

Encounters with problems and challenges and the formal complaints mechanism in public health: Accounts and perceptions of a set of junior health professionals during early employment experience.



A minor dissertation submitted by Wendy Petersen (PTRWEN002) in partial fulfilment of the requirements of the Mphil Development Studies Programme in the Humanities Faculty at the University of Cape Town.

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ABSTRACT

The South African health system consists of partly privatized and partly public health care. It is the latter that is responsible for the wellbeing of the majority of the South African population. It is also the latter however that faces multiple challenges. Of these are challenges relating to working hours, staff to patient ratio, and burnout, as well as the availability of resources / equipment; supervision and training and the experiences of bullying. Moreover, research shows that while the working conditions / contexts as well as the availability of supervision that junior healthcare professionals work in and have access to has been studied extensively in both Northern and Southern literature; the bullying experienced by junior doctors and other junior health professionals have been extensively studied in Western literature with very little being done to study this phenomenon. Further, very little has been done to study questions pertaining to the mechanisms of laying complaints about these challenges in the South. Against this background, the thesis was concerned to explore experiences and perceptions of laying complaints to supervisors and the largest health regulatory body in South Africa, the Health Professions Council of South Africa (HPCSA).

The thesis used semi-structured interviews to interview six junior healthcare professionals who are registered and thus regulated by the HPCSA in South Africa and who are in the process of or who have recently completed their compulsory year/s of internship / community service in any public hospital in South Africa. This was done in order to explore their accounts and perceptions of challenges and complaints mechanisms pertaining to these challenges in their first postgraduate years.

The public health system in South Africa is still rife with many challenges. My research found that according to their own accounts, junior healthcare workers encounter these as direct challenges in their everyday experience. They bear the brunt of these by having to deal with major burnout associated with long working hours and understaffing. It also shows that their account is that there is a lack of much needed resources and equipment and that challenges associated with this often have dire consequences for both them and their

patients. Further, my research showed that they continue to feel that they are not being properly trained and supervised and that they do indeed face many challenges relating to bullying behavior by senior health professionals. Connected to this, my research showed that despite being aware of the complaints mechanisms in place, these junior healthcare workers often have had negative experiences with laying complaints and / or have negative perceptions about complaint mechanisms such as their supervisors and the HPCSA.

In sum, the findings show that these challenges sustain and exacerbate each other in a vicious cycle in South Africa. While the sample used in this research was based in issues of access and availability and is not representative, these patterns and themes emerged consistently and thus warrant further investigation both in themselves and as possibly representative of what is happening in the medical profession in South Africa.

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LIST OF ACRONYMS

ANC	African National Congress
BCEA	Basic Conditions of Employment Act
EEA	Employment Equity Act
HOD	Head of Department
HPCSA	Health Professions Council of South Africa
HRH	Human Resources for Health Strategy for the Health Sector
JuDASA	Junior Doctors Association of South Africa
LRA	Labour Relations Act
MDG's	Millennium Development Goals
NCSHE	National Core Standards for Health Establishments in South Africa
NDoH	National Department of Health
NCD's	Non-communicable diseases
SAMDC	South African Medical and Dental Council
SAMA	South African Medical Association
NSP	The National Strategic Plan for Nurse Education, Training, and Practice
TB	Tuberculosis
UN	United Nations
WHO	World Health Organization

1 INTRODUCTION AND LITERATURE REVIEW

The South African health system has been described as characteristic of what Field (1980) has termed a 'pluralistic system'. This is because it consists of partly privatized and partly public health care. It is the latter that is responsible for the wellbeing of the majority of the South African population. It is also the latter however that faces multiple challenges. Indeed, there have been a number of studies that have argued that the quality of public health care in South Africa has declined in the last decade (Delobelle, 2013:161); (Keeton, 2010). Here, the argument is that although South Africa has made some progress towards achieving goals that are aligned with the World Health Organization (WHO) and the United Nations (UN), such as the Millennium Development Goals (MDG); the progress has been inadequate and often not at all present (Chopra & Lawn et al, 2009). These studies then mostly cite mismanagement, underfunding, and deteriorating infrastructure as contributors to this decline.

Another key factor that has been cited is the shortage of human resources in the public health sector. For example, at the end of 2008, 33 534 Medical Practitioners were registered with the Health Professions Council of South Africa (HPCSA); however, it has been estimated that only 11 309 of those Practitioners worked in the public sector at the end of 2010 (Labonte' & Sanders et al, 2015:2). This then means that between 2008 and 2010, only 30% of registered Practitioners worked in the public sector. This then also translates into the fact that the remaining 70% worked in the private sector, servicing 16% of the South African population who have access to private medical insurance, and another 16% who are able to pay out-of-pocket (Labonte' & Sanders et al, 2015:2). This has led many such as Peter Delobelle (2013:162) to argue that the South African public health sector is under-resourced and overused.

This over-use has a lot to do with the fact that South Africa faces a quadruple burden of disease (Econex, 2009:4). This then means that the overall health of many South Africans is characterised by a quadruple burden of communicable, non-communicable, perinatal and

maternal, and injury-related disorders. Indeed, in addition to having one of the world's highest Tuberculosis (TB) and HIV rates, as well as high maternal and child mortality rates; in 2008 non-communicable diseases (NCD's) accounted for 29% of all deaths in the country (Global Health, 2015). Today, these rates are ever increasing with the TB epidemic in South Africa remaining among the worst in the world, and it is the second cause of death after HIV/AIDS (WHO, 2016). Indeed, in 2011, the WHO reported that South Africa is one of the only countries in the world where TB incidence is still rising and where NCD's such as cardiovascular diseases, diabetes, chronic respiratory conditions, and cancer, are emerging rapidly in both rural and urban areas, but most prominently among poor black people living in urban settings.

This burden, coupled with the inequality of numbers in the private and public health sector, is then also exacerbated by the fact that each year, more than 30% of South Africa's health workforce emigrates to countries such as Canada, the USA, Britain, New Zealand, and Australia (Mayosi & Benatar, 2014:1348-1349); (van Rensburg, 2014). There are indeed many reasons for this migration, however, according to reports, some of the key reasons are many of the challenges mentioned above – that being, deteriorating working conditions, and the uneven distribution of resources, among others (Erasmus & Breier, 2009:119). Of course, the movement of health workers across the globe is not unique to South Africa. However, it has been argued that healthcare workers generally migrate from developing countries to more developed countries, leaving behind an understaffed and overburdened health system in the former.

To be clear, it has been estimated that only 10% of the global burden of disease occurs in Canada and the USA, yet nearly 37% of the world's health workers live and work there (van Rensburg, 2014); (Frambach & Manuel et al, 2015:64). This then means that developing countries, like South Africa, are particularly hard-hit by migration (Kissick, 2012:1). It is then this reality of an over-used, and under-resourced public health sector that has led many such as Jose Figueroa-Munoz and Karen Palmer et al (2005), as well as Emmanuelle Daviaud and Mickey Chopra (2008), among others, to argue that South Africa is facing a crisis in terms of its healthcare workforce and that as such the needs of many vulnerable and marginalized populations will remain unmet.

Of course, many of these challenges are also rooted in the history of South Africa. During apartheid – the ideology that underpinned racial capitalism – equal distribution of health services along race, gender, and class were hindered, thus creating gaps in service delivery across regions and population groups (van Rensburg, 2014); (Delobelle, 2013:161); (Labonte' & Sanders et al, 2015:2). It was also a system that entrenched the development of South African health workers along the same lines. Indeed, exclusion based on race from the health professions and mainstream training institutions prevailed for many decades during apartheid while deprived populations, mainly black people in South Africa, were dealt smaller supplies of healthcare that was provided in racially segregated, understaffed, and poorly equipped public facilities (van Rensburg, 2014); (van Rensburg and Fourie, 1994). Apartheid was thus a system that was characterised by the development of a poorly organised, highly fragmented, and deregulated health sector.

It is then clear that these legacies still influence the public health sector today. Indeed, many such as Ronald Labonte' & David Sanders et al (2015:2) and Hendrik van Rensburg (2014) argue that today's health workers favouring the private sector is inherited from the apartheid era and its underfunding of the public sector. In much the same vein, remnants of apartheid's race discrepancies and back-logs are still present. For example, in 2012, studies showed that there were 16 936 white Practitioners in South Africa, while only 8354 were Black, 5314 were Indian, and 927 were Coloured (van Rensburg, 2014). Further, studies show that access to decent healthcare is still allotted to the wealthy, privately insured 16% of the population; while the poor who make up more than 70% of the population are dependent on the public sector that continues to be underfunded and under-resourced, as stated above.

It is given this history that the democratic government continuously introduced policies with the over-arching goal of re-engineering and strengthening the public health sector. Indeed, since the 1990's, with the 'birth of South Africa's democracy', in the hopes of doing away with the racist and unequal health systems inherited from the apartheid era, the African National Congress (ANC) implemented the Employment Equity Act (EEA) which had its aim in achieving equity in the workplace by promoting equal opportunity and fair treatment in

employment. This was done by stating that there should be an elimination of unfair discrimination and the implementation of affirmative action measures that redressed the disadvantages in employment that were seen under apartheid between black and white healthcare workers (Health & Democracy, 2014:325). The EEA thus covered all the grounds for discrimination listed in the Constitution such as race, gender, and ethnicity.

There were also a number of other policies, such as the Labour Relations Act (LRA) and the Basic Conditions of Employment Act (BCEA) which deals with a number of issues from working hours, annual and sick leave and notice pay (Health & Democracy, 2014: 319). Furthermore, Section 24 of the Constitution states that everyone has the right to an environment that is not harmful to their health or well-being. Linked in with this, the Occupational Health and Safety Act placed concern on how the workplace impacts the physical, emotional and psychological health and wellbeing of employees. This included everything from work activities themselves to the materials and processes that are used in the working activities. The Act was thus based on the principle that workers, including healthcare workers, were to be provided with safe working environments without risk to their health (Health & Democracy, 2014:331). As such, it states that top management, for example in hospitals, should organise work, equipment and machinery in a safe way; provide information and training that makes workers aware of any risks to their health and safety; and ensure that work is supervised properly (Health & Democracy, 2014: 330-334).

The Act also states that protective clothing against airborne disease such as Ebola and TB must be provided. Moreover, the National Health Act 20 (3a) states that health establishments 'must implement measures to minimise injury or damage to the person or property of health personnel working at that establishment'. Indeed, the failure to minimise such injury or damage to the person or property of health professionals may be regarded as unlawful and a breach of the National Health Act (Salie, 2016:2). In sum then, with such policies in place, there was a vision and mission to strengthen the effectiveness of South Africa's health systems by developing the healthcare workforce in ways where they would be able to meet the health needs of South Africans and would be able to control and combat the burden of disease. The argument here was that this healthcare workforce needed to be properly skilled, valued, respected, and motivated (Health & Democracy, 2014:326).

However, it was argued that post-1994 reforms had, for the most part, failed to adequately change health worker distribution and access to good healthcare (van Rensburg, 2014) and in 2009, 15 years into South Africa's democracy, South Africa's new Minister of Health, Dr Aaron Motsoaledi, argued the importance of defining key health challenges that the country still faced (Mayosi & Lawn et al, 2012:5). Motsoaledi subsequently developed the vision to improve access to healthcare and health outcomes through the prevention of illness, disease, and the promotion of healthy lifestyles by focusing on access, equity, efficiency, quality, and sustainability under the banner, "A long and healthy life for all South Africans" (Human Resources for Health Strategy for the Health Sector [HRH], 2012:8). To realize this vision – which was in line with the 2011 objective set by the UN and the WHO to achieve universal health coverage – Motsoaledi noted that South Africa's healthcare system required a larger healthcare workforce whose 'skills, knowledge, and caring attitude' would be needed to build a healthcare system that could adequately control these burdens (HRH, 2012:9).

Recently, more consensus has emerged in both literature and policy on the power of healthcare workers and their critical importance in strengthening health systems and disease control programmes. Indeed, the saying 'no health without a workforce' has become an increasingly universal saying (Crisp & Chen, 2014:951); (Mills, 2014); (Kotzee & Couper, 2006).

In sum then, South African policies were and still are aimed at ensuring that healthcare workers work in a democratic, decentralised and equal national health service so as to ensure that they are trained, and motivated to be part of these re-engineered health systems (Daviaud & Chopra, 2008); (HRH, 2012); (Siegel & Yassi et al, 2016). Included in this is the idea that junior health professionals are of out-most importance as they present the future of healthcare in South Africa. Here it has been argued that these junior professionals are to be properly trained and mentored in their compulsory intern and community service year/s so as to ensure that they become part of a public health workforce that is valued, respected, and able to combat the continuing public health crisis in South Africa (National

Core Standards for Health Establishments in South Africa [NCSHE], 2011:1-9); (HRH, 2012:8-13).

It should be noted that internship training for newly qualified doctors was introduced in South Africa in 1950. This one-year programme was not uniform for all medical graduates and focused only on specialised training in secondary and tertiary hospitals (Nkabinde & Ross et al, 2013:930); (Meintjes, 2003:336). Following the end of apartheid in 1994, with the democratic government wanting to provide primary-level healthcare to all South Africans, as outlined above, there was a recommendation that post-graduate training, with suitable supervision, be made compulsory. Over time, this programme changed its structure from an internship to a programme that consisted of 'service and not training' (Nkabinde & Ross et al, 2013:930), and finally, in 2005, a decision was made to implement a two-year internship programme for medical graduates from universities in the Free State and the Transkei. From 2006 to 2008, graduates from other medical schools across the country began theirs. This programme was fully structured and had its aim in training graduates through hands-on experience under careful supervision. The aim of this programme is then designed to 'bridge the gap' between the knowledge learnt as a student and the skills that are required as a competent healthcare worker (Bola et al, 2015:535).

For many other health professionals, such as Occupational Therapists and Physiotherapists, this training and supervision takes place in their compulsory one-year community service programme in their first post-graduate year. Although one of the aims of this community service is to improve the provision of healthcare (Reid, 2001:329); (van Stormbroek & Buchanan, 2016:63); (Pillay & Harvey, 2006:260), particularly in rural areas; much like doctors in their internship year, training through hands-on experience and careful supervision, is noted as incredibly important. The argument then is that because newly graduated Occupational Therapists and Physiotherapists are relatively inexperienced, they too are in need of proper support and supervision in order to practice their professions efficiently (Reid, 2002:136). For example, studies have shown that the role of proper supervision has been crucial to both identity-formation and the ability to provide quality service delivery in Occupational Therapists (van Stormbroek & Buchanan, 2016:69-70).

In sum then, the purpose of these initial post-graduate year/s is to equip junior health professionals with the knowledge and practical skills of medical practice so that they may become competent medical professionals, as stated above (Sein & Tumbo, 2012:10). Indeed, it has long been argued that early post-graduate years provide a significant opportunity for junior health professionals to consolidate knowledge and skills (Rolfe & Pearson et al, 1998:312). The key here though is that this ought to be done under proper supervision. Indeed, it has also long been argued that supervision is incredibly important for the professional development of junior healthcare workers, because supervision by an experienced medical practitioner allows junior health professionals – under the guidance of a ‘seasoned’ mentor – to gradually step into their future role as professional health decision makers (Busari & Weggelaar et al, 2005:697); (Baldwin et al, 2010:37); (Lack & Cartmill, 2005:70).

Further, it is argued that a lack of proper supervision can be harmful to healthcare workers and their patients. Indeed, numerous studies in the United Kingdom (UK) and Canada have suggested that an increase in patient deaths can be closely linked with less supervision of junior doctors (Kilminster & Jolly, 2000:828-831); (Kennedy & Lingard et al, 2007). The argument here then, is that the primary responsibility for junior health professionals in their first post-graduate year/s rests with senior medical staff at accredited training facilities (Bola et al, 2015:538).

Moreover, there is strong agreement in the literature that in order for these training year/s to be effective, key characteristics in supervision need to be present; such as supervisors always being available, and able to offer empathy, instruction, knowledge, respect, and support (Kilminster & Jolly, 2000:833). Of course, supervision is context-bound. Further, by its very nature, there are power-relations between supervisor and trainee. Here individual social positions such as race, class, gender and sexuality all confers relative power (Kilminster & Jolly, 2000:835). However, it is argued that despite these power relations, supervisors should be guided by ethics and as such be respectful and approachable in ways that do not exude intimidation, harassment, or discrimination based on social positions (Sein & Tumbo, 2012:10-13).

Another important aspect of this post-graduate training is the availability of resources in training facilities. Here the argument is that the availability of resources, along with proper supervision, play a significant role in the competence of junior health professionals. For example, it is argued that a lack of equipment and medicines hinder the training and the ability of these juniors to attain the necessary skills (Sein & Tumbo, 2012:10-11). It has also been argued that working hours for junior health professionals need to be regulated so as to avoid burnout or over-exhaustion.

In sum then, it is argued that these post-graduate training years for junior health professionals should include among other things, constant, reliable and ethical senior personnel for supervision and support; suitable patient facilities that include an availability of resources and equipment; and working hours that are not conducive to healthcare worker burnout (Prinsloo, 2005:3). In other words then, the training context and environment, as well as availability and methods of supervision and support has a key impact on post-graduate years for junior health professionals. Moreover, what is flagged as most important here is that these post-graduate training years should be properly regulated and that as such, healthcare workers should always have various mechanisms where they can lay complaints if they face any challenges relating to the above. Here the HPCSA plays a crucial role.

The HPCSA's (although then called the South African Medical and Dental Council (SAMDC)) origins can be dated back to 1928. However, changes as a result of the democratic dispensation in South Africa have inevitably had a profound impact on the regulation of health professions in the country (Dhai & Mkhize, 2006:8). In 1995, as a consequence of the merger of the SAMDC and the Transkei and Ciskei Medical Councils, the Interim National Medical and Dental Council of South Africa was established. After a five-year transitional period the Health Professions Council of South Africa (HPCSA) was launched (Dhai & Mkhize, 2006:8-9).

Today, the HPCSA, in conjunction with its 12 Professional Boards, is a statutory body established in terms of the Health Professions Act. As such, it is tasked with guiding and regulating health professionals in the country in aspects pertaining to registration,

education and training; as well as setting and maintaining standards of ethical and professional practice in democratic South Africa. It does so by setting standards for supervision and the workload of post-graduate trainees as well as standards for the working context / conditions in which they work (HPCSA, Online); (Bola et al, 2015:537); (Jaschinski & De Villiers, 2008:70a). All individuals who practice any of the health care professions incorporated in the scope of the HPCSA are required, by South African law, to register with the Council. These include doctors, occupational therapists, and physiotherapists, among others; and exclude pharmacists, chiropractors, dental technicians, nurses, and homoeopaths (HPCSA, Online).

As such, its councils have issued a set of guidelines and policies to assert practitioner independence and patients' rights which is founded on the relationship of trust that health care professionals have with their patients and each other (Dhai & Mkhize, 2006:8); (HPCSA, Online). Implicit in this is the requirement for a life-long commitment to good professional and ethical practice by both senior and junior health professionals. For example, one of the HPCSA's statutory obligations is to ensure that hospitals maintain minimum standards to enable effective teaching and thus retain official council accreditation (Bateman, 2014:264). This then means that all hospitals where junior health professionals train at, should be equipped with the needed resources as well as ethical supervision.

Here the HPCSA guidelines state that all junior health professionals should be supervised by registered Medical Practitioners who have at least three years post-internship clinical experience and that access to supervisors should be available to these post-graduate health professionals 24 hours per day. Further, guidelines state that they should not work alone in any critical areas (Bola et al, 2015:536). Moreover, the HPCSA rules make it unethical for doctors to be 'exploited in any manner' and states that if an intern became impaired because of long-working hours or felt that they were being exploited, coerced, or harassed in any way, and / or possibly became harmful to their patients because of this, they should report to their supervisor and also 'self-report' their condition and challenges to the HPCSA (HPCSA, Online); (McQuoid-Mason, 2016:54); (Dhai et al, 2006:1070).

To be clear, the Constitution of South Africa states that everyone, including junior doctors, has 'the right to fair labour practices' and not to be subjected to 'forced labour' (section 13);

and that everyone also has 'the right to bodily and psychological integrity' (section 12) which applies to patients, third parties and junior health professionals. It is these policies as well as the other policies outlined above that are incorporated into the HPCSA rules. The gist here then is that the HPCSA aims to protect the public as well as the professionals. This then means that as much as post-graduate years should be used as an opportunity to learn, senior staff members, especially supervisors, and the HPCSA have a joint responsibility to ensure that the quality of training and supervision in accredited facilities is maintained and that where it is not, junior health professionals should be able to lay complaints or report to the HPCSA (Prinsloo, 2005:3).

Despite this however, there remains, in addition to the 'general' challenges outlined above in the public health sector, challenges pertaining to working conditions / contexts and supervision that junior health professionals face in South Africa. For example, in 2016, junior doctors in the Western Cape, began calling for regulations on working hours following the death of a young intern who allegedly fell asleep behind the wheel after working a very long shift at Paarl Hospital where numerous interns had complained about working long hours (Medical Brief, 2016). These interns were placing blame on the Western Cape Department of Health and the HPCSA for allowing interns to work shifts of up to 30 hours or more. Indeed, at the time, junior doctors were required to work 40 normal working hours and then 60 to 80 hours of overtime a month (Medical Brief, 2016). In August 2016, it was announced that working hours for medical interns would be reduced from 30 to 24-hour shifts (ENCA, 2016). However, various studies continue to show non-compliance with this ruling despite the fact that it has long been argued that a lack of sleep and continuous work impairs human functioning and leads to healthcare worker burnout.

For example, in Scotland in 2014, Brian Connelly, the father of Dr Lauren Connelly, who was killed in a car accident after working more than 107 hours in the weeks prior, campaigned to limit the hours worked by junior doctors. Subsequently, hospitals in Ireland were told to reduce their working hours because there was an agreement that arduous shift patterns and subsequent burnout affected the safety of patients and how well doctors performed (Medical Brief, 2016).

Here it should be noted that the first published studies on burnout is said to have appeared in the mid-1970s in the USA (Prins & Gazendam-Donofrio et al, 2007). It should also be noted that the causes of burnout vary. For example, it has been related to workload, a lack of resources needed to carry out workload, a lack of support, and an increase in 'emotionally demanding' workplace situations such as patient deaths (Prins & Gazendam-Donofrio et al, 2007:788). However, one of the most common factors is long working hours and the effect it has on sleep patterns. For example, in 1971, a study by Friedman et al based on electrocardiograms, (Quoted in Landrigan & Rothschild et al, 2004:1839) showed that junior health professionals made twice as many errors after a 24 hour plus shift than after resting for the night. Indeed, today, studies done in the USA on sleep deprivation and impaired performance by medical interns show that being awake for 24 continuous hours causes impairments in performance similar to those induced by a blood alcohol level of 0.10% and that the chances of being involved in car accidents after work doubled for those working these 24 hour plus shifts (McQuoid-Mason, 2016:52).

This is then the equivalent of saying that when these junior health professionals leave work and get into their motor vehicles, their impairment is the same as someone who would be 'drunk driving' (Dawson & Reid, 1997:235); (Salie, 2016:1); (Erasmus, 2012). Further, studies have found that this sleep deprivation that medical interns face could cause them to make up to 36% more serious errors in hospitals, and that those who work these long shifts have 61% more of a chance of needle stick injuries (McQuoid-Mason, 2016:52); (Ayas & Barger et al, 2006:1060). Indeed, in South Africa, 69% of interns reported being exposed to these injuries (Sun & Saloojee et al, 2008:33). To be clear, these needle stick injuries could result in the transmission of blood-borne pathogens, including HIV (Ayas & Barger et al, 2006:1055). This is alarming given that a recent national survey in the USA showed a 45.8% burnout rate among health professionals (Cook & Arora et al, 2015:3). Much the same can be said for a study done in England whereby 41% of medical professionals reported that in their first post-graduate year, most of their biggest mistakes, of which 31% resulted in patient fatalities, were caused by high levels of fatigue (Landrigan & Rothschild et al, 2004:1839).

Moreover, a longitudinal study of first year postgraduate doctors in the USA showed that these junior health professionals began their training year with 'high-levels' of well-being

but that by the end of the year, they were experiencing high levels of depression (Eckleberry-Hunt & Lick et al, 2009:269); (Bellini et al, 2002:3143); (Collier & McCue et al, 2002:384). All of them associated this with burnout which was then associated with long working hours. The argument here then is that the number of working hours associated with burnout can negatively affect the productivity and safety of junior health professionals (Barger & Cade et al, 2005:125). To be sure, it has been argued that in various studies done, junior health professionals reported burnout more than senior health professionals did (Prins & Gazendam-Donofrio et al, 2007:789).

Further, it has been argued more and more in the literature that junior doctors are negatively affected by 'dismal' working conditions in public hospitals in which there is very often a lack of (or any) supervision, and a rarity (or non-existence) of life saving equipment and resources (Bateman, 2014:264). For example, in my own previous research, interviews with junior health professionals showed that there is a major gap between the imagined reality, outlined by health and healthcare policy, of having health establishments which are safe for healthcare workers against diseases such as TB (for example) (Petersen, Unpublished). Here, all my participants stated that many of the hospitals and clinics they have worked in are unsafe due to a lack of ventilation and separate TB wards as well as the lack of available masks and protective gear (Petersen, Unpublished).

Moreover, in a study done in Limpopo South Africa, 95.7% of junior health professionals stated that equipment in hospitals often did not work; with 58% reporting that they experienced the death of a patient that can be directly related to system failure such as broken machines (Nemutandani et al, 2006:181). Other studies in South Africa confirm this, by showing that one of the biggest forms of stress for junior health workers is the lack and disrepair of hospital equipment. For example, in a study done at three hospitals in Johannesburg, 63% of junior health workers said that the availability of basic supplies such as gloves, needles, and drip stands were 'very poor' (Sun & Saloojee et al, 2008:33).

In another study, there were numerous reports that hospitals did not have radiology equipment machines which have resulted in harm to patients (McQuoid-Mason, 2016:681). Further, in 2014 in the country's largest hospital, a broken X-ray machine, as well as a

broken computed tomography (CT) scanner resulted in many urgent cases not being attended to (McQuoid-Mason, 2016:671). The same can be said for many other hospitals such as those in KwaZulu-Natal and the Western Cape. For example, in 2015, several hospitals in Durban had broken CT scanner machines and in 2016, it was reported that there was a shortage of radiology equipment in Cape Town (McQuoid-Mason, 2016:681).

Further, studies in the UK show that supervision of junior health professionals is inadequate because trainees do not always receive the required amount of supervisory time with their supervisors (Kilminster & Jolly, 2000:830). Further, in a recent study on Occupational Therapists in South Africa in 2013, there were reports that 24% of these first year post-graduate OT's felt they had a lack of supervision and thus that they were 'unsupported' (van Stormbroek & Buchanan, 2016:68). To be clear, it has been argued that inadequate training and supervision is one of the biggest concerns facing the future of health and healthcare in South Africa (PPS, 2014:1).

In addition to this, there have been various reports of challenges pertaining to the type of supervision and the overall treatment that junior health professionals face in their first post-graduate year/s. It is these challenges, which include experiences of harassment such as racism and sexual harassment, as well as coercion and intimidation, which has recently been labelled a 'culture of abuse' (Khan-Gilmore, 2016); (Levey, 2001), but which has mostly been labelled as 'bullying' has long been discussed in the literature. Such "bullying" behaviour is said to include, among other things, a refusal to answer questions, the use of condescending language and tone of voice; and showing impatience when asked on the job questions (Anderson, 2013:53). More recently, research has identified practices including humiliation such as mocking and scolding or demeaning junior health professionals (Scott & Caldwell et al, 2015:185e.1).

Indeed, in 1982, Henry Silver (Quoted in Cook & Arora et al, 2015:2), highlighted the mistreatment of medical students in the USA. Over the last two decades, an increasing literature has developed on this, by highlighting workplace bullying in various organizations but most significantly in healthcare. Indeed various studies over time have shown that bullying among healthcare workers is a persistent problem. These reports range from gender and racial discrimination to belittlement and humiliation (Cook & Arora et al,

2015:2); (Rees & Monrouxe, 2011:1374). For example, a study done in the UK showed that 52% of healthcare workers reported experiencing some sort of aggression at hospitals (Ariza-Montes & Muniz et al, 2013:3122). Further, studies in Australia show that within the healthcare workforce, junior doctors experience the highest level of bullying (Rutherford & Rissel, 2004:66).

In New Zealand, surveys of medical students and first year post-graduate interns showed that humiliation and belittlement were the most common forms of bullying (Crowe et al, 2017:70). In the USA, there have also been numerous reports of harassment and the belittlement of junior health professionals. For example, a study done among medical students and first year interns showed that 40% of juniors reported being harassed by senior doctors, while 84% reported that they had been belittled (Frank & Carrera et al, 2006:5). Of course, there have been many instances where this bullying takes on a more physical form. In a study done in Ireland for example, there were numerous cases where junior health workers reported being pushed around (Cheema & Ahmad et al, 2005:2).

Further, various other studies also done in the UK show that female, black and Asian doctors are more likely than other junior interns to be bullied (Imran et al, 2010:594). Much the same can be said about studies done in the Netherlands and parts of North America as well as other parts of the world (Neville, 2008:447). In Australia for example, most studies showed a pattern of male bullies and female victims. Here though, some females reported being bullied by both men and women but men tended to be bullied by male seniors (Rutherford & Rissel; 2004:67). This too has been long documented in the literature, with studies from as far back as 1991 and 1998 in the USA showing that 68.4% of female junior health professionals reported experiencing sexual harassment or discrimination (Daugherty et al, 1998:1195).

Indeed, in January 2017, Yumna Moosa, a then junior doctor in the process of completing her compulsory medical internship, appeared before a HPCSA inquiry, and played a recording of a conversation with her supervisor at Addington Hospital in Durban South Africa. In the recording, her supervisor is heard making threats to arrest her if she refused to throw away her internship logbook which contained what she refers to as comments about his and his colleagues' 'inappropriate behaviour' towards her (YumnaApology, 2017). This

included comments about racism, sexual harassment, coercion and intimidation, and the unavailability of senior staff after hours. The supervisor can also be heard instructing her to lie about what happened, and saying that he will blackmail her with that lie if she tried to retract it. He then also threatens her with being bankrupted in court for an email that she sent to the Head of Department (HOD) alongside the logbook (YumnasApology 2017).

This recording was part of a mountain of evidence that Yumna submitted to the HPCSA in which she argued showed a clear case for charges of professional misconduct against at least two of the Addington senior doctors involved. For example, Yumna stated that when she complained of sexism to senior staff members at the hospital, she was asked if she could provide a breakdown of the staff by sex, and when she could not, he informed her that the intern body at the hospital she worked at, was made up of 68% of females and thus her claims of sexism were invalid. Of course, this is based off his on idea of what 'sexism' is.

Nonetheless, Yumna argued that the HPCSA committee did not look into any of her complaints and that they only disputed her assumption that what happened was unacceptably unprofessional (YumnasApology, 2017). Yumna had also sought help from leadership throughout the Provincial and National Departments of Health who she says only action was to aggressively defend the Addington senior doctors. They have since closed the enquiry, stating that her supervisors "remain ethical, clinical and professional". The HPCSA chairperson also criticised her for being "a free speaker", "too friendly", "too open-minded" and "too bright" (YumnasApology, 2017). Since then, at least two more interns at the Durban hospital have had their careers severely disrupted after raising similar complaints (YumnasApology, 2017).

Here it should be noted that the precise origins of the term "sexism" are hard to trace. However, it has been argued that it "almost certainly" dates back to the 1960s along with the political activities undertaken by feminists. Indeed, sexual harassment has been the subject of research papers since the 1970s and has long been campaigned against by feminist (Samuels, 2003:467). While the term has evolved over time to encompass different 'forms' such as subtle vs overt sexism; definitions have in common the idea that sexism is "A system of oppression based on gender differences that involves cultural and institutional policies and practices as well as the beliefs and actions of individuals (Dick, 2013:647).

Today it is recognized as a serious problem, with increased coverage in the literature and in media reports worldwide. Further, guidelines for dealing with sexual harassment has been included in workplace policy globally. For example, a survey done in the United Kingdom found that 111 organizations had a policy on it and that 69% of respondents viewed it as a “fairly important problem for employers” with 17% viewing it as a “major problem” and only 2% viewing it as “no problem at all” (Samuels, 2003:467).

However, despite this, undertaking research on sexism has been seen as a “controversial undertaking” and one that could be “problematic” given that many individuals are often reluctant to name certain experiences or practices as “sexist” (Dick, 2013:645). There are thus arguments that it is both an objective and subjective experience. There are some such as Harriet Samuels (2003:467) who even argue that sexual harassment in the workplace shouldn’t be viewed as synonymous with workplace bullying as it is detrimental to women. Here her argument is that viewing it in this way means that the sexual element, which includes the power relations between men and women, are “downplayed” and are not seen in light of the overarching patriarchal environment (Samuels, 2003:468). The feminist perspective in turn, sees violence against women as a result of structural inequality (Samuels, 2003:478). The argument here is then that we need to take account of both the public and private spheres.

Maria Ontiveros (1993:817) on the other hand argues that sexual harassment is rarely, if ever, about sex or sexism alone for women of colour. Here she argues that it is also about race. Moreover, her argument then is that while sexual harassment is about sexism and power, it is also about race and culture (Ontiveros, 1993:818). This argument is based on the idea that many times from the viewpoint of the harasser, women of colour appear to be less powerful and less likely to complain (Ontiveros, 1993:818).

While I believe that Samuels (2003) argument holds warrant in that as Sociologists, it is important to take account of both the public and private spheres of life in order to gain a wider scope of inequality, it is within the limits of this report, that I have accessed the public experiences of participants in relation to sexual harassment. Thus, sexual harassment remains under the scope of “bullying” here, as with many of the other literature. A further

study, using Samuels (2003) argument might warrant otherwise. My argument here then is that workplace harassment is about power dynamics and that this includes sexual harassment, and that much of what Ontiveros (1993) has argued, is present in Yumna's case. It is thus her trajectory that I follow here.

It is because of the above experiences that Yumna has argued that the institutions that govern medical practice in South Africa, like the HPCSA, are not prepared to support the challenges faced by junior health professionals and that they demonstrate little commitment to the modern, humane standards of conduct that the young generation of health professionals were promised in democratic South Africa (Yumna's Apology, 2017).

Indeed, in a cross-sectional survey in Pakistan in which 654 junior doctors participated, 417 or 63.8% of them reported being bullied while 436 or 66.7% of them stated that they had witnessed other junior doctors being bullied by senior consultants. 73.4% of these junior doctors did not make a complaint against their seniors (Imran et al, 2010:592). In Australia as well, it has been reported that complaints mechanisms in hospitals were 'under-utilised' to a large extent because the process has been labelled 'unfair' and hierarchical, and thus not in the favour of juniors (Rutherford & Rissel, 2010:71). Further, in studies done across 20 European countries, stats showed that a large number of junior health professionals did not report their challenges because they didn't want to be seen as 'troublemakers', and that 'nothing would change' because they wouldn't be taken seriously over the seniority of older employers (Carter & Thompson et al, 2013:7).

In Pakistan as well, it has been argued that regulatory bodies are not playing effective roles in addressing the challenges of junior health workers (Gadit & Mugford, 2008:464). It is because of this, that much like Yumna's argument, there has been an increase in the call to further explore the barriers to reporting bullying or challenges faced (Carter & Thompson et al, 2013:1). This is a key factor given that many argue that bullies tend to target those who they know have inadequate support (Joint Commission, 2016:1).

Of course, the first postgraduate year/s are generally said to be stressful because of long working hours, challenging workloads, lack of personal time, and sleep deprivation (Rosen & Phyllis et al, 2006:84). However, the gist of it is, healthcare professionals are expected to be sympathetic, kind, and ethical by the very nature of them being caregivers and healers. However, the literature shows that this fabric of the healthcare profession is being challenged by increasing harassment and bullying, which is often referred to behaviours that are found to be threatening and offensive (Gadit & Mugford, 2008:463); (Neville, 2008:447); (Newton & Barber et al, 2008).

How ironic then that a profession that espouses 'caring' has a history and a presence of creating and exacerbating a learning environment that is the antithesis of that expectation. Here it could very well be argued then that junior health professionals are not being provided with the needed services and behaviours that they are expected to provide (Dhai et al, 2006:1069). Indeed, it has been argued that if junior health professionals are expected to behave ethically towards patients, then their mentors must themselves behave ethically towards them (Frank & Carrera et al, 2006:6).

What the above shows is that while the working conditions / contexts as well as the availability of supervision has been studied extensively in both Northern and Southern literature; it has been noted though that while bullying experienced by junior doctors and other health professionals have been extensively studied in Western literature, very little has been done to study this phenomenon in the South (Imran et al, 2010:592); (Neville, 2008:447). What Yumna's story highlights though, is that decades after first being reported and despite the fact that many have argued that interns 'invent' or 'overstate' these challenges pertaining to 'bullying', it continues to persist (Scott & Caldwell et al, 2015:185). Moreover, it brings about questions pertaining to the mechanisms of laying complaints about these challenges.

From the above, it is clear that the public health system in South Africa is still rife with many challenges like understaffing, mismanagement, and a lack of resources, which have long

been outlined in the literature (von Holdt & Murphy, 2007). Here, my argument though is that it is the threat of the complete collapse of services however that has only sharpened the need to treat staff well, especially given that South Africa cannot afford to lose more young health professionals. The question then is, if it has been argued that people work and heal better when they are part of institutions that value them and respect their human dignity – and this has been argued in polices, as seen above – especially given the quadruple burden of disease and the need for junior health professionals – the future of South Africa’s health and healthcare system – to fight against it; why have accounts and perceptions of challenges and the role that complaints mechanisms play in addressing these challenges not being explored more in South African literature? Yumna had the opportunity to formally document her story. Why is it then that we have not explored the stories of all the other Yumnas despite the fact that stats, globally, show they exist?

My argument then is that surely it needs to be noted that it is only the users and in this case, the providers of services that can define whether they work or not because it is their perceptions and experiences that make-up the lived reality of health and healthcare in South Africa. This then means that we need to explore the issues and challenges experienced by those impacted by healthcare systems; because without it, we cannot hope to develop and improve the professional culture that should be leading to the healing of human bodies. Indeed, as noted, South Africa is losing young health professionals at an alarming rate and there is a possibility that poor working conditions, a lack of supervision, and ‘bullying’ will exacerbate that. It is imperative then the experiences and perceptions of junior health professionals be documented because it cannot be that their voices – the voices of the future generation of our healthcare system – is silenced in a democratic system that is supposed to be offering the exact opposite.

This thesis thus uses semi-structured interviews to interview six junior healthcare professionals who are registered and thus regulated by the HPCSA in South Africa and who are in the process of or who have recently completed their compulsory year/s of internship / community service in any public hospital in South Africa; in order to explore their accounts and perceptions of challenges and complaints mechanisms pertaining to these challenges in their first postgraduate years. This is done in the hopes that this research will add to the growing literature on the working conditions / contexts and the availability of supervisors in

which junior health professionals work in and have access to as well as lessen the gap in the literature on the various challenges that junior health professionals face in relation to 'bullying' and laying complaints with supervisors and the HPCSA.

2 RESEARCH QUESTIONS

The following research questions were used to meet the aims of this thesis:

- What are the lived experiences and challenges of junior health professionals in their postgraduate year/s?

Here the research questions relating to 'challenges' were specifically focused on challenges highlighted as major in the literature as follows:

- ❖ Working hours, staff to patient ratio, and burnout
 - ❖ Availability of resources / equipment
 - ❖ Supervision and training
 - ❖ Experiences of bullying
-
- What are their encounters with the official complaints process in relation to their challenges?
 - Are there complaints in relation to these challenges which they do not pursue? What accounts for this?

3 RESEARCH METHODS

Given that my worldview holds that language provides a sensitive and meaningful way of recording accounts of human experiences which are key points in qualitative studies as opposed to statistical methods such as counting and various scales – key points in quantitative studies; in order to answer my thesis questions, I drew on a qualitative research approach.

3.1 Sampling

As stated, my research was based on the accounts of experiences and perceptions of junior healthcare professionals who are registered and thus regulated by the HPCSA in South Africa during their first post-graduate year/s. I therefore used a purposive sampling method to look for research participants that offered complex and rich information while fitting the above criteria. My sample was thus made up of junior health professionals who practice any of the health care professions incorporated in the scope of the HPCSA and who are in the process of or who have recently completed their compulsory year/s of internship / community service in any public hospital or clinic in South Africa. It thus included junior doctors, occupational therapists, and physiotherapists, and excluded those not registered with the HPCSA such as pharmacists, chiropractors, dental technicians, nurses, and homoeopaths.

This sample of seven, was chosen from a group of junior health professionals who I have networked with over the last few years as a postgraduate student at the University of Cape Town. Here it should be noted that using this network helped me maintain feasibility in terms of time available to me while undertaking my research (Bless & Higson-Smith et al, 2013:47) because in no way did I need to find and build relationships or rapport with new participants. Each of these junior health professionals were then approached via email. This email explained the details and aims of my research in the form of a mini research proposal. In it, I also drew on Yumna's experience as a background as to why I undertook this thesis topic. These participants were then also asked to respond to the email, indicating whether or not they were interested in partaking in the research project. All but one responded that they were interested because they felt they could talk more on the subject matter at hand.

One junior health professional declined, stating that they were not willing to partake. Time was then taken to respond to the latter respondent, thanking them for taking the time to read and respond. Further correspondence with the final sample of six junior health professionals took place via email.

3.2 Data collection

In these emails, all participants were advised that they have the right to decline to participate or to discontinue their participation in the research at any time during the research process if they so wished. Times and places of the semi-structured interviews were then also discussed via email. Here it should be noted that given that I am a junior researcher, travelling outside of Cape Town would require time and money not readily available to me and as such, it was initially agreed with one of the participants that our interview would be conducted via skype. However, subsequently, the participant became available in Cape Town; meaning that all interviews took place in person.

In order to ensure that I was prepared for these individual face-to-face interviews, an interview guide was prepared in which I set up an informal grouping of topics and questions based on my review of the literature, that I would be exploring during the interview process. I then met with each research participant individually in places chosen by them. These places ranged from rooms in their own homes, to small, quiet coffee shops in Cape Town. In order to keep in line with the qualitative guidelines set up by Bless and Higson-Smith et al (2013:32-33), each participant was given the option of choosing a pseudonym so as to keep their original names anonymous and confidential. This was done before the interviews began. Also before each interview, all participants were handed an informed consent form which they were asked to sign, and which was taken as an indication that they did indeed understand what had been explained to them. I then eased each participant into the interview by asking easy and straightforward questions in order to create a more discursive conversation. I then moved from general type questions to more specific ones, according to my research aims.

The topical trajectory of my interview guide was followed as best as possible during each interview but there were times during each interview where I strayed slightly from the guide where I felt it appropriate to do so. As such, I kept room for new ideas to be brought up

during the interview as a result of what my participants said while also discovering reliable and comparable qualitative data because specific topics and themes were covered in each interview. Furthermore, even though I asked questions relating to these themes and topics, I avoided using leading questions so as to not influence my participant's responses. Closed-ended questions were also avoided as much as possible but where it was used for affirmation, I used a technique outlined by Earl Babbie and Johann Mouton (2001:289) and Bless and Higson-Smith et al (2013:215) called 'probing' in which I followed up using my respondents' ordering and phrasing of answers in order to elicit further narratives.

Each interview was conducted in English, as agreed to by each participant, and lasted between 1 hour and 1 hour 30 mins. After the interview had taken place, each participant was sent a copy of the signed form for their own records via email. It should also be noted that all interviews were recorded using a recording application on a mobile phone and my laptop which I was familiar with having used it before, as agreed to by each participant; and supplementary notes, as stated in the consent form, and thus also agreed to by participants, were jotted down on a notepad during the interview process. A copy of the informed consent form which was based on the example by Bless and Higson-Smith et al (2013:39) can be found in Appendix 1.

Recordings of each completed interview were then clearly marked and stored onto my laptop's internal and external storage. In line with guidelines by Bless and Higson-Smith et al (2013:340-341), each recording was then backed-up on another hard drive which was password protected, and all notes that were jotted down was kept in a locked filing cabinet so as to ensure that the collected data was protected from being heard and read by anyone else.

3.3 Data analysis

Using headphones to listen to the recordings, I then used Word to manually transcribe the data collected from the responses to each semi-structured interview. I completed this task of data analysis myself because as a junior qualitative researcher, I believe that the process of transcribing helps immerse myself in my data. Then, in order for my methods of analysing data to be systematic and disciplined; I used a data analysis method associated with the work of Matthew Miles and Michael Huberman as outlined by Keith Punch (2014) because it

enabled me to trace regularities and sequences in my data. As such I followed the three components of their approach labelled 'transcendental realism' which was data reduction, data display, and drawing and verifying conclusions.

During the data reduction stage I edited my transcripts by 'cleaning' the collected data. In doing so, I removed any information that could be used to identify my participants such as clinic and hospital addresses and names as well as any other personal information that could be used to identify my participants. This process of editing and cleaning the data was done in the best possible way to ensure confidentiality without significant loss of information by ensuring that the information given was not stripped from its context (Punch, 2014:172). An example of an edited transcript can be found on Appendix 2.

I then read and re-read each transcript so as to then again immerse myself in the data and to create a 'mental picture' of the entire data set. Because the collected data was quite dispersed and fairly voluminous, I followed the data display component of analysis by creating mind maps of my data which helped me visually organize and summarize mental pictures of the data set (Punch, 2014:172). Following from this began to draw vague conclusions about my data which was jotted down in a notepad for later analyses. Each transcript was then imported into a computer software package Nvivo which I am familiar with and which I saw as a convenient tool for coding or labelling the voluminous data I had collected and analysed.

Indeed Nvivo helped me to build a rigorous and systematic coding system which helped me rule out human error in analysing my data. The data was then coded on Nvivo using First and Second Level coding methods associated with Miles and Huberman. As such, the First level codes were descriptive, low inference codes which required very little inferences of the data itself. These codes were useful for getting a 'feel' of the data and for summarizing certain segments of the data (Punch, 2014:174-175). Subsequently, the Second level codes which were more interpretative helped me collect material into a smaller number of more meaningful units. In this way I was able to pull together themes and identify patterns in the data without stripping the data from its context – a key point of qualitative research and analysis.

These processes of data reduction, data display, and coding were made easier by the use of semi-structured interviews which were based on themes and topics, as previously noted. This is because these themes and topics became a basis for my priori coding scheme. This then meant that my First level codes were based on the coding scheme I had created before the analysis was done by using the themes and topics found in the literature as my list of codes. These First level codes, which became 'parent' and 'child codes' – to show hierarchical systematic levels – in NVivo were thus based on the following preliminary code list:

- Burnout: Working Hours and staff to patient ratio
- Support services / Training: By Supervisors
- Bullying: Intimidation and Sexism and Racism
- Equipment / Resources: Availability
- Experiences of laying complaints: Negative and Positive
- Reasons for not pursuing complaints
- Effects of these challenges: Positive and Negative

However, following from this, themes and patterns began to emerge within certain codes and as such certain codes were merged with others to create new codes or combined categories. Furthermore, I created new codes while others were discarded a number of times until I reached a set of codes that I thought fit my data well and that addressed my research aims appropriately (Bless & Higson-Smith et al, 2013:343). Here for example, it is interesting to note that despite the fact that my respondents all had a long list of complaints and challenges which their supervisors had largely failed to deal with, none of them had ever taken the 'next' step and laid a complaint with the HPCSA. Thus, while one of my research aims was to examine junior health professionals encounters with the HPCSA, given that none of them had actually complained to the HPCSA, it became imperative that I try to find out why this was the case. My respondents were then asked about their perceptions of the HPCSA which then became one of the expanded Second Level codes. This Second Level of codes was then given definitions that explained what kind of data would be categorized under that code so as to ensure that I coded consistently. These coding definitions can be found on Appendix 3. Once the coding system was finalized, I worked through each

transcript and broke up fragments which included words, sentences, and sometimes whole paragraphs, which were then allocated to particular codes in NVivo.

Following guidelines from Punch (2014:176), I used the 'Parent' code in NVivo as a directional signage or label and as such I only coded into the 'Child' codes while leaving 'Parent' codes as an identifier category. NVivo also enabled me to give each code a colour. This helped me create coloured coding stripes that showed me a production of visual index trees which made it easier for me to visualize my data and see which theme or topic had the most and least amount of information. This helped me draw more concrete conclusions and helped me visualize the sub-sections of my research report and the depth I could possibly go into discussing each theme. The final coding list can be found on Appendix 4.

Throughout the process of my research and of my data analysis I created a Memo on NVivo. This memo included theoretical, methodological, and often personal ideas about my research; which I used in conjunction with the data collection notes in my notepad, as a way of documenting and making-sense of my research. Here then, while coding was a systematic and disciplined part of analysis, memoing became a more creative way of keeping track of my ideas, and the difficulties of the research process and analysis. Together then, coding and memoing became the 'building blocks' of my qualitative analysis (Punch, 2014:177).

It should also be noted that given that the research for this project followed on from research I had previously conducted, it became clear through both data collection and data analysis that there were similarities and connections in the data I had collected over the last three years. Thus, under careful consideration with my supervisor, I decided to use some of the data collected in my previous interviews with junior health professionals in this research paper.

The previous research paper titled "An alienated healthcare workforce at the front line of Tuberculosis control" was a qualitative research report exploring the gaps between healthcare policy and the lived experiences of healthcare workers in the Western Cape, South Africa. In it, I used a purposive sampling method to look for a research participant that would offer complex and rich information while fitting the criteria of having worked or

currently worked with TB patients in a clinic or hospital in the Western Cape. Here it should be noted that the Western Cape was chosen because of its high prevalence of TB incidents as well as because it fitted into the feasibility of my research in that it is a research site close to home thus ensuring I spent less time and money on transport. Here, student nurses and doctors were chosen because they are part of the healthcare workforce and because such participants were easier to gain access to given my network of colleagues and peers.

Subsequently, a student doctor from the Western Cape, who was suggested to me through a network of colleagues, was chosen as my first research participant. Thereafter a snowballing sampling technique was used in which my first research participant identified and guided me to one other student doctor who became my second research participant. My second research participant then introduced me to a student nurse who then introduced me to another student nurse and these student nurses then became my third and final research participants. Through these sampling methods I managed to increase the size of my sample to four participants and develop a network of participants who fit the criteria of my research while still maintaining feasibility in terms of the time and money available to me while undertaking my research (Bless & Higson-Smith, 2013:47).

I used the same approach with my participants in my previous research as in this report. That is, each participant was approached and time was taken to explain the details of my research, what would be required of them in terms of participation, as well as discussion of any questions they might have had about my research and its aims. Participants were also advised that they had the right to decline to participate or to discontinue their participation in the research at any time during the research process if they so wished. A hard copy outline of my research proposal was also given to each research participant. Furthermore, each participant was asked to sign an informed consent form which was taken as an indication that they did indeed understand what had been explained to them. Each participant was also given a copy of the signed form for their own records.

Further, a date and time as well as suitable locations were then arranged with each participant in order to conduct semi-structured interviews. An interview guide was then prepared in which I set up an informal grouping of topics and questions, based on my review of health and healthcare policy in South Africa, that I would be exploring during the

interview process. Thereafter, I met with each research participant individually in their own homes in order to conduct the semi-structured interviews in their own private and quiet rooms.

Again, I followed the topical trajectory of my interview guide as best as possible during each interview but I also strayed slightly from the guide where I felt it appropriate to do so. Each interview was conducted in English, and lasted one hour. All interviews were recorded using a recording application on a Samsung Tablet, as agreed to by my participants. The same methods for transcribing and analysis in this report was used in my previous research. Given that two of my four participants in my previous research did not meet the requirements for this research paper, I made use of the other two participants (who were doctors) recorded data that was relevant here.

4 RESEARCH ETHICS

Due to the fact that I have previously conducted research in the Sociology Department at the University of Cape Town, I was familiar with its policies and procedures on research ethics. After submitting a research proposal to my supervisor, I presented a proposal of my intended research to peers, and lecturers in the Sociology Department at the University of Cape Town in which all ethical concerns and how to handle such concerns were discussed with me (Bless & Higson-Smith et al, 2013:31). Thereafter, I submitted a Research Ethics form to my supervisor who advised me further and subsequently signed off my form and submitted it to the Ethics Committee in the Sociology Department for further review. After the initial review, I was advised further, and a revised ethics form was submitted to the committee who then signed off my research and provided me with ethical clearance. This ethical clearance document can be found on Appendix 5.

Here it should be noted that all advisement from the ethics committee and my supervisor was followed throughout my research process. As such, even though none of my participants knew each other, for confidentiality reasons, none of their names were used in my thesis. Here it should be noted that although the networks I have built up with these junior health professionals do not stem from 'personal' relationships; they are networks that I have not made public for any research I've done before (for my Honours Thesis) or thereafter, in this report. Furthermore, the research interviews were also kept separate from each other to further ensure this confidentiality. Moreover, after discussions with my supervisor, it was also decided that I will not name the hospitals they work at. Here it should be noted that all these decisions were made, because I was aware that I needed to minimize any risk to the employment of these junior health professionals as well as any risk between participants and their colleagues.

It should also be noted that The Western Cape Government of Health as well as the National Department of Health states that research clearance must be obtained from their various committees if the following research is done:

- All research at public sector facilities including research to be conducted at tertiary hospitals.
- Community-based or laboratory-based research that affects referral to and workloads at public sector facilities.
- Recruitment of patients from public health facilities to be involved in studies that themselves are conducted outside of public sector facilities.
- Drug trial research that is conducted at public sector facilities and/or requires the recruitment of patients.

I thus decided that due to the time constraints of applying for research clearance by these departments, I ensured that the interviews with my participants fall outside of these four categories by conducting interviews in a personal capacity.

As previously noted though, before conducting any interviews, participants were given an Informed Consent Form so as to ensure their confidentiality and assure their understanding that their participation was voluntary. It was also noted that some of the questions in the interviews with my participants may touch on sensitive areas. Here then, it must be noted that every effort was made to minimise their discomfort. In order to do so, I equipped myself with the contact details of support services that can assist junior health professionals (where ever they may be placed in South Africa).

It was then decided that these contact details will be shared with my participants if the need arises. It is important to note here that due to the nature of my research that involves an exploration of perspectives and experiences with the HPCSA, these contact services were mainly in the form of lobbying groups such as the Junior Doctors Association of South Africa (JuDASA) or the South African Medical Association (SAMA) etc who offer such support services. However, none of the interviews presented such a need; as it showed through discussion, that they already knew of such groups. Further though, all of my participants were encouraged to discuss with me any negative or difficult feelings or experiences they had as a result of participating in this research project. Here, as noted, they were advised that if at any time they felt they would like to stop their participation in the study, they were free to do so.

Further, as noted, under careful consideration with my supervisor, I decided to use some of the data collected in my previous interviews with junior health professionals. Here I only made use of data that was present in the already public Honours thesis document so as to ensure that I did not breach any ethical agreements with my previous participants. In other words, all data used in this thesis from my previous research, is from interview material which has since been made public with my participant's consent. Moreover, in upholding research ethics during analysis and reporting of my old and new data, I did not change the information of the data, except where cleaning it to ensure confidentiality of my participants; and I did not fabricate or falsify any of the collected data for my research.

Throughout the process of this research, I have followed research ethics as discussed with my supervisor and the research committee, to the best of my knowledge by including informed consent forms, discussing voluntary participation and the right to discontinue participation, ensuring the right to anonymity and confidentiality, equipping myself with referral numbers, as well as providing honesty in analysis and writing in ways that did not bring harm to my research participants while producing research that is relevant, significant and of a high quality.

5 FINDINGS AND DISCUSSION

5.1 Working hours, staff to patient ratio, and burnout

In August 2016, it was announced that working hours for junior doctors / interns would be reduced from 30 to 24-hour shifts after numerous arguments that a lack of sleep and continuous work impairs human functioning and leads to healthcare worker burnout (ENCA, 2016). However, various studies have continued to show non-compliance with this ruling; whereby long working hours have continued to be flagged as one of the leading challenges that junior health professionals face in South Africa (Barger & Cade et al, 2005; Bateman, 2014; Bola & Parkinson, 2015). Indeed, all junior doctors in my research stated that working hours and the burnout associated with it was very often the biggest challenge for them in their first postgraduate year.

For example, Usman, one of my research participants who is a junior doctor, stated that one of the 'main bad' experiences he has had, is the working hours. Here, when asked to elaborate on this challenge, he stated:

"It never ends. When I'm on call, I have to do my normal day's work, right. Then from 4pm till 8am I see new patients, then the next day I can only leave once my normal ward or clinic work is done which is around 12 or 1. We uh, get paid for 80 hours overtime a month. I work about 120."

Further, when asked what effect these working hours has had on him, he stated,

"The next day your brain is mush – you can't humanly function effectively!"

He also stated that many of his junior colleagues are 'not coping' with these long working hours and the 'pressure' that comes with it. Here he said:

"I'm glad I stay close to work and don't have to sit in traffic. I uh, I do think personally it affects different people more severely like some of friends are really not coping with the hours and pressure. People cry at least once a week."

Much of the same was said by another participant, Dane, who stated that:

“The working hours are too much. I’m really just suffering from major fatigue and many times this means that my patients suffer the most because I’m too tired to function and help them properly.”

Another participant, Peter, who is also a junior doctor, also stated that this burnout was “not good” for patient care. Usman stated much of the same by saying:

“Professionally, you can't give your all to patients when you are tired. Shame, sometimes I feel bad about how blunt I am to patients in the middle of the night but yoh it's difficult.”

He continued by saying that this burnout has also had much effects on him both in his work and personal life. Here he stated:

“Being tired isn't only dangerous to patients but to yourself. Also, you don't concentrate and you are bound to get a needle stick injury or something, you know? And, it's also difficult to have a personal life because you have to plan everything around long working hours.”

Interestingly, other healthcare workers in my research such as the Occupational Therapists and Physiotherapists did not seem to have any of these challenges associated with long working hours. For example, Tash, one of my respondents who is a junior Occupational Therapist who completed her first year of postgraduate training in 2017, stated:

“Luckily for OTs, we work 7-4 and only from Monday to Friday, so I can't really comment or have an opinion about the challenge of working hours.”

Another Occupational Therapist, Lucy, who completed her first postgraduate year in 2016, had much of the same response. Here she stated:

“Our working hours were fine. It was supposed to be from like half past 7 to 4 and nothing ever really changed and that was fine. We could work overtime but we didn't get paid for working overtime. You could basically just take that time back. And then, ya. Our leave was normal. Everything was fine in terms of working hours.”

Claire, a junior Physiotherapist, who also completed her first postgraduate year in 2017, stated that even though working hours in a private practice after her community service has been challenging, during her community service, she didn't face these challenges of ‘long calls’. Here she stated:

“So obviously we don’t do calls like doctors do. So, we don’t have that part of it which I am so grateful for!”

Here though, what is interesting to note is that these Occupational Therapists and Physiotherapists all recognized that the working hours of junior doctors in their first postgraduate year/s seems to be a big challenge for them. For example, when discussing these long working hours, Tash immediately responded by saying ‘*Poor Doctors*’ and Lucy stated:

“I think definitely with junior doctors it’s very different. Like, we obviously met some of the doctors that were doing their internships and community service when we worked there and they would work very long hours and be on call all the time.”

In addition to long working hours, another major cause of burnout that has been flagged in the literature, is the staff to patient ratios in public hospitals (Pillay & Harvey, 2006; Salie, 2016; Reid, 2001; Mills, 2014). Indeed, the National Department of Health (NDoH) has continuously noted that the failure of the public healthcare system in South Africa can be attributed to understaffing which often means that healthcare workers have to work longer hours. Due to this, in its recent core policies on health and healthcare in South Africa, the NDoH set out a requirement for all patients to have shorter waiting periods and for junior healthcare workers to have shortened working periods so as to lessen the burden on them and decrease the burnout that they have continuously flagged over the last few years. This was then to be met by increasing the staff to patient ratios in health establishments across the country (NCSHE, 2011:1-9); (HRH, 2012:8-13); (The National Strategic Plan for Nurse Education, Training, and Planning [NSP], 2012:3-10).

However, what my research shows is that this staff to patient ratio is still one of the major challenges that these junior healthcare workers face in South Africa, often with dire effects for both professional and patient. For example, Usman stated that even though junior doctors get 12 days sick leave for the year, if he or his colleagues needed to be absent from work for any reason, such as illness, the department at the hospital where they work would “*fall apart*”. When asked why he thought this was the case he responded by saying, “*Because they are hella short staffed*”. Tash also stated that she had “*major challenges*” working in a

public hospital, and that one of these challenges was the shortage of staff. Here she responded by saying:

“We had very few doctors employed at the hospital so the nurses were basically running the hospital. We were never on the same page. There was no ward rounds. I was at the hospital for a year and probably only met about five doctors, which is quite bad because it is a regional hospital with nearly 500 beds.”

Claire also stated that:

“In terms of the staffing – there was not a lot of it – and where there was a lot of it, staffing, it didn’t make sense. So, for example, we were lucky, we were uhm, five, five physios, no four physios and a physio assistant, uhm, and then, the OT’s were only two. And for like, it was a 250 or 300 bed hospital – that’s not a lot of people to see that many patients.”

When asked what the effects of this shortage of staff were, Claire’s response was that patients “get left behind”. She continued by saying:

“We were lucky in our physio department but even so, with five physios, you know, in a 250-bed hospital, that’s 50 people per physio for you to see at least once a day. Uhm, but I mean, 50 patients in a day is literally impossible.”

Again she reiterated the effects this had on patients by saying:

“You didn’t get to see your patients often enough. So, I’d see them like maybe once a month if I was lucky – it could be once every six weeks. Uhm, and with that kind-of thing, if you’re treating the patient today and the next time you see them is only in a month, you’re treating the same patient again because they would’ve not gotten any better because they need continuous input.”

Claire also recounted an experience that she associated with this shortage of staff and the pressure it put on her to see many patients during a busy schedule. Here she stated:

“I almost burnt a patient but that was because I was too busy. I had too many people to see. So, I put a hot-pack on my patient and I had to go do something else and like, I came back and this patient hadn’t said, like, I gave him a bell and I told him, ‘Ring the bell if it gets too hot’, and he didn’t ring the bell and when I came back, I took off the hot-pack and like, his skin was red. And I was like ‘Did you burn?’”

Indeed, this reiterates many of the statements made by junior health professionals in my previous research. For example, John, one of my research participants stated that:

“Some emergency patients would wait hours to be seen because there are only one or two doctors working at a time. Even things like theatre, there’s an emergency theatre list but people would still wait days to be operated on because of the lack of surgeons.”

Furthermore, another participant, Jill stated:

“In most government hospitals there is [A lack of staff]. Like, those hospitals have more patients, longer hours and more work loads.”

When asked how this shortage of staff to patient ratio affected their work life, all my previous participants also stated that it results in a “burn-out”. For example, John stated:

“It makes things much more difficult than what it should be. For one you have to see more patients and work longer hours so you have to rush through patients obviously impacting the care you give them. And when you really tired you don’t care the same about patients.”

Greg also responded that the shortage of staff in hospitals made things “really difficult”.

Moreover, Gabi responded by saying:

“Some patients end up not getting adequate care or go unnoticed thus leading to serious conditions. Patients who need to get their medication don’t get it and they can get really sick. Without TB medication for example, patients can die, you know.”

On further discussions around burn-outs, John stated:

“I did a 24 hour call. It was so exhausting. I probably only felt normal a few days later again.”

Such findings tie in with the contention that almost 50% of healthcare worker posts are vacant in the healthcare sector in South Africa, and largely so in the public sector (Engelbrecht & van Rensburg et al, 2016:24). It also shows that the requirements that working hours for junior health professionals, particularly junior doctors, needing to be regulated so as to avoid burnout or over-exhaustion has not been met. It is findings such as these that are most worrisome, especially given that there have been many studies that show that when junior health professionals leave work and get into their motor vehicles

after extended working hours, their impairment is the same as someone who would be 'drunk driving' (Dawson & Reid, 1997:235); (Salie, 2016:1).

Further, such findings are also worrisome because burnout has been associated with withdrawal, loss of productivity, and a reduction in the quality of patient care (Prins & Gazendam-Donofrio et al, 2007:789). It has also been associated with the intention to leave the job or country of work (Prins & Gazendam-Donofrio et al, 2007:789), something that the South African public health system cannot afford given that South Africa still requires at least three times its current healthcare workforce to adequately provide for the number of patients affected by the quadruple burden of disease (Mayosi & Benatar, 2014:1348-1349).

In sum then, while it has been argued that post-graduate training years for junior health professionals should include working hours and staffing levels that do not result in healthcare worker burnout (Prinsloo, 2005:3), my findings show that these junior healthcare workers continue to face challenges that include incredibly long working hours; that they continue to be burdened by low levels of staff; and that these factors have led to increased burnout which often have dire consequences for both them as junior professionals and their patients. Indeed if South Africa is to achieve its goal of properly meeting the needs of patients in the public health system, as well as retain its junior healthcare workers who are the future of healthcare, then more needs to be done to adequately fight these challenges.

5.2 Availability of resources / equipment

In terms of the regulation of working conditions / contexts, one of the HPCSA's statutory obligations is to ensure that hospitals maintain minimum standards to enable effective teaching and thus retain official council accreditation (Bateman, 2014:264). This then means that all hospitals where junior health professionals train at, should be equipped with the needed resources and equipment. Here the argument is that the availability of resources in training facilities play a significant role in the competence of junior health professionals as it enables them to attain the necessary skills to do their job properly. As such, my participants were asked if they had experienced any challenges relating to the availability of resources and equipment in the hospitals they were placed in for the first postgraduate year/s. All of them stated, that in addition to long working hours, and a lack of staff, one of the biggest challenges they faced is the non-availability of needed resources and equipment. For example, Usman stated:

"While I've been here, so many departments have closed down because of money. Like, some lab and imaging services closed down because there's no equipment. Some of the specialist departments even closed."

He continued, saying:

"The other day when I couldn't find those special TB masks – I probably have TB now because I couldn't find one and the patient was coughing all over me. It was really bad."

When asked what effect this had on him, he stated:

"It makes the job so much harder and again compromises patient care. We have one CT scanner and patients wait weeks for scans."

Tash had much the same to say. For example, she stated:

"The main challenges for me was when I knew what I had to do to help a patient or what the patient needed but the hospital could not provide the service due to lack of resources. I would say that was quite frustrating. I really had to learn how to manage these challenges without compromising patient care."

Lucy also stated that dealing with a lack of resources was *"very difficult"*. Here she stated:

“There was very little resources. Just the whole set-up of the hospital as well. Uhm, like in the TB ward, they didn’t have any aircon everywhere. Just like the way the people were living was so bad. Because they obviously had to stay at the hospital and couldn’t be out. And also like the mental health patients, they obviously sit in one ward. So, I would see the male patients. All in one ward. It’s dirty, it just wasn’t nice.”

She continued by saying:

“You need air-conditioning. You work in a mental health clinic and they should be treated like this and like this. But like, they had pajamas and it was broken. Like, obviously it was things that people wore already. So like, they didn’t always follow what they needed to follow at the hospital in terms of equipment and basic resources.”

Claire also stated that the lack of resources and equipment was one of her biggest, and most shocking challenges in her first postgraduate year. Here she stated that many times she did not have access to “sterile” equipment such as suction catheters. Reflecting on this, she stated:

“Sometimes you had to reuse them and sometimes we just didn’t have them.”

Here she continued, saying that this was a “breeding ground” for germs that often had deadly impacts on her patients. For example, she stated:

“There were times when I’d leave a patient on a Friday and I’d come back and my patient would be dead on a Monday because they would’ve aspirated on their own phlegm and there was nothing you could do about it.”

Reflecting on one of her experiences with a lack of resources and equipment, Claire stated:

“The first time one of my patients died I was so upset and I honestly felt like it was my fault. Like, I know that it wasn’t. Like, there’s nothing that a physio can do that will kill someone! But, uhm, just knowing like, maybe if I had been able to suction or if I had been able to do something more then we could’ve bought her enough time for something to, like, happen. So, maybe I couldn’t have saved her life completely, but, you know, I could’ve helped her along the way a little bit. But ya.”

This again ties into much of the responses from my previous research. For example, when asked if they always had access to safety masks as it was a requirement set out by the NDoH, John responded by saying:

“At certain hospitals no. One hospital I worked at has a TB ward and there are masks available but not at the emergency wards where we see new undiagnosed TB patients. I can’t think of any preventative measures in any emergency wards.”

Greg responded by saying:

“No. In one of the main hospitals I work at there’s hardly ever access to masks. And here I’m talking about for patients and healthcare workers. So always? No. Maybe in certain clinics and hospitals. But not all. And defs not always.”

While Gabi responded by saying:

“No. Not always. Also there are always incidents where a TB patient does not have a mask and nobody was aware of their condition until they have been approached.”

And Jill responded:

“No we don’t always have access to masks. Sometimes they have to wait on stock and such.”

Further, when asked how this lack of availability of masks affected their work life, John responded by saying:

“Every time I’m on call in an emergency ward I feel unsafe or exposed. We are not safe.”

While Gabi stated that:

“It’s really disheartening. It makes me very paranoid when dealing with certain patients and causes me to sort-of avoid patients I suspect of having TB.”

Here Jill also stated:

“I don’t feel safe at all; especially against airborne diseases.”

Findings such as these show that even though it has been argued that all hospitals where junior health professionals train at, should be equipped with the needed resources and equipment so as to ensure that they are able to attain the necessary skills to do their job properly, junior healthcare workers continue to train at hospitals where there is a major lack of much needed and often very basic resources and equipment. This is alarming given that

other studies in South Africa have shown that one of the biggest forms of stress for junior health workers is the lack and disrepair of hospital equipment (McQuoid-Mason, 2016 & Mayosi & Lawn et al, 2012).

Further, the finding that there is a lack of access to TB masks is particularly alarming given that the average annual risk of developing TB is three times higher for healthcare workers compared to the general population in South Africa (von Delft & Dramowski, 2015:148). Moreover, given the discussion above that healthcare workers are in short supply in South Africa despite being valuable assets in the fight against the quadruple burden of disease, which includes TB; it is alarming that these junior healthcare workers are not safeguarded in hospitals. TB is preventable and in many cases, it is curable, however, if healthcare workers are not being kept safe as shown by a lack of available masks in hospitals, then it is clear that those under their care are not safe either. Clearly then, the reality is that for junior healthcare workers, exposure without protection is one of the biggest challenges that they face.

Moreover, the findings that a lack of resources and equipment has led to patient deaths is also alarming. This then shows that this lack of resources and equipment has dire effects on junior health professionals and their patients. In sum, this lack of resources and equipment in public hospitals and the consequences of it, is a reality that South Africa cannot afford, both socially and economically; as such occupational risks could worsen the loss of an already limited healthcare workforce, both at present and in the future, and result in unnecessary suffering and death of many in South Africa. Indeed then, in order to protect both junior health professionals and their patients, more needs to be done in order to ensure that these challenges pertaining to working conditions / contexts are eradicated.

5.3 Supervision and training

One of the most important aspects of the first postgraduate year/s for junior health professionals is supervision. Indeed, as noted, it has long been argued that supervision is incredibly important for the professional development of junior healthcare workers, because supervision by an experienced medical practitioner allows junior health professionals to gradually step into their future role as professional health decision makers (Busari & Weggelaar et al, 2005:697); (Baldwin et al, 2010:37); (Lack & Cartmill, 2005:70). It is because of this importance that the HPCSA is tasked with setting guidelines for the adequate supervision of junior health workers in South Africa.

These guidelines then state that all junior health professionals should be supervised by registered Medical Practitioners who have at least three years post-internship clinical experience and that access to supervisors should be available to these post-graduate health professionals 24 hours per day. Further, guidelines state that these junior health professionals should not work alone in any critical areas (Bola et al, 2015:536). However, despite these guidelines, it has continuously been argued that inadequate training and supervision is one of the biggest concerns facing the future of health and healthcare in South Africa as an increased amount of junior health professionals state that they do not receive adequate supervision in their first postgraduate year/s (PPS, 2014:1).

Again, my research adds to this growing literature on inadequate supervision. Here it should be noted that when asked about supervision in their first postgraduate year/s, many of my participants had mixed answers where some were positive and some were negative. However, over all, all of my participants came to the conclusion that they did not receive the training and supervision that they had expected to as juniors. For example, Usman first responded by saying:

"I guess there are always seniors available that you can phone."

But then continued by saying:

"In an emergency though, you kinda forced to just act and can't try to get hold of them via phone. Because it will take too long."

On further reflection, Usman again responded negatively by saying:

“The physical support is lacking. In this department that I’m in right now, uh, they don't really teach us that well so you kinda just learning on the job. For example having a really sick patient that you have to resus without anyone more senior to help. So, you just there trying to do the basics that you know or having to do a procedure and googling how to do it.”

When asked what effect this had on him, Usman responded by saying:

“When you mess up it really gets to you and also, it’s not the best for patient care. I mean, it messes you up.”

He then concluded by saying:

“I definitely thought I would be receiving much more support than what I'm getting right now. I mean, the consultants complain that the interns see too many patients during the night compared to the MO's but what are we supposed to do if they disappear all night?”

In much the same vein, Tash first responded by saying:

“I felt my supervisors were always accessible to me when I needed assistance. Uh ya, my supervisors were always willing to assist if I approached them or needed assistance with a patient.”

However, on further reflection she stated:

“There was no direct supervision. I could have been doing who knows what with my patients, and no one would know. To conclude, uh, there was definitely a lack of direct training and supervision.”

When asked how this affected her, she responded that often she just tried to “follow ethical rules” as best as possible and tried to see it as a “learning experience”. However, she stated in her opinion, a lack of supervision affected people differently, where while some tried to “make it work” others could not. Here she stated:

“This approach does not work for everyone, hence the need for supervisors to train us on the standards and protocols set to avoid malpractice. I hate to compare but this approach did not work for a colleague. She never followed treatment protocols, never adhered to medico-legal standards. So, patient’s records were incomplete, she barely documented assessment or treatment notes, her patient’s files were not kept in a safe place. She literally left them lying around all over the OT

department, and often, like six or 10 times, she did not attend to received referrals because she wasn't being monitored or trained to do it."

Lucy also responded positively at first, by saying that when she started her first postgraduate year she was fully supported. Here she stated:

"Uhm, like in terms of having support within our department, the OT's, I feel like I had enough support."

However, she stated that later in the year, there was a "mix up" in the department she was working in which resulted in her receiving a new supervisor who was not "qualified" to be in the position she was in. Here she then stated:

"But then when it came to, like, that whole mix up, she couldn't support us properly as a supervisor because she didn't know what to do."

Again in much the same vein, Claire first responded by saying that her supervisor was "emotionally supportive". When asked to elaborate, she stated:

"Like, she would, like, especially when for me that was, I came from, I was living alone and I was by myself and I was quite, like, lonely. So, she would always take that into consideration and check how I was in terms of that. Uhm and like, if a patient died or something, then she would always be like 'Are you okay?'. Like that kind of stuff."

However, she also responded that the direct supervision was lacking and that her supervisor also wasn't fully qualified and committed to her position. She responded by saying that she could talk about a lack of proper supervision "for days". Here she stated:

"Like, clinically speaking, I could go and ask her like a very proper like clinical question and she'd be like, 'What do you think?'. Then like, you tell them what you think and she's like, 'Ag ya, go with that'. And I'm like [Stares blankly]. 'Why? Can you give me more?' and she couldn't. Uhm, like I said, she was busy doing her Masters and she was doing it in Public Health on teenage pregnancy so her mind wasn't really in the bones and the fractures and whatever."

Further she stated:

"And my supervisor, she also didn't like make contact with me, I just knew who she was. And she was just kind of my supervisor by default because she was the head of the physio department. So, we like just worked underneath her."

She then elaborated even further on this by saying:

“It was more like [Laughs] ‘How many patients are you seeing? This many? Okay’ [Laughs]. And then like, every three months, she’d rotate us so that we could get experience in different wards. But she wasn’t, uhm, she was busy doing her Masters, so she clearly had better things to do than [Laughs], like, listen to us talking about patients. So, we basically, it was a lot of reading up, uhm, on your own.”

Her conclusion then was, much the same as the above respondents, mostly negative. Here she reiterated:

“Okay, so in our community service year it was bad. Like, she didn’t supervise us. Uhm, she was there and she was emotionally supportive but like clinically, she wasn’t very supportive at all. And I think, like, emotional support is good – you want them to be emotionally supportive – because a lot of them aren’t. But ya. It was bad.”

What is interesting to note here is that Claire stated that this lack of proper supervision was something that she had experienced even while studying. Here then, her argument was that her student years and her training years was very much a continuation in terms of not receiving adequate training. Here, for example, she reflected on her student years by saying:

“They just, kind of, make assumptions and they don’t ask so if you aren’t comfortable with something, if you go to them and you tell them that you aren’t comfortable with something, they’ll make you feel like, shitty for like not, for like, not knowing that. And the point was that we were students and we shouldn’t be afraid to ask a question when you’re a student because that’s when people get hurt because then the student doesn’t learn and then they go do what they think is best but we don’t have any clinical judgement so we don’t know what’s best.”

Further, she stated:

“And we know that but if we can’t ask the people that we’re working with everyday then who are we really supposed to ask – you only see your supervisor once a week. And you can ask them as much as you can in that session but after that like, what more can you ask. And you can like, email them and you do but then you get like, an article and it’s like, not what you need. Like, and like I said before, reading is good, you need to read, you need to go and do the research and all of that stuff but it’s nothing without a clinical reasoning, like a full picture. And you need like an expert, [Pause], an ‘expert’ [Rolls eyes] opinion to get that which you often often didn’t get.”

Dane and Peter however were the only two who didn't alternate between positive and negative. These two respondents only had negative reviews about the availability of supervisors in their first post-graduate years. For example, Peter stated that he often felt "alone" and that his first postgraduate year was a very "lonely" experience as he did not feel he could approach his supervisor in any way; and Dane stated that while he worked with many "nice" people, there were supervisors who didn't really "worry" about their interns. Here is stated:

"Many times it was like the supervisor didn't even know you exist. They didn't really offer any support or training. We just do our own thing."

In sum then, these findings show that the HPCSA guidelines that state that all junior health professionals should be supervised by registered Medical Practitioners who have at least three years post-internship clinical experience is often not being met. It also shows that even though it has been argued that access to supervisors should be available to these post-graduate health professionals 24 hours per day, this is very often not the case. Further, the findings above show that these juniors who are supposed to be fully supported in "critical" areas (Bola et al, 2015:536), are very often carrying out major procedures by themselves, often while attempting to use their own, often limited knowledge or sometimes even the help of Google.

These findings then, although not entirely new, are still alarming, especially given that it has long been argued that a lack of proper supervision can be harmful to healthcare workers and their patients (von Holdt & Murphy, 2007:312). These findings are also alarming given that one of the key goals of the NDoH is that junior professionals be properly trained and mentored in their compulsory intern and community service year/s so as to ensure that they become part of a public health workforce that is valued, respected, and able to combat the continuing public health crisis in South Africa (NCSHE, 2011:1-9); (HRH, 2012:8-13). How can it be then, that in their key postgraduate training years, junior health professionals feel they are not being properly trained and supervised when indeed, it is the primary responsibility of senior medical staff to ensure that these juniors are trained and supervised in ways that allow them to step into their role as future healthcare providers. What the findings above

then show is that inadequate training and supervision is indeed one of the biggest concerns and challenges facing the future of health and healthcare in South Africa. A challenge that needs to be acted on if South Africa hopes to have an adequately trained future healthcare workforce.

5.4 Bullying

In addition to the working conditions / contexts that these junior health professionals find themselves in, and the availability of supervision they receive, there have been various reports of challenges pertaining to the type of supervision and the overall treatment that junior health professionals face in their first post-graduate year/s. These challenges include experiences of harassment such as racism and sexual harassment, as well as coercion, humiliation, and intimidation, which has recently been labelled a 'culture of abuse' (Khan-Gilmore, 2016), but which has mostly been labelled as 'bullying' in the health profession.

Indeed as noted, various studies over time have shown that bullying among healthcare workers is a persistent problem (Imran et al, 2010 & Neville, 2008). However, also as noted, while bullying experienced by junior doctors and other health professionals have been extensively studied in Western literature, very little has been done to study this phenomenon in the South (Imran et al, 2010:592); (Neville, 2008:447). In 2016 though, a junior doctor in South Africa, Yumna Moosa, publicly highlighted the bullying she had experienced. Thereafter, many other junior health professionals have continuously begun to highlight their own experiences. However, these experiences remain very limited in the South African literature. In the hopes of lessening this gap, my respondents were asked about their accounts of any experiences with bullying in their first postgraduate year/s. Here again, my findings were interestingly mixed with both positive and negative experiences.

For example, when asked if he felt he had ever been humiliated or belittled by a senior health professional, Usman stated:

"Nah, I haven't come across that. Everyone I've worked with has been nice. I mean, I've made so many mistakes but luckily, I was always corrected in a professional way."

He then added:

"I think that is really dependent on the senior's personality. I uh, I guess yeah, it depends on the person, man. Maybe I just don't let other people's shitty personalities affect me [Laughs]."

Interestingly though, he stated that he had however witnessed other junior doctors, particularly women, being publicly humiliated by senior doctors. Here he stated:

“All the females in my group has been complaining about this one doctor that's inappropriate – not sexually, but he's just an ass to them. The girls literally swop their calls with us when he is on call.”

When asked to elaborate, he said:

“He would make them do unnecessary work or shout at them. Uh, if he needs them he wouldn't call directly he would get a nurse to call. Stuff like that.”

Similarly, when asked if he had ever felt humiliated, Dane said he hadn't but then added:

“You should see how they [senior staff] treat the women doctors though.”

When asked to elaborate, he stated that very often junior female doctors would complain that senior doctors treated them “*differently*” and that they felt junior male doctors were treated better and as if they were “*smarter*”.

In much the same vein, Tash stated that she felt senior health professionals were often sexist. Here she stated that often she was made to “*feel stupid just because she is a woman*”.

Here, when asked to elaborate on this, she stated:

“There is a whole mentality that your view or opinion doesn't matter because we are newbies and female. Sometimes it felt like some of the senior professionals wanted to see you fail if you were passionate about your job. For example, during our first few weeks, we were told by one of the senior physiotherapists whenever one of the community service therapists wanted to implement change regardless of how practical and necessary it was we were told ‘Don't think you can come here and try to change the world, I hate naïve people’.”

She further stated:

“You also had to take the blame even if you were correct just to keep the peace between the senior professionals.”

Again, in much the same vein, on the topic of humiliation, Peter stated:

“They [Senior health professionals] were just allowed to treat you however they wanted to. Just because you were a junior.”

Also recounting an experience on humiliation, Lucy stated:

“An example that I have, we did, uh, we had like different projects to do so we’d make pillows. We had to cut like, uh, sponge, and then put it in the pillow. So, we had the males cut the pillow, the uh, sponge and then I was cutting it and then uhm, it was on the table. But I didn’t do it on purpose. I just did it because I was like okay this is what we are supposed to do. And then my supervisor came in and shouted at me, asking if I’m doing it wrong on purpose because I’m only going to be there for a year. And I was like, no, why would I do that? Like, I didn’t like that. I feel like why would I come in and . . . she was basically saying that I wanted to mess it up because I was only going to be there for a year and I could leave.”

Recounting another experience, she stated:

“We used to have other support groups as well. So, we’d have it with the doctors and physios and all of that and then often one of the junior doctors would have to present a patient to me and that would sometimes be humiliating because of the questions the seniors would ask and the way they would ask it in a very condescending tone, and then just push them and push them [those questions], in front of a whole group of people. And we felt humiliated.”

On the topic of humiliation, Claire however responded positively by saying:

“No. She [Her supervisor] was never humiliating, she just wasn’t very helpful [Laughs].”

Interestingly though Claire’s further response uncovered something that I had not fully accounted for. Here she spoke about hierarchy between different junior health professionals and senior health professionals such as between doctors and physios. For example, she stated:

“Uhm, the doctors, uh, sometimes were. . . So, if you had a different opinion to the doctor then the doctor would be like ‘Oh well, I read this article from 1995’ and I’m like ‘Okay, well, there’s a new article [Laughs] but okay, if you want to keep doing stuff from that 1995 article then you can’ [Shrugs]. So, like, they were trying, maybe they were trying to be humiliating or belittling but I was kind of like [Shakes head], ‘I can’t take you seriously’ because like I don’t trust your clinical judgement.”

She further responded by saying:

“We have to get it through a doctor and then the doctor has to send the patient for the x-ray. Uhm, and in doing that, doctors kind-of just get mad at you [Laughs]. Like, if you like, want to send the patient for the x-ray then it’s kind-of like you’re doubting their judgement and you’re not really,

you're just saying, 'I understand that you only have five minutes with a patient but I've got 30 and this is what I found and this is what I think we should do. I'm not saying that we have to but I think it would be a good idea.' And a lot of the doctors do not like that and so you, uh, eventually just don't say anything anymore, you just leave the patient or you treat them as best you can. Uhm, ya. That's basically it. There were like one or two [Senior] doctors who I had like, bad experiences with."

Recounting an experience based on this, Claire stated:

"Uhm, the one [doctor], he never called me by my name, which I got very annoyed with because he knew my name."

When asked to elaborate on this experience, she responded by saying:

"So, uhm, this doctor came in, I was standing and he walked right past me and he didn't even greet me, he just walked right passed me to the physio assistant and he told the physio assistant to do what I didn't want to do with the patient. Uhm, like, he didn't greet me, he didn't do anything and then like, the physiotherapy assistant, he came and told me what had happened and I told him 'you can go and do that but I'm not going to be held responsible for what happens to that patient – he needs to respect the, like, the healing phases and those kinds of things.' Uhm, but, like, everyone said that you have to stand up to him and then he'll respect you more but that wasn't really the case, it was more like I stood up to him and then he just ignored me so uhm, that was a bit weird."

Further, when asked why she thought there was this hierarchy between different health professionals, she stated, between exasperated laughs:

"Mostly I, I think there's a very uhm. Doctors do think that they're smarter than everyone else – that's the first part of it. And, uhm, so this is, I experienced it there but it was something that you could see. Like, even when we were studying but when you're studying it's more from the students, so like, the other medical students will definitely show that they feel they are smarter than you. Uhm, so that's why, like you notice that they, uh, that's what they're taught – they're taught that they're the best and that they can't really listen to anyone else. Ya, so I think that was the first part of it."

Elaborating further, she stated:

"Uhm, and then the second part of it was that we were just comm serves – you're there for a year and then you're gone. So how seriously do they really want to take you. Uhm, and basically you're coming into their space, it's their hospital, they've been there for 10 or 15 years and here you are just popping in, popping out again."

Also noteworthy, is that there was a mix of responses in terms of accounting for experiences of racism in their first postgraduate years. For example, Tash responded with a plain “No” when asked if she felt she had been racially discriminated against. In much the same vein, Usman responded by saying:

“Oh my word. No!”

Interestingly though, he compared his lack of experience here with experiences he had while he was a student at another hospital, in another province. Here he stated:

“Maybe I haven’t noticed it so much here, because at the other hospital where I was a student and spent most of my time when I was a student, is just damn racist but racism doesn’t happen here where I’m working now. Or uh, maybe just not as openly as the other hospital. Here, I haven’t actually worked with a white doctor [Frowns] [Nods head]. I uh, I think ortho is the only really white department and I haven’t worked there yet. Where I’ve worked so far, they mostly judge people based on their knowledge and abilities.”

On further reflection, Usman did however state that he felt people were treated “differently” according to their social or cultural positions. Here, while reflecting on a senior doctor that he had witnessed treating other juniors ‘badly’, he added:

“He is really nice to me [Hides face with hands]. But again, I really don’t take it personally when others are assholes [Pause]. Oh, but also, it’s a very Muslim department and I’m the only Muslim intern in my group so that’s also a thing [Hides face with hands]. I really hate that it’s a thing but it’s very obvious that they are more nice to me than the others [Hides face with hands]. Ya, but it’s awkward, because they speak to me about the other interns and I’m not going to gossip about my friends. Anyway.”

Claire also stated that she had not experienced any discrimination based on her race but added that she had witnessed “racial tension” again interestingly, between different health professionals. Reflecting on such an experience, she stated:

“I saw a lot of contentious conversations. So, there would be like, maybe a black junior doctor and maybe a white occupational therapist or whatever and you’d see that there was just, like, this struggle. The power struggle was very interesting to watch because here was this black male and this

white female and they were like coming at each other with both, both of them with varying degrees of superiority that they had given themselves. And I would just watch this whole situation and I would watch it a lot.”

She further added:

“And it just wasn’t working, they really just needed to meet each other on a half-way point and they couldn’t. Uhm, and I think it’s [Racial tension] very, like it’s there.”

Lucy was however, one of the only respondents who firmly stated that she had experienced discrimination based on her race. Here, recounting her experience she stated:

“There was this big argument in the department and then it became like a racial thing because, I don’t know, like, the thing was, even like uh, it’s very subtle. Because, okay, so our supervisor was a white woman, not the lady I spoke about previously, the previous lady, was a white woman. And then we had one white lady working with us and then it was coloured girls, the rest of us. And then uhm, like, people don’t see what they do.”

When asked to elaborate she stated:

“Like, she would get preference a lot of the time. Like, she could do whatever she wanted to at work or be busy with other things that wasn’t or didn’t have anything to do with work. And then the new supervisor would come in and she would like ask only me, like, in a rude way, why I wasn’t working, even when I was.”

What the chapters on working conditions / contexts show is that many of these junior health professionals face stressful first postgraduate years because of long working hours, challenging workloads, a lack of resources and equipment as well as a lack of personal time, and sleep deprivation; and that they often do not have adequate training and supervision during this time. What the findings show here then, is that in addition to these challenges, these junior health professionals are also faced with challenges pertaining to the type of supervision and overall treatment that includes experiences of discrimination based on gender, as well as experiences of humiliation and / or belittlement, also known as ‘bullying’.

Of course, it must be said that supervision is context-bound and by its very nature, there are power-relations between supervisor and trainee. Here individual social positions such as

race, class, gender and sexuality all confers relative power (Kilminster & Jolly, 2000:835). However, findings such as these are worrisome given that it has been argued that despite these power relations, supervisors should be guided by ethics and as such be respectful and approachable in ways that do not exude intimidation, harassment, or discrimination based on social positions (Sein & Tumbo, 2012:10-13). Indeed, the HPCSA guidelines state that there should be a relationship of trust that health care professionals have with their patients and each other (Dhai & Mkhize, 2006:8); (HPCSA, Online). Implicit in this is the requirement for a life-long commitment to good professional and ethical practice by both senior and junior health professionals. This then means that all junior health professionals should be equipped with ethical supervision at the hospitals in which they train. In other words, healthcare professionals should embody and act out the antithesis of bullying behaviour.

It is alarming then that these junior health professionals argue that such bullying behaviour by senior health professionals seems to be persisting. It is indeed stories such as this which have resulted in many to argue that even though it has not been fully uncovered in Southern literature, centuries of bullying within the health profession has been manifested by “abusive” senior professionals and continues to persist. Of course, bullying and discrimination come in many different forms, and the responses here are individual experiences; however, these findings are alarming given South Africa’s racist and sexist history, and the fact that many policies put in place were supposed to eradicate it.

Indeed, the responses above, with regards to sexual harassment, race, and culture link into Maria Ontiveros (1993:817) argument that sexual harassment is rarely, if ever, about sex or sexism alone for women of colour. Here she argues that it is also about race. Moreover, it also links then to her argument that while sexual harassment is about sexism and power, it is also about race and culture (Ontiveros, 1993:818). The argument here then is that many times from the viewpoint of the harasser, women of colour appear to be less powerful and less likely to complain (Ontiveros, 1993:818). Further, Ontiveros (1993:821) argues that many women feel that they will be blamed for the harassment. Many of these experiences are discussed in the below chapter as well and are present in the responses above.

The issue is then that South Africa has one of the most gender progressive Constitutions in the world but the findings here show that female health professionals continue to feel the brunt of sexism in the workplace and that these are often linked to racism in South Africa. Indeed, based on these findings, one has to question why these healthcare workers feel that they continue to receive the short end of labour policies in South Africa. Moreover, it begs the question, why is it that female healthcare workers here feel that they continue to bear a double burden, that is, the short end of both labour and gender policies.

It is clear then that more needs to be done in terms of gendered discrimination in South Africa's workplaces. Indeed, an important overall question to ask here is how can it be argued that people work and heal better when they are part of institutions that value them and respect their human dignity but at the same time junior healthcare workers, the future of health and healthcare in South Africa, continue to be burdened by the antithesis of what they are expected to provide? In other words, junior healthcare professionals are expected to be sympathetic, kind, and ethical by the very nature of them being caregivers and healers. However, what the findings above show is that this fabric of the healthcare profession is being challenged by increasing bullying behaviour. Indeed then, in sum, what these findings show, is that in a supposedly progressive and democratic country such as South Africa, more needs to be done to ensure that junior health professionals no longer face challenges pertaining to bullying behaviour.

To be clear then, surely, if junior health professionals are expected to behave ethically towards patients, then more needs to be done to ensure that their mentors themselves behave ethically towards them (Frank & Carrera et al, 2006:6). My argument here then is that we cannot hope to develop and improve the professional culture that should be leading to the healing of human bodies if such a profession is filled with hierarchy and the abuse of power that hinders good relations between health professionals and has such negative impacts on the future of our healthcare workforce – medical interns.

5.5 Experiences and perceptions of laying complaints

It is flagged that one of the most important aspects of postgraduate years for junior health professionals is that their training years should be properly regulated. Further, it is noted that healthcare workers should always have various mechanisms where they can lay complaints if they face any challenges such as those highlighted in the above chapters. Here both the supervisor at the hospital in which they work and the HPCSA play crucial roles. For example, HPCSA rules state that if a junior health professional became impaired because of long-working hours or felt that they were being exploited, coerced, or harassed in any way – which, again, based on the literature, I have called ‘bullying’, and / or possibly became harmful to their patients because of this, they should report to their supervisor and also ‘self-report’ their condition and challenges to the HPCSA (HPCSA, Online); (McQuoid-Mason, 2016:54); (Dhai et al, 2006:1070).

The gist here then is that the HPCSA aims to protect the public as well as the professional. This then means that as much as post-graduate years should be used as an opportunity to learn, supervisors, and the HPCSA have a joint responsibility to ensure that the quality of training and supervision in accredited facilities is maintained and that where it is not, junior health professionals should be able to lay complaints or report to the HPCSA (Prinsloo, 2005:3). As such, my respondents were firstly asked if they were aware of how to make use of these complaints mechanisms. Here Usman had a mixed response, stating:

“No, not really, we have each other to vent to [Rolls eyes]. Okay, we do have an intern coordinator that we can go to I guess. So, uhm, she's meant to liaise with heads of departments if we have issues. Then there's also the JuDASA reps.”

Tash also had a bit of a mixed response stating:

“There was no physical handout to explain it [The complaints mechanisms] but we had an induction or, uh, orientation where this information was presented to us. So uh, yes, we had an organogram that was explained to us during our induction or orientation.”

When asked to explain this process, she stated:

“Okay. So if I had a complaint the process would work as follows. You discuss your concern directly with the person, then discuss the concern with your supervisor. If you're still unhappy, discuss concern with clinical support manager. Lastly, discuss concern with CEO.”

Lucy also stated that she had knowledge of who to complain to in the hospital but that she wasn't "that sure" who to complain to if the complaint was about challenges pertaining directly to the supervisor. Here she stated:

"We had reflective meetings, and well obviously, you would have to go to your supervisor usually first but I can't even remember who you were supposed to go to if it was your supervisor that you were having a problem with. You'd obviously have to go to the person above them."

Peter however stated that he wasn't really "too sure" but he knew that you had to go to your supervisor first about any complaints while Dane said that he was told to go to the supervisor or head of department. Claire however responded negatively by saying:

"In comm serve? Uhm, no [Laughs]. So, they have these meetings [Laughs]. Like, and then they . . . But it's really like, like it's quite silly."

When asked to elaborate, she stated:

"There was nowhere [to complain]. We were made aware that there was nowhere [to complain]. So it was quite, ya."

Further, my respondents were asked to recount some of the experiences they had when making use of these complaints mechanisms. Here, what is important to note is that all respondents recounted that they had negative experiences when laying complaints to their supervisors. For example, Dane stated:

"I did it [complained] once to my supervisor, and I'll never do it again. He wasn't helpful at all and just seemed to brush it aside."

Similarly, Usman stated:

"Someone in a previous group complained to the HoD but the department is such a clique, they all have each other's backs and nothing came of it."

In much the same vein, recounting her experience, Tash responded by saying:

"It was quite tough despite how lovely and caring my supervisor was, she struggled to manage people in the sense that she tried to avoid conflict and please everyone. There was various

complaints not just from myself but from other therapists, doctors and nurses that were brought to my supervisor's attention and she did nothing about it because she did not know how to handle the situation. She called me in and said 'You know what, the year is almost over and CommserveOT won't get a good reference'. She was basically turning a blind eye to the fact that CommserveOT was causing harm to patients and us."

Recounting another experience, Tash stated:

"I was once in a situation where I had referred a 10 year old boy who was clinically depressed after having a stroke. I could not progress with him in my treatment due to his depression. I expressed my concerns to our Senior Clinical Psychologist who refused to see him as an inpatient and wanted to give him a date a month later where he will be seen in a group by one of the registered nurses. The group was to screen behavioural issues which really was not appropriate for the little boy. Keep in mind this boy stayed about 50km away and his mom did not have money to come back. Anyway, I then went to the nurse responsible for conducting the group and expressed my concerns to her and she fully agreed that the boy will need individual therapy as an inpatient and will not benefit from the group, however, she asked that I not mention this to the psychologist. I uh, went back to the psychologist and once again kindly expressed that I fear the little boy not being able to come back due to funds and distance and if she cannot fit a session in with him in her not so busy schedule while he is admitted in the hospital, as hospital policy states inpatients should be prioritised. She refused and I thanked her for her time and left. She then called my supervisor complaining that I am trying to run the psychology department and my supervisor should keep her community service therapists in check. My supervisor called me in and I then explained to her what had happened and the nurse requested that I go back, instead of doing the right thing which was to take it to our clinical support manager. She told me that despite me being correct I need to go and apologise to keep the peace."

She continued by saying:

"Another time, an OTT became verbally aggressive towards me and walked out in a meeting. And when I complained to my supervisor, she just sat and shrugged her shoulders and said she does not know how to handle the situation and that I should instead learn to pick my battles carefully."

Tash elaborated even further by saying:

"This was a painful process because the clinical support manager was hardly around, especially during the last few months of the year, and I was never formally introduced to the CEO so I had no idea who she was. I had no idea who to go to next."

Claire also recounting her experience stated:

“Uhm, they told one of, uhm, the senior psychologist told us ‘Don’t try and fix the system yourself because then the system will never change’.”

Recounting another experience of trying to laying a complaint, she stated:

“In comm serve, it was this meeting and it, there was this man [Laughs], uhm, and he was like, he’s in charge of the community service physiotherapists. Like, all the auxiliary health people. So, it was physios, OT’s, uhm diet – uh, I actually don’t know if dieticians were a part of us, uhm, but dentist were and the audios and speech therapists. Uhm, so like, we had one massive meeting together and a lot of the people, uhm, like, we’d go to the meeting and then we’d say things like ‘Ah, the audios didn’t have a booth’ or ‘I didn’t have a suction catheter’ and stuff like that. And then they were like, ‘Oh we can’t really do anything about that at the moment’. It was like that.”

Elaborating further, she stated:

“So, then they were like, ‘How do I talk about this?’ and then they were like, ‘You need to write a letter and give it to your superior’. So then they were like, ‘Okay, so I must write a letter about my superior and then give it to my superior?’ [Laughs]. And then they were like, ‘Ya’. And then, [Laughs], like, they didn’t see how that was a problem. So, no, to answer your question, there is no, like they tried to make one but it was obviously not very helpful because all they used to tell us was ‘Hey, we can’t really help you but here’s a place to talk about your problems because that will make you feel better’. Knowing that it will be talking about your problems, having it acknowledged as a problem, and then being told ‘I can’t fix it’.”

While Lucy stated that her supervisor often didn’t look into complaints because she “didn’t know what to do”. Here she elaborated by saying:

“Other supervisors also had to explain [to her supervisor] what we were doing because she didn’t know what was going on, and why we doing certain things. So she couldn’t deal with our problems.”

She also stated though that there were “reflection meetings” where they could discuss their challenges.

Based on these experiences, my participants were asked about their perceptions of these complaints mechanisms. Again, they all had negative responses. For example, Usman stated:

"I feel like nothing would get done if I did [complain]. Because nothing gets done. Ever."

Again, he reiterated:

"The department is such a clique, they all have each other's backs and nothing came of it [a complaint]."

He then elaborated by saying:

"The underlying problem is that people are allowed to act so unprofessionally because they know that nothing will be done about it, yeah. Another reason we don't complain is that we're only four months in each department so just sucking it up is easier."

Further, he stated:

"But I think most of us just suck it up because one, nothing gets done and two, you know how they treated Yumna so no one wants to end up in that situation."

Here, he responded even further by saying:

"On the real though, we are part of the problem why change doesn't happen, man. Yes, a few people complain but most of us just push through the two years."

When asked why this was the case, Usman stated:

"I don't know, man. It's easier [Shrugs shoulders]. It's easier because the risk of getting victimized by seniors is real. Look what happened with Yumna. I think she was very brave. I would've suck it up [Pause]. Uhm, I've heard many stories about people complaining and it ending by them having to repeat a block. I don't know if they were true but still."

Moreover, Tash stated:

"It was frustrating and discouraging. Reflecting back, yes I should have took it further and discussed my concerns with the clinical support manager and or CEO, but at the time you feel as if it would be so pointless you get to a point where you lose hope in the system."

She elaborated by saying:

“I don’t know hey, it’s so emotionally draining especially in the Public sector, you honestly see something that should not be happening and just shake your head, because you kind of feel like hey what are the odds that it will change. They [seniors] won’t listen to us [juniors].”

Reflecting on her experiences, Lucy stated:

“I didn’t say exactly what I felt in that meetings because it was like, uh, everybody was like sitting there and looking at you and now you must say okay my week was like, uh. And I know like, one of my friends that I worked with, she also didn’t say exactly what she felt. We would keep quiet if we were frustrated about something because we don’t want to stand in front of everyone. So, we, uh, we don’t really, we would talk to each other.”

When asked to elaborate, she stated:

“I didn’t ever feel comfortable complaining because well, I think well obviously they believe more the supervisor than they believe us.”

When asked why she felt this way, she responded by saying:

“Because, just because of the way that things were run. Uhm, ya. If we did bring up a frustration, we’d be told ‘no no it’s like this and like that’, uhm, so we just left things, a lot of the time. And talk to each other, and complain to each other because there wasn’t anything else we thought we could do.”

In much the same vein, Claire responded negatively by saying:

“Like, where? Who would I do it to? I would just, so the big thing is that once you complain, and that’s where I do relate to what happened with Yumna, that once you complain people don’t, like, they don’t care about you. That person has been sitting in their position for five, seven, 10 years and you’re just there, and you’ll be gone soon. Especially if you’re a comm serve – you’re gone in the next year; if you’re doing your internship, you’ll be gone in the next two. So, they don’t care if they make your life difficult or if you’re having a tough time – you’re going to be gone soon.”

She elaborated by saying:

“She [Yumna] was very, she was very brave – she went and she laid a complaint but the rest of us just silently suffer. Like, just take it and go and just know that you’ll be gone soon and then go like as soon as you can. Uhm, again, not the best or healthy way of managing it but that’s what it is and uh, I think you learn very quickly to just take it and just, you know, let it slide and leave the day behind you. But, ya, it’s not healthy and that’s why the system is not changing because we have to do that –

can't complain, complaints not taken seriously, there's no place to complain. And uhm, ya, it's hectic actually."

What is interesting to note is that despite the fact that my respondents all had a long list of complaints and challenges which their supervisors had largely failed to deal with, none of them had ever taken the 'next' step and laid a complaint with the HPCSA. Here then it should again be noted that while one of my research aims was to examine junior health professionals encounters with the HPCSA, given that none of them had actually complained to the HPCSA, it became imperative that I try to find out why this was the case. My respondents were then asked about their perceptions of the HPCSA. Thus, when asked why they had never made use of the HPCSA in terms of laying complaints, especially given their negative encounters and perceptions of laying complaints with their supervisors, all of my participants responded in the same way – with negative perceptions about the statutory body. For example, Peter stated:

"I don't really know much about the HPCSA and I don't see them as a place that could help me with my challenges."

Further, Usman stated:

"We are allowed to write down any of your challenges in our logbook for the HPCSA. But [Laughs], nobody reads it. I, uh, I haven't filled it in yet. The HoD just signs one page so I doubt they read it, ya. And at the end there's just one page in the book that HPCSA wants. It's not a very good outlet for complaints."

He then elaborated by saying:

"No man, if I had a complaint I'd rather get SAMA or JUDASA to help than the HPCSA."

When asked why this was the case, Usman stated:

"It's [The HPCSA] a money-making scheme [Rolls eyes]. Uh, they, the HPCSA, seems like more of a regulatory body than someone who is there to really assist us. Whereas SAMA seems to do that. Like, with our mess up of intern applications last year, the HPCSA done nothing. So [Laughs], yeah, I'd just be too scared they'll find a reason to take my license if I complain anyway."

Peter also stated:

“Don’t we just pay them [The HPCSA]? Actually, I don’t even know why we pay them.”

In much the same vein, Lucy stated:

“I just feel like they [the HPCSA] do nothing. I feel like I pay them every year and I pay them, we pay them so much money! And I, I don’t know what they’re doing. What are they doing for me?”

Elaborating further she stated:

“Also just because of seeing that video [Of Yumna] and like I don’t, I, you don’t hear from them a lot. You pay them one five a year, you don’t hear from them. They’re supposed to be supporting the public and the professionals but I’m like, what are you doing? And not only that, like we have to do continuous professional development so we have to pay the HPCSA and then still pay for doing courses and stuff. It’s a lot. And the you have your own professional board as well. So maybe that would be better to complain. But I don’t know.”

Again she reiterated:

“I don’t know what the HPCSA does. Like, you get an email when you need to pay them and that’s when you hear from them. Uhm, ya. I mean, imagine all the money they get. All those different professions and I just, like, what do they do with it? Where does it go? I mean, I’ve been wondering for a long time. I mean, I’ve been saying to my friends who also studied with me, like, where does the money go? What are they doing? Are they running workshops? What are they doing? If they could use the money for something useful where we could see what’s going on then I might have a different reaction to them or wanting to go to them and lay a complaint or when I have a problem. But I don’t.”

Similarly, Claire’s perception about the HPCSA was a negative one. Here she stated:

“No no no. I mean I guess that is what the HPCSA is supposed to do [see to complaints] but basically we were always just taught to be afraid of them. So, like, so, uhm, like they’d always tell us ‘You know, if you mistreat a patient, then you’re gonna end up in front of the HPCSA with like seven people in front of you trying to decide whether or not you were ethically correct’. Uhm, and basically they just always told us ‘Make sure your clinical notes are amazing so that if the HPCSA ever comes at you for anything, you can just shove your clinical notes at their face and be like, this is what it was, if you can find fault with that then do whatever but if you can’t then ya’.”

She elaborated further by saying:

“So, they were never shown to us as a supportive place. Uhm, never. They are kind of like our traffic cops [Laughs]. I just feel like that is what the HPCSA would do to me, like, they’d expect me just to do . . . Like, they have these guidelines and you’re supposed to do all these things and you do them and if you do them, everything is fine, they ignore you but if you don’t do them, then it’s a really big problem. Uhm, that’s my view of the HPCSA – I don’t see them as a supportive structure and I’m not surprised that that happened to Yumna. And all the lobbying groups are only for doctors. Not us. We don’t have any of that.”

She further iterated:

“To be very honest, it would have to be like a major major major major thing for me to go to the HPCSA. Like if I actually felt like maybe my livelihood was in danger and the only people left who could help me was the HPCSA, then I’d probably go. Uhm, but, like for example, ya, no, I don’t know. Even, like, even if I was going to, like, I watch how our practice works, like now the practice that I’m at. And a lot of it is unethical but if I took it to the HPCSA, to get to the point where I would take it to the HPCSA, like, I’d probably have to go through some people who would stop me before I even got there and then once I got to the HPCSA and it got back to the place that I worked at, they wouldn’t change the system, they would just fire me. So like, what is the point of that? – then I’m jobless and the system stays the same. So like, ya [Laughs]. So, I don’t know, probably not – it would have to be something major, like really really big!”

Here it should be said that even though the challenges that my respondents faced were a wide range of individual experiences, the experiences and perceptions about complaints mechanisms such as their supervisors and the HPCSAs shows a very common link. What these findings then show is that in addition to experiencing a range of challenges in their postgraduate year/s, these junior healthcare workers feel that they have little to no support structure when these challenges occur. This then begs the question, how is it that in a democratic country, healthcare workers feel that these challenges are their burdens to bear, alone, despite the fact that there are numerous policies, regulations, and statutory bodies put in place to eradicate these in post-apartheid South Africa? Again, my argument here, based on these findings, is that these junior health professionals are not being provided with the needed services and behaviours that they are expected to provide.

Moreover, there seems to be a connection between bullying and the experiences and perceptions of formal complaints procedures. Here on the one hand, these junior health professionals seem reluctant to lay complaints with their first point of call – their supervisors. This is either because they think their complaints won't be taken seriously, or, more often than not, they fear that their supervisor will respond in an intimidating, humiliating, or coercive way. Then, on the other hand, it would seem, based on my findings, that their next point of call – the HPCSA, is an absolute 'no-go' for these junior health professionals. Here again though, this is because they do not see the HPCSA as a place of help, they see it as a place that is intimidating, a place that can coerce them, a place to be feared.

Indeed this is very much in the same vein as the experiences of Yumna Moosa. To recount, in her recording of a conversation with her supervisor at Addington Hospital in Durban South Africa, he is heard making threats to arrest her if she refused to throw away her internship logbook which contained what she refers to as comments about his and his colleagues' 'inappropriate behaviour' towards her (YumnasApology, 2017). This included comments about racism, sexual harassment, coercion and intimidation, and the unavailability of senior staff after hours. The supervisor can also be heard instructing her to lie about what happened, and saying that he will blackmail her with that lie if she tried to retract it. He then also threatens her with being bankrupted in court for an email that she sent to the Head of Department (HOD) alongside the logbook (YumnasApology 2017).

Then, when she submitted the recording to the HPCSA, she felt that she also experienced bullying from them. Again to recount, she argued that the HPCSA committee did not look into any of her complaints and that they only disputed her assumption that what happened was unacceptably unprofessional (YumnasApology, 2017). Further, the HPCSA chairperson also criticised her for being "a free speaker", "too friendly", "too open-minded" and "too bright" (YumnasApology, 2017).

To be sure, it was because of this experience that Yumna argued that the institutions that govern medical practice in South Africa, like the HPCSA, are not prepared to support the challenges faced by junior health professionals and that they demonstrate little commitment to the modern, humane standards of conduct that the young generation of

health professionals were promised in democratic South Africa (YumnasApology, 2017). This is not far removed from the documented accounts and perceptions of my findings. To take it even further, while Yumna's story has encouraged many other junior health professionals to 'go public' with their own stories of their challenges relating to work place conditions and bullying (YumnasApology, 2017), my respondents have reacted differently. Here, while they see Yumna as 'brave' for laying her complaints, they see her negative experience with complaining to supervisors and the HPCSA as one that they fear going through themselves.

This then leads to questions about hierarchy and the abuse of power in the medical profession especially because it would seem that although there are complaints procedures put in place, these junior health professionals feel as if they have no negotiating power because the experiences and perceptions of and about bullying behaviour negate these for them. It is based on this that I argue, just as Yumna Moosa (2017) has argued, that there is an aggressively hierarchical, patriarchal professional culture in the medical world and that if we hope to develop and improve the professional culture that should be leading to the healing of human bodies, then such hierarchy filled with bullying and discrimination cannot be acceptable in South Africa and globally. Moreover, it cannot be that when feedback about such challenges, such as those outlined and above, are given, that they are shut down and not dealt with, often in callous ways. Surely, in a country like South Africa, where such behaviour is historically noted, such repression cannot be allowed to still rein.

To be clear, the connection between bullying and complaints mechanisms add to a growing argument in the literature that regulatory bodies are not playing effective roles in addressing the challenges of junior health workers (Gadit & Mugford, 2008:464). There is then clearly a need to further explore the barriers to reporting bullying or challenges faced (Carter & Thompson et al, 2013:1) because it cannot be that junior healthcare workers feel that these are their burdens to bear, especially when supervisory roles and bodies like the HPCSA exist.

Further, it could be noted that the above also links in with Ontiveros (1993) argument that the legal system plays a huge role in bullying cases, especially with regards to sexual harassment. Here her argument is that very often members in legal mechanisms tend to disbelieve what women of colour say and that this has a lot to do with the dominant

culture's construct of their sexuality (Ontiveros, 1993:824). Her argument is thus that the perception of sexual harassment needs to be reconstructed in order to properly face the issue of workplace harassment of women of colour. She offers some solutions by firstly saying that the rules governing sexual harassment need to be modified. She also however states that these reforms are not easy. Here her argument is that deeply held notions of race, gender, identity, sexuality, and power must be examined and reevaluated and that this must take place both within and across cultural and class lines (Ontiveros, 1993:828). I argue that the latter discussion needs to take into account other perspectives such as those by Samuels which argue that we need to take into account both the private and public spheres in relation to inequality and the over-arching patriarchal environment. (2003). However, such a discussion beyond the scope of this report, but remains an important point worth considering for future research.

5.6 Effects of challenges

Given my argument that the threat of the complete collapse of services in the public health sector only sharpens the need to treat staff well, especially given that South Africa cannot afford to lose more young health professionals; because as noted, South Africa is losing young health professionals at an alarming rate and that there is a possibility that poor working conditions, a lack of supervision, and 'bullying' will exacerbate that; I attempted to find out from my respondents what overall effects they felt these challenges had on them. Here most of the responses were two fold. There was mixed discussions on migration and / or leaving the medical profession and a discussion on 'dealing' with these challenges in ways that made them better professionals by 'working harder' because such challenges were 'expected'. For example, Usman stated:

"Yoh honestly it [these challenges] makes me want to stay and do my small part. Hopefully I'll still feel the same way by the end of this internship. I just think that running isn't going to fix this messed up system, man."

However, Tash and Lucy held different views from Usman, as Tash said:

"Yes. I'd leave South Africa for personal reasons such as travelling and financial gain and because I'm tired of dealing with the challenges here."

And Lucy saying:

"I don't know. Would I leave South Africa? Yes [laughs]. I would. And that's sad because we need OT's here but just the way the government runs things. Also, now it's about who you know and not what you know and what you're able to do. Like now that I'm looking for a job, I can't find a job. Uhm. Ya I think the things you go through, uhm, sometimes maybe you don't want to work in government again. Uhm, like I said also, just the way they operate with getting into government it's so difficult, it's got like uhm ya. But like also, I just definitely think about leaving here because the challenges in the public sector is too much."

On the topic of leaving the medical profession, Lucy also stated:

"Even now I think about leaving and doing something else. Like I've been thinking about doing something else, studying something else as well because I don't know if this is worth it anymore."

Here Claire had a mixed reaction and responded by saying, while sighing:

"I think I'd definitely leave Cape Town. Uhm, I'm not sure and uhm, I don't know. There's a part of me that thinks that this particular problem, so, like, the problems with supervision and like, senior people belittling younger people, uhm, a part of me feels like, that's everywhere. I feel like it might not be different if I moved away. And I think it's maybe easier to deal with that stuff when you are at home – closer to like, the familiar. Uhm, and until I've reached a point where I am very confident in myself as a physio, I don't think I would. Like, I'm getting more confident now but I'm not confident enough to hold my own in another country and so I, I don't know, basically."

She elaborated by saying:

"I don't know where that [emigration] is in the five-year plan [Laughs]. Initially I thought I would – I thought I'd go to New Zealand uhm, but you have to pay a hell of a lot of money to write their exams and like, I didn't have that initially. Uhm, maybe if I did but again it's like R30 000 to write an exam and then if you fail, you must pay again. [Laughs]. So that's R60 000 that I do not have. So, uhm, ya, I don't know. I think, uhm, so, if I was working with the same mentality that I had in the beginning of last year, I think I would've left physio a long time ago."

This then again ties in with my previous research where all but one of my participants stated that due to the challenges they face in the public health sector, they would emigrate. For example when asked if she would emigrate to another country overseas, Gabi responded by saying, *"Yes. Most definitely"* while Jill responded by saying *"Yes, that's the plan"* and Greg stating that he would only leave South Africa for a year or two.

Then, on the topic of 'working harder' and just 'dealing' with these 'expected' challenges, Usman stated that this treatment of junior health professionals and the challenges that came with it seemed to be a *"norm"*. Here he elaborated by saying:

"We are really thrown into the deep end. So, I'm forced to adapt and be able to manage a patient quickly but effectively at the same time. it's just like that."

While Dane said:

"We're always told that these challenges are just something that we as juniors need to go through and that we will be better doctors because of it. I've just come to expect that these are things that I will have to go through to be a good doctor. It really is what it is."

Lucy also stated:

“We were juniors and it was like we just had to go through it.”

Here, while the former is worrying given that South Africa already loses nearly 30% of its healthcare workforce each year, making it clear that it cannot afford to lose more; the latter, while not fully explored as part of my research, is also noteworthy. This is because it ties in with many studies that have argued that teaching by humiliation (for example) is a ‘part’ of the ‘culture’ in the medical profession where senior health professionals do what was done to them as juniors thus perpetuating the idea that these juniors need to be ‘toughened up’ (Scott & Caldwell et al, 2015:185; (Musselman & MacRae et al, 2005). Indeed it has long been argued that some junior health professionals see this kind of treatment as “the natural socialization” of a good health professional (Scott & Caldwell et al, 2015:185e.4); (Timm, 2014:5); (Cavenagh et al, 2000:897). The argument here is that because the health profession is not homogenous, each group of professionals have their own norms and rhetoric which often involve this ‘toughening up’ of juniors or as a part of ‘personal development’ (Cleland & Johnston, 2012:835-836) & (Babaria & Abedin et al, 2012:1013-1014); (Field, 2002:787); (Howe et al, 2012).

In other words here, there is an argument that the first postgraduate year/s should ‘test’ the limits of junior professionals in a ‘rite of passage’ often called ‘a baptism of fire’ (Touyz & Kelly et al, 1988:175); (Daugherty et al, 1998:1194) & (Crowe et al, 2017:72). For example, there have been numerous studies where junior health professionals stated that they had to ‘learn to tolerate’ the challenge of sleep deprivation because it was an ‘expected’ part of training that was not ‘within their control’ (Rosen & Gimotty et al, 2006:82) & (Schweitzer, 1994:354); (Haas & Shaffir, 1977). Thus again, while not explored in my research, with findings from my research tying in with other previous studies, it is clear that this socialization needs to be explored further because one could argue that just because something is a ‘norm’, if it negatively affects someone, then more needs to be done to ensure that these ‘norms’ are challenged and changed.

6 CONCLUSION

This thesis used semi-structured interviews to interview six junior healthcare professionals who are registered and thus regulated by the HPCSA in South Africa and who are in the process of or who have recently completed their compulsory year/s of internship / community service in any public hospital in South Africa; in order to explore their accounts and perceptions of challenges and complaints mechanisms pertaining to these challenges in their first postgraduate years. This was done in the hopes that this research will add to the growing literature on the working conditions / contexts and the availability of supervisors in which junior health professionals work in and have access to as well as lessen the gap in the literature on the various challenges that junior health professionals face in relation to 'bullying' and laying complaints with supervisors and the HPCSA.

In doing so, my research showed that the public health system in South Africa is still rife with many challenges and that according to their own accounts junior healthcare workers encounter these as direct challenges in their everyday experience. They bear the brunt of these by having to deal with major burnout associated with long working hours and understaffing; there is a lack of much needed resources and equipment and that challenges associated with this often have dire consequences for both them and their patients. Further, my research showed that they continue to feel that they are not being properly trained and supervised and that they do indeed face many challenges relating to bullying behavior by senior health professionals.

Connected to this, my research showed that despite being aware of the complaints mechanisms in place, these junior healthcare workers often have had negative experiences with laying complaints and / or have negative perceptions about complaint mechanisms such as their supervisors and the HPCSA. My research also showed that these challenges have the potential to have dire effects on the future of health and healthcare in South Africa whereby many of my respondents have stated their intention to emigrate and / or to leave the health profession.

What is important to note here though is that in this thesis, I have asked my participants to not only describe and narrate, but also reflect on their own experiences as junior health professionals. It is important to note then that in this research process, I was then myself reflecting on their experience and their reflections. Given such a reflection it has become clear to me, based on the experiences identified here, that the documentation of the mainstream problems in the healthcare system that has long been outlined in the literature, such as a lack of resources, mismanagement, underfunding, and deteriorating infrastructure is important and valid. However, I would argue that this mainstream documentation largely excludes an aspect which has emerged from the documentation of the experiences here. That is, an aspect on hierarchy and the abuse of power in the medical profession. Such experiences highlight that the problems in the healthcare sector is not simply about resources, decay, and scarcity, it is about the way that people treat people.

It is based on these experiences documented here that I argue, just as Yumna Moosa (2017) has argued, that there is an aggressively hierarchical, patriarchal professional culture in the medical world and that if we hope to develop and improve the professional culture that should be leading to the healing of human bodies, then such hierarchy filled with bullying and discrimination cannot be acceptable in South Africa and globally. Moreover, it cannot be that when feedback about such challenges are given, that they are shut down and not dealt with, often in callous ways. Surely, in a country like South Africa, where such behaviour is historically noted, such repression cannot be allowed to still rein.

Of course, here I need to reiterate that I am not saying that nothing needs to be done in terms of budget allocations in the public health sector, which will surely help in terms of resources, and staffing etc. Indeed, again, this has long been argued in the literature. However, what I am arguing is that the problems in the medical profession run deeper than a lack of money. Here, it would be important to remember that it has also long been argued that people work and heal better when they are part of institutions that value them and respect their human dignity. If we are to meet the vision of an equal, efficient, sustainable, and quality health sector in South Africa, then we must ensure that the professionals who are expected to espouse 'caring' do not receive the antithesis of that expectation.

It should also be noted then that although such research is significant in that it aimed to give a platform for silenced voices to be heard, there is a lack of another set of important voices left unheard – that of public health sector patients in South Africa as a whole. This is not to say that these voices are not important. However, given my Industrial Sociology background, my main focus and argument here is that it is only the providers of services that should define whether they work or not because it is their perceptions and experiences that make-up the lived reality of health and healthcare in South Africa. For me, this then meant that my research needed to explore the issues and challenges experienced by those impacted by healthcare systems; because without it, we cannot hope to develop and improve the professional culture that should be leading to the healing of human bodies. My research then fully took on the pre-set that there can be no health without a workforce.

There are however many findings in my research that need to be explored further. For example, the findings that there is a hierarchy between different health professionals and that this hierarchy and the bullying behaviour that comes with it as well as other challenges that junior health professionals is a 'norm' and part of 'socialization' is worthy of exploring in projects much bigger than this one. With that being said, it is my hope however, that my research will be a stepping stone in providing opportunities for more research to be done that is inclusive of the voices of thousands of other junior health professionals, as well as patients who continue to be burdened by major challenges in the public health sector. It is also my hope that this research will add to what needs to be a growing literature on bullying behaviour in the South and the experiences and perceptions of complaints mechanisms pertaining to this. Indeed, while the findings here are significant, it is my belief that it is just the tip of a very large iceberg.

It is also not my aim to generalise as my small sample doesn't allow that. I am aware that the experiences documented here are individual experiences. However, given that all my respondents are currently junior health professionals who have or are working in public hospitals in South Africa, and who are all registered with the HPCSA, and that many of their responses are incredibly similar, I would argue that there is a level of consistency relating to their experiences that one could very well expect. It is based on this saturation that my hope here, as stated, is that further research on these topics will be carried out. In other words,

while my sample is not representative, patterns and themes emerge consistently and warrant further investigation.

Overall, based on my findings, my argument is that challenges pertaining to working conditions / contexts, an availability or access to adequate training and supervision, and the continued bullying behaviour experienced by junior health professionals as well as the negative experiences and perceptions they have about complaints mechanisms pertaining to these challenges sustain and exacerbate each other in a vicious cycle. This is because while there are clearly still major challenges that junior health professionals face in South Africa, based on the perceptions and accounts of experiences here, it would seem as if they feel these challenges are their burdens to bear, alone, despite the fact that numerous policies and statutory bodies have been put in place in post-apartheid South Africa. Based on these findings, it seems that it has become more imperative that it is genuinely asked, who cares for the carers?

It is then clear that if South Africa wishes to meet its goal of properly training and mentoring junior healthcare workers – the future of health and healthcare in the country – in their compulsory intern and community service year/s so as to ensure that they become part of a public health workforce that is valued, respected, and able to combat the continuing public health crisis in South Africa (NCSHE, 2011:1-9); (HRH, 2012:8-13), then it is this cycle that needs to be broken.

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8 APPENDICES

8.1 Appendix 1: Informed Consent Form

UNIVERSITY OF CAPE TOWN

WENDY PETERSEN

SOCIOLOGY DEPARTMENT. 083 8600 638. PTRWEN002@MYUCT.AC.ZA

CONSENT FORM

RESEARCH PROJECT TITLED: *Challenges and complaints during the first medical postgraduate year/s? Accounts and perceptions of junior health professionals in South Africa.*

INVITATION TO PARTICIPATE

You are being asked to participate in this research study because you meet the criteria of being a junior healthcare professional who is registered and thus regulated by the HPCSA in South Africa who is in the process of or who has recently completed their compulsory year/s of internship / community service in any public hospital or clinic in South Africa; and therefore hold needed insight into accounts of experiences and perceptions of challenges and complaints mechanisms pertaining to these challenges in these first postgraduate years.

PROCEDURES

As a participant, you will be enrolled in the study and asked to answer a set of questions in a semi-structured interview which will be recorded in a quiet and safe place of your choosing.

RISKS

Some of the questions in the interview may touch on sensitive areas. However, every effort will be made by the researcher to minimise your discomfort. You are encouraged to discuss with me (the researcher) any negative or difficult feelings or experiences you have as a result of participating in this research project. If at any time you feel you would like to stop your participation in the study, you will be free to do so.

COSTS AND FINANCIAL RISKS

There are no financial costs directly associated with participation in this project.

COMPENSATION

You will not receive any compensation for participating in the study.

CONFIDENTIALITY

Every attempt will be made by the researcher to keep all information collected in this study strictly confidential, except as may be required by court order or by law. If any publication results from this research, you will not be identified by name.

ADDITIONAL INFORMATION

Your participation in this study is entirely voluntary, and you are free to refuse participation. You may discontinue your participation at any time without prejudice. If you discontinue participation in the project, you may request that I not use the information already given to me. You are encouraged to ask questions concerning the study at any time as they occur to you during the interview process. Any significant new findings developed during the course of the study that may relate to your willingness to continue participation will be provided to you.

DISCLAIMER / WITHDRAWAL

You agree that your participation in this study is completely voluntary and that you may withdraw at any time without any prejudice.

PARTICIPANT RIGHTS

If you have any questions pertaining to your participation in this study, you may contact me, WENDY PETERSEN by telephoning 083 8600 638 or emailing ptrwen002@myuct.ac.za

CONCLUSION

By signing below, you are indicating that you have read and understood the consent form and that you agree to participate in this research study.

PARTICIPANT'S SIGNATURE

DATE

RESEARCHER'S SIGNATURE

DATE

8.2 Appendix 2: Edited transcript

Introductory Note:

This interview was conducted with a 25 year old female junior Physiotherapist who resides in Cape Town, South Africa and who completed her first medical postgraduate year in 2017. The name used here is not the interviewee's real name so as to ensure anonymity. The interview was one of six interviews conducted by Wendy Petersen in 2018 for the purpose of the research report entitled: *Challenges and complaints during the first medical postgraduate year/s? Accounts and perceptions of junior health professionals in South Africa*.

Interviewer: So, you're a Physiotherapist, right?

Claire: Yes

Interviewer: Why choose to become a Physiotherapist?

Claire: Uh, [Laughs]. So, I don't know. Uhm, so basically when I was in grade 11, uhm, I didn't know what I was doing with my life [Laughs]. Like, I was quite, uhm, I was very academically inclined, uhm, but I didn't know what I wanted to do but I knew that whatever I needed to do it needed to be like service – I needed to help people. Uhm, and then, the thing about the human body is that it's fascinating because it's forever changing and we're forever finding out new things about it, uhm, and I wanted to be somewhere where I could like foster a life-long learning kind-of thing and that I would never be bored and sitting behind a desk is basically what – that's exactly what I didn't want. Uhm, and then I kind-of looked at the options, uhm, and I had a few, and uh, I don't know, physio just stuck out to me and what it was, you get to spend a longer time with your patients than you do with doctors uhm and you get to form a relationship with them and that really helps your therapy. I think that's the part of it that really – maybe that's something that I actually found out later on but now that's a – while I was studying – but now it's a uhm, probably the best part of my job is to build those relationships.

Interviewer: So how long did you study to become a physio?

Claire: Uhm, five years. It's a four-year degree but I had to repeat one year. Uhm, and after that one year I wasn't so sure if I wanted to be a physio anymore [Laughs]. Uhm, but then I went back and I got another lecturer that I came into contact with and she was very, uhm, supportive and encouraging and she got me out of my funk and I became a much better physio after it so I'm grateful for it.

Interviewer: Okay. So, while you're studying did you go do rounds in clinics and hospitals for training in your five years?

Claire: Yes.

Interviewer: Okay and when did you complete your community service?

Claire: In 2017.

Interviewer: Okay, so in general, what was that year like?

Claire: Uhm, so, in terms of the hospital itself it was very different to what I had experienced elsewhere in another province. Uhm, especially in terms of the staffing – there was not a lot of it – and where there was a lot of it, staffing, it didn't make sense. So, for example, we were lucky, we were uhm, five, five physios, no four physios and a physio assistant, uhm, and then, but the OT's were only two. And for like, it was a 250 or 300 bed hospital – that's not a lot of people to see that many patients. Uhm, and when that happens, patients get left behind and that, uh, is not what you want to see. Uhm, the doctors were, uh, flippant, for lack of a better word [Laughs]. There were a few situations were, ugh, like, there, they were, uh, they didn't really investigate patients further so like, uh, what's nice about physio, because we get to really sit down with these patients and we really do try to understand where they're coming from and what they're trying to say, it's easier for us to pick up on things that maybe need more investigation and generally, like, in places like America or Australia, uh, I'm actually not sure about America, but definitely Australia and definitely in the UK we are seen as first-line Practitioners so we can like send patients for x-rays and stuff like that without having to get a doctors approval first. But the way the South African system works – the government system works – basically it means that we can't do that. We have to get it through a doctor and then the doctor has to send the patient for the x-ray. Uhm, and in doing that, doctors kind-of just get mad at you [Laughs]. Like, if you like, want to send the patient for the x-ray then it's kind-of like you're doubting their judgement and you're not really, you're just saying, 'I understand that you only have five minutes with a patient but I've got 30 and this is what I found and this is what I think we should do. I'm not saying that we have to but I think it would be a good idea.' And a lot of the doctors do not like that and so you, uh, eventually just don't say anything anymore, you just leave the patient or you treat them as best you can. Uhm, ya. That's basically it. There were like one or two doctors who I had like, bad experiences with.

Interviewer: Tell me more about that?

Claire: Uhm, the one, he never called me by my name, he always just called me only by my surname, which I got very annoyed with because he knew my name [Laughs]. Uhm, but it was more, there was a patient and uhm, I had been seeing the patient but with, say for example, you break your arm, you, uh, there are certain, there are phases of healing and there are certain things you can do in certain phases of healing. And what the doctor was asking me to do, I didn't want to do because it didn't match the phase of healing and if you do something too soon your patient will get more hurt. Uhm, and I told him that much; I explained why I wasn't going to do what he asked me to do and then uhm, he came into our physiotherapy department uhm and, so, our physiotherapy department was long and our physiotherapy assistant, he used to sit outside in like the storeroom because he used to like, smoke there and stuff [Laughs] and so, uhm, this doctor came in, I was standing and he walked right past me and he didn't even greet me, he just walked right passed me to the physio assistant and he told the physio assistant to do what I didn't want to do with the patient. Uhm, like, he didn't greet me, he didn't do anything and then like, the physiotherapy assistant, he came and told me what had happened and I told him 'you can go and do that but I'm not going to be held responsible for what happens to that patient – he needs to respect the, like, the healing phases and those kinds of things.' Uhm, but, like, everyone said that you have to stand up to him and then he'll respect you more but that wasn't really the case [Laughs], it was more like I stood up to him and then he just ignored me so uhm, that was a bit weird. Uhm, and then there was another patient that, uhm, she

was in a very bad car accident and her hand, uhm, so if somebody has nerve damage you can see it. Like, they will start, there will be muscle wasting and their fingers will start to form contractions – things that you can't fake. Uhm, and this lady, she just wasn't getting better. They said that they had checked her nerves but it really didn't look like they had. Uhm, and then I sent her back to the doctor and then the doctor sent her back to us with a referral to a psychiatrist. And I was like, this woman is not insane, she just, there is something wrong with her. And so, then I went to the psychiatrist and I said 'look here, this is exactly what's going on, uhm, but, this lady is not lying. She can't fake a deformity!' [Laughs]. And nobody believed her. And uh, I don't know what happened because I left, uhm but ya, so that, it's not a nice thing to see happen.

Interviewer: And the doctor or doctors that you're speaking about, were they senior doctors?

Claire: Uh, it was people who had been there for a while.

Interviewer: For a while?

Claire: Ya.

Interviewer: And why do you think they reacted in this way?

Claire: Mostly I [Laughs]. I think there's a very uhm [Laughs]. Doctors do think that they're smarter than everyone else – that's the first part of it. And, uhm, so this is, I experienced it there but it was something that you could see. Like, even when we were studying but when you're studying it's more from the students, so like, the other medical students will definitely show that they feel they are smarter than you. Uhm, so that's why, like you notice that they, uh, that's what they're taught – they're taught that they're the best and that they can't really listen to anyone else. Ya, so I think that was the first part of it. Uhm, and then the second part of it was that we were just comm serves – you're there for a year and then you're gone. So how seriously do they really want to take you. Uhm, and basically you're coming into their space, it's their hospital, they've been there for 10 or 15 years and here you are just popping in, popping out again. Uhm, but I think those were the two main reasons why it was like that. Ya.

Interviewer: Did you face any racial challenges?

Claire: I think a lot of people kinda just ignored my race [Laughs]. Uhm, but I do know that the white people, they had a bit of a tougher time. Like, especially with the current climate in South Africa, uhm, I think it's very easy for people to just not like white people just because they're white. And uhm, it is, it's very easy to do – some of them make it so easy [Laughs]. So I saw a lot of contentious conversations. So, there would be like, maybe a black doctor and maybe a white occupational therapist or whatever and you'd see that there was just, like, this struggle. The power struggle was very interesting to watch because here was this black male and this white female and they were like coming at each other with both, both of them with varying degrees of superiority that they had given themselves. And I would just watch this whole situation and I would watch it a lot and I would just be like . . . And the girl I was very, not close to, but, we had this great relationship where I could just tell her like, 'Look here dude, that's not okay, like you can't do that'. And then one day I just said to her like, 'Just look where you're coming from, you came from like up here with your whiteness and he came from like up there with his black maleness and the two of you were just like tryna go over each other!'. And it just wasn't working, they really just needed to meet each other on a half-

way point and they couldn't. Uhm, and I think it's very, like it's there. But where I was working there was a lot of people of colour and I think when you go into places like that with a lot of people of colour and you are of colour then you go with a position of strength in there and then when you not, you don't. uhm, and now I work for a company that's got a lot of coloured people but our manager is super racist! Like, at the moment, she doesn't want to hire another Muslim person because she's like 'Ah you guys take too many holidays'. I'm like, 'It's two days I the whole year'. [Laughs]. And like she said that. She was like 'That's why I don't want to hire another Muslim person'. And I'm just like, that's not okay. Uhm, and she's just like very openly racist. Uhm, I don't think she knows it but like when we talk to her then . . . So, we there are two of us that got hired recently and both of us are coloured. Uhm, and, but we both, if you talk to me over the phone, you may not know that I'm coloured because I can sound like a white person and I think that's what made her want to hire us is because when we spoke to her we were like, more refined – I didn't speak like how I looked kinda thing [Rolls eyes]. Uhm, and I think she likes that. Uhm, but it is just so shocking to me that like, this is still happening. Like, why is this still happening? Uhm, ya but it is and I, there are other places, like job interviews that I've gone to now where I feel like people think I'm a stupid because I'm coloured. Uhm, like when you do, I don't know, like, they don't say it out loud but you can feel it. You can feel it. You know it's there. It's sitting there in the room and you know it's there. So, I still feel that sometimes. Uhm ya, in my class that I'm in, because I'm studying further, so in my class, there are four coloured people and we're a class of like 38 – and that's four coloured people, there's no black people. So, it's four coloured people and the rest are white. Uhm, which is also, that's also something to me because it just shows me that I don't know what's happening. Either, we aren't, so people of colour aren't wanting to do this kind of thing – not wanting to study further and then we don't or, it's either that, or we don't feel like we can, or, uhm, I don't know. I don't know what the other reason, I hope it's not that we are trying and then people are rejecting us because that would be terrible and that would be the third option but I really hope it's not that one [Laughs]. That wouldn't be so great. And ya, it's weird because you put yourself in positions, like, for example, with the tut groups I work with, I'm the only coloured person and then we'll have conversations about like Ashwin Willemsse and then you kinda just have to sit and listen to people be just, wrong. Like, [Laughs], just hopelessly hopelessly wrong. But like, you're also outnumbered so, you can't come and be like this hectic freedom fighter and be like 'Ah, you can't say it'. [Laughs].

Interviewer: So the dynamic is different?

Claire: Ya, it's just totally different.

Interviewer: Mmm. Okay, and are there any other challenges that you faced in your comm serve year that you'd like to add?

Claire: Uhm.

Interviewer: You mentioned understaffing?

Claire: Uh, ya, like, so, like I said, we were lucky in our physio department but even so, with five physios, you know, in a 250-bed hospital, that's 50 people per physio for you to see at least once a day. Uhm, but I mean, 50 patients in a day is literally impossible. Uhm, and then, one of the other things was, like, you didn't get to see your patients often enough. So, I'd see them like maybe once a month if I was lucky – it could be once every six weeks. Uhm, and with that kind-of thing, if you're

treating the patient today and the next time you see them is only in a month, you're treating the same patient again because they would've not gotten any better because they need continuous input. Uhm, so that was one thing. And then the other thing was definitely the lack of equipment. Uhm, I had patients, so physios are, we didn't have an ICU but we had a medical ward and in the medical ward you are required to do things like suction so if somebody for example has like a pneumonia or whatever and they have a lot of phlegm and they maybe can't get rid of it themselves then you go in and you stick a pipe down their throats and suck it out – not exactly like that, it's a lot more sterile [Laughs] but ya. The problem is, we couldn't be sterile – there wasn't enough equipment – you had to reuse, uhm, like the suction catheters. And that's like, disgusting. Like, it's literally germs just breeding. Uhm, and sometimes we didn't even, so sometimes you had to reuse them and sometimes we just didn't have them. So, there were times when I'd leave a patient on a Friday and I'd come back and my patient would be dead on a Monday because they would've like aspirated on their own phlegm and there was nothing you could do about it. Uhm, and just like general, you know like, human rights stuff. Like, people would be left to lay in their, like, they'd wear nappies because they can't get out of bed – they have strokes or whatever – and then they'd like dirty the nappy and then there aren't enough nurses to change them consistently so they will just lay there for like, four hours, just like in their own stuff. And it's terrible. Like, you'd never want to do that. Uhm, ya, so that was also just, like, a thing. You, ag, you know, eventually you're just like, you know what, the nurse is going to get mad at me if I ask again so I just, uhm, I'm not going to ask. But then, like, you can't. So, one day I walked in and one of my patients, she, uhm, she, I can't remember but I think she was HIV positive and she had just come out of the infectious part of TB. So, you know like, it's infectious for a while but then when you start taking your medication, after a while, you're not infectious anymore. So, she had come out of that part, so she was in the general ward and she really wanted to walk but she was so confused and delirious from all of the stuff that was going on. So, she couldn't walk by herself, uhm, and she had managed to get herself out of the bed but then she pulled her drip out so when I walked into the room there was just blood. Like, everywhere – on her clothing, like, on her arm. It looked like she had tried to commit suicide, well, obviously she hadn't but ya. Uhm, and I went to the nurses and I said to them, 'Look, this lady, she uhm' – I was like look this is what's happening and they were like 'Look, I'm busy right now.' And I was just like 'Wow, this lady is full of blood and the drip is like out of her arm!'. So, then I had to go, and I was so worried that she was going to eventually, like, she was so delirious and she didn't notice the blood, but I was worried that she was going to and that when she did that she'd just be like 'Oh my gosh!'. Uhm, so then I had to like run and get clothing for her. Uhm, get a plaster, that kinda stuff so that we could fix her. So, it was more – I'm very much about the patients because we get to spend so much time with them and we build that relationship with them – you can't help but care. And also, these are just like general things that I would care about anyway even if it, even if these people weren't my patients! Uhm, if I had to hear this on the street then I would feel the same way about it.

Interviewer: And what effect would you say this has had on you?

Claire: Uhm, so it was a lot of that stuff that you kind of just had to get over because nobody was going to, uhm, they told one of, uhm, the psychologist told us 'Don't try and fix the system yourself because then the system will never change.' But I was like, if we don't try and fix the system and nothing changes then nothing happens for these people. Uhm, so it's quite, it's difficult to come into it and know that this is already like this and it's been like this for however long and it's just getting worst and we're producing more young health professionals but none of us are reaching a point

where we can actually make the differences that we need to make. And a lot of us, by the time we do get to the point where we can make those differences, we already stopped caring. And, you can't help but stop caring because if you had to care about every single thing that goes wrong, you'll drive yourself insane. Uhm, ya, so that was the major, the big things for me. Like, some people just don't care. Like, a lot of the doctors, like, the other physios, they just don't care anymore – it's been too long. And they're like 'I get paid every month and if I work here for long enough, I'm going to get paid more so ya'.

Interviewer: So, do you think that this is more the attitude of senior staff?

Claire: Ya. They're like 'I've already worried about it and it didn't change, so I decided to stop worrying about it because if I had to keep worrying about it, it would affect my life basically.' Uhm, so I think that's the, uh, it's quite major. It's, people, yoh, it's insane. If I just think about that, like we, like, the first time one of my patients died I was so upset and I honestly felt like it was my fault. Like, I know that it wasn't. Like, there's nothing that a physio can do that will kill someone! But, uhm, just knowing like, maybe if I had been able to suction or if I had been able to do something more then we could've bought her enough time for something to, like, happen. So, maybe I couldn't have saved her life completely, but, you know, I could've helped her along the way a little bit. But ya, so that's . . . Oh! So once, [Laughs]. Oh, this is a good one! So, I didn't know this lady was dead [Laughs]. And then I went into the room . . . Oh my god. [Pauses]. She was just laying and she had an oxygen mask on and I was, uh, she was quite sick. Uhm, so it was like a palliative care type of thing. Uhm, and I went in and I was like, 'I don't see any mist!'. Like, you know when you have an oxygen mask on, you can see, like, if you're breathing. And I was like, 'I don't see anything'. Uhm, and I tried to wake her up and I was scratching her face and whatever, doing a bit of a sternal rub, because if you rub here [Points to chest], it's very sore and people are supposed to feel it immediately, but she didn't. And then I was like, 'I don't have any authority so say anything about this'. So, I just went to one of the nurses and I was like 'Uhm, I think you need to go check on that patient'. And then she was dead and I was like 'I touched a dead person!'. And ya, like, I couldn't tell you how long she had been lying there dead because I didn't know. I mean, that was at like, 10am. So, I don't know what they had done in the ward that morning but like, I don't know how long she had been dead for before I got there. Uhm, which was, it's insane to think about it! Like, she could've been lying there for at least like, two to three hours because they do like the bathing and stuff like really early in the mornings. Uhm, so that was quite hectic. Ya, it's, shame, poor lady, but she is in a better place now. Ya.

Interviewer: Is there anything else you'd like to add about that?

Claire: Uh, I don't think so.

Interviewer: Okay. So, right at the beginning of your community service year do you receive some kind of handbook where it's outlined what you can expect in terms of working hours, training, supervision, ethics and so on?

Claire: Uhm, no [Laughs]. I didn't know where I was going until September the year before. Uhm and then, in September, they just basically came up on the system and then I knew I was going there. And then I phoned them. And then after that I basically had no communication – that was it. I found out where I was going and then I did everything myself. So, they're normally supposed to offer you

accommodation and those kinds of things. They didn't do that. Uhm, I had to find my own accommodation. And then, well, I don't, maybe they would've offered me accommodation but it was October and they hadn't and I was like 'I'm moving in December!' and I'm not the kind of person to leave this until December. Uhm, so, I did it myself. Uhm, I didn't have a contract until I had been working for like one week [Laughs]. Uhm, ya and in the contract, it basically just said that I was a comm serve person. And my supervisor, she also didn't like make contact with me, I just knew who she was. And she was just kind of my supervisor by default because she was the head of the physio department. So, we like worked underneath her. Uhm ya, and then all the stuff ethically, was in our, uhm, well, like in our contract – maybe even – I don't even remember now. Uh, but a lot of the stuff, like, I don't know, ya, we weren't, like, it's not something that was told to us before we entered the workplace but it is something that we had learnt and uhm, it's stuff that we had gone over excessively in terms of HPCSA guidelines and that kind of stuff. Like, we know that kind of stuff.

Interviewer: You mean you learnt about it while you were studying?

Claire: Yes, while we were studying. Uhm, they made us do really stupid assignments on it [Laughs]. But ya, so we knew that kind of thing. Uhm, but in general, it's mostly, like, for us, it's mostly just confidentiality – like just keeping your patients stuff quiet and uhm ya, treating them like human beings. First, [Sighs], not doing any harm – I think that's the most important one of them all basically. Ya, professionalism, but ya.

Interviewer: Okay that is quite interesting. So, when I first contacted you, I spoke about Yumna's story.

Claire: Ya, when I saw it I was just like 'Wow, nothing I've ever faced has been as bad as hers'. But like, there's still things and challenges that need to be said.

Interviewer: Yes, so obviously, as you know, that is where I'm heading with my thesis. But as I said, I know not everyone's experiences are the same but in her video, and her blog, as well as in some of the literature, there's this emphasis on, again, this idea that there are guidelines but that these are not being followed.

Claire: Ya.

Interviewer: So, for example, there would be guidelines in your contract that says this is your working hours. But then there's this emphasis that there's very long working hours for health professionals. What was your experience of this in your community service year?

Claire: Uhm so, uhm, okay. So obviously we don't do calls like how doctors do. So, we don't have that part of it which I am so grateful for! Uhm, but in terms of, even in the place I'm working now, uhm, I was at work until 7pm yesterday and I got there at 6am yesterday morning. That's a long nine hour, like uh, is it nine hours? I don't even know [Laughs] but it's a really long day! And I saw, before 3pm, I had seen 12 patients. And for a physio that's a lot. Uhm, and so, ethically speaking, in that respect, we are required to see too many people in too short a space of time and you cannot treat those people ethically. Like even I know, I'm treating them and to the best of my ability but actually I could and should be treating them better. Uhm, but you know, because it's workers compensation, nobody really cares. Nobody is going to check it, nobody is going to check in on it, uhm, everyone is just going to kind of leave it. And, uhm, we as physios, uh, specifically, are very uh, well, medicine in

general is very evidence based so if you do something and there is a better way to do something that has been researched then you should be doing it the other way. That's like, just how it is. Uhm, and a lot of – a lot a lot a lot a lot – of physios do not. So, the other day I had a, a lady came in, or we were actually just chatting in one of our like tut sessions and they were telling us about this physio who had put on a hot-pack on a patient. So, hot packs are like, they are, uhm, you basically, uh, ugh, I don't know how to explain it – so basically you dip them in hot water, like, boiling hot water, and then you wrap them in towels – and you have to wrap them in a towel otherwise they burn the patient. So, this lady just took a hot-pack, slapped it on a patient, and left it there for 20 minutes and now the man has got like, a second degree burn on his back! Like, that's insane. You can't, I don't know. Like, how on earth can you do that? Like, that's absolutely, it's shocking! Uhm, so ya, like, so, then I started to think like 'Aw man'. Like, now the other day, I almost burnt a patient but that was because I was too busy. I had too many people to see. So, I put a hot-pack on my patient and I had to go do something else and like, I came back and this patient hadn't said, like, I have him a bell and I told him, 'Ring the bell if it gets too hot', and he didn't ring the bell and when I came back, I took off the hot-pack and like, his skin was red. And I was like 'Did you burn? Like, why didn't you tell me?' [Sighs]. And then like, the next week, he was late for his appointment and I was freaking out because I was like, 'Oh god, I burnt this man. He's done with me'. And then I like, then he came in, and I was like, 'Are you okay? Did you burn?'. And he had forgotten about it but it stayed with me. Uhm, so ya, in terms of the long working hours, you don't really get the major part of it but even when I was studying, uhm, we'd have to work until 5pm and then we'd have like an exam on the Friday and like, like, working and being in class until 5pm are two very different things so we were working like full time physios, seeing as many patients as the normal physios were. And what they did a lot when we were studying is like, the physios, the head-physio would just be like, 'Oh, I've got students' [Laughs] and then just send students to all of their patients. And then it's quite hectic. Like, you see a lot of patients that you're kind of, like, a little underqualified to see because like you haven't graduated yet, you haven't got any experience. Uhm, and then a lot of times when you want to ask for help, they kind of like, 'Just go read about it'. And I'm like, 'I know, obviously I'm going to [Laughs] but I need some clinical experience to like, supplement what I'm going to read because what is written in the literature is not enough!'. Like, it's there, and it gives very good guidelines but every patient is different, so you need, like, a clinical perspective. Like, you don't have that when you're studying. And so that was another thing that was quite, uhm, hectic. And we didn't have a lot of supervision basically. So, uhm, the supervisor would only come in once or twice a week and that would kind of be it and then you'd spend, if you were lucky, two hours with them, but most of the time just one, maybe even 45 minutes.

Interviewer: Is this while you were studying?

Claire: Yes

Interviewer: And in your community service year?

Claire: Oh, like, I didn't get supervision like that. It was more like [Laughs] 'How many patients are you seeing? This many? Okay' [Laughs]. And then like, every three months, she's rotate us so that we could get experience in different wards. But she wasn't, uhm, she was busy doing her Masters, so she clearly had better things to do than [Laughs], like, listen to us talking about patients. So, we basically, it was a lot of reading up, uhm, on your own, uhm, ya.

Interviewer: Okay that is interesting because my next point is that there is indeed an emphasis on a lack of proper supervision.

Claire: Oh, that I could talk about for days [Laughs].

Interviewer: [Laughs]. Go ahead.

Claire: Okay, so in our community service year it was bad. Like, she didn't supervise us. Uhm, she was there and she was emotionally supportive but like clinically, she wasn't very supportive at all. And I think, like, emotional support is good – you want them to be emotionally supportive – because a lot of them aren't.

Interviewer: And what do you mean by 'emotionally supportive'?

Claire: Like, she would, like, especially when for me that was, I came from, I was living alone and I was by myself and I was quite, like, lonely. So, she would always take that into consideration and check how I was in terms of that. Uhm and like, if a patient died or something, then she would always be like 'Are you okay?'. Like that kind of stuff. Uhm but, like, clinically speaking, I could go and ask her like a very proper like clinical question and she's be like, 'What do you think?'. Then like, you tell them what you think and she's like, 'Ag ya, go with that'. And I'm like [Stares blankly] 'Why? Can you give me more?' and she couldn't. Uhm, like I said, she was busy doing her Masters and she was doing it in Public Health on teenage pregnancy so her mind wasn't really in the bones and the fractures and whatever. And then while I was studying, so, wow! [Laughs]. So like I mentioned, before, I said that I failed that one year. Uhm, so basically how it works is that in your third year, you have three clinical blocks and at the end of each clinical block, you uhm, you have an exam. Uhm, and then your last exam is weighted the most. Uhm, so first of all, I, okay, and this is maybe my fault also but okay. So there was already like 45 minutes to an hour of travelling every day. Uhm and then, so when they start placing you for your clinical blocks they ask you for information like where do you live, do you have your own car, stuff like that so that they can put you somewhere where you don't have to drive too far and where you don't have to put too much effort into going to the clinical blocks. Or like, grouping people who maybe live close together to get to the clinic so then they could like drive together or travel together whatever. So I was travelling for at least two hours every day. Uhm, and then my supervisor, she firstly, her uhm, so what they, and I hope they've changed it now uhm, uhm but they, so physio is very general – you can do anything in physio. But physios find their niche'. So like some people work in community health, some people are ortho-physios, some people are neuro-physios, peds-physios. Like, you can find what you are good at and then you can just do that. And then, this lady was more of a community physio but we were doing like a baby-ICU block. So, it wasn't in an ICU, it was more in the medical wards. And she is one of those people, like, we'd organize a supervision session and then she'd come in and she'd be late and be like 'Aw no, I was busy with my fourth-year community students – because that's where her love was. So, she was giving more attention to the fourth-year community students anyway and we were just third-year like, babies. Like uhm, so, we'd have 40 minutes to an hour sessions with her between the two of us. Uhm, and she really, like, she didn't put a lot of supervision into it. And then, she failed me in my exam for stuff that she had never said. So like, in the sessions, that was the point of those sessions. Like, it was to like, uhm, learn basically [Laughs] and to be taught things that you otherwise wouldn't learn. Like, to be taught clinical skills. And then she failed me on it and then I failed the entire year because somebody decided that like, she'd spend 45 minutes with us and then because she hadn't

taught us things and uhm like things that I didn't know, she had failed me on. And I was like, I was so angry. And that was just, so that was one block. Uhm, and then in my actual ICU block, so, the supervisors, uhm, you get lecturers who lecture you and then you get supervisors, and then you get clinicians. So, clinicians are the people who actually work in the hospital who are then just supposed to make sure that you don't kill anyone but they don't, like, they just, kind of, make assumptions and they don't ask so if you aren't comfortable with something, if you go to them and you tell them that you aren't comfortable with something, they'll make you feel like, shitty for like not, for like, not knowing that. And the point was that we were students and we shouldn't be afraid to ask a question when you're a student because that's when people get hurt because then the student doesn't learn and then they go do what they think is best but we don't have any clinical judgement so we don't know what's best. And we know that but if we can't ask the people that we're working with everyday then who are we really supposed to ask – you only see your supervisor once a week. And you can ask them as much as you can in that session but after that like, what more can you ask. And you can like, email them and you do but then you get like, an article and it's like, not what you need. Like, and like I said before, reading is good, you need to read, you need to go and do the research and all of that stuff but it's nothing without a clinical reasoning, like a full picture. And you need like an expert, [Pause], an 'expert' [Rolls eyes] opinion to get that which you often often didn't get. But that being said, I did have some very good supervisors. So, uhm, I also think, so, uhm, that was the other thing. So, they told us when we were studying, they had these programs where, not programs, but they would identify problem students and then they would help those students. Uhm, but, I was never identified as a problem student and then I failed an entire year! So, I just feel like, if I was a problem student then somebody should've picked it up sooner and they weren't paying enough attention to me then as a person or to me as a student. Uhm, and then, so, like, they, they said that, they said they would pick out the problem students and they would help the students to become, like, to pass and whatever. And I just felt like a little left behind. Like, how come nobody helped me? Because then even afterwards, they uhm, so then those people, after I had failed, then they decided to uhm, help me. And then I was like, 'Well, shit bro, I don't want it'. Like, what are you gonna? Like, I, uh, anyway [Shakes head]. Like, I just didn't want help from them and maybe that was bad on my part but I was just like, what are you going to do for me now that you should've done like a year ago when I actually needed you. Uhm and then, but, through that, I was like, look, I do need the help I just don't want it from them [Laughs]. Uhm, and then I found other people. So, uhm, like I said, I mentioned that supervisor in the beginning. And she became quite a, like a really, like even now, I would call us friends. Like, we've become friends now, or colleagues, fellow physios [Laughs]. But she really, like, she helped me with what I really needed help with and that was gaining confidence. And she gave me so much. Like, I will actually always be grateful to her but she was probably the only person I can say that about. Her and another lady. But the other lady, she was known to be really terrible to everyone else – I don't know why we got along but ya [Laughs]. And she also, she gave, she was very smart. So she also, she gave me a lot of that clinical advise. But that's two! In three years I did 11 blocks and I only had two supervisors that I found, that I actually learnt something valuable from. Uhm, I think that kinda speaks for that in terms of, I mean, the other ones, they weren't terrible but they were just, they had other things going on so they were just, they didn't really, ya.

Interviewer: Earlier you mentioned asking for an expert opinion and then being made to feel 'shitty'. So, there is this emphasis on 'teaching by humiliation' or coercion, or maybe even intimidation in the literature. Would you like to elaborate on this?

Claire: Mmm. So, not uh, not me specifically. But, I was in a session. So, I've never felt humiliated, uhm, but there were times where I felt belittled. Uhm, okay, so there was once, so, this lady [Sighs] [Laughs], okay, so, maybe I must preface this, she had cancer and then she survived it but when she survived it, she decided that she could be the biggest bitch because she had survived cancer [Laughs]. And you can't really, like, what do, what you gonna argue with that? [Laugh]. You can't [Laughs]. But she was terrible. So, she was, I was doing my paediatric [Pause] block, and she was just, just the way that she spoke to us. Like, she might as well have, she never called us idiots to our faces but she might as well have because she, like, she was always angry, everything that came out of her mouth was just angry. Like you could never understand why. Like, I was just like, 'I'm learning. I'm not doing anything wrong'. Uhm, but then there was one block where, when I was studying, so, it was a community block. So, basically, on your community block, you, uhm, you do home visits and you're not allowed to do home visits alone. So uhm, we always worked in pairs. It was for safety and I'm grateful for it, because we did ours in Bishop Lavis, and I don't want to be driving around alone in Bishop Lavis [Laughs]. Uhm, so we went on this home visit once and this, the other guy that I was with, uhm, he was, [Pause], struggling – community is different because you have to really be in tune with the people. It's not as much about your clinical knowledge as it is about your people skills. And he did not have a lot of those [Laughs]. Uhm, and then the lady who was our supervisor, who was with us, she told him, and I'm like, so I'm strong in that respect, I'm, like with the interpersonal relationships and with just like, thinking out of the box. So for example, it's like going into someone's house and watching how they walk to the bathroom and if they can't go to the bathroom, then you need to find out why, is it how the room is set up; then you change how the room is set up – and I was good at thinking like that. Uhm, and he was not. So, uh, every session, I kept very quiet because like, I wanted to help him but I knew that I shouldn't. uhm, and then at the end of it, I kinda just told him like 'Aw, maybe you can do this', but just like, it was very quiet and we were just talking to each other while the supervisor was talking to the patient. And then we got into the car and she told him in front of me, and I felt so bad for him. And then she told him like uhm, like, that, that was terrible, uhm, you're letting her carry you. And I'm like 'I'm not [Hides face], I'm not carrying him. He's doing his own work'. But like just that moment, and after, you could like see, after that he got like so withdrawn. Like, he didn't interact with her the way you should interact with your supervisor; he didn't want to ask her questions anymore. Like, he just felt like he couldn't. Uhm, and I, I felt like really bad for him because he was trying and obviously, like, it was just a skill that he didn't have yet – that he wasn't a full physio so he wasn't expected to. Uhm, and I always thought that that was just a little bit unfair, just the way that they treated him. Uhm, and this other lady, she was our head of department and she's very very clever, like, super clever – she knows a lot – especially about ICU stuff. Uhm, and she used to lecture us on ICU stuff. But then she used to stand with a pen [Laughs] and she'd ask a question to the class, right, and then we'd all be really scared to answer because if we answered wrong then she kind of like, berates you. But if you take too long to answer then she stands with her pen and she clicks it and the more irritated she gets, the faster she starts to click and then you know, like, hectic. And then so, if you answered the question and you answered wrong then she wouldn't say anything but she would just be like 'UGH!' and like go on. And I'm just like 'What?'. Like, you can't do that. Uhm, and uhm, ironically enough, she was like, uhm, she had been

chosen as my advisor but I could never go and ask her for advice – I was hopelessly too, I was too scared. Uhm, I didn't want the information bad enough for me to feel like an idiot after I got it. Like, I would then rather, uhm, even if it meant that I wouldn't have that clinical knowledge, like, expertise part, I'd rather just not – like, I'd rather go read about it and figure it out by myself which is not the best way to do it. And uhm, I know that I am that kind of person so I know I'm a quiet person and I don't handle well, especially to do with like conflict with people of authority. So, conflict, uh, I'm not great with it but I'll, uh, I mean, I'll deal with it, I'm a grown-up but conflict with people of authority who then use their authority to manage the conflict is not something I like to take part in. So, then you withdraw and you learn less – you don't know as much, you don't get as much information and you feel less qualified. Like, you feel less qualified to take that information to someone else and it's very important to be able to do that. Uhm, ya, so that's it. She went on to become the head of the department [Laughs]. So, apparently it worked – people liked her [Laughs]. Maybe not the students.

Interviewer: And in terms of your supervisor in community service?

Claire: Uhm, no. She was never humiliating, she just wasn't very helpful [Laughs]. Ya, she was ya. Uhm, the doctors, uh, sometimes were. So, if you had a different opinion to the doctor then the doctor would be like 'Oh well, I read this article from 1995' and I'm like 'Okay, well, there's a new article [Laughs] but okay, if you want to keep doing stuff from that 1995 article then you can' [Shrugs]. Uhm, but also, when it came to the doctors, they were making such stupid decisions all the time in terms of patient care that I stopped taking them seriously. So, like, they were trying, maybe they were trying to be humiliating or belittling but I was kind of like [Shakes head], 'I can't take you seriously' because like I don't trust your clinical judgement and if I don't respect you as a clinician, then you can't make me feel anything basically. Uhm, which is also not a good thing [Laughs]. So ya, just those kinds of thoughts and relationships with your superiors. You are supposed to want to and be able to ask them things and especially when it comes to doctors, they do know things that we don't, especially in terms of like, medication; some of the classifications of fractures, stuff like that, that we don't like really go into depth with it. Uhm, so sometimes you need them but like, if you don't trust their clinical judgement on the stuff that you do know how can you trust them on the stuff that you don't. So ya.

Interviewer: And have you experienced this from any other senior staff?

Claire: Uhm, I just felt like, a lot of them had no idea what they were doing [Laughs]. They're like, I don't have the knowledge but I'm gonna pretend like I do but don't ask me a question because I'm not gonna answer it very well. Uhm, so ya. Like, [Laughs], this one doctor, so, uh, I got sick, and I didn't have a medical aid in that year and so, like, we were in the hospital and so we used to get like these fast-track passes, so you could like skip the line and just go to the doctor. [Laughs] and then I went to the doctor one day and I was violently sick, I don't know, I might have had food poisoning or something but I started throwing up. Anyway, and then, uhm, I went to him and I was like look I need to give me something to stop this nausea. Uhm, and then he was like, uh, I think this is viral but let's give you some antibiotics. And I'm like, [Stares blankly], like, for who? [Laughs]. Like, why? And then afterward that I was like, I can't trust anything you say because you gave me antibiotics and you knew that they weren't gonna work so you made me sit with a drip in my arm for like an hour for something that wasn't gonna make me feel better. And after that I was like [Shakes Head]. But the people, like all of them were very friendly. So, besides those two doctors that I mentioned

before who were a bit like, ya, the other ones were all like, quite nice just not always quite knowing what they were doing. Uhm ya [Laughs].

Interviewer: Okay. And do you guys have logbooks where you can keep track or write down certain things like your challenges, perspectives etc?

Claire: Uhm, no. But we did have portfolios to hand in. And in the portfolios we would do like reflections and that kinda stuff. So, you do like a half reflection of a block and then an end of block reflection.

Interviewer: And how long is a block?

Claire: Uh, it's about six weeks. Well, when I was in third year they were four and then I got to fourth year and they were six.

Interviewer: And in your community service year?

Claire: Uhm, it was just, uhm, you just worked. So, how they worked it, you would spend three months in two wards. So, like I would spend three months doing like female medical and outpatients and then the next three months I'd do peads, uhm and then like male surgical.

Interviewer: And did you also have to do portfolios during comm serve?

Claire: No, not in comm serve.

Interviewer: So just while you were studying?

Claire: Yes, just while we were studying ya. And then they used to give us like feedback forms at the end where you could talk about the supervision and it was anonymous.

Interviewer: Okay, so during community service was there then any other outlet for you to give feedback?

Claire: In comm serve?

Interviewer: Yes, in comm serve.

Claire: Uhm, no [Laughs]. So, they have these meetings [Laughs]. Like, and then they . . . But it's really like, like it's quite silly.

Interviewer: Are the meetings like some kind of reflection time?

Claire: No. Not like the ones we did when we were studying [Laughs]. The ones we did when we were studying, they were written down, the only person who saw it was your supervisor and if you had a good relationship with your supervisor you could write anything. Uhm, but in comm serve, it was this meeting and it, there was this man [Laughs], uhm, and he was like, he's in charge of the community service physiotherapists. Like, all the auxiliary health people. So, it was physios, OT's, uhm diet – uh, I actually don't know if dieticians were a part of us, uhm, but dentist were and the audios and speech therapists. Uhm, so like, we had one massive meeting together and a lot of the people, uhm, like, we'd go to the meeting and then we'd say things like 'Ah, the audios didn't have a

booth' or 'I didn't have a suction catheter' and stuff like that. And then they were like, 'Oh we can't really do anything about that at the moment'. It was like that. And then, uhm, [Laughs], so some people did have, so like I said, my supervisor didn't really clinically help me but she was nice. And some people had people we weren't clinically helpful and they weren't nice! So, then they were like, 'How do I talk about this?' and then they were like, 'You need to write a letter and give it to your superior'. So then they were like, 'Okay, so I must write a letter about my superior and then give it to my superior?' [Laughs]. And then they were like, 'Ya'. And then, [Laughs], like, they didn't see how that was a problem. So, no, to answer your question, there is no, like they tried to make one but it was obviously not very helpful because all they used to tell us was 'Hey, we can't really help you but here's a place to talk about your problems because that will make you feel better'. Knowing that it will be talking about your problems, having it acknowledged as a problem, and then being told 'I can't fix it'. So, no – you don't get that at all.

Interviewer: Okay. That's interesting, because my next question is were you ever made aware of who you could complain to if the need arises?

Claire: There was nowhere. We were made aware that there was nowhere. So it was quite, ya.

Interviewer: So if I ask you if you've ever laid a complaint?

Claire: My answer would be no [Laughs]. Like, where? Who would I do it to? I would just, so the big thing is that once you complain, and that's where I do relate to what happened with Yumna, that once you complain people don't, like, they don't care about you. That person has been sitting in their position for five, seven, 10 years and you're just there, and you'll be gone soon. Especially if you're a comm serve – you're gone in the next year; if you're doing your internship, you'll be gone in the next two. So, they don't care if they make your life difficult or if you're having a tough time – you're going to be gone soon. So, no. And I don't, and that's another, so, she was very, she was very brave – she went and she laid a complaint but the rest of us just silently suffer. Like, just take it and go and just know that you'll be gone soon and then go like as soon as you can. Uhm, again, not the best or healthy way of managing it but that's what it is and uh, I think you learn very quickly to just take it and just, you know, let it slide and leave the day behind you. But, ya, it's not healthy and that's why the system is not changing because we have to do that – can't complain, complaints not taken seriously, there's no place to complain. And uhm, ya, it's hectic actually.

Interviewer: Mmm. And you're aware of the role that the HPCSA plays?

Claire: Uhm, kind of [Laughs]. They make me pay them a lot of money every year! So I hope that they're doing something [Laughs]. They give us malpractice cover which is nice.

Interviewer: So, you never laid a complaint with them?

Claire: No no no. I mean I guess that is what the HPCSA is supposed to do but basically we were always just taught to be afraid of them. So, like, so, uhm, like they'd always tell us 'You know, if you mistreat a patient, then you're gonna end up in front of the HPCSA with like seven people in front of you trying to decide whether or not you were ethically correct'. Uhm, and basically they just always told us 'Make sure your clinical notes are amazing so that if the HPCSA ever comes at you for anything, you can just shove your clinical notes at their face and be like, this is what it was, if you can find fault with that then do whatever but if you can't then ya'. So, they were never shown to us as a

supportive place. Uhm, never. They are kind of like our traffic cops [Laughs]. I just feel like that is what the HPCSA would do to me, like, they'd expect me just to do . . . Like, they have these guidelines and you're supposed to do all these things and you do them and if you do them, everything is fine, they ignore you but if you don't do them, then it's a really big problem. Uhm, that's my view of the HPCSA – I don't see them as a supportive structure and I'm not surprised that that happened to Yumna. And all the lobbying groups are only for doctors. Not us. We don't have any of that.

Interviewer: And so if the need arises, do you think you would ever lay a complaint with the HPCSA?

Claire: To be very honest, it would have to be like a major major major major thing for me to go to the HPCSA. Like if I actually felt like maybe my livelihood was in danger and the only people left who could help me was the HPCSA, then I'd probably go [Laughs]. Uhm, but, like for example, ya, no, I don't know. Even, like, even if I was going to, like, I watch how our practice works, like now the practice that I'm at. And a lot of it is unethical but if I took it to the HPCSA, to get to the point where I would take it to the HPCSA, like, I'd probably have to go through some people who would stop me before I even got there and then once I got to the HPCSA and it got back to the place that I worked at, they wouldn't change the system, they would just fire me. So like, what is the point of that? – then I'm jobless and the system stays the same. So like, ya [Laughs]. So, I don't know, probably not – it would have to be something major, like really really big!

Interviewer: Interesting. So overall based on what you've said, what effect has these challenges had on you?

Claire: Mmm. Uhm.

Interviewer: So, for example, Yumna left medicine for a while because of the challenges she faced. Would you do that?

Claire: I think, uhm, so, if I was working with the same mentality that I had in the beginning of last year, I think I would've left physio a long time ago [Laughs]. And even where I'm working now, seeing the way that somethings are done, uhm, it doesn't always make me proud to be a physio. Uhm, but I do realize that every patient that I see, that's somewhere where I can make a difference. Uhm, and so, with regards to that, I still love my profession, I still love being a physio, and I'm proud of the physio that I am becoming. Uhm, and unfortunately, there are people in our profession that aren't the same, you know, they just wanted to be physios because you'd have a job forever – well, debatable [Laughs]. But uhm, so, I'm trying very, like, okay, look, this is just the first year of my real career, uhm, so it could take a, maybe in five years you should ask me again [Laughs]. But right now, I'm trying to uhm like, just treat my patients the best way I can and be the best physio I can be for them so that every patient that I see, I would've made a difference. Uhm, and right now, that's my main goal – is to just focus on that. So, to take the resources that I do have, uhm, and kind of ignore the stuff that other people are ignoring for the time being. Uhm, I recently [Laughs], I was talking to my manager, uhm, and she was saying how she hates marketing and she watched this video by Elon Musk and Elon Musk was like you don't have to market if your product is good, then the rest of it doesn't really matter. And so that's very, I think that's quite a good, like, the way I'm thinking right now is that if I can just be good physio, uhm, then maybe it will just rub off on other people. Like, they'll see that it's possible to do it and like that kind of thing. So, I think that's more where my head

is right now. I am solely focused on the patients and making sure that they get better and that their quality of life is back to what they would want it to be. Uhm, and then ya, I feel like as long as that is my goal and my focus then all of the other things will just become white-noise in the background. Uhm, and I think that's kind of, for now, that's the best way. Like, I'm gonna focus on doing it like that. Uhm, but I still, the more that I do what I do, the more patients I see, the more clinical experience I get, I do enjoy physio and I'm glad this is what I do.

Interviewer: So, in your opinion, what do you think should be done differently to address these challenges that you've mentioned?

Claire: As in with the health system as a whole?

Interviewer: Yes.

Claire: Well first and foremost, I think we need to get, not the old people, but the people who are still working with these mentalities, we just basically need to weight them out [Laughs]. And then get people who are just more in-tune with what our country needs. So there are needs for this country and the way that the government is trying to meet the needs is just, there's a major major mismatch. So, I think that firstly, as everything in this country tends to be, it's about money. Uhm, so if we can just get a proper, like, there's a very very big misappropriation of funds, so if we can just sort that out [Laughs]. Dude, like the amount of money that a physio gets paid for working in the same place for 10 years is ridiculous! – you don't need that much money. If we could take that money away and maybe put it into like getting a new treadmill and then we'd have another piece of exercise equipment and you wouldn't have a new car [Laughs]. Like, that would, that kinda stuff . . . Or, like, ya, last year, there were people earning double – I earned a lot of money last year and I didn't deserve it. Like, for a young adult to go into a job and earn that much money, it just made no sense. And I was one person, there were like 300 of us earning that salary. If you add all of that money together, it's millions! Millions that could've been spent on those poor people who are waiting for cancer doctors who don't have one. Or like, the suction catheters that we don't have. Like, it's just a major major major misappropriation of funds. And I think that, uhm, ya, so that is the first thing – money. And then the second thing is, like I said, getting those people who have been in this position for years out. Because we need people who are like a bit more open-minded, who actually know, like, how to, because there are ways of doing or managing complaints and dealing with these things. But, we just need people who are willing to listen and to like, mediate properly! So, there are tons and tons of very very different personalities when you look at the health profession – there are people who went into it because they care about people, and there are people who went into it because they are flippen smart and they want to be the smartest and they want to be the best and they became doctors, and they specialized in this and that. And I am, some of those people are great. It's amazing that they are so smart but uhm, there needs to be a balance between the two. So you can be very smart, but you are working with people, so you need to be able to deal with people and so I think that what we're lacking is very very good mediators – people who can look at the situation objectively and not pick a side based on anything. So, based on whether or not the person is a specialist or how long the people have been working – just to look at the situation for what it is and then to take the human rights into account. Ya, so like also, just basic human decency! Where is that? It's not, it's nowhere – you don't see it! Uhm and I think, uhm, ya, if we can just get people who can mediate better, I think that would be quite good as a start.

Interviewer: Do you think you'd ever leave South Africa?

Claire: [Sigh]. I think I'd definitely leave Cape Town [Laughs]. Uhm, I'm not sure and uhm, I don't know. There's a part of me that thinks that this particular problem, so, like, the problems with supervision and like, senior people belittling younger people, uhm, a part of me feels like, that's everywhere. I feel like it might not be different if I moved away. And I think it's maybe easier to deal with that stuff when you are at home – closer to like, the familiar. Uhm, and until I've reached a point where I am very confident in myself as a physio, I don't think I would. Like, I'm getting more confident now but I'm not confident enough to hold my own in another country and so I, I don't know, basically [Laughs]. I don't know where that is in the five-year plan [Laughs]. Initially I thought I would – I thought I'd go to New Zealand uhm, but you have to pay a hell of a lot of money to write their exams and like, I didn't have that initially. Uhm, maybe if I did but again it's like R30 000 to write an exam and then if you fail, you must pay again. [Laughs]. So that's R60 000 that I do not have. So, uhm, ya, I don't know.

Interviewer: Okay. Thanks for your time. Is there anything else you'd like to say concerning your experiences in the healthcare sector as a junior health professional?

Claire: [Laughs]. No I don't think so. I just hope this was helpful [Laughs].

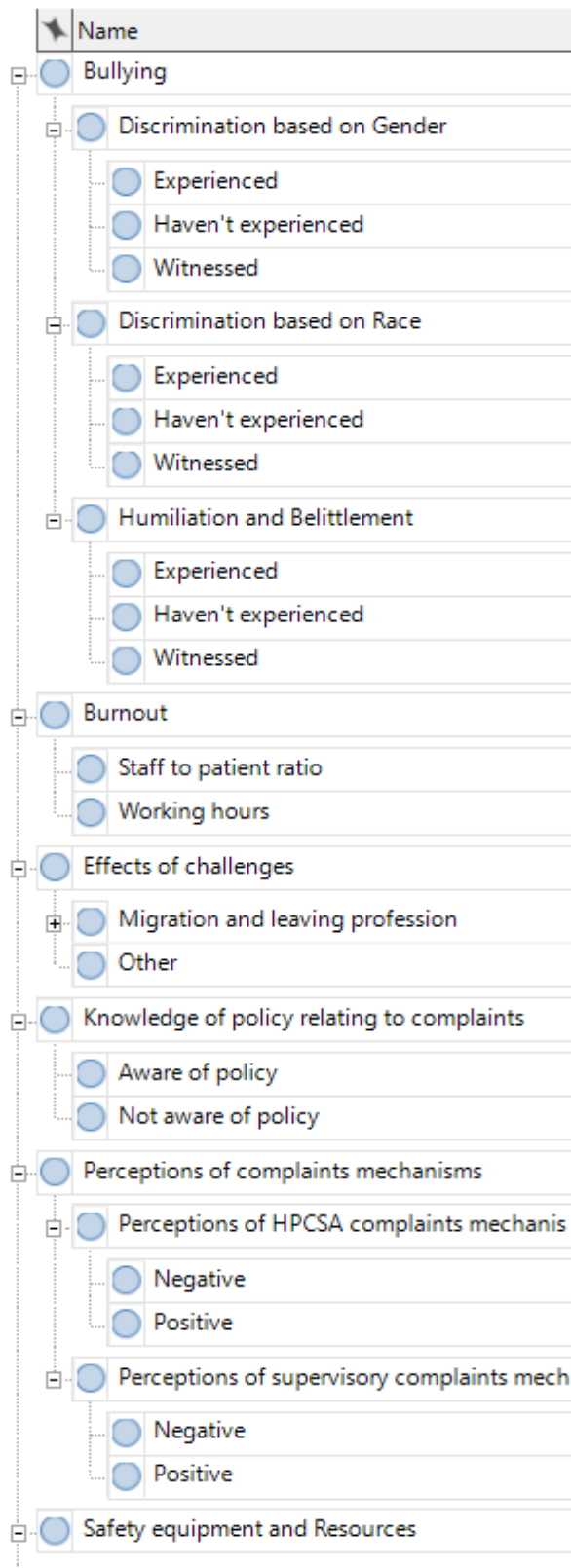
Interviewer: Thank you again! All the best going forward.

8.3 Appendix 3: Coding descriptions

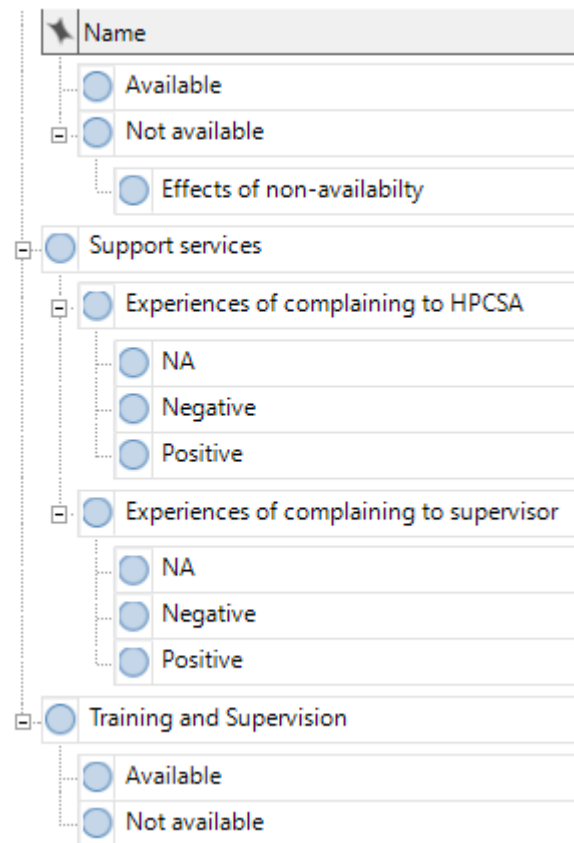
- KNOWLEDGE OF POLICIES RELATION TO COMPLAINTS: Discussions about the knowledge of complaints processes in hospitals and at the HPCSA.
- PERCEPTIONS ABOUT COMPLAINTS MECHANISMS: Discussions about how they perceive complaints mechanisms in relation to their supervisors and the HPCSA.
- TRAINING AND SUPERVISION: Discussions about the availability and quality of supervision and training by senior professionals.
- BULLYING: Discussions about accounts of experiencing bullying behaviour from senior professionals in relation to harassment / belittlement, discrimination based on race, and discrimination based on gender.
- 'BURNOUT': Discussions about working hours, and the ratio of staff to patients in hospitals and clinics.
- EXPERIENCES OF COMPLAINTS PROCESSES: Discussions about accounts of experiences of laying complaints to supervisors and / or the HPCSA.
- SAFETY EQUIPMENT AND RESOURCES: Discussions about the availability of hospital equipment relating to patient care as well as safety equipment such as TB masks.
- EFFECTS OF CHALLENGES: discussions about whether they felt these challenges meant they would migrate and / or leave the medical profession.

8.4 Appendix 4: Final Coding List

Nodes



Nodes



8.5 Appendix 5: Ethics clearance form



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24 July 2018

Confirmation of Research Ethics Approval: Wendy Petersen [SOC2018/17]

This is to confirm that Wendy's research proposal, Complaints during medical internship years? Accounts and perceptions of junior health professionals in South Africa, under the supervision of Dr J. Grossman, has been reviewed by the Sociology Department. Ms Petersen presented her proposal to the Department on 15 March 2018.

The Department is satisfied that the research carries no significant risk of harm to human subjects. We are further satisfied that appropriate informed consent and confidentiality/anonymity/data protection mechanisms are in place.

It is a condition for the acceptance of Ms Petersen's proposal that she complies consistently with strict ethical standards. This will entail proceeding only on the basis of the consistently informed consent of interviewees and will require regular monitoring of ethical issues which may emerge as the project develops.

Please contact the Department should you have any questions or concerns.

Kind regards,

A handwritten signature in black ink, appearing to read 'Lorraine Valentine'.

Lorraine Valentine