drainage and sink blockages and poor drainage in patients' bathrooms and toilet worsened the physical and psychological distress among the patients. Flooding of bathrooms and delays in cleaning the patients' shared toilet were frequent phenomena. Some patients preferred using bid pans and portable urinals due to the fear of using the toilets. However, nurses did not always empty these hospital utilities in time due to their busy schedules. In order to control use of the toilet and frequent requests for bed and urinal pans some patients said that they limited their food and drink intake.

Patients repressed direct criticism of the ward environment in spite of their unpleasant experiences. They emphasised positive aspects of the ward in order to mobilise their emotional resources for coping with other challenging hospitalisation experiences. Silence or covert complaints about the ward were their strategies for safeguarding the 'good patient' picture. Similarly, holding back negative evaluation of the ward facilitated patients' positive thinking about their hospitalisation. The ward was the setting of hope and hence called for endurance of its negative characteristics. Their experiences and the discourse of carers within and outside medical settings generated idioms of hope which facilitated endurance. The idioms refer to expressions that manifested patients' optimism in spite of uncertainty and anxiety that resulted from their treatment circumstances, mitigating emotional distress and sustaining hope for positive outcomes of hospitalisation. Patients also invoked hope expressions in order to promote their confidence in hospital intervention. Their hope thrived on the confidence they had in the technology and expertise of the hospital. Religious faith among patients and their carers renewed hope. This facilitated coping with the anxiety and uncertainty that the physical and emotional ward space created.

The medical staff added an authoritative voice to patients' hope idioms that facilitated their endurance of the treatment setting. They often assured patients that 'there is some treatment for the disease' or 'something could be done' to alleviate their suffering. Many respondents found consolation in the view that the ward environment reduced loneliness. They said that it was easier to share experiences with fellow sufferers in the ward. One respondent for instance observed:

We have more people here to comfort us here than at home. We comfort each other. People who are okay cannot comfort you. They cannot understand when you tell them about pain ... They cannot relate to it when they are not sick! (Ms. Marina)

Mutual support among cancer in-patients provided them with the sociability space they required. As Chapter 4 will illustrate, sociability is an important

aspect in patient care relations. Many patients viewed the ward as an appropriate place to learn how to cope with physical suffering; however, the physical space and available human and non-human resources can have emotional consequences. Daily life experiences in the ward further influence the contribution of physical and emotional space to patients' well-being. Patients recognised the part played by the ward in strengthening emotional and objective coping resources. Mr. Johana for instance, remarked:

We build immunity to the illness from this ward. Someone can tell the other how he is unable to eat, how he has had sores in his mouth, or what medicine he used before a wound disappeared. I do not feel like an island even after I am discharged to go and 'live alone'. I always remember that I have a problem that my "colleagues" are coping with well. After this learning experience I do not feel that my condition has reached an end and that 'I am going' (to die). When my mouth dries up ... I know it is something somebody else has managed ... The ward introduces us to conditions even before they come to us.

Being in the cancer ward entailed significant encounters and interaction with fellow sufferers. Patients got the chance to evaluate their condition in relation to others. They reckoned with the reality that some of the cases were even more severe and hopeless than their own. While this intensified their emotional stress, it also provided them the space for learning from each other about how to cope. However, frequent and prolonged hospitalisations implied more exposure to episodes of death in the ward. This constituted the most significant challenge that the ward presented to in-patients' emotional resilience. Some patients feared that being in the ward enlisted them into what they perceived as a sequence of death when it occurred. They held that death seemed to follow a particular pattern within ward rooms with an end to the cycle in the 'private room.'

Cycle of death

A ward assistant's sentiments below provide a view of the experience of death in the ward.

... This was my first posting in a hospital. I previously worked in a company where I was dealing with healthy people. I used to hear about death in hospitals but I never experienced it the way I see it nowadays ... I almost resigned during the first three months of my posting. I was shocked. I thought this environment was not friendly. So a matron did some sort of counselling for me to help me continue, because I was about to tender my resignation ... I used to hear that people die but not at rate death occurs here. The mortality rate is very high, because you can easily lose five or seven people in a week! This means one patient daily. It is shocking. So one day, I followed a programme on television, they were saying; if you see a coffin, if you hear people crying at the mortuary, you should know that is the way ... And when you see the coffin you should be reminded that death is real ... Then the programme reminded me that I will also sleep (die) one day. That is why a corpse cannot scare me. I can even prepare a body for burial ... Yes, we clean the body, wrap it in nice sheets in preparation for mortuary preservation ... It has come to be a routine job in this ward ...

The 'private room' was almost at the centre of the ward. It was also very close to the spaces that were essential for patients (see Appendix 2). It was partly or

fully open on occasion, exposing an empty bed or the deceased and the mystery of life. Ward assistants at times washed the room with a strong-scented decontaminating cleanser after a body had been removed. The location of the private room did not conceal the frequent deaths or the reality of the low survival rates in the ward. The death rate was very high relative to the ward's small capacity (see Appendix 3). It was inevitable for patients to witness fellow patients' distressing last moments of life. Beds were close, but the ward personnel did not isolate very ill patients. Some respondents describe situations in which they feared the 'cycle or succession of death' in the ward. As Mukuru's remarks in the section on ward layout above indicate, some patients believed that death followed a sequence. Coincidentally, when very ill patients lay in adjacent beds they were likely to die in a succession. Mukuru observed:

I feel so much fear when I see someone dying. I would not see people dying if I were not here ... I saw the patient who was here and the one who was there dying. I fear that I will be the next to die. If we followed the cycle I thought that I would be the next ...

There was subtle fear of beds and spaces which dead patients had occupied. Patients categorised deaths in the ward as 'painful, sudden, or peaceful (silent).' Long-stay patients had more exposure to the processes of dying in the hospital. The cancer ward unfolded the reality of death as an outcome of hospitalisation. It is in this sense that some ward personnel indicated that their colleagues in other departments likened the ward to a repository of very ill and dying patients. The experience of the cancer ward as a place with the most number of deaths was traumatising for patients and their kin as well as hospital carers. Stella, a long-stay breast cancer patient recounted her distressing experience of witnessing four deaths in a week. Her son was anxious when he found she had been moved to a bed that had been vacated after a deceased patient had been wheeled away. "I also wonder if this means I should be the next to go (to die)," Stella remarked.

Some ward staff and patients associated the ward with physical deterioration and death rather than cure or healing. They speculated that frequent deaths resulted from toxic chemotherapy or neglect of patients in distress. They argued that many patients appeared strong upon admission and prior to their deaths. They therefore questioned the safety of the ward and some of the chemotherapy regimes. In a conversation with Stella about this, she said:

They come when they are still a bit strong. Therefore we feel they can be assisted. Many patients deteriorate all of a sudden ... Most of them die at night. The woman who was here was eating well. I thought she would be all right ... I cannot understand whether there is no medicine. Maybe they delayed buying the medicine ... Her husband has been coming and I think he bought her medicine. I do not know if they (staff) used the medicine ... I do not know why she passed away. She did not deserve to die ... You come here when you are still a bit strong, but you become exhausted, then you just die silently. They have not told me anything about my case ... yet; the doctor comes and treats the other patients. We may be

talking just as we are doing now, but after a short time somebody changes abruptly and dies, just like that ...

Some patients associated the ward with exposure to the risk of “undeserved death.” They argued that hospital staff could fail ‘do their best’, making hospital stay futile. Therefore the ward provided space for either professional concern for sufferers or lack of it. In this regard, considerate staff were often prompt in responding to patients’ calls for help. If carers had ‘done their best’, patients would describe death as a chance for the sufferer ‘to go and rest.’ Viewed in this way, the hospital was a mere transition place for patients beyond medical help. This notion was applied to long-term hospitalisation cases or patients whose critical illness or desperation was more noticeable. The same consideration related to patients who died relatively old in spite of cancer and unsuccessful hospitalisation. Some patients were eager tell relatives about what they perceived as undeserved deaths. They attributed some of the deaths to staff laxity and insufficient treatment resources. Nurses on occasion transferred such patients to other rooms in order to control their tendency to turn fellow patients and relatives against hospital staff.

Issues in patient-carer relationships featured in narratives of incidences of death in the ward. Patients feared that their reactions could upset the hospital staff, thereby affecting their treatment as Chapter 6 illustrates further. They speculated that hospital workers could bring about some suffering or refuse to provide appropriate care due to negative attitude towards particular patients. They associated some aspects of suffering and death with either lack of compassion among carers or their temperament. Some patients therefore believed that some deaths and prolonged suffering were due to carers’ avoidable errors. The excerpt below illustrates patients’ views about suffering and death that they associated with either vindictive carers or professional errors.

... so many people died and I was very scared ... Six deaths occurred within five days! This terrified everybody. We felt that it was better to go home because we did not know who would be next. Mabeywo’s death disturbed me for over a month. She had been well and jovial ... She used to wake up early and bathe by herself until a doctor came to administer an injection. He said he would inject her in the stomach instead of the hand ... Mabeywo accepted reluctantly ... She later started complaining of severe headache. The doctor and nurses told her that she would be well ... The next day a nurse brought her water, but she said that she was unable to bathe ... She was unable to wake up. We knew that in her condition, she ‘was going’ (to die). Nurse Debra came in to ask how she was faring, but she did not reply ... The nurse took ‘the bed’ away. (Mrs. Pakot)

Patients were suspicious of some hospital staff whom they associated with untimely death and suffering. They were ambivalent about the hospital as a place in which they hoped to find a remedy for their physical and emotional adversities. The hospital seemed to be a dangerous place the increased suffering which many patients linked to their initial medical treatment elsewhere. As an example, Ms.

Stella said that doctors in a district hospital were to blame for her mastectomy because they injected directly the breasts. Others felt that the hospital would control suffering and deaths if physicians would avoid some surgical operations and ‘dangerous chemotherapy drugs’. While it is true that the referral hospital was the setting for cancer patients’ they also perceived it and especially the ward as a dangerous place. Therefore long-stay patients and those who had experienced numerous hospitalisations tended to oscillate between discreet resistance and compliance. They resisted staff that they perceived as responsible for unsafe or inappropriate medications. In relation to this, Mrs. Pakot remarked:

... If that doctor came to give me medicine, I would excuse myself. I told him; let me take it another time. If he insisted I would take the medicine politely and pretend that I wanted to take it. I would just throw them away later (laughs). I would not take his medicine. Everyone in the ward was worried when he came around to give medicine. People really fear that person ...

Patients concealed their resistance. Sometimes they argued with physicians and nurses about the treatment they were refusing. Episodes of physical deterioration and death in the ward challenged patients’ emotional resilience and prompted their resistance. However, the patients and their kin still struggled to sustain their faith in the hospital’s medical technology and expertise. Hope idioms were handy in the face of death. The medical staff encouraged the idioms and these facilitated patients’ endurance of hospitalisation. The staff often reminded grieving and occasionally bitter relatives that they all ‘did their best’. Hospital staff and patients apportioned mutual responsibility for successful treatment, as shown in Chapter 5. Experiences in the ward, however, provided patients and their families with the chance to come to terms gradually with the reality of cancer treatment outcomes. Long-term and repeat stays in the cancer ward revealed the intrinsic helplessness of the hospital staff. Treatment efforts are therefore part of their encouragement for patients to disprove the notion that death is the obvious or imminent outcome of having cancer. Patients and ward staff repeatedly referred to the idiom that ‘death does not result from cancer alone’. In this sense, the ward was a place for endurance of the prolonged suffering that cancer causes. The notion that not only cancer, but also ‘other diseases and accidents cause death’ consoled suffering patients. In this regard, the ward is a place where health workers and patients combine material and emotional resources to cope with indefinite treatment, increased uncertainty and a frequent lack of answers to cancer management challenges. A patient’s remark below is an illustration of this.

I was shocked ... I refused to let them amputate my leg. I could see that the disease is not curable. I later accepted the amputation. I considered that even if I stay with the leg, so many thoughts would hurt me. I responded to God and he still has helped. There are many people who have died and cancer did not kill them. Even the doctor told us that the first thing a per-

son needs to do is to accept the disease ... That is how he or she will start to heal faster. The doctor said that it does not help to think too much that cancer is not curable. He said that if you believe and take the medicines, they can cure or reduce the (cancer) cells. (Mr. Toi)

Sentiments of religious faith intertwined with hope idioms to ease anxiety among patients and hospital staff. Being in the hospital represented a struggle against a seemingly 'incurable disease'. While exposure to death in the cancer ward increased anxiety and uncertainty, the staffs' dedication to treatment sustained most patients' optimism. Mr. Ndege demonstrated this hope in spite of an apparently contradictory reality when he said:

... My friend who was here died two days after I was admitted ... The one who was here has also gone (has died) ... The nights have gotten too long ... You know, treating and healing are two different things. You treat and it is the work of God to heal. People believe that cancer is a deadly disease, but which one is not deadly? Malaria is also deadly and can kill you in a day ... As we get the treatment we also need to learn about spiritual life. I always wonder when someone says, 'that ward is for cancer people and cancer has no medicine.' Here we are, buying the medicine ... Why are we doing it? Why can't we just go home to wait for the day (to die)? (Mr. Ndege)

Medical staff and other carers inspired patients to accept the disease and tolerate the treatment. Doctors were the first credible hospital contacts who strengthened patients' anticipation to restore their well-being. Religious beliefs and attitudes facilitated their endurance of the emotional distress that the disease treatment environment engenders. Adherence to treatment and healthcare instructions was an important aspect of religious belief and faith. In the end, patients perceived the success of hospitalisation in terms of a combination of factors, including the adequacy of medical resources and services, and personal endurance of treatment and its context. The type and stage of cancer determined the success of hospital intervention. Shortages of medical facilities and patient care personnel further shaped patients' experiences in the cancer ward. This context did not guarantee that therapy in the hospital would be successful; daily life in the ward entailed a persistent struggle to improve the sufferers' quality of life.

Summary and discussion

Most patients and their family carers believed that being in the cancer ward implied privileged access to superior medical technology and expertise. They perceived the referral hospital as the ultimate source of hope after their previous, unsuccessful treatment trajectories. However, the hospital staff concealed their sentiments about the perceived limitations to cancer management in the hospital. The ward seemed to embody the intrinsic weaknesses of physicians and other staff with regard to meeting the physical and emotional needs of patients fully. Ward and other hospital staff's views of the treatment environment mirror their

uncertainties about the hospitalisation outcomes of cancer patients. The cancer ward seemed secluded from the rest of the wards located in the modern block of the hospital. Some ward staff connected the ward's isolation with its apparent invisibility within the hospital system. Discourse about the cancer ward reflected its perceived low status. The ward was not as physically visible as other units in the hospital, a fact which caused uncertainty and suggested low esteem with regard to the careers of the hospital staff responsible for treatment and care of cancer in-patients. Their experiences in the cancer ward reflect inadequate cancer management resources in the hospital and the Kenyan healthcare system. An important element that this situation portrays is the low priority given by the healthcare system and public health policy to cancer management in Kenya (Murray *et al.* 2003). Healthcare policy in Kenya, as in other developing countries, somewhat neglects cancer. This results from the fact that cancer is a complex health problem, which requires extensive human, technical and financial resources. According to the International Network for Cancer Treatment and Research (INCTR) (2008), this acts as a disincentive to national policymakers and international agencies to address the cancer problem. Available resources in Kenya remain inadequate for dealing with basic public health issues and the menace of communicable diseases. Therefore, non-communicable diseases such as cancer receive negligible funding allocation from the national healthcare budget.

Cancer in-patient care in the present study took place in premises that were not planned for this purpose. This had negative consequences for patients' comfort and the quality of care they received. The architecture and configuration of the cancer ward and clinic also affected the gratification that the hospital personnel derived from their work environment. Similarly, the physical layout and setting of the ward had implications for patients' physical and psychological comfort. This constitutes part of a 'healing hospital environment' or design that contributes to patients' satisfaction (cf. Van de Glind *et al.* 2007). Ward arrangement, adequate treatment facilities, and human resources are significant aspects of a favourable treatment environment. Prolonged and subsequent hospitalisations in the cancer ward exposed the limitations of the treatment setting, and this gradually undermined the confidence that most of the patients came with to the referral hospital. Ward environment and structure are part of the healthcare design which influences patients' well-being, quality of life and the recovery process. Patients' access to comforting views through the window, for example, may have a positive effect on patients recovering from surgery (Ulrich 1984). Conversely, the ward environment in the present study increased anxiety and uncertainty. The corridor of the main entrance exposed patients to distressed visitors reacting to news about the death of their kin. The open ward arrangement further compro-

mised patients' privacy and dignity, which are essential to patients' satisfaction with care (Whitehead & Wheeler 2008; Zaman 2005). The curtained screening in the dormitory-like rooms did not guarantee privacy and self-esteem especially during treatment, visiting time, and when patients were experiencing adverse therapy side effects such as diarrhoea and vomiting. Similarly, the ward arrangements could not provide adequate visual and auditory privacy when they needed to rest.

Contrary to patients' expectations, the ward was a place for further waiting and care delays. Heavy workloads, a broken calling system, and occasional congestion constrained nurses' prompt attention to patients. Shift nurses remained busy with paperwork at their desks when they were not performing routine duties. Patients were often out of the nurses' sight, and nurses could not attend to them spontaneously due to the ward's design. The current design thus constrained effective nursing care as it did not facilitate maximum contact between nurses and patients (Seelye 1982). Patients who were not able to call out for a physician or nurses waited until staff could come around or sent available people to them. A shortage of cancer treatment facilities increased the waiting time in the ward for appropriate care. In addition to inadequate cancer treatment equipment in the hospital, a shortage of specialists worsened in-patients' quality of care and life. The large workload and few functional machines also restricted treatment. This situation contributed to a backlog of unattended patients and a decline in treatment accuracy (Onyango *et al.* 1987). The referral hospital did not guarantee the timely attention to both physical and emotional needs as patients anticipated. The cancer ward did not offer the final refuge after the multiple formal and informal referrals that characterised the help-seeking trajectories of cancer patients in Kenya (Onyango & Macharia 2006). Delays in meeting treatment and general care needs during hospitalisation worsened patients' physical and psychological suffering. Being in the ward implied further uncertainty, anxiety and unforeseen treatment postponement and interruptions.

The cancer ward, like other medical settings, is a context for specialised treatment and patients' search for physical comfort. The experience of illness and its unpleasant aspects contribute to sufferers' emotional vulnerability. The ward therefore constitutes both a physical and emotional space for patients and their carers. Technological limitations to cancer treatment and exposure to some physical conditions in the ward shaped patients' feelings about the care setting. The configuration of the ward had either direct or indirect effects on patients' emotions. The ward exposed patients to events that threatened their endurance and hope. Frequent deaths were apparent to most patients, especially in the temporary repository for the deceased. This was the most threatening experience that caused greater doubt and anxiety about the outcome of hospital treatment of can-

cer. The constraints to emotional space in the ward also included their exposure to fellow patients' symptoms, and both physical and psychological suffering. Patients in distress seek both the emotional participation and empathy of their carers. The ward constitutes a setting for medical treatment and the 'sociability' that affect patients' non-material coping resources. While it is true that the open ward design exposed patients to emotionally threatening conditions, it is also true that the layout granted them the opportunity for interaction with each other. Such an arrangement reduces feelings of loneliness that in-patients would experience if they were admitted in single, isolated rooms (cf. Van de Glind *et al.* 2007: 159). Exposure to the experiences of fellow patients while they are not very ill provides them with good mutual learning opportunities for coping with cancer treatment. Similarly, the ward setting provided a chance for favourable mutual emotional and social support among fellow sufferers, Who offer better consolation to each other due to their shared experience of cancer and treatment (Kelly *et al.* 2004).

The hospital workers have an important role in ameliorating patients' emotional space. Some of the staff in the cancer ward attempted to enhance patients' emotional resilience through verbal encouragement. This was essential for patients' endurance of their hospital stay and treatment circumstances. However, cancer management professionals understated the reality of limited resources, low survival rates, poor prognosis and limitations of medical interventions in cancer management. This constitutes a coping strategy for specialists facing uncertainty during patient care. The hospital in this regard becomes a place of sociability immersed in a specific cultural context in which heightening the secrecy surrounding medical practice increases uncertainty, anxiety, and desperation (Comelles 2002: 271). The lived experience in the treatment setting causes gradual and inevitable erosion of patients' confidence and hope in the hospital. In the present study, the cancer ward turned out to be a place where time prevailed over the limitations and contradictions of the hospital's management of cancer. Arguably, the medical professionals facing such a challenge may use hope idioms as rhetorical tools to justify their healthcare efforts in cases they perceive as hopeless (Good *et al.* 1990). In this regard, medical professionals' positive evaluations of treatment progress tend to contradict patients' subjective experiences.

The physical and emotional space of the cancer ward shaped the patients' endurance and hope further. They tended to overlook the inadequacies of the treatment setting in order to keep their focus on the objective of pulling through. Avoidance of directly criticising the treatment environment helped safeguard their hope. This attitude denotes an important aspect of patients' hopeful adjustment during life-threatening illnesses and treatment effects. As part of coping

with unpleasant conditions, most respondents sustained talk that could promote 'positive thinking' and curb less positive feelings (cf. Wilkinson & Kitzinger 2000: 809). As an example, patients argued that the ward was good, after all, because it was better than the other wards in public hospitals. Maintenance of hope among patients entailed their active engagement in life as they attempted to identify and emphasise what was positive for them (Elliott & Olver 2007). This is in conformity with the expected role of 'the good patient', that is, the one who does not complain much about available treatment, care and the hospital living infrastructure. Taking on the good patient role, patients may accept the hospital environment as given and as a setting for treatment different from home (Sommer & Dewar 1963). They believed that an appreciation for their treatment environment would facilitate their goal, that is, 'to get treatment and go back home'. The resort to idioms of hope facilitated emotional endurance of treatment and hospitalisation circumstances.

The setting of treatment may either increase or allay the suffering that results from severe illness. Patients expect the hospital to facilitate both physical and emotional healing; however, the medical setting and especially the ward arrangement and available care resources may cause emotional suffering. The cancer ward in the present study can thus be viewed as a new context for patients' lived experience of the body (Scheper-Hughes & Lock 1987). Satisfaction with the hospital living infrastructure has consequences for the constituent parts of the body, especially the mind, psyche and self. These aspects interact in influencing the way patients experience suffering, health, illness and quality of life in the hospital. The treatment setting affects patients' emotional predisposition. This may result in subtle resistance and despair. Emotions as such serve as a means for transforming knowledge into human understanding, which brings intensity and commitment to human action (Blacking 1977). In this sense, the physical and social environment of the ward may be emotionally disruptive, thereby affecting patients' hope and endurance. Events in the ward and its physical space contribute to patients' experiences of adversity, uncertainty and anxiety. This characterised the cancer ward as the physical and emotional space which embodied inevitable and increasing tribulation that patients had to endure. Physical and emotional discomforts are often experienced as inescapable consequences of treatment (Radley & Taylor 2003).

The cancer ward revealed the truth about cancer as a fatal and terminal disease. However, idioms of hope in spite of the reality of death point to the fact that patients may consider the possibility of death, but not its certainty (Little & Sayers 2004). Persistent hope for cure and life over death redeemed anxieties about death. Patients construed some deaths as 'deserved' when supposing that genuine treatment and care efforts had failed. Deaths were either undeserved or

unacceptable when patients evaluated hospital personnel and kin's efforts to save the lost lives as insufficient. Due to this, the hospital setting is not only a physical and emotional space but also a 'sociability' space. The ward provides space for both social and therapeutic relations that are germane to patients' well-being. The suffering body is dependent on and vulnerable to the feelings, wishes and actions of others (Scheper-Hughes & Lock 1987: 21). The hospital is in this sense an arena of social relations and interactions that influence therapeutic processes. Therefore the reassurance of medical personnel, encouragement from fellow patients, and support from other actors' underpin patients' struggles to cope with uncertainty, which was visible in the cancer ward environment.