The Influence of Burnout on Skills Retention in Junior Paediatric Doctors at Red Cross War Memorial Children’s Hospital

A Thesis
presented to
The Graduate School of Business
University of Cape Town
in partial fulfilment
of the requirements for the
Masters of Business Administration Degree
by
Mark Stodel
December 2009

Supervisor: Dr Ailsa Stewart-Smith
This thesis is not confidential. It may be used freely by the Graduate School of Business.

I wish to thank Dr Ailsa Stewart-Smith for her valuable advice, assistance and encouragement. I
would also like to thank Prof. George Swingler, Dr Heloise Buys and Dr Thomas Blake for
allowing me into Red Cross War Memorial Children’s Hospital (RXH) to complete this thesis and
for their assistance in gathering the data from the doctors at RXH. It is my hope that this thesis
will provide valuable insights and will assist in the provision of the high quality care with which
RXH has become synonymous.

I certify that, except as noted above, this thesis is my own work and all references used are
accurately reported in footnotes.

Signed:

[Signature]

Mark Stodel
The Influence of Burnout on Skills Retention in Junior Paediatric Doctors at Red Cross War Memorial Children’s Hospital

ABSTRACT

This study evaluates the degree of burnout, using the Maslach Burnout Inventory, among junior doctors at Red Cross War Memorial Children’s Hospital (RXH) in Cape Town, and the influence thereof on the retention of valuable skills within the hospital. It further considers the measures that could be taken to mitigate the causes of burnout, by means of qualitative methods.

BACKGROUND: The research explores the significance of burnout and the role it plays in the retention of junior doctors at RXH. There has been an increase in the migration of medical doctors worldwide, with an exodus of doctors from South Africa. This, along with the effects of HIV/AIDS is putting extra strain on those that remain. Over the past two years, RXH has seen the turnover of nine of its junior doctors before the end of their contracts. This research looks at the degree of burnout experienced at RXH, what influence it has on the retention of skills, and what can be done to mitigate it.

METHODOLOGY: A two-part, mixed quantitative and qualitative study consisting of a validated measure: The Maslach Burnout Inventory was sent to 39 junior doctors at RXH, with responses from 23 doctors (one of which was invalid). This constituted a 60% response rate. The second part consisted of four semi-structured interviews.

RESULTS: Of the 22 respondents 100% experienced a high degree of burnout on one of the three scales of burnout, namely: emotional exhaustion, depersonalisation and reduced accomplishment. Of those surveyed, 95% expressed an intention to leave RXH. The degree of
emotional exhaustion and depersonalisation experienced by the junior doctors at RXH was significantly higher than a normative sample of 1 104 doctors. Recruitment, improved management and planning, increased support, mentorship and a more empathetic administration were some of the factors suggested to mitigate the burnout experienced by the junior doctors.

CONCLUSION: Burnout is endemic among the junior doctors at RXH. This has a direct negative effect on the retention of skills and the quality of care given by RXH. For this reason steps must be put in place to mitigate the burnout experienced by the junior doctors.

KEYWORDS: Burnout, Skills Retention, Turnover, Maslach Burnout Inventory, Junior Doctors, Paediatric, Human Resource Management, Medical Migration, South Africa.
CONTENTS

LIST OF FIGURES .............................................................................................................. 7
LIST OF TABLES .................................................................................................................... 7

1 INTRODUCTION .............................................................................................................. 8
   1.1 RESEARCH AREA AND DILEMMA ............................................................................. 8
   1.1.1 BACKGROUND ........................................................................................................... 8
   1.2 RESEARCH QUESTIONS AND SCOPE ........................................................................ 10
       1.2.1 PRIMARY QUESTION ............................................................................................ 10
       1.2.2 SECONDARY QUESTIONS ...................................................................................... 10
       1.2.3 SCOPE ..................................................................................................................... 10
   1.3 RESEARCH ASSUMPTIONS ......................................................................................... 11
   1.4 RESEARCH ETHICS ...................................................................................................... 12

2 LITERATURE REVIEW .................................................................................................... 13
   2.1 DISCUSSION ................................................................................................................ 13
       2.1.1 THE MASLACH BURNOUT INVENTORY (MBI) .................................................... 13
       2.1.2 BURNOUT AND SKILLS RETENTION .................................................................. 14
       2.1.3 BURNOUT IN MEDICAL SERVICES .................................................................... 15
       2.1.4 BURNOUT IN SOUTH AFRICA ............................................................................. 17
       2.1.5 WHAT CAN BE DONE TO MITIGATE BURNOUT? ................................................. 17
   2.2 CONCLUSION .............................................................................................................. 19

3 RESEARCH METHODOLOGY .......................................................................................... 20
   3.1 RESEARCH APPROACH AND STRATEGY .................................................................. 20
   3.2 RESEARCH DESIGN, DATA COLLECTION METHODS AND RESEARCH INSTRUMENTS .................................................................................................................. 22
   3.3 SAMPLING ................................................................................................................... 24
   3.4 DATA ANALYSIS METHODS ...................................................................................... 25

4 RESEARCH FINDINGS, ANALYSIS AND DISCUSSION ................................................. 26
   4.1 RESEARCH FINDINGS AND ANALYSIS .................................................................... 26
4.1.1 DEMOGRAPHICS ........................................................................................................ 26
5.1.1 TURNOVER INTENTIONS ...................................................................................... 28
5.1.2 BURNOUT .................................................................................................................. 30
5.1.3 IMPACT OF MENTORS ON BURNOUT .............................................................. 33
5.1.4 RECOMMENDATIONS FROM JUNIOR DOCTORS ........................................... 34
5.1.5 ANALYSIS OF INTERVIEWS – CAUSATIVE AND MITIGATING FACTORS OF BURNOUT .............................................................................................. 36
5.1.5.1 FACTORS THAT CAUSE BURNOUT ............................................................. 36
5.1.5.2 FACTORS THAT MITIGATE BURNOUT .......................................................... 37
5.2 RESEARCH DISCUSSION ........................................................................................... 38
5.2.1 DEMOGRAPHICS ...................................................................................................... 38
5.2.2 BURNOUT AND SKILLS RETENTION ................................................................. 39
5.3 RESEARCH LIMITATIONS ......................................................................................... 39

6 RESEARCH CONCLUSIONS ......................................................................................... 40
6.1 FINANCIALLEY-BASED MITIGATING FACTORS ..................................................... 40
6.2 NON-FINANCIALLY-BASED MITIGATING FACTORS ............................................. 41

7 FUTURE RESEARCH DIRECTIONS ........................................................................... 41
7.1 COMPARATIVE STUDIES ......................................................................................... 41
7.2 LONGITUDINAL STUDIES .......................................................................................... 42

8 BIBLIOGRAPHY ............................................................................................................. 42

9 APPENDICES ............................................................................................................... 46
9.1 APPENDIX 1 – SURVEY QUESTIONNAIRE AND RESEARCH INSTRUMENT ......... 46
9.2 APPENDIX 2 – JUNIOR DOCTOR-SUGGESTED METHODS OF INCREASING SKILLS RETENTION AT RXH ................................................................. 48
9.3 APPENDIX 3 – TRANSCRIPTION OF INTERVIEWS ................................................. 51
9.3.1 INTERVIEW 1 .......................................................................................................... 51
9.3.2 INTERVIEW 2 .......................................................................................................... 60
9.3.3 INTERVIEW 3 .......................................................................................................... 65
9.3.4 INTERVIEW 4 .......................................................................................................... 72
LIST OF FIGURES

Figure 1: Gender Proportions of Junior Doctors at RXH ........................................... 26
Figure 2: Occupational Proportion ............................................................................ 27
Figure 3: Turnover Intentions .................................................................................... 29
Figure 4: Intentions to Migrate from South Africa ..................................................... 29
Figure 5: Burnout experienced by Junior Doctors ..................................................... 30
Figure 6: Proportion of Junior Doctors with Mentors ................................................. 34

LIST OF TABLES

Table 1: Comparison between Emotional Exhaustion and Intention to leave ........... 28
Table 2: Recommendations from junior doctors for improving skills retention at RXH ................................................................................................................................. 34
Table 3: Factors that cause burnout ......................................................................... 37
Table 4: Factors that mitigate burnout ...................................................................... 38
1 INTRODUCTION

1.1 Research Area and dilemma

1.1.1 Background

The research aims to explore the significance of burnout and the role it plays in the retention of junior paediatric doctors at Red Cross War Memorial Children’s Hospital (RXH). According to Grant (2006), there has been a significant exodus of doctors from South Africa. These doctors tend to be young (below 42 years), male and not yet specialised. This exodus vastly increases the workload of the doctors who remain. The effects of globalisation on the retention of skills have become increasingly significant in recent years, as it has become easier to migrate as a result of improved transport, telecommunications and accessibility of information (McIntyre, Thomas and Cleary, 2004). Unless sufficient emphasis is placed on the effects of burnout and other causes of medical migration, and attempts are made to mitigate them, South Africa will continue to lose doctors to the global labour market, ultimately resulting in detrimental standards of medical care.

Skills retention is salient in an industry such as medical services, which is dependent on the knowledge of its workers (Loria, 2002). This applies particularly to the health industry where a lack of clinical acumen can have devastating results for the population it serves. The dilemma with regard to the retention of skills in the health industry in South Africa is compounded by the fact that it faces significant challenges due to lack of resources, HIV/AIDS and the migration of health personnel due to globalisation (McIntyre et al., 2004). Due to these additional pressures many health professionals choose to leave South Africa for other countries where better working conditions exist (Grant, 2006).
In many junior doctor posts in South Africa, doctors work on a rotation basis. In addition, every fourth or fifth day junior doctors work 30-hour hour shifts. This equates to 80 to 100-hour working weeks. Very little provision is made for illness, with colleagues having to cover for each other if a fellow junior doctor is sick. AIDS has resulted in increasing deaths of patients in South Africa, and a resultant higher burden of disease. This has added to the work load and, in many cases, also to the complexity of decisions. In short, long working weeks, high patient loads, tough clinical decisions and increased loss of patients due to AIDS has increased the burnout rate of junior doctors.

Paediatric doctors, in particular, are under severe pressure. Paediatrics is one of the medical areas that has been hardest hit by AIDS due to the late roll-out of Prevention of Mother to Child Transmission (PMTCT) treatment. In addition, there has been no further development of paediatric facilities in Cape Town since 1994, despite the population increasing from 2,563 million to 3.497 million between 1996 and 2007 (Small, 2008). More recently, between January 2008 and December 2009, RXH has seen turnover of nine junior doctors prior to the end of their contracts (Personal Communication, November 18th, 2009). This equates to approximately 20% of the junior doctor component, constituting a significant loss of skills from a system that can ill afford it.

The purpose of the research is to measure burnout in junior paediatric doctors at RXH through the administration of a standardised measure known as the Maslach Burnout Inventory (MBI). Thereafter, a sample of these doctors was interviewed to qualitatively assess what can be done to mitigate the burnout and the effects thereof.
1.2 Research questions and scope

1.2.1 Primary Question

What proportion of junior paediatric doctors at Red Cross War Memorial Children’s Hospital (RXH) experience burn-out?

1.2.2 Secondary Questions

What influence does burnout have on the retention of paediatric skills at RXH?
What factors contribute to burnout?
What proportion of junior doctors at RXH intend to remain at RXH or in South Africa?
What can the administration at RXH do to mitigate burnout?

1.2.3 Scope

Due to financial and time constraints, the research focused on junior doctors at RXH. The research seeks to function as a pilot study, which will, in the future, be compared with similar studies of junior paediatric doctors in hospitals in first world countries, particularly those countries to which South African doctors migrate. The study will focus on junior doctors, who are more likely to migrate, as they tend to be younger and less constrained by family and financial ties (Grant, 2006). The research is aimed at junior paediatric doctors at RXH in Cape Town. For the purposes of this research, junior doctors are defined as Senior House Officers (SHOs), Registrars and Medical Officers (MOs).

The following is an explanation of the terms used for junior doctors. Within the medical hierarchy at Red Cross, SHOs are the most junior doctors. The SHOs work on contracted rotations of six months. Most SHOs do only one rotation, but a small minority
continue to work as SHOs until they are accepted on to the registrar rotation. At the end of each six month rotation, SHOs either move on to another speciality, attempt to get on to the registrar (Specialist in training) rotation, leave the country, or stay on as a SHO.

Paediatric registrars are specialist paediatricians in training. They are divided into junior registrars and senior registrars. All registrars have to complete four years training and pass two sets of exams (part 1 and part 2). Once they pass both exams they become senior registrars.

Medical Officers are doctors who are not specialists, but have a significant amount of experience in their field. They have generally completed the SHO rotation.

Ideally, a number of groups of junior doctors from different hospitals should have been surveyed in order to obtain a larger sample size, thereby excluding any bias. It may be worthwhile, in future, to include a larger sample of paediatric junior doctors from a number of South African hospitals and conduct a comparative study with one of the countries to which South African doctors migrate.

1.3 Research Assumptions

In this study, the following assumptions have been made:

\[ \sum \text{ Burnout is a dominant factor in the experience of junior doctors at RXH.} \]
\[ \sum \text{ Burnout contributes negatively to the junior doctors’ experience at RXH.} \]
\[ \sum \text{ The results of burnout contribute to the loss of “knowledge workers” in the form of junior doctors.} \]

The underlying assumption of this research is that junior doctors at RXH experience burnout. The assumption is based on the long working hours and tough working conditions at RXH. The assumption is shown to be valid, with junior doctors at RXH
displaying a significantly higher degree of burnout than other doctors on two of the three subscales of burnout. Furthermore, 95% of the doctors surveyed expressed their intention to leave RXH. According to Fogarty, Singh, Rhoads and Moore (2000), turnover intentions have a direct relationship to turnover (leaving one’s job and searching for another). Therefore, even though the research does not indicate an actual loss of skills, the overwhelming intention to leave is directly related to the probable loss of skills in the future.

The research further assumes that burnout is a factor in skills retention. According to Sockel, Mak and Buckolz (2004), turnover is more likely among people who are under constant stress. Furthermore, Sockel et al. cite Moore, 1997; Grensing, 1991; Lee, 1990; and Winnubs, 1993 to indicate that high stress has been linked to employee burnout. This is supported by the research, with 91% of junior doctors experiencing a high degree of burnout on the emotional exhaustion subscale and 95% of junior doctors surveyed indicating that they intend to leave RXH.

1.4 Research Ethics

Prior to the commencement of the research, permission was obtained from the Professor of Paediatric Medicine at Red Cross War Memorial Children’s Hospital (Prof. George Swingler), and the Senior Medical Superintendent (Dr Thomas Blake). The research was also approved by the UCT Faculty of Health Sciences as well as the UCT Graduate School of Business. Confidentiality clauses were signed with interviewees.

The utmost care has been taken to ensure that there is no breach of confidentiality. Confidentiality is vital as the personal opinions of respondents and interviewees have been expressed. The potential exists to damage the occupational progression of the interviewees if there is a breach of confidentiality.
An ethical clearance on-line form from the UCT Graduate School of Business was also completed.

## 2 LITERATURE REVIEW

### 2.1 Discussion

Burnout among health care professionals has received considerable attention in psychological literature (Cherniss, 1980; Freudenberger, 1974, 1980; Koocher, 1979; Maslach, 1978, 1979; Wills, 1978, cited in Rafferty et al., 1986). According to Kalliath, O’Driscoll, Gillespie and Bluedorn (2000), the conceptualisation and measurement of burnout among human service professionals has centred on the most widely used instrument in burnout research – the Maslach Burnout Inventory (MBI).

#### 2.1.1 The Maslach Burnout Inventory (MBI)

Maslach and Jackson (1981) define burnout as the syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishments. Burnout also takes the form of physical, emotional and psychological response to work-related stress. According to Maslach and Jackson, burnout should be viewed as a continuous variable and not as a dichotomous variable that is either present or absent.

The MBI was initially designed for use in all categories of human service workers (Kalliath et al., 2000). This measurement tool was first formulated by Maslach et al. in 1981. In a study by Richardsen and Martinussen (2004), the MBI was found to be both valid and consistent across a sample of seven different professions in Norway. The study cited Leiter and Schaufeli (1996); Enzmann et al., (1995); and Schaufeli & Janczur (1994), concluding that the MBI was both valid and consistent, having been used to study burnout across professions and cultures. The MBI has been tested extensively as
a measure. Internal reliability was estimated using Cronbach’s coefficient alpha (n = 1316). The reliability coefficients for the subscales were: 0.90 for Emotional Exhaustion, 0.79 for Depersonalisation and 0.71 for Personal Accomplishment, where any value greater than 0.70 suggests validity (Maslach et al., 1996). Convergent and discriminant validity of the measure was also demonstrated by Maslach et al. (1996). The convergent validity of a survey instrument indicates whether, if one measures the same trait using another tool or measure, one will get similar results. Discriminant validity indicates whether the survey instrument measures the specific trait and not a similar, yet different trait. In other words, the MBI is an accurate tool for the measurement of burnout.

The MBI measures burnout on three subscales: emotional exhaustion, depersonalisation and reduced personal accomplishments (Maslach, 1981). Bhanugopan and Fish (2004) describe emotional exhaustion as being characterised by lack of energy and a feeling that one’s emotional resources have been depleted. Reduced personal accomplishment is characterised by low motivation and self-esteem, while depersonalisation results in detachment and callousness towards others. “Exhaustion” is viewed as the central quality of “job burnout” and the most obvious manifestation of this complex syndrome.” (Bhanugopan et al., 2004, p. 453) A study by Fogarty et al. (2000) demonstrated that while symptoms of emotional exhaustion and depersonalisation lead to declining performance, job satisfaction and eventual turnover, reduced personal accomplishment does not lead to turnover.

### 2.1.2 Burnout and Skills retention

Medland, Howard-Ruben and Whitaker (2004, p. 48) state that: “Burnout results from prolonged high levels of stress at work and, if left untended, can contribute to the exodus of healthcare workers from these emotionally intense situations.” Medland et al. further state that burnout is costly, not only in turnover, but also with respect to patient care. Increased absenteeism and reduced productivity are common in areas with increased
burnout. Leiter, Harvie and Frizzell (1998, cited in Medland et al., 2004) describe a direct correlation between burnout and quality of care: Patients reported less satisfaction with the quality of care they received in units where the staff was burnt out.

Barak, Nissly and Levin (2001) state that high employee turnover has grave implications for the quality, consistency and stability of services provided. Barak et al. also cite Todd and Deery-Schmitt (1996) and Geurts et al. (1998), who found that high turnover rates can reinforce patients’ mistrust of the system and can discourage health care workers from remaining in or even entering the field. Barak et al. further cite Powell and York (1992), stating that “turnover can have detrimental effects on clients [and therefore patients] and remaining staff members who struggle to give and receive quality services when positions are vacated and then filled by inexperienced personnel” (p. 626) and “Human capital lies within a person. Hence, it is not easily transferable; it can be gained only by investing in a person over a long period of time” (Barak et al., 2001, p. 627). In healthcare this is particularly relevant, as there is a vast cost of lives, time and commitment in transferring clinical acumen from one person to another. It follows, therefore, that the prerequisite for a health system which is itself healthy, is a system in which healthcare workers are not burnt out.

2.1.3 Burnout in Medical Services

According to Garza, Schneider, Promecene and Monga (2004), individuals who experience burnout perpetuate burnout in those around them. Furthermore, Lert, Chastang and Castano (2001) state that it is commonly accepted that high levels of stress in medical practice lead to increased risk of suicide, psychiatric morbidity, drug use and family disruption (Valiant et al. 1970, 1972; Johnsen et al. 1995; cited in Lert et al. 2001). "Stress can be of utmost importance in a paediatric and neonatal intensive care unit (PNICU), as the interpersonal relations between staff and relatives can create
dysphoric and depressive reactions in the professionals.” (Fogaça, Carvalho, Citero and Norgueira-Martins, 2008, p. 262)

According to Fogarty et al. (2000), burnout has a direct dysfunctional influence on psychological performance and behavioural outcomes (job satisfaction, turnover intentions and job performance). In addition, “burnout tendencies appear to significantly and positively affect turnover intentions” (Fogarty et al., 2000, p. 50). According to Barak et al. (2001, p. 653) burnout is an important predictor of both intention to leave and turnover among human service professions. However, many employees feel a greater responsibility and commitment to their patients than they do towards their work organisation. This results in a conflict between the conditions (e.g. high case loads) and the employees’ own professional sense of duty, which results in some employees placing the needs of patients above their own emotional health, with high resulting levels of burnout. The net result is the loss of healthcare workers and the knowledge which they possess.

According to Thanacoody, Bartram and Casimir (2009), the issues of burnout and intention to leave are particularly salient in the healthcare industry, which is currently facing critical shortages of clinicians and a difficulty in retaining these employees. Job stress has been shown to be positively associated with absenteeism and turnover among clinicians, in general (Stordeur et al., 2001, cited in Thanacoody et al., 2009). Barak et al. (2001) cite Dunkin et al. (1994); Coward et al. (1995); Alexander et al. (1998) and Hendrix et al. (1999), stating that there is evidence to prove that workers typically make a conscious decision to quit long before doing so and that this decision is the single strongest predictor of turnover. It is therefore more practical to measure intention to quit in a cross-sectional study than to opt for a longitudinal study and track down workers who have already quit. In addition, this methodology puts the research at risk for hindsight bias.
Grant (2006) found that doctors who migrate tend to be young. This is echoed by Barak et al. (2001) who state that it is generally accepted that younger employees are more likely to leave than their older counterparts. Barak et al. further state that turnover rates are considerably higher among employees with a shorter length of service than those with longer tenures (Bloom, Alexander and Nuchols 1992; Gray and Phillips 1994; Somers 1996; cited in Barak et al. 2001).

### 2.1.4 Burnout in South Africa

Peltzer, Mashego and Mabeba (2003) found that in South Africa, job stress levels predicated burnout experienced by doctors. Job stress was higher among South African physicians than physicians in Europe or the United States. In their study, Peltzer et al. (2003) found that the three greatest factors for job stress among South African physicians were: working overtime, making critical, on-the-spot decisions and dealing with crisis situations. One might deduce, therefore, that if healthcare workers migrate due to burnout, they would choose to migrate to countries where overall job stress levels are lower. These countries would therefore be ones where physicians work more favourable hours, have greater support and fewer crisis situations to manage. One might further deduce, therefore, that in South Africa, the main contributing factors to burnout are the long hours, lack of support and the stress brought about by crisis situations, which is confirmed in the qualitative analysis this research provides.

### 2.1.5 What can be done to mitigate burnout?

Existing literature suggests a number of interventions to mitigate burnout. Some are more applicable in resource-scarce South Africa than others. Thanacoody et al. (2009) recommend mentoring programmes, in order to provide a coping resource. Further recommendations include the suggestion that hospital managers find inventive ways to
set shifts according to individual needs, as well as providing incentives to do unpopular shifts. The establishment of workload standards (e.g. maximum hours worked per day/week/month) is also suggested by Thanacoody et al. “Other steps associated with the amelioration of burnout may include improved recruitment and retention of new trainees and the introduction of productivity aides such as enhanced information systems” (Grunfeld et al., 2004, cited in Thanacoody et al., 2009, p. 65).

Medland et al. (2004) propose that expressing appreciation for the clinician as a cherished resource helps mitigate burnout. This can be done in a number of ways: financially, verbally, furthering their education, and “including programs that allow them to creatively manage the emotional components of their role and to learn and cultivate life- and practice-enhancing skills” (p. 48). Medland et al. (2004) also suggest building a sense of community in the work place, in order to cultivate social support networks.

Furthermore, Barak et al. (2001) note that their research found that, workers with less experience and those workers who feel less competent are more likely to leave. Barak et al. go on to suggest that, “managers might avoid turnover if they invest in training and job-related education that increases work-related knowledge and employee self-efficacy. These feelings of increased competence might be accomplished through more comprehensive new-employee orientation programs, the development of peer-support groups, or the teaming of new employees and more experienced colleagues.” (p. 656) Further equipping employees with competence and work-related knowledge may be achieved through mentoring programmes.

Other strategies identified in the literature by Medland et al. (2004) include staff retreats, four-day work weeks and an increase in staff size (Keidel, 2002). These strategies are, however, less applicable to the resource-scarce South African environment due to budget constraints and the lack of personnel to provide relief for those on retreats.
2.2 Conclusion

Although extensive research has been devoted to burnout, turnover and skills retention in other medical specialities, very little research has been conducted on the topic of burnout in paediatric doctors. In particular, there appears to be very little literature on burnout in paediatric doctors in South Africa.

The following salient points have emerged from the literature:

The Maslach Burnout Inventory is a valid and reliable tool to measure burnout in paediatric doctors. There is evidence in the literature to suggest that there is a direct relationship between burnout and the intention to leave, absenteeism, reduced productivity, low morale and psychiatric morbidity. Intention to leave can be used as a proxy for turnover/skills retention. Burnout is inversely related to patient satisfaction, patient care, stability and consistency of services provided. Younger doctors are more likely to migrate or leave an organisation. It is therefore prudent to study the effects of burnout on young doctors in order to build and sustain the health industry in South Africa. In order to stop the “medical carousel” (Grant, 2006, p681) we need to “address the antecedents of burnout” in order that we “may potentially contribute to the challenges associated with attracting and retaining critical clinicians” (Thanacoody et al., 2009, p. 64).

Maslach and Leiter (1998, p. 18, cited in Medland et al., 2004) state that burnout “represents an erosion in values, dignity, spirit, and will – an erosion of the human soul” and that it occurs in areas where job demands exceed the support and resources available to employees. Maslach and Leiter conclude that burnout is not related to people, but rather to the places in which they work, and that self improvement alone will therefore not ameliorate burnout.
Maslach (1982, p. 40) provides an apt summary of the burnout dilemma: “the promise inherent in understanding burnout is the possibility of doing something about it.” The research therefore attempts to investigate the existence of burnout at RXH and provide potential avenues to address the effects thereof.

3 RESEARCH METHODOLOGY

3.1 Research approach and strategy

The research was conducted in two sections.

The first section is quantitative in nature. An instrument known as the MBI (see Appendix 1) was used to measure the level of burnout experienced by the junior doctors. This standardised inventory allows the measurement of the degree of burnout in an individual. The inventory consists of 22 items answered on a Likert scale from “never” to “every day”. Each aspect of burnout is then scored according to the Likert scale; the higher the score, the greater that aspect of burnout. The questionnaire also included questions regarding the demographics of the respondent, as well as intentions to leave or migrate and questions regarding mentoring. The burnout scores were compared statistically to normative data of a sample (n=1104) of doctors, supplied by Maslach et al (1996). The first section of the research is therefore deductive in nature in that it seeks to compare the doctors at RXH to a larger group of doctors from a wider selection of countries and hospitals; reasoning that if the burnout scores are significantly greater in the sample from RXH than the normative sample, one can deduce that the doctors at RXH are burnt out. Furthermore (though more tenuously), if burnout is directly related to turnover as Medland et al. (2004) claim, and a high proportion of junior doctors intend leaving, it can be deduced that something needs to be done to mitigate the antecedents of burnout.
The second section of the research is qualitative in nature and consists of four interviews. The interviewees comprised one SHO, one junior registrar and two senior registrars. The interviews were recorded and transcribed (see Appendix 3). The interviews were subsequently coded and analysed in order to provide suggestions of what can be done to mitigate burnout at RXH. This section of the research is inductive in nature.

Since its creation by Maslach et al. in 1981, the Maslach Burnout Inventory has been widely used as a measure of burnout in many professions, including health services. Kalliath et al. (2000) tested the MBI in three samples of healthcare professionals, while Rafferty, Lemkau, Purdy and Rudisill (1986) tested the validity of the MBI in family practitioners as long ago as 1986. According to Kalliath et al. (2000), the MBI is the most widely used instrument in burnout research. It consists of a questionnaire comprising 22 questions which rate the individual’s state of emotional exhaustion, depersonalisation and lack of sense of personal accomplishment.

The use of a measure like the MBI was selected in order to examine the current situation with a degree of objectivity (the index has been shown to be both reproducible and valid (Richardsen and Martinussen, 2004)). Thereafter, it is possible, through inductive reasoning, to provide suggestions to mitigate the effects of burnout, basing the suggestions on recommendations in the literature.

This approach rested on the assumption that there was a significant amount of burnout experienced at RXH. However, through inductive reasoning, it is possible to argue that even if there was not a significant amount of burnout at RXH, procedures would still have to be put in place to mitigate its effects, as the literature suggests that it leads to the turnover of skills.
The research further assumes that one can induce plausible suggestions to mitigate burnout by means of interviewing junior doctors and not the administrators and senior doctors. Although junior doctors were the sole interviewees, they were interviewed regarding their reality. This is an important perspective to present, as the junior doctors are the employees experiencing the burnout. The subsequent coding of the interviews was garnered from the relevant literature. Relying on the interviews as a view of the perspective of the junior doctors, the categories that were mentioned most often were used to formulate suggestions to mitigate burnout. In this manner, the suggestions formulated were based on evidence from existing research.

3.2 Research design, data collection methods and research instruments

The research design is cross-sectional in nature. It attempted to obtain MBI responses from as many of the junior doctors at RXH during November 2009 as possible. Most previous studies regarding burnout in the literature are cross-sectional (Cordes and Dougherty, 1993 cited in Kalliath et al., 2000). Because anyone can be susceptible to burnout, given the right conditions, cross-sectional studies are done to assess the amount of burnout in a community at a particular period in time, for a particular set of conditions. As conditions in any organisation are fluid, the time period that is measured was limited to one month. Furthermore, due to the nature of the work required by the junior doctors, their time is limited. Motivating the doctors to give of their time for this study therefore posed a major challenge. As participation in the study could keep the doctors away from their patients, it was regarded as ethically prudent to take up as little of their time as possible. For this reason an electronic questionnaire was constructed and disseminated amongst the junior doctors via email. They were encouraged at regular intervals to complete it after hours.

The completion of the questionnaire was performed on a voluntary basis and the respondents were able to complete the questionnaire privately, thereby minimising
response bias. In addition, the questionnaire was anonymous, as it was conducted through a third party, which ensured respondent confidentiality. Anonymity served to allow the respondents to express their true feelings. Furthermore, the questionnaire was presented as a survey on skills retention and it did not make any mention of burnout. This ensured that the respondents were not sensitised to the concept of burnout and did not tailor their responses in this regard. Only those questionnaires which were completed in full were analysed. Partial answers were discarded to protect the validity of any correlations or assumptions made.

The first section of the research consisted of a questionnaire, including the 22 points of the MBI discussed above (see Appendix 1), demographic data and turnover and migration intentions. This section was analysed quantitatively. The MBI consists of 22 Likert scale questions which assess how frequently a respondent experiences certain thoughts and feelings. The scale ranges from “never” to “every day”. The questions assess the respondent’s burnout on each of the three subscales in a non-uniform manner. The totals were subsequently added up and compared to normative samples supplied by the MBI manual.

The second section of the research involved four interviews. The interviews followed a semi-structured standardised format and were completed in person. They were subsequently transcribed (see Appendix 3) and coded into categories, based on previous research conducted by Grunfield et al., Thanacoody et al., Medland et al. and Keidel. Interviews were quantitatively assessed to induce those factors which the interviewees felt contributed to burnout, and what action they felt should be taken by the administration of RXH to mitigate these factors.

The interviewees were chosen by means of convenience sampling – i.e. they volunteered as a part of the survey. Due to the nature of the standardised, semi-
structured interviews and the subsequent transcription and coding, the size of the sample is not likely to radically influence the results. Similar qualitative research has been used extensively in ethnographic studies in order to understand organisations or cultures. This approach may, however, detract from the validity of the study, and as the reproducibility may be limited (Bryman and Bell, 2003).

A comparative study, comparing the degree of burnout and skills retention at RXH to another hospital in a country without the same stressors and hours of work experienced by the junior doctors at RXH, was also considered. However, this was not conducted due to time and financial constraints.

3.3 Sampling

The sample for section one of the research was derived from the population of junior doctors at RXH in the month of November 2009. The relevant population for the time period concerned consisted of 24 registrars and 15 SHOs (a total of 39 junior doctors). An email with a link to an electronic survey was sent to all the SHOs and registrars. At no time was burnout mentioned in the emails. The email informed potential respondents that a study was being done on skills retention. Completion of the survey was voluntary, resulting in a random sample. However, there may have been a certain element of bias due to the fact that people who are dissatisfied with their work environment are perhaps more likely to respond to such a survey.

In order to ensure a high response rate and minimise potential bias, the questionnaires were sent out by email repeatedly until 60% of the population had responded. According to Bryman and Bell (2003), who cite Mangione (1995), a 60–70% response rate for postal questionnaires is acceptable and adequately represents the population studied. This response rate represents a 90% confidence interval with a 10% margin of error.
The sample for section two was accomplished through convenience sampling, consisting of one SHO, one junior registrar and two senior registrars. In the survey a request was made that the respondents volunteer for interviews. Eight responses were received, of which four were selected. Although there is a potential for bias from the volunteers, as one is more likely to volunteer if one is unhappy, the objective of the interviews was to discern ways in which burnout could be mitigated. For this reason the researcher felt comfortable with the sampling technique with respect to the interviews.

The interviews were conducted after hours in the interviewees’ own time.

3.4 Data analysis methods

Section one consisted of a self-answered questionnaire which relied on the MBI as its backbone. The MBI measures three aspects of burnout: depersonalisation, emotional exhaustion and reduced personal accomplishment, and subsequently provides a score to measure total burnout.

Respondents were also questioned regarding the average hours of work per week, the degree of perceived supervisor support and intentions to leave. Supervisor support has a direct correlation with job satisfaction and, as a result, also influences burnout (Hyrakäs, Appelqvist-Scmidechner and Haataja, 2006).

Measures for each aspect of burnout were calculated by means of the MBI research manual. A mean score and standard deviation for the sample was calculated. Using a z-test, these measures were subsequently then compared to a normative sample of medical doctors (n=1104) to discern if there was a statistically significant difference in the means.

Section two of the study consisted of four semi-standardised interviews. These interviews were transcribed and analysed into subjects and themes by means of coding
to assess the following: the factors that lead to burnout and the steps that can be taken by the administration to mitigate burnout.

4 RESEARCH FINDINGS, ANALYSIS AND DISCUSSION

4.1 Research Findings and Analysis

4.1.1 Demographics

5 Figure 1: Gender Proportions of Junior Doctors at RXH

As is evident from Figure 1, the predominant proportion (73%) of respondents was female. This is not surprising, as there has been a trend towards increased numbers of female graduates in the health sciences in recent years. Furthermore, the proportion of female to male doctors in the under-35 year age group in Canada is 56% to 44% respectively (Canadian Medical Association, 2007). Figure 2 shows the breakdown by occupation of the respondents.

The mean age of the respondents is 30 years (SD: ±3.26 years). The mean postgraduate experience is five years and nine months (SD: ±2 years 9 months). The mean hours worked per week is 62.4 hours (SD: ±12 hours). This suggests that the average junior doctor at RXH is a 30 year old female, with almost six years post-
graduate experience who works approximately 62 hours a week. This is significant, because if RXH aims to attract and retain staff, allowances must be made for the fact that female employees might want to have a family. In a scarce skill environment such as this, an organisation that has progressive maternity and childcare policies is more likely to attract and retain the skills it requires. This is confirmed by interviewee 2 (Appendix 3): “I have got a one year old at home, so that overtime has been completely hectic for me….so I got a job where I won’t have to do overtime.”

In Figure 2 (below), it is evident that 11 out of the 22 respondents were SHOs. Of the remaining 11 respondents, 10 were registrars, and one was a medical officer. This equates to a 73% response rate from the 15 SHOs and a 42% response rate from the 24 registrars. These results are not surprising as the SHOs were actively encouraged to respond by their supervisor. The total response rate was 60%. There were 22 responses and two incomplete responses from 39 junior doctors.

**Figure 2: Occupational Proportion**

![Pie chart showing occupational proportion of SHOs, Registrars, and Medical Officers.]

<table>
<thead>
<tr>
<th>SHO</th>
<th>Registrar</th>
<th>MO</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>45%</td>
<td>5%</td>
</tr>
</tbody>
</table>
5.1.1 **Turnover Intentions**

Virtually all the respondents indicated an intention to leave at the end of their rotation (Figure 3). This corresponds to the high levels of emotional exhaustion illustrated by the survey (Table 1). Further research remains to be conducted in this regard as the low numbers in the “stay” row contra-indicate the use of statistical tools to make statistical deductions.

**Table 1: Comparison between Emotional Exhaustion and Intention to leave**

<table>
<thead>
<tr>
<th></th>
<th>High</th>
<th>Moderate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leave</td>
<td>19 (86%)</td>
<td>2 (9%)</td>
<td>21 (95%)</td>
</tr>
<tr>
<td>Stay</td>
<td>1 (5%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Total</td>
<td>20 (91%)</td>
<td>2 (9%)</td>
<td>22 (100%)</td>
</tr>
</tbody>
</table>

As is evident from the contingency table above, there is a strong correlation between high levels of emotional exhaustion and intention to leave.

Figure 3 (below) is a striking illustration of the fact that, with only 5% of the sample indicating an intention of staying at RXH once their rotation is completed, there is a significant problem regarding the retention of valuable skills.
Furthermore from Figure 4 (above) it is clear that almost a third of paediatric junior doctors intend migrating from South Africa at some stage, taking their valuable skills with them. According to Benetar (2007) cited in Bezuidenhout, Joubert, Hienstra and Struwig (2009), it costs approximately US$100 000 to train a medical graduate (or R750 000 at
As a result, the migration of health care workers costs developing countries approximately US$500 million annually (or R3.75 billion). These amounts do not include the costs of attaining additional skills. RXH and South Africa therefore stand to forgo a significant amount of capital in lost medical skills.

5.1.2 Burnout

All 22 respondents experienced burnout on one of the three subscales of burnout. Figure 5 clarifies the percentage of junior doctors surveyed that experienced high, moderate or low degrees of burnout on each of the burnout subscales. Each subscale was then statically compared to a normative sample of 1 104 doctors.

Figure 5: Burnout experienced by Junior Doctors

5.1.2.1 Emotional Exhaustion (emotional resources are used up)

The score for Emotional Exhaustion can be categorised as follows:
Low  \leq 18
Moderate  19 – 26
High  \geq 27

These scores represent the lower, middle and upper thirds of a normative sample of 1104 doctors, with a mean of 22.19 (SD: ±9.53). The mean score for emotional exhaustion from the sample of junior doctors at RXH was 37.68 (SD: ±8.90).

The probability of a significant difference in the mean score for emotional exhaustion was calculated by means of a z-test.

\[ H_0 = \mu_1 - \mu_2 = 0 \]
\[ H_a = \mu_1 - \mu_2 > 0 \]

p-value = 3.29 \times 10^{-13}

The null hypothesis was therefore rejected. In other words, the levels of emotional exhaustion among the junior doctors at RXH are significantly higher than one would expect from a population of doctors when compared to the normative sample (n=1104) supplied by Maslach et al (1996) in their research guide. This is evident in Figure 5 below. At RXH, 91% of junior doctors are emotionally exhausted, and 9% are moderately exhausted. None of the junior doctors experienced a low level of emotional exhaustion.

5.1.2.2 Depersonalisation (detachment and callousness towards others)

This score can be categorised as follows:

Low  \leq 5
Moderate  6 - 9
High  \geq 10

The mean from the normative sample previously described is 7.12 (SD: ±5.22). The mean score for this subscale of burnout for the sample was 12.63 (SD: ±5.60).
Once again a z-test was used to measure whether a significant amount of depersonalisation was experienced at RXH.

\[ H_0 = \mu_1 - \mu_2 = 0 \]
\[ H_a = \mu_1 - \mu_2 > 0 \]
\[ \text{p-value} = 2.35 \times 10^{-7} \]

The null hypothesis is therefore rejected. In other words, there are significantly higher levels of depersonalisation at RXH than one would expect in a population of doctors when compared to the normative sample \((n=1104)\) supplied by Maslach et al (1996) in their research guide.

As is evident from Figure 5 (above), 73% of junior doctors at RXH experience a high degree of depersonalisation. This is particularly concerning, as it implies that three quarters of the junior doctors are detached and callous to their patients, which has implications for the quality of patient care.

### 5.1.2.3 Reduced Personal Accomplishment (low motivation and self esteem)

This score can be categorised as follows:

- **Low** \( \geq 40 \)
- **Moderate** 39-34
- **High** \( \leq 33 \)

The mean from the normative sample previously described is 36.53 (SD: ±7.71). The mean score for this subscale of burnout was 32.14 (SD: ± 5.83). In other words, on average, junior doctors at RXH experience a moderate degree of personal accomplishment.
Once again a z-test was used to measure whether a significant amount of reduced personal accomplishment was experienced at RXH.

\[ H_0 = \mu_1 - \mu_2 = 0 \]
\[ H_a = \mu_1 - \mu_2 > 0 \]
\[ p\text{-value} = 0.998 \]

The null hypothesis is therefore not rejected, and it can be concluded that the junior doctors at RXH experience an average degree of personal accomplishment when compared to an average population of doctors. With significantly higher degrees of emotional exhaustion and depersonalisation, this result prompts the question: “Why do the junior doctors at RXH experience a degree of personal accomplishment that is experienced by doctors in less stressful environments?” In their research, Fogarty et al. (2000) suggest that low personal accomplishment is not related to intention to leave. This raises the question of the significance of personal accomplishment. However, as is evident from interviewee 1 (“You see amazing things. You have an opportunity to manage quite complicated cases to an extremely high level”), autonomy and experience are strong motivators for remaining at RXH.

5.1.3 Impact of mentors on burnout

As is evident from Figure 6 below, only 5% of junior doctors have a formal mentor, with just over half having no mentor at all. A comparison of the presence of a formal or informal mentor with the different scales of burnout does not appear to provide any correlation. This is contrary to the findings of Thanacoody et al. (2009) who recommend supervisory social support. However, from Table 2 it is clear that the lack of support is a significant stressor for junior doctors. Furthermore, the lack of a mentor is also viewed by interviewees as a stressor and a factor that could be addressed to mitigate burnout.
5.1.4 **Recommendations from junior doctors**

Among the responses to the survey of the junior doctors, by far the most common recommendation for improvement for skills retention was revising the shift and leave system. This suggestion was strongly linked to the recruitment of additional staff (see Table 2 and Figure 9.)

**Table 2: Recommendations from junior doctors for improving skills retention at RXH**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revising shift and leave system</td>
<td>16</td>
<td>28%</td>
</tr>
<tr>
<td>Recruitment</td>
<td>11</td>
<td>19%</td>
</tr>
<tr>
<td>acknowledgement</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Training</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Supervisor input and support</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>Job sharing</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Improve recreational facilities</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Pay incentives</td>
<td>2</td>
<td>3%</td>
</tr>
</tbody>
</table>
Other key areas that could be prioritised in order to mitigate burnout, according to the junior doctors surveyed, were greater acknowledgement for the work done; improved training, with dedicated times for training that are covered by colleagues; and greater supervisor input and support.

**Figure 9: Recommendations from junior doctors for improving skills retention at RXH**

Other key areas that could be prioritised in order to mitigate burnout, according to the junior doctors surveyed, were greater acknowledgement for the work done; improved training, with dedicated times for training that are covered by colleagues; and greater supervisor input and support.
5.1.5 **Analysis of interviews – causative and mitigating factors of burnout**

The interviews were analysed to assess what causes burnout at RXH and what can be done to mitigate burnout at RXH. Categories were coded from previous research conducted by Grunfield et al., Thanacoody et al., Medland et al. and Keidel.

### 5.1.5.1 Factors that cause burnout

Workload is by far the greatest contributing factor to burnout amongst the junior doctors. Due to the workload, the doctors felt that there was not enough time to provide a level of care that they deemed necessary. This was exemplified by interviewee 3, “You feel you aren’t necessarily doing the best you can for every patient because people are spread just too thinly on the ground.” This confirms the research of Fogarty et al. (2000) who suggest that role overload (i.e. workload) and role conflict (imposition of mutually incompatible expectations) are antecedents of burnout. Unrealistic workload expectations are associated with the second highest contributing factor – insufficient recruitment. This outcome echoes the findings of Grunfeld et al., 2004, cited in Thanacoody et al., 2009. Likewise, long working hours are also associated with workload and insufficient recruitment, but whereas the latter two can only be solved through recruitment, working hours can, to some extent, be ameliorated through inventive shift systems and the spreading of responsibility.

The category “Poor Planning” relates to administration foresight, and the management of potential problems. These include both HR management, such as pending maternity leave of colleagues, (as stated by interviewee 4: “there is no backup plan, there are two registrars on maternity leave…then the second doctor took maternity leave and will be off for eight months and they are still not replacing her”) and Operations Management planning with regard to the potential influx of patients (as is typically the case during the annual gastroenteritis season).
Emotional stress also added to the experience of burnout amongst junior doctors. This can be mitigated through mentorship, peer support groups, debriefing sessions and more comprehensive new employee orientation programmes. Examples of how interviewees could have benefited from the latter include not placing an SHO in “Med Reg” on her first night or a new registrar in ICU on their first night.

Table 3: Factors that cause burnout

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td>40</td>
<td>26%</td>
</tr>
<tr>
<td>Insufficient Recruitment</td>
<td>30</td>
<td>19%</td>
</tr>
<tr>
<td>Emotional Stress</td>
<td>29</td>
<td>19%</td>
</tr>
<tr>
<td>Poor planning</td>
<td>25</td>
<td>16%</td>
</tr>
<tr>
<td>Long hours</td>
<td>25</td>
<td>16%</td>
</tr>
<tr>
<td>Lack of empathy from Administration</td>
<td>24</td>
<td>15%</td>
</tr>
<tr>
<td>No Supervision/Support</td>
<td>16</td>
<td>10%</td>
</tr>
<tr>
<td>No Mentoring</td>
<td>15</td>
<td>10%</td>
</tr>
<tr>
<td>Poor training</td>
<td>13</td>
<td>8%</td>
</tr>
<tr>
<td>No Acknowledgement/Appreciation</td>
<td>7</td>
<td>4%</td>
</tr>
<tr>
<td>Inter-colleague stress</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>Effect on personal life</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>No job sharing</td>
<td>2</td>
<td>1%</td>
</tr>
</tbody>
</table>

5.1.5.2 Factors that mitigate burnout

The analysis of the interviews suggested that a great deal of burnout experienced by the junior doctors could be mitigated through increased recruitment and improved management and planning by the administration. Increased support from senior colleagues, formal mentorship and an administration that is empathetic to their situation also featured highly as factors that would mitigate the experience of burnout.

Formal mentorship and 360° feedback sessions at the end of each block would serve to motivate, encourage and support junior doctors in their efforts to become better doctors.
Table 4: Factors that mitigate burnout

<table>
<thead>
<tr>
<th>Factor</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>17</td>
<td>13%</td>
</tr>
<tr>
<td>Improved Management/Planning</td>
<td>17</td>
<td>13%</td>
</tr>
<tr>
<td>Support</td>
<td>15</td>
<td>12%</td>
</tr>
<tr>
<td>Mentorship</td>
<td>14</td>
<td>11%</td>
</tr>
<tr>
<td>Empathetic Administration</td>
<td>14</td>
<td>11%</td>
</tr>
<tr>
<td>Improved Staff relationships</td>
<td>13</td>
<td>10%</td>
</tr>
<tr>
<td>Reduced hours</td>
<td>13</td>
<td>10%</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>10</td>
<td>8%</td>
</tr>
<tr>
<td>Acknowledgement</td>
<td>9</td>
<td>7%</td>
</tr>
<tr>
<td>Improved Training</td>
<td>8</td>
<td>6%</td>
</tr>
</tbody>
</table>

5.2 Research Discussion

5.2.1 Demographics

A significant proportion of the junior doctors are female. This is not surprising as there are increasing numbers of female medical graduates, with women being highly represented in paediatrics (Heru, 2005). The average age of junior doctors is approximately 30 years. This is significant as many junior doctors are consequently forced to choose between continuing with their careers or having a family. Bearing in mind the affinity for children one might expect from those who choose to work in a profession geared towards the health of children, this is an onerous choice to place on such individuals. With this in mind, it would be prudent to make a concerted effort to devise solutions which allow for both a family and a career, if an organisation such as RXH wishes to retain these skills.
5.2.2 Burnout and skills retention

It is clear that a significant amount of burnout is experienced at RXH, with 100% of the junior doctors experiencing burnout on one of the three subscales. The causative factors of this burnout are long hours, high workload, complicated cases, lack of support and a lack of empathy from the administration. These factors have been linked to 95% of the junior doctors expressing an intention to leave RXH. According to Medland et al. (2004) this is costly, not only due to the loss of skills, but also in terms of a decline in the levels of patient care.

Along with globalisation has come an ease of migration (Grant, 2006), resulting in a situation where South Africa is forced to compete with wealthier countries for its own scarce skills. Almost one third of the junior doctors at RXH intend migrating. As South Africa’s healthcare resources are limited, it is prudent that creative ways are found to increase the attractiveness of working in the healthcare industry in South Africa.

5.3 Research Limitations

The limitations of the research were primarily influenced by time and financial constraints, resulting in limited collection of data. The study is cross-sectional in design, and examined a relatively small population of doctors at one point in time in one hospital. A larger sample and population would have been beneficial to reduce bias. A longitudinal study would have also assisted in tracking the degree of burnout over time, and the correlation thereof with turnover of doctors.

Furthermore, the research group, junior doctors, are overworked and, as such, had limited time available to complete the survey, let alone meet for an interview, while balancing social and study commitments.
As a result of financial constraints, a comparative study was not entered into. A comparative study would have assisted in discerning some of the factors causing and mitigating burnout. The study only examined junior paediatric doctors at RXH. It is therefore not representative of all junior doctors or all paediatric doctors in South Africa.

The research was further limited by the difficulty in obtaining permission from all the relevant departments at RXH. This placed further time pressures on the research, resulting in a lower response rate.

6 RESEARCH CONCLUSIONS

All 22 respondents (from the total group of 39 junior doctors at RXH) experience burnout on one of the three subscales of burnout. Only one respondent intends to remain at RXH. This has grave consequences for the quality of care and the ability for RXH to attract and retain further skilled “knowledge workers”.

The loss of these junior doctors is costly to RXH. Discounting the additional skills gained during their tenure at RXH, the loss of each junior doctor costs the organisation US$100 000 (Bezuidenhout et al., 2009). With 21 junior doctors intending to leave, the total cost thus exceeds US$2.1 million – and this amount does not include all the indirect costs incurred while training new junior doctors. There is also an additional cost in terms of the lives of the patients who are treated by the organisation.

Steps must be taken to mitigate the burnout experienced at RXH. These steps may include:

6.1 Financially-based mitigating factors

a) Recruitment of additional clinical staff (MO, SHOs, registrars and consultants);

b) More liberal use of temporary staff such as locums;

c) The introduction of improved productivity aids such as information systems;
d) Team building activities within departments; and  
e) Dedicated training times

6.2 **Non-financially-based mitigating factors**

a) A mentor system with regular sessions for all junior doctors;

b) 360° feedback sessions at the end of each rotation, focusing on both the positive areas of the junior doctor’s block and the areas for improvement;

c) An orientation programme that allows new junior doctors to buddy with an experienced junior doctor;

d) Improved communication and transparency between the administration, senior doctors and junior doctors. This could include the election of a “Chief Registrar” and “Chief SHO” to represent the junior doctors and their needs;

e) Creative shift and leave rosters;

f) Job sharing; and

g) Exit interviews with junior doctors to ascertain why they are leaving and what can be done to improve the system.

7 **FUTURE RESEARCH DIRECTIONS**

7.1 **Comparative studies**

Future studies could compare the burnout between specialities such as anaesthetics (which is comparatively well staffed and involves less arduous hours), or within the same speciality at different hospitals. It might be of interest to compare the burnout at RXH with that at Tygerberg, or alternatively Starship Children’s Hospital in New Zealand. A comparative study would enable the determination of the differences in levels of burnout between the hospitals, and the underlying reasons for these differences.
7.2 Longitudinal studies

If any changes to the working situation of junior doctors at RXH are instigated in the near future, it might be of interest to repeat the survey and determine the effect of the changes on the degree of burnout experienced by the junior doctors.

8 BIBLIOGRAPHY


9 APPENDICES

9.1 Appendix 1 – Survey Questionnaire and Research Instrument

---

University of Cape Town - Graduate School of Business

**Doctor’s Survey - Skills Retention at Red Cross Children’s Hospital**

1. Gender?  
   - Male □  
   - Female □

2. Age?  
   _ _______________

3. Year qualified?  
   __________________

4. Registrar □  
   SHO □  
   MO □

5. Average hours of work per week?  
   __________________

6. How long have you worked at RXH? (in months)  
   __________________

7. Do you intend staying at RXH when you have finished your rotation?  
   Yes □  
   No □

8. Do you intend to work overseas?  
   Yes □  
   No □

9. Do you have a mentor at RXH?  
   Formal □  
   Informal □  
   None □
Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>Never</th>
<th>A few times a year or less</th>
<th>Once a month less</th>
<th>A few times a month</th>
<th>Once a week</th>
<th>A few times a week</th>
<th>Every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Statements
How Often
(0 – 6)

1. ______ I feel emotionally drained from my work.
2. ______ I feel "used up" at the end of my working day.
3. ______ I feel fatigued when I get up in the morning and have to face another day on the job.
4. ______ I can easily understand how my patients and the parents of my patients feel about things.
5. ______ I feel that I treat some patients as if they were impersonal objects.
6. ______ Working with people all day is a real strain for me.
7. ______ I deal very effectively with the problems of my patients.
8. ______ I feel burned out from my work.
9. ______ I feel that I'm positively influencing other people's lives through my work.
10. _____ I've become more callous towards people since I took this job.
11. _____ I worry that this job is hardening me emotionally.
12. _____ I feel very energetic.
13. _____ I feel frustrated by my job.
14. _____ I feel I am working too hard on my job.
15. _____ I don't care what happens to some patients.
16. _____ Working with some people directly puts too much stress on me.
17. _____ I can easily create a relaxed atmosphere with my patients.
18. _____ I feel exhilarated after working closely with my patients.
19. _____ I have accomplished many worthwhile things in this job.
20. _____ I feel like I am at the end of my rope.
21. _____ In my work I deal with my emotional problems very calmly.
22. ____ I feel patients are to blame for some of their problems.
9.2 Appendix 2 – Junior Doctor-suggested methods of increasing skills retention at RXH

1. Recruit additional staff, particularly in gastro season.
2. Restructure the shift system in the short stay wards (S11 & gastro). This is the most draining part of the SHO rotation and invariably it is what makes most people leave the SHO rotation.
3. We need more staff, to cope with workload and reduce burnout.
4. Post call should end at 8am, instead of 1pm.
5. Provide more supervision and help from consultants.
6. Pay incentives if working extra hours.
7. Employ more staff.
8. Offer better pay.
10. Improve the attitude of authoritative figures towards their staff.
11. Acknowledge the fact that doctors also have personal lives and are professionals who need to be treated as such.
12. More bodies to cover the workload, not only junior, but also senior staff. This will improve service delivery and training. I feel the training of registrars comes last in line after all the students have been sorted out.
13. Personal mentors will be great, but they will need to have time available to make it useful.
14. Some practical procedures, e.g. venopuncturing can easily be shared with nursing staff, which would decrease workload on junior doctors immensely.
15. Parents of patients need to be made more aware of the referral system to prevent walk-ins after hours.
16. Allow people to opt out of overtime and use their unused overtime money to pay for locums.
17. Weekend rounds should to be abolished. Or encourage the consultants to come in and see patients on the weekends so it is only necessary to be in the hospital on the weekends when one is on call.
18. Offer more support internally for doctors and stress-related problems.
19. Encourage a supportive environment among colleagues.
20. Provide designated mentors.
21. Initiate debriefing sessions.
22. Develop a better system to allow people to choose when they want to take leave.
23. Allow the option of opting out of overtime, or allow breaks from overtime as necessary (e.g. one month at a time) to allow for rest. Most people cannot live without the extra income anyway and will opt to do overtime.
24. Develop a better shift system.
25. The training programme should be more structured towards specific goals, equal for all and it should not be left to chance which rotations one gets.
26. Initiate a fixed four-year programme with regular fixed entry and exit times not dependent on exams passed or time recognised, so posts can be properly planned and filled.
27. Job share options for pregnant registrars/registrars with young children.
28. Increase the number of experienced junior staff so registrars have more time to manage wards rather than do constant patient care.
29. Increase staff numbers.
30. Get rid of the S11 shift system.
31. Reduce work hours.
32. Offer mentorship.
33. Hold regular debriefing sessions.
34. Grant occasional time off (apart from scheduled leave).
35. Increase staff numbers to cope with patient load.
36. Offer job sharing for women with children.
37. Provide jobs with the option of not doing overtime.
38. Increase junior staff to ease service load on registrars to allow time for academics.
39. Pay appropriate rates for locums.
40. Improve recreational facilities for staff while on site, e.g. a registrar’s tea room.
41. Reduce on-call hours - working 28 hours or more continuously is frustrating and draining.
42. Get more staff on board.
43. Reduce on-call frequency.
44. Make provision for more teaching time/study time.
45. Offer better working hours.
46. Provide more recognition.
47. Create better recreational areas.
48. Effectively manage patient load - hospital management needs to be visibly pro-active when the patient load gets overwhelming and not rely on protocols that are outdated.
49. Cultivate better working relationships between staff, e.g. surgical sub-specialties/allied medical professionals.
50. Reduce the over-reliance on student interns in assisting with the work load.
51. Improve the cafeteria where staff can enjoy healthy meals in a relaxed atmosphere. Current cafeteria looks like a spaza shop with service to match.
52. Renovate the B-wards.
53. Decrease working hours.
54. Be more understanding to the staff and do not merely treat them like objects for use.
55. Appreciate what the employees deliver.
9.3 Appendix 3 – Transcription of interviews

9.3.1 Interview 1

What is the best thing about working here?

You see amazing things. You have an opportunity to manage quite complicated cases to an extremely high level. I feel [that we are] comparable to developed world systems. We have incredibly bright, incredibly driven senior colleagues and we have amazing members of staff who are superb and we have great colleagues, great registrars and SHOs. You see what poverty is about, you get a very good sense of how different people are and I think that is important to know. And there are a lot of consultants who, although they are brilliant academics, and although they know absolutely everything, which is something very special, they have a very balanced view of patient care, a very holistic view of patient care and actually are able to look after very complex, problem patients and look after how to solve this problem or what the patient’s circumstances are [like] can you get them safe water?

Is there anything else positive that you'd like to mention?

There are friends of the children that really look after patients. I have my reservations about it, but there is a wonderful group of volunteers that are around and they really do make a difference. They are very visible and I am very complimentary of the volunteers that care for the patients.

What is the worst thing about working here?

It’s disorganised. It’s very disjointed. You can work in a peripheral hospital and have to go on call in ICU, walk in at night and finish in ICU at five o’clock in the afternoon as the senior associate on call and be expected to run an ICU with a Junior Registrar, MO and
suddenly you are just expected to look after very sick patients when you missed half the handover round, and it’s tough luck that you haven’t been introduced to 10 of the patients. The fact that you don’t do calls where you are actually working is very frustrating. The fact that you do handover only at five o’clock in the afternoon, when everybody is moving around, is very frustrating.

The fact that, for registrars in particular, it feels like Human Resources (HR) is trying to protect the SHOs because they are not a captive group of people, they are trying to make the SHO posts attractive and therefore load registrars more in order to retain SHOs. So they are basically penalising us for trying to retain SHOs and they tend to treat us as a captive audience and we just have to kind of stick it out because we can’t leave. That is very frustrating. And they don’t seem to take our concerns seriously - they have been talking about it now for a year and a half, we are still not getting emails, there is still no transparency as to what is happening, what is being discussed and it gets to be very frustrating that management has no inclination of improving our working conditions at all. And I think people have lost hope and whereas before I think people would have loved to do a proper four-year rotation and have a proper training programme and then know in that four years you are going to learn this, now everybody is trying to [see how] quickly they can get out and get time recognised and they just can’t wait to leave. For me certainly that was the case. I walked into RXH not knowing that you can shorten your rotation by having time recognised. I did not know that. Although I have got enough experience to take a year off and I could walk out in January, I was quite prepared to stay there for four years, but after having worked there I just want to leave because physically I can’t handle this, I can’t do it any more and it is affecting me personally and affecting my personal life. What is the point of neglecting your home life for a job that isn’t looking after you at all? And I think that they are exploiting us, much more than we actually realise, much more than we say and much more than we act on.
If you feel burnt out, what contributes to the burnout:

- In terms of your workload?

I think if you are trying to study on top of an 80-hour work week with no support and no time out and working in a system where nothing is geared towards you achieving academic goals. Everything is about patient service and I think what really is exhausting is trying to learn and manage, but also being an intern and doing the SHO job, because there either aren’t enough of them or they are incompetent or the patient load is so much. And I think what has been really frustrating, what I have seen in the last two years [is that] we have seen patient numbers skyrocketing. I was in S11 in gastro season, I’ve done ICU and then the next gastro season I was back in S11, and back there again for the next gastro season and I’m avoiding doing that again for the fifth year in a row.

And you would have thought [someone would have] put certain things in place and would actually divert a certain number of patients to Tygerberg, or wherever, but that hasn’t happened. And we have seen numbers almost doubling from one year to the next and these are province-wide figures and there doesn’t seem to be any cognisance of that and it would just be nice to know that there is a plan. If people [are] coming here from the Eastern Cape and they come here and we have 25% more delivery, it really impacts on us and I think it is poor that management doesn’t take cognisance of this and you don’t see the end of it. And you’re not part of any decision making or feedback.

- In terms of supervisors?

I don’t think we have much... we don’t have a mentor, which I think would be good because we can... I mean if you have worked in the UK as well you sit down and you have your six months, your plan and you get feedback, even though it doesn’t make a difference to your working day it gives you a set of goals and you get feedback. I think feedback would be the best word; positive feedback would be really great because you get the feeling that there is a lot of gossip going round. I have been lucky in that I have
walked in with more experience than most, so although I didn’t know the set up, I knew that I could manage certain things.

But to have positive feedback when you have done well... you don’t really get that. You have the feeling that if I put a foot wrong everybody will be on me and I don’t think that is necessarily on purpose, but I do think that positive feedback in a structured environment with a dedicated mentor would be helpful, even if it is just to offload, because in the end we all offload to each other. It’s pretty ineffectual and I think that the effective venting or off-loading that actually has a feedback, that would really help.

- And in terms of the administration?

Well, they don’t really seem to do anything about it. They walk around S11 when we have patients lying on stretchers and they say nothing and come the next week and say “Well, it’s busy today isn’t it?”, but we still have the same problem.

They seem really ineffectual. I don’t think that management is very helpful at all. I think they are part of the problem and they seem to be - from our experiences and from what people are saying - quite obstructive and ineffectual, and then not being part of the solution.

What three major factors lead to the stress of your job?

- Very sick patients with nowhere to send them.

- Not being able to manage everything you have to deal with on your own and having nobody else to ask.

- And just patient load.
What can be done to minimise the stress:

- In a non-financial manner?

I think they should be stricter about taking somebody to Red Cross and it seems like most hospitals are very strict about the areas that they serve and the things that they see. Whereas, Red Cross, which is a great thing, has a very open door policy. So I think if we could support primary level care better and we could offload all those non-tertiary patients better to secondary level and be much stricter about that and even maybe have a nurse practitioner triaging patients and seeing simple cases rather than having to send them through the doctor and making the workload bigger.

- And in a financial manner?

I think it would be great to have more permanent MOs who actually would take over a bigger burden of patient care so that the registrars can [function as] managers and can actually problem solve. That would make our workload better. And, of course, more registrars and actually building units, like building ICU so that ICU is self-sufficient and actually [has] staff [of] its own on-call rather than having to borrow people from other places. But I think for that we need to incentivise career MOs and make it attractive. You need to give them research opportunities and good remuneration.

I don’t think you necessarily need to increase registrars because with SHOs you can actually run and work pretty well, or [with] MOs, I think that would help.

Something else I didn’t say about work stress is that there is a disproportionate amount of acute care going on as compared with chronic care. We get almost no benefits there. We get very little cold paediatric experience.

I think you underestimate how stressful it is to deal with acute patients all the time. Sometimes it would be nice for a registrar to have the opportunity to be in a clinic for
some period of time so that you have your own patients coming back and learning that process.

**What has been done to increase your sense of accomplishment with respect to your job?**

We get regular assessments, and we get good feedback on that. And I think that is a very supportive environment and the assessments are... I think that is a very nice, positive way of feeding back and I have had only good experiences with the way they commented on the way you work.

And the feedback at the end of blocks is actually quite... I have had feedback from people who know how to give positive feedback and they can tell you where you can improve in a clinical way. I think that has been quite nice. Whereas there were areas where that hasn’t happened and I think the places where that feedback has happened you actually feel you have learnt something. It’s nice to hear that people see that you have actually grown in your career and that is important.

**What would you like to be done to increase your sense of accomplishment?**

I would have liked a more structured rotation, not this random rotation that we have. I would have liked to have had the chance to be more independent earlier on and I think maybe if I had a little support in that and I think more academic time and more time away from the ward so that you can actually do journal club, which doesn’t happen at all, apart from one rotation. And the journal club, and academic ward rounds, also doesn’t happen and if it does happen, it happens for medical students, not for registrars and it would be nice to have that for registrars. All the academic stuff is geared towards medical students.

**What is your sense of the organisational commitment to you and your skills?**
I think that they expect it to happen and they are willing to push when they’ve got funds which they often don’t have. There is no structure about it and there is no feedback. But I think it does happen. It happens by virtue of having brilliant clinicians and having the workload.

I think the programme does want to see improved skills and there is commitment to it, but I think it is secondary to the patient load, always. There is no sense of further commitment and training commitment. I think we are completely overloaded and the sense is that training commitment from management comes by default or if there is time.

And the retention of your skills? Have they encouraged you in any way or found ways for you to stay on?

They have, but I don’t want to specialise so.... and I have also only just finished my exams, so I am going partially on my own decision because I need more training and I need more exposure to super-specialities.

They have asked us to do those jobs, but I am not interested. In terms of general paediatrics I don’t know what the intention there is and I think that is an area where a lot of people are struggling, people who want to stay and they end up going into private practice because there is no planned job progression.

I don’t think there are a lot of jobs for young, [recently] qualified paediatricians, just coming out of the rotation so that they don’t lose that and also, at the moment, they are going to lose us to private practice or overseas.

Can you describe an event when you feel your supervisor was willing to listen, or was able to be relied upon when things got tough?
I think our supervisors are very approachable. There have been times when I needed to speak to someone when they were quite willing to listen, but to do something about it is difficult.

There have been times when I have been at the end of my tether. I think some consultants are better at handling that than others. I think people are willing to listen, and they are willing to accommodate us.

One thing that I found very difficult was I walked into Red Cross as a new registrar and there was never any orientation. I come from a rural hospital, a level one hospital, we’ll put you in a general paediatric rotation, and on the first day I was put into ICU, and you are expected to know where everything is, you are expected to know how everything works and you are expected to perform and then you end up putting a lot of pressure on [everyone else]. Then you don’t know where irradiated blood from the blood bank is. All those things become very irritating.

And I think I have had one time when I just walked out the door…

**Why are you staying/leaving?**

Because I can’t maintain the pace, I can’t maintain the night calls any more. I am physically not as healthy as I was 10 years ago. I am not exercising any more. I have no control over my private life. My husband feels neglected and is saying I am not the wife he married any more. I’m saying it as a joke, but it is a true saying. I was a person who loved to do things, [who] always had energy and was good company and knew stuff that was going round and that person is gone. And I am not willing to sacrifice my private life for a job that doesn’t care what becomes of me, and this is something that I really learned: You can only feel guilty for being a doctor and not using your skills up to the point where it actually starts making you unhealthy and making your private life fall apart.
I would like to have a family and that doesn’t seem to be catered for at all in Red Cross. There is no maternity option available at all to any doctor. This is despite the issue having been raised apparently vociferously years ago. And married women with children have left registrar jobs and super-specialisation because Red Cross is not willing to accommodate that.

I love my patients and I [like] most of us, would do anything for my patients, but I can’t do that at the cost to myself. At the moment I have never been so unhealthy in my life. And I hate that. I am not willing to risk my marriage and my health and I have a family around here that I never see, despite the fact that I am living closer to them for the first time in 15 years and that is just too much to ask.

**Would you say you are burnt out?**

Yes I [am]; one day I just didn’t want to go to work and I called in sick and for me that is a massive issue. I have never done that in my life before and I just couldn’t get out of bed and I am really not like that. I know so many of us have done it, but it’s not part of my work ethic at all and I just didn’t want to get out of bed. It’s quite embarrassing that I have done that, and I think that people do that more often, I don’t think it is unusual.
9.3.2 Interview 2

What is the best thing about working here?

It’s the biggest children’s hospital in the Southern Hemisphere. That’s a good thing and it’s got a good reputation. That is the best thing about Red Cross, that when you are there you are in the best facility this side of the world.

What is the worst thing about working here?

The patient numbers - there are just too many patients. There are just too many patients coming through the door and sometimes we really cannot handle all these people - it’s too many.

If you feel burnt out, what contributes to the burnout:

- In terms of workload?

It’s again the lack of equipment to do the work with. There are simple things that go out of stock. You can be out of stock of plaster, so you can’t attach drips for weeks. And sometimes you have to run around looking for equipment when you shouldn’t be doing so... We run out of sterile equipment sometimes, which takes away from the fact that this is supposed to be the best hospital for kids. That you can run out of equipment….

- In terms of supervisors?

I’d say the registrars are our immediate superiors. They are under pressure with their workload. And that they are seeing the same type of patients that we get and from some of them you can just feel the stress and some of the time you feel that they take it out on you as a junior person. I don’t know if that is my perception of how other people feel, but you just get the impression that they are frustrated by the system, and they take it out on the junior staff. Because when they feel that they can’t change things, the senior role
that they take, they don't have the tools to implement what they want us, as the junior doctors, to do, so that frustrates them quite a lot, because they made recommendations which are changed by someone more senior than they are, and that frustrates them.

- And in terms of the administration?

I'd say I don't know that many problems that are particularly tremendous. Except for the payslips that are always late, but that doesn't really upset us that much. So from that perspective, no.

**What three major factors lead to the stress of your job?**

I am feeling like I am physically working very hard, but I am not making a difference, like my days are long, but when I get home I get the feeling there is nothing I did in this day that made a difference in anyone's life. I feel like that most of the time. That frustrates me a lot, cause I feel like, if I were doing a job like building a wall, at least by Friday you see the wall has built up by eight foot, by ten foot. In this job, the outcomes are not tangible.

The second thing is dealing with very, very, very sick children and unfortunately children who will die. That depresses me a lot. Because sometimes you get the feeling that only if... you are not really doing anything for them... I don't know... I feel like I am not making a difference at all.

I'm constantly feeling like my instructions are not listened to. I am not supported by the nurses as much as other departments are supported. For example, say I need to put a drip up; I can ask two or three different people before I can get someone who is willing to help me and I feel that some people who have been working at the hospital for much, much longer than we have been and therefore really don't feel like you should be telling them anything and I think that is just lack of teamwork - basically they don't consider you as part of the team because they know that the SHOs are just passing through and
therefore you are not really part of the team and they are not willing to help. It actually
takes a lot of time, because sometimes you find that you have got some of the more
skilled people in the team doing a simple thing, like two SHOs helping each other,
putting up a drip whereas one of you could be doing something else, and some people
don't see that as part of the team, trying to get the work done. I don't know if it's
despondency.

**What can be done to minimise the stress:**

- **In a non-financial manner?**

Basically exercising teamwork, everybody is part of the team. I get the feeling that we
have pockets of people who feel certain things are not their job; these particular things
are not my job and I don't have to do this, and that makes the team fall apart basically
and sometimes... some of the people are not pulling up their socks, but sometimes the
more senior people are not assertive enough in letting people know that they are not
pulling their weight for the team, because we don't even have team-building exercises.
Sometimes you are not even introduced properly to each other when you start working.
You get to the ward and you only get to know people as the day goes on, and I don't
think that is right.

- **And in a financial manner?**

I am not sure if finances could really make a difference - except getting more people in.
Currently no amount of money would make people want to work harder. Get other
people in, not just permanent people, but also locums when you see that the work is
getting too much, because there are people who will do locums, because you can give
the people as much money as you can, but you will still feel the same.
What has been done to increase your sense of accomplishment with respect to your job?

Nothing... I mean. No really, nothing. I haven’t had anything.

What would you like to be done to increase your sense of accomplishment?

I am actually not sure. In terms of... I don’t know, hey... I don’t know.

What is your sense of the organisational commitment to you and your skills?

You mean the employer’s commitment? Really, none. Because basically there is no incentive for you to want to stay on, nothing is really changing. You just basically get there and they know the kind of skills you have. They basically say to you, people have done this and move on. I don’t feel there is any attempt to try and retain people in their jobs.

Can you describe an event when you feel your supervisor was willing to listen, or was able to be relied upon when things got tough?

There have been a couple of times. Most examples you do, you do when you are dealing with an emergency case and you are actually just not sure what is going on, this is your first contact with the patient and you... basically most of the time, a child that comes into Med. Reg. completely unresponsive and at that time the person you rely on is the registrar who is on call and they always respond to our calls, I’d say. And they come there and take over and what you have to do is give them the background with what has happened and what is [being] done. They come in, they take over, they give you directions and most of them even take over the case by writing the clinical notes and making sure the patients go to the appropriate place. So I would say in that respect most... well, all the registrars basically you can rely on them when you are in that kind of emergency situation, they come in...
That’s really part of their job, but nobody’s gone beyond that... Has there been a
time when you felt you just can’t do this any more, that you almost felt that you
would rather just walk off the job?

Actually no, I can’t really feel like that, but you know that you can’t do that because you
basically, you are the only person...

So there was nobody to speak to who would be willing to listen?

I must say I haven’t tried. You must just basically just suck it up and just move on.

Why are you staying/leaving?

I am leaving, because I am looking to do something different and I got a job that is
completely non-clinical and I won’t have to do overtime. I have got a one-year-old at
home, so that overtime has been completely hectic for me. The 24 hour calls have been
the worst, especially having a one-year-old, [that] has been something else.

So I got a job where I won’t have to do overtime. I am hoping that I am not going to miss
interacting with the patients. But I think that the hours will be much better for me.
Basically that’s opened my mind, that there is more to medicine than hospitals, hospitals,
hospitals.

Would you say you are burnt out?

I am tired, I am tired, but I won’t say I am basically unable to do anything else. I think
that maybe sometimes knowing that I can’t afford not to work and I can’t just allow
myself not to be able to do anything else.
I won’t say I am entirely burnt out... I am tired, I’m tired.

9.3.3  Interview 3

What is the best thing about working here?

It is a small hospital, so there is support. People are on first name terms, the staff relationship actually is really good, you get to know people really well - which also has its bad sides; you know it is quite a small hospital; it’s a friendly place to work. People generally know each other very well and there is an ethos of working hard, so you get the feeling that everyone wants to do the best for the patients. So that is clearly the best thing; the staff attitude and the way colleagues are treated is actually very special at Red Cross.

What is the worst thing about working here?

The hours, definitely. Long days and... not so much the long days, but the weekends in that the call roster doesn’t necessarily reflect the hours, in that you still end up coming in a lot of weekends for ward rounds. Even if you are not on call you end up coming in certainly every second weekend till twelve, one o’ clock Saturday and Sunday. You spend a lot of days coming into the hospital, even if you aren’t necessarily on call.

If you feel burnt out, what contributes to the burnout:

- In terms of workload?

The hours certainly, the sheer burden of the number of patients that you see or are responsible for at any one time, specifically during the busy season which is February, March, April, and how desperately sick those children are. And the fact that you deal with incredibly ill children constantly and you, there are just not enough staff, you feel you aren’t necessarily doing the best you can for every patient because people are just
too thinly [spread] on the ground, when a lot of the time you just need more hands, more people on duty at any one time.

- In terms of supervisors?

I think that RXH is generally quite well supported in terms of consultant cover. There is always a person who you know is responsible, who you can call, who you are expected to call if there is a problem. I think what is good about Red Cross is that there isn’t that ethos of not phoning a consultant and there are no ego issues involved and that registrars are encouraged to call consultants if there is a problem. I think similarly the consultants are thinly spread on the ground and also can’t be in more than one place at a time. So I think, if anything, more consultants should be available because generally, I think, you always know exactly who the person to phone is and you usually feel very comfortable phoning them. And there isn’t an ethos of not phoning a consultant - I think that is quite important.

- And in terms of the administration?

I think for the junior registrars on ward call, one of the biggest stresses is finding beds for patients and moving patients around. You spend so much time trying to put children in beds and moving people around and trying to find spaces for kids, which doesn’t necessarily need to be done by the registrar. So that I think is a big stress and most of the stress of a ward call, especially in gastro season, is just finding places to put children, and then again - hand in hand with that goes shortages of nursing staff and the frustration of feeling that your patients that you can’t admit aren’t getting looked after adequately because the nurses are also short-staffed. And you know again - staff numbers and bed space is really bad, almost critical. And then obviously ICU bed space is always an issue and is always a stress; that is a constant stress, especially for a junior registrar, doing ward calls, having to move kids out of ICU in a hurry because of a
shortages of beds and put sicker children in the wards, [who] are more stressful to look after and also more exhausting.

**What three major factors lead to the stress of your job?**

- I think hours, especially.

- I think the emotional stress of desperately sick children. I think that is a big factor.

- I think the lack of support in terms of all the facilities, in terms of bed spaces and staff constraints.

I think that those are probably the three biggest points.

**What can be done to minimise the stress:**

- **In a non-financial manner?**

  I don’t know, at the end of the day, it all comes down to money. I think maybe more awareness by the higher powers of the registrar training. I think that is becoming an issue and people are becoming more aware of and acknowledging that, which I think is helpful. But at the end of the day, if there were more posts, people would feel less stressed, but I feel like acknowledging that working conditions are not right and focussing [on putting] processes into place, I think that is a step in the right direction. I don’t think, at the end of the day, it will eliminate it completely. It’s difficult to run the system with fewer people, or it’s difficult to decrease the hours without extra people. So, at the end of the day, most of it just comes down to bodies and money unfortunately.

- **And in a financial manner?**
I think funding and posts and more registrars. And not only more registrars, but more junior staff, because a lot of the stress of registrars is that you are expected to provide the service, but then you are also expected to be studying, researching, reading up on your patients, finding general articles, getting time to do clinical case presentations and at the moment the predominant amount of your time is spent doing service delivery, and a fair amount of that could be done by junior staff, which would free us registrars to do our studies, sit in the library, look for articles, prepare stuff. At the moment, all of that gets done after hours which I think is very difficult for a registrar programme, and I think a lot of other registrar programmes provide for that during the working day, and I think it is one of the stipulations from the HPCSA that time should be allocated during the working day for academic pursuits and there is very, very little of that. So I think junior staff should be able to deal with a lot of the more routine things that registrars do, I think that would make a huge difference. And then more emphasis on academia because I feel that is what also stresses registrars, is the fact that they are aware that they are not studying, that they are not reading up, they just don’t have the time. I think that is also something that would decrease stress a lot, to put some emphasis on that and our time.

What has been done to increase your sense of accomplishment with respect to your job?

I think, in my situation, it is nice to have acknowledged that I finished exams and I have now moved on to a more senior position, and have gone on to a senior call roster and that has made a huge difference in terms of lifestyle. And I think that Red Cross is good about acknowledging when people have done a good job. I think Red Cross is good about acknowledging when people have gone the extra mile. I think that is important and I think Red Cross is quite good at that, actually.

Could you give me an example?
I think when you have a difficult call and you have a particularly difficult patient and you have sat there all night, I think the seniors, the consultants, firstly, are usually quite good at feeding back to you and I think are good at saying “Well done, we appreciate that, thank you for sorting out that patient.” I think it is consultant-specific or dependant and I think when people progress, they do acknowledge that your opinions count and then certainly when you finish exams you very much get the feeling of being treated like a colleague. I think that does make you realise that you actually are progressing in it and that you are achieving something.

What would you like to be done to increase your sense of accomplishment?

I don’t know. I can’t think of anything specific.

What is your sense of the organisational commitment to you and your skills?

I think that one of the issues is that there isn’t really a feeling that there is a career progression, in that you finish your registrar time and that’s great, now sort yourself out, in some respects. But in other respects, and I think it is more a personal thing, depending on certain people rather than an organisation as a whole, certain departments, certain people do show an interest in “Oh, what are you doing next year?”, “Have you thought about applying for a consultant job or senior registrar job?”. I definitely think that that is a fairly personal thing and a personal interest by consultants who you get on well with. In the organisation itself, to be honest, I think at the moment we’ve got a bit of a feeling that, one more registrar has done their exams, let’s kick them out so we can get the next one in. It is a little bit of a feeling we have at the moment and that they encourage you to leave as soon as your time is done, because they are aware of wanting to get registrars in and out as quickly as possible. So there is a bit of a feeling that we get at the moment. But on the other hand, there is definitely a feeling that if Red Cross knows you and likes you, your chance of getting a senior registrar or consultant
job is certainly better than if they didn’t know you. I think that is important, you kind of feel that they want you, to keep you in the system. So I think it’s kind of a bit on both sides, to be honest.

Can you describe an event when you feel your supervisor was willing to listen, or was able to be relied upon when things got tough?

There have been many instances when my consultants have been very willing and eager to come out and help at night; specifically oncology, neonatology and renal. Those have probably been the most specific instances from a clinical basis. And on a personal level, I feel that the registrar coordinators have always been quite approachable, in terms of, if you want to chat to them about something, on either a personal basis or to do with your rotation. I feel that they are quite approachable. We haven’t had a formal mentor system, but I always feel that there are people available who, if I needed support, were available and I do think people feel that and I do think that is made available to people, so I think that there is good support.

Why are you staying/leaving?

We are leaving because we are going to go and get experience overseas for a year. But the plan is to come back, and I would come back hopefully into a junior consultant or senior registrar job. The reason why I would come back is because I think academically it has got a lot to offer. The hours in terms of senior registrars are not as bad as the junior registrars and Red Cross is still considered to be an excellent training facility.

Would you say you are burnt out?

I think I am, in that I am tired and I think obviously you go through phases when you feel better and phases when you feel worse. As a junior registrar I certainly had times where
you thought this and you certainly lose your empathy for your patients and you have seen so many sick children that... And if you consider most of us who got into medicine are generally very empathetic, caring people and I think that it takes a lot for a doctor to lose that.

I think, personally, over the last four years, I have had phases where you are definitely burnt out. I think if you ask any first year registrar how many times they have wanted to resign in their first year most of them would say every month and I think definitely, definitely at times. I think now that I am nearing the end of my rotation and the worst is over I think it is better than it has been, but over the last four year there have definitely been times where I have been very burnt out.
9.3.4 Interview 4

What is the best thing about working here?

The children. I’d say the children. I love children and I enjoy working with them and I enjoy making a difference and you do actually see that you are making a difference even though… I mean they are helpless, they can’t help themselves. So it’s nice to actually be able to do something for them. I think that’s the main thing - the children. And also the people that I work with, I like the people I work with and we all share the same frustrations. So I think the children and the people.

What is the worst thing about working here?

I’d say the hours, I don’t mind hard work, but I think they expect too much from us. So I would definitely say the hours and the quantity of work. I think that the patient-doctor ratio is completely out of reach, really, and you really have to be “grafting” so hard to actually get through your work during the day. And also I think at the moment the burden of HIV and TB is quite a lot worse than a lot of people out there think and that has quite a big impact on your day at work, and that is just another part of the frustration because you see the same children over and over and sometimes you get a bit hopeless because you work so hard and get them better and then see the patient back again.

If you feel burnt out, what contributes to the burnout - in terms of workload?

I think it’s mostly the calls, the amount of calls per month, which is on average at the moment, probably about six, if you are lucky five, and of those at least three are 24 hour hours plus post-call results, which probably makes it about 30 hours and you are expected to be back at work the next day, you are not given a long break in between. If
you are lucky you are getting two weekends a month off, if you are unlucky, you probably get one weekend a month off. So that is only 48 hours that you are actually away from the hospital and, at most, manage to work 30 days straight before, sorry that’s a lie, probably more like 21 days straight before you actually get a break. So that’s the one thing.

The other thing is: the amount of cover. It’s not just the hours, it’s that for those hours you actually work, it’s no sleep for ten hours, you actually do physical work, you cover the whole of Red Cross. You have two registrars covering for ICU and one registrar covering the rest of the hospital, which is a lot. I think it is mentally you need to be on the ball constantly and still be able to function like a normal doctor the next day.

- In terms of supervisors?

The fact that you don’t have a lot of supervision - there is a positive and a negative to that. The positive is that you are allowed to make decisions on your own, you are allowed to act as the senior. But it’s also not nice in the sense that sometimes you actually want someone to be there to help you and then they’re not. I mean they are always reachable by phone. I feel that at night the consultants that are on call should come in at 23h00 and come do a ward round with you and make sure everybody is okay, but you don’t get that, you are actually acting as the supervisor because the interns and the medical officers are all looking up to you because you are the most senior person and even when I was an SHO at Red Cross I hadn’t done paediatrics for five years and I was put in Med Reg in the medical emergency unit of Red Cross without anybody supervising me and you just learn the hard way. I mean they are there, they are a telephone call away, but you also don’t want to phone a consultant at tree o’ clock in the morning, four o’ clock in the morning to come in for something you can do yourself so, I think if they were more obliging to come in then we would probably phone them more, but we don’t because they never say they won’t come, but it’s not that confidence that
you can actually phone them and say “Come in”. They are actually happy not to be phoned because the registrars are so busy - unless it really is an emergency - so it’s you and the intern and often you are the most experienced there, even though you don’t have a lot of experience.

- And in terms of the administration?

I think there is no understanding of what our actual job entails. They don’t have the knowledge. You almost get the idea that they are not aware, they kind of live in a bubble. If you tell them you have got to do… We sign an overtime contract for a maximum of 60 hours overtime a [week] and we actually do 80 hours. 80 hours overtime is actually the minimum we work in a month, most of us work between 80 and 110 hours overtime a month. When you put that on paper, we were all told to write down our hours for the month, when you actually presented that to them, they said “No, we are lying, there is actually no way we are working those hours”, so they are not actually realising what we work.

Second of all, there is no back-up plan in place, we have two doctors on maternity leave at the moment, one went off about two or three weeks prior to actually going on maternity leave. They expected us to cover all of her patients, plus all her calls although we are already doing the maximum overtime and they refused to get a locum. Then the second doctor took maternity and she is only two months pregnant, so she will be off for eight months and they are still not replacing her. We just got an email today saying, “Who is going to cover her calls for December?” We are all already doing calls for Christmas, New Years so, they are not getting locums, they are not getting any replacements, they... If there is a locum, we are expected to do that locum because they pay hospital rates (they refuse to pay locum rates) which means you have to work for R100 an hour, where the agencies pay you R290 an hour.
That is the other thing: job creation. For instance they have 52 in Gauteng, we’ve got 22 registrars at Red Cross Hospital, we are covering six rosters. Just in the Western Cape, at Tygerberg, they do five calls a month which are only 12-hour calls, which means that they only actually do two calls; they receive exactly the same pay. There are a lot of people wanting to be paediatric registrars, but job creation... they are not creating the place. And that goes across the board for medical officers, for SHO’s... last year, or the year before, when I was still an SHO, the second half of the year an SHO quit and they still didn’t realise that there is a problem. Last year I think four registrars quit, they still didn’t realise there is a problem. Now two have gone on maternity leave and nothing has been done.

What is it going to take for them to realise that we need more people? I mean that is what is going to make a difference... is more people. Because we don’t mind doing a little bit extra, working an hour later here or there, but at the end of the day we need more bodies, and if you have more bodies you have more happy people, less sick leave. I mean you hate the people going on sick leave, or going on maternity leave, you feel resentful for it; it’s not fair. We are all entitled to have sick leave, to have maternity leave, but when somebody gets sick you are resentful for that, but the reason for that is that they are overworked. And all that happens is that the people staying behind are doing extra work, so they actually get short-changed.

**What three major factors lead to the stress of your job?**

- Tiredness

- The emotional burden, because if you are a doctor you have an inborn need to fix, or to help, and you can’t always do that and it’s stressful because everyone wants to be their best and sometimes you feel that it is definitely not possible.
- And also I think your personal life, because when you are home your husband or your wife expects you to be 100% emotionally involved and physically involved and you are not because you are tired. I mean that is an extra stress, you go home and your personal life is not happy.

- And also constantly trying to achieve. When I was at medical school I said I would never specialise, then I took the SHO job and then all of a sudden there was this pressure to become a registrar and you almost felt like a failure if you are not a registrar. Then I became a registrar, now there is pressure to become a consultant, it’s never enough, it never ends. And especially for a woman as well - I want children, it kind of makes you feel you are weak if you want children. Just move the goal posts slightly further away because you can’t have children when you are an SHO, you can’t have children when you are a registrar, so at the end of the day that is also stressful because you never feel like you are actually reaching your goals and it also causes inter-colleague stress, because we are all stressed out and we are all tired and we all kind of want the same thing and some people take that stress more easily out on others and others stress and can’t function, which makes the workload even more difficult.

What can be done to minimise the stress:
   - In a non-financial manner?

I think sharing responsibility, by that I mean between registrars and consultants and senior registrars. Because at the moment there is a senior roster and a junior roster and although I do realise that I am going to be a senior registrar in a few years’ time and I might also want to benefit from not being on 24-hour call, I feel that we are one body of junior registrars and senior registrars and the workload needs to be shared equally, and I think once you do that and everybody gets off their pedestal of “I am a senior and I don’t
have to do that” there will be less calls and I will have more hours away from work. I think sharing the responsibilities, and also I think the consultants can all put in a bit more. I’m not saying that they have to come in and sit till five o’clock in the morning, but if they can do a ward round more than once a day, or if they come in at night on call and they say “Listen here, you are doing a good job”. It’ll also take the load off you as the one person who has to deal with everything yourself. And also maybe introducing activities amongst ourselves outside the hospital, because at the moment nobody wants to socialise with each other outside of our work times, so maybe we can do some nice things that is not work-related and maybe get to know your colleagues a bit better. I did the whole SHO time without actually getting to know any of my colleagues. At the moment there are cliques, or there are two or three people who stick together, there is no camaraderie, I think people at the end of the day just want to get out of there and not think about it.

- In a financial manner?
Definitely employing more people, on all levels getting more staff. Actually that may change… they made a big difference, they have got more interns and community service officers and that has made a huge difference, but definitely more registrars, we need at least five more registrars. It doesn’t help if we import from other areas, because they don’t often have to do calls, which doesn’t really help us. And I think more people; I don’t think that the hospital has to be nicer; I think there are some wards that aren’t so nice, they spend the money on their renal and the oncology wards. I don’t think that it contributes to stress if you have a ward that is not up to scratch, I think that the main thing is we need more bodies, when you have more bodies you have more happy workers. Ja, money for locums, because if you are not going to employ a person on a permanent basis then the least they can do is get a locum to do at least three calls a month, or even just two calls a month, it would already make a big difference, and if they
expect us to do the calls, then they must pay us according to what we could get out there. Why would you, if you can work on a public holiday and earn R5 000, why would you work and earn R1 000? It sounds superficial, but we know we all chose this career, we want to be able to live, we are not charity workers. At the end of the day, it’s a job and you should be rewarded for what you do.

What has been done to increase your sense of accomplishment with respect to your job?

Nothing, I don’t think we get rewarded for any accomplishments we do. I mean, I haven’t been here for that long, but I did my DCH, that was myself, there was congratulations - you passed your DCH, but there was no real incentive to do it, we had to pay for ourselves, there was just a pat on the back, congratulations. This was actually where I was very upset, you would have thought with your part 1’s you are still expected to do the same amount of calls that you do every month, but I had to do them all in the first three weeks of the month because I was writing an exam for the last week of the month. If I didn’t take my three days study leave, I wouldn’t have gotten them. It was frowned upon when I first asked for it and I was told “We’ll have to see if we can”, so I actually just took them, so otherwise it wouldn’t have been offered to me. One of the doctors that was writing their part 2’s exam had to come in the day before her exams because the person who was supposed to cover her was sick. There wasn’t anything put in from the senior person – “You must just come in and help us the day before exams”. But then, afterwards, it’s a pat on the back for the hospital because one of their doctors passed the exam. So there is no actual personal gain, they don’t have your back. Once you qualify, you become a consultant - they won’t offer you a job, they will take you if there is nothing better. So everything is for yourself and it shouldn’t be like that. It’s kind of like a dog-eat-dog world and they don’t make you feel special because you passed your exam, it’s let’s move on to the next thing.
What would you like to be done to increase your sense of accomplishment?

I mean it would be nice… salary incentives, but it is the government. It would be nice to even earn like R300 - R400 a month [extra] because you got your DCH or you got your Part 1’s. Any other career, if you do an exam outside your work that is not expected of you, you will be rewarded for that, you be promoted or you will have a salary incentive or you will have a bonus or something like that. There are people who have done their DCHs, HIV diplomas, all sorts of diplomas, there is no financial reward or career reward for that so, it would be nice, even a small incentive, that will be great. Or maybe even if they were to encourage you to do it they could subsidise it, they don’t subsidise, and you have to pay for it out of your own pocket. So it would be nice if they could put that as an incentive, because at the end of the day it’ll benefit them, because you are a more well rounded doctor, but you don’t get an incentive to do that.

What is your sense of the organisational commitment to you and your skills?

Once again I can say nil, because they don’t value the doctors that they do have, they actually... the doctors that have left, they haven’t tried to keep them, they basically said to them “Well, you are making a mistake, so if you leave now don’t expect us to take you back when you feel like it. You have made a mistake.” So there is no trying to find out why, why is this person leaving? You have a registrar, she has done almost two years, two and a half years of registrar training that has left, they don’t try and find out why, what can we do to try to accommodate you and what can we do to make it better? I don’t think that they – if they can manage to drop somebody else in your position or to make an alternative plan, they will just let you go. To them you are actually just a number; there is no commitment from their side. And I think that is part of the problem, because you feel they don’t care, you aren’t going to necessarily care either. You feel a loyalty and you... I think that this is quite sad… a lot of people have defected to Tygerberg, because there you actually feel that somebody cares, that someone actually listens. I mean we don’t need babysitters, we shouldn’t be wrapped in cotton or anything like that,
but you should feel that someone appreciates what you are doing and they are always having these lunches at the end of the year where everybody pats each other on the back and that doesn’t mean anything.

**Can you describe an event when you feel your supervisor was willing to listen, or was able to be relied upon when things got tough?**

No. I must say there is one person that I have known over the past three years that I know I can always count on, not based at Red Cross Hospital, but he is in the system and I do feel he is the one person who I can trust and is the one person who I have gone to when I have had problems. So ja, I’d say that there is one person.

**Why are you staying/leaving?**

Well, it’s difficult to say. I want to do neonatology, so if I get a neonatology post I’ll stay. If I can’t, then I will probably try and find work somewhere else. If I do stay, it’s because there’s no other options. And that would be mainly because you try and learn from your experiences and I think that if you are not happy then you should leave and I know I am not happy most of the time. Even in the rotation I am happy when I am not there. I love Somerset, I love Groote Schuur. I am happy there. I feel that there is camaraderie between everyone who works there and everybody has got the same goals at the end of the day. So I feel if I had to stay it would be because I would benefit from it and not because I would feel obliged to provide them with a service. If I can provide that same service somewhere else then I have to do that, even though it is Red Cross Hospital, the only children’s hospital in sub-Saharan Africa, I actually don’t give a shit. And it’s sad because it has got the potential to be such an amazing place and there are a lot of people who have made an effort over the years now that have really, really tried very hard and they have also left because they decided they can’t anymore and it’s sad because there is such potential to do wonderful things there.
Would you say you are burnt out?

You go through phases and, just when you think you can’t any more, you have two weeks’ holiday and then when you come back you think it’s not so bad, and then after like a month or two months you feel “Oh, now I need a holiday again.” I have been burnt out, but not to a point where I felt that I can’t any more. I moan, I complain to my husband saying I am going to quit, I am just doing this year then I am quitting, I am just doing this exam then I am quitting. There are days that I think “Wow, I have an amazing job. I do love my job, I love what I do and I don’t want to do anything else”, but… at the moment I don’t feel burnt out. If after Christmas and New Years, if we haven’t had a break, then maybe I might feel different. But I definitely have been, but not at the moment.