

Perceptions of hospital managers regarding the impact of doctors' community service

Omole OB, MBBS, MCFP (SA), M Fam Med (Medunsa)

Dept. of Family Medicine & PHC, University of Limpopo (Medunsa Campus), Pretoria, South Africa

Marincowitz G, MBChB, M Fam Med (Medunsa), MD (Medunsa)

Dept. of Family Medicine & PHC, University of Limpopo (Medunsa Campus), Pretoria, South Africa

Ogunbanjo GA, MBBS, MFGP (SA), M Fam Med (Medunsa), FACCRM, FACTM, FAFP (SA)

Dept. of Family Medicine & PHC, University of Limpopo (Medunsa Campus), Pretoria, South Africa

Correspondence: Dr OB Omole, Dept. of Family Medicine & PHC University of Limpopo, (Medunsa Campus) Box 222 Medunsa, 0204, South Africa, E-mail: omole1@absamail.co.za

Keywords: Perceptions, hospital managers, impact, community service doctors

Abstract

Background: In South Africa, the distribution of doctors is skewed in favour of the urban areas, but it is not uncommon to find many peri-urban facilities in short supply of doctors. In 1997, the South African government introduced compulsory community service (CS) to address this uneven distribution of doctors in the country. The CS doctors posted to the Letaba-Sekororo hospital complex in Limpopo Province refused to take up their appointments for various reasons, ranging from lack of supervision to poor basic infrastructure. This study is one of the earliest conducted to understand the perceptions of hospital managers on the impact of the national community service on the health service.

Methods: After ethical approval was obtained from the Research, Ethics and Publications Committee (REPC) of the Medical University of Southern Africa (now University of Limpopo – Medunsa Campus), three focus group interviews were conducted with hospital managers from three purposefully selected hospitals. The interviews were audio-visually taped and supplemented with field notes, transcribed verbatim, with themes identified using the 'cut and paste' and 'colour coding' methods. Combined themes were categorised and interpreted within the context of the study and the available literature.

Results: CS has improved health services delivery, alleviated work pressure, and improved the image of hospital managers. In addition, it has provided a constant supply of manpower, and increased the utilisation of health services by the community. The negative perceptions identified included a lack of experience and skills, poor relationships with the rural health team, lack of support structures for CS doctors, poor continuity of care and budgetary constraints.

Conclusions: Hospital managers perceive CS to have had a positive impact on the supply of needed manpower, health service delivery and patient care. As this was a qualitative study, further quantitative and community-oriented studies are required to validate the results.

(SA Fam Pract 2005;47(8): 55-59)

Introduction

The maldistribution and migration of doctors are global problems that challenge the health services of developing countries in terms of human resource development and health service delivery. Increased trade and greater global mobility have compounded these problems and many developing countries, such as Zambia and South Africa, have not been able to provide adequate health care to their citizens, despite the production of doctors in reasonable numbers. Some of the dictatorial African governments have also created a 'brain push' that encourages professionals to use their qualifications as passports to freedom and emotional and professional satisfaction. A

medical curriculum that is Western oriented has also produced young doctors who cannot cope in their own African context.¹

In the United States of America, many inner-city hospitals rely almost exclusively on foreign-qualified doctors for the provision of health services, a trend that is also reported in the South African public health services.^{2,3} In 1995, Limpopo Province (rural) had 15.5 doctors per 100 000 population, while Gauteng province (urban) had 127.4 doctors per 100 000 population.⁴ This is consistent with findings from Ecuador, which show 1:492 (urban) versus 1:3 226 (rural).⁵ The massive overwork, high crime rate, threat of infectious diseases such as HIV/Aids and South Africa's unfriendliness have

been cited as reasons for the emigration of doctors to developed countries.⁶ The call to impose stiff penalties on the recruiting countries has gone unheeded, creating a medical carousel, with doctors moving from one country to another in search of higher standards of living. By mid 2000, an estimated 600 and 1 500 South African trained doctors were registered in New Zealand and Canada respectively.

In the 1920s, the former Soviet Union commenced a three-year rural service, an example that was followed by Mexico in 1936. Cuba and the Dominican Republic followed suit in the 1960s, and the 1970s heralded CS in Ecuador and Nigeria, amongst other nations.^{5,7} An Ecuadorian study

showed that, despite several frustrations experienced during CS, the majority of the recruits found the CS year rewarding, as it afforded them the opportunity to understand the deplorable state of health services in the rural areas. In Nigeria, compulsory national service has addressed the scarcity of qualified human resources in rural and remote areas.⁷

In 1997, CS was introduced in South Africa as part of an initiative to address the inequitable distribution and emigration of doctors. Whether CS has had a positive impact on the health services is a question yet to be fully explored in South Africa. Reid and Conco reported that there was a relief of work pressure on the health team members, better staffing, less crowding of the out-patient units, a fast turnover of patients in the wards and improved clinic visits.⁷ Given that hospital managers are an important group involved in the implementation and monitoring of this programme, it was important to understand how they perceived the impact of CS on health services.

Methods

This was a qualitative study in which three focus group interviews were conducted with seven, nine and ten hospital managers respectively from three purposefully selected hospitals in the Mopani health district of Limpopo Province. Ethical approval was obtained from the Research, Ethics and Publications Committee (REPC) of the Medical University of Southern Africa (now University of Limpopo – Medunsa Campus). After the aim of the study was explained to the participants, a signed consent form was obtained from each participant. The exploratory question was “How do you perceive your experience of the impact of doctors’ community service in your hospital?”. The interviews were conducted in English, audio-visually taped and supplemented with field notes. The

recorded interviews were then transcribed verbatim and themes were identified using the ‘cut and paste’ and ‘colour coding’ methods. Themes were categorised and the data were validated through member checks, peer review and mental triangulation.⁸

Setting

Mopani health district is located in the eastern part of Limpopo Province, South Africa, with an estimated population of one million. It has six hospitals, of which one is a level II (referral) hospital and the other are level I (district) hospitals. One hospital is semi-urban, two are in semi-rural areas and the remaining three hospitals are in rural, underserved areas. The three purposefully selected hospitals reflect the ethnic diversity, different levels of care and urban-rural dichotomy of the district.

Results

The following themes were identified from the data:

1. Impact on health service delivery
2. Impact of experience and skills of CS doctors
3. Impact on continuity of care
4. Impact on resource utilisation
5. Impact on the local community
6. Impact on hospital posts
7. Impact on the rural health team
8. Impact on local administration
9. Lack of support for CS doctors

Impact on health service delivery

CS has led to decreased work pressure, especially for senior doctors and nurses. Health facilities are now better covered at all times of the day: “Previous doctors were struggling, but now at least, it (CS) has brought some changes, for 24 hours you will find a doctor when you come to the institution”. The rural, underserved areas in particular have benefited in terms of an improvement in health service delivery: “So the service in the rural places has improved”. There was

a perceived reduction in referrals from the clinics and a decreased waiting time in hospitals that previously had staff shortage: “The patients do not wait for a long time. They are quickly helped and then off they go”. In contrast to the positive impact, the hospital managers in the level II hospital indicated: “Now that they (CS doctors) came to help us, the flow in the Outpatient Department is crawling”. The reason for this is that CS doctors take much longer when the patients consult them than senior doctors take.

Impact of experience and skills of CS doctors

The majority of the hospital managers interviewed identified deficiencies in the procedural skills of the CS doctors. One of the managers said: “But there is a lot to be done on their part to improve their skills because their skills are still lacking.” This lack of experience and skills affects service negatively and slows down the pace of consultations. The CS doctors have made requests for unnecessary laboratory tests, lack confidence to function independently, request prescriptions that are not included in the Essential Drug List (EDL), and submit motivations for medications that are not dispensed.

In contrast to the level I hospitals, managers in the level II hospitals said that the CS doctors were more competent than interns, although they (CS doctors) still lacked certain procedural skills. To address this concern, some of the participants suggested the extension of the CS period to two years to consolidate the skills learnt during the first year. In addition, the recruitment and retention of senior doctors was suggested as crucial to the transfer of procedural skills to the CS doctors. However, there was a contrary opinion that this lack of competence needs to be validated with evidence: “What makes you think we should pay CS doctors for another one year?”

Impact on continuity of care

The hospital managers experienced a lack of continuity of care, as the CS doctors leave after one year of service: *"You find out that the following year, the patient will come and say, I am looking for doctor so and so, and telling them that the doctor is no longer here, he's gone. It frustrates them (the patients)..."*. This theme was consistent in facilities with a severe shortage of doctors.

Impact on resource utilisation

More patients are utilising the hospital services than before: *"Our statistics have increased a bit unlike before"*. But, the CS doctors wasted resources: *"When they are coming from the background which is rich in terms of resources, in institutions where there is big budget and they come to small institutions where you have to streamline on your budget, then you find it a bit difficult. At the end of three months your costs (expenditure) are alarming."* The managers suggested that the budget should be increased to match this increase.

Impact on the local community

CS was perceived as a means of reintegrating doctors into their rural roots after many years of schooling in urban universities. Communities valued the services of the CS doctors, as they *"make a difference"*. In contrast, some managers reported that CS has not affected the communities, especially in relation to health promotion and prevention: *"It (CS) has got to give much more impact on health education"* and *"They (CS doctors) are unable to reach the clinics and the community presently, because of lack of transport"*.

Impact on hospital posts

CS provides constant manpower to underserved areas and more posts are now being filled. However, poor post planning has created a biphasic problem; there are fewer or no posts

at level I hospitals to employ permanent senior doctors to supervise the CS doctors. Also, the retention of the CS doctors on completion of the mandatory period is becoming problematic, as this is dependent on available posts. This view was supported by one participant, who expressed the lamentation of a CS doctor: *"What will happen to me after I finish?"*, as there were no permanent posts to absorb him into one of these hospitals. These problems were not experienced in the level II hospitals, which had many unfilled posts.

Impact on the rural health team

Most facilities reported good working relationships with the CS doctors: *"These doctors (CS doctors) are good and relate well to our staff members"*. In previously white-only facilities, CS enhanced racial integration, because patients of different races are now seen by doctors from other racial groups. However, some relationships were detrimental to service delivery and some managers felt that most of the CS doctors who were troublemakers *"(were) blacks"*. These negative relationships emanated from feelings of being forced to work in rural areas against their wishes, an inability to get things they asked for, and resistance to reprimand by other staff members. A manager quoted an instance where a nurse reprimanded a CS doctor over a clinical mistake. In reply to the reprimand, the CS doctor was reported to have said, *"You are making yourself a doctor now. Those who want to be doctors must go to MEDUNSA."* *"These sorts of statements cause problems,"* reiterated the manager.

Impact on local administration

With the availability of CS doctors, the image of the managers has improved, as *"Managers are now seen to be bringing some change (providing service) towards the community"*. However, poor planning has led to

local hospital management's *"clearing up the mess"* created by the national and provincial health departments. This was perceived to have created the extra burden of sorting out problems of implementation, especially because the local management was not consulted on issues such as accommodation, posting, posts, etc. The lack of orientation and preparedness of CS doctors also led to the *"feelings of being dumped"* at hospitals by the Health Department. This made managing the doctors difficult. Managers were unsure of the expectations of the CS year and did not have clear guidelines. It was perceived that each hospital had different opportunities and expectations for the CS doctors. A suggestion was therefore made that *"The Health Professions Council needs to provide a uniform guideline on what must be covered during CS"*. As the period of CS is for learning and providing service, *"They must learn and implement; it must be 50-50"*.

Managers who were medical practitioners in hospitals with a serious shortage of doctors reported that supporting CS increased their workload. These managers had to provide clinical supervision and, at the same time, attend to administrative work. Serious conflicts then developed and they found it difficult to satisfy both demands.

Lack of support for CS doctors

The majority of the hospital managers indicated that the CS doctors were not given enough social, administrative and clinical support. Teaching and supervision were not adequately addressed because of a shortage of senior doctors: *"I think in this regards we have not done well"*. They recommended that the issue of support be addressed by:

- creating a friendlier referral system according to which senior doctors and specialists could easily be accessed: *"Maybe in the future, a*

consultant makes a visit to (our) hospital once a week or once a month".

- sorting out problems relating to salaries, as *"Salaries are not ready sometimes for three months"*.
- providing social amenities - *"All work and no play make Jack a dull boy"*.

Discussion

This study showed that managers experienced an improvement in service delivery and patient care with the introduction of CS. This view is in agreement with the main objective of community service, which is to ensure the improved provision of health services to all citizens of South Africa.⁷ The managers also indicated that CS resulted in an improved supply of doctors to the rural areas. It is now possible to have 24-hour medical coverage in these facilities and *"they (patients) are quickly helped and off they go"*. The improved supply of doctors to rural areas has also resulted in a perception that local communities are benefiting from the investments made in the medical training of these doctors. This view confirms Mennen's opinion that "the training of a doctor should be seen as a bursary from the nation to the individual" and may therefore justify the call for reimbursement, in an amount equal to the actual or potential loss in investment, for every doctor poached from a developing country.⁹ It is apparent that CS is beginning to address the lack of doctors in the public service, especially in rural areas, and the urban/rural divide in the distribution of health care providers.

These findings are consistent with those of an earlier study by Reid and Conco, who reported a relief of work pressure on the health team members, better staffing, less crowding of the outpatient units and a fast turnover of patients in the wards.⁷ In this study, this improvement in service and the supply of doctors was appreciated

more in hospitals that had previously experienced a shortage of doctors. While health services have improved and more doctors are available, there was no corresponding improvement in community-based health services, as these doctors were not involved in outreach activities at the primary care clinics. This was in contrast to the findings of Reid and Conco, who found improved clinic visits by CS doctors. In addition, some hospitals managers observed that the flow of patients has slowed down. This can be explained partly by the increased number of patients seen (increased utilisation), the failure of CS doctors to visit clinics, a shortage of senior doctors and poor supervision of CS doctors. The principle of continuity of care is challenged (especially in areas with a severe shortage of doctors), as CS doctors leave after completion of their one year of service. The result is that their patients wonder who their next doctor will be. This was confirmed by one of the managers, who said: *"You find out that the following year, the patient will come and say I am looking for Dr. so and so, and telling them that the Dr. is no longer here, he is gone. It frustrates them (the patients)"*. In order to provide quality health care, there is a need to ensure continuity of care with a stable medical team. This can be realised if career paths are created for generalist medical practitioners within the public service after the CS year.

The problem of inadequate posts at the level I hospitals is a reflection of discrepancies in post allocations amongst the various levels of the health services. This allocation system needs to be reviewed in the light of the pivotal role of primary health care in the district health system. It is also important to address the inequalities in posts, and to provide career opportunities for those CS doctors who want to pursue a career in the public service. Difficulties in the execution of this programme, as

experienced by these managers, created a perception of poor planning on the part of the National Department of Health. While this may be true, the extent of dialogue/consultation at the inception of CS was a sign that the execution of CS would be a learning process for all stakeholders.

There was the perception among the hospital managers that the CS doctors lacked experience and procedural skills to work effectively and independently in the rural hospitals. This creates conflict between the CS doctors and other healthcare providers, and may suggest difficulties in blending with the rural health team. In order to succeed, CS doctors need to be supervised and supported academically and administratively. The rural health team presents peculiar challenges to healthcare providers. An ability to work independently with little resources, adequate interpersonal and procedural skills, and extensive collaboration with other healthcare providers are some of the attributes needed to work effectively in this context. Although CS is not a year for training, it is expected to provide the young doctor opportunities to develop procedural skills and acquire extra clinical knowledge. However, the medical curriculum in most developing countries, especially in Africa, is Western oriented, urbanised and centred on specialists. It does not equip the new graduates with the appropriate skills for the realities of general medical practice in Africa.

To address these deficiencies, adequate rural exposure during undergraduate medical training should be ensured and programmes aimed at teaching team work and team building should be established.⁵ In this study, the perceived lack of experience and skills was most evident in hospitals where there was little supervision, which confirms some of the concerns raised at the commencement of CS in South Africa and reiterates the need for supervision

and skills transfer from senior doctors.^{3,13} The economic sequel of lack of supervision, experience and skills resulted in inappropriate laboratory tests and prescriptions, increased costs and increased risk of litigation. When added to the increased demand for health services, these create a strain on the available budget of smaller hospitals, and the managers therefore suggested an increase in their budgetary allocation to cope with these challenges. Since it is difficult to use perceptions as objective measures of impact, the results of this study cannot be generalised, but they provide insight into how hospital managers perceive the impact of CS on the health services. In addition, these results represent the perceptions of one group of stakeholders. Therefore, to explore this phenomenon in depth, studies that examine the perceptions of CS doctors, their patients and the community are essential.

Conclusions

The hospital managers interviewed in this study perceived CS as having had a positive impact on the supply of needed manpower, health service delivery and patient care. It is important to create a "rural magnet" that draws professionals to rural areas and that make health care a window of development within a bigger rural developmental plan.¹⁴ As this was a qualitative study, quantitative and community-oriented studies are required to validate the results.

Limitations of the study

This study has some limitations, namely a lack of in-depth understanding of the impact of CS, which could only come from studying all the stakeholders, the fact that the qualitative nature of this study limits its generalisation and that the results may only be transferable to a similar context. In addition, obtaining data from only three focus groups is a

weakness in the study design, as a saturation of data might not have been reached when the process was completed. The difference in the status of the hospitals was a potential source of bias. However, these differences were minimised by the purposefulness of the sample, i.e. to obtain information-rich sources. The principal researcher, who conducted the interviews, could have influenced the interview process with some of his preconceptions of CS, but these were minimised through the process by which the data were validated, which confirmed the results and the interpretation of the researcher. Although the hospital managers were assured of confidentiality and anonymity, the topic being investigated was sensitive enough for them to offer responses that were complimentary to their functions as managers, thereby avoiding possible reprimand by their supervisors.

Recommendations

The following recommendations are suggested to improve the CS programme:

- The internship year should focus on equipping young doctors with procedural skills that will make them more functional within the rural health team.
- CS doctors should have compulsory clinic visit rotations, where their impact on the community could be better appreciated.
- Career opportunities for doctors after their CS year should be developed within the public health service, and provision should be made for incentives to recruit and retain senior doctors in rural, underserved areas. This should include the restructuring of posts at different levels of health care.
- Structured orientation programmes at the commencement of every CS year would provide opportunities to address the concerns, fears and expectations of the CS doctors
- Increased rural exposure during undergraduate medical training would improve the CS doctors' understanding of rural health and teamwork.
- There should be a comprehensive support system for the CS doctors, which should include continued professional development, clinical support, and life strategies to cope with the challenges of CS.

This study was conducted by the first author in June 2001 in partial fulfilment of the requirements for the Master of Medicine (Family Medicine) degree at the Medical University of Southern Africa (now University of Limpopo – Medunsa Campus).

Conflict of interests: None

References

1. Lucas S. Medical migration. *The Lancet* 2000;356:1197.
2. Brundred PE, Levitt C. Medical migration: who are the real losers? *The Lancet* 2000;356:245-6.
3. Naude M. Concern over community service and rural health services. *SAMJ* 1998;9:60.
4. Couper I. The future of medicine in South Africa. *SAMJ* 1997;3:290-2.
5. Cavender A, Alban M. Compulsory medical service in Ecuador: The physician's perspective. *Soc Sci Med* 1998;12:1937-46.
6. Loeffler IJP. Medical migration. *The Lancet* 2000;356:1196.
7. Reid SJ, Conco D. Monitoring the implementation of community service for doctors in South Africa. Centre for Health and Social Studies, University of Natal, Durban; 1999. pp 3-33.
8. Reid AJ. What we want: qualitative research-promising frontier for family medicine (Editorial). *Canadian Family Physician* 1996;42:387-9.
9. Mennen U. Maldistribution-redistribution. *S African Bone and Joint Surgery* 1994;1:26.
10. Heard N. Medical migration. *The Lancet* 2000;356:1198.
11. Asuzu MC. The influence of undergraduate clinical training on the attitude of medical students to rural medical practice in Nigeria. *African Journal of Medical Science* 1989;18:245-50.
12. Easterbrook M, Godwin M, Wilson R et al. Rural background and clinical rural rotations during medical training: effect on practice location. *Canadian Medical Association Journal* 1999;8:1159-63.
13. Golele R. Orthopedic services in peripheral hospitals. *S African Bone and Joint Surgery* 1994;1:24-6.
14. Mankazana M, Setubi O. The high road to rural medicine. Letter to the editor. *SAMJ* 1997;6:768.