SOUTH AFRICAN MEDICAL PRACTITIONERS’ EXPERIENCES OF THE CURRENT HEALTH-CARE DELIVERY SYSTEM

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South Africa is at a critical point in the debate about the future of health-care in the occupation-specific dispensation (OSD). It also faces the exodus of valuable human resources that was perceived as greener pastures, as medical practitioners become increasingly dissatisfied with governmental policy, wage negotiations, work-place disillusionment, lack of service delivery, expressions of corruptions, and lack of resources. This research aimed to thematically analyse the experiences, opinions and feelings of medical practitioners in both the public and private health-care sectors as well as explored international trends with the intention of drawing comparisons, highlighting problem areas, and discussion of possible solutions. It was hoped that this research would contribute towards understanding the dynamics that marked the exodus of medical practitioners from South Africa, at a time when change in the health-care system was imminent. In order for the medical practitioners to remain in the current health-care system, a new dialogue would have been opened in which their concerns could be raised and evaluated.
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CHAPTER 1: INTRODUCTION

Chapter 1 comprises a general introduction to the present study. Thereafter the motivation for and significance of the study are discussed. The research problem and aims are noted briefly, and the chapter concludes with an outline of the organisation of the thesis chapter by chapter.

1.1 INTRODUCTION

Health-care systems are designed to meet the health-care needs of various target populations. Internationally a wide variety of such systems exist, for example, in some countries decisions relating to health-care are made by market participants, whilst in others planning is done more centrally among governments, trade unions, charities, religious, or other co-ordinated bodies that aim to deliver planned health-care services specifically targeted to the populations they serve (Gawande, 2009). However, in most cases, health-care planning has often been evolutionary rather than revolutionary, with systems constantly changing.

In South Africa, Section 36 of the Constitution has been implemented with a goal to protect the poor and vulnerable. However this legislation has had limited success in enforcing rights to health-care and human dignity, as the realisation of these rights is subject to the availability of resources (Vallabh, 2009). Furthermore, evidence points to a South African health-care system that is crumbling at the core. Overworked doctors have staged countrywide protests to demand fair pay and better working conditions. The Business Day newspaper reported that bus drivers were now earning more than junior doctors, who have to complete six years of study. This frustration is evident in the more than 20 000 certificates of good standing that have been issued by the Health Professions Council of South Africa (HPCSA) to medical practitioners since April 2003. The majority of these certificates are requested by doctors applying for positions overseas (Gopal, 2009).

This situation has led to disillusionment in health-care services. There seems to be a prevailing belief that the South African Constitution, which is designed to protect the poor and vulnerable, has had limited success in enforcing rights to health-care and human dignity. Some medical practitioners report that they abandon their paperwork to attend to some 200 patients who arrive each morning for treatment and who leave their homes at 5am to join the queue before it stretches out of the doors (Chronicle of Higher Education, 2004).
The ANC’s 2009 election manifesto proposed a “National Health Insurance” (NHI) system as a key component of its efforts to address the serious problems afflicting South Africa’s health-care system. At this stage, very little is known about the details of any NHI proposals. However, key elements of the proposals are reported to include the implementation of a new dedicated payroll tax for health-care along with the establishment of significant administrative infrastructure to oversee these funds and purchase health-care benefits for the population.

Thus far, the NHI debate has been held behind closed doors, with no public or stakeholder participation. It is vital that detailed policy documents be put into the public domain as soon as possible to allow all interested stakeholders to participate in this important process. It is also vital that proposals be based on hard evidence, and not on ideological assertions and beliefs. In particular, it is critical to understand the true economic cost and impact of any proposals as accurately as possible. As part of the debate a detailed understanding of the successes and failures of other countries which have attempted reforms of these kinds, particularly those countries with similar socio-economic profiles to our own, is essential. It took countries like South Korea, Australia, Canada and many other European countries decades to establish universal health-care access at the scale that we are contemplating in South Africa. Much more can be done in a shorter space of time, but this will require contributions and collaboration on the part of all stakeholders (Broomberg, 2009).

The motivation for the present study thus stems from the need to gain greater insight into the experiences of those working under the present occupation-specific dispensation in the medical field.

1.2 MOTIVATION
This study has been motivated by various contemporary problematic issues in the South African health-care system such as the “brain drain”; current wage negotiations between medical practitioners, labour unions and government; the proposed National Health Insurance (NHI) plan; overwork and stress-related conditions; and problematic service delivery particularly in the public service. The statement of the problem motivating this proposal has been succinctly summarized as follows:

“Evidence points to a health-care system that is crumbling at the core. Overworked doctors have staged countrywide protests to demand fair pay and better working conditions. The Business Day
newspaper reported that bus drivers were now earning more than junior doctors, who have to complete six years of study. The Health Professions Council of South Africa has issued more than 20 000 certificates of good standing to medical practitioners since April 2003. The majority of these certificates are requested by doctors applying for positions overseas” (Gopal, 2009, p.1).

South Africa has “faced large-scale emigration, especially of professional people, commonly referred to as the ‘brain drain’” (Pillay & Kramers, 2003, p. 52).

Furthermore, much discourse surrounds the relatively new “Occupation Specific Dispensation” which was issued by the Department of Public Services and Administration of South Africa (Department of Public Services and Administration of South Africa, 2009). Occupation specific dispensation refers to revised salary structures that are unique to each identified occupation in the public service (http://www.info.gov.za/speeches/2009/09122109451001.htm).

South Africa is at a critical point in the debate about the future of health-care in this occupation-specific dispensation. By highlighting the experiences, opinions and feelings of doctors in the various sectors of the health-care community, another platform for debate will have been opened. Personal and social solutions also inevitably arise from such experiences. This study could contribute to the evolution of the health-care system at a time when change is imminent. Additionally, through exploring these issues, the exodus of doctors from South Africa could be prevented. Current discourses surrounding issues in the health-care system have been analysed for common threads and further analysis on an on-going basis.

1.3 RESEARCH PARADIGM
This thesis departs from a social constructionist paradigm in its critical interrogation of the predominant questions, discourses and issues that reflect the prevailing context and structure of the South African Health-care delivery system. In its focus on revealing and explicating contemporary medical practitioners’ experiences within this context and structure it may be described as interpretive and/or phenomenological (Terre Blanch, Kelly & Painter, 2006). Social constructionist and interpretive paradigms converge with regard to the central concern of the thesis which may be described as interventionist in attempting to offer some (albeit minimal and incomplete) solutions to problems in relation to the current South African Health-care Delivery System and related
experiences of its personnel, especially medical practitioners, the research participants in the present investigation.

The research also has a positivistic slant in the DASS, but it is acceptable if you view this as minimal and covered by the other two paradigms – Your decision

1.4 RESEARCH QUESTIONS
The review of the literature revealed that to date, there have been no studies that address South African Medical Practitioners' experiences of the current health-care delivery system within the South African context. Thus, the research question arose as to what contemporary medical practitioners actually experience in the Health-care setting. In this context, the term ‘experience’ is a broad one, commonly found in the psychological literature, which includes all phenomena that people have lived through and are currently living through (Edwards, 2001). The research question provided further motivation with regard to the intention and aim of this dissertation which may be stated as follows:

There are currently many questions surrounding the experiences of medical practitioners in the current milieu in South Africa and abroad. However, common factors linking the different perspectives and viewpoints of medical practitioners worldwide are apparent in relation to their struggles, stresses, fears, frustrations and expectations. This research aims to provide insights and explanations for the different contexts in which medical practitioners find themselves both in South Africa and abroad. It also offers recommendations for the improvement of the profession as a whole as well as self-help suggestions which are not costly but have the potential to alleviate some of the dire circumstances in which these practitioners work and which cause occupational and emotional distress.

1.5 DEFINING KEY TERMS AND CONCEPTS
Below, the various terms and concepts used throughout this thesis are outlined and discussed:

HEALTH
The World Health Organisation (WHO) does not define health as merely a lack of disease or illness. It views health as a state in which the individual experiences complete social, physical and mental well-being (WHO, 1946). It may be argued, that people always face stressors in life and thus it may
never be possible to attain complete mental, physical and social well-being. However, stress can be divided into two types, each affecting health differently; eustress, (positive type) and distress (negative type). The manner in which people evaluate stress, and the resources at their disposal, plus the extent to which they can control those stressors, are factors which, to an extent, control the impact which stress has on them (Baum & Posluszny, 1999). This type of control over stressors may be referred to as environmental mastery, which is a component of psychological well-being (Edwards et al., 2004). It is difficult to remain healthy in a dysfunctional environment; one which is emotionally and physically so taxing that an average person cannot cope with the strain. A person with low self-efficacy will, according to Pervin and John (1977), experience far more anxiety from stressors than a person with higher self-efficacy. Thus, when a person is faced with events which they perceive to be unmanageable, they are likely to experience high levels of distress which will in turn affect their health negatively. It has always been an observation that people respond differently to similar stressors – and that their sense of feelings of control and mastery may be the key to successfully negotiating difficulties.

In the South African context, health may be linked with the spirit of Ubuntu, the African philosophy that “a person is a person through other persons” (Schutte, 1994, p. 29). In order to be healthy, a participatory consciousness frees oneself from categories and notions imposed by objectivity and subjectivity. It is in the “re-ordering of the understanding between the self and the other to a deep kinship of ‘self-other’, between knower and known” (Kotze, 2002, p. 5) that an attitude of participatory consciousness, receptivity and openness is born (Heshusius 1994, p. 15).

HEALTH-CARE WORKERS
The WHO defines health workers are people whose job it is to protect and improve the health of their communities (WHO, 2006). The global profile presented by the WHO in 2006 shows that the 59 million health workers world-wide are unequally distributed within countries. They are found where the need is less severe and in predominantly richer areas where the health needs are less concerning. These numbers are sadly insufficient to meet global health needs, with shortages being in the region of 4.3 million health-care workers (WHO, 2006).
HEALTH-CARE SYSTEMS
Health-care systems are designed to meet the health-care needs of target populations. There are a wide variety of health-care systems around the world. In some countries, the health-care system planning is distributed among market participants, whereas in others planning is made more centrally among governments, trade unions, charities, religious, or other co-ordinated bodies to deliver planned health-care services targeted to the populations they serve. However, health-care planning has often been evolutionary rather than revolutionary (Gawande, 2009). Health-care service delivery service is a fundamental function of any health-care system and is intended to provide therapeutic and medical measures to improve and preserve the health condition of patients. According to the WHO, the goals for health systems should be: good health, fair financial contribution and responsiveness to the population's expectations (WHO, 2000).

HEALTH-CARE SERVICE DELIVERY
The public sector in South Africa is under-resourced and over-used, while the mushrooming private sector, run largely on commercial lines, caters to middle- and high-income earners who tend to be members of medical schemes (18% of the population), and to foreigners looking for top-quality surgical procedures at relatively affordable prices. The private sector additionally attracts most of the country's health professionals” (Health-care in South Africa. www.southafrica.info).

Health services in African countries are increasingly placed under stress because of limited budgets and increasing services demands. To address this paradox some countries are turning to quality assurance and improvement approaches (Whittaker et al, 1998). In South Africa, the Council for Health Services Accreditation of Southern Africa (COHSASA) has implemented a programme to assist private and public hospitals implement services such as catering, maintenance, managerial, clinical and other continuous quality improvement programmes and provide guidelines for meeting professional organisational standards (Cochasa, 1977).

In order to address the inequality of health-care service delivery, there has been a shift of health-care services towards a primary health-care approach (i.e. from hospitals to district-based clinics) which has resulted in other financial cut-backs especially to the severely challenged resources of the public hospitals which are funded entirely by the state (Whittaker et al., 1998).
NATIONAL HEALTH INSURANCE PROPOSALS FOR SOUTH AFRICA

The African National Congress’ (ANC) 2009 election manifesto proposed a “National Health Insurance” (“NHI”) system in order to rectify the dire situation which South Africa’s health-care system finds itself in (African National Congress, 2009). Currently not much is publicly available regarding the details of the NHI system. However, the introduction of a new payroll and substantial administrative infrastructure to purchase and oversee health-care benefits for the people of the country, appear to be key elements of the proposal (Broomberg, 2010). Broomberg (2009) furthermore believes that any health-care reform in South Africa should be transparent and open to testing through lively public debate.

OCCUPATION SPECIFIC DISPENSATION

According to the Department of Public Services and Administration 2007, “Occupation Specific Dispensation means revised salary structures that are unique to each identified occupation in the public service.” These salary structures will be graded into and aligned to the market, encourage career pathing models for employees, base increases on criteria such as performance, qualification, scope of work and experience. Specialists and professional’s salaries will be higher than or equal to managers without them needing to move into managerial or supervisory positions. Government has indicated that this move will attract and retain skilled personnel. It will improve salary structures through large salary increases and also reward performance and seniority where necessary. The OSD will be implemented over 5 years, beginning for medical practitioners in April 2008 (Department of Public Services and Administration, 2007).

SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

SAMA is a professional association for medical doctors in South Africa. Its aims are to empower doctors to bring health to the nation. It supports medical practitioners in terms of advice pertaining to medical law, ethics, labour relations, representation on health matters and monthly scientific journals. Its principle activities are to provide medical skills, education, knowledge and leadership to medical practitioners, represent their rights, uphold the medical profession’s image, promote research and academic excellence, negotiate health reform and affordable health services for all (South African Medical Association, 2010).
HIPPOCRATIC OATH
The Hippocratic Oath is one of the oldest binding documents in history. It is traditionally taken by graduate physicians to uphold the ethical standards of their profession, particularly to preserve life above all (Encarta, 2001).
**STRIKE**
Is the organised, collective slow-down or cessation of work by employees to force their employer to accept their demands (http://businessdictionary.com).

**WORK TO RULE**
This is a labour protest in which workers make a point of adhering strictly to the rules of the workplace so that work will slow down (Encarta, 2001).

**1.6 METHOD AND ORGANISATION OF THE THESIS**
In chapter 1, an introduction to the study is provided. The motivation and significance of the research regarding the South African context is outlined, and the research problem and aims are discussed briefly. Chapter 2 is a review of the relevant literature pertaining to medical practitioners’ experiences in the international and local contexts are provided. Chapter 3 provides an overview of the methods used to obtain and analyse the data rendered by the present study are discussed. The results are reported in Chapter 4. The main findings are presented as they pertain to the content, number, intensity and pattern of experiences of medical practitioners in the South African context. The results are discussed further in chapter 5. This chapter concludes the study and the general findings are summarised. A critical review and recommendations for future research are also provided.
CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION
Examining South African medical practitioners’ experiences of the current health-care system should begin with the assumption that, are these lack of spaces typing problems? The unequal “Apartheid” medical system failed the majority of South Africans, and the current medical system cannot cope with the demands of the morbidity of South Africans. Provision of Medical care in South Africa has been further complicated, and burdened by, the complex pathology of the HIV/AIDS epidemic. These extreme demands and changes in the context of health, in combination with the changes in the medical system and society as a whole, have caused many controversies and frustrations within the medical fraternity. The examination aims to assess the psychological, contextual, ethical and physical challenges that medical practitioners face, working in different environments within the health-care system in South Africa.

2.2 THE RESEARCH CONTEXT
In order to understand the context in which medical practitioners live and work, a brief outline of the South African, as well as international, research context will be outlined below.

2.2.1 THE SOUTH AFRICAN CONTEXT
South Africa has been a democracy for almost 18 years; however, the country’s Apartheid history still has a large influence on its social atmosphere and government policy. The inequality entrenched by the Apartheid system is still visible and still negatively impacts many South Africans’ lives. Factors such as violence, poor health, deprivation and poor education continue to perpetuate theoretical and cultural inequality in South Africa (Biersteker & Robinson, 2000). Some of the medical practitioners in the present study grew up in the 1990s and have not directly experienced Apartheid. However, their parents and older members of their families and community have. Under the Apartheid regime, violence against non-white people was promoted and these acts may have aroused feelings of insecurity in members of the non-white communities in turn leading to feelings of fear and anxiety. This was perpetuated through the generations by socialisation processes. These negative aspects notwithstanding, in the post-Apartheid era there are better opportunities for all South Africans, irrespective of culture, race, gender and religion. Medical practitioners are living in one of the most dynamic and rapidly growing societies on earth and they are protected by a progressive first world constitution which promotes and upholds their well-being.
It might be argued that the struggles medical practitioners face at present is a reminder of a system which was far from perfect during the pre-Apartheid years – and thus feelings of insecurity, anger, fear and frustration may be a re-emerging problem.

While typical countries devote about forty two percent of health expenditure on paying salaries to health-care personnel, governments in Africa and South-East Asia typically devote a lower percentage. In addition, countries with the lowest need for medical practitioners have the highest numbers and South Africa, one of the countries with the greatest burden of disease, has to make do with a smaller workforce. It is not clear what the actual ratio of Medical practitioners per hundred thousand people is in South Africa, as there is no clear census of immigrants who are living illegally in the country. Health workers are distributed unevenly world-wide (WHO, 2006).

There are an enormous amount of posts available for doctors countrywide, with eighty percent of vacancies in Limpopo Province and forty nine percent for doctors and forty four percent for specialists’ country wide. In South Africa’s nine provinces, there appears to be a 42.5% overall post vacancy. It is further estimated that there are 55 doctors for every 100 thousand people which is a low ratio in comparison to other countries. Also of concern, is that South Africa has similar economic developmental levels to Brazil and Mexico, yet it is quite clear that it lags behind quite seriously. Brazil has one hundred and eighty five doctors per hundred thousand people and Mexico, one hundred and ninety eight respectively (Watson, 2010).

THE INFLUENCE OF HIV/AIDS

In 2002, it was estimated that thirty million people in sub-Saharan Africa were living with the HIV/AIDS (Dworzanowski, 2002). Even though only eleven percent of the world’s population lived in this area, it remained the centre of this pandemic (Goliber, 2002). If one considers this area identified as the “AIDS belt” in Southern and Eastern Africa and that four percent of the world’s population live in this area, and that this area constitutes 50% of the world’s HIV/AIDS infections, then the statistics become more frightening (Population Reference Bureau, 2004). In 2004, 21, 5% of the South African population was reported to be living with AIDS (Population Reference Bureau, 2004).

By 2005, it was estimated that South Africa had 5,5 million people living with AIDS with KwaZulu-Natal having the highest infection rates, reporting 33,5% of pregnant women testing
positive for HIV (UNAIDS, 2005). In parts of rural KwaZulu-Natal province, where this study was conducted, the infection rates were placed as high as 50.8% (Anon 2, 2003). The estimate for 2006 was similar, making South Africa the country with the second highest infection rate and the highest on the African continent (UNAIDS, 2006; Department of Health, 2007; Dorrington et al., 2006). Approximately two million people did not know they were infected (UNAIDS, 2006), and the epidemic escalated to enormous proportions, along with social and political transformation in South Africa (UNAIDS, 2006).

More recently, death notification statistics indicate that AIDS is drastically impacting on the South African population (Adam & Johnson, 2009). South Africa therefore needs to urgently expand and strengthen public hospital’s antiretroviral treatment programmes, although there are significant unmet needs for antiretroviral medication. By the middle of 2008, it was estimated that only 40.2% of adults needing antiretroviral medication were getting them. In addition, there is unfortunately no centrally co-ordinated data collection system to estimate the current public-sector patients receiving antiretroviral medication, except for the Western Cape Province. The situation places an extraordinary burden on medical practitioners in the region (Adam & Johnson, 2009).

Stress, patient burden and current circumstances are overwhelming with HIV/AIDS being possibly the biggest health challenge in Africa, and with the migration of medical practitioners creating severe shortages. Many have migrated to developed countries, exacerbating the enormous problem (Dovlo, 2004). Much is still unknown with regard to antiretroviral coverage in South Africa at present, and the real impact of service delivery in this regard (Adam & Johnson, 2009). Over and above this, little attention seems to be being given to the plight of the medical practitioners who serve a vital role within the country. Questions undoubtedly arise, such as: How do caregivers cope with the personal stresses arising from their jobs? How do they manage to cope with the demands and stress of their daily jobs? How do they manage their own health? How do they manage to provide a sense of being ‘normal’ in their own lives, given their circumstances? In other words, are the caregivers able to care for themselves? It might be easy to imagine why medical practitioners, involved in wage negotiations, struggling with the pressures of an overburdened health-care system, might be suffering from stress, burnout, frustration and fantasies about life in a better and seemingly more lucrative environment.
2.2.2 THE INTERNATIONAL RESEARCH CONTEXT

There are a wide variety of health-care systems around the world in which medical practitioners work. Currently, many Western industrialized countries are experiencing a crisis in health human resources, and are recruiting foreign-trained medical practitioners. As far back as the 1960s, Western countries revised immigration policies to attract thousands of health-care practitioners that migrated from poorer countries to the Western industrialized countries. During the 1980’s and 1990’s migration declined, only to re-emerge in the last 10 years, sparking a global debate about the ethics of health-care policies world-wide. The rise of South Africa as a donor country, possibly due to globalization, has elicited ethical debates especially in light of the current catastrophe of the HIV/AIDS epidemic (Wright, 2008). Despite this, South Africa ironically attracts doctors from poorer states, forming a “medical carousel” in which medical practitioners move to countries they perceive to offer them a better standard of living (Bundred et al., 2000).

There is a global shortage of 4.3 million doctors, nurses, midwives, and support workers. Paradoxically, these often co-exist in countries with large rates of unemployment of health professionals. Beuocratic red tape, lack of public funds, political interference, poverty and labour markets which are imperfect, produce this effect in the midst of underutilized medical talent. On top of this, migration of the work force compromises the country of origin’s culture, knowledge and memory (WHO, 2006).

A shortage of health-care workers puts a great strain on medical practitioners internationally, with the greatest shortfalls being in Bangladesh, India and Indonesia (WHO, 2006). In sub-Saharan Africa, an increase of 140% is necessary to meet the health-care worker threshold. However, South Africa is not on the critical-shortage list, but debate is on-going about the accuracy of the current total population in South Africa (WHO, 2006). With health-care linked strongly to global labour markets, poor countries medical practitioners are lured by strong market signals from the wealthier countries (WHO, 2006).

In Lesotho, Malawi, Mozambique and South Africa, the health system is paralyzed by a lack of health-care workers, particularly in rural areas. Malawi had 10% of doctors recommended by the WHO and about half of them work in urban areas, leaving severe shortages in rural area. Mozambique is facing the same predicament, as there are only 2.6 doctors per 100 thousand people. One in four doctors trained in Africa is working abroad and in Ghana (Nduru, 2005).
WHO reports that 57 countries, most of them in Africa and Asia, face a severe health workforce crisis (WHO, 2006). “At least 2.4 million health service providers and 1.9 million management support workers, or a total of 4.25 million health workers, are needed to fill the gap. Without prompt action, the shortage will worsen” (Nduru, 2005).

With medical practitioners migrating inter-continentally, health staff is being robbed from African countries by the developed world because it is much cheaper to employ medical staff internationally, as many of their health systems are under their own budgetary pressures. The World Health Report of 2006 summarized a number of reasons why medical practitioners and other healthcare workers moved to richer countries. These included concerns about a lack of promotion, poor management, heavy workloads, lack of facilities, declining health services, inadequate living conditions, high levels of violence and crime, better remuneration, upgrading qualifications, gaining more experience, living and working in a safer environment, and family related matters. The concerning factors which make medical practitioners leave are known as the ‘push’ factors (as they push people away) and the prospects of better circumstances in other countries are known as the ‘pull’ factors. Each year, substantial numbers of health workers leave the health workforce, either temporarily or permanently. These exits can result in shortages if workers who leave are not replaced, and such shortages compromise the delivery and quality of health services (Coombes, 2005).

A common health-care problem around the world is the long waiting lists for treatment, promises of universal coverage which seldom materialize, and escalating health-care costs. However, in countries with long waiting lists which lean towards government control, and in countries with effective national health-care, there are factors such as cost-sharing, competition and consumer choice. In essence, national health-care systems have not solved rising health-care costs and medical practitioners are moving between countries for the above-mentioned reasons (Tanner, 2008). In summary, it seems that most medical practitioners in nearly all health-care systems worldwide are under pressure and struggling to stem the tide of escalating expenses and limited access to care (Tanner, 2008).
2.3. MEDICAL PRACTITIONERS AND EMOTIONAL FACTORS

STRESS

Stress is an inevitable part of modern living. It can be defined as symptoms of physical and mental tension or strain (www.yourdictionary.com) and as “non-specific aspects of dealing with environmental change, demand, and/or threat” (Baum & Posluszny, 1999, p. 140). With reference to how medical practitioners experience stress, it has been reported that the manner in which people evaluate the resources which they have at their disposal, as well as the extent to which they can control stressors, affects the impact that stress has on them (Baum & Posluszny, 1999). People with low self-efficacy experience more anxiety than individuals with high self-efficacy. This is why people who are faced with events they believe are unmanageable, are likely to experience great distress, resulting in a negative effect on their health (Pervin & John, 1997). Societal and cultural perceptions can affect the way in which caregivers perceive stress. The same degree of stress may be experienced differently by different cultures. Hence, where care-givers have internalized these expectations, they come to act as an appraisal tool in the future, to which caregivers compare themselves. Therefore, personal orientation of caregivers can be defined as “feelings related to the self-appraisal of fulfilling the role of caregiver, based on self and social expectations (Goodman et al, 1997). A noticeable feature of caregiver stress is the continuity with which it occurs. Issues such as death and despair, which medical practitioners are faced with on a daily basis, cause emotional stress (Goodman et al, 1997). In addition, the unresolved grief and sense of helplessness they may feel from dealing with HIV/AIDS, and witnessing the deaths of patients with whom they may have become emotionally connected, leads to chronic occupational stress and “occurs in every profession concerned with AIDS care, i.e. doctors, consultants, psychologists and social workers” (Bellani et al., 1996, p. 207). Levels of caregiver commitment also appear to influence stress levels, in that the stronger the level of commitment, the higher the caregivers stress levels have been found to be (Goodman, et al., 1997).

Characteristics and levels of caregivers’ skills mediate the degree to which medical practitioners experience and handle stress, according to recent research (Anon 1, 2000). When a caregiver is more competent, s/he will be less likely to find care-giving overwhelming or as stressful as someone less competent (Goodman et al., 1997). Eighty-seven percent of medical practitioners in South Africa claim that government intervention in the profession is a significant source of stress (Landman et al., 2000).
**BURNOUT**

Burnout is caused by a type of stress which occurs primarily in professional situations where most notably work demands of an interpersonal nature may cause depersonalization, a sense of reduced personal achievement and emotional exhaustion (Gueritault-Halvins, 2000). In the context of health-care, there are several stressors that can lead to care-giver burnout. These include profound feelings of loss and grief, repeated exposure to death, fears relating to attachment and loss, feelings of helplessness, and ineffectiveness related to possessing inadequate medical expertise to care for people with AIDS, increased workload, and coping with inadequate social resources for AIDS patients (Anon 3, 2000; Bellani et al., 1996). Symptoms of burnout include emotional exhaustion, a reduced sense of personal accomplishment, loss of a positive attitude toward clients, and an increased desire to quit the profession (Bellani, et al., 1996). Hence, it can be seen how these chronic levels of occupational stress lead to burnout (Pines & Maslach, 1978).

A survey of South African medical practitioners’ experiences and feelings relating to occupational burnout and stress (Peltzer et al., 2003) revealed that high severity of job stress resulted from:

1. Colleagues not doing their job,
2. Insufficient salary,
3. High frequency of job stress and covering work for a fellow-doctor,
4. Making critical decisions, dealing with crises, and working overtime.

Female doctors felt a lack of support on job stress severity more than male doctors, and consequently were found to experience more emotional exhaustion. White doctors related more job stress and burnout symptoms than doctors of colour. Very elevated levels of burnout (emotional exhaustion and depersonalization) were found among all categories of doctors. The results predicted that work stress led to emotional exhaustion and depersonalization (Peltzer et al., 2003).

Notwithstanding the fact that the physical demands of the caregiver job can be severe, being in close interactive situations with patients at all times with “excessive demands, time pressure and job stress” can cause caregivers to feel emotionally burnt out and exhausted (Bellani, et al., 1996, p. 207). In addition, the close interaction with clients means that apart from the demands, pressure and stress, it is the severe reaction to them that leads to burnout (Bellani et al., 1996; Goodman et al., 1997). Emotional overload is therefore a strong predictor of burnout. This occupational burnout
ultimately leads to higher levels of absenteeism, staff turnover and reduced productivity at work. When considering these factors in the medical field, the potential impact is devastating (Nesbitt et al, 1996).

ANXIETY

Anxiety can be described as an unpleasant, vague emotional state which includes apprehension, distress, dread and uneasiness (Reber & Reber, 2001). It is characterized by an uncomfortable and ambiguous feeling which is accompanied by undesired changes in one’s physical state, such as dizziness, headaches, stomach discomfort, perspiration, palpitations, an increase in blood pressure, agitation and shaking (Khan et al, 2005). It has the potential to affect an individual’s thinking, perception and learning abilities (Sadock & Sadock., 2007). Anxiety can therefore become intertwined within the experience of everyday human life (Khan et al., 2005).

The experience of anxiety consists of two components: the awareness of physiological sensations (e.g. palpitations, sweating), and awareness of feelings (e.g. nervousness, fear). Anxious medical practitioners’ may distort their perceptions which can potentially render their attention span ineffective. Anxiety can impair cognitive, emotional and occupational functioning and can preclude sufferers getting needed social support to improve their symptoms and return to good health once again. Patients are often unaware of the anxiety their doctors may experience or its potential effect on their thinking and perceptions (Sadock & Sadock, 2007). In the U.S, the combined economic cost of anxiety and depression is approximately $72 billion annually (Forbes et al, 2008). This has significant consequences if inferred to medical practitioners. If South Africa is similarly affected by anxiety, the implications for medical practitioners could be devastating.

Of course, medical practitioners experience anxiety in everyday life situations that are a normal reaction to their stressful work. However, chronic anxiety is associated with unhappiness and has the potential to erode an individual’s sense of well-being as well as giving rise to physical consequences such as tension headaches, panic attacks and stomach complications (Edelman, 2006). Forty percent of the adult population in America suffer from anxiety (Forbes et al., 2008). If South African statistics are similar, then one can assume that in a stressful field such as health-care, medical practitioners must struggle with anxiety and its associated complications. Statistics of the World Health Organisation indicate that mental illness accounts for up to fifteen percent of disease world-wide (Streeter et al., 2007).
FRUSTRATION-AGGRESSION

“The single most potent means of inciting human beings to aggression is frustration” (Sadock & Sadock, 2007, p. 150). John Dollard’s frustration-aggression hypothesis proposes that frustration almost always leads to aggression (whether overt or covert) and that aggressive behaviour is always an indication of frustration (Dollard et al., 1939; Reber, 2001). Reber (2001), Sadock and Sadock (2007) suggest a revised version of this hypothesis: Frustration appears to increase aggression when the level of frustration is intense. If frustration is perceived as deserved or legitimate, rather than arbitrary or illegitimate, the frustration is likely to facilitate aggression (Reber, 2001).

2.4 MEDICAL PRATITIONERS AND SKILLS

BRAIN DRAIN AND SKILLS SHORTAGES

Since the end of Apartheid, South Africa and other African nations have faced large-scale emigration of professionals (Pillay & Kramers, 2003). The reason for this ‘brain drain’ seems to be related to lack of opportunities, political instability, economic depression and health risks (Merriam-Webster Dictionary, 2010). Not only is this damaging to these ‘drained’ countries’ economies and the disadvantaged poor who are dependent on public Health-care, but to those who become deprived of the care they need especially in light of the HIV-Aids epidemic (Collier et al., 2004; Padarath et al., 2011). The brain drain demonstrates racial ‘contours’. The skills distribution legacy of South Africa such as policies favouring black economic empowerment has contributed to the large white South Africans communities living overseas (Bhorat et al., 2003). The South African government requested Canada in 2001 to desist from recruiting its medical practitioners (Ehman & Sullivan, 2001).

The flight of skilled professionals is occurring despite the weak labour market in Europe and the United States of America. The number leaving South Africa in 2010 went up by 62%. The report said that 192 medical practitioners left the country in 2003, which was more than in 2002. Bearing in mind that it costs a minimum of R120 thousand to train a doctor over seven years, the more they flee, the worse the conditions will be for those who remain in the country. The process of migration will continue to escalate as long as there is enough talent remaining to flee (Parker, 2004). African professionals tend to migrate to Western Europe and North America. Most are reluctant to return home due to the economic and political crises that have affected continent over the last few
decades. Some of the reasons for this trend have been: failing economies, wars, poor social services such as education and health and high unemployment (Mutume, 2003).

Highly skilled professionals from all over the world are migrating to the United States. They are drawn here by the world's best universities, the most dynamic companies, the freest economic and social environment and the highest standard of living (Weber, 2004). African countries lose 20 thousand skilled workers to the developed world each year. Nearly one in ten adults with university qualifications from the developing world, almost half of its science and technology personnel, are now living in the developed world (Lindsay-Lowell et al., 2004). Ironically, if all the professionals and skilled workers are absent, the entire developed world’s aid will not help. Each year, 20 thousand fewer people in Africa are available to deliver key services to the public. That something needs to be done to stem the tide of brain drain is not in question (Sriskandarajah, 2005). If the issue of health-care workers is not resolved, the number of South Africa’s medical practitioners leaving the country over the next ten years could reduce current percentages by twelve to sixteen percent (Watson, 2010). Further declines in medical practitioner numbers will bring further losses of care and service for the entire population.

South African Minister for Education, Kader Asmal said that even though South Africans were attracted to emigrate by favourable exchange rates and alternative social environments, they were nevertheless bound to become disappointed as these attractions were often more of a subjective than an objective reality (Asmal, 2004). Asmal (2004) states further, that the demand for South Africa’s professionals is so large due to the quality of training and education they receive. Asmal (2004) asserts that although migration builds global understanding, it should not debilitate the sending countries. Responses to Asmal (2004) revolved around the notion that South Africa should focus more creating incentive for professionals to remain in the country through improving working conditions, rather than trying to prevent the drain through strict migration policies. Many responses argued that factors such as crime, racial quotas in employment, and other social problems ultimately drive professionals to seek work internationally (Asmal, 2004).
2.5 MEDICAL PRACTITIONERS AND COMPENSATION

REMUNERATION AND WAGE NEGOTIATIONS
Landman et al. (2000) interviewed a representative sample of medical practitioners in South Africa, and found that for 91% of the participants, inadequate remuneration was a significant source of stress. In 2007, the Department of Public Services and Administration issued a statement regarding the plans for Occupation Specific Dispensation (OSD) in the Public Service. It promised career pathing opportunities through experience, competencies, and performance, with incremental salary level increases. The promise included the government’s desire to attract or retain medical practitioners, as well as other skilled personnel, by offering improved remuneration, and it promised to do so within five years (Department of Public Services & Administration, 2007).

By 2009, public sector medical practitioners were preparing for a national strike as it appeared that the government had not satisfactorily implemented the OSD as promised in 2008. They claimed that they were being paid 50 to 75% less than promised (Cullinan et al., 2009). However, by December 2009, the Department of Health issued a statement acknowledging that there had been a delay in the promised remuneration to medical practitioners and appealed to the Department of Health to implement the OSDs per the initial agreement (Department of Health, 2009). By June 2009 a strike ensued, crippling public services for a month (Associated Press, 2010). (REF)

By the end of 2010, another strike occurred which threatened to bring the country’s health services to its knees. It was felt by some that the government could resolve the crisis by granting workers' an 8.6% salary increase and other fringe benefits, instead of the 7% it claimed to be the limit. A deadlock ensued, and unions who had not joined the strikes previously threatened to do so, planning major marches. The government was forced to bring in military medical practitioners and volunteers to try to keep hospitals running and avert a national disaster. (Associated Press, 2010)

STRIKES
Medical practitioners in South Africa have carried out strikes, go-slow and protests against unacceptable working conditions and low pay since the African National Congress banned striking by law post-1994. Military and medical personnel have been mobilized by the government to break the strikes, threatening hundreds of doctors with dismissal, including those who defied the ‘back to
work’ court order. The doctors contended that although their strikes may have been illegal, their reasons for doing so were legitimate (International Communist League, 2009).

The strike which took place in 2010 was led by a dozen unions who formed a coalition to represent nearly 1.5 million South African government employees, including medical practitioners, many of whom had defied a court order issued shortly prior to the strike, obliging those in essential services to return to their posts (Smith, 2010). Some medical practitioners became concerned that patients were not getting treated. This was particularly concerning in South Africa, the country with the highest rate of HIV Aids (Associated Press, 2010).

In the heat of the strike action, police fired rubber bullets, tear gas, and water cannons to prohibit workers from blocking hospital entrances and preventing staff from entering who did not want to be part of the strike. Many were arrested and numerous injuries were reported (Smith, 2010). The strike divided public opinion bitterly with medical practitioners being accused of deliberately neglecting and endangering the lives of their hospital patients. Thousands of people volunteered, as striking staff went as far as to disrupt surgery in operating theatres.

A teacher from Cape Town, writing anonymously in the City Press newspaper, defended the strikers' conduct:
"This is war. Sadly, in any war there is collateral damage. It is painful and sickening that nurses have to abandon their posts and refuse to treat children and those suffering. But what choice have they been left with?” (Smith, 2010).

A frustrated medical practitioner wrote:
“Every time I feel a pang of guilt at the thought of patients dying as a result of a doctors’ strike, I remind myself that thousands more have already died, and thousands more will die, if drastic measures are not taken by the South African government soon. As contrary as it may sound, I do hope that the public will support us in applying pressure for reform despite the inconvenience they will face – our ultimate goal after all is to enable us to serve them better” (Wonkie, 2009).

2.6 MEDICAL PRACTITIONERS AND ETHICS
Ethics is a branch of philosophy that is concerned with deemed right or wrong, good or bad acceptable or unacceptable human behaviour in pursuit of aims and goals (Reber, 2001). People are
likely to be discerning in decision making if they know that they can be held accountable (Janis & Mann, 1977; Rozelle et al., 1981; Tedlock, 1983.; Tedlock & Kim, 1985) or that if they make a mistake it will reflect negatively on them (Freund et al., 1985; Kruglanski & Freund, 1983; Kruglanski & Mayseless, 1988). Medical practitioners’ own dispositions, subjective values, tensions and emotions will influence their definitions and answers to problems as well as their perceptions (Betan, 1997; Betan & Stanton, 1999; Gelatt, 1989). Ethical decisions are made within a social context (Cottone, 2001). Medical practitioners’ work in a particular system and are shaped by that system. To make matters more difficult, systems as well as people are always in a state of change (Cottone et al., 1994) and thus the outcomes of the decisions which they make and/or the degree of harm they may inflict will always remain uncertain (Bursztajn, et al., 1991).

Medical Practitioners may therefore choose to make the wrong ethical decisions for many reasons. Firstly, because of inherent human decision-making factors and one can include in this people’s tendency to rationalize wrong behaviour (Koocher&Keith-Spiegel,1998).Social-cognitive researchers have often commented on and documented this form of illogical reasoning (Bandura, 1996). Secondly, people often get into trouble due to deficient understanding of ethical norms that govern their professional practice (Lichtenberg, 1996).

In an ethics survey conducted in South Africa in 2000, it was found that 73% of South African medical practitioners believed that doctors in this country were ethical in their professional conduct and 91% had higher standards of moral integrity than other professions. Most (72%) people believe that the medical profession is being treated unfairly by being singled out regarding ethics issues (Landman et al., 2000).

Most medical practitioners in South Africa believe that the Health Professionals Council of South Africa (HPCSA) has poor guidelines about what constitutes ethical and unethical behaviour. Eighty four percent of medical practitioners had not received any documentation addressing ethics from the HPCSA in the past year (Landman et al., 2000). The overwhelming impression seems to be that the medical profession is trapped between ethically sound practice and its traditional commitment as well as demands which are growing with regards to financial survival. Nevertheless, even though doctors may have the best interests of their patients at heart, they are increasingly frustrated by the government’s unrealistic demands. It may not be far-fetched to refer to the medical profession as a profession under siege (Landman et al., 2000).
The large-scale strike of 2009 which devastated hospitals in South Africa heralded the emergence of intense focus on medical ethics in South Africa resulting in heated debate (De Villiers, 2009; Naidu, 2009). Bearing in mind that healthcare-related strikes have occurred over the past forty years, it is important to understand the South African scenario relative to the escalating debate about what medical professionalism and related obligations really are (Wynia et al., 1999). Contemporary medical practitioners are alarmingly being faced with divided loyalties and perverse incentives. As a result, an air of patient and public mistrust has begun to prevail (Kassirer, 1995; Feldman et al., 1998; Wilson, 2009). However, there is also evidence that much of the pressure for healthcare policy reform is not exerted by the medical practitioners but by the patients who are affected by the strikes (Loewy, 2000). It is because of this, that patients are used by medical practitioners as a means to an end – which is clearly in contention with professional practice. It is also a violation of fundamental and mainstream ethical principles. For example, Kantian ethics postulate that others should never be used as merely a means to an end and should always also be used as an end in themselves (Loewy, 2000). The basic medical principles of beneficence, non-malfeasance and social justice are in stark contrast to the recent types of strikes and thus cannot be regarded as justifiable or professional (Stuart, 2010).

Currently, the trend of the medical employee’ has become more popular than that of ‘medical professional’ and the strike action is an extension of that trend. Nevertheless, patient care is incompatible with medical practitioners’ strikes, and patient neglect can never be justified as professional behaviour. South African strikes form part of this scenario with documented reports of harm to patients and withholding care. This can no doubt be deemed unacceptable and detrimental to the medical profession in this country (Bateman, 2009). There is no clear indication currently about what actually defines professional action in these situations. What may be needed is a more explicit and definable moral philosophy of what professionalism is for medicine in the twenty-first century. The current ethical dilemmas would have been inconceivable to the founding members of this ancient profession (Stuart, 2010).

2.7 CHAPTER SUMMARY

In this chapter, the relevant literature pertaining to South African Medical Practitioners experiences of the current healthcare delivery system was reviewed with relevant discussions regarding the status of healthcare delivery in South Africa and abroad. There is a tendency to use this term when
examining ideals when actual human behaviour is considered in social and cultural situations. Codes of ethics are acquired and become the backdrop against which behaviour is evaluated.
CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION
The present study’s aim was to gain greater insight into, document, explicate, analyse, and expose medical practitioners’ experiences of the current health-care delivery system with the aim of finding solutions to problems. The research approach included the following perspectives: phenomenology, exploratory, interpretive, social construction, and qualitative action research.

This research was structured in terms of the three main paradigms in psychology: social constructionism, positivism, and interpretivism (Terre Blanche, Durheim & Painter, 2004). This translated into a mixed quantitative and qualitative methodology as represented in the social constructionist context of contemporary discourses related to the South African Health-care Delivery System, the positivistic, quantitative orientation of the Depression Anxiety Stress Scales (DASS-21) findings, and related phenomenological interpretations of the sample of medical practitioners’ experiences as revealed through thematic content analysis.

The present study was exploratory in nature, as there is still a relative amount of knowledge lacking around the notion of medical practitioners’ experiences of the current health-care delivery system in South Africa. A few studies have touched on this topic, but not addressed it directly (Harrison, 2008). Qualitative methods are subjective and seek to understand the experiences of the phenomena they seek to study (de Vos et al., 2008). Qualitative research is unique in that it allows the researcher into the context within which the phenomena may be studied (Cresswell, 1998). An advantage of using qualitative techniques was the possibility for the researcher to gain a first-hand and holistic understanding of the subjects under study (de Vos et al., 2008).

Phenomenological research seeks to portray the meaning of experiences of the phenomena for different people. This may be achieved by systematically collecting the data, and, in due course, meanings, themes and descriptions of the various experiences are analysed within a specific context (de Vos et al., 2008).
3.2 OBJECTIVES OF STUDY

Each of 13 medical practitioners (6 public and 7 private) was asked to complete the DASS-21 questionnaire measuring depression, anxiety and stress on a scale 0 to 3. The questionnaire consists of 21 statements referring to feelings of anxiety, depression or stress (7 statements for each type of feeling). A response of 0 refers to “not at all”, 1 to “some degree”, 2 to “considerable degree” and 3 to “very much”. Interviews were also conducted with 12 of the practitioners (6 public and 6 private). The purpose of the analysis is to:

1. Analyze the overall responses to the DASS-21 questionnaire according to the items.
2. Analyze the overall responses to the DASS-21 questionnaire according to the respondents.
3. Test for differences in the responses to the DASS-21 questions according to practice (public or private).
4. Test for differences in the responses to the DASS-21 questions according to gender.
5. Compare the questionnaire and interview responses.

3.3 SAMPLING

For the purpose of this study, a convenience sample was used. Participants were recruited by means of snowball sampling. One doctor was contacted and from this contact, further participants were introduced to the researcher. Participants included medical practitioners working in the private and public sectors in the KwaZulu-Natal province of South Africa. The reason for choosing doctors from the public and private sectors is that at present medical care in South Africa is strictly divided into these two categories. The private sector meets the expectations of world-standards and provides first-class service, whilst the public sector experiences major limitations in terms of high patient numbers and public demand. This situation is also a reflection of the past political system of Apartheid in South Africa and the deficits it created through separate development of different population groups. These factors inevitably affect doctors working in the private and public environments differently.

PARTICIPANTS

The original sample comprised a group of 14 doctors, but because of incomplete responses, the final sample consisted of 13 participants. As mentioned above, this sample was divided into two groups, doctors working in the public sector and doctors working in the private sector. The private sector group consisted of 7 participants. The public sector group consisted of 6 participants. To be
included in the study, the participants had to be registered medical practitioners within the South African context.

### 3.4 INSTRUMENTS

**OPEN-ENDED QUESTIONNAIRE**

An open-ended questionnaire was used to gather data relating to medical practitioners' experiences of the current health-care delivery system in South Africa. The open-ended approach was chosen so as to allow participants the freedom to formulate their own responses, rather than restricting them to choose from a list of pre-coded categories (Clark, 1999). Open-ended questions leave the answer entirely to the participant, as the researcher either has little prior knowledge of possible responses, or feels that responses that are more detailed might add depth to the research (Payne & Payne, 2004). Furthermore, open-ended qualitative findings may also be interpretative in nature, as people constantly interact empathically with each other in normal, natural, day-to-day settings and they know things simply by being able to speak, look, and listen (Terre Blanche et al, 2006).

**DASS21 SCALE**

The open-ended questionnaire was complemented by a measuring instrument, the DASS-21 scale. The DASS-21 is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. It consists of 42 items each reflecting a negative emotional symptom. Each item is rated on a four-point Likert scale of frequency or severity of the participants' experiences over the last week. Scores range from 0 (items did not apply to them at all), to 3 (the item applies to them very much, or most of the time) (Lovibond et al., 1995). The Stress scale, originally labelled "tension/stress", measures a syndrome that is factorially distinct from depression and anxiety, characterised by nervous tension, difficulty relaxing and irritability. It is quite similar to the DSM-IV diagnosis of Generalized Anxiety Disorder (GAD).

The sum of the relevant 14 items for each scale constitutes the participants' scores for each dimension (i.e. Depression, Anxiety and Stress) (Lovibond et al., 1995). The scale include items such as "I couldn't seem to experience any positive feeling at all", "I was aware of the dryness of my mouth" and "I found it hard to wind down" in the respective order of the scales. The items are in random order so that items of the same scale are not clustered together.
Although the stress scale can be distinguished from depression and anxiety in factor analysis, it is important to note that all three syndromes are moderately intercorrelated (Lovibond, 1995).

Depression subscales assess aspects such as dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia. The Anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious affect. The stress scale's subscales highlight levels of non-chronic arousal through difficulty relaxing, nervous arousal and being easily upset/agitated, irritable/over-reactive and impatient (Lovibond et al., 1995).

The main purpose of the DASS-21 is to assess the degree of severity of the core symptoms of depression, anxiety or stress. While the DASS-21 can be administered and scored by individuals without psychology qualifications, it is recommended that the interpretation and decisions based on results are made by an experienced clinician in combination with other forms of assessment (Lovibond et al., 1995).

The DASS-21 was developed by researchers at the University of New South Wales, Australia. It was developed using a sample of responses from the comparison of 504 sets of results from a trial by students, taken from a larger sample of 950 first year university student responses (Lovibond, et al., 1995). The test was then normed on a sample of 1044 males and 1870 females aged between 17 and 69 years, across participants of varying backgrounds (e.g. university students, nurses in training, blue and white collared employees of a major airline, bank, railway workshop and naval dockyard). The scores were subsequently checked for validity against outpatient groups including patients suffering from anxiety and depressive disorders, insomniacs, myocardial infarction patients, as well as patients undergoing treatment for sexual, menopausal and depressive disorders(Lovibond et al., 1995). The reliability scores of the scales in terms of Cronbach's alpha scores rate the Depression scale at 0.91, the Anxiety scale at 0.84 and the Stress scale at 0.90 in the normative sample. The means and standard deviations for each scale are 6.34 and 6.97 for depression, 4.7 and 4.91 for anxiety and 10.11 and 7.91 for stress, respectively. The mean scores in the normative sample did vary slightly between genders as well as varying by age, though the threshold scores for classifications do not change by these variations (Lovibond et al., 1995). The Depression and Stress scales meet the standard threshold requirement of 0.9 for research; however,
the Anxiety scale still meets the 0.7 threshold for clinical applications, and is still close to the 0.9 required for research.

3.5 DATA COLLECTION
During December 2009 and January 2010, data was collected from the participants at a time and place that was convenient to them. The data was quantitative (DASS-21 Scale) and qualitative (interviews and open ended questionnaires) in nature and no manipulation occurred. The medical practitioners were asked to give written responses to open ended questions on a questionnaire (Addendum A). The participants were given the questionnaires to be completed and returned to the researcher in their own time. The raw data obtained was then prepared for analysis. Numbers were assigned to each participant’s answer sheet. The participant’s written responses were re-typed verbatim (Addendum C). Identifying data was removed to protect the anonymity of participants. The qualitative inquiry formed part of the phenomenological data, where the study attempted to understand South African medical practitioners from the public and private sectors’ “perceptions, perspectives and understanding of a particular situation” (de Vos et al., 2008, p. 264). In this case, the phenomenological data explored medical practitioners’ experiences of the current health-care delivery system in South Africa. Of particular interest was their experience, perception and feelings, their views on the future, wage negotiations with the governmental bodies, whether they wanted to leave the country and information relevant to each of them individually and collectively at the time.

According to Terre Blanche, (2004), phenomenology is concerned with human existence and experience, rather than metaphysical reality, and the way in which phenomena are experienced by human beings. That is, this approach is more concerned with participants’ experience of their lived realities than any objective nature of the reality itself. Phenomenologists urge researchers to immerse themselves in the actual phenomena of lived experience and revelations in consciousness, rather than to quote or insist on theories from the past in their quest to understand human behaviour better.

3.6 DATA ANALYSIS
For the purpose of this study, both qualitative and quantitative analyses were used. The qualitative data was analysed using thematic analyses. Boyatziz (1998), states that the aim of thematic analyses is to systematically construct and identify themes within the collected data, while simultaneously examining the phenomena that are being studied. This process requires heightened awareness of and
concentrated attention directed towards the data. It is essential that the researcher is skilled in identifying salient themes and ideas. To develop this skill, it is important that the researcher reads and re-reads the participant’s scripts, until common themes, categories and patterns are revealed (de Vos et al., 2008).

The goal in this study was to gain a richly detailed account of medical practitioners’ experiences. This existential-phenomenological approach was aimed at uncovering the basic structures of human existence through seeking to describe and identify themes that are associated with being a medical practitioner in various contexts (Murray, 1998). Furthermore, this phenomenological research method focused on the participants lived experiences and describes how these experiences interact within the everyday environment (Murray, 1998). This description was obtained by the identification of focal meanings and themes through analysing, describing and validating subjects’ words.

Once the data was collected, it was transcribed verbatim and medical practitioners personal and identifying data was concealed to maintain confidentiality. The transcripts were analysed to identify recurring themes, experiences and feelings. The responses were thematically coded according to pre-described themes that had been identified in the literature, especially along the lines of the DASS-21. The DASS-21 itself was analysed to ascertain levels of stress-related symptoms as percentages, in order to code those findings back to the qualitative thematic analysis and integrate quantitative and qualitative results of the study.

The DASS-21 thus provided a quantitative theoretical and conceptual framework for the qualitative phenomenological analysis of the participants’ experiences.

In the present study, the participants’ experiences are investigated from quantitative and qualitative, individual and collective, subjective and objective perspectives.

3.7 ETHICAL CONSIDERATIONS
Research was done following the ethical guidelines put forth by (Terre Blanche & Durrheim, 1999). These guidelines include: consent, privacy, confidentiality, competence and ethical reporting. Informed consent was obtained from the participants and the participants were informed of the goals, characteristics, risks as well as advantages that the study holds. Therefore, informed consent
was viewed as a two-way communication process between the researcher and participants and did not simply involve the signing of a consent form (Boshoff, 2009). Participants were consenting adults and willing participants. They had the option to decline or withdraw from the study at any stage. The research was conducted out of working hours and in a place and time convenient for the medical practitioners.

Participants’ right to confidentiality and privacy was protected throughout the study. To ensure that this was done, pseudonyms were used. Raw data containing participants’ personal credentials and information were kept safely and destroyed after completion of the study.

In terms of competence, it is important that research is undertaken by persons who have the necessary skills and competencies to undertake such a task. The researcher has been trained in research skills and holds an honours degree with Research methodology and thus was sensitive to the participant’s concerns and if necessary was able to organize appropriate counselling. In terms of ethics, ethical reporting of research stresses that attention should be given to the rights of the research participants. It is important that no facts are fabricated of falsified and that only the findings of the study are highlighted. Richards and Schwartz (2002), stress that researchers should be cautious when interpreting data. To avoid researcher bias and misinterpretation researchers have to have a clear awareness of their own subjectivity. Furthermore, findings should be checked with participants before publication, in this way misunderstanding can be prevented. Therefore, the results of the present study were available to the participants to prevent misunderstanding and misinterpretation.

Keeping the aim of this study in mind, namely, to ascertain what contemporary medical practitioners’ actually experience in the health-care setting, the research was conducted with the well-being and best interests of this population kept in the highest regard. The research was non-therapeutic in nature; participants were only required to share their experiences subjectively. The participants were not inconvenienced, as they were able to complete their responses at a time suitable to them. Furthermore, all participants were briefed on the nature and objectives of the study before its commencement, and only consenting adults took part.

Sampling was taken from medical practitioners in the private and public sector. The reason for choosing doctors from the public and private sectors is that at present medical care in South Africa
is strictly divided into these two categories. The private sector tends to meet the expectations of internationally accepted Health-care standards, whilst the public sector experiences major limitations in terms of resources, high patient numbers and public demand.

3.8 THEMATIC CONTENT ANALYSIS OF QUALITATIVE INTERVIEWS
After data had been collected, it was analysed for recurring themes. These themes were explored further and unified to achieve a better overall perspective of medical practitioners’ experiences of the current health-care delivery system. A more complete picture was obtained from the more subjective, qualitative view of human experience, rather than by a statistical and quantitative approach.

3.9 CHAPTER SUMMARY
This chapter explained the research methodology that was implemented in this research project. It discussed the research design, as well as the data collection methods and procedure. The technical aspects of the research were discussed, including the reason behind using qualitative research and thematic content analysis. The experiences of medical practitioners as well as data from local and international perspectives were explored in relation to current trends in medical practice. Finally, the manner in which the data was analysed was explained.
CHAPTER 4: RESULTS AND DISCUSSION

4.1 INTRODUCTION
In this chapter, the main findings of the present study are presented, including the thematic content analysis (qualitative) and the DASS-21 analysis (quantitative) pertaining to the experiences of Medical Practitioners in the current health-care delivery system in South Africa. This chapter also seeks to interpret the results and draw conclusions from the responses of public service medical practitioners and private medical practitioners. As different groups, it became apparent that they experienced the current health-care system in South Africa in different ways. The qualitative data was analysed and interpreted.

4.2 RESULTS AND DISCUSSION

4.2.1 QUANTITATIVE RESULTS AND DISCUSSION

OVERALL RESPONSES TO THE DASS-21 QUESTIONNAIRE ACCORDING TO ITEMS
The tables that follow show the numbers of responses to each of the 4 scores on the scale 0 to 3. In the first column of each table a “d” refers to depression, an “a” to anxiety and an “s” to stress. The items are labeled D1 to D21 (for item questions, see addendum). The final column in the table shows the percentage of responses less or equal to “some degree” i.e.:

\[
\frac{(\text{notapply} + \text{somedegree}) \times 100}{13}.
\]
Table 1a. Responses to DASS-21 items d1-d11

<table>
<thead>
<tr>
<th>Item no</th>
<th>Not apply</th>
<th>Some degree</th>
<th>Considerable degree</th>
<th>Very much</th>
<th>% &lt;= Some degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1 – s</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>76.9</td>
</tr>
<tr>
<td>D2 – a</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>76.9</td>
</tr>
<tr>
<td>D3 – d</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>92.3</td>
</tr>
<tr>
<td>D4 – a</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>D5 – d</td>
<td>5</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>D6 – s</td>
<td>3</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>84.6</td>
</tr>
<tr>
<td>D7 – a</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>D8 – s</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>53.8</td>
</tr>
<tr>
<td>D9 – a</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>84.6</td>
</tr>
<tr>
<td>D10 – d</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>92.3</td>
</tr>
<tr>
<td>D11 – s</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>84.6</td>
</tr>
</tbody>
</table>

Table 1b – Responses to DASS-21 items d12-d21

<table>
<thead>
<tr>
<th>Item no</th>
<th>Not apply</th>
<th>Some degree</th>
<th>Considerable degree</th>
<th>Very much</th>
<th>% &lt;= Some degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>D12 – s</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>76.9</td>
</tr>
<tr>
<td>D13 – d</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>76.9</td>
</tr>
<tr>
<td>D14 – s</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>53.8</td>
</tr>
<tr>
<td>D15 – a</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>D16 – d</td>
<td>8</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>92.3</td>
</tr>
<tr>
<td>D17 – d</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>D18 – s</td>
<td>3</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>84.6</td>
</tr>
<tr>
<td>D19 – a</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>D20 – a</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>92.3</td>
</tr>
<tr>
<td>D21 – d</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>92.3</td>
</tr>
</tbody>
</table>
CORRESPONDENCE ANALYSIS PLOT

In the plot below, each plotted point represents one of the 21 items (d1 to d21) and 4 responses (“not at all” to “very much”). The purpose of the plot is to identify associations between items and responses.

Figure 1. Correspondence analysis plot of responses per item to DASS-21
The correspondence analysis plot suggests the following groupings for the responses:

**Not at all**
D2 (Dryness of mouth), d4 (Breathing difficulty), d7 (Trembling), d9 (Worried about panicking), d15 (Close to panic), d16 (Unable to become enthusiastic), d17 (Not worth much as a person), d19 (Aware of heart’s action), d20 (Scared without reason), d21 (Life is meaningless).

**Some degree**
D1 (Hard to wind down), d3 (No positive feeling), d5 (Difficult to work up initiative), d6 (Over reacted), d10 (Nothing to look forward to), d11 (Get agitated), d12 (Difficult to relax), d13 (Down-hearted and blue), d18 (Touchy).

**Considerable degree**
D8 (Using a lot of nervous energy), d14 (Intolerant).

**DISCUSSION**
The anxiety feelings (d2, d4, d7, d9, d15, d19, d20) and some depression effects (d16, d17, d21) do not apply. Some stress feelings (d1, d6, d11, d12, d18) and some depression feelings (d3, d5, d10, d13) apply to some degree. The stress related feelings d8 and d14 apply to a considerable degree.

**Responses to DASS-21 questionnaire, according to public or private medical practitioners.**
The tables below show results of Fisher’s exact test applied to tables showing the “not apply” and “apply” counts for practitioners in public and private practice. The “apply” counts were obtained by combining the “some degree”, “considerable degree” and “very much” categories.
Table 2a – Comparison of DASS-21 items d1-d11 according to public (pu) or private (pr)

<table>
<thead>
<tr>
<th>Item no</th>
<th>not apply (pu)</th>
<th>Apply (pu)</th>
<th>Not apply (pr)</th>
<th>Apply (pr)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>0.266</td>
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<tr>
<td>D2</td>
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<td>4</td>
<td>5</td>
<td>2</td>
<td>0.286</td>
</tr>
<tr>
<td>D3</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>0.103</td>
</tr>
<tr>
<td>D4</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>1.000</td>
</tr>
<tr>
<td>D5</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1.000</td>
</tr>
<tr>
<td>D6</td>
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<td>5</td>
<td>2</td>
<td>5</td>
<td>1.000</td>
</tr>
<tr>
<td>D7</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>0</td>
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<tr>
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<td>2</td>
<td>5</td>
<td>1.000</td>
</tr>
<tr>
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<td>2</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>0.103</td>
</tr>
<tr>
<td>D10</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>0.286</td>
</tr>
<tr>
<td>D11</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Table 2b – Comparison of DASS-21 items d12-d21 according to public (pu) or private (pr)

<table>
<thead>
<tr>
<th>Item no</th>
<th>Not apply (pu)</th>
<th>Apply (pu)</th>
<th>Not apply (pr)</th>
<th>Apply (pr)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
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<td>0</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>0.070*</td>
</tr>
<tr>
<td>D13</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>1.000</td>
</tr>
<tr>
<td>D14</td>
<td>0</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>0.462</td>
</tr>
<tr>
<td>D15</td>
<td>5</td>
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<td>6</td>
<td>1</td>
<td>1.000</td>
</tr>
<tr>
<td>D16</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>0.103</td>
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<tr>
<td>D17</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>0.266</td>
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<td>D18</td>
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<td>4</td>
<td>1</td>
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<td>6</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>1.000</td>
</tr>
<tr>
<td>D20</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>1.000</td>
</tr>
<tr>
<td>D21</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>0</td>
<td>0.070*</td>
</tr>
</tbody>
</table>

*Significant at the 10% level of significance
Table 3 – d12 (Difficult to relax) versus public/private

<table>
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<tr>
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<th>Public/private</th>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>D12</td>
<td>Not apply</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Some degree</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Considerable degree</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>7</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

“Difficulty to relax” applies more to public than private medical practitioners.

Table 4 – d21 (Life is meaningless) versus public/private

<table>
<thead>
<tr>
<th></th>
<th>Public/private</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>D21</td>
<td>Not apply</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Some degree</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Considerable degree</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>7</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

“Life is meaningless” applies more to public than private medical practitioners.

It should be noted that the practitioners’ r13 and r14 are listed as private practitioners, but are still working on a part time basis at government hospitals. For this reason they are familiar with the situation in government hospitals and their responses fit the public practitioners’ rather than the private practitioners’ profile. In the abovementioned tests, these two practitioners were classified as private practitioners. If they are re-classified as public practitioners, variables d1 (hard to wind down), d2 (dryness of mouth), d9 (worried about panicking) and d16 (unable to become enthusiastic) also show significant differences between private and public practitioners. In each of these cases, the feeling applies significantly less to private than to public practitioners.
Responses to DASS-21 questionnaire according to gender
The same tests described in the previous section were performed on the responses to the questionnaire in order to test for differences between the genders. The results are shown in the tables below.

Table 5a – Comparison of DASS-21 items d1-d11 according to gender

<table>
<thead>
<tr>
<th>Item no</th>
<th>Not apply (f)</th>
<th>Apply (f)</th>
<th>Not apply (m)</th>
<th>Apply (m)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1.000</td>
</tr>
<tr>
<td>D2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>0.576</td>
</tr>
<tr>
<td>D3</td>
<td>3</td>
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<td>3</td>
<td>4</td>
<td>0.545</td>
</tr>
<tr>
<td>D4</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>0.364</td>
</tr>
<tr>
<td>D5</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>0.545</td>
</tr>
<tr>
<td>D6</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>1.000</td>
</tr>
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<td>0</td>
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</tr>
<tr>
<td>D8</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>0.236</td>
</tr>
<tr>
<td>D9</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>1.000</td>
</tr>
<tr>
<td>D10</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>0.545</td>
</tr>
<tr>
<td>D11</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Table 5b – Comparison of DASS-21 items d12-d21 according to gender

<table>
<thead>
<tr>
<th>Item no</th>
<th>Not apply (f)</th>
<th>Apply (f)</th>
<th>Not apply (m)</th>
<th>Apply (m)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>D12</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>0.576</td>
</tr>
<tr>
<td>D13</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>1.000</td>
</tr>
<tr>
<td>D14</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>0.491</td>
</tr>
<tr>
<td>D15</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>0.364</td>
</tr>
<tr>
<td>D16</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>0.491</td>
</tr>
<tr>
<td>D17</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>1.000</td>
</tr>
<tr>
<td>D18</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>0.236</td>
</tr>
<tr>
<td>D19</td>
<td>3</td>
<td>1</td>
<td>7</td>
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<td>2</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>0.491</td>
</tr>
<tr>
<td>D21</td>
<td>4</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>1.000</td>
</tr>
</tbody>
</table>
Since there is no variation in the results, no p-value could be calculated for d7. There are no significant differences due to the effect of gender.

**Responses to DASS-21 items according to respondents**

The counts described in section 2 were obtained for each respondent. The respondents were labeled r1 to r15. Since respondents r1 and r4 did not complete the questionnaire, their responses are missing from the table below.

**Table 6 – Responses to DASS-21 items per respondent**

<table>
<thead>
<tr>
<th>Respondent no</th>
<th>Not apply</th>
<th>Some degree</th>
<th>Considerable degree</th>
<th>Very much</th>
<th>% &lt;= Some degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2</td>
<td>20</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>R3</td>
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<tr>
<td>R5</td>
<td>9</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>85.7</td>
</tr>
<tr>
<td>R6</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>1</td>
<td>71.4</td>
</tr>
<tr>
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<td>9</td>
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<td>0</td>
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<td>81</td>
</tr>
<tr>
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<td>4</td>
<td>11</td>
<td>5</td>
<td>1</td>
<td>71.4</td>
</tr>
<tr>
<td>R10</td>
<td>15</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>R11</td>
<td>17</td>
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<td>85.7</td>
</tr>
<tr>
<td>R13</td>
<td>6</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td>85.7</td>
</tr>
<tr>
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<td>5</td>
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<td>57.1</td>
</tr>
<tr>
<td>R15</td>
<td>18</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

**Correspondence analysis plot**

In the correspondence analysis plot that follows, each of the 13 respondents and 4 responses (“not at all” to “very much”) shown in the table above is represented by a plotted point. The purpose of the plot is to identify associations between respondents and responses.
The feelings of anxiety, stress and depression does not apply to 5 (r2, r3, r10, r11, r12) of the 7 practitioners in private practice. The remaining two practitioners in private practice (r13, r14) are still working part time at government hospitals and therefore show feelings of anxiety, stress and depression that are more in line with public practitioners.
DISCUSSION OF MAIN INTERVIEW COMMENTS

The tables below show a summary of the main interview comments as well as list of all items that were rated “considerable degree” or “very much”. The summaries for practitioners in public practice and private practice are shown in separate tables.

Table 8a. Comparison of DASS-21 and interview responses for public practitioners

<table>
<thead>
<tr>
<th>Respondent no</th>
<th>Comments</th>
<th>DASS-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>R5</td>
<td><strong>Interview</strong> Not smart enough, Traumatized, Get little pay, Will emigrate</td>
<td>Considerable – d8 (nervous energy), d13 (down-hearted), D14 (intolerant)</td>
</tr>
<tr>
<td>R6</td>
<td><strong>Interview</strong> Sacrifice, Forces against, Pleas on deaf ears, Too much work, Personal crises, Work long hours, Run out of stock, Too little pay for work Paid little, Go into private practice, Will emigrate as soon as loan is paid off</td>
<td>Considerable – d1 (not wind down), d8 (nervous energy), D10 (nothing to look forward), d11 (agitated), D18 (touchy) Very much – d14 (intolerant)</td>
</tr>
<tr>
<td>R7</td>
<td><strong>Interview</strong> Frustrated, Angry and upset about work, Despise patients, Would stay if conditions improve</td>
<td>Considerable – d12 (difficult to relax), d14 (intolerant)</td>
</tr>
<tr>
<td>R8</td>
<td><strong>Interview</strong> Motivation a problem, High work load, Poor support, Disappointed, Depressed, Angry with bosses, Frustration with work load, No representative union, Wage negotiations with government is problematic, Stay and help, Future does not look good</td>
<td>Considerable – d2 (dryness mouth), d13 (down-hearted), D14 (intolerant), d16 (not enthusiastic)</td>
</tr>
<tr>
<td>R9</td>
<td><strong>Interview</strong> Bad working conditions, Should get better incentives for specializing, If nothing changes doctors, nurses will leave</td>
<td>Considerable – d2 (dryness mouth), d3 (not positive), d8 (nervous)</td>
</tr>
</tbody>
</table>
Table 8b – Comparison of DASS-21 and interview responses for private practitioners

<table>
<thead>
<tr>
<th>Respondent no</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2</td>
<td>Interview Happy with practice</td>
</tr>
<tr>
<td>R10</td>
<td>Interview No energy for working conditions in public practice, Committed to remain in South Africa</td>
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<tr>
<td>R11</td>
<td>Interview Nurses do not do their duties, DASS-21 Considerable – d18 (touchy)</td>
</tr>
<tr>
<td>R12</td>
<td>Interview Happy in South Africa and will stay, DASS-21 Considerable – d6 (over react), d8 (nervous energy), d12 (difficult To relax)</td>
</tr>
<tr>
<td>R13</td>
<td>Interview Tragic situation, Bad working conditions due to so-called “budget restraints”, Refusal to increase doctor’s salaries, Will stay in SA if government puts things right, DASS-21 Considerable – d1 (hard to wind down), Very much – d2 (dryness mouth), d8 (nervous energy)</td>
</tr>
<tr>
<td>R14</td>
<td>Interview Government administrators enrich themselves, Devise systems to help doctors improve income, Want to stay in South Africa, DASS-21 Considerable – d1 hard to wind down, d6 (over react), D9 (worried panicking), d13 (down-hearted), D20 (scared), Very much – d8 (nervous energy), d11 (agitated), d12 (difficult To relax), d14 (intolerant)</td>
</tr>
</tbody>
</table>
DISCUSSION

Public practitioners and private practitioners’ r13 and r14 (who work part time in government hospital) are dissatisfied with working conditions and salaries. This includes: too much work for too little pay, being exposed to traumatic situations, lack of support from bosses who are overpaid and enrich themselves, running out of stock, lack of a union when negotiating wages, lack of incentives to specialize, lazy and incompetent staff that cannot be fired and so-called “budget restraints”.

The bad working conditions and too little pay for public practitioners have the following consequences: frustration, anger, disappointment, depression, trauma, problems with motivation, wrong attitude towards patients.

The consequences of the bad working conditions and too little pay, result in feelings of stress, depression or anxiety. Of these feelings stress is by far the most common (20 cases rated “considerable” or “very much” by public practitioners) followed by depression (7 cases rated “considerable” or “very much” by public practitioners) and anxiety (6 cases rated “considerable” or “very much” by public practitioners). Of the individual feelings the stress feelings d8 (using a lot of nervous energy) and d14 (intolerant) were listed most.

As a result of the working conditions and feelings related to these, public practitioners plan to leave their work as soon as circumstances allow. These practitioners either intend to go into private practice or emigrate.

The negative feelings towards work experienced by public practitioners is not nearly as prevalent among the 4 practitioners in private practice only (this excludes practitioners r13 and r14 who work part time in public practice). Two of these 4 practitioners did indicate some level of stress (5 cases) while the other two did not indicate any feelings of stress, depression or anxiety. It is not clear what the reasons behind the stress feelings might be.

None of the 4 practitioners who are only in private practice expressed a desire to emigrate.
4.2.2 QUALITATIVE RESULTS AND DISCUSSION

4.2.2.1 EMERGING THEMES

The themes emerging from the qualitative data support the findings indicated by the DASS-21. Many respondents in their open-ended responses indicated that they were feeling stressed, depressed and anxious and hopeless about their professional lives.

HOPELESSNESS

The theme of hopelessness emerged, with many respondents presenting with constellations of feelings around work practices and their futures.

“I don’t think I’d study medicine again… if it were possible to turn back time… that part of me has to cling to the hope that this is what God plans for me… In order to serve mankind, we sacrifice our own humanity! How can one continue fighting the good fight if no one is helping you and it feels like all forces are directed against you? The even sadder part is … all our pleas fall on deaf ears.” (Respondent 6)

“The disappointment… is plain depressing. Working has become a drag, you force yourself to wake-up and go to work… and when you get to work, you are struck down by the workload, nothing to work with, poor supervision and support. I doubt that the wage is coming soon, or is going to be a satisfactory one.” (Respondent 8)

“In any case, I’ve accepted that I’m not smart enough to be one of them…” (Respondent 5)

These respondents are clearly feeling some regrets and disappointment about studying medicine, even though they feel they were using their talents to serve the greater good of mankind.

STRESS AND ANXIETY

The theme of stress and anxiety emerged with predominantly public medical practitioners experiencing symptoms of acute and generalised anxiety and feeling overwhelmed at work leading to severe stress. Only half of the private medical practitioners reported feeling any stress. It is not clear what the reasons behind those who did not comment were.
“I feel I don’t have the energy for the sort of working conditions I have experienced previously.” (Respondent 10)

“Anyone will tell you that the things you see in government hospitals are probably worse than anywhere else in the world. Last week there was a little girl brutally raped, strangled and left for dead. Traumatising for every one involved. This was almost as traumatizing to me as seeing a man with both his hands cut off. It’s not easy to cope with these kinds of experiences.” (Respondent 5)

“Sometimes you … as a doctor – have to push the queue…you are only three doctors that need to see a hundred patients…do ward rounds…go to clinic, you will to have time to conduct a meaningful interview with ever patient. As a doctor…if I also experience personal crises, there is no support for me”. (Respondent 6)

“There are times…that situations in the hospital make me brutally angry. I vent to my family (even if it’s at 2am in the morning) and this usually helps put things back in perspective.” (Respondent 7)

“How I feel…numbness sums up the general feeling. The disappointments…are depressing. Working has become a drag and…you are struck down by the…workload, nothing to work with and poor supervision and support.” (Respondent 8)

“Working conditions are terrible…e.g. expected to work full day from 08h00 till 16h00 and coming on call at 18h00 to knock off the next day at 12h00 midday and still be expected to make sane decisions.” (Respondent 9)

“It is becoming a tragic situation…I feel empathy for …the patient…nurses…doctors. The future is an issue which I am finding difficult to understand and deal with, so I take baby steps, that’s the only consolation.” (Respondent 13)

These respondents feel exhausted and traumatised by their working experiences.
FRUSTRATION AND ANGER
Because of stress feelings, respondents feel angry and frustrated about their work environments and plan to leave their work as soon as circumstances allow. They either want to go into private practice or emigrate.

“The bosses kick back and (exploitive) all work in the hospital and make a super income and even run a private practice on the side! No consultants can do that; they work too hard. The main work that many consultants is ‘brow-beat’”. (Respondent 8)

“We work long hours, further complicated by our hospitals running short of/out of stock. This is not just frustrating it is disheartening. Unfortunately, we now have to treat symptoms, not patients.
But, pay me peanuts, make me work my fingers to the bone, deprive me of sleep and just continue making life difficult for me and even a loyal, hungry meek dog will come and bite you.” (Respondent 6)

“…Situations in the hospital make me brutally angry…when I get upset about work, it tends to be severe. There are moments when I truly despise the people I need to care for. Once I have vented this though, I feel better.” (Respondent 7)

“…Your efforts are of no value to us…if push comes to shove you can be replaced…SA doctors do not have a representative union…” (Respondent 8)

“…Nurses are negligent…even insulting towards patients. That is frustrating as they spend most of the time either writing they’re nursing files or doing nothing for the patient. Patients often complain about them not greeting or spending time with them.”(Respondent 11)

“…Young doctors in state hospitals have the courage to expose the conditions under which they work and the deficiencies with regards to the treatment meted to patients because of the so-called Budget restraints.” (Respondent 13)

“I feel…antagonistic to government administrators who want to line their pockets and enrich themselves on the promise that they are going to provide healthcare for the poor.” (Respondent 14)
“State health delivery is appalling…because of systemic laziness and incompetence…it does not matter how little you work, you can’t get fired.” (Respondent 15)

These respondents feel anger and some contempt about their working conditions and the demands especially in the public Health-care system.

FUTURE ORIENTATION/EMIGRATION
Respondents’ comments about the future were varied. Medical practitioners in private practice were not planning to emigrate whilst public practitioners either wanted to emigrate or move into the private healthcare sector.

“I am quite happy with the way my single handed practice is run and I don’t wish to see any particular changes.” (Respondent 2)

“The question about bailing out of South Africa is a definite yes. It’s a shame because I have already emigrated once…and not to move again…seldom do you see people return once they have left.” (Respondent 5)

“If I knew what I know now, I don’t think I’d study medicine again…When I finish my community service, I am leaving South Africa…I’d rather go to Canada, work as a locum for a couple of years, pay my debt off, buy a house, then come back with enough financial support…I can’t bail out now…a large study loan needs to be paid off…” (Respondent 6)

“I would stay in South Africa provided the pay and management improves; otherwise, I would consider leaving.” (Respondent 7)

“Bailing out…is plain wrong. Conscience and common sense says, stay behind and help those in need. The future – this does not look bright.” (Respondent 8)

“To be honest, there is nothing at the moment motivating both medical and nursing personnel to remain in the public healthcare system – if this isn’t changed in the near future I’m afraid we going to lose doctors and nurses to private sector or overseas.” (Respondent 9)
“I am committed to remaining in SA – I love this country and people but I don’t see myself remaining to the public sector.” (Respondent 10)

“I am happy to be a doctor in SA. I do not want to bail out of SA at this stage. I feel secure about the future both professionally and personally. I am in private practice. Nothing to discuss at this stage.” (Respondent 12)

“Yes, at times I do feel like flying out of SA to another land, but there is turmoil everywhere. The future is an issue which I am finding difficult to understand. Divided we fall, united we stand…if our government puts that into practice, then yes, the future is bright.”(Respondent 13)

“I do not want to bail out of SA, I want to stay, contribute and make a difference.”(Respondent 14)

“I feel that private health has very likely a bright future because the only way to expand service delivery as per pre-election promises will be to expand private health.”(Respondent 15)

These respondents had mixed responses about leaving South Africa. Some feel it would be morally wrong to leave whilst others are unhappy and have made up their minds to emigrate. Some respondents are happy to remain in their current situations.

**WAGE DISSATISFACTION**

Respondents expressed their feelings about wages and wage negotiations.

“There are actually many advantages to being a civil servant…I don’t have…overheads. My taxes are taken off the top. By the way, we do have outside sources of income. To get back to the subject of pay rises, it looks as if all the striking and negotiating has been for nothing…the people who do the most work get little…the grass is greener here…if only the money was greener!”(Respondent 5)

“We work long hours and get a meagre salary for this, in comparison to…peers working in the private sectors. If we ask for more money to better ourselves and care for our families…we are deemed as greedy and ungrateful…Unfortunately the salary isn’t very good. Start specialising…work like a dog again and be paid little.” (Respondent 6)
“The government…has ‘pawns’ doing the controlling for close to nothing. Wage increase – all negotiations with the government have proved to be fruitless. I doubt that the wage is coming soon, or is going to be a satisfactory one.” (Respondent 8)

“Working hours are long…with too little salary…how can medical officers who form the backbone of the Health-care system be the ones who get the least increase? We should be getting better incentives for specialising.” (Respondent 9)

“Corruption, fraud, ego and the dictators of the people who refuse to increase these doctor’s salaries and improve the Health-care meted to people!” (Respondent 13)

“Wage negotiations – government heal care workers must be supported…There should be other systems to assist government doctors to improve their income.” (Respondent 14)

“There is still a spectacular proliferation of grand titles/posts with salaries to match, while the work ethos almost disappeared…” (Respondent 15)

These respondents have mixed feelings about their wages and how the government is dealing with their issues.

4.3 CHAPTER SUMMARY
In this chapter both qualitative and quantitative data analysis was presented and discussed in relation to presiding themes of the medical practitioners’ self-report responses and of symptoms of anxiety and depression on the DASS-21. These in turn were synthesised in order to ascertain differences and similarities.

The DASS-21 responses suggest that respondents are presenting less with acute symptoms of stress and anxiety, but rather more insidious, chronic symptoms such as feelings of irritability, anxiety, and hopelessness, as well as a dysthymic syndrome.

Emerging themes from qualitative responses appear to be congruent with the DASS-21 responses, with themes such as: stress, depression, anxiety, frustration and anger, future orientation/emigration and wage dissatisfaction presenting as pervasive and chronic affective states leading some to
helplessly accept them and others to experience feelings of anger and frustration leading to plans to relocate.

Medical Practitioners in the private healthcare sector were happier and less stressed, depressed and anxious overall than those in the public healthcare sector.
CHAPTER 5: CONCLUSION

5.1 INTRODUCTION
This chapter seeks to draw conclusions on the research topic, recognize the limitations of the project, and in the light of what has been learnt, suggest directions for further research in this area of enquiry.

5.2 MAIN FINDINGS
This study has examined the experiences of medical practitioners in South Africa as well as perspectives from abroad. A review of literature suggests that this explication may be one of the first to investigate the feelings of medical practitioners about government and private medical practices.

It appeared from the DASS-21 responses and the self-directed qualitative responses that respondents experienced feelings of stress and anxiety leading to depression. It also emerged that a rather more pervasive syndrome which may point to dysthymic and generalised anxiety symptoms were presented. It seems to show that these professionals and in particular those in the public sector are suffering from a ‘dysthymic syndrome’ of sorts; a collection of vague complaints around not feeling positive about life, feeling irritable, sensitive and tired. The open-ended responses also indicate a more pervasive set of complaints similar to dysthymia and generalised anxiety disorder.

The research furthermore reveals medical practitioners in the private Health-care sector seem more content with their professional lives and do not wish to emigrate, although they will continue to assess their situations and make relevant changes if necessary. However, it appears that all medical practitioners experience some stress and anxiety symptoms regardless of the sector divisions (public and private) they work in.

Some of the responses to the open-ended questions can be considered incongruent with the DASS-21 responses, with some responses to the DASS-21 being more conservative regarding stress and anxiety symptoms and more overtly expressed in the open-ended responses. This might indicate some degree of dissociation or denial of symptoms as a defence or coping strategy when answering sequentially. By contrast, the “free-association” of the self-report seems to have allowed
respondents the space to reflect deeply using a more holistic right-brain and abstract posture whilst also synthesising some left brain analytical personal reflections of their individual reality.

DESCRIPTION OF DYSTHYMIA AND GENERALISED ANXIETY DISORDER
Dysthymia and Generalised Anxiety Disorders are described in the Diagnostic and Statistical Manual of Mental Disorders and other publications as follows:

Dysthymia

Dysthymia is a mood disorder with less severe symptoms than major depressive disorder (Hersen et al., 2007). The Diagnostic and Statistical Manual of Mental Disorders (DSM), characterizes dysthymic disorder as consisting of symptoms involving the feelings of being depressed, having low energy levels, sleep and appetite disturbances and low self-esteem (American Psychiatric Association, 2000). Dysthymia is a type of mild depression (American Psychiatric Association, 2007). The prevalence estimate for dysthymia of "clinical significance" among the adult United States population is 1.7 % based on the Epidemiologic Catchment Area Program and 1.8 % based on the National Comorbidity Survey (Narrow et al., 2002). The research in this dissertation indicates that medical practitioners might be experiencing higher percentages than the general public in the United States.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, characterizes dysthymic disorder. [9] The essential symptom involves the individual feeling depressed for the majority of days and parts of the day for at least two years. Low energy, disturbances in sleep or in appetite and low self-esteem typically contribute to the clinical picture as well. Sufferers have often experienced dysthymia for many years before it is diagnosed. People around them come to believe that the sufferer is 'just a moody person'. Note the following diagnostic criteria:[1][10]

1. During a majority of days for two years or more, the adult patient reports depressed mood or appears depressed to others for most of the day.
2. When depressed, the patient has two or more of:
   1. Decreased or increased appetite
   2. Decreased or increased sleep (insomnia or hypersomnia)
   3. Fatigue or low energy
4. Reduced self-esteem
5. Decreased concentration or problems making decisions
6. Feels hopeless or pessimistic
3. During this two-year period, the above symptoms are never absent longer than two consecutive months.
4. During the first two years of this syndrome, the patient has not had a major depressive episode.
5. The patient has not had any manic, hypomanic, or mixed episodes.
6. The patient has never fulfilled criteria for cyclothymic disorder.
7. The depression does not exist only as part of a chronic psychosis (such as schizophrenia or delusional disorder).
8. The symptoms are often not directly caused by a medical illness or by substances, including drug abuse, or other medications.
9. The symptoms may cause significant problems or distress in social, work, academic, or other major areas of life functioning (American Psychiatric Association, 2000).

**Generalised anxiety disorder**

Generalised anxiety disorder (GAD) is an anxiety disorder that is characterized by excessive, uncontrollable and often irrational worry about everyday things that is disproportionate to the actual source of worry. This excessive worry often interferes with daily functioning, as individuals suffering GAD typically anticipate disaster, and are overly concerned about everyday matters such as health issues, money, death, family problems, friend problems, relationship problems or work difficulties (National Institute of Mental Health, 2011).

A DSM-IV-TR diagnostic criterion for generalised anxiety disorder is as follows:
A. Excessive anxiety and worry (apprehensive expectation), occurring more-days-than-not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The person finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more-days-than-not for the past 6 months).

1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating or mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
D. The focus of the anxiety and worry is not confined to features of other Axis I disorder (such as social phobia, OCD, PTSD etc.)
E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism), and does not occur exclusively during a mood disorder, psychotic disorder, or a pervasive developmental disorder (American Psychiatric Association, 2000).

Moving forward, further research would broaden the understanding of the complexities inherent in medical practice world-wide. In particular, medical practitioner’s feelings would inform the motivation behind their behaviour.

**COMMENTS ON INDIVIDUAL MEDICAL PRACTITIONER’S RESPONSES IN RELATION TO ONE ANOTHER**

Public practitioners and private practitioners’ r13 and r14 (who work part time in government hospital) are dissatisfied with working conditions and salaries. This includes:
Too much work for too little pay, being exposed to traumatic situations, lack of support from bosses who are overpaid and enrich themselves, running out of stock, lack of a union when negotiating wages, lack of incentives to specialize, lazy and incompetent staff that cannot be fired and so-called “budget restraints”.

The bad working conditions and too little pay for public practitioners have the following consequences: frustration, anger, disappointment, depression, trauma, problems with motivation, wrong attitude towards patients.

The consequences of the bad working conditions and too little pay results in feelings of stress, depression or anxiety. Of these feelings stress is by far the most common (20 cases rated “considerable” or “very much” by public practitioners) followed by depression (7 cases rated “considerable” or “very much” by public practitioners) and anxiety (6 cases rated “considerable” or
“very much” by public practitioners. Of the individual feelings the stress feelings d8 (using a lot of nervous energy) and d14 (intolerant) were listed most.

Because of the working conditions and feelings related to these, public practitioners plan to leave their work as soon as circumstances allow. These practitioners either intend to go into private practice or emigrate.

The negative feelings towards work experienced by public practitioners is not nearly as prevalent among the 4 practitioners in private practice only (this excludes practitioners r13 and r14 who work part time in public practice). Two of these 4 practitioners did indicate some level of stress (5 cases) while the other two did not indicate any feelings of stress, depression or anxiety. It is not clear what the reasons behind the stress feelings might be.

None of the 4 practitioners who are only in private practice expressed a desire to emigrate.

5.3 LIMITATIONS
This study is limited because of the selected use of convenience sampling due to the research being conducted in a rural setting and the resultant restriction of access to a bigger sample of medical practitioners.

A further limitation of this study is that the sample was taken from one region of South Africa, namely Kwa Zulu -Natal. However, some of the medical practitioners did not reside in the area permanently and thus could be considered a valuable source of information with regards to potential transferability of findings to the country and the world as a whole. For example, interns and medical officers who worked in the area but had lived in different provinces of South Africa and parts of the globe in the past.

Finally, due to the on-going debate and tension between medical practitioners and the South African government, particularly in the public service and the governing bodies responsible for service delivery, the research was limited to participants who were willing to “break the rules of silence” either due to despondency, frustration and possible anger towards the present government. Private practitioners on the other hand, were willing to participate freely and openly.
5.4 RECOMMENDATIONS

BETTER TRAINING, PROMOTION AND REDUCTION OF CRIME
According to Crush (2002), it is believed that brain drain could be reversed if the South African government could take steps to improve career prospects for doctors through better training and promotion. It is also believed that official emigration statistics are being underestimated with many people anticipating a decline in economic and social conditions over the next five years. This pessimism was found to be higher in men than women. Motives for emigration for both males and females were similar with regard to economic factors such as cost of living, taxation and dissatisfaction around concerns for safety and security. Findings in their study revealed that black African men had the highest potential for emigration followed by white men, Black African women and white women, with women having the lower emigration potential of the two genders. Women of both genders cited family as the main reason for staying in South Africa. The implication of this study is that women would influence the decision for families deciding to emigrate and therefore an affirmative action on the grounds of gender may effectively reduce South Africa’s brain drain. What is clear, is, that “gender matters” and that women make reluctant emigrants. The most important factor though for stopping the exodus would be to reduce the threat of crime, as South Africans of all races and gender consider a future without crime as a bright one for themselves and their families. A peaceful, stable, economically prosperous South Africa would not only encourage immigration but would solve the health crisis as well (Crush, 2002).

SELF-HELP TECHNIQUES TO REDUCE STRESS, FRUSTRATION AND ANXIETY
Self-help techniques such as relaxation, meditation, guided imagery and yoga could assist medical practitioners to deal with the intensity of their working days and would reduce stress, frustration and anxiety. For example, a half an hour or meditation or guided imagery between patients or during a lunch break could offer a valuable respite from tension and stress.

Forbes et al. (2008) argue that yoga has a remarkable potential to influence the treatment of anxiety. By addressing client’s physical bodies along with thoughts and emotions, the practice of yoga has the potential to reduce anxiety. It offers medical practitioners a technique that they can practice on their own and, in a relatively short time, outside or inside the context of therapeutic sessions. This gives clients a more active role in their healing process. (Forbes et al, 2008:87).
MEASURES TO REVERSE BRAIN-DRAIN

Various initiatives, like the internet, are being deployed in order to attract South African medical practitioners living abroad, to return home. Approximately twenty thousand are reported to have left per year since 1990 alone (Matume, 2003).

Strategies and programs such as:

1. Adding extra years to medical student’s training, to keep them in the country for longer;
2. Tax proposals, which require entry and exit taxing, thereby creating economic potential from migration by remunerating the exit country after immigration;
3. Encouraging wealthy countries not to recruit medical practitioners from developing countries;
4. Transferring medical practitioners between countries; and repatriating medical practitioners, although this is often costly, with practitioners requiring matching salaries and reimbursement of relocation costs to their families.
5. Tapping the skills of medical professionals living abroad via networking and Internet solution based initiatives, whereby patients can be consulted and diagnosed remotely via internet imaging. The Africa Foundation, for instance exports refurbished “retired” computers from America to be used in developing countries. Other medical practitioners assist their South African counterparts to conduct research and help transfer technology to their home country. In this way, skilled practitioners living abroad could become an asset, if they remain committed. The Rand Forum Project relocates medical practitioners from countries that are in political and economic distress, to countries where they can be productive instead of becoming confined to refugee camps. They can be repatriated when their political and economic crises stabilize once again. Sequenced visits to the country of origin has also proved successful, with medical practitioners spend a couple of months in a specific-needs area in their country of origin and returning to live abroad (Matume, 2003).
ECONOMIC

“As exemplified by the case of international migration, the health workforce is strongly linked to global labour markets. Shortages in richer countries send strong market signals to poorer countries with an inevitable response through increased flows of migrant workers. In articulating their plans for the workforce, countries must recognize this and other linkages beyond their borders” (WHO, 2006:112).

In view of the shortcomings of this study with regards to the limited number of samples used, it is a recommendation that similar research is conducted using a larger and more diverse sample across larger populations in order for results to be generalised.

MANAGEMENT AND LEADERSHIP RECOMMENDATIONS

Government hospital Chief Executive Officer’s authority and powers need to be similar to those in private-sector hospitals. Currently they are centralised and distant. These powers should include, discipline, staff procurement and firing, internal budgeting. Budgets at government hospitals should be increased and could be reviewed with input from the private-sector hospitals. This could become a social-responsibility initiative. Issues such as remuneration, overtime pay, on-call duty, accommodation, transport, crèche facilities, and conditions of service, should be reviewed periodically and be conducted as an open process. Incentives and performance evaluations with a view to remuneration adjustment can be implemented. This should be an interactive process with performance improvements being discussed on a regular basis.

Unilateral changes implemented by the government has caused dissatisfaction more than what remuneration has, per say. For example, yearly salary increases were unilaterally replaced by notch increases which were based on performance evaluations. However, these increases were withheld by the Department of Health.

Due to the violent social conditions in South Africa, Security systems which protect staff and material resources need to be implemented after a comprehensive security audit by an independent security facility in order to ensure a safe working environment.
Ensuring that all equipment is adequate for use in order to exercise quality patient care. The state of disrepair, out-dated equipment and ordering patterns seems to be issues which are cause for concern amongst medical practitioners and other staff at government hospitals.

Due to the numbers of very sick patients, such as those with HIV-Aids, putting an ever increasing demand on government hospitals, the demographics of these hospitals will be unlike any in the past or in other parts of the world. These hospitals need to obtain reliable data and policies in order to address infrastructure consequences such as number of beds, linen, food, and length of stay, to name but a few.

An ethical committee for each government hospital could become a vehicle for advising about issues such as clinical practice, which medical practitioners and all stakeholders including patients can appeal to. This would encourage a reflective culture regarding the complexities of hospital administration. The committee could also be advisory in disputes (Landman, 2001).

**BEING AWARE OF MEDICAL PRACTITIONERS’ AND PATIENTS’ RIGHTS**

The “PATIENTS RIGHTS CHARTER” (Department of Health, 2002) is a valuable insight into the ethical and legal responsibilities which medical practitioners, government hospitals, private hospitals and patients have in society as a whole. Denying a patient these rights is considered a violation of fundamental human rights.

**5.5 CONCLUSION**

This study has examined the feelings of medical practitioners in the South African and International context with regard to the current healthcare dispensation in South Africa and abroad. It has sought to expose their conflicts and encouraged commentaries around subjects related to their professions, such as: strikes, wage negotiations, emigration, as well as their scores on the DASS-21 reflecting their states of depression, stress and anxiety.

A review of the literature seems to indicate that this study may be one of the first to investigate the experiences and feelings of Medical Practitioners and the differences which emerged between the public and private medical sectors.
This study paves the way for further research which would further extrapolate the complex articulations of South African medical practitioners as a central reference point for future planning by the government in relation to providing working environments and patient facilities which could see the imbalances between public and private becoming narrower and more feasible.

The present study’s findings suggest that Gopal’s (2009) comment regarding the South African health-care system is still applicable today “Furthermore, evidence points to a South African health-care system that is crumbling at the core” (p.5).

The aims and motivation of the study were outlined and explained at the beginning of the study. These were followed by a review of the current literature and explications relating to the medical profession in South Africa and abroad. The methodology followed and description thereof. The results were presented and discussed. The main findings, limitations and implications were discussed in detail thereafter. A number of important factors emerged during the process of this study which could add important insights into the experiences of medical practitioners in the current health-care dispensation in South Africa. These factors could be further explored in a more in-depth study with a larger sample, in future research.
ADDENDUM A: RESEARCH QUESTIONNAIRE

Dear Doctor

1. In assisting with the information needed to complete a master’s thesis on the subject at the bottom of this page, you have been selected to kindly assist in the collection of important data by answering the question below (in bold), in order to highlight the confusion in South Africa with regard to the Occupation Specific Dispensation in South Africa.

- Please “talk” about how you feel.
- Do you want to bail out of South Africa?
- How do you feel about the future?
- Talk about the latest wage negotiations, the increases Government has offered etc.

(Kindly use the blank paper supplied)

Information used will be kept confidential.

QUESTION:

“How Are You Experiencing The Current Health-Care System”

Master’s Thesis Dissertation Topic:
Phenomenological explication of experiences of medical practitioners in the health-care delivery system within the South African context

2. Attached please complete the Stress/Anxiety questionnaire.

(Subtitle the past tense for the present)

Results will be coded back to other data and analysed for common threads, percentages which are similar or prevailing with regard to the raised issues
Dear Participant

I am doing my Masters in Clinical Psychology at the University of Zululand. Thank you so much for being prepared to take part in my research project. I am investigating South African Medical Practitioners experiences of the current health-care delivery system.

Kind regards

Joan Stoyanov (Mobile: 0829296012)

CONSENT FORM

By signing below, I (full name)………………………………...……. agree to take part in a research study entitled: South African Medical Practitioners experiences of the current health-care delivery system.

I declare that:

I have read or had read to me this information and consent form and that it is written in a language with which I am fluent and comfortable.

I have had a chance to ask questions and all my questions have been adequately answered.

I understand that participation in this study is voluntary and I have not been forced to take part.

I understand that all information gathered from the study will remain confidential and anonymous.

I may choose to withdraw from the study at any time and I will not be penalized or prejudiced in any way.

I understand that no potential risks exist for me if I participate in this study.

I understand that the information gathered in the study will be published; however, none of the presented information will be linked to me directly in any way.

I understand that I will be required to complete a short questionnaire.

Signed at (place) ................................................... On (date) ................................. 2010.

Signature of participant
### ADDENDUM C: DASS Items

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>Hard to wind down</td>
</tr>
<tr>
<td>D2</td>
<td>Dryness of mouth</td>
</tr>
<tr>
<td>D3</td>
<td>No positive feeling</td>
</tr>
<tr>
<td>D4</td>
<td>Breathing difficulty</td>
</tr>
<tr>
<td>D5</td>
<td>Difficult to work up initiative</td>
</tr>
<tr>
<td>D6</td>
<td>Over reacted</td>
</tr>
<tr>
<td>D7</td>
<td>Trembling</td>
</tr>
<tr>
<td>D8</td>
<td>Using a lot of nervous energy</td>
</tr>
<tr>
<td>D9</td>
<td>Worried about panicking</td>
</tr>
<tr>
<td>D10</td>
<td>Nothing to look forward to</td>
</tr>
<tr>
<td>D11</td>
<td>Get agitated</td>
</tr>
<tr>
<td>D12</td>
<td>Difficult to relax</td>
</tr>
<tr>
<td>D13</td>
<td>Down-hearted and blue</td>
</tr>
<tr>
<td>D14</td>
<td>Intolerant</td>
</tr>
<tr>
<td>D15</td>
<td>Close to panic</td>
</tr>
<tr>
<td>D16</td>
<td>Unable to become enthusiastic</td>
</tr>
<tr>
<td>D17</td>
<td>Not worth much as a person</td>
</tr>
<tr>
<td>D18</td>
<td>Feeling touchy</td>
</tr>
<tr>
<td>D19</td>
<td>Aware of heart’s action</td>
</tr>
<tr>
<td>D20</td>
<td>Scared without reason</td>
</tr>
<tr>
<td>D21</td>
<td>Life is meaningless</td>
</tr>
</tbody>
</table>
PIE CHART REPRESENTATIONS OF DASS-21 RESPONSES

The pie charts presented below represent the participants’ responses to the various items on the DASS-21.

Feeling Touchy

- 69%: Doesn't apply to me
- 23%: Applied to me to some degree
- 0%: Applied to me to a considerate degree
- 8%: Applied to me very much, most the time
Anxious in Situations

- 61% Doesn't apply to me
- 23% Applied to me to some degree
- 8% Applied to me to a considerate degree
- 8% Applied to me very much, most the time

Scared without reason

- 69% Doesn't apply to me
- 23% Applied to me to some degree
- 8% Applied to me to a considerate degree
- 0% Applied to me very much, most the time

Feeling of shakiness

- 85% Doesn't apply to me
- 0% Applied to me to some degree
- 0% Applied to me to a considerate degree
- 15% Applied to me very much, most the time
Difficulty Breathing

- 8% Doesn't apply to me
- 0% Applied to me to some degree
- 92% Applied to me to a considerable degree
- 0% Applied to me very much, most of the time
ADDENDUM D: MEDICAL PRACTITIONERS SELF-REPORT QUESTIONNAIRE RESPONSES

Note: Participants 1, 3, and 4 did not submit responses.

Respondent 2:
You wanted some comments from me about the health services in this country. I trained in (omitted) under the (omitted) and it seemed to work well there but I was always under the opinion that the fee for service was a better incentive than the non-payment system. In fact, the service was not free; everybody paid their monthly ‘stamp’ which included their health contribution. I have subsequently been in private practice and done sessional work at our government hospitals in South Africa which do provide a good service when the staff and equipment are available but unfortunately, over the years this has been eroded and now seems to be in a state of chaos. I don’t know what the governments are going to do, if anything about this, but they seem to be heading towards nationalizing the whole health system which I think would be a total disaster. I’m not socialistically inclined so I do not subscribe to this ‘free’ service. I believe a fee structure is necessary, for both satisfaction of the patient and the provider, in this case the Doctor. It doesn’t have to be excessive and it will be more satisfactory. I realize this is an expressive opinion, so we are going to have to have a government subsidized service for the less fortunate amongst us, but unless they can improve their administrative abilities, it is not going to be of much success. I am quite happy the way my single handed practice is run and I don’t wish to see any particular change. I hope this little missive helps you with how I think.

Respondent 5:
Thanks for giving us all this opportunity to vent our frustrations. But first let me warn you that we are instructed by the province not to speak to the media. Media are instructed to use the website for ‘official’ information. This is to prevent misleading figures being published, but this has the ‘knock-on’ effect of silencing legitimate complaints and making the Department of Health look bad (on others), but I will try to be kind. When the employer says not to speak to the media, you must know there could be something rotten in Denmark. I’ll divide me presentation into two parts. One part about me and the other part about the ‘employer’ I always felt compelled to go into medicine for several reasons. One, nothing else interested me, two, I wanted to make my father happy because he
was a (expletive), and three, I always fancied that I could be my own boss, own my own business (practice) and answer to no-one. Two negative aspects would be (1) I didn’t quite fancy taking over my father’s practice, which he clearly wanted me to do (too boring to live in the same spot I grew up in, although I know fifty percent of people do) and (2) I didn’t like the idea of the phone ringing twenty four seven and having to go to the hospital. Maybe that’s why I was a bed-wetter as a child. To carry on with my complaints about working for the (omitted): as stated above, I thought as a professional, I could be my own boss. However, as things turned out I am a cog in an organisation. Don’t get me wrong. I am not going to start complaining. There are actually many advantages to being a civil servant. May I begin: I don’t have to buy equipment, hire staff, rent or buy office space, in other words ‘over heads’. My taxes are taken off the top, so I don’t have to worry about the taxman. By the way, we do have outside sources of income, namely, (omitted). I don’t want to get into all that at this point, but I get a few extra thousand a month doing this, which I hope will help me pay the bond of the house I’m building. But again, this is like working for the government, because I don’t pay the rent or employ the staff. Another issue is the pure medicine that you see. A general practitioner does a lot with what I was saying in ‘general’ problems, a specialist in private practice has a better quality of patients and therefore less chronic diseases. Anyone will tell you that the things you see in (omitted) Provincial Hospitals are probably worse than anywhere else in the world. Therein lies the problem. There is little but too much to experience. Last weekend there was a (omitted) year old (omitted) who was brutally (omitted), strangled and reckoned left for dead. Her (omitted) was ripped to her (omitted) and she was comatose from a state of shock. Yes, we see anywhere between 30 to 50 (omitted) a month, and many alleged (omitted) where 8 out of 10 times you see no evidence of injury. But this last case, the (omitted) year old, is really traumatizing for everyone involved. (Omitted) ended up with a (omitted) so her (omitted) can heal properly. This was almost as traumatizing to me as seeing a man with his hands cut off when I was an (omitted) in (omitted). It’s not easy to cope with these kinds of experiences. But I find that time ‘heals all wounds’ and one gets over it. With over (omitted) a week, we see just about anything that can happen. Some years ago (omitted) I admitted (omitted) one body. Unfortunately, it wasn’t picked up on omitted) and the (omitted) died during (omitted), or (omitted) would have lived. Let’s get to what, if I had to say, really eats at me: Would be consultants. I tried to take the primary examinations a few times but I found it too difficult to work as a (omitted) and study at the same time. One has to take months off to truly prepare for the exams. But even then, I also found that that’s not enough. South Africa has a really corrupt academic system. Where I went to school in the (omitted), most of the exams were multiple choices and graded by a computer. Very objective, no-
one can argue with a computer. But when one has to write an essay for an exam under a supposedly anonymous ‘code number’ it becomes apparent that there are many ways one can be failed with no way to double check the errors. Asking for papers to be remarked is a big joke. I sometimes feel that these consultants with the letters after their names that say they are ‘fellows’ should say that they are in the ‘broederbond’. I smell something crooked sometimes (and have actually overheard consultants saying why they pass this person or that person, and it’s not always based on knowledge). In any case, I’ve accepted that I am not smart enough to be one of them, and will actually have to practice (omitted) rather than just talk about it or sit (or sleep) on the other end of the phone and just talk or consult about it. I mean really, (omitted) consultants really have a disturbed night’s sleep. Over the past (omitted) years of practicing (omitted), I guess I’ve called the consultant on call to come out and help with a difficult case around 10 times or less. They like to do what I call ‘brow-beat’ the junior doctors by criticizing after the mishaps have happened. They are never on the floor when the mishap actually takes place. The idea is that we ‘donkeys’ ARE SUPPOSED TO ‘CONSULT’ WITH THEM BEFORE THINGS GO WRONG. But that’s not the way things happen. So we donkeys learn to make our own decisions and they get left ‘out of the loop’. At least as far as I’m concerned. I’m certain some of the younger doctors buy them a lot more than I do. The shame is that I consider many of these guys as good friends. Because after all, we have to work together. That’s the secret to work, I believe, and that is to be able to get along and keep good attitude while the ‘bosses’ kick back and do (expletive) ‘ol work in the hospital and make a super-income and even run a private practice on the side! (NO consultants at (omitted) Hospital can do that, they work too hard). The main work that many consultants do is ‘brow-beat’ (show others that they are smarter than them) and the once a week slate of a few (omitted) that are non-life threatening, as opposed to (omitted) which are lifesaving. That brings another point, occasionally for some reason or another, short staffed, etc. when the hospital has to cut back, the first things that are cut are elective cases. That means the consultants operating case are out while we donkeys have to carry on. (Final entry) Sorry if I seemed to have drifted off the subject, but it’s probably good therapy to vent one’s spleen now and again. To get back to the subject on pay rises, it looks as if all the striking and negotiating has been for nothing, as I think I mentioned, the two groups getting the most increase are the interns and the consultants, and people who do the most work get little. It would appear that all we did was get the ball rolling for many other groups to express their dissatisfaction, such as SABC, mine workers, municipality workers and others. At the end of the day I’ll just have to be happy with what I have and be glad I don’t have any kids and their tuitions to worry about. My wife, (omitted), (omitted) work which suits me just fine. I always
like her around when I need her. The question about bailing out of South Africa is a definite “yes”. I am definitely looking into taking the test for (omitted), but it is very difficult to pick up books again, so I’m going to rely a lot on experience. There is an (omitted) limit so I have to start applying now. It’s a shame because I’ve already emigrated once from the (omitted) to here, and now to move again. The proof that the grass is greener elsewhere is that seldom do you see people return once they’ve left. But using that logic you would say that, to me, the grass is greener here in RSA than in (omitted). If only the money was greener!

**Respondent 6**

If I knew what I know now, I don’t think I’d study medicine again or be so bright eyed about being chosen to become a doctor, if it were possible to turn back time!... Lately, I’ve found myself thinking the above, quite often. The only things that keep me going are the fact that I can’t bail out now not after working so hard to get where I am now – (omitted) years and a large study loan that needs to be paid off and that a part of me has to cling to the hope that this is what God plans for me – at least in part. My ‘favourite’ saying lately? In order to serve mankind, we sacrifice our own humanity! A strong statement, yes, but true! We work long hours and get a meagre salary for this, in comparison to colleagues – peers working in private sectors. This is further complicated by our hospitals sometimes running short of/ out of stock i.e. drip sets, gloves, CT scan/ blood gas machines breaking or machines used to do essential blood investigations, that break... or no laboratory staff to run samples. This is not just frustrating, it is also disheartening. How can one continue fighting the good fight if no-one is helping you and it feels like all forces are directed against you? It is not only doctors that suffer – our patients suffer too. I cannot and do not want to know what it feels like to wait in a queue for 8+ hours, just to get a follow-up consultation of maybe 10 minutes. Sometimes you – as a doctor – have to push the queue, thus meaning that, if you are only i.e. 3 doctors that need to see 100 patients (after doing your ward rounds first), then going to clinic, you will not have time to conduct a meaningful interview with every patient. You determine the problem and get a solution for it. For many people, a visit to the doctor is their only exposure to a professional who can help them bio psychosocially. Unfortunately, we now have to treat symptoms, not patients. The even sadder part is that we work for an employer who doesn’t realize this or does, but chooses not to. All our pleas fall on deaf ears. If we ask for more money to better ourselves and care for our families, especially in the midst of living expenditures and a world-wide financial recession that all affects us, as we are also human beings, we are deemed as greedy and ungrateful. Well, I feel that if a ‘slave’ respects his/her master, as that master is good and takes to
heart his employee’s needs, that employee will walk the extra mile, be innovative and try harder to make things work, cause they are in it as a team. But, pay me peanuts, make me work my fingers to the bone, deprive me of sleep and just continue making life difficult for me, and even a loyal, hungry, meek dog will come and bite you. When I finish community service, I am leaving South Africa. I want to be able to pay off my study loan, start building a healthy home for my family and not worry where tomorrow’s money is going to come from. As an intern, 2 years of extra supervision, was good, because it made me feel more competent. Unfortunately, the salary isn’t very good and as I am a doctor, I have to pay specific insurance to cover me if there are any legalities/ injuries more than a normal person on the street has to. If I want to specialize, to better myself, get a better pay, however, I have to wait at least 4 years now before I can even get into a specialized direction – 2 years internship, 1 year community service, 1 year as an MO. I’d rather go to Canada, work as a locum for a couple of years, pay me debt off, buy a house etc. then come back with enough financial support, to fall back in the SA Health System and start specializing… work like a dog again and be paid little. As a doctor, I must always have compassion and be caring, yet, if I also need the same or experience personal crises, there is no support for me. ‘A little ironic, don’t you think?’ – Alanis Morrissette.

**Respondent 7:**

Most of the time, I feel good about my work. There are times, however, that situations in the hospital make me brutally angry. It is not often, but when I get upset about work, it tends to be severe. There are moments when I truly despise the people I need to care for – once I have vented this though, I feel better. I vent to my family (even if it’s at 2am in the morning) and this usually helps put things back in perspective. Without the support of my family and friends, I would be unable to do this. I feel that SA’s Health-care system is under tremendous strain – there are many doctors and nurses who work beyond what they are paid for – because, if they don’t, the system will collapse. The situation is currently working, but I feel that it cannot take much more. Our health-care system needs: better management of resources, more health-care workers. As things are, I would stay in SA provided the pay and management improves; otherwise, I would consider leaving.

**Respondent 8:**

I am an intern doing my first year of the 2 year internship programme. How I feel – numbness sums up the general feeling. The disappointments, the ever deteriorating health-care structure, is plain depressing. Working has become a drag, you force yourself to wake up and go to work in the
morning when you get to work you are struck down by the amount of workload, nothing to work with and the poor supervision and support. Bailing out – the politicians, the strike on and off, the varying percentages on offer and the whole media basis of the operation is plain wrong. Conscience and common sense says, stay behind and help those in need. But introspection and reason puts it out – your efforts are of no value to us, you are the one who cares, we just want the job done (anyhow by anyone) if push comes to shove you can be replaced by? Ghosts? Whosoever. The corruption at all levels is also a major downturn. The future – this does not look bright, at the moment all seems to be pulled in by vortex which is going to crush it all into pieces. The government is not anticipating anything, has ‘pawns’ doing the controlling for close to nothing. Wage increase – all negotiations with the government have proved to be fruitless. SA doctors do not have a representative union, and are unwilling to join existing unions or come up with a new one (there is no representation). I doubt that the wage is coming soon, or is going to be a satisfactory one. But!!!! The negotiations go on.

Respondent 9:
Health-care system is a disaster to put it mildly (public sector). Working conditions are terrible, there is sometimes not enough equipment, shortage of staff both medical and nursing staff, long working hours with too little salary to take home e.g. expected to work full day from eight in the morning till four in the afternoon and coming on call at six in the evening to knock off the next day at twelve midday. Still expected to be making sane decisions. I was very disappointed about the way the department of health handled the doctors wage negotiations – how can medical officers who form the backbone of the health-care system be the ones who get the least increase? Disappointing! I would like the department to also consider revising the salaries for specialists; otherwise as it is they are not motivating people to specialize ten years of university not equivalent to level 11 salaries!! We should be getting better incentives for specializing. To be honest, there is nothing at the moment motivating both medical and nursing personnel to remain in the public health-care system – if this isn’t changed in the near future I’m afraid we gonna lose doctors and nurses to private sector or overseas.

Respondent 10:
Working in private sector and due to recent family responsibilities, I feel completely detached and oblivious to what my colleagues are experiencing in private sector. I feel quite embarrassed to admit that I feel bored by the beaurocracy and although I naturally support improved wages and working
conditions I feel I don’t have the ‘fight’ in me to get emotionally involved. I am committed to remaining in SA – I love this country and people but I don’t see myself returning to public sector. Feel don’t have the energy for the sort of working conditions I have experienced previously and now want to use my positive energy on my family.

**Respondent 11:**
I really feel happy being a doctor in South Africa. My only concern is the government section, where the nurses are negligent, sometimes even insulting attitude towards patients. That is frustrating at times, as they spend most of the time either writing in their nursing files or doing nothing for the patient. Patients often complain about them not greeting or spending time with them. Apart from that, I don’t have any recommendations as I have worked????? in the private section for about 10 years and the things there are completely different.

**Respondent 12:**
I am happy to be a doctor in SA. I do not want to bail out of SA at this stage. I cope reasonably well emotionally with my work and life as a medical practitioner. I feel secure about the future both professionally and personally. I am in private practice. Nothing to discuss at this stage.

**Respondent 13:**
It is becoming a tragic situation – the current health-care system. I feel empathy for the majority of people who range from the patient to the service provider to the health-care giver i.e. GA to nurses to DRs. Unfortunately, and as usual the fault lies at government level. Greed and power and ego always seem to overwhelm our public servants hence the vicious cycle continues. At the present moment, young doctors in the state hospitals have the courage to expose the conditions under which they work and the deficiencies with regards to the treatment meted to patients because of the so called budget restraints! Corruption, fraud, ego and the dictators of the people who refuse to increase these doctors’ salaries and improve the health-care meted to people! Yes, at times I do feel like flying out of SA to another land, but where? There is turmoil everywhere. I have resigned myself to living in the now. Now the construction workers who are responsible for the 2010 stadiums etc. have downed tools – why? – wages too little! The future is an issue which I am finding difficult to understand how to deal with, so I take baby steps, that’s the only consolation. Divided we fall, united we stand, but human nature is such that the ego gets the better of you and
one loses track of righteousness. If our government puts that into practice, then yes, the future is bright.

**Respondent 14:**
I feel ambivalent, scepticism, antagonistic to government administrators who want to line their pockets and enrich themselves on the promise that they are going to provide health-care for the poor. I feel the philosophy is sound, that the poorest of the poor must be given access to health-care – not only primary health but comprehensive. Primary health-care/ community health has failed – clinics don’t have basics in terms of equipment and medicines. Staffing of these facilities are by poorly motivated health workers. I do not want to bail out of SA, I want to stay, contribute and make a difference. The future – in global terms and fear of turmoil. The environment is making people ill, and they need health-care access, but the focus should be on environmental health – access to clean water and sanitation and facilitation of subsistence farming to provide for basic needs. Wage negotiations – government health-care workers must be supported – private practices should not provide ‘scab’ labour to government hospitals when their doctors are on strike. There should be other systems to assist government doctors to increase their income and improve their efficiency – fee for service – crossover between public and private sectors.

**Respondent 15:**
State health delivery is appalling like various other government services, not so much because of a lack of infrastructure/equipment, but because of systematic laziness and incompetence. There was/is still a spectacular proliferation of grand titles/posts, with salaries to match, while the work ethos almost disappeared, is quite unspectacular and almost fell into a deep obsolescence. These posts and titles are seen as entitlements by its occupants and sinecures – does not matter how little you work, you can’t get fired. Government cannot manage anything as well as private enterprise, that’s why state services are badly managed, more often corrupt, compared to private. The view that eighty percent of all health expenditure is on only twenty percent or less of our population and vice-versa, is true, but the polarization between the haves and have-nots is more obvious in housing, education, transport. The five percent of private taxpayers in SA usually pay/fund duplicated systems: police and private security, public and private schools, public and private transport, state health and private health, etc. others. The reason for this apparent discrepancy is simply the service in private health, and, whoever can afford it, goes to private health. That eighty percent is not money that is taken away from the pauper-patients, just as I buy my own car with my own money, not be stealing
money from the poor. The government cannot nearly manage what it has, so it has zero hope to manage/ convert private health. (In a cynical way, the appalling government health service is the salvation of the private health, because: which politician will go to his or her own abominable creation, if he/she can go private?). Future health will not run down/ nationalize private health, because the politicians themselves usually attend private health-care, not public care. I feel that private health has very likely a bright future because the only way to expand service delivery as per pre-election promises will be to expand private health. Our restrictions on beds/ expansion will be eased/ disappear (do Checkers, Woollies, etc. need government approval for new shops? No. So why hamstring Life-healthcare, Mediclinic, Netcare, etc. I shall be very unhappy to pay one cent extra tax for national health insurance (NHI) or see my medical aid funding National Health Insurance. The rich get richer and the poor get more – we are flooded by immigrants and population explosion, the masses can never be satisfied.
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