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

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ABSTRACT

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

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

INTRODUCTION

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

Lack of a career structure, inappropriate training at undergraduate and postgraduate level, spouse dissatisfaction, limited schooling opportunities for children, academic isolation and bureaucratic problems have been identified as factors that discourage doctors from working in underdeveloped areas. Furthermore, scant management support and too little time or opportunity for continuing their education were found to contribute to discontentment or frustration. Other problems of rural practice include a lack of recreational facilities, poor housing, inferior clinical facilities, violence and inadequate pay.5,6,7

There is a need to create an attractive career structure, not only to draw medical practitioners to the rural areas, but also to keep them there.8 The Rural Doctors’ Association of Southern Africa (RuDASA) has published a position paper that focuses attention on the dilemma facing many rural hospitals in the country in terms of maintaining adequate staffing by experienced medical officers. The document contains constructive solutions to recruiting and retaining professional staff in rural areas, with recommendations regarding community service, senior doctors and foreign doctors.9 The fast tracking of registration for suitably qualified practitioners from developed countries and the introduction of a substantive increase in rural allowances are examples of steps that can readily be implemented.

It is important that factors that satisfy or dissatisfy doctors working in rural areas be identified, as the level of doctors’ satisfaction with their workload is an important factor determining the retention of doctors in rural hospitals.10 The purpose of
the analysis by identifying the re-
were formulated from the data.
veloped. Finally, conceptual models
dherent categories from which
This enabled the formation of co-
reread, labelled, cut and pasted.
were analysed using probing depth
taping and transcribed. The data
hospital?”. The interviews were au-
professional skills you have to per-
ntroduced by the interviewer was:
view technique.
ried consent from each inter-
dominantly by full-time medical of-
which practitioner would be availa-
cause it was impossible to predict
viewed. This was necessary be-
statistician’s preconceptions and
terms of reference before the ana-
yses, and maintained by continu-
ously examining the data for com-
peting conclusions. The free attitude
interview technique, rather than fo-
cus group discussions, was used to
explore individual views. Internal
validity was maintained by strictly
applying the technique. Triangula-
tion of the results was done with the
results from the district hospitals’
medical officer questionnaire (not
reported here), which assisted in
the external validation of the results.
Stellenbosch University’s Re-
search Committee approved the
study protocol (2001/C040). Provin-
cial authorities and the hospital su-
perintendents granted permission
to conduct the study. The Health
Systems Trust provided a research
grant to fund the study.

RESULTS
The demographic profile of the 20
interviewees is shown in Table I.
Eight of the respondents were in full
time provincial employ, while 12
were in part-time employ, simulta-
neously running private practices.
During the interview analysis, issues
common and unique to both full-
time and part-time groups were
identified. The results are reported
simultaneously with reference to
differences between the groups,
including verbatim quotes support-
ing the findings. Table II lists the
themes and sub-themes that were
identified.

Knowledge and skills
The interviews revealed that medical
officers were confronted with a wide
variety of problems requiring a
broad range of knowledge and
skills. There were recurrent refer-
ces to the need for trauma man-
agement. General surgical, obstet-
ic and anaesthetic skills were also
frequently required.

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

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

TABLE I: Demographic profile

<table>
<thead>
<tr>
<th>Type</th>
<th>Total</th>
<th>Female</th>
<th>Male</th>
<th>Years qualified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>1 - 11</td>
</tr>
<tr>
<td>Part-time</td>
<td>12</td>
<td>2</td>
<td>10</td>
<td>5 - 26</td>
</tr>
</tbody>
</table>

TABLE II Themes and Sub-Themes

<table>
<thead>
<tr>
<th>1 Knowledge and skills</th>
<th>3 Support structures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Scope of knowledge and skills</td>
<td>3.1 Specialist support</td>
</tr>
<tr>
<td>1.2 Knowledge and skills gap</td>
<td>3.2 Regional and tertiary hospitals</td>
</tr>
<tr>
<td>1.3 Knowledge and skills development</td>
<td>3.3 District Health System</td>
</tr>
<tr>
<td>2 Situational factors</td>
<td>3.4 Nursing staff</td>
</tr>
<tr>
<td>2.1 Remoteness</td>
<td>3.5 Other support staff and services</td>
</tr>
<tr>
<td>2.2 Job satisfaction</td>
<td>3.6 Community service doctors</td>
</tr>
<tr>
<td>2.3 Job frustration</td>
<td>3.7 Management</td>
</tr>
<tr>
<td>2.4 Work-related stress</td>
<td>3.8 Public-private partnerships</td>
</tr>
<tr>
<td>2.5 Community issues</td>
<td></td>
</tr>
</tbody>
</table>
ment, and skills attrition due to limited exposure. These perceived "missing skills or knowledge" were a common source of concern.

"I had two anaesthetic lectures in fourth year and not much before I came here and started to do gas this year for the first time because I was too terrified to do them before."

"But because if you do something wrong here and it goes seriously wrong, it's too far from town B (secondary hospital) to take the risk. And then you slowly unlearn some of the skills that you did know."

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

**Situational factors**

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

The interviewees elaborated on conditions in the district hospitals as causing frustration and hindering optimal service. The lack of resources, both in terms of equipment and specialist back-up, emerged as sub-themes of frustration. The full-time medical officers felt that the excessive workload, especially after-hours duties and coping with large numbers of primary health care problems, assaults and trauma were a problem.

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

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

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

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

**Support structures**

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

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

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

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

A commonly recurring theme involved the lack of nursing staff and their training and motivation. Laboratory tests were often done off-site, causing delays and limited after-hours availability. Special investigations had to be kept to an absolute minimum due to budgetary constraints, and patients who needed urgent and repeated laboratory tests were better off if referred to a higher level of care. Radiology services were frequently not available after hours. The ambulance services...
drew widespread criticism, as did the lack of social support services. The introduction of community service doctors was considered a positive development, but the frequent rotations and inappropriate training of these new doctors placed a further burden on particularly the full-time staff.

“We try to provide a good service but I think the nurses are dispirited most of the time and they can’t observe most of the patients.”

“Resuscitations are a problem at night. They tried training sessions but now the staff changes such a lot that there is no fixed personnel.”

“One of the weakest links in our whole chain of supplying good medical services to the inhabitants of this area at this point in time is the ambulance service.”

“One negative point is the budget all of a sudden went a bit haywire because these newly qualified (community service) doctors tend to request an enormous amount of laboratory tests.”

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

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

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

“It’s expensive to keep your private practice running. That’s very important because that’s our main source of income. We’ve got to look after that.”

“If I would only do hospital medicine as it is at the moment, I would find it extremely unstimulating.”

**Conceptual framework**

Two conceptual models were developed from the themes:

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

*Figure 1* assists in conceptualising the influence of conditions in a district hospital on the performance of and the quality of services provided by the medical officers. The picture emerging from (especially) the full-time medical officer interviews can be compared to an inverse spiral forming a downward movement in which the quality of skills progressively decreases as the spiral progresses. The medical officer enters the spiral when taking up a post at a district hospital, often with expectations of a rewarding time in a rural area, performing interesting procedures. The medical officer is confronted with an unexpected patient profile, which includes violence, social problems, abusive patients, plus the inappropriate use of after-hour services for minor complaints. The workload and antisocial hours prevent the medical officer from engaging in “real medicine”. The chronic lack of staff aggravates the situation. Other setbacks include the malfunctioning of the ambulance system and the refusal of referral hospitals to accept patients. Only basic procedures are performed, resulting in skills atrophy and little time to acquire new knowledge and skills. Limited support from management further undermines morale.

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

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

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

- Reduce after-hours duties for full-time practitioners by the appointment of part-timers to duty rosters on a sessional basis;
- Provide a career path for medical officers in district hospital service;
- Develop the system of using part-time private practitioners in district hospitals as a model private-public partnership;
- Grant sabbatical leave to experienced full-time employees to update knowledge and skills;
- Institute appropriate continuing professional development and vocational training programmes for district hospital practitioners;
- Address the inappropriate primary health care load at district hospitals, with better functional integration of district health services;
- Improve relations with management and higher levels of care; and
- Implement a strategic plan for a well-motivated rural medical workforce.4

The in-depth free attitude interviews used in this study complemented the literature by exploring unarticulated areas of individual experiences. This qualitative approach is appropriate for interpreting the data in order to develop theoretical insights explaining and translating...
the meaning of people’s perceptions. Systematic rigour was applied to the process by documentation and revision of a quality trail of procedures and interpretations.12,13,15,16

This study reports substantive evidence reinforcing anecdotal information of struggling rural hospitals with stressed staff trying to serve their communities. Our findings confirmed that substantial after-hour duties, an excessive workload and a perceived lack of management support impact negatively on rural district hospital doctors.6,12,14,17,18 The inverse performance spiral assists our understanding of the influence of the working conditions on medical practitioners. Interventions aimed at reversing the cascade of events at any point in the spiral can be valuable in improving staffing and the quality of care in district hospitals.

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

CPD Questionnaire p.45

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