A focus group study on primary health care in Johannesburg Health District: "We are just pushing numbers"

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Abstract

Objectives: South Africa is striving towards a strong primary healthcare system. Since 2007, departments of family medicine have been established in Gauteng to improve quality of care through improved access to doctors, the coordination of health services and better referrals. There have been anecdotal difficulties around clinical quality, the role of the increasing number of doctors and the value of family medicine as a new speciality in Johannesburg since these changes. This study aimed to explore Johannesburg stakeholder views on clinical priorities, the role of doctors and family medicine in primary care.

Design: The study design comprised qualitative focus group discussions.

Setting and subjects: Groups of nurse clinicians, clinic managers, senior managers, doctors and interns within the Johannesburg Health District.

Outcome measures: The content was thematically analysed and a model developed.

Results: There were nine focus groups, with 6-13 participants per group. Addressing staff burnout and poor management were viewed as clinical priorities in primary care. Discussing the role of doctors reflected deep conflict between doctors and nurses. Nurses and managers expected doctors to help to "push the queues". It took some time for further roles, such as helping with referrals, training, research and administration, to emerge. There was initial confusion and tension when participants were asked about family medicine. However, its role was seen as useful.

Conclusion: Nurses appeared to suffer from burnout and resented the increasing burden placed on them with regard to primary care in Johannesburg. There appeared to be confusion with respect to the role of doctors, with doctor-nurse conflict and poor teamwork. This may threaten attempts to re-engineer primary health care in order to increase the presence of doctors at clinic level. The discipline of family medicine can make a difference, but reorganisation of the system is required.

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Introduction

South Africa is striving towards a strong primary healthcare (PHC) system,[1] using the district health system as a building block.[2] The establishment of the district health system has been protracted, despite continued political pressure.[3] District health leadership appears to be poor, and to feature entitlement, inexperience and incompetence.[3] Family physicians, as specialist clinicians in primary care, have embraced the district health system, despite distrust by officials.[4]

Gauteng is a microcosm of South Africa, with its struggle to establish PHC[5] and address the burden of disease.[6] One of the five Gauteng Department of Health goals is to "strength the district health system with caring, responsive quality health services".[7] However, PHC in Gauteng suffers from poor communication, fragmented health services and a hospicentric focus.[5] These contribute to poor service delivery at clinic level. Many patients seek out doctors, bypassing clinics and the referral system, thus overloading central hospitals.[6]

In 2006, the Gauteng Department of Health established departments of family medicine across five health districts in Gauteng. Family physicians were jointly appointed with the university departments of Family Medicine at district level to improve the career path and recruitment of doctors. District family physicians were expected to

Table I: Profile of participants in the focus group discussions

Participants	Number of focus groups	Number of people from Johannesburg Health District	Number of people from City of Johannesburg	Representation by region, or subdistricts A-G in Johannesburg
Nurse clinicians	2	11	14	A (2), B (1), C (4), D (10), E (2), F (2) and G (4)
Clinic managers	2	9	11	A (2), B (1), C (2), D (9), E (2), F (2) and G (2)
Senior managers	1	3	6	Not applicable
Doctors	2	7	6	All regions
Interns	2	15	10	All regions
Total	9	45	47	

coordinate clinical service, and thus improve access to doctors, as well as the quality of clinical care and training.[6] The first author was appointed as the first district family physician for Johannesburg Health District in September 2007, taking over an existing staff of 72 full-time doctors working in community health centres (CHCs) and clinics across Johannesburg. Approximately 600 nurse clinicians in Johannesburg functioned separately from these doctors. Nurses were accountable to PHC nurse managers, who also served as overall clinic managers. There was visible conflict with regard to the role of doctors and the value of family medicine as a new discipline in the DHS. There was a perception by clinic managers that the increased presence of doctors would undermine the role of the nurse clinician in the district health system.

When appointed, the family physicians sought to develop a team-based approach, which proved to be challenging and difficult to implement among clinicians. Previous literature, whereby hospital doctors conducted rural clinic visits,[8] and private general practitioners carried out sessions in township clinics,[9] suggests that clinic teamwork can be challenging when doctors are present. There was a need for better understanding within the Johannesburg Department of Family Medicine of the operations of full-time doctors in the urban public health services of Johannesburg, especially as there was a desire to improve PHC service delivery.[10] The objectives of this study were to describe stakeholder views on priorities for clinical care, the role of doctors and the role of family medicine in Johannesburg primary care.

Method

This was an exploratory qualitative study that used focus group discussions. Five groups of stakeholders (doctors, interns, nurse clinicians, clinic managers and senior managers) were purposively sampled from all seven subdistricts in the Johannesburg Health District. This was carried out with the help of provincial (Johannesburg Health District) and local government (City of Johannesburg) managers. An information sheet was circulated to managers to recruit participants, with telephonic reminders of the meetings and purpose. The second author, as a trained member of the Department of Family Medicine at the University of Witwatersrand, conducted the discussions and audiotaped them, following written informed consent. The focus groups were continued until saturation of data was reached. This was achieved with nine focus groups (two with nurse clinicians, two with clinic managers, one with senior managers, two with doctors and two with interns).

The following three open-ended questions were used, and featured reflection, summarising and clarification:

- What do you see as the clinical priorities of primary care?
- What are your views on the role of doctors in primary care?
- What are your views on family medicine in primary care?

The audiotapes were transcribed verbatim and cross-checked. The transcripts were analysed using thematic content analysis and then checked. Approval was obtained from the Human Research (Medical) Ethics Committee of the University of Witwatersrand (R14/49 Moosa). Official permission was also obtained from the authorities.

Results

Nine focus group discussions took place from October 2007 to August 2008 (Table I). (Interns were added as a separate group of doctors). The senior managers were at director and deputy director level.

The responses and results were framed by the three questions pertaining to the clinical priorities of primary care, the role of doctors in primary care and family medicine in primary care. They are presented on that basis.

Clinical priorities of primary care

The overwhelming response was that clinical priorities for primary care should be to address staff burnout caused by the overwhelming numbers of patients seen at the clinics, and limited available time within which to see such a large number of patients. Specific priorities, e.g. triaging, facilities and recordkeeping, were captured within a broad view of poor management in the district.

Burnout of staff

Nurses and doctors were overwhelmed by patient numbers. Nurses and clinic managers were especially unhappy, and complained of lack of information and involvement when planning new services, and the absence of recognition of the role that they play in difficult circumstances. They specifically complained about new programmes being introduced without additional resources being provided.

Burnout was frequently mentioned:

"We are just pushing numbers." - Clinic manager

"This influx causes nurses to be burned out." - Nurse

It was observed that quality was compromised because of lack of time. It was thought that managers focused on programmes, and did not appreciate the difficulties of managing general disease and queues at the clinics:

"If the patients are too many, you can't give the time to the patient, and you can't explore what is going on, and the patients will continue coming back again and again." - Doctor

It was also thought that there was a shortage of staff, as well as a poor work ethic and poor attitude among nurses and doctors.

One senior manager captured the overall sentiment:

"Quality care is not ensured because people are trying to get through numbers. If you don't have adequate staffing, then it demoralises people, and they can't cope with the demands." - Senior manager

Nurses conflicted with managers, who wanted them to go beyond their scope of duty. Trained nurses were unable to implement their new skills. Their widening scope of work caused them to feel ill treated:

"How much are we going to be trained to be abused?" - Nurse

Poor management

There was harsh criticism of managers as many participants thought that planning was poor, and that systems were inadequate, with poor allocation of staff at the clinics:

"From top management to the ground, there are no systems." - Nurse

"Lack of good planning, lack of good implementation. There is zero." - Clinic manager

While managers regarded primary care as a port of entry into the continuum of care, nurses and doctors reported that referral was severely hampered by fragmentation and poor systems between provincial and local government clinics and the hospitals:

"At the moment, the referral system is not functioning properly." – Nurse

"The referral system, it is a nightmare, it really is a nightmare." - Doctor

Participants believed that the lack of triaging and poor referrals between doctors and nurses also compromised clinical quality. This was worsened by extreme fragmentation of district health system facilities, caused by programmes such as verticalised antiretroviral treatment centres. There was lack of communication between doctors and nurses. Doctors thought that they were disempowered in terms of playing a role in wider primary health care.

Training was believed to be very important:

"I also believe triaging is important, right. It's very important." - Doctor

"People need to be empowered to render quality care." - Nurse

It was reported that lack of facilities, including space, equipment and drugs, compromised clinical quality:

"Equipment! Ok. Very, very lacking."

"Hot water (laughter) and ventilation. And sterile soap, we don't even have that!" - Intern

Doctors believed that recordkeeping was a serious problem, and made suggestions for the improvement of information systems. Nurses complained about the lack of patient centeredness and prevention and health promotion activities.

They said that community participation and intersectoral collaboration could change patient behaviour:

"(There needs to be) a change of mindset by the community, by sensitising and influencing them into self-care." - Nurse

The role of doctors in primary care

Discussing the role of doctors reflected deep conflict between the doctors and nurses. Nurses and managers expected doctors to help to "push the queues". It took some time for further roles to emerge, with respect to helping with referrals, training, research and administration.

Nurse-doctor conflict

There was an immediate sense of conflict when nurses and clinic managers discussed the role of doctors. They believed that doctors needed to help with the numbers, and not just the referrals. Some nurses reported that doctors added work, or did not add value, by not working their hours. Some were rebellious. Most of the discussion centred around the number of patients that a doctor should see, when taking his education and training into consideration:

"Their role needs to be clarified because this is the PHC setting, and we need to push the queues." - Nurse

"They should know that we are not helpers, as such, like the type of Florence Nightingale, we also are independent." - Nurse

"He pushes the queue. I like it, because that is the whole aim, to see clients and go." - Clinic manager

This conflict was specifically observed in terms of management control. Nurses insisted that the matron was in charge, whereas doctors believed that doctors should be in a management role, especially with regard to clinical coordination. However, there was agreement that there was a strong need for collaboration between nurses and doctors:

"Maybe he thinks he is the manager of the clinic. So now there is some confrontation (laughter)." - Nurse

"Management always took an attitude … the doctor belonged to the consulting room. We never included him, and that's why sometimes that cooperation we had with our senior clinicians, we have lost it completely. It was never so bad." - Senior manager

"I think we should not forget to always remind doctors that we need them at our meetings; especially our morning meetings with the heads of department." - Clinic manager

"Supposed to work as a team." - Doctor

Senior managers thought that doctors needed to act like consultants, as well as seeing clients, depending on demand. They believe that doctors give confidence to the system.

Emerging doctor roles

After some discussion, nurses and clinic managers recognised the role that doctors could play in managing difficult patients, referrals and emergencies. Nurses believed that a doctor's role was to assist with referrals as he or she could network with doctors at the hospital and identify and manage patients who were really sick or with complications:

"They must help us to network with the doctors at the hospital." - Nurse

A group of nurses also thought that doctors should perform more minor procedures to reduce referrals.

Nurses strongly believed that doctors should train them. Doctors also believed that they had a role to play in training junior staff:

"Doctor as educator." - Nurse

"We should update each other." - Intern

Nurses complained that doctors didn't practice patient centeredness, nor follow the standard guidelines used by the nurses. Doctors said that there were gaps in the nurses' training.

Research was also believed to be the role of doctors:

"Research I think is an important role of the doctor." - Nurse

Nurses said that doctors should be encouraged to conduct research, including audits and reviews of priority health programmes.

"We need to look at the community we are serving." - Nurse

However, interns' believed that this was not core to their work, and that they were not trained for it.

Doctors thought that they should play a community role for continuity and early diagnosis, with a doctor allocated to a specific geographical community, but interns struggled with the concept of community:

"Because most of the time, especially in the urban areas, you have your CHCs, but that's where you end up." - Intern

Doctors, nurses and clinic managers also regarded doctors as having an administrative role to play, such as completing J88 (for assaults) or unemployment insurance fund forms.

Family medicine in primary care

Initially, there was confusion about the role of family medicine, in the light of its newness. However, its role was seen to be useful.

Initial confusion

The initial response by nurses and clinic managers to family medicine was confusion. Some linked it to home remedies:

"No one knows about family medicine." - Nurse

Senior managers said that family medicine was new, and brought useful innovations. Some perceived it to be a threat:

"Why call it family medicine because now I think I am rendering some kind of family medicine." - Nurse

"At primary level, primary (family) medicine is actually not a new thing. They have just attached a new name to it. We had it in the past. We used to go out, and people had family cards, and you would follow-up the whole family, but that's not my issue. My issue at primary level is that the nurses are the backbone of the primary healthcare service." - Senior manager

"Family medicine … when it is coming, it is undermining doctors unfortunately." - Doctor

Interns thought that the current focus at the clinics was to move the queue along, and that primary care in the public service was not suited to the practice of family medicine. There was extensive discussion within doctor and intern

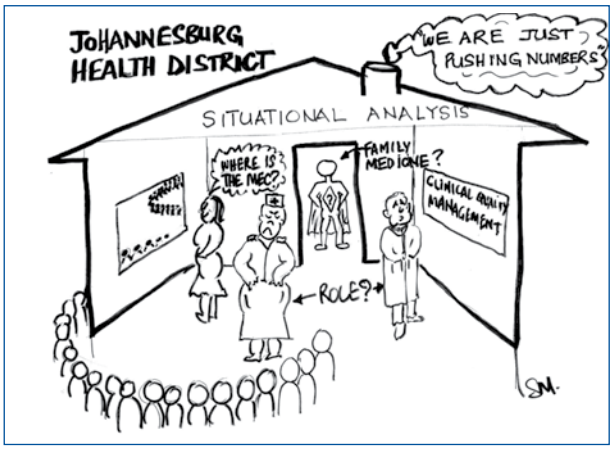

Figure 1: The model, encapsulating the overall results

groups on the need for family physicians within the management structure.

Interns said that knowledgeable family physicians could reduce referrals by improving communication between the clinics and referral hospitals. They were quite cynical about the future of family medicine:

"I think that what we've got is a stop-gap measure, and until we can, you know, make something better, I don't think family medicine will really flower in this setting, and it goes back to management, and to the system itself." - Intern

Useful role

Nurses and managers saw family physicians as supporting quality, and having a large but indirect role in management. Family medicine was seen as valuable, although senior managers were concerned about university links:

"It's the most important speciality." - Doctors

"We should integrate the family medicine philosophy in our primary healthcare approach." - Senior manager

When probed further, nurses' responses were revealing. Comprehensive, preventive and patient-empowering family medicine principles emerged, together with teamwork and continuity:

"It is not just the doctor and the patient. It's the whole service which does family medicine." - Nurse

Many related to the population-based Cuban and British models of health care:

"The doctor is part of the team. The team can be allocated a certain portion of the - in an ideal world, I'm dreaming here - of the community, and the community then becomes the primary (focus); the responsibility of these people." - Nurse

Clinic managers described the Cuban experience as family and community based, and made mention of a similar project in Meadowlands, Soweto. Interns stressed the need for continuity and strong recordkeeping systems.

It was thought that family medicine was essential to build respect for doctors as specialists. Interns regarded family physicians as central to the district health system through the use of a team-based approach:

"I think the whole system should belong to them. I mean, they should be in charge of it." - Intern

The summarised results and a model were presented at a follow-up meeting of participants.[11] Issues which arose included the power struggle between nurses and doctors, the need to change the hospital culture, and the impact of nurse rotations on clinical quality. A draft report was tabled for managers of the district. Changes were not made to the results or to the model. The model, which depicts the results, is captured in Figure 1.

The model, encapsulating the overall results, shows an unhappy, exhausted nurse confronted by long queues. It also depicts a senior manager looking outside, beyond the crowd, focusing more on politicians, than on the nurse's predicament. The nurse is also very displeased with the doctor. She has her back to him as she wants him to help her to "push the queue". The doctor, with his hands in his pocket, appears to be theorising about clinical quality, but is completely bewildered as to how to go about this. A family physician is the new presence at the door. There is no clarity on what his or her face look like, but expectations are high (Superman-like). Expectations include the need for him or her to improve the quality of person-centred clinical care, deal with referrals and practise community-oriented primary care.

Discussion

Strengths of this study were the large number of participants, the wide diversity in service provision and the geographical spread across Johannesburg. Limitations were selection bias, the authority bias of the researcher and the long period of data collection. The active implementation of family medicine may have possibly influenced views. The implications of this study with regard to nurse-doctor clinical teamwork in primary care are manifold and important, and discussed herein.

Clinical priorities

Primary health care re-engineering, PHC outreach proposals and human resource models are strongly premised on nurses. However, nurses appear to suffer from burnout and to resent the increasing burden that is being placed upon them. There is also a challenge with ageing nurses, a declining interest in nursing in primary care, and questionable training quality and competencies.[12] It is very important that the scale of the problem is quantitatively measured with regard to staffing distribution, burden of service, competencies and appropriate use of nurses and

doctors at clinic level. Addressing management capacity is even more important in the district health system than it is in the hospitals; i.e. the current focus of the Minister of Health.

Role of doctors

Family medicine was expected to improve doctors' presence in the Gauteng district health service, and to reduce the number of patients bypassing the referral system.[6] However, this appears to have been confounded by poor teamwork. Similar problems pertaining to complex nurse-doctor conflict were evident in the Western Cape province ("Getting all the patients through the CHC"), and featured fragmented care and an opposing nurse-doctor culture,[13] as well as in the North West province, where there was a need for senior doctors to work with clinic nurses.[8] The re-engineering of primary health care seems to be premised on nurse-driven primary care and task shifting, with very limited focus on teamwork and the doctors' role. Human strategy documents[2] reaffirm the role of medical officers in clinical care,[2] but the latter are criticised for "playing a PHC nurse role" and for "referring extensively" to specialists. Doctors are considered to be essential members of the PHC team,[12] but nurse clinicians and doctors are managed separately, with problems of clinical accountability.

Family medicine

Serious power issues are evident in primary health care. Senior managers believed that nurses were the "backbone of the primary healthcare service". Nurse managers believed themselves to be in charge. However, senior managers realised that they have excluded doctors and lost their cooperation. They wanted to get "the balance right". Communication and role clarity are vital to improve teamwork,[9] but a poorly defined team structure will simply encourage power contests and confound integrated primary healthcare teamwork. Young interns asked why doctors couldn't "be in management roles" and thought that family physicians "should be in charge". While the issue may be complex, it is clear that confused lines of supervision and accountability, with more doctors at clinic level, may produce more power struggles.

Conclusion

The aim in setting up the district departments of family medicine was to strengthen the district health service with a clear, holistic team-based programme, and to improve access to comprehensive primary health care across Gauteng.[6] However, the district health service is seriously challenged by staff burnout, poor management and nurse-doctor conflict. There are constructive views on the role of doctors and family physicians, but they need to be supported by detailed policy. A well structured, team-based health system can deliver accountable, population-based care.[14] However, an intern's remark, previously mentioned, seems to be prescient:

"I don't think family medicine will really flower in this setting, and it goes back to management, and to the system itself." - Intern

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Conflicts of interest

The authors declare that writing this paper was not inappropriately influenced by any financial or personal relationships.

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