

Doctors' views of working conditions in rural hospitals in the Western Cape

De Villiers MR, MBChB, MFamMed, PhD
De Villiers PJT, MBChB, MFamMed, DOM, HonsBScMedSci (Epid), PhD
 Department of Family Medicine and Primary Care,
 Faculty of Health Sciences, Stellenbosch University

Address for correspondence:
 Prof. MR de Villiers, P.O. Box 19063, Tygerberg 7505, Tel 021 9389035,
 Fax 021 9389558, E-mail mrdv@sun.ac.za

Keywords: district hospitals, working conditions

ABSTRACT

There has been a lively debate in the media about working conditions in rural South African hospitals, with a particular focus on staffing and quality of care. From a medical perspective, it has been stated that poorly equipped and managed hospitals, inappropriate training and an excessive workload are significant contributors to the problem. This study was conducted to investigate the experiences of medical practitioners in performing their professional duties in rural district hospitals in the Western Cape. Twenty in-depth, free-attitude interviews were conducted.

Three major themes became apparent from the data, namely the importance of situational factors, knowledge and skills, and support structures. Two conceptual frameworks emerged from the themes that describe the impact of working conditions on the quality of care, and captured positive and negative factors influencing performance. This study provides evidence that substantial after-hour duties, an excessive workload and a perceived lack of management support impact negatively on doctors' views of working in district hospitals. Unless these are addressed, the problem of retaining medical staff in rural hospitals will continue, and equity of access to health services for rural communities will remain an unfulfilled obligation. Recommendations are made on how these issues can be addressed. (*SA Fam Pract* 2004;46(3): 21-26)

INTRODUCTION

Working conditions in rural hospitals of South Africa have recently been under scrutiny in the press and medical publications, with understaffing, an excessive workload, inadequate supervision or support and long working hours described as factors that compromise care in rural hospitals.^{1,2} Doctors are unable to perform their duties satisfactorily due to a lack of equipment, drugs and transport and unsupportive management systems.^{3,4}

Lack of a career structure, inappropriate training at undergraduate and postgraduate level, spouse dissatisfaction, limited schooling opportunities for children, academic isolation and bureaucratic problems have been identified as factors that

discourage doctors from working in underdeveloped areas. Furthermore, scant management support and too little time or opportunity for continuing their education were found to contribute to discontentment or frustration. Other problems of rural practice include a lack of recreational facilities, poor housing, inferior clinical facilities, violence and inadequate pay.^{5,6,7}

There is a need to create an attractive career structure, not only to draw medical practitioners to the rural areas, but also to keep them there.⁸ The Rural Doctors' Association of Southern Africa (RuDASA) has published a position paper that focuses attention on the dilemma facing many rural hospitals in the country in terms of maintaining ad-

equate staffing by experienced medical officers. The document contains constructive solutions to recruiting and retaining professional staff in rural areas, with recommendations regarding community service, senior doctors and foreign doctors.⁹ The fast tracking of registration for suitably qualified practitioners from developed countries and the introduction of a substantive increase in rural allowances are examples of steps that can readily be implemented.

It is important that factors that satisfy or dissatisfy doctors working in rural areas be identified, as the level of doctors' satisfaction with their workload is an important factor determining the retention of doctors in rural hospitals.¹⁰ The purpose of

this study was to examine the positive and negative experiences of medical practitioners working in rural district hospitals in the Western Cape. It formed part of a larger study investigating the knowledge and skills gap of district hospital practitioners in the Western Cape.

METHODOLOGY

The district hospitals were grouped according to geographical areas. Purposive sampling was done in each of the areas to include at least one hospital of each different size (>80 beds; 40-80 beds; <40 beds), as well as all hospitals staffed predominantly by full-time medical officers, because of the particular interest expressed by provincial management in full-time employees. The result of this was a list of 20 hospitals, all complying with the definition of "rural" as being one hour or more by road transport or 80 km away from a referral center.^{11,12} The medical superintendent at each hospital was asked to nominate a medical officer to be interviewed. This was necessary because it was impossible to predict which practitioner would be available at the time of the site visit. The research assistant obtained informed consent from each interviewee before the interview.

In-depth interviews were conducted, using the free attitude interview technique.¹³ The key question introduced by the interviewer was: "What is your experience of the professional skills you have to perform as a medical officer in a district hospital?". The interviews were audio-taped and transcribed. The data were analysed using probing depth analysis. The text was read and reread, labelled, cut and pasted. This enabled the formation of coherent categories from which themes and sub-themes were developed. Finally, conceptual models were formulated from the data.

Reflexivity was introduced into the analysis by identifying the re-

searcher's preconceptions and terms of reference before the analyses, and maintained by continuously examining the data for competing conclusions. The free attitude interview technique, rather than focus group discussions, was used to explore individual views. Internal validity was maintained by strictly applying the technique.¹³ Triangulation of the results was done with the results from the district hospitals' medical officer questionnaire (not reported here), which assisted in the external validation of the results.

Stellenbosch University's Research Committee approved the study protocol (2001/C040). Provincial authorities and the hospital superintendents granted permission to conduct the study. The Health Systems Trust provided a research grant to fund the study.

RESULTS

The demographic profile of the 20 interviewees is shown in **Table I**. Eight of the respondents were in full time provincial employ, while 12 were in part-time employ, simultaneously running private practices. During the interview analysis, issues

common and unique to both full-time and part-time groups were identified. The results are reported simultaneously with reference to differences between the groups, including verbatim quotes supporting the findings. **Table II** lists the themes and sub-themes that were identified.

Knowledge and skills

The interviews revealed that medical officers were confronted with a wide variety of problems requiring a broad range of knowledge and skills. There were recurrent references to the need for trauma management. General surgical, obstetric and anaesthetic skills were also frequently required.

"It is such a general job that you never know from one minute to the next where your next challenge is going to be."

The interviewees described a number of situations in which they believed a personal knowledge and skills gap existed. Explanations for the gap included a lack of training, inexperience, inadequate equip-

TABLE I: Demographic profile

	Total	Female	Male	Years qualified
Full-time	8	4	4	1 - 11
Part-time	12	2	10	5 - 26

TABLE II Themes and Sub-Themes

<p>1 Knowledge and skills</p> <p>1.1 Scope of knowledge and skills</p> <p>1.2 Knowledge and skills gap</p> <p>1.3 Knowledge and skills development</p> <p>2 Situational factors</p> <p>2.1 Remoteness</p> <p>2.2 Job satisfaction</p> <p>2.3 Job frustration</p> <p>2.4 Work-related stress</p> <p>2.5 Community issues</p>	<p>3 Support structures</p> <p>3.1 Specialist support</p> <p>3.2 Regional and tertiary hospitals</p> <p>3.3 District Health System</p> <p>3.4 Nursing staff</p> <p>3.5 Other support staff and services</p> <p>3.6 Community service doctors</p> <p>3.7 Management</p> <p>3.8 Public-private partnerships</p>
---	--

ment, and skills attrition due to limited exposure. These perceived “missing skills or knowledge” were a common source of concern.

“I had two anaesthetic lectures in fourth year and not much before I came here and started to do gas this year for the first time because I was too terrified to do them before.”
“But because if you do something wrong here and it goes seriously wrong, it’s too far from town B (secondary hospital) to take the risk. And then you slowly unlearn some of the skills that you did know.”

A need for skills development and knowledge updating was expressed during the interviews, with suggestions as to how this could be addressed. Generally, knowledge and skills acquisition took place through in-service learning from more experienced colleagues and, to a lesser extent, from visiting experts. Rotations, especially through secondary or tertiary hospitals, were highly regarded as a means of updating skills. Practical hands-on training was preferred to lectures. Lack of time, need for locums, remoteness and expense were identified as barriers to professional development.

Situational factors

Despite the Western Cape being considered a province with less remote areas than other parts of the country, the medical officers perceived isolation as a problem. This was countered by job satisfaction from the generalist nature of their work, getting to know the local population, benefiting the community, the financial security of employment in the public sector and the opportunity to perform procedures not usually carried out by general practitioners in urban settings.

The interviewees elaborated on conditions in the district hospitals as causing frustration and hindering optimal service. The lack of resources, both in terms of equipment and

specialist back-up, emerged as sub-themes of frustration. The full-time medical officers felt that the excessive workload, especially after-hours duties and coping with large numbers of primary health care problems, assaults and trauma were a problem.

“The only problem I have with the job at the moment is that I think it’s unsustainable in the long term. I’m working 50-60 hours a week, but in the long term it is unsustainable. It doesn’t sound so bad until you try and do it – it’s relentless and it’s exhausting and it’s frustrating. And I think it’s unhealthy – people who say it’s OK should try it.”

“They (doctors) come here and they think they are going to be water-skiing and walking in the forest and mountain biking – and then they spend a lot of time in casualty on a Saturday night with drunk, aggressive, assaulted patients.”

The doctors identified situations beyond their control that impinged on their work satisfaction. For full-time doctors, these were the lack of a career path in district hospital service. For the part-timers, medico-legal risks and inappropriate remuneration for performance of advanced skills were considered a threat. Social problems, such as poverty and violence, burdened district hospital services and impacted on the morale of the medical officers.

“The people that work here feel that it is not worth it working here any longer because we have been trying, especially myself, for 10 years. I like to work in this hospital, but for so long, we have taken so much, we have written letters, it is as if nobody listens to you. This is not about the higher post or the money, it’s about working conditions in this hospital.”

Support structures

Support from specialists was a sub-

stantial theme identified by the full-time interviewees. Outreach visits by specialists were regarded as very helpful, provided they were coordinated with the needs of the medical officers. The relationship with higher levels of care, especially the secondary hospital, was regarded as important.

“About referring to (secondary) hospital X – it’s like sending stuff into the Bermuda triangle. They never come back with summaries, we never found out what happened to them, there’s no interconnection between the two.”

Interaction with primary health care facilities within the district was an important theme for the part-timers. These practitioners were more involved in health services outside the hospital. Fragmentation of services and governance within the District Health System were a concern and resulted in problems with service delivery. The fact that primary health care services were not available after hours placed an inappropriate work load on the district hospital.

“You see what is happening is that the district hospital casualty department is overflowing with primary health care problems after hours. That is the crux of the matter. The primary health care centres all over this district close at 4 o’clock in the afternoon.”

A commonly recurring theme involved the lack of nursing staff and their training and motivation. Laboratory tests were often done off-site, causing delays and limited after-hours availability. Special investigations had to be kept to an absolute minimum due to budgetary constraints, and patients who needed urgent and repeated laboratory tests were better off if referred to a higher level of care. Radiology services were frequently not available after hours. The ambulance services

drew widespread criticism, as did the lack of social support services. The introduction of community service doctors was considered a positive development, but the frequent rotations and inappropriate training of these new doctors placed a further burden on particularly the full-time staff.

"We try to provide a good service but I think the nurses are dispirited most of the time and they can't observe most of the patients."
"Resuscitations are a problem at night. They tried training sessions but now the staff changes such a lot that there is no fixed personnel."
"One of the weakest links in our whole chain of supplying good medical services to the inhabitants of this area at this point in time is the ambulance service."
"One negative point is the budget all of a sudden went a bit haywire because these newly qualified (community service) doctors tend to request an enormous amount of laboratory tests."

A dysfunctional relationship with management was one of the problems that emerged from interviews with the part-timers. There was a feeling that the practitioners were not consulted on issues regarding the service, and that provincial management was making decisions in a top-down fashion, with predetermined agendas.

"For instance increasing a ward by one and a half meters by breaking out one wall and the whole sewage systems and plumbing and everything just to make it a meter bigger so that it can accommodate a new size bed or something. It's things like this that happen where we feel that this is being done by guys that sit in Cape Town and they come and talk to us but they don't listen to what we say."

Some private-public partnerships

were reported to be successful, but concern was expressed that the authorities appeared not to support these ventures. For most of the part-time practitioners, their private practices were their main source of income and needed time to be managed properly. The private work provided a different practice profile, making the work more varied and lucrative and enabling the doctors to remain in a rural community.

"It's expensive to keep your private practice running. That's very important because that's our main source of income. We've got to look after that."
"If I would only do hospital medicine as it is at the moment, I would find it extremely unstimulating".

Conceptual framework

Two conceptual models were developed from the themes.

- The inverse performance spiral (see **Figure 1**); and
- The skills boat (see **Figure 2**).

Figure 1 assists in conceptualising the influence of conditions in a district hospital on the performance of and the quality of services pro-

vided by the medical officers. The picture emerging from (especially) the full-time medical officer interviews can be compared to an inverse spiral forming a downward movement in which the quality of skills progressively decreases as the spiral progresses. The medical officer enters the spiral when taking up a post at a district hospital, often with expectations of a rewarding time in a rural area, performing interesting procedures. The medical officer is confronted with an unexpected patient profile, which includes violence, social problems, abusive patients, plus the inappropriate use of after-hour services for minor complaints. The workload and antisocial hours prevent the medical officer from engaging in "real medicine". The chronic lack of staff aggravates the situation. Other setbacks include the malfunctioning of the ambulance system and the refusal of referral hospitals to accept patients. Only basic procedures are performed, resulting in skills atrophy and little time to acquire new knowledge and skills. Limited support from management further undermines morale.

The knowledge and skills gap widens, quality of care decreases,

FIGURE 1: THE INVERSE PERFORMANCE SPIRAL

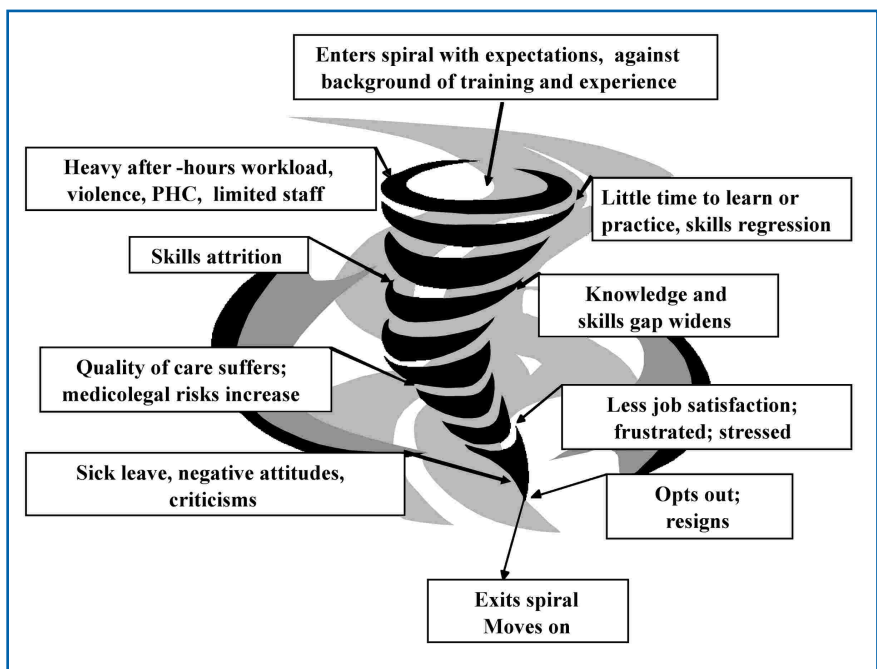
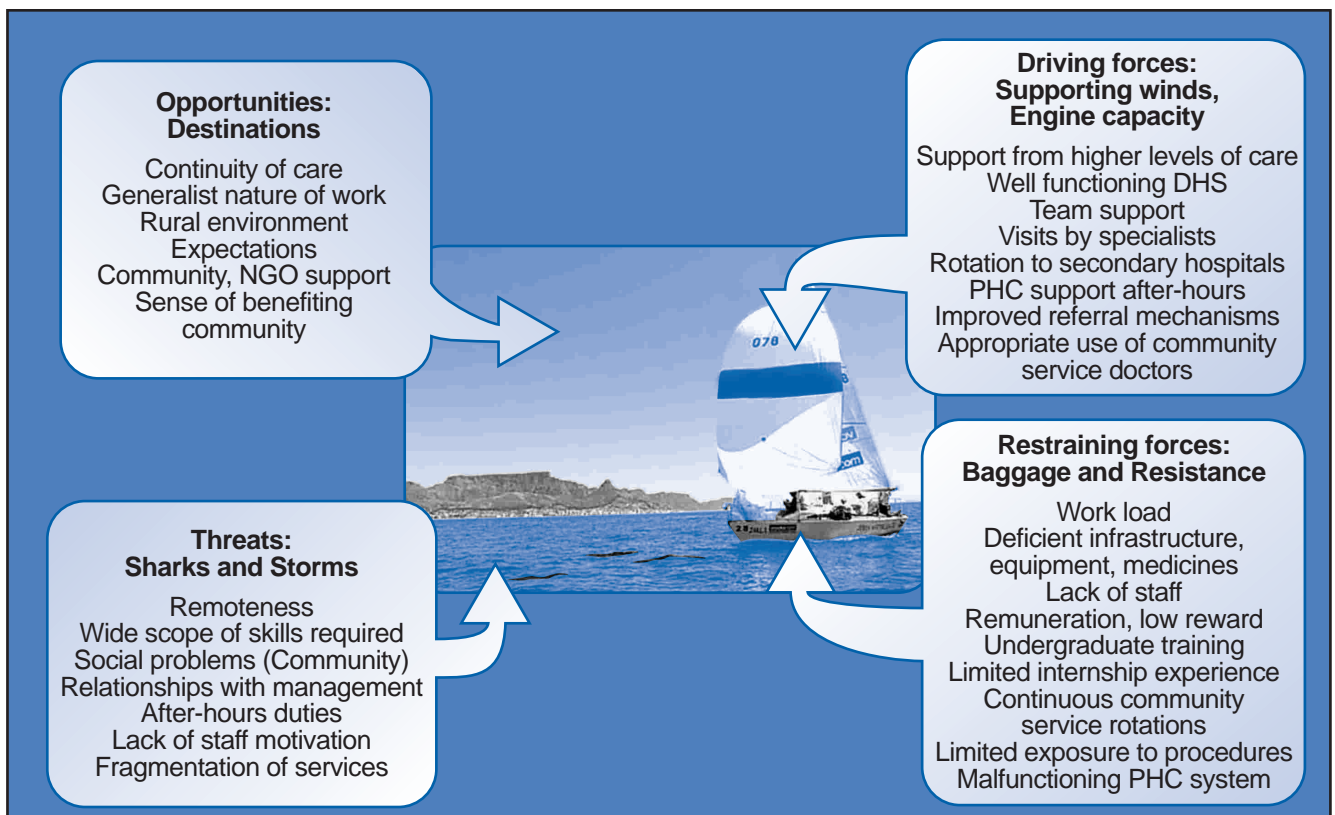


FIGURE 2: THE SKILLS BOAT

and medico-legal risks increase. Job satisfaction decreases and frustrations mount. Motivation to carry out procedures dwindles and the doctor becomes increasingly stressed. Burnout looms. The medical officer faces a decision on how to respond to the situation, often leading to resignation.

A figurative picture that emerged from the key question used in the interviews was that of a skills boat. The boat could move forward, stall, sink, or alternatively its progress could be enhanced by a number of influences. These were grouped as restraining forces or threats, and driving forces or opportunities. **Figure 2** demonstrates the influence of these factors on the performance of district hospital medical practitioners.

DISCUSSION

Close examination of the theoretical framework depicted by the skills boat model reveals the complex interaction between opportunities

and threats, as well as restraining and driving forces influencing the performance of medical practitioners in rural district hospitals and, ultimately, the health care of communities served by these hospitals. Improved functioning within the district health system and between levels of care, and appropriate matching of skills levels with tasks can greatly enhance district hospital services. Perceived opportunities, such as procedural practice and the ability to practice continuity of care, should be utilised.^{6,14} Working conditions and training deficiencies are the two main restraining factors that need to be addressed to enable medical practitioners to deliver an equitable and quality district hospital service. Recommendations from our study include:

- Reduce after-hours duties for full-time practitioners by the appointment of part-timers to duty rosters on a sessional basis;
- Provide a career path for medical officers in district hospital service;
- Develop the system of using part-

time private practitioners in district hospitals as a model private-public partnership;

- Grant sabbatical leave to experienced full-time employees to update knowledge and skills;
- Institute appropriate continuing professional development and vocational training programmes for district hospital practitioners;
- Address the inappropriate primary health care load at district hospitals, with better functional integration of district health services;
- Improve relations with management and higher levels of care; and
- Implement a strategic plan for a well-motivated rural medical workforce.⁴

The in-depth free attitude interviews used in this study complemented the literature by exploring unarticulated areas of individual experiences. This qualitative approach is appropriate for interpreting the data in order to develop theoretical insights explaining and translating

the meaning of people's perceptions. Systematic rigour was applied to the process by documentation and revision of a quality trail of procedures and interpretations.^{13,15,16}

This study reports substantive evidence reinforcing anecdotal information of struggling rural hospitals with stressed staff trying to serve their communities. Our findings confirmed that substantial after-hour duties, an excessive workload and a perceived lack of management support impact negatively on rural district hospital doctors.^{8,14,17,18} The inverse performance spiral assists our understanding of the influence of the working conditions on medical practitioners. Interventions aimed at reversing the cascade of events at any point in the spiral can be valuable in improving staffing and the quality of care in district hospitals.

Dissatisfaction with the workload is the single most important factor influencing a doctor's decision to leave rural practice, particularly the doctor's perception of the workload.¹⁰ Unless these factors are addressed, rural district hospitals in the Western Cape will not be able to retain the services of experienced practitioners and equity of access to health care will remain an unfulfilled challenge in the rural communities.

CPD Questionnaire p.45

Acknowledgements

We wish to thank the following people for their valued assistance with various aspects of this work namely Athol Kent, Joey Cupido, Ann Lloyd, Shantall Renecke, Pierre de Wet, Bob Mash, and the Health Systems Trust. ✨

References

- Bateman C. Baptism of fire for young doctors. *S Afr Med J* 2001;51(10):792-3.
- Verkuijl S. At the coalface. Being a rural doctor in South Africa: a personal story. *CME* 2002;20(10):664-6.
- National Department of Health Task Team: Maternal, Child, Women's Health and Nutrition Cluster. *Skills and Competencies of Interns and Community service doctors*. Pretoria: Department of Health; 2002.
- Engelbrecht B, Bamford L, Grazin N, Isaacs G. *The first lady of the Northern Cape – hospital management in Gordonia District Hospital*. Durban: Health Systems Trust; 2000.
- Edginton ME, Holst HE. Doctors in rural hospitals in KwaZulu and Natal. *S Afr Med J* 1991;80:511-2.
- Sankar U, Jinabhai CC, Munro GD. Health personnel needs and attitudes to rural service in KwaZulu-Natal. *S Afr Med J* 1997;87(3):293-8.
- Cameron D, Blitz J, Durrheim D. Teaching young docs old tricks – was Aristotle right? An assessment of the skills training needs and transformation of interns and community service doctors working at a district hospital. *S Afr Med J* 2002;92(4):276-8.
- Jacques P. Recruitment and retainment of staff in rural areas. *S Afr Fam Pract* 1994;15(7):398-400.
- Reid S. *Crisis in staffing of rural hospitals*. Position Paper. Durban: Rural Doctors Association of Southern Africa; 2001.
- Mainous AG, Ramsbottom-Lucier M, Rich EC. The role of clinical workload and satisfaction with workload in rural primary care physician retention. *Arch Fam Med* 1994;3:787-92.
- College of Family Physicians of Canada, Society of Rural Physicians of Canada, Society of Obstetricians and Gynaecologists of Canada. Joint Position Paper on training for rural family practitioners in advanced maternity skills and caesarean section. *Can Fam Phys* 1999;45:2416-22.
- Solanke TF. Training of medical practitioners in Nigeria (West Africa) for surgery in the rural areas. *S Afr J Surgery* 1997;35(3):139-41.
- Mash B. *The development of distance education for general practitioners on common mental disorders through participatory action research* [dissertation]. Tygerberg: Stellenbosch University; 2002.
- Jacques P, Reid S, Chabikuli O, Fehrsen S. Developing appropriate skills for rural doctors. Phase 1. *Procedural skills of rural doctors in South Africa*. Durban: Health Systems Trust; 1998.
- Giacomini MK, Cook DJ. User's guides to the medical literature XXIII. Qualitative research in health care. B. What are the results and how do they help me care for my patients? *JAMA* 2000;284:478-82.
- Malterud K. Qualitative research: standards, challenges, and guidelines. *Lancet* 2001;358:483-8.
- Strasser RP. Attitudes of Victorian rural GPs to country practice and training. *Austr Fam Phys* 1992;21(7):808-12.
- Damp MH. A rural general surgeon's thoughts on surgery in South African rural areas. *S Afr J Surgery* 1997;35(3):145-6.