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# A survey of South African psychiatrists

Analysis of the demographics, interests and clinical practices of psychiatrists registered in South Africa in 2008

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## DECLARATION

I, Judith Bentley, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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## **PART A**

### **PROTOCOL**

#### **A survey of the professional activities of psychiatrists in South Africa in 2009**

##### **Introduction**

As we move toward 2010 we retain in South Africa the intention to transform our mental health care system to one based on a primary mental health care approach (eg. The Comprehensive Service Plan, WCape). The rationale behind this system is one of equitable and easy access for all to health and mental health services close to home.

In 1993, Flisher, Riccitelli, Jhetam and Robertson conducted a survey of all the registered psychiatrists in South Africa in order to obtain demographic data and details of their professional practices. This is now fifteen years out of date and it is important to replicate this study and compare our current situation with that in 1993 to see how far we have come towards attaining the goal of having psychiatrists of all subspecialties easily accessible to people in all areas of South Africa, proficient in all the South African languages and with an equitable split between state and private practice.

##### **How many psychiatrists are there?**

The study by Flisher et al was published in 1997 in *Psychiatric Services* and described the characteristics and professional activities of psychiatrists registered with the HPCSA at June 30 1993 (Flisher et al 1997). Findings from that survey indicated that the psychiatrist to population ratio was 6.4 psychiatrists per million population. In a survey of public sector psychiatrists, Lund et al (2002) recorded this figure as 0.4 psychiatrists per 100 000 population and both sets of authors note the vast discrepancy between the provinces, with 77% of the total number of psychiatrists practising in Gauteng or the Western Cape.

Internationally the bulk of the work done in this area comes from the USA, Canada and Australasia. In the USA in 2003 it was noted that the total number of psychiatrists had grown by 86.7% since the 1970s giving a total of 16.5 psychiatrists per 100 000 population (Scully and Wilk 2003). In New Zealand this figure is 7.14 per 100 000 (again with vast differences between different regions) and in Australia there are 11.6 psychiatrists per 100 000 in the urban areas but only 2.8 per 100 000 in the rural areas (Lau et al 2004).

### Where are all the psychiatrists?

The 1993 survey showed that, of the 261 psychiatrists then practising in the country, 56.3% were in full-time private practice (servicing 20% of the country's population (Emsley 2001)) (Flisher et al 1997). Trends towards greater privatisation are present in the USA (Dorwart et al 1992) and in France (Georg et al 1999, Lafitte et al 1996) (where almost 50% of private psychiatrists utilise psychoanalytic psychotherapy as their chief treatment modality). It will be interesting to note whether, in South Africa, we are managing to retain and recruit psychiatrists in the state sector or whether psychiatrists are choosing the private sector in ever greater numbers. There is also a perception that psychiatrists are choosing to emigrate and the reality behind this perception needs to be explored.

In addition, of the registered psychiatrists in 1993, only 7% spent any time working in rural areas and only 10.8% could communicate proficiently in one or more African languages (excluding Afrikaans) (Flisher et al 1997). The urban/rural split reflects international trends with much higher psychiatrist to population ratios in urban areas being the norm in most countries where figures are calculated (eg Japan – Tsuchiya and Takei 2004; USA – Gillie et al 2001; Canada – Hodges et al 2006; Australasia – Lau et al 2004; France – Verdoux et al 2003). There have been concerted efforts in South Africa to redress this imbalance in a number of ways, but it is not yet clear if these efforts have been successful.

### Do women and men psychiatrists practise differently?

Differences in the practice of male and female psychiatrists become important when one notes the increasing feminisation of medicine (Price and Weiner 2005) and of psychiatry in many countries including our own (Flisher et al 1998; Gillie et al 2004; Garfinkel et al 2001; Georg et al 1999). In Canada it would appear that more women than men specialise in child, geriatrics and women's mental health, and that these women do less research (Garfinkel et al 2004). In South Africa there would appear to be fewer differences between male and female psychiatrists except that the latter are more inclined to have a special interest in child and adolescent psychiatry (Flisher et al 1998).

### What are their main areas of professional interest?

In the 1993 survey, 61.3% of psychiatrists reported a special interest in biological psychiatry, 56.2% reported a special interest in psychotherapy, 32% in research, 24.7% in child and adolescent psychiatry, 24.2% in consultation-liaison psychiatry, 23.7% in community psychiatry, 23.7% in forensic psychiatry, 18% in substance abuse and 13.9% in geriatric psychiatry. Fewer than 10% indicated an interest in administration, epidemiology or mental retardation. Questions were not expressly asked about an interest in HIV/AIDS and psychiatry (Flisher et al 1997).

Areas of interest vary quite widely from country to country, but there is a definite discernable trend internationally towards subspecialisation. Of all the subspecialties, child and adolescent psychiatry has experienced the greatest boom – especially in the USA where the number of child and adolescent psychiatrists has increased by 194.6% since 1970.

### How do psychiatrists spend their time?

As expected, there were marked differences between the activities of psychiatrists in private and state employ (Flisher et al 1997) and this is likely to have remained the case. However, because of our relative dearth of psychiatrists both overall and especially in the state sector, the authors of the 1997 article recommended that, in a primary mental health care system the traditional role of the psychiatrist might need

to change to include a greater emphasis on the training and continuing education of those providing direct clinical services (predominantly mental health carers other than psychiatrists), consultation-liaison, policy development, service planning and research. In 1993 these activities formed only a small part of the daily activities of those surveyed and this issue will be addressed and expanded upon again in the present study.

## **The study**

### **Purpose**

To repeat the survey performed in 1993 in order to determine whether or not the last 15 years have resulted in a greater number of psychiatrists being more accessible to the majority of the South African people. In addition, attention will be paid to structure of each psychiatrist's practice to determine whether or not there has been any shift towards the proposed changes in the way of working as outlined by Flisher et al in 1997.

### **Objectives**

1. To document the characteristics of the psychiatrists currently registered in SA in terms of age, gender, marital status, number of minor dependants, geographical location, private/public sector, languages in which they are competent to practice, areas of specialty, time spent on different work-related activities, and patient demographics.
2. To compare the current data with that obtained from the 1993 survey.
3. To analyse the data to determine if there are any discernable trends linking either the nature or location of the practice with the demographics of psychiatrists eg do Xhosa speaking psychiatrists remain in the Eastern or Western Cape to practice, are Black psychiatrists more inclined to practice in rural areas, do women tend to stay in the public sector etc (Price et al 2005).

### **Implementation objectives**

1. To present the obtained data and recommendations in a publishable format for publication in a peer reviewed journal.
2. To inform planning for retention, recruitment and placement of psychiatrists
3. To inform planning for training of psychiatrists
4. To formulate suggestions for further research based on the data elicited by the survey. The intention is to develop a research base for planning for an equitably distributed and satisfied psychiatric workforce.

### **Methodology**

This will be a cross-sectional descriptive and analytical study of all the psychiatrists registered as specialists with the HPCSA in 2009.

The medical and dental register has been obtained from the HPCSA and a database will be formed from this. Email addresses of registered psychiatrists will be obtained from SASOP, Medpages and university websites.

### **Ethical considerations**

The protocol has been presented to the Department of Psychiatry at the University of Cape Town. Ethical approval has been obtained from the relevant research committees.

Consent will be obtained from each respondent at the beginning of the questionnaire.

Anonymity will be assured using the procedures outlined below. Participation will be entirely voluntary and no remuneration will be offered for participation.

### **Questionnaire**

A questionnaire will be developed to capture the information required to fulfil the objectives outlined above. Please see Appendix 1.



## Procedure

The questionnaire will initially be piloted on 20 South African psychiatrists. Following necessary amendments, the final questionnaire will be sent by email or mail to all psychiatrists registered with the HPCSA in 2008. Consent will be obtained at the beginning of the questionnaire.

For those receiving questionnaires by mail, anonymity will be maintained by having no indication of the psychiatrist's name on the questionnaire itself. Respondents will be required to write their name on the return envelope to enable tracking of non-respondents, however the envelope and questionnaire will be separated immediately on receipt by administrative personnel.

For those for whom email addresses are obtained, a third administrative person will send and receive the emails. On receipt of the completed questionnaire, a record will be made of the receipt, and the questionnaire separated from the original email such that there is no way of identifying the respondent on the questionnaire.

Non-respondents will be followed by email or telephonically on two further occasions.

The survey results will be distributed to all respondents.

## Data analysis

All data will be entered onto an Excel spreadsheet and standard statistical tests used to determine mean values, confidence intervals and statistical significance of differences between measures as appropriate.

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## PART B

### Literature Review

#### **Objectives**

The objectives of the literature review are as follows:

1. To determine what data already exists regarding the demographic characteristics and clinical practice of psychiatrists in South Africa
2. To determine what still needs to be researched regarding the demographic characteristics and clinical practice of psychiatrists in South Africa
3. To gain an appreciation of international trends and norms regarding the demographics and clinical practice of psychiatrists

#### **Literature Search Strategy**

I searched three databases (Psycinfo, Pubmed and Medline) using the following search terms:

South Africa\* AND (psychiatrist\* OR mental health care worker\*)

Psychiatrist\* AND (characteristics of)

#### **Inclusion criteria**

1. Human subjects
2. English language
3. Articles published in peer-reviewed journals
4. Review or original articles studying psychiatrists, their demographics, their characteristics or the characteristics of their practices

#### **Exclusion criteria**

1. Not in English
2. Articles published in non-peer reviewed journals, books or electronic media
3. Articles not pertaining to psychiatrists (eg other mental health care workers only), their demographics, their characteristics or the characteristics of their practices

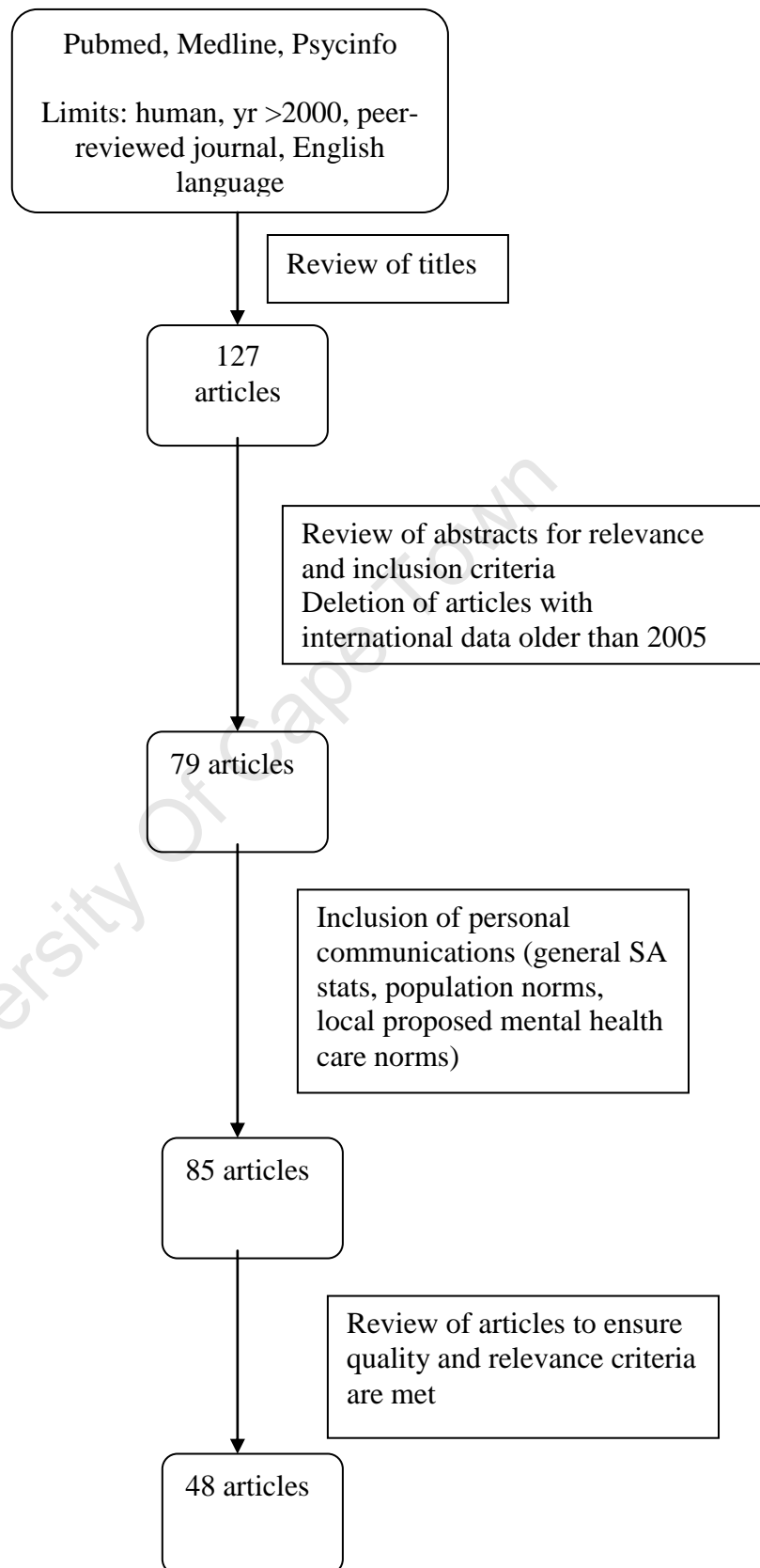
4. Articles published prior to 2005 (for international data) or 2000 (for South African data) unless of historical importance (eg to demonstrate trends)
5. Opinion pieces without a substantial literature review

I obtained a further six reports through personal communications. These were sought out to provide context for the review and included general South African demographics and South African mental health care norms.

#### Quality criteria

Review articles were included if they clearly indicated and made explicit a systematic search strategy, and were published in a peer reviewed journal. Original articles were included if they were based on a sound research study (this was most commonly a survey). Studies were considered to be sound if sampling methods and sample size were designed to minimise bias and maximise generalisability of results, methods of data analysis were described and valid, and if the discussion included an examination of the generalisability of results and the presence or absence of bias in the data.

**Flowchart of search strategy:**



## Summary of the Literature

### Characteristics and Demographics of South African Psychiatrists

In 1993 there were 261 psychiatrists practicing in South Africa, 147 of them (56.3 percent) in full-time private practice (serving approximately 20% of the country's population). This translated to a ratio of 6.4 psychiatrists per million citizens (0.64:100 000) with large discrepancies between provinces (eg 2.47: 100 000 in the Western Cape and 0.02:100 000 in the Northern Transvaal). Only 10.8 percent of those psychiatrists practising in South Africa could communicate in one or more African languages (excluding Afrikaans).<sup>1</sup>

20.8% of the sample were women who were, on average, younger than their male colleagues. Women tended to have a higher mean percentage of patients presenting with disorders first manifesting in infancy, childhood or adolescence than their male colleagues, but there were no other significant differences between genders in terms of patient profile.<sup>2</sup>

By 2001 there were 429 registered psychiatrists, though the proportion of those working within South Africa at that stage was not known.<sup>3</sup> By 30 June 2004, 539 psychiatrists (two-thirds of whom were male) were registered with the Health Professions Council of South Africa but only 60% were practising in the country.<sup>4</sup> There therefore seemed to be a trend for increasing numbers of psychiatrists to be registered in the country with an increasing proportion of them female, but details regarding their demographics and comparisons with local and international norms were absent.

The first comprehensive survey of national public mental health services in South Africa was conducted under the auspices of the Mental Health and Poverty Project in 2005.<sup>5</sup> At that stage, the public sector psychiatrist per 100 000 population ratios per province were as follows:



<u>Province</u>	<u>Psychiatrist:100 000 population</u>
Western Cape	0.8
Gauteng	0.8
Kwazulu-Natal	0.3
Eastern Cape	0.2
Mpumulanga	0.2
Northern Cape	0.1
North West	0.1
Free State	0.1
Limpopo	0.1

**Table 1: Psychiatrists per 100 000 population by province in South Africa, 2005**

Two things are strikingly clear from this data: firstly, there are large disparities in the number of psychiatrists in each province and, secondly, few provinces even approach community psychiatrist to population norms proposed by Flisher et al (2:100 000) or the norms for core essential services developed by Chisholm et al (1.2:100 000 for low income countries and 2:100 000 for middle income countries), let alone norms for the entire psychiatric service.<sup>5-7</sup> This is confirmed by a more localised study of community services in Southern Gauteng.<sup>8</sup>

Child and adolescent health services (CAMHS) are also grossly underserved in all provinces compared to international norms.<sup>9,10</sup>

### **International data**

#### **Africa**

There is little data available for other African countries, but in those in which data is available the numbers of psychiatrists are few and inequitably distributed between urban and rural areas, and richer and poorer provinces.

In Kenya in 2007 there were only 53 psychiatrists for a population of 31.5 million (a psychiatrist to population ratio of 0.17:100 000). Up to 34% of Kenyan psychiatrists are in private practice, and of the remaining 66% (35 psychiatrists) more than 20

occupy full time administrative or academic positions and are therefore not available for full time clinical work.<sup>11</sup>

No comprehensive surveys were found on other African countries, but it would seem that the majority of sub-Saharan African countries have fewer than one psychiatrist per million population.<sup>12</sup> In fact in Malawi in 2006 there was only one qualified psychiatrist for a population of approximately 13 million.<sup>13</sup> ([www.nso.malawi.net](http://www.nso.malawi.net).)

#### The rest of the developing world

Outside of Africa the statistics are not always better. For example, in Pakistan the psychiatrist to population ratio is 0.16:100 000. Less than half of the psychiatrists have a postgraduate qualification in psychiatry, and psychiatry training is not a prerequisite for students to graduate with a medical degree.<sup>14</sup>

In India the psychiatrist to population ratio is 0.4:100 000, in Bangladesh and Sri Lanka 0.1:100 000 and in Nepal there are only 25 psychiatrists in the whole country.<sup>15</sup> Gender splits are not discussed in most of these articles, but Ruksheda does note that in 2008 women psychiatrists still made up less than 10% of the psychiatric workforce in India.<sup>16</sup>

#### The developed world

The developed world fares considerably better in terms of numbers of psychiatrists. Even in countries that have struggled economically or politically in the recent past, psychiatrist to population ratios are enviably high. For example, Bulgaria has a ratio of 10.04 psychiatrists to 100 000 population, Slovakia 10.38: 100 000, and Slovenia 10: 100 000. However, psychiatric training and subspecialist training varies greatly in quantity and quality between countries.<sup>17</sup>

France has one of the highest psychiatrist to population ratios in the world (23:100 000), but this abundance poorly reflects huge regional inequities. Additionally, a large number of private French psychiatrists practice psychoanalytically orientated psychotherapy exclusively and do not prescribe.<sup>18</sup> The French ratio compares favourably even with the wealthy USA which has an overall psychiatrist to population

ratio of 16.5:100 000 (14.3:100 000 general psychiatrists and 2.2:100 000 child psychiatrists).<sup>19</sup>

Even in the developed world there are countries or provinces with too few psychiatrists. The WHO recommends a ratio of 10 psychiatrists:100 000 population but, while urban Australia is doing well at 11.6 psychiatrists per 100 000, there are only 2.8 psychiatrists per 100 000 in the rural areas.<sup>20</sup> New Zealand also falls short of the WHO recommended ratio of 10:100 000 with an overall ratio of 6.67:100 000 and with gross inequities between regions.<sup>21</sup> The United Kingdom claimed a shortfall of psychiatrists of 12% in 2004 with peaks well above this in certain subspecialties and geographic regions,<sup>22</sup> and Japan just falls short of the WHO recommendation with a ratio of 9.4:100 000.<sup>23</sup>

Although there is a general international trend for an increase in the actual number of psychiatrists, the cohort as a whole is getting older leading to concerns that this growth is not sustainable. In addition, the percentage of women psychiatrists has risen considerably, and both women and older people have been noted to work fewer hours. The concern is, therefore, that in future there will be insufficient full-time-equivalent psychiatrists to cope with the caseload internationally.<sup>24</sup>

Not only are the numbers of psychiatrists generally below the desired norms, but there is also an inequitable distribution of psychiatrists in all studied countries with the bulk of psychiatrists practicing in the urban areas. This is as true for Canada, the USA and New Zealand<sup>24-26</sup> as it is for South Africa.<sup>1</sup>

Worryingly for the developing world, countries such as the USA (with 16.5 psychiatrists per 100 000 population)<sup>19</sup> and New Zealand (7.14 per 100 000)<sup>20</sup> rely heavily on overseas-trained psychiatrists. More than half of New Zealand's psychiatrists and one fifth of the USA's specialist population are overseas trained.

<sup>19,20</sup>

### Gender and ethnicity

Throughout the Western world and in South Africa as reported earlier, psychiatrists are predominantly Caucasian males. In the USA, Australia and New Zealand they are also predominantly English speaking.<sup>1,20,27</sup> However, women are forming an

increasingly large proportion of the psychiatric workforce and this is likely to continue to increase – at least in Western countries – as they currently represent a small majority of medical students.<sup>19,28</sup>

Although few differences were noted between women and men in the South African study,<sup>2</sup> international studies tend to show that women work fewer hours (up to 13% fewer) than their male counterparts, were younger and earned less. Earnings were lower even after adjustment for workload and practice characteristics.<sup>28</sup> Additionally, women psychiatrists in Scotland intend to retire significantly earlier than their male counterparts.<sup>29</sup>

### **Practice characteristics**

Psychiatric practice in South Africa is split into two main groups – state employed and private practitioner – with a considerable overlap between the groups with state psychiatrists doing limited private work and private psychiatrists doing sessions in the public sector.<sup>30</sup> However, in general the two groups have quite different practices. Additionally, public sector doctors may be affiliated to universities and work up to a third of the 40-hour working week in academic work.

The survey by Flisher et al in 1993 showed that academic psychiatrists were working a mean of 49.5 hours per week and spending 14.8 hours in direct patient care, 6.9 hours attending ward rounds, 8.2 hours performing administrative work, 5.7 hours conducting research, 7.6 hours teaching and 2.7 hours in consultation liaison work. Those in private practice were working a mean of 48.8 hours per week with 43.2 hours in direct patient care.<sup>1</sup>

The authors assert that, because of the relative scarcity of psychiatrists in the country, academic psychiatrists and those in the public sector should focus on the training and continuing education of those providing direct clinical services, consultation-liaison, policy development, service planning, and research.<sup>1</sup>

The only current South African study is of psychiatrists in a primary health care setting where they should theoretically be fulfilling a predominantly supervisory role. However, in this Southern Gauteng survey, psychiatric care was provided primarily

by psychiatrists, registrars and psychiatric nurses, with minimal support from primary health care workers, psychologists, social workers or occupational therapists.<sup>8</sup>

There is no current South African literature on the different working patterns between the private and public sector doctors, and between public sector doctors with or without academic affiliations.

#### International public/private split

Healthcare funding policies and practice vary considerably between countries and even between states and/or provinces within countries. It is therefore difficult to make international comparisons with respect to the public/private split. However, two examples are given below.

In the USA psychiatrists tend to work in both the public and the private sector. There has been a steady increase in the time psychiatrists spend in the public sector since 1982 when a survey revealed that 57.7 percent of psychiatrists worked primarily in private practice. By 1989, that figure was down to 45.1 percent and more recent studies show that psychiatrists are now spending as much time in organizational settings as in private office practice. This has been attributed to the fact that state psychiatrists are spared the business side of practice, receive a steady salary and do not have to accept rates set by medical insurance schemes.<sup>27</sup>

In Australia approximately 19% of psychiatrists work exclusively in the public system, while twice as many work exclusively in private practice. About two-fifths (41%) work in both. A small number are academics (3%) or administrators (1%) and some of these do clinical work in the public or private systems or both.<sup>31</sup>

#### Time spent at work

In the UK, psychiatrists work a total of 44.2 hours per week, excluding time on call. This includes a mean of 1.9 evenings per week and 1.7 weekends per month.<sup>22</sup>

In the USA psychiatrists are spending less time at work than in previous years with psychiatrists working an average of 48.2 hours per week in 1989 and only 42.5 hours per week in 2002. This has been attributed to the increased average age of

psychiatrists in 2002 (55 years) and the fact that there were greater numbers of women. Women and older psychiatrists have previously been shown to work shorter hours. However market forces may also come into play as it would appear that greater numbers of patients are being seen despite the shorter hours.<sup>19</sup>

There is little data from other countries, but a survey in India showed that psychiatrists see around 50 patients per day in an outpatient clinic with around twenty new patients and 20 to 30 follow up patients.<sup>32</sup> This is an enormous case load and clearly must influence the nature of the consultation.

### **Subspecialisation and special interests**

The literature in this area is confusing as authors vary considerably in terms of what they consider to be a subspecialty or special interest. They also do not always indicate whether they are referring to registered subspecialties or merely a chosen focus area of the psychiatrists being studied. Certainly in South Africa there is currently only one registerable subspecialty (child and adolescent psychiatry) although a number of others are before the Health Professions Council (HPCSA) for review.

### **Trends**

Internationally there appears to be a trend towards subspecialising – either formally or informally. Child and adolescent psychiatry in particular has grown enormously as a subspecialty, as has biological psychiatry (as opposed to a predominantly psychotherapeutic approach). Six subspecialties appear most commonly in the literature as areas of change, and these are discussed below. Forensic psychiatry appeared frequently as an area of interest but was not specifically discussed in the literature reviewed.<sup>18,20,23</sup> Using search terms specific to each subspecialty would undoubtedly have yielded a more comprehensive coverage of the literature, but was beyond the scope of this review.

### **Child and adolescent psychiatry**

The most comprehensive study of child and adolescent mental health services (CAMHS) in South Africa was published in 2004 by Dawes et al. At that stage the

authors noted that there were very inadequate CAMHS services in all provinces and that the integration of these services into the primary health care system lagged behind that of general psychiatry. The psychiatrist to child and adolescent population ratio cited in that study was taken from 1997 figures and was 0.1:100 000 (the same ratio as in Japan).<sup>9,23</sup> There was no data obtainable at that stage from other African countries or countries comparable to South Africa. WHO norms are 2.9:100 000.<sup>9</sup>

The developed world fares somewhat better with the USA having 9 psychiatrists per 100 000 child and adolescent population, Germany 4.3 and Quebec (Canada) 13.25.<sup>9</sup> In particular, the USA has seen an enormous growth in the subspecialty with numbers of general psychiatrists increasing by 86.7% and child psychiatrists by 194.6% over the last thirty years.<sup>19</sup> However, the USA still claims a shortage of child and adolescent psychiatrists, particularly in the poorer and more rural areas. Despite this inequitable distribution, in 2001 there were no states with fewer than 2 child and adolescent psychiatrists, although up to 50% of metropolitan counties (subdivisions of states) had none.<sup>33</sup>

#### Intellectual disability psychiatry

The bulk of literature reviewing psychiatrists in intellectual disability services comes from Australia and Canada, although this does not necessarily reflect where these services are best developed. Flisher's 1997 report indicated that less than 10% of South African psychiatrists expressed an interest in intellectual disability (formerly referred to as mental retardation). In Queensland, Australia, the majority of psychiatrists expressed concerns about treating this group and 43% of those surveyed were reluctant to treat adults with intellectual disability at all. 75% of the psychiatrists felt they needed more training in dual diagnosis (people with mental illness and intellectual disability) with priority areas identified as the assessment and diagnosis of people with ID, the recognition of depression, psychosis and mood disorders, and the management of complex behavioural problems.<sup>34</sup>

In Canada services are organized on a provincial rather than a national level and therefore vary across the country. Most of the medical schools do not have special programs or divisions in intellectual disabilities and intellectual disability is not a recognized subspecialty in family medicine or psychiatry. Training of mental health professionals in intellectual disability is seen as suboptimal and specialized services

few and far between. The situation is further complicated for those with both mental illness and intellectual disability as the funding for the care of these individuals comes from two separate government agencies leading to uncertainties about who is in fact responsible.<sup>35</sup>

Services in the United Kingdom and the USA are relatively well developed, but not well described in the literature reviewed for this study.

### Psychotherapy

Internationally there appears to be a trend away from providing psychotherapy during consultation and a move toward a more biologically orientated psychiatric practice.<sup>36,37</sup> In Flisher's 1997 study, 56.2% of South African psychiatrists expressed a special interest in psychotherapy and it would be interesting to see what the current figures show.<sup>6</sup>

This trend away from providing psychotherapy is particularly prominent in the USA. In 1996/7, 44% of psychiatrist visits included psychotherapy. By 2004/5 this figure had decreased to 28.9%. The number of psychiatrists providing psychotherapy to all their patients decreased from 19.1% to 10.8% over this same period.<sup>37</sup> This decline has been attributed to financial incentives (reimbursement in the USA for one 45 to 50 minute psychotherapy session is 40.9% less than reimbursement for three 15 minute medication management visits), an increase in the number of medications available to treat psychiatric illness, a growth in the public acceptance of these medications, a focus on short term therapies (such as cognitive behavioural therapy) rather than long-term therapy, and increased incentives to refer patients to other mental health care providers for therapy.<sup>36-38</sup>

### Old age psychiatry

13.9% of South African psychiatrists expressed an interest in old age psychiatry in 1997.<sup>1</sup> In the USA in 2002, about 25% of psychiatrists were designated as high geriatric service providers but only 31% of them were certified subspecialists. Those who were certified subspecialists tended not to have exclusively geriatric practices and Colenda and colleagues comment that this seems to imply there is little incentive to subspecialise.<sup>39</sup>



### Addiction psychiatry

18% of South African psychiatrists indicated an interest in substance abuse in 1997.<sup>1</sup> Currently in the England there are 117 full time equivalent addiction psychiatrists, which equates to approximately 0.23:100 000 population (given a population estimate for England of 51.4 million ([www.statistics.gov.uk](http://www.statistics.gov.uk))). The Royal College of Psychiatrists recommends four times this number and the rate of the recruitment to the subspecialty is insufficient to result in an improvement of the situation.<sup>40</sup>

### Management and administration

Fewer than 10% of South African psychiatrists indicated an interest in administration in the 1997 survey.<sup>1</sup> This topic is not extensively explored in the literature but mention is made of the fact that, although there is support for psychiatrists to enter into management positions, they often feel inadequately trained for the role and feel a lack of support from clinical colleagues. Those still in clinical work appear to devalue the role and feel that management is 'easy to learn' and can be done by any experienced clinician.<sup>41</sup>

### Job satisfaction and stress

There is a fairly extensive international literature from the developed world concerning both the levels of satisfaction experienced by psychiatrists in their work and the amount of stress and burnout they experience. To my knowledge, there is no relevant South African literature in this area.

### Levels of job satisfaction

Stress and burnout are generally directly correlated with lower levels of job satisfaction<sup>21</sup> although certain groups (such as women academic psychiatrists) describe relatively high levels of job satisfaction despite being stressed.<sup>42</sup>

88% of Australian psychiatrists say they are satisfied with their work yet 15% said they would not study psychiatry again.<sup>31</sup> In the United Kingdom 55.8% of psychiatrists were satisfied or very satisfied and 21% dissatisfied or very dissatisfied

(leaving 23.2% neutral).<sup>22</sup> This means that almost half the UK psychiatric workforce does not derive much satisfaction from their work life. Psychiatrists in the USA are even worse off. While 25% of Texan psychiatrists were considering leaving the field, 70% of those in Manhattan said they would not recommend a career in private practice. It is not clear how many of these would be happy to switch to the public service and still remain within psychiatry. Canadian psychiatrists seem less dissatisfied than those in USA.<sup>43</sup>

General adult psychiatrists in the UK have significantly lower levels of job satisfaction than subspecialists,<sup>22</sup> and women appear to be less satisfied and more stressed than their male counterparts.<sup>29,31</sup>

The effect of age seems to vary across the world. In the USA older psychiatrists in solo practices are particularly dissatisfied whereas in the UK the older psychiatrists are happier with their lot.<sup>31,44</sup> The reasons for these differences were not explored in these articles.

#### Factors influencing job satisfaction

There are four established predictors of job satisfaction in psychiatry: an adequate degree of autonomy (the ability to make independent clinical decisions freely), good relationships with patients (satisfaction with the duration and quality of consultations), financial compensation, and low administrative burden.<sup>29,45,46</sup>

Additional factors enhancing job satisfaction that were cited by individual authors included having time to develop a special interest<sup>29</sup>, support from others (from management, colleagues and a multidisciplinary team)<sup>46</sup>, a belief in the intrinsic value of psychiatry, satisfaction with psychotherapeutic work, a low degree of emotional burden from patients<sup>43</sup>, a sense of belonging, enhanced self-esteem, self-actualisation<sup>47</sup> and intellectual stimulation.<sup>43</sup> Community psychiatrists in the USA were the only cohort to rank control of life (limited calls) as being important.<sup>48</sup> This is contrary to reasons given for choosing psychiatry as a career in the first place where lifestyle and time factors rank more highly.<sup>22</sup>

Private and public sector psychiatrists in Australia give different reasons for dissatisfaction with their work. Private psychiatrists identified litigation/indemnity

issues as the most frequent cause of dissatisfaction (69%), while the most common factor for public psychiatrists was a lack of beds (47%). The main reason for satisfaction was helping patients get better (72%).<sup>31</sup>

Female psychiatrists with academic affiliations (versus those without) expressed a significantly higher degree of economic and career satisfaction, but reported higher levels of stress.<sup>42</sup>

### **Emigration**

It is a common perception amongst colleagues that many South African psychiatrists have emigrated or are planning to emigrate, though no local literature was found to support this. International literature states the numbers of international medical graduates but does not specify their origin so it is not clear whether or not a significant proportion of these psychiatrists originate from South Africa.

Almost all of the work studying the emigration of psychiatrists has been done in New Zealand where many psychiatrists choose to work in the more lucrative and resourced posts in Australia.<sup>20</sup> The most common reasons given for wanting to emigrate include higher remuneration, better professional support and development, improved career opportunities, being closer to family members and stress or burnout. Those that wanted to stay in New Zealand appeared to have different values and tended to cite lifestyle factors as a reason to stay in the country.<sup>20</sup>

As mentioned above there is very little literature from Africa, but the one Kenyan survey found that those who trained within the country tended to stay in the country, were more likely to work in rural rather than urban areas and in the public rather than the private sector.<sup>11</sup>

### **Areas for further study**

There have been very few South African studies regarding the more detailed aspects of the demographics of South African psychiatrists such as where they practice (which province, urban versus rural), the gender proportions and differences, the languages they speak and their ages, and data that is available is out of date. There has been no study reproducing the data from Flisher et al's 1997 study to determine

whether or not public sector psychiatrists have moved towards a more supervisory role and whether or not the distribution of psychiatrists has become more equitable in terms of language accessibility and location.

There is also no current South African data looking at subspecialisation, special interests, further degrees or research outputs of South African psychiatrists. Without this data we cannot know which areas are in need of special attention.

Finally, I am not aware of any studies looking at the levels of job satisfaction of South African psychiatrists or of their feelings around emigration. This information is extremely important if we are to ensure adequate provision of mental health services to all South Africans in all areas of the country.

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## **PART C**

### **Manuscript prepared for submission to the South African Journal of Psychiatry**

### **A survey of South African psychiatrists: demographic and practice characteristics, job satisfaction and emigration intentions.**

#### **Abstract**

##### Objectives

The objectives of the study were (a) to document the demographic and practice characteristics, levels of job satisfaction and emigration intentions of psychiatrists registered in South Africa in 2008; and (b) to compare the current data with that obtained from a 1993 survey to discern trends and observe if changes suggested following the earlier survey have indeed occurred.

##### Methods

We conducted an anonymous survey of all the psychiatrists registered with the HPCSA in 2008 *via* email, fax or post. Data was entered onto an EXCEL spreadsheet, coded then analysed using PASW statistics (SPMSS) version 18.

##### Results

There were 632 psychiatrists registered with the HPCSA in 2008. Of these, 61 were not in the country at the time of the survey, 31 had retired and 4 were deceased. We obtained 189 usable responses giving a response rate of 35%. The psychiatrist to population ratio has increased since 1993 from 0.64:100 000 to 1.29:100 000 but there is still a markedly inequitable split between provinces with Gauteng and the Western Cape being significantly better resourced than the other provinces. However, most provinces showed a slight improvement in the numbers of registered psychiatrists since 1993. There has also been a significant increase in the proportion of female psychiatrists who are noted to work significantly fewer hours than their male colleagues. Little change was noted in terms of representivity of languages spoken or the proportion of private versus state sector psychiatrists.

Most South African psychiatrists are satisfied or extremely satisfied with their careers, but a third had recently taken steps to explore the possibility of emigration (8% were already outside South Africa at the time of the survey).

### Conclusions

The most marked changes in the South African workforce since 1993 have been the increase in numbers and the large increase in the proportion of women psychiatrists. However, representivity and accessibility are still grossly suboptimal with very little real change occurring in the 15 years between the two surveys.

The number of psychiatrists already abroad or considering emigrating is disturbingly high. These figures may have been inflated by the timing of the survey during an election year and prior to the roll out of the occupation specific dispensation.

### Article

In 1993 there were 261 psychiatrists practicing in South Africa, 147 of them (56.3 percent) in full-time private practice (serving approximately 20% of the country's population). This translated to a ratio of 6.4 psychiatrists per million citizens (0.64:100 000) with large discrepancies between provinces (eg 2.47: 100 000 in the Western Cape and 0.02:100 000 in the Northern Transvaal). Only 10.8 percent of those psychiatrists practising in South Africa could communicate in one or more African languages (excluding Afrikaans).<sup>1</sup>

20.8% of the South African psychiatrists in 1993 were women who were, on average, younger than their male colleagues. Women tended to have a higher mean percentage of patients presenting with disorders first manifesting in infancy, childhood or adolescence than their male colleagues, but there were no other significant differences between genders in terms of patient profile.<sup>2</sup>

Later studies indicate that the number of psychiatrists in South Africa still falls far below locally developed norms in general psychiatry, community psychiatry and child

and adolescent mental health services<sup>3-8</sup>, and although the psychiatrist to population ratio is comparable to other developing countries<sup>9-12</sup>, it falls very far behind ratios found in developed countries such as Australia, New Zealand, Canada and the USA.

13-15

There have been no studies subsequent to the 1993 survey that have looked at the demographic characteristics of South African psychiatrists in any depth. In particular, the proportion of psychiatrists in state employ, the time spent on different activities during the working week, trends in subspecialisation, clinical interests and gender differences in South African psychiatrists were issues raised by the authors of the 1993 survey which have not since been followed up.<sup>1</sup> This survey attempts to update this data. Additionally, numbers of psychiatrists in South Africa are suboptimal yet there have been no studies in the last decade examining the levels of job satisfaction or intentions to emigrate in this group, two factors that are likely to influence the attrition rate of South African psychiatrists. These factors are addressed in this study.

## **Methods**

We obtained names and limited contact details of the target population from the 2008 HPCSA register. We obtained contact details for all psychiatrists registered in South Africa in 2008 through SASOP, Medpages, the HPCSA register or through colleagues. Contact details were available for all registered psychiatrists still in South Africa at that time. We sent surveys via email for online completion, in person, or via fax or mail. Consent for use of the data generated from the survey was obtained through the first survey question. Nonrespondants were contacted via email, telephonically, by fax or by mail over a period of three months. All responses received were anonymous as the questionnaires were separated from identifying data on or prior to receipt.

Responses were entered onto an EXCEL spreadsheet, coded and then imported to SPSS version 18 for statistical description and analysis.

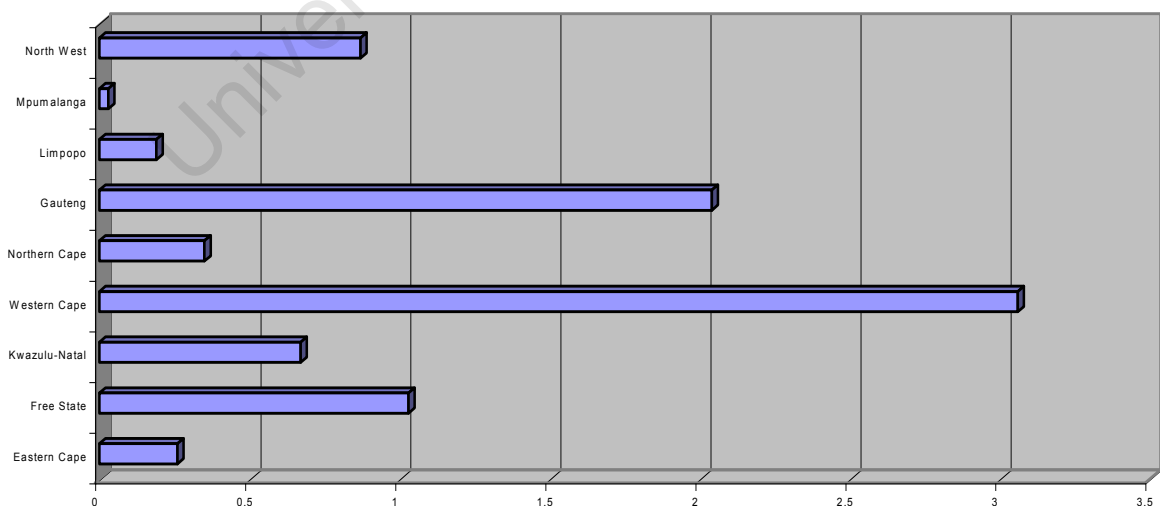
## Results

There were 632 psychiatrists registered with the HPCSA in 2008 (1.29 per 100 000 population). Of these, 61 were not in the country at the time of the survey, 31 had retired and 4 were deceased (leaving 536 in practice in South Africa – a ratio of 1.09 psychiatrists per 100 000 population). We obtained 189 usable responses from those in South Africa, giving a response rate of 35%. We were also able to obtain partial data on a further 336 psychiatrists which allowed a comparison between responders and nonresponders. This comparison showed no significant differences in terms of gender or time since specialisation, but there were significant differences between the groups in terms of place of under- and postgraduate study and the provinces in which they are registered.

### Demographic characteristics

Of all 525 psychiatrists on whom we had some data, 44.4% were female and 55.6% were male. There were marked differences between the psychiatrist to population ratios of the different provinces with Gauteng and the Western Cape much better resourced in this regard (Fig 1).

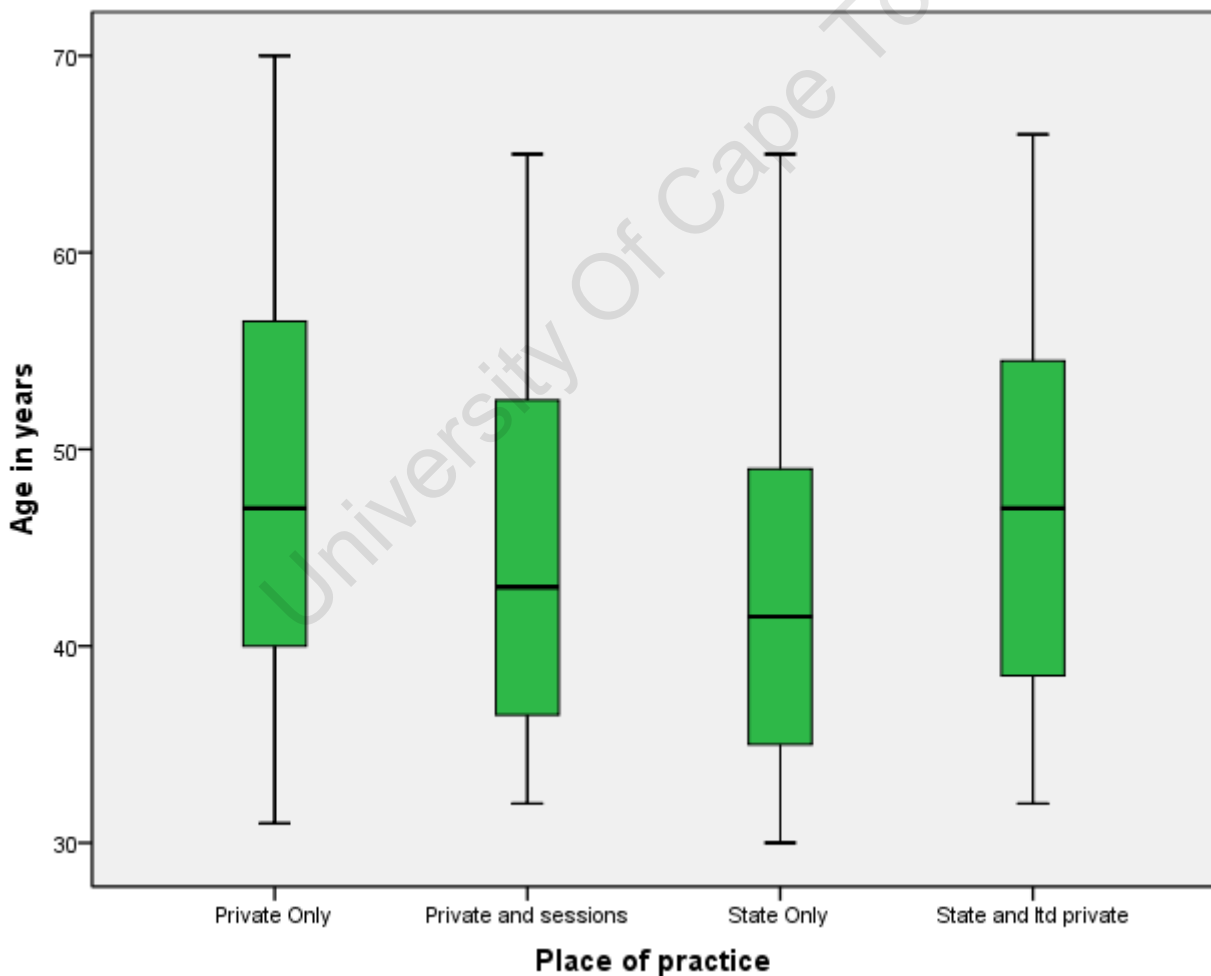
**Figure 1: Psychiatrists per 100 000 population by province:**



There were 31 registered subspecialists in child and adolescent mental health and of these 16 were female, 13 male and 2 gender not known.

The mean age of the surveyed psychiatrists was 46.5 years (SD 10). Women are significantly younger than men and there are also significant age differences between psychiatrists in state versus private practice (significance 0.22 using Kruskal-Wallis independent samples test). Those in state practice alone are younger than those who combine state and private practice. Those in private practice alone are the oldest group (Fig 2).

**Figure 2: Age versus place of practice of South African psychiatrists**



## Languages

85.6% of the sample spoke only English or Afrikaans, and only 5.9% of those with English or Afrikaans as a home language had learnt an additional African language.

Of the whole sample, 13.7% could speak one or more African languages other than English or Afrikaans. Only 1 psychiatrist in the entire country is proficient in South African Sign Language (SASL) (incidentally the same person also speaks English, isiXhosa, isiZulu, Setswana and siSwati).

## Practice characteristics

54% of psychiatrists are in private practice only or private practice with some state sessions. 46% are in state employ or state with limited private practice. Of those in state service, 78% are in joint appointments. Of those in state employ, the majority work in psychiatric hospitals (47.9%) or general hospitals (39.6%). Few work solely in community clinics (7.3%).

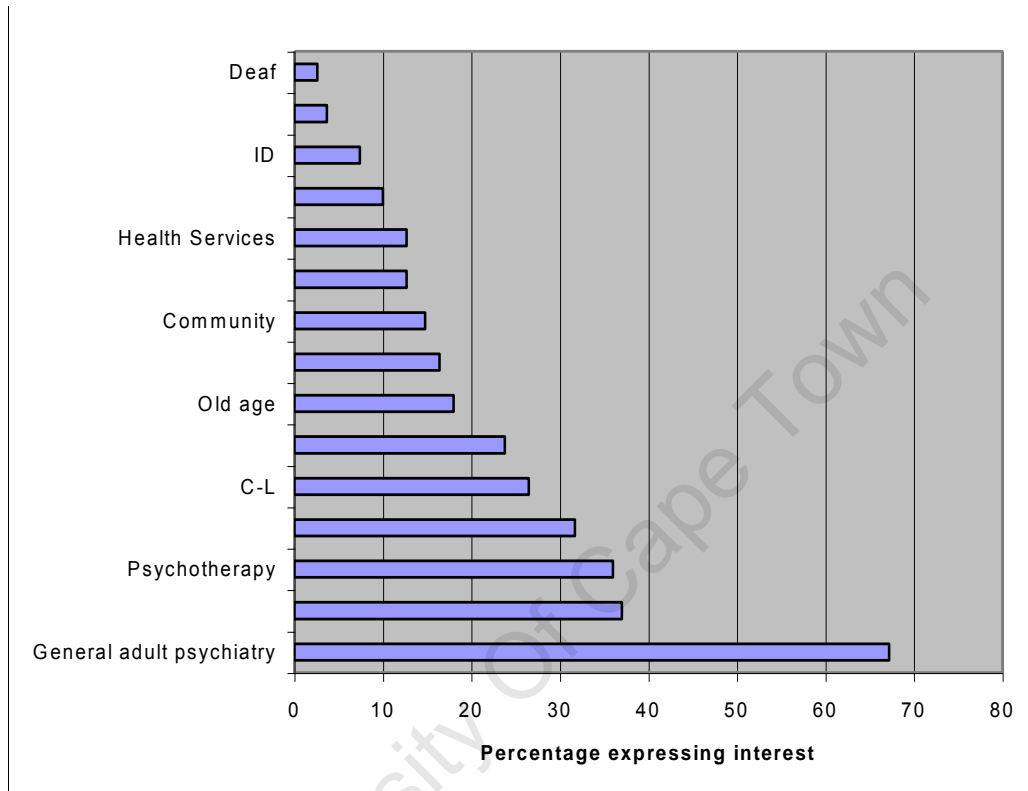
State-employed doctors work longer hours (mean of 44.6 hours per week (SD=10)) than their colleagues in private practice (41.2 hours per week (SD=15)) although there was large variance within groups. Most state psychiatrists (68.2 %) spend >8hours per week in consultation with patients, 50.6% spend >8hours per week in ward rounds, 24.7% spend >8hours on supervision, 18.8% spend >8hours per week on research related tasks, 15.3% spend >8 hours on formal teaching. Only 14.1% spend >8hours per week on consultation liaison.

## Interests

Most psychiatrists (67.2%) expressed an interest in general adult psychiatry. Moderate numbers expressed an interest in neuropsychiatry (37%), psychotherapy (36%), mental illness in substance abusers (31.7%), consultation liaison psychiatry (26.5%) and child and adolescent mental health (CAMH) (23.8%). Old age psychiatry forensic psychiatry and community psychiatry attracted the interest of 18%, 16.4% and 14.8% respectively, while the psychiatry of HIV/AIDS and health services development and management were both areas of interest to 12.7% of the

psychiatric workforce. Few psychiatrists expressed an interest in the genetics of psychiatry (10%), mental illness in people with intellectual disability (7.4% or 14 psychiatrists), the epidemiology of mental illness (3.7%) or the mental health of the deaf (2.6% or 5 psychiatrists) (Figure 3).

**Figure 3: Percentage of psychiatrists indicating an interest in specified area**



**Intellectual disability (ID) and pervasive developmental disorders (PDD)**

58% of psychiatrists see people with ID at most every six months with 19.9% seeing them less than annually and 11.4% never. 54.8 % claim at least some training in intellectual disability at both undergraduate and postgraduate level, but 9.6% had no training at all. 19.8% of psychiatrists in South Africa have never received training in mental illness in intellectual disability

Nearly 80% of psychiatrists do not see people with PDD more often than once every six months or so. 22% never see people with PDD and 35% see them once per year or less. 37.9% claim some training at undergraduate and postgraduate level, but 14.1% claim never to have received training in PDD.

There were no significant differences between universities in terms of their training in these areas and CAMH psychiatrists did not appear to have had more extensive training in these areas than general psychiatrists. Only 2 CAMH psychiatrists reported postgraduate training in ID, 6 in PDD, 6 in dual diagnosis and 3 in behavioural phenotypes.

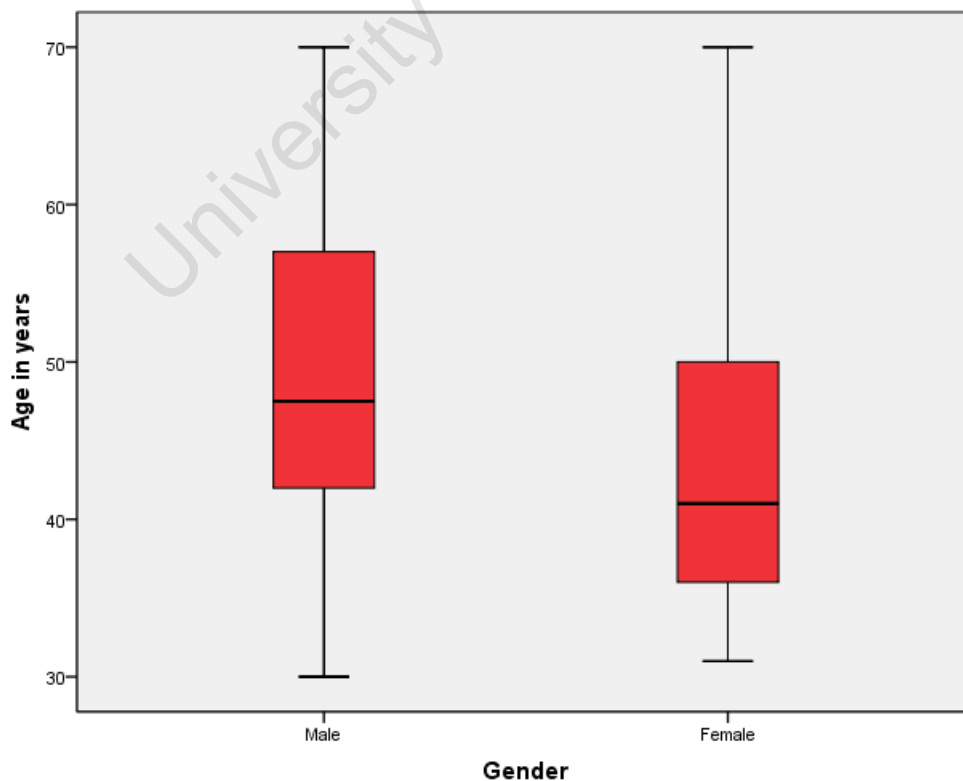
### Research and higher degrees

49.7% of all psychiatrists are doing some form of research but only 33.9% (60 psychiatrists) had published any paper at all in the last five years in a peer-reviewed journal. 8.4% of the respondents have a PhD (15 psychiatrists).

### Differences between genders

Women psychiatrists in South Africa specialised significantly more recently than their male colleagues as determined by the Mann-Whitney U test (women mean time since specialisation 9.36 years, men 15.99 years) and were significantly younger (mean of 43.3yrs (SD 9) versus 49 yrs (SD10)).

**Figure 3: Age and gender of South African psychiatrists**





The split between private and state practice is close to 50/50 for women whereas more men work in private practice than in the state system. However this difference between men and women did not reach statistical significance.

Women work significantly fewer hours than men per week (mean of 39.8 hours vs 45 hours) but are more likely to subspecialise than men (11.8% of women versus 4.9% of men, but this did not reach statistical significance). Interestingly, significantly more women psychiatrists see adolescents on a regular basis, but this is the only age group where there is a significant difference between the genders.

A significantly higher proportion of women are interested in CAMH than their male counterparts (32.9% vs 16.3), significantly fewer are interested in HIV/AIDS (4.7 vs 19.2), consultation liaison (17.6 vs 33.7), forensic psychiatry (9.4 vs 22.1), health services development and management (5.9 vs 18.3), and general adult psychiatry (57.6 vs 75). There were no other significant differences in interests between men and women.

### Satisfaction

The majority of South African psychiatrists are satisfied or extremely satisfied (70.6%) with their careers, whereas only 14.2% were dissatisfied or extremely dissatisfied. There were no significant differences in levels of satisfaction between women and men, between different age categories or between those in private or state employ.

The following themes emerged from those expressing dissatisfaction:

A lack of money, poor salaries when compared to colleagues in other professions or in business, a lack of career pathing, inability to progress further, lack of time for research, chaos in infrastructure and bureaucracy, struggling with medical aids, lack of support from university or government structures and a lack of respect from employers and patients.

### Emigration intentions

8% of psychiatrists registered in South Africa in 2008 were not in the country at the time of the survey. 31.1% of those surveyed had taken steps to examine the

feasibility of emigrating in the previous year. There were no significant differences in terms of intentions to emigrate between those working in the state sector and those in the private sector, although reasons given for wanting to emigrate were different. There were also no significant differences in emigration intentions between the genders. However, there were significant differences between the age groups with the younger 36-40 year age group more likely to consider emigrating. This was the only age group where more psychiatrists were considering emigrating than were intent on staying in the country (53.1% considering emigrating).

Reasons cited for wanting to emigrate varied between private practice and state sector. Themes that emerged from psychiatrists in private practice were violence, education of children, politics, medical aids, proposed national health insurance and limited earning potential.

Those in state employ cited the general issues above as well as poor salaries, limited academic opportunities, poor work resources, and a lack of respect from others.

## **Discussion**

The psychiatrist to 100 000 population ratio has increased from 0.64 in 1993 to 1.09:100 000 in 2008. Although there continues to be a markedly inequitable split between the provinces with the Western Cape and Gauteng having two to three times as many psychiatrists per unit population than any other province, this inequality is not as severe as in 1993 when the two wealthy provinces had 5 to 7 times as many psychiatrists per unit population than their closest competitor. The biggest improvements in psychiatrist to population ratios are seen in the Free State and in the North West province. Despite the increase, we still fall far short of the majority of developed countries.

The number of psychiatrists able to communicate fluently with their patients in one or more African languages has risen slightly from 10.8% to 13.7%. With black people forming 79.3% of our population ([www.statssa.gov.za](http://www.statssa.gov.za)), the profile of psychiatrists in this country clearly does not adequately reflect the total population profile, thereby limiting accessibility. Worryingly, only 5.9% of those whose home language is English

or Afrikaans are able to speak an additional African language fluently. This is an issue that needs to be addressed urgently.

In terms of practice setting, there has been a very slight decrease in the proportion of psychiatrists in the private sector since 1993 (56.3% in private in 1993 versus 54% in 2008). However, psychiatrists working primarily in the private sector still represent a majority of the psychiatric workforce yet serve the minority of the population.

Although there are more psychiatrists in the country, they seem to be working fewer hours (a mean of 49.5 hours per week for academic psychiatrists in 1993 versus 44.6 hours for state psychiatrists and 41.2 hours for private psychiatrists in 2008). It is not clear how large the variance was for this measure in 1993, but the current study showed a wide range of hours worked with a number of psychiatrists appearing to work part-time. This has potential implications for service provision and needs to be studied further.

Women make up a much greater proportion of the workforce now than in 1993 (20.8% in 1993 versus 44.4% in 2008). They are still younger than their male counterparts and work significantly fewer hours. They tend to be more interested in CAMH but less interested in HIV/AIDS, consultation liaison, forensic psychiatry, health services development and management, and general adult psychiatry than their male colleagues. All of these factors have potentially significant implications for service delivery and need to be taken into account for service planning.

The profile of interests amongst psychiatrists has shown some marked changes, the most notable being a decline in the number of psychiatrists expressing an interest in psychotherapy (36% in 2008 vs 56.2% in 1993). Other areas of interest that have declined in popularity include community psychiatry (14.8% in 2008 vs 23.7%) and forensic psychiatry (16.4% versus 23.7%). Areas of interest that have increased in popularity since 1993 include substance abuse and old age psychiatry. CAMH, consultation liaison, and intellectual disability have remained unchanged. The decline in interest in psychotherapy is in line with the more effective use of the psychiatric workforce suggested in Flisher's earlier study

Certain populations appear particularly underserved by the psychiatric workforce in terms of expressed interests and prior training. These include those with intellectual

disability and pervasive developmental disorders and, more especially, the Deaf. Only 1 psychiatrist indicated fluency in South African Sign Language, but according to the National Institute of the Deaf (SA) there were 412 421 Deaf South Africans in 2001 and 1 237 264 extremely hard of hearing and of these, 400-500 000 use South African sign language ([www.deafnet.co.za](http://www.deafnet.co.za)). Only 5 psychiatrists in South Africa indicated an interest in the mental health of the Deaf.

It is gratifying to note that over 70% of South African psychiatrists are satisfied or extremely satisfied with their careers, but sobering to note that 14.2% are dissatisfied or extremely dissatisfied. Themes underlying the dissatisfaction are quite diverse and these need to be addressed more comprehensively if we are to retain psychiatrists within the profession.

The number of psychiatrists already outside the country or seriously considering emigrating is extremely worrying. The timing of the survey may have contributed to the figures with recent political elections and the non-implementation of the occupation specific dispensation at the time of survey completion, but the numbers are so large that this remains an issue that needs further, urgent attention.

One weakness of this study is the low response rate which may impact on the survey in terms of generalisability of the data. However, there were no significant differences between responders and nonresponders to this survey in terms of gender, years since specialisation, proportion of subspecialists or whether they obtained their qualifications abroad or in SA. They did however differ significantly in terms of location (province) and university attended for both undergraduate and postgraduate qualifications.

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## Part D

### Appendices

1. Questionnaire:
  - a. Print format. Online format contained identical wording but had drop down menus from which to choose answers.
2. Cover letters:
  - a. As sent out by survey monkey
  - b. For faxed questionnaires
  - c. For mailed questionnaires
3. Official Ethics Approval letter
  - a. Extension of ethics approval
4. Instructions to authors for admission to South African Journal of Psychiatry

## Survey of South African Psychiatrists

**1. I hereby agree to the completion of the questionnaire, and to the use of and publication of the data by the authors. All the information imparted in this questionnaire will be separated from the name of the respondent and answers will therefore be anonymous. I consent to the forwarding of the anonymous data to SASOP if, and only if, I am a member of SASOP. If I am not a member of SASOP, the data will remain the property of the researchers.**

I have read the above and agree to the use of the data as outlined.

I have read the above and do not agree to the use of the data as outlined.

### **2. Are you a current member of SASOP?**

Yes

No

### **3. What was your age, in years, at your last birthday?**

### **4. Are you male or female?**

Male

Female

### **5. Are you still practising psychiatry?**

Yes

No

### **6. Did you complete your undergraduate degree in South Africa?**

Yes

No

### **7. If yes, at which university?**



**8. Did you do most (or all) of your specialist training in South Africa?**

Yes  No

**9. If yes, at which university?**

**10. In which year did you obtain your specialist registration?**

**11. Are you registered as a subspecialist?**

Yes  No

**12. In which province do you practise (please indicate if you do not practise in South Africa or if you are no longer in practise)**

**13. In which city or town do/did you practise/ which city or town is nearest to your practice?**

**14. Which language(s) do you use to communicate with friends and family on a daily basis?**

(eg English, Afrikaans, isiZulu, isiXhosa, isiNdebele, Sepedi, Sesotho, Setswana, Siswati, Tshivenda, Xitsonga, SASL, Other (please specify))

**15. Which language(s) do you/could you use proficiently in your practise?**

**16. How many hours per week, on average, do you spend in private practice?**

**17. How many hours per week, on average, do you spend working in the State sector? Please exclude on call time unless calls are done from place of work.**

**18. If you are employed in the State Sector, do you have a joint State/University appointment?**

Yes  No

**19. If in State service, which of the following options best describes your main place of employment. (You may choose more than one option if applicable).**

- Psychiatric hospital
- Inpatient psychiatric unit in a general hospital
- Outpatient psychiatric unit in a general hospital
- Community/primary health care setting
- Other (please specify)

**20. Which of the following activities are you involved in for more than 8 hours of your working week?**

- Consultation with patients
- Ward rounds
- Administrative or managerial tasks
- Research-related tasks
- Formal teaching
- Consultation-liaison
- Supervision
- Reading scientific literature to inform clinical practice
- In court
- Other (please specify)

**21. Which of the following activities are you involved in for more than 4 hours but less than 8 hours per week?**

- Consultation with patients
- Ward rounds
- Administrative or managerial tasks
- Research-related tasks
- Formal teaching
- Consultation-liaison
- Supervision
- Reading scientific literature to inform clinical practice
- In court
- Other (please specify)

**22. Which of the following activities do you perform regularly but for less than four hours per week?**

- Consultation with patients
- Ward rounds
- Administrative or managerial tasks
- Research-related tasks
- Formal teaching
- Consultation-liaison
- Supervision
- Reading scientific literature to inform clinical practice
- In court
- Other (please specify)

**23. Please indicate the approximate percentage of your patients that fall into each of the following age categories (total must equal 100 please)**

0 to 12 years	<input type="text"/>
13 to 18 years	<input type="text"/>
18 to 60 years	<input type="text"/>
Older than 60 years	<input type="text"/>

**24. Please indicate with a tick which of the following diagnostic categories are seen REGULARLY (at least 4 times per year) in your practice. You may indicate as many as are applicable.**

Dementia, and amnesic and other cognitive disorders	<input type="checkbox"/>
Mental disorders secondary to a general medical condition	<input type="checkbox"/>
Substance related disorders	<input type="checkbox"/>
Schizophrenia and other psychotic disorders	<input type="checkbox"/>
Mood disorders	<input type="checkbox"/>
Anxiety disorders	<input type="checkbox"/>
Somatoform disorders	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>
Adjustment disorders	<input type="checkbox"/>
Personality disorders	<input type="checkbox"/>
Pervasive developmental disorders	<input type="checkbox"/>
Attention deficit disorders	<input type="checkbox"/>
Disruptive behaviour disorders	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

**25. How often do you see patients with moderate to profound intellectual disability?**

- Never
- Less than once per year
- Every six months or so
- Less than monthly but more often than every six months
- At least once per month but not as much as weekly
- At least weekly but not daily
- Daily

**26. How often do you see patients with autism spectrum disorders (pervasive developmental disorders)?**

- Never
- Less than once per year
- Every six months or so
- Less than monthly but more often than every six months
- At least once per month but not as much as weekly
- At least weekly but not daily
- Daily

**27. In which of the following areas do you remember receiving training as an undergraduate? (tick as many as are applicable)**

- Intellectual disability
- Pervasive developmental disorders (autism spectrum disorders)
- Mental illness in intellectual disability
- Behavioural phenotypes of genetic syndromes
- None of the above

**28. In which of the following areas do you remember receiving training as a psychiatry registrar? (tick as many as are applicable)**

- Intellectual disability
- Pervasive developmental disorders (autism spectrum disorders)
- Mental illness in intellectual disability
- Behavioural phenotypes of genetic syndromes
- None of the above

**29. Please indicate which of the following therapeutic interventions you use in your practice on a regular basis. You may indicate as many as are applicable:**

- Individual psychotherapy
- CBT
- Supportive psychotherapy
- Group therapy
- Couples or family therapy
- None
- I refer patients if they require psychotherapy
- Other (please specify)

**30. Please indicate your area(s) of special interest :**

- Neuropsychiatry
- Genetics of psychiatry
- Psychotherapy
- Psychiatry of HIV/AIDS
- Child and adolescent psychiatry
- Mental illness in the intellectually disabled
- Consultation liaison psychiatry
- Community psychiatry

Appendix 1

- |  |                          |
|--|--------------------------|
| Forensic psychiatry                        | <input type="checkbox"/> |
| Old age psychiatry                         | <input type="checkbox"/> |
| Health services development and management | <input type="checkbox"/> |
| Epidemiology                               | <input type="checkbox"/> |
| General Adult psychiatry                   | <input type="checkbox"/> |
| Mental health of the deaf                  | <input type="checkbox"/> |
| Mental illness in substance abusers        | <input type="checkbox"/> |
| Other (please specify below)               | <input type="checkbox"/> |

**31. Do you have a doctorate?**

- Yes
- No

**32. If you are currently involved in research, please indicate whether this is predominantly academic, industry based/commercial or a combination of both (even if these are separate projects).**

- Academic
- Commercial
- Both academic and commercial

**33. Please list your main research interests, if any.**

**34. Have you published a paper in a peer reviewed journal as principal or co-author in the past five years?**

- Yes
- No

**35. Please indicate how satisfied you currently are with your career:**

Extremely satisfied	<input type="checkbox"/>
Satisfied	<input type="checkbox"/>
Neither satisfied nor dissatisfied	<input type="checkbox"/>
Dissatisfied	<input type="checkbox"/>
Extremely dissatisfied	<input type="checkbox"/>

**36. If you are dissatisfied or extremely dissatisfied, please comment on the reasons for this:**

**37. Have you seriously considered emigrating within the last year? (ie at least taken steps to evaluate the feasibility of emigrating)**

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

**38. If yes, please indicate the main reason(s) why you might choose to emigrate.**

**Thank you for completing our survey!**



## Appendix 2a

**From:** judybentley@vodamail.co.za

---

**Subject:** Survey of the Clinical Practices of South African psychiatrists

**Body:** Dear colleague

Respond to our survey and enter a draw to win the latest edition of Stahl's Essential Psychopharmacology! (Sponsored by Sanofi-Aventis)

Why another survey?

Recent surveys have focussed on practice management issues. This survey is different in that we seek to answer the following questions:

How many practising psychiatrists are there in South Africa?

What are they doing in terms of their clinical work?

Are they satisfied with their careers?

How many are planning to emigrate?

A similar survey was conducted in 1993 and the intention of this survey is to replicate the work done at that stage and to see how things have changed.

All South African registered psychiatrists will be contacted and will be requested to complete the survey.

Who is conducting the survey?

The survey is being conducted by Dr Judy Bentley (UCT, Alexandra Hospital), Dr Pete Milligan (UCT, Lentegour Hospital) and Prof Alan Flisher (UCT, RXH DCAP), and has received ethics clearance through UCT.

Please be assured that your responses to the survey will remain anonymous as responses will be separated from all identifying details.

Here is a link to the survey:

## Appendix 2a

<http://www.surveymonkey.com/s.aspx>

This link is uniquely tied to this survey and your email address. Please do not forward this message. If you require me to use a different email address, please let me know at judybentley@vodamail.co.za

Thanks for your participation!  
Judy Bentley, Pete Milligan and Alan Flisher

Please note: If you do not wish to receive further emails from us, please click the link below, and you will be automatically removed from our mailing list.

<http://www.surveymonkey.com/optout.aspx>

University Of Cape Town

## Survey of the Clinical Practices of South African Psychiatrists

Why another survey?

Recent surveys have focussed on practice management issues. This survey is different in that we seek to answer the following questions:

How many practising psychiatrists are there in South Africa?

What are they doing in terms of their clinical work?

Are they satisfied with their careers?

How many are planning to emigrate?

A similar survey was conducted in 1993 and the intention of this survey is to replicate the work done at that stage and to see how things have changed. All South African registered psychiatrists will be contacted – by fax, personally or by email – and will be requested to complete the survey.

### **Who is conducting the survey?**

The survey is being conducted by Dr Judy Bentley (UCT, Alexandra Hospital), Dr Pete Milligan (UCT, Lentegeur Hospital) and Prof Alan Flisher (UCT, RXH DCAP).

### **Anonymity**

Please be assured that your responses to the survey will remain entirely anonymous as responses will be separated from all identifying details on receipt.

### **Returning questionnaires**

Please complete the attached questionnaire and return to me via fax on 0865174888. Please write your name on the cover page and return this with the survey. It will be separated from the questionnaire on receipt.

Thank you for your interest in our survey.

Judy Bentley, Pete Milligan and Alan Flisher

## Survey of the Clinical Practices of South African Psychiatrists 2008

Dear

### **Why another survey?**

Recent surveys have focussed on practice management issues. This survey is different in that we seek to answer the following questions:

How many practising psychiatrists are there in South Africa?  
What are they doing in terms of their clinical work?  
Are they satisfied with their careers?  
How many are planning to emigrate?

A similar survey was conducted in 1993 and the intention of this survey is to replicate the work done at that stage and to see how things have changed.

All South African registered psychiatrists will be contacted – by mail or email – and will be requested to complete the survey.

### **Who is conducting the survey?**

The survey is being conducted by Dr Judy Bentley (UCT, Lentegeur Hospital), Dr Pete Milligan (UCT, Lentegeur Hospital) and Prof Alan Flisher (UCT, RXH DCAP).

### **Anonymity**

Please be assured that your responses to the survey will remain entirely anonymous as responses will be separated from all identifying details on receipt.

### **Returning questionnaires by mail**

Please return the completed questionnaire to Dr J Bentley, 51 Washington Road, Claremont, 7708.

Please fill in your name on the envelope. This is to enable us to keep a record of respondents. However, the questionnaire will be separated from the envelope on receipt and at no time will your responses be linked to your name.

Thank you kindly for your interest in our survey.

Judy Bentley, Pete Milligan and Alan Flisher



UNIVERSITY OF CAPE TOWN

Health Sciences Faculty  
Research Ethics Committee  
Room E52-24 Groote Schuur Hospital Old Main Building  
Observatory 7925  
Telephone [021] 406 6338 • Facsimile [021] 406 6411  
e-mail: lamces.emjedi@uct.ac.za

19 November 2008

REC REF: 471/2008

**Dr JM Bentley**  
Psychiatry and Mental Health  
Lentegeur

Dear Dr Bentley

**PROJECT TITLE: A SURVEY OF THE PROFESSIONAL ACTIVITIES OF PSYCHIATRISTS  
IN SOUTH AFRICA IN 2008**

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

**Approval is granted for one year till the 25<sup>th</sup> November 2009.**

Please submit an annual progress report if the research continues beyond the expiry date. Please submit a brief summary of findings if you complete the study within the approval period so that we can close our file.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

**Please quote the REC. REF in all your correspondence.**

Yours sincerely

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, HSF HUMAN ETHICS**

Federal Wide Assurance Number: FWA00001637.  
Institutional Review Board (IRB) number: IRB00001938

lemjedi



UNIVERSITY OF CAPE TOWN

Health Sciences Faculty  
Research Ethics Committee  
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e-mail: shuretta.thomas@uct.ac.za

10 November 2009

REC REF: 471/2008

Dr JM Bentley  
Psychiatry & Mental Health

Dear Dr Bentley

**PROJECT TITLE: A SURVEY OF THE PROFESSIONAL ACTIVITIES OF PSYCHIATRISTS IN SOUTH AFRICA IN 2008.**

Thank you for submitting a report on the progress of your research.

It is a pleasure to inform you that the Ethics Committee has **granted approval** to extend the study for a further 12 months until 20<sup>th</sup> November 2010.

Please submit a further progress report if the research continues beyond the expiry date. Please submit a brief summary of findings if you complete the study within the approval period so that we can close our file.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

**Please quote the REC. REF in all your correspondence.**

Yours sincerely

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, HSF HUMAN ETHICS**

S Thomas

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All named authors must give consent to publication. Authorship should be based only on substantial contribution to: (i) conception, design, analysis and interpretation of data; (ii) drafting the article or revising it critically for important intellectual content; (iii) final approval of the version to be published. All three of these conditions must be met (Uniform requirements for manuscripts submitted to biomedical journals; [www.icmje.org/index.html](http://www.icmje.org/index.html)).

### **CONFLICT OF INTEREST**

Authors must declare all sources of support for the research and any association with the product or subject that may constitute conflict of interest.

### **PROTECTION OF PATIENT'S RIGHTS TO PRIVACY**

Identifying information should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives informed written consent for publication. Informed consent for this purpose requires that the patient be shown the manuscript to be published. ([www.icmje.org](http://www.icmje.org))

### **ETHNIC CLASSIFICATION**

Work that is based on or contains reference to ethnic or racial classification must indicate the rationale for this.

### **MANUSCRIPTS**

Short items are more likely to appeal to our readers and therefore to be accepted for publication.

**Original articles** of 3 000 to 4 000 words or less, with up to 6 tables or illustrations, should normally report observations or research of relevance to clinical medicine. References should preferably be limited to no more than 15.

**Short reports or scientific letters**, which include case reports, side effects of drugs and brief or negative research findings should be 1000 words or less, with 1 table or illustration and no more than 6 references.

**Editorials, Opinions, Issues in Medicine**, etc. should be about 1000 words and are welcome, but unless invited, will be subjected to the SAJP peer review process.

## Appendix 4

**Review articles** should be rigorously written with a clear focus, should reference the most the recent literature, and be no more than 4000 words.

**Letters to the editor**, if intended for the correspondence column, should be marked 'for publication' and signed by all authors. Letters should be no longer than 400 words with only one illustration or table.

**Obituaries** should not exceed 400 words and may be accompanied by a photograph.

### **MANUSCRIPT PREPARATION**

Research articles should have a structured abstract not exceeding 250 words (50 for short reports) comprising: Objectives, Methods, Results and Conclusions. Refer to articles in recent issues for guidance on the presentation of headings and subheadings.

Abbreviations should be spelt out when first used in the text and thereafter used consistently.

Scientific measurements should be expressed in SI units except: blood pressure should be given in mmHg and haemoglobin values in g/dl.

If in doubt, refer to 'uniform requirements' above.

### **ILLUSTRATIONS**

Figures consist of all material that cannot be set in type, such as photographs and line drawings. If any tables or illustrations submitted have been published elsewhere, the author should obtain written consent to republication from the copyright holder and the author(s). All illustrations, figures etc. must be of high resolution/quality, preferably jpeg or equivalent but not powerpoint, and preferably attached as supplementary files.

### **REFERENCES**

References should be inserted in the text as superior numbers and should be listed at the end of the article in numerical and not in alphabetical order.

Authors are responsible for verification of references from the original sources.

References should be set out in the Vancouver style and approved abbreviations of journal titles used; consult the List of Journals in Index Medicus for these details.

Names and initials of all authors should be given unless there are more than six, in which case the first three names should be given followed by et al. First and last page numbers should be given.

Journal references should appear thus:

1) Price NC . Importance of asking about glaucoma. BMJ 1983; 286: 349-350.

Book references should be set out as follows:



## Appendix 4

- 2) Jeffcoate N. Principles of Gynaecology. 4th ed. London: Butterworth, 1975: 96-101.
- 3) Weinstein L, Swartz MN. Pathogenic properties of invading microorganisms. In: Sodeman WA jun, Sodeman WA, eds. Pathologic Physiology: Mechanisms of Disease. Philadelphia: WB Saunders, 1974: 457-472.

Manuscripts accepted but not yet published can be included as references followed by (in press).

Unpublished observations and personal communications may be cited in the text, but not in the reference list

### **GALLEY PROOFS**

Galley proofs will be forwarded to the author before publication and if not returned within 2 weeks will be regarded as approved. Please note that alterations to typeset articles are costly and will be charged to the authors.

### **CHANGES OF ADDRESS**

Please notify the Editorial Department of any address changes so that proofs and invoices may be mailed without delay.

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Authors can earn up to 15 CPD points for published articles. Certificates will be provided on request after the article has been published.

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As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

- .....
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  2. The submission file is in Microsoft Word, RTF, or WordPerfect document file format.
  3. When available, the URLs to access references online are provided, including those for open access versions of the reference. The URLs are ready to click (e.g., <http://pkp.sfu.ca/>).
  4. The text is single-spaced; uses a 12-point font; employs italics, rather than underlining (except with URL addresses). Figures consist of all material that cannot be set in type, such as photographs and line drawings. If any tables or illustrations submitted have been published elsewhere, the author should obtain written consent to republication from the copyright holder and the author(s). All illustrations, figures etc. must be of high resolution/quality, preferably jpeg or equivalent but not powerpoint, and preferably attached as supplementary files.

## Appendix 4

- 
5. The text adheres to the stylistic and bibliographic requirements outlined in the [Author Guidelines](#), which is found in About the Journal.

University Of Cape Town