



Subjective Experiences of Working as a Healthcare Worker in South Africa: A Qualitative
Study

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Declaration

I, Daniela Sounes (607236), declare that this dissertation entitled “Subjective Experiences of Working as A Healthcare Worker in South Africa: A Qualitative Study” is my original unaided work. It has not been submitted before for any other degree or examination at this or any other university.

Signature:

A handwritten signature in blue ink, appearing to read 'Daniela Sounes', written in a cursive style.

Date: 06 September 2024

Table of Contents

Chapter 1: Introduction	6
Aims of The Study	6
Rationale.....	6
Context of This Study.....	8
<i>First Study</i>	8
Research Questions	8
Structure of the Report	9
Chapter 2: Literature Review	11
Introduction	11
Healthcare in South Africa	11
<i>Shortage of Healthcare Workers</i>	12
<i>Disparity Between Public, Private, and Provinces</i>	13
Research on South African Healthcare Workers.....	14
Healthcare Workers during COVID-19	17
Working as a Healthcare Worker in South Africa	18
Conclusion.....	21
Chapter 3: Methods	22
Theoretical Paradigm	22
Research Design and Theoretical Framework.....	22
Sampling.....	23
Sample	24
Procedure.....	26
<i>Permissions and Data Management</i>	26
<i>Survey Administration</i>	26
<i>Data Collection</i>	27
Ethical Considerations.....	28
Data Analysis	29
<i>Phase One: Familiarisation</i>	30
<i>Phase Two: Coding</i>	30
<i>Phase Three: Generating Initial Themes</i>	30
<i>Phase Four: Developing And Reviewing Themes</i>	31
<i>Phases Five: Refining, Defining and Naming Themes.</i>	31
<i>Phase Six: Writing Up the Themes</i>	32
Results Structure.....	32
<i>Pattern of Answers</i>	33
<i>Context of Quotes</i>	34
Rigor and Trustworthiness	34
<i>Credibility</i>	35
<i>Dependability</i>	35
<i>Transferability</i>	36
<i>Confirmability</i>	36
Reflexivity.....	37

Conclusion.....	39
Chapter Four - Theme One: South African Healthcare System	40
Introduction	40
Subtheme One: “The Whole System Is Broken” (3).....	40
Subtheme Two: “Being Governed by Government” (83).....	43
Subtheme Three: “Resources! We Need More” (158).....	45
Conclusion.....	48
Chapter Five - Theme Two: Working Conditions.....	50
Introduction	50
Subtheme One: “Extremely Long Hours” (143).....	50
Subtheme Two: “Admin Staff to Do Stats Instead of Doctors” (12).....	53
Subtheme Three: “I Love the Space I Work In” (122) Vs “Lack of Safety” (170)	55
Conclusion.....	56
Chapter Six - Theme Three: Psychological Conditions.....	57
Introduction	57
Subtheme One: “Being Part of A Brilliant, Dynamic Team” (6) Vs “Lazy Co-Workers Who Don't Care” (171).....	57
Subtheme Two: “The Hierarchy of Toxicity” (174)	60
Subtheme Three: “Emotionally Taxing Work” (170)	63
Conclusion.....	66
Chapter Seven - Theme Four: Purpose and Value	67
Introduction	67
Subtheme One: “Recovered Patients” (91) Vs “Death” (152)	67
Subtheme Two: “More Acknowledgment and Reward and Recognition” (40).....	70
Subtheme Three: “Research, New Patients, Unusual Diagnoses, Teaching, Publishing” (107)	73
Conclusion.....	75
Chapter Eight - Theme Five: Feeling Stuck and Trying to Cope.....	76
Introduction	76
Subtheme One: “Fear of Risk and The Unknown” (141)	76
Subtheme Two: “Self-Care” (141).....	79
Subtheme Three: “Struggling with That at The Moment” (192)	82
Conclusion.....	85
Chapter Nine - Conclusion.....	86
Introduction	86
Summary of Findings	86
Limitations.....	87
Implications for Policy and Practice	88

Future Research Directions	88
Recommendations	89
Personal Reflections	91
References	92
Appendices.....	101
Appendix A: Participant Discipline Categories	101
Appendix B: Informed Consent Form.....	102
Appendix C: Ethical Clearance for First Study.....	103
Appendix D: Ethical Clearance for Current Study.....	104
Appendix E: Participant Information Sheet	105
Appendix F: Demographic Questionnaire.....	107
Appendix G: Qualitative Questionnaire	108

Chapter 1: Introduction

Aims of The Study

This study aimed to explore the lived experiences of healthcare workers (HCWs) in South Africa by examining the complex realities of their professional lives. It sought to capture the positive and negative aspects of their roles, including the challenges they face and the moments of fulfilment they encounter. The study explored HCWs' sentiments about remaining in or leaving their current positions. It investigated how they navigate and cope with the demands and pressures of their work environments. By highlighting HCWs' personal and professional experiences, the study aimed to provide an in-depth understanding of their struggles, resilience, and coping strategies within the South African healthcare system.

Rationale

South Africa faces critical shortages of HCWs, (Bateman, 2007; Department of Health, 2020; Econex, 2015; George et al., 2012) exacerbated by psychological distress, burnout, and high turnover intention within the South African healthcare sector. Without targeted interventions to alleviate psychological distress, the ongoing attrition of South African HCWs will further compromise the standard of medical care due to the unsustainable workload pressure on those who remain (Achoki & et al, 2022; Bateman, 2007; George et al., 2012; Stodel & Stewart-Smith, 2011). The rising turnover intention rates, often seen as the end stage of severe burnout, (Bothma & Roodt, 2013; Demerouti et al., 2001; Maslach & Leiter, 1997; Petriglieri, 2011) highlight the urgent need to explore the underlying causes of distress within the healthcare sector.

Existing literature on burnout and turnover intention among South African HCWs reveals alarming prevalence rates (Naidoo et al., 2020; Peltzer et al., 2003; Rajan & Engelbrecht, 2018; Rossouw et al., 2013; Sirsawy et al., 2016; Stodel & Stewart-Smith, 2011; Zeijlemaker & Moosa, 2019). However, these studies predominantly employ quantitative methods, providing valuable statistical insights but lacking the depth needed to understand the subjective realities of those affected. The prevalence rates alone do not capture the lived experiences of HCWs, including the systemic, environmental, and interpersonal factors contributing to their psychological distress and turnover intentions. This disconnect between the numerical data and the real-world context of HCWs creates a significant gap in the literature, leaving the complex dynamics of their work environments underexplored.

Given the high percentages of burnout reported in local studies, it is critical to ask: what has become of these burned-out HCWs? Many may have left their roles or even the country, with little opportunity for follow-up outside of longitudinal studies. South African cross-sectional studies have reported the rising prevalence of turnover intention over time (Ayalew et al., 2021; Blaauw et al., 2013; George & Reardon, 2013; Sinsky et al., 2021; Van Wyk et al., 2010) the most recent being 62% (Sounes, 2022). However, these findings do not offer insight into the specific workplace conditions that may drive these intentions. This study argues for a qualitative approach to gain a deeper, more nuanced understanding of the experiences behind these statistics, as a qualitative exploration offers a unique opportunity to provide insight and ascribe meaning to the subjective experience (Creswell, 2009) of being a HCW in South Africa and provide rich and contextual insights into their challenges (Creswell, 2009).

The South African healthcare landscape is marked by significant disparities, including the uneven distribution of resources between the public and private sectors, provinces, and urban and rural settings (Achoki & et al., 2022; Econex, 2015; George et al., 2012; Sounes, 2022). These systemic factors undoubtedly influence the working conditions and psychological well-being of HCWs, yet the specific ways they manifest in daily experiences are rarely explored in depth. To date, only one (Kazadi et al., 2023) in-depth qualitative study on the subjective experience of South African HCWs has been conducted, yet it was limited within the specific context of COVID-19. Kazadi et al. (2023) used an in-depth interview method, and thus, their sample was limited to 11 participants. This highlights the urgent need for broader qualitative research that captures the experiences of HCWs in the post-pandemic era.

This study aims to address the significant gap in the literature by providing an in-depth exploration of the subjective experiences of South African HCWs. By engaging directly with the voices of South African HCWs through qualitative methods, this study seeks to contextualise their experiences within the broader healthcare system, offering insights that quantitative studies alone cannot provide. The findings will not only contribute to the literature on the experience of being a HCW in South Africa but also serve as a beneficial resource for policymakers, healthcare organisations, and government in providing understanding to inform interventions (Chemali et al., 2022) that are responsive to the real needs of those on the frontlines. In addition to providing a deeper understanding of HCWs' working conditions and psychological well-being, this study aims to act as a catalyst for

change, emphasising the urgent need for action to prevent further losses of critical skills and human resources in the healthcare sector. By highlighting the lived experiences of HCWs, this research seeks to motivate stakeholders to address the root causes of psychological distress and turnover intention, ultimately improving the sustainability and quality of healthcare in South Africa.

Context of This Study

This study was a second study based on pre-collected quantitative and qualitative data collected simultaneously from a sample of HCWs in South Africa. In the first study (Sounes, 2022), quantitative data was analysed to explore the prevalence rates of burnout and turnover intention. Results revealed that 82% of the sample of 189 HCWs in South Africa experienced moderate to high burnout, and 62% reported the intention to leave their role (Sounes, 2022). This current study focused on qualitative data collected using open-ended questions requesting a written response. These questions focused on HCWs' subjective experiences of their occupational life.

First Study

The first study (Sounes, 2022) produced concerning prevalence rates of burnout and turnover intention, which were significantly positively correlated. The South African context is unique in demographic factors, and group differences were also investigated across the factors of burnout and turnover intention. Sector, setting, and qualification were significantly associated with burnout and turnover intentions. Further analyses suggested that the main contributing factor was whether or not HCWs were based in a hospital setting, where there was a high risk for burnout. These findings paint a concerning picture for South Africa as severe burnout in HCWs impacts patient care, outcomes, and error rates. The high turnover intention due to burnout puts South Africa at risk of losing more HCWs and our healthcare system. This was supported by the quantitative finding that burnout significantly predicts turnover intention.

Research Questions

The following areas of investigation were considered when conducting the study:

1. What are the positive working experiences of healthcare workers in South Africa?
2. What are the negative working experiences of healthcare workers in South Africa?

3. What are the sentiments of healthcare workers regarding leaving or staying in their current roles?
4. How do healthcare workers navigate and manage their experience of working in healthcare in South Africa?

Structure of the Report

Chapter One – Introduction: This chapter positions this qualitative study within the broader local literature, highlighting the need for qualitative insights beyond quantitative data by emphasising the focus on the lived experiences of South African HCWs. It outlines the study's aims, rationale, and research questions.

Chapter Two – Literature Review: This chapter introduces the unique healthcare context in South Africa, emphasising the lack of generalisability of global studies to the South African context. It advocates for the exclusive use of locally produced literature, discussing the current literature on HCWs in South Africa. It also provides a detailed comparison between quantitative and qualitative methods, highlighting their strengths and limitations. Lastly, the chapter uses available literature to set the scene of working as a HCW in South Africa, and the effects their working conditions have been shown to have.

Chapter Three—Methods: This chapter describes the current study's theoretical paradigm, research design, and theoretical framework. Sampling, procedures, and data analysis are also clearly defined, including the structure of the results. Lastly, rigour and trustworthiness are explored, followed by the researcher's reflexivity.

An integrated analysis and discussion is then presented in chapters four to eight. For ease of reading, each chapter focuses on a particular theme.

Chapter Four – Theme One: South African Healthcare System: This chapter explores how HCWs perceive the healthcare system, how they experience being managed by various levels of authority, including the Department of Health and Government, and how they experience a dire lack of resources in their workplaces. The subthemes include '*The Whole System Is Broken*', '*Being Governed by Government*', and '*Resources! We Need More*'.

Chapter Five – Theme Two: Working Conditions: This chapter explores HCWs' on-the-job working conditions, including long hours, increased administration responsibilities, and perceptions of their physical workspace. The subthemes include *'Extremely Long Hours'*, *'Admin Staff to Do Stats Instead of Doctors'*, and *'I Love the Space I Work in Vs Lack Of Safety'*.

Chapter Six – Theme Three: Psychological Conditions: This chapter explores the psychological conditions of HCW's work experience. HCWs describe how their team and co-workers affect them, how they experience the bureaucratic and hierarchical nature of the healthcare system, and how the nature of their work takes a significant emotional toll on their well-being. The subthemes include *'Being Part of a Brilliant, Dynamic Team Vs Lazy Co-Workers Who Don't Care'*, *'The Hierarchy of Toxicity'*, and *'Emotionally Taxing Work'*.

Chapter Seven – Theme Four: Purpose and Value: This chapter explores the fulfilment that HCWs derive from their work through purpose and feelings of adding value. HCWs describe the effects of positive and adverse patient outcomes, how they value acknowledgement and appreciation of their work, and their perception of additional activities such as teaching and learning in the profession. The subthemes include *'Recovered Patients Vs Death'*, *'More Acknowledgement and Reward and Recognition'*, and *'Research, New Patients, Unusual Diagnoses, Teaching, And Publishing'*.

Chapter Eight – Theme Five: Feeling Stuck and Trying to Cope: This chapter explores the emotional aspect of HCWs' work experience. HCWs describe the level of agency they feel in their job, the different coping strategies they implement to cope, and the struggle some HCWs experience in implementing any coping strategy at all. The subthemes include *'Fear of Risk and The Unknown'*, *'Self-Care'*, and *'Struggling with That at The Moment'*.

Chapter Nine—Conclusion: This chapter concludes the research report with key points, including the study's limitations and future recommendations.

Chapter 2: Literature Review

Introduction

This chapter describes the unique context of South African healthcare and the factors that differentiate the healthcare system in South Africa from other countries. These factors include a shortage of HCWs nationwide and a stark disparity between the public and private sectors. Global studies lack generalisability to the South African context, and thus, relevant literature on the experiences of HCWs is presented in this study with a sole focus on locally conducted studies. A brief consideration is made for the context of research on HCWs during COVID-19 and how this has impacted the kind of literature currently available. The significant gap in qualitative studies on the experience of HCWs in South Africa is discussed alongside the larger body of quantitative studies, with their aims and limitations. Lastly, this chapter sets the scene of working as a HCW in South Africa based on available locally produced literature. Prominent aspects include the significant lack of resources, which has rippling effects on the day-to-day work of HCWs and their anger and frustration towards systemic challenges. HCWs work long hours, with little rest or reprieve, and often feel unappreciated. Their stressful working environments put them at higher risk for psychological distress and conditions, including anxiety, depression, post-traumatic stress disorder (PTSD), and burnout, as well as medical errors and compromised patient care. Lastly, it will be highlighted how current studies lack a subjective account of how HCWs experience these challenges.

Healthcare in South Africa

The healthcare system in South Africa is burdened by a lack of resources, personnel, and critical facilities (Bateman, 2007; George et al., 2012; Young, 2016), as well as the fact that a considerable portion of the population lives with serious diseases such as tuberculosis, diabetes, and human immunodeficiency virus (Cook et al., 2021; George et al., 2012). Although HCWs across the world are at risk of psychological distress due to the physically and emotionally demanding nature of healthcare (De Hert, 2020; Demerouti & Bakker, 2008; Freudenberger, 1974; Gray et al., 2019; Maslach & Leiter, 1997; Schaufeli et al., 2009), South Africa has a particularly unique context that has been shown to put HCWs at higher risk of psychological distress (Naidoo et al., 2020; van Mol et al., 2015). The healthcare system in South Africa has unique factors compared to other countries, which both influence and compound the strenuous circumstances that HCWs experience. These include a critical

shortage of HCWs, the disparity between public and private sectors, and skewed provincial, rural, and urban distributions.

Shortage of Healthcare Workers

South Africa has been declared to have a shortage of doctors, with the World Health Organisation's (WHO) statistics reporting approximately 62 doctors per 100,000 people in 2010 and 80 doctors per 100,000 people in 2021, both of which are below the WHO's estimate for middle-income countries of 180 doctors per 100 000 people, and closer to the ratio of 50 doctors per 100 000 for low-income countries (Cook et al., 2021; Econex, 2015; George et al., 2012). South Africa drastically lags behind other middle-income countries, such as Mexico and Brazil, who last reported 198 and 185 doctors per 100,000 people, respectively (Econex, 2010; George et al., 2012). The shortage of doctors in South Africa aligns with the broader trend of the African continent. The WHO reported in 2006 that 78% of African countries were experiencing a critical shortage, suggesting there should ideally be 230 doctors per 100,000 people (George et al., 2012). This shortage was particularly exacerbated in 2008 when policies changed to mandate doctors to complete two years of internship before commencing community service, and an already 31% understaffed system had to manage 74% fewer community service doctors (Bateman, 2007). A recent analysis suggests that the number of medical specialists needs to increase significantly by 2025 to keep up with demographic and epidemiological changes (Department of Health, 2020). Despite the shortage of HCWs, medical schools in South Africa cannot train more doctors, as in 2015, eight thousand students applied at WITS medical school, which only accommodated 250 first-year students (Econex, 2015). With only eight medical schools, South Africa underperforms in producing medical graduates, with only 3.7 trained doctors per 100,000 people in 2012, less than a third of 38 other countries belonging to the Organisation for Economic Co-operation and Development (OECD) (Econex, 2015). This is influenced by South Africa's policy that prohibits the private sector from training doctors and places the burden and limitation of training on public university medical schools (Econex, 2015). However, the shortage of doctors in South Africa is challenging to quantify as the number of doctors registered with the Health Professionals Council of South Africa (HPCSA) is not an accurate representation, with doctors retaining registration after retiring or emigrating (Econex, 2015) and often inaccessible to researchers due to confidentiality (Bezuidenhout et

al., 2009). Despite this difficulty, the shortage of doctors is strikingly apparent in the severe inequalities between the public and private sectors (Econex, 2015).

Disparity between Public, Private, and Provinces

A unique factor to South Africa is the differentiation between the public and private healthcare sectors, with a skewed distribution of financial and human resources favouring the private sector and the reality that the under-resourced public sector serves most of the population (Achoki & et al, 2022; Econex, 2015; George et al., 2012). The skewed distribution between public and private sectors was quantified in a review report whereby the distribution of medical specialists and general practitioners in the private sector was 86.5 and 92.5 per 100,000 people, respectively, compared to 11.4 and 25.1 per 100,000 in the public sector (Econex, 2015). This situation is exacerbated by approximately 70-80% of trained South African doctors not retained in the public sector by being absorbed into either the private sector or emigration (Bateman, 2007; Econex, 2015). This leaves South Africa's rural health care system primarily serviced by foreign-qualified and local community service doctors with a challenge in retaining a mix of skills and expertise in the public sector (Bateman, 2007; George et al., 2012). Additionally, the significant investment by the government into training medical doctors represents a sizeable potential loss with doctors emigrating or moving into the private sector (George & Reardon, 2013).

In addition to the skewed distribution between public and private sectors, a significant variation exists between provinces and rural and urban areas regarding resources and health outcomes in South Africa (Achoki & et al, 2022; Econex, 2015; George et al., 2012). The provincial discrepancy has been argued to be because of the fragmented nature of the healthcare system whereby provincial governments determine their financial health priorities (Achoki & et al, 2022). It has been found that the provinces with the most urbanisation and private sector concentration, namely the Western Cape, Gauteng, Free State and KwaZulu Natal, have a much higher count of medical specialists compared to more rural provinces, namely Eastern Cape, Limpopo, Mpumalanga, North West, and Northern Cape (Econex, 2015; George et al., 2012). This disparity shows that provinces with the highest poverty headcount report the lowest count of medical specialists (Department of Health, 2020; Econex, 2015) with continued migration from rural to urban facilities by medical doctors (Bateman, 2007; Department of Health, 2020). This provincial disparity is still currently

stark, with 2019 values of the Healthcare Access Quality Index (HAQ) reporting the highest for Western Cape and KwaZulu Natal and the lowest for Free State, Northern Cape, and Eastern Cape, with the latter four provinces also having the least improvements over time (Achoki & et al., 2022). Therefore, in the South African context, it is essential to address the shortage of doctors not only to aim to increase total numbers but also to address the disparities between public and private, provincial, and rural and urban areas (Achoki & et al., 2022; Econex, 2015). Until the shortage of doctors is adequately addressed, pressure is placed on doctors, particularly in their formative years, and this has long-term effects (Bateman, 2007). Some of these effects can be observed in the working conditions and challenges that HCWs experience. The severity of these matches the disparity between the public and private sectors.

Research on South African Healthcare Workers

With the above-described unique healthcare system in South Africa, it is important to have a focused account of the literature on the South African context, as worldwide studies lack generalisability and the complex nuances found in South African healthcare. It is noteworthy to highlight that research in the African and South African context is limited, with only 2.5% of the global sample (N= 14770) in a systematic review on compassion fatigue and burnout in HCWs from the African continent, while 70% were from Europe and North America (van Mol et al., 2015). Most studies investigating HCWs' experiences in South Africa are quantitative, focusing on analysing the prevalence of psychological or mental health conditions. These include burnout (Cook et al., 2021; Moses et al., 2024; Naidoo et al., 2020; O'Connor et al., 2022; Peltzer et al., 2003; Rajan & Engelbrecht, 2018; Rossouw et al., 2013; Sirsawy et al., 2016; Sounes, 2022; Stodel & Stewart-Smith, 2011; Van Der Merwe et al., 2023, 2023, 2023; Zeijlemaker & Moosa, 2019), anxiety (Cook et al., 2021; Naidoo et al., 2020; Pool et al., 2024, 2024; Rossouw et al., 2013), depression (Cook et al., 2021; Naidoo et al., 2020; Pillay et al., 2016; Pool et al., 2024; Rossouw et al., 2013), coping and resilience (Cook et al., 2021; Engelbrecht et al., 2021; O'Connor et al., 2022; Rossouw et al., 2013; Van Der Merwe et al., 2023) turnover and emigration (Ayalew et al., 2021; Bezuidenhout et al., 2009; Delobelle et al., 2011; George & Reardon, 2013; Sounes, 2022; Stodel & Stewart-Smith, 2011; Van Wyk et al., 2010), job satisfaction and professional quality of life (Blaauw et al., 2013; Delobelle et al., 2011; Elkonin & Van der Vyver, 2011; Jensen et al., 2022, 2022; Pillay et al., 2016; Pool et al., 2024), occupational stress or PTSD (Engelbrecht et al.,

2021; O'Connor et al., 2022; Peltzer et al., 2003), coping styles (Engelbrecht et al., 2021; Pool et al., 2024; Van Der Merwe et al., 2023), and substance use (van der Westhuizen et al., 2019).

Although these quantitative studies are beneficial, prevalence ranges are challenging to report in comparison across studies in South Africa as studies examine different constructs or utilise different measuring instruments even when investigating the same construct (Hamad et al., 2008; Rossouw et al., 2013). South African studies have used the Maslach Burnout Inventory (Naidoo et al., 2020; Peltzer et al., 2003; Rajan & Engelbrecht, 2018; Rossouw et al., 2013; Sirsawiy et al., 2016; Stodel & Stewart-Smith, 2011; Zeijlemaker & Moosa, 2019), the Oldenburg Burnout Inventory (Sounes, 2022), the Stanford Professional Fulfilment Index (O'Connor et al., 2022), the Burnout Measure – Short Version (Cook et al., 2021) and the Copenhagen Burnout Inventory (Van Der Merwe et al., 2023). The studies that used the Maslach Burnout Inventory measurement of burnout implemented different cut-off scoring methods, making comparability questionable even across the same measurement instrument. The lack of common depression measurement scales also questions comparability across local studies, which used the Hospital Anxiety and Depression Scale (Cook et al., 2021), the Patient Health Questionnaire-9 (Naidoo et al., 2020), the Zung Self-Rating Depression Scale (Pillay et al., 2016), the Beck Depression Inventory (Rossouw et al., 2013), and the Center for Epidemiologic Studies Depression Scale (CES-D) (Pool et al., 2024). More importantly, measurement instruments in quantitative studies cannot explore the lived working experience of HCWs as they are confined to the strict presence or absence of the construct under investigation. In a systematic review of the psychological impact of the pandemic on HCWs in Africa, only two of the 18 included studies were qualitative in design and were conducted in Uganda and Ghana (Mudenda et al., 2022).

Quantitative studies that have aimed to explore the more nuanced occupational life of HCWs have done so with pre-defined lists of working environment factors for participants to rank or rate (Bezuidenhout et al., 2009; George & Reardon, 2013; Naidoo et al., 2020; Rossouw et al., 2013; Van Wyk et al., 2010), losing the possibility of gaining an in-depth understanding of the experiences of the HCWs (Bidwell et al., 2014). Mixed method studies that implemented a qualitative aspect through additional interviews or open-ended questions aimed to explain or add insight only to the prevalence of the explored construct. For example, open-ended questions on personal health and support experiences were explored to add

insight into depression, anxiety and burnout (Cook et al., 2021), job roles and working environment to add insight into effort-reward imbalance (Jensen et al., 2022), working factors to explain burnout (Stodel & Stewart-Smith, 2011), and work aspects that need improvement to add insight to job satisfaction (Delobelle et al., 2011). Wagner and Pather (2019) implemented semi-structured qualitative interviews on a smaller section of their sample to add further insight into the resilience scale they initially administered.

Few qualitative studies explore the general lived experiences of HCWs in South Africa (Kazadi et al., 2023). The qualitative studies that have been conducted have aimed to explain particular psychological phenomena such as moral distress (Voget, 2017), turnover intention and migration (Bidwell et al., 2014; Fletcher-Nkile et al., 2022), work roles and resources (Ijumba, 2002; Ramukumba, 2020), patient and health professionals' experience of care (Watermeyer et al., 2020), challenges in working relationships (Mokoena et al., 2023), and perceptions of workplace learning opportunities (Erumeda et al., 2023).

The qualitative studies used semi-structured interviews or focus groups, and the questions were framed within the context of the construct under investigation. For example, interview schedules were designed based on the motives of the migration of South African HCWs (Bidwell et al., 2014) and questions such as "Please tell me the reasons that made you contemplate leaving South Africa" (Fletcher-Nkile et al., 2022) were used. Wagner and Pather, (2019, p. 3) commenced their interviews by requesting participants to reflect on the statement: "Resilience is the ability to maintain personal and professional well-being in the face of ongoing work stress and adversity" and probed further based on responses. Although these studies add qualitative understanding, they are limited to the research agenda and susceptible to response bias based on the priming of the questions.

Reported as one of the first in-depth qualitative studies in South Africa to explore the lived experiences of HCWs, Kazadi et al. (2023) found experiences to be diverse and marked by contradictions, which is unlikely to be captured in studies with focused agendas. However, they had a time period focused on COVID-19, which was constantly referred to in their interview questions, and found participants to express an emotional roller coaster during the pandemic. For Kazadi et al. (2023) to be the first in-depth qualitative study on the lived experiences of HCWs demonstrates the gap in the literature on this sample within the South African context, and more so outside of the focus of COVID-19.

With samples of HCWs, availability for participants to attend in-depth interviews is often challenging due to their work hours. Therefore, qualitative studies have had relatively small, focused samples ranging between 6 and 46 participants (Bidwell et al., 2014; Fletcher-Nkile et al., 2022; Ijumba, 2002; Kazadi et al., 2023; Ramukumba, 2020; Voget, 2017; Wagner & Pather, 2019; Watermeyer et al., 2020). Although smaller samples are more suitable for in-depth interviews, the qualitative South African samples tend to be limited in their sector, setting, and location. For example, samples have been limited to one profession, such as anaesthesiologists (Fletcher-Nkile et al., 2022), family physicians (Erumeda et al., 2023; Wagner & Pather, 2019), community HCWs (Ramukumba, 2020), nurses (Bidwell et al., 2014; Mokoena et al., 2023; Voget, 2017) or registrars (Erumeda et al., 2023). Samples were often located in one province or area (Bidwell et al., 2014; Erumeda et al., 2023; Fletcher-Nkile et al., 2022; Mokoena et al., 2023; Ramukumba, 2020; Voget, 2017; Wagner & Pather, 2019; Watermeyer et al., 2020) and only Fletcher-Nkile et al. (2022) and Kazadi et al. (2023) explicitly reported samples from both the public and private sectors. An additional limitation to samples of HCWs, both globally and locally, is the unique effect that COVID-19 had on this sample population regarding that change in their working environment and experience of increased occupational stress.

Healthcare Workers during COVID-19

The COVID-19 pandemic placed HCWs as an essential first line of defence and created unprecedented circumstances for the profession (Cook et al., 2021; Kazadi et al., 2023; Robertson et al., 2020; Shaukat et al., 2020), showing that HCWs across the world had a disproportionate risk for adverse mental health outcomes during COVID-19 (Kazadi et al., 2023). This unique event led to a global increase in media coverage and research on the psychological strain HCWs experienced during the pandemic, including anxiety, depression, distress and fear (Robertson et al., 2020; Shaukat et al., 2020). The increase in research on HCWs' experience during COVID-19 is reported by Chemali et al. (2022) who mentioned twenty-four global reviews between 2020 and 2021 and screened 3976 articles in their review. This can also be seen in a simple search on Google Scholar, whereby most studies about HCWs are specific to the context and influence of COVID-19. Although it is vital to protect the mental health of HCWs during pandemics such as COVID-19 (Cook et al., 2021; Robertson et al., 2020), this importance needs to be extended to HCWs in South Africa who work under strenuous circumstances on a 'normal day'. It is argued that the strain HCWs

experience in South Africa was a cause for concern preceding the COVID-19 pandemic, mainly due to the unique context of South Africa's healthcare system (Cook et al., 2021). Although this study aims to explore the lived experiences of HCWs in South Africa in a post-pandemic time, the recent available literature is predominantly contextual to COVID-19 and, therefore, needs to be considered. It has been argued that it is challenging to gauge whether the prevalence or severity of mental health conditions experienced by HCWs during COVID-19 was worse than usual due to the lack of longitudinal comparisons in the same samples (Robertson et al., 2020). Therefore, a more recent exploration into the lived subjective experiences of HCWs would be beneficial to understanding the current working life of HCWs in South Africa beyond the intense impact of COVID-19. However, this cannot be done without ignoring the longer-lasting effects of the pandemic on HCWs and how it may have shaped and added nuance to their subjective experiences.

Working as a Healthcare Worker in South Africa

Although the above-discussed South African studies have corresponding limitations, they produce data that paint a grim picture for South African HCWs. They support the view that the South African Healthcare system is arguably broken, with various challenges that HCWs face in their working conditions and the emotional effects of their work.

Based on the locally conducted studies, the most prominent system challenges include poor infrastructure and the lack of equipment and personnel resources, unmanageable caseloads with a high burden of patients and ineffective administrative planning processes (Bateman, 2007; Bidwell et al., 2014; Cook et al., 2021; George et al., 2012; Ijumba, 2002; Jensen et al., 2022; Naidoo et al., 2020; Robertson et al., 2020; Stodel & Stewart-Smith, 2011; Voget, 2017; Watermeyer et al., 2020), little or poor management and supervision support (Ijumba, 2002; Jensen et al., 2022; Mokoena et al., 2023; Naidoo et al., 2020), lack of infection control (Robertson et al., 2020; Young, 2016), fragile systems that provide healthcare to communities with a large range of socio-economic factors and a considerable number of the population living with HIV, TB, malnutrition, and diabetes (Cook et al., 2021; Econex, 2015; George et al., 2012; Jensen et al., 2022; Stodel & Stewart-Smith, 2011; Watermeyer et al., 2020), as well as high levels of exposure to violent incidences (Bidwell et al., 2014; Fletcher-Nkile et al., 2022; Ijumba, 2002; Jensen et al., 2022). HCWs experience frustration and helplessness at the lack of resources and system challenges they face (Fletcher-Nkile et al., 2022; Ijumba,

2002; Kazadi et al., 2023; Ramukumba, 2020), with some experiencing growing concern about the future of the healthcare system (Ijumba, 2002; Kazadi et al., 2023).

HCWs work long hours in stressful environments with inadequate equipment, have poor management, insufficient leave and vacation time, and are sleep-deprived (Bateman, 2007; Cook et al., 2021; George et al., 2012; Jensen et al., 2022; Naidoo et al., 2020; Rispel, 2015; Theron et al., 2021). The poor planning also leads to little provision for illness, with colleagues covering for fellow HCWs who are ill (George & Reardon, 2013; Stodel & Stewart-Smith, 2011). Over and above, HCWs feel a mismatch between the effort they spend and the rewards and benefits they receive (Jensen et al., 2022). Dissatisfaction with remuneration is prevalent across the literature (Bezuidenhout et al., 2009; Bidwell et al., 2014; Delobelle et al., 2011; George & Reardon, 2013; Ijumba, 2002; Mokoena et al., 2023; Peltzer et al., 2003; Ramukumba, 2020), as are feelings of underappreciation from patients and supervisors/management (Bidwell et al., 2014; Delobelle et al., 2011; Fletcher-Nkile et al., 2022; Stodel & Stewart-Smith, 2011; Voget, 2017; Wagner & Pather, 2019).

For HCWs to work under such dire circumstances, be submersed in suffering and loss daily, and not be psychologically affected is as unrealistic as expecting to “walk through water without getting wet” (Remen, 1996 as cited in Miller & Sprang, 2017, p. 153). Systemic challenges have been found to place HCWs at high risk for psychological distress and mental health conditions (Naidoo et al., 2020) including depression, anxiety, poor coping, exhaustion, insomnia, and finally, burnout. Prevalence rates have varied across South African HCW samples. For example, burnout has been reported between 36% and 100% (Cook et al., 2021; Naidoo et al., 2020; Peltzer et al., 2003; Rajan & Engelbrecht, 2018; Rossouw et al., 2013; Sirsawy et al., 2016; Stodel & Stewart-Smith, 2011; Zeijlemaker & Moosa, 2019), depression has been reported between 21.3% and 76.5% (Naidoo et al., 2020; Pillay et al., 2016; Pool et al., 2024; Rossouw et al., 2013), and anxiety has been reported between 20% and 49.5% (Cook et al., 2021; Naidoo et al., 2020; Pool et al., 2024) of South African HCW samples.

Many HCWs struggle to cope with the taxing demands of the profession and resort to various coping strategies, both adaptive and avoidant (Engelbrecht et al., 2021; Pool et al., 2024; Van Der Merwe et al., 2023), commonly including substance use (Pool et al., 2024; van der Westhuizen et al., 2019), venting (Pool et al., 2024), self-blame (Pool et al., 2024), self-

distraction (Van Der Merwe et al., 2023), positive framing and acceptance (Van Der Merwe et al., 2023), spirituality (Pillay et al., 2016), and absenteeism (Nyathi & Jooste, 2008). Sometimes, the coping strategies are insufficient, and HCWs feel the only way out is to leave their job or emigrate (Bateman, 2007; Bezuidenhout et al., 2009; Bidwell et al., 2014; Blaauw et al., 2013; George et al., 2012; George & Reardon, 2013). It has been proposed that as part of the process of burnout, people reach the point whereby the only option is to quit, and even if necessary, this decision can cause further psychological distress as people may end up walking away from a career that was once a source of pride and personal identity (Maslach & Leiter, 1997; van Mol et al., 2015). In addition to the impact of more doctors leaving the South African healthcare system, the impact of them staying while suffering is also concerning, as burnout, fatigue, emotional exhaustion, and poor concentration have been shown to have serious implications such as sub-optimal patient care, clinical errors (De Hert, 2020; Naidoo et al., 2020; Robertson et al., 2020; Voget, 2017) breaches in infection control, and increased staff infections (Robertson et al., 2020). In addition has been shown that sleep deprivation and exhaustion has a profound effect on HCWs' functional ability and increases the risk of medical errors (Samkoff & Jacques, 1991; Williamson & Feyer, 2000) and motor vehicle accidents after long shifts (Kotze et al., 2020; Mak et al., 2019). Medical errors place HCWs at risk of being sued for medical malpractice, which elicits fear in many HCWs (McQuoid-Mason, 2022; Pepper & Labuschaigne, 2011).

Although the above literature provides a factual narrative of working as a HCW in South Africa, research lacks the accounts and perceptions of HCWs subjective experiences, particularly across professions, provinces, and sectors. Understanding the lived experiences of HCWs would be beneficial to inform interventions to address their working conditions and psychological well-being and is ultimately important for all South Africans who use healthcare services.

Literature on the South African healthcare system and the experiences of HCWs has predominantly employed quantitative methods, often focusing on statistical analyses of working conditions, job satisfaction, burnout rates, and systemic inefficiencies. This quantitative focus has led to an empirical orientation in the literature, prioritising measurable outcomes over the nuanced, lived experiences of HCWs. As a result, the literature review in this study naturally leaned towards an empirical account, emphasising data-driven findings due to the lack of exploration of the rich, qualitative dimensions of HCW experiences. While

valuable for identifying trends and correlations, this creates a disconnect between the literature review and the rest of the thesis, which aims to provide a deeper, qualitative understanding of HCWs' personal narratives and contextual factors. This disjointedness further reflects the broader gap in the literature, where qualitative insights into HCWs' emotional, psychological, and workplace dynamics are underrepresented. The reliance on quantitative research often overlooks the complexities of the healthcare environment that can only be captured through qualitative approaches, highlighting the need for studies like this to bridge that gap and offer a more comprehensive understanding of HCWs' challenges and experiences.

Conclusion

In conclusion, this chapter provided an in-depth exploration of the distinct landscape of South African healthcare, highlighting the unique challenges that set it apart from other countries. The pervasive shortage of HCWs and the pronounced divide between the public and private sectors underscore the complexities within the system. The review of locally focused studies shed light on the specific experiences of HCWs in South Africa. The impact of the COVID-19 pandemic on the available literature was acknowledged, revealing the evolving nature of research priorities. By examining the qualitative and quantitative studies, this chapter has demonstrated the stark realities of HCWs, including the severe resource shortages and the resultant stress and frustration. The discussion has also addressed the profound psychological toll on HCWs, who frequently experience anxiety, depression, PTSD, and burnout, all of which can lead to medical errors and diminished patient care. Ultimately, this chapter emphasised the need for more subjective narratives to truly capture the lived experiences of HCWs in South Africa, paving the way for future research that can better inform policy and practice to support our essential HCWs.

Chapter 3: Methods

Introduction

This section outlines the ontological, epistemological, and research approaches that formed the foundation of this research design. This study used the theoretical paradigm of critical realism and the theoretical framework of phenomenology as an approach under contextualism. This chapter demonstrates not only how these paradigms and approaches align but also how they motivate the suitability of Reflexive Thematic Analysis as the method of data analysis. This qualitative research design is described in terms of sampling, procedure, and ethical considerations. The six steps of Reflexive Thematic Analysis taken in this study are described, followed by a detailed account of the rigour, trustworthiness and reflexivity ensured in this research study process.

Theoretical Paradigm

Critical realism was this study's theoretical paradigm and ontological belief, whereby knowledge is believed to be fallible and should be based on the best evidence available (Ryan, 2019). Critical realism asserts that each person has an individual perspective of reality mediated by language and culture, and we cannot proclaim knowledge with certainty when studying human behaviour (Bhaskar, 2008; Braun & Clarke, 2022; Ryan, 2019). The quantitative data of the first study (Sounes, 2022) provided prevalence rates as a view into the 'objective reality' of the experience of HCWs. In contrast, this qualitative study aimed to explore their lived reality by analysing different subjective perspectives and possibilities. Critical realism combines ontological realism with epistemological relativism, whereby the truth is present but impossible to access directly, and human experiences give rise to perspectival and contextual truths (Braun & Clarke, 2022). Critical realism aims to assist in explaining social events and provides insight for policy change and recommendations addressing social problems (Fletcher, 2017). This study aimed to explore the subjective experience of being a HCW to inform how interventions can be designed and implemented. Critical realism has also been recently argued to be the appropriate paradigm for qualitative analysis, particularly Reflexive Thematic Analysis (Braun & Clarke, 2022).

Research Design and Theoretical Framework

This study followed a qualitative research design within an exploratory, descriptive phenomenological framework to provide insight into the subjective experiences of a specific

sample population (Braun & Clarke, 2022; Willig, 2013), namely HCWs in South Africa. The aim of this research study, within the descriptive phenomenological framework, was to explore as closely as possible the participants' experience and ways of looking at the world through their eyes by extracting the experiential quality of working as a HCW as presented by the participants (Willig, 2013). This study aligned itself with the argument by Braun and Clarke (2022) that phenomenology should be considered a contextualist epistemological approach as the subjective experience created by a human is contextually situated, partial and perspectival. This is important as the contextualist approach assumes the researcher's values and practices as influential in shaping the knowledge that is produced and that the researcher and participant are co-producing meaning (Braun & Clarke, 2022). Therefore, this study used Reflexive Thematic Analysis as the method of data analysis focusing on text and meaning (Braun & Clarke, 2022), which is additionally most suitable for the data collected via open-ended questionnaires.

Sampling

The study's target population was HCWs practising in South Africa, including professionals providing direct and front-line services across all disciplines. Therefore, purposive sampling was used to select participants based on the aims of this research. The exclusion criteria were professions outside the human healthcare services, administration-based roles, and medical students below their 4th year of medical school. Students below their 4th year of medical school were excluded from the target population due to their lack of experience working in a healthcare environment, as their experience is mainly limited to the theoretical aspects of university lectures and practicals. Inclusionary criteria were HCWs practising in South Africa, regardless of their nationality or discipline. Non-South African citizens were included in the target population as the South African healthcare system includes many foreign doctors completing their community service (Bateman, 2007) who have valuable experiences to share. This study's target population did not exclude any discipline, as this study explores experiences of working in healthcare in a broader South African context. Many previously conducted studies on HCWs in South Africa limited their sample to one discipline, thereby limiting their findings to a specific sample within a smaller context. This contrasts with the multidisciplinary collaboration that occurs in many healthcare settings. This study aimed to capture the experiences of HCWs within their nuanced context of interacting and working with colleagues across disciplines and levels of experience. The study used non-probability

and convenience sampling as the sample comprised individuals who were available and willing to participate; therefore, it does not necessarily represent all HCWs in South Africa (Creswell & Plano Clark, 2018; Rosenthal & Rosnow, 2008). The study aimed to achieve maximum variation sampling across demographic factors by gaining a large sample to cover the spectrum of positions and perspectives concerning the phenomenon under investigation. Therefore, convenience and snowball sampling were utilised by encouraging participants to share the survey with colleagues on the concluding page of the survey.

The survey was shared via a generic message with a link on public digital media platforms, such as Facebook, LinkedIn, and through the University of the Witwatersrand's registrar for medical school students in their 4th year and above of training. Facebook groups were chosen initially by a search method on Facebook for groups that included HCWs, doctors, allied professionals, and South Africa in their group name. The survey invitation was shared on the open-access groups, and closed groups were accessed via the group administrators requesting permission to share the survey invitation. Final Facebook groups that the research participation information was shared on included "Doctors South Africa" with 4 800 members, "SA Doctors United" with 13 900 members, "Medical Internship South Africa" with 16 300 members, and "Allied Health in South Africa" with 11 900 members.

The University of the Witwatersrand's registrar disseminated the study participant invitation to 7406 students, including registrars. Additionally, the researcher recruited participants through an informal HCWs network group on WhatsApp, that they were involved with. This informal group was formed during the pandemic to offer HCWs across South Africa and disciplines a virtual space to debrief and share their challenges. The group organically grew and now takes the form of a combination of webinar series with guest speakers aimed at sharing their experiences and learnings from working in healthcare and smaller sessions with supportive debriefing for HCWs. At the time of the participant recruitment, 156 participants from this informal group were invited to participate.

Sample

After data cleaning, the final sample of the study consisted of 177 HCWs across eight of the nine provinces of South Africa. The participants ranged between 21 and 75 years old, most in their mid-thirties ($M = 37.03$, $SD = 10.836$). The sample consisted of mostly females (81%),

with a majority of White (50.8%) and Black (19.8%) participants. Participants were primarily in Gauteng (57.6%) and the Western Cape (19.8%). The length of professional experience ranged between 0.5 and 57.50 years, with most participants having approximately 13 years of experience ($M = 13.46$, $SD = 11.49$). Most participants were currently working in the public sector (65.6%) and in a hospital setting (50.3%) compared to a non-hospital setting (34.5%). The discipline areas across the sample included musculoskeletal, critical, surgery, medical science, occupational therapy, general, paediatrics, student, mental health, and public health. These categories were coded based on sub-area classifications provided in participant responses ([See Appendix A](#)).

Table 1
Descriptive Statistics of Sample

Demographic Factor	n		Frequency	Percentage	Age (M)	Career Length (M)
Gender	176	Male	31	17.5	36.81	13.07
		Female	144	81.4	37.50	13.18
		Other	1	0.6	27.00	3.00
Race	177	Asian	3	1.7	44.33	19.67
		Black	35	19.8	35.09	10.57
		Coloured	21	11.9	36.00	11.61
		Indian	25	14.1	36.64	13.06
		White	90	50.8	37.92	15.07
		Other	3	1.7	36.33	9.33
Province	176	Eastern Cape	15	8.5	31.47	7.12
		Free State	2	1.1	53.00	32.50
		Gauteng	102	57.6	35.04	11.25
		KwaZulu Natal	12	6.8	34.42	10.40
		Limpopo	5	2.8	38.80	12.72
		North-West	4	2.3	37.25	13.25
		Northern Cape	1	0.6	34	14.00
		Western Cape	35	19.8	45.03	22.60
		Mpumalanga	0	0	0	0
Sector	177	Public	116	65.5	35.04	11.02
		Private	61	34.5	40.83	18.16

Setting	150	Hospital	89	50.3	33.72	9.34
		Non-Hospital	61	34.5	40.85	18.02
Qualification	166	In Training	30	16.9	28.60	5.29
		Qualified	136	76.8	39.98	15.32
Discipline	176	Musculoskeletal	12	6.8	29.67	6.80
		Critical	20	11.3	36.25	11.25
		Surgery	8	4.5	36.75	11.85
		Medical Science	8	4.5	39.63	17.13
		Occupational Therapy	19	10.7	33.42	11.16
		General	20	11.3	40.95	18.04
		Paediatrics	38	21.5	41.46	17.30
		Student	21	11.9	27.00	3.96
		Mental Health	20	11.3	35.90	9.45
		Public Health	10	5.6	53.67	33.10

Procedure

Permissions and Data Management

The data analysed in this study was collected by the same researcher in a previous study (Sounes, 2022), during which participants gave informed consent for their data to be used in future studies ([See Appendix B](#)). Ethical clearance for the original data collection was granted by the Human Research Ethics (non-medical) Committee at the University of the Witwatersrand (Protocol Number MAPSYC-22-11) ([See Appendix C](#)). Subsequent ethical clearance was granted to analyse the data for this study by the Human Research Ethics (non-medical) Committee at the University of the Witwatersrand (Protocol Number MAPSYC-22-11) ([See Appendix D](#)). The collected data was stored on the researcher's password-protected computer. This data will be stored in the researcher's personal collection following the analysis of this study, as participants received permission for the original data to be used in future studies conducted by the researcher.

Survey Administration

The data was collected in a single self-administered online survey with the Google Forms platform. The survey consisted of a participant information sheet as the landing page ([See Appendix E](#)), including the study information, researcher details, and distress protocols. The online self-administered survey was employed to accommodate the target population, as healthcare professionals often have varying and long hours and may have little time and

capacity for face-to-face interviews. The online survey allowed participants to participate at their most convenient time and location. This was motivated by the aim to gather data from as large a sample as possible. The survey was live and accepted responses for three months, from the 8th of August 2022 to the 8th of October 2022.

Data Collection

The online survey included both a demographic, quantitative, and qualitative questionnaire. The demographic factors were age, gender, race, province, years of practice, area of discipline, and sector of employment, public or private. The demographic data was collected via closed-ended multiple-choice questions, except for age, career length, and area of discipline, which was collected via an open-ended free text question to allow for more detail and range of responses ([See Appendix E](#)). The quantitative section included the Oldenburg Burnout Inventory (OLBI) and the Turnover Intention Scale (TIS) analysed in the first study (Sounes, 2022). The qualitative data was collected through open-ended free text block questions without word or character limits ([See Appendix G](#)). The questions were designed to collect information and contextually frame insights by asking about the participants' experiences working as a HCW. The questionnaire used two differently worded questions to explore each area under investigation to gain more nuanced insight and to reduce the limitations of online text-based data collection methods. The four areas under investigation were the positive working experiences, the negative working experiences, the sentiments of leaving or staying in their role and navigating and managing the experience of being a HCW in South Africa. The questions were derived by excluding words and constructs that are commonly investigated in HCWs (such as burnout, anxiety, or depression) to mitigate priming and to encourage HCWs to refer to their working lives holistically. This consideration was also made to the wording of the participant information sheet and framing of the study invitation. Although the complete survey included the OLBI and TIS, the terms burnout or turnover intention were excluded from any participant information. To explore holistic experiences, positive and negative experiences were questioned, how participants navigated their experience through coping skills and what structures they felt they would benefit from. The four areas entail the below corresponding survey questions:

1. Positive working experiences of healthcare workers in South Africa.
 - a. What aspects of your work bring you joy and fulfilment?

- b. What would you keep the same about your work?
2. Negative working experiences of healthcare workers in South Africa.
 - a. What aspects of your work bring you distress and frustration?
 - b. What would you change about your work?
3. Sentiments of healthcare workers regarding leaving or staying in their current role.
 - a. What reasons keep you in your current role?
 - b. What reasons would make you consider leaving/changing your current role?
4. Navigating and managing the experience of working in healthcare in South Africa.
 - a. How do you deal with distress caused by your work?
 - b. What kind of support structures would you like to see more of in your work?

Ethical Considerations

The initial study used informed, voluntary participation and informed consent via a digital tick box and submission function on the online survey platform. The informed consent form was presented following the participation information sheet, and participants could only proceed with the survey with informed consent being selected. The aim of the research study was positioned to participants as an investigation into HCWs' current state of mind. Participants were informed of their autonomy to withdraw during the survey on the landing page, and no questions were compulsory besides the informed consent tick box. This was ensured by allowing participants to move freely between the online survey pages with no restrictions on blank responses imposed. Confidentiality and anonymity were practised via the survey administration as no identifying personal information was collected nor asked for besides the demographic questions.

Due to the phenomenon under study, it was recognised that participants may already be in psychological distress before completing the survey. Should any participants have felt overwhelmed or psychologically triggered by the content of the survey, resources were provided for accessible mental health counselling specific to HCWs. Front-end distress protocols were followed, and the list of resources was displayed on the survey landing information page. The resources provided included:

1. The Healthcare Workers Care Network which includes 24-hour healthcare workers care network helpline (0800 21 21 21 or SMS 43001), monthly support group

sessions, and online mental health resources.

<https://www.healthcareworkerscarenetwork.org.za>

2. SADAG's 24-hour helpline 0800 456 789
3. SADAG's 24-hour suicide crisis helpline 0800 567 567
4. National Medical Frontliners Counselling 24-hour Hotline WhatsApp: 079 513 7015

Data Analysis

Responses to the survey were exported from the Google Forms platform into Excel format and saved onto a password-protected folder on the researcher's hardware device. As the survey was conducted anonymously, each participant was allocated a case number for report identification during data export. These case numbers were used to reference quotes in the results chapter.

Reflexive Thematic Analysis was used to analyse the qualitative data to develop, analyse, and interpret patterns of meaning (Braun & Clarke, 2022). Although Braun and Clarke (2006) noted that thematic analysis has theoretical freedom, their more recent revision has argued that Reflexive Thematic Analysis is best aligned with the critical realist paradigm and the phenomenological contextualism approach, with the acknowledgement that the role of the researcher as subjective and reflexive is an asset (Braun & Clarke, 2022). In line with the paradigm of this study, namely critical realism, Braun and Clarke (2022) position Reflexive Thematic Analysis as providing access to interpreted realities that are situated and not decontextualised truths, which therefore encourages a more subjective view of analysis.

This study followed the six phases of Reflexive Thematic Analysis developed by Braun and Clarke (2006, 2022). These phases include familiarising oneself with the data, coding, generating initial themes, developing and reviewing themes, refining, defining, naming, and writing up the themes. These six phases are described below based on Braun and Clarke's (2022) most recent detailed revision of Reflexive Thematic Analysis. This data analysis method aimed to provide a rich and detailed yet complex data account. It was suitable as this research aimed to add a deeper and more nuanced understanding of the subjective experiences and range of perspectives of the sample. As highlighted by Braun and Clarke (2006, 2022), a reiterative process occurs between the phases of Reflexive Thematic Analysis, which was apparent in this analysis and outlined below.

Phase One: Familiarisation

During the first phase, the researcher read and re-read the data as a form of immersion to develop a deep and intimate knowledge of the data set. During familiarisation, the researcher's main goal was to try to make meaning of the world presented by the data (Braun & Clarke, 2022). Due to the large sample, familiarisation was done within each question's responses to allow for a critical engagement facilitated by informal notetaking. This phase was necessary as the data was not collected through direct interaction with participants, nor was prior familiarity with the data developed. Therefore, this phase was conducted over a lengthy period.

Phase Two: Coding

After familiarisation, initial codes were developed by reviewing each data segment under each survey question and attributing codes to parts of the data. The codes during this phase were plentiful and detailed. The coding was conducted by one person, the researcher, which has been described as good practice for Reflexive Thematic Analysis by Braun and Clarke (2022). An inductive approach was taken to provide a rich account of the data, whereby patterns were extracted from the data in a reiterative bottom-up process (Braun & Clarke, 2006, 2022; Creswell, 2009). This bottom-up process was particularly evident during the coding phase, whereby code labelling occurred at various levels, including data's semantic and latent meaning, to compile clusters of shared meaning (Braun & Clarke, 2022). Due to the aim of exploring the participants' experiences, this inductive approach was most suitable.

Phase Three: Generating Initial Themes

Once codes were created, they were organised into potential themes. This was done by grouping codes that shared an idea, meaning or pattern. Braun and Clarke (2022) differentiate between a topic summary and a theme, whereby in this study, a topic summary was one of the four main areas under which the research questions were categorised. Namely the positive working experiences, the negative working experiences, the sentiments of leaving or staying in their role, and navigating and managing the experience of being a HCW in South Africa. The initial themes were created under each topic summary; however, it was noted that repeated codes were evident across many topic summaries. This method produced a factor-based theme structure rather than nuanced experiences of the sample.

After consulting peer supervision, the researcher returned to Phase One and re-coded the data across all topic summaries and survey questions. After re-coding the data, they were clustered into potentially connected codes referred to as candidate themes. The researcher constructed Potential candidate themes as broader shared meanings when reviewed in relation to the entire dataset. “Radical revision” sometimes occurred whereby themes were potentially discarded, collapsed or split (Braun & Clarke, 2022, p. 35). Generating the themes from the data was indicative of bottom-up inductive analysis, whereby the analysis was data-driven (Braun & Clarke, 2006, 2022). As constructed by the researcher, this active process was informed by the data set, the research questions, and the researcher’s own knowledge and insights, (Braun & Clarke, 2022) highlighting the subjectivity in Reflexive Thematic Analysis.

Phase Four: Developing And Reviewing Themes

The candidate themes were reviewed for coherence across the data and built around a singular central idea. The goal of this phase was to ensure that themes were distinct and did not merge into each other but rather weave together to tell the overall story that addresses the research questions (Braun & Clarke, 2022). This was a recursive process whereby each theme was reviewed against all the coded data clustered into the theme. The guiding reflective stance during this phase was whether the pattern was a viable theme as it had an “identifiable central organising concept as well as different manifestations of that idea” (Braun & Clarke, 2022, p. 98).

Phases Five: Refining, Defining and Naming Themes.

This phase focused on refining the themes and determining the structure and flow of the analysis. This included writing a definition of each theme as part of the reviewing process. Significant quotes were allocated to each theme and the themes were then named with the goal of signalling their meaning and analytic direction. As suggested by Braun and Clarke (2022), one-word theme names were avoided in order to capture the patterning of meaning within the themes. In vivo sub-theme names were used to capture a more nuanced account of the data.

Phase Six: Writing Up the Themes

This was included as the final step of analysis as Braun and Clarke (2022) strongly argue that writing the final analysis provides an opportunity for refinement during which significant changes may still occur. Initially, six themes were present and structured into sub-themes. Refinement included splitting one theme across others to have five themes in total, each with three subthemes. The writing during this phase focused on finessing and finalising the themes for an audience, changing from a causal and informal approach to a more formal and structured one. During this phase, quotes were also edited to include segments appropriate to the sub-theme, and ellipses were used to indicate the segmented nature of the quote. The quotes were edited to reduce spelling errors, which were common across the free-text responses of the data, only when there was clarity on what the misspelt word represented. Hospital or institution names were replaced with the [bracketed] type of institution mentioned to ensure the confidentiality of both participants and institutions.

Results Structure

The results adhere to a thematic organisation, whereby each chapter is dedicated to a distinct theme. Each chapter presents the empirical results obtained through the thematic data analysis technique, integrating discussion to facilitate a holistic interpretation of the findings in relation to existing literature.

The results comprise five main themes, each with three sub-themes, as outlined below in Table 4.1. The data was analysed across all survey questions, and the main themes centred around HCWs' perception of the *South African Healthcare System*, how they experience both the *Working Conditions* and the *Psychological Conditions* of their profession, what *Purpose and Value* they derive from their work, and lastly their experience of *Feeling of Stuck and Trying to Cope* with all the stressors of their work.

Table 4.1*Outline of Themes and Sub-Themes*

Theme	Sub-Themes
Theme One: The South African Healthcare System	1. The Whole System Is Broken 2. Being Governed by Government 3. Resources! We Need More
Theme Two: Working Conditions	1. Extremely Long Hours 2. The Admin and Stats We're Expected to Do 3. I Love the Space Vs Lack of Safety
Theme Three: Psychological Conditions	1. Brilliant Team Vs Co-Workers Who Don't Care 2. The Hierarchy of Toxicity 3. Emotionally Taxing Work
Theme Four: Purpose and Value	1. Recovered Patients Vs Death 2. More Acknowledgement and Reward and Recognition 3. Research, New Patients, Unusual Diagnoses, Teaching, Publishing
Theme Five: Feeling Stuck and Trying to Cope	1. Fear of Risk and the Unknown 2. Self-Care 3. Struggling With That at The Moment

Pattern of Answers

The online survey permitted participants to submit without answering every question. This demonstrated two interesting patterns across the whole data set and between questions. The first pattern was the response of 'all or nothing' answers. Answers of this nature were short and abrupt words such as "everything" or "nothing/none". Although semantically opposite, both answers demonstrate a more general response without providing specific details. This may suggest a participant's hesitancy to share their thoughts openly or to avoid more in-depth reflection. Alternatively, some individuals may naturally express themselves in more extreme terms, emphasising positive or negative sentiments without much middle ground. The second pattern was leaving answers blank or responding with "I don't know". This could suggest avoidance of the question or express ambivalence. Participants possibly used this response when feeling uncomfortable, unsure about sharing their thoughts or lacking confidence in their ability to articulate their experiences. Some participants may generally find it challenging to articulate their thoughts or feelings, especially if the question requires self-reflection or the expression of subjective experiences.

The 'all or nothing' and 'blank/I don't know' responses were most apparent across three questions, namely "What would you keep the same about your work?", "What would you

change about your work?” and “What kind of support structures would you like to see more of in your work?”. Both response types may suggest the experience of cognitive load or overwhelm when faced with a particularly challenging question. These questions required participants to reflect on positive aspects of their work or ways that might make their work a more positive experience, and the prevalence of these responses suggests this reflection was particularly more challenging for HCWs.

Context of Quotes

While deriving themes across the entire dataset, it became apparent that some quotes may seem out of context when viewed in isolation. Therefore, a [bracketed] phrase from the corresponding question the quote was responding to was chosen to enhance clarity and ensure a contextual understanding of the quotes used. The survey questions and corresponding phrases can be seen below in Table 4.2. This contextual integration aimed to provide a more nuanced and precise interpretation of the data.

Table 4.2

Survey Questions with Corresponding [Bracketed] Phrases for Quote Context

Survey Question	[Phrase]
What aspects of your work bring you joy and fulfilment?	Brings joy
What would you keep the same about your work?	Would Keep
What aspects of your work bring you distress and frustration?	Brings Distress
What would you change about your work?	Would Change
What reasons keep you in your current role?	Would Stay
What reasons would make you consider leaving/changing your current role?	Would Leave
How do you deal with distress caused by your work?	To Deal
What kind of support structures would you like to see more of in your work?	Would Like

Rigor and Trustworthiness

In line with critical realism, qualitative research does not claim to produce knowledge of absolute truth but aims to achieve trustworthiness (Creswell & Plano Clark, 2018).

Trustworthiness has been employed in qualitative research to ensure rigour and demonstrate a legitimate research process by satisfying the criteria of credibility, dependability, transferability, and confirmability (Breakwell et al., 2012; Nowell et al., 2017; Shenton, 2004; Tobin & Begley, 2004). Each of the four criteria is discussed below, along with the strategies which were used in this study to ensure satisfaction of the criteria were achieved.

Credibility

Credibility refers to the fit between the participants' views and the researcher's representation of them and how congruent the findings are with reality (Nowell et al., 2017; Shenton, 2004; Tobin & Begley, 2004). The researcher established an early familiarity and prolonged engagement with the context of the participants before data collection (Shenton, 2004; Tobin & Begley, 2004) through the researcher's involvement with the facilitation of groups with the target sample. This allowed the researcher to gain a more immersive understanding of the context under study before data collection and analysis. A form of triangulation to ensure credibility employed in this study was to include a wide range of participants across different sites and areas to allow recognition of multiple realities (Shenton, 2004; Tobin & Begley, 2004). This study analysed 177 responses across South Africa in various healthcare organisations which allowed rich and comprehensive accounts of viewpoints and experiences of HCWs in South Africa to be explored based on the contributions of a large range of participants (Shenton, 2004; Tobin & Begley, 2004). Tactics to ensure honesty from the participants included an anonymous form of data collection, the ability to withdraw from participation at any point, and a clear independent researcher stance to limit candid responses out of fear of managers or organisations having access to their responses (Shenton, 2004).

Supervisor debriefing sessions were used as an external check and sounding board of the research process and data analysis, as well as peer scrutiny through presentations and peer review of the research proposal (Shenton, 2004; Tobin & Begley, 2004). Patton (1990, as cited in Shenton, 2004) argued that the researcher's background, experience, and qualifications are particularly important in qualitative research as they are the main instruments of data analysis. The researcher of this study has had experience, not only with the target sample but also in psychological research through undertaking two master of arts degrees in neurocognitive psychology and clinical psychology. An examination of previous research findings on the experiences of HCWs was conducted not only to set the scene for the research study but also to demonstrate congruency with the previous findings (Shenton, 2004).

Dependability

Dependability refers to ensuring the research process is logical, traceable and well-documented (Nowell et al., 2017; Tobin & Begley, 2004). It has been argued that credibility

and dependability are closely linked and that a demonstration of the former impacts the insurance of the latter (Lincoln & Guba, 1985 as cited in Shenton, 2004). A detailed research process was provided in this study as well as the rationale for methodological choices (Shenton, 2004). An audit trail (Nowell et al., 2017; Tobin & Begley, 2004) was kept by the researcher including the raw data, coding reiterations, and a reflexive journal as elaborated below under reflexivity. The details of the research design and implementation, the operational detail of data collection, as well as the evaluation of the effectiveness of the process of inquiry have been provided (Shenton, 2004) in this methods chapter. These detailed accounts allows for the reader to assess the employment of proper research practices (Shenton, 2004; Tobin & Begley, 2004) and for the study to be repeated by another researcher, if not necessarily to gain the same results (Shenton, 2004).

Transferability

Qualitative findings are often impossible to be applicable to other situations and populations due to the contextual factors of the sample (Shenton, 2004). Therefore, transferability refers to the ability of other researchers to replicate the study methods with a focus on generalisability of inquiry rather than results as there is no single correct or true interpretation of qualitative data (Nowell et al., 2017; Tobin & Begley, 2004). Transferability was ensured by providing a detailed account of the research process and detailed contextual information of the sample that would allow the study to be replicated with another sample, if desired (Shenton, 2004).

Confirmability

Confirmability refers to the establishment that the researcher's findings are based on and derived from the actual data and participants and not figments of the researchers imagination or their preferences (Nowell et al., 2017; Shenton, 2004; Tobin & Begley, 2004). This requires a demonstration of how conclusions and interpretations were reached (Tobin & Begley, 2004). Confirmability has been claimed to be reached when credibility, transferability and dependability have all been achieved (Guba & Lincoln (1989) as cited in Nowell et al., 2017) which has been demonstrated above. The use of Reflexive Thematic Analysis has been argued to be a rigorous process by (Braun & Clarke, 2022) as coding ensures a systematic engagement with meaning and patterning across the entire data set, therefore, theme development is based on a robust and detailed interrogation of the data. This

aids in minimising the selecting of patterns to fit pre-determined ideas about what meanings are evident through poor analytic practice or partial data engagement (Braun & Clarke, 2022). Additionally, results have included direct quotes from the data to show how the data eventually led to the processing and formation of the results (Shenton, 2004).

Reflexivity

Reflexivity refers to the researcher critically presenting how their personal assumptions and design choices shape the research process and knowledge that they produce (Braun & Clarke, 2022; Breakwell et al., 2012; Olmos-Vega et al., 2023). This requires the researcher to include their internal and external dialogue (Nowell et al., 2017; Tobin & Begley, 2004) as a set of continuous, collaborative and multifaceted practices of self-conscious critique, appraisal and evaluation (Olmos-Vega et al., 2023). Qualitative researchers use reflexivity to account for how their subjectivity shapes their inquiry, and accounts for how the significance of the researcher's personal, interpersonal, methodological and contextual factors intertwine to bring the research to life (Olmos-Vega et al., 2023). Due to the subjective nature of Reflexive Thematic Analysis, reflexivity is an essential aspect of trustworthiness as it limits the likelihood of developing poor quality analysis as the engagement with data can never be purely inductive, as who we are as researchers always shapes what we notice about our data (Braun & Clarke, 2022). Poor quality analysis would result in fitting the data to pre-existing ideas or shallow interpretation, and forcing oneself to interrogate how one is making sense of the data limits this occurrence (Braun & Clarke, 2022). Reflexivity was established in this study through personal reflections, by keeping a research journal throughout the research process and acknowledging my personal interest and motivation for the research topic within the target sample population. These reflections are described below within the categories of personal, interpersonal, methodological, and contextual reflexivity (Olmos-Vega et al., 2023; Walsh, 2003).

Personal reflexivity is focused on the researcher and their unique perspectives, attitudes and expectations that shape the research (Olmos-Vega et al., 2023; Walsh, 2003). As the primary researcher, I first became interested in HCWs when I facilitated an online support group for HCWs in South Africa during the COVID-19 pandemic. What emerged from this group was how HCWs in South Africa were struggling to manage their working conditions prior to COVID-19 and many of them were experiencing psychological distress. Many HCWs

expressed how their concerns were not taken seriously or that they lacked constructive channels to voice them. My initial motivation to conduct this study was ignited to advocate for HCWs. Prior to familiarising myself with the data, I journaled my expectations of responses based on my experience with HCWs in the support groups, and this was done to reflect on biases and pre-conceptions I might have before analysing the data. This included topics of toxic hierarchies, training through humiliation, lack of psychological support or debriefing, a high level of workplace dissatisfaction, and lack of resources and administrative and manageable support. Additionally, topics of team comradery and support, family and friend support, and resilience emerged through the support groups. I considered my disciplinary training as a Clinical Psychologist and reflected upon how that might constrain or limit my sense-making of the data. I was also aware of how making meaning of data occurs at the intersection of the researcher, the data, and the data contexts and not that the meaning of the data was already there, waiting to be discovered (Braun & Clarke, 2022).

Interpersonal reflexivity is concerned with the relationship and dynamics between the researcher and participants and how they influence the research and participants (Olmos-Vega et al., 2023; Walsh, 2003). Due to my interpersonal relationship with various HCWs through my work, I had a wide network of participants to recruit. However, a power dynamic of support group facilitator and participant had already been established whereby many distressing topics were at the forefront of conversations. To mitigate participants from feeling obliged to participate, online survey invitations were circulated through communication channels but not mentioned in the support group sessions. Although it is hypothesised that having a prior trusting relationship with support group members would elicit psychological safety in providing honest accounts of their experience, some participants may have declined participation in fear of their demographic details being too revealing of their identity. However, the support group was a significantly small percentage of the overall sampling group to whom the invitation to participate was shared, and therefore not assumed to be particularly impactful to the overall sample. Additionally, to mitigate any dynamics from influencing the research process, an anonymous online survey method was chosen.

Methodological reflexivity acknowledges the research approach and how one makes methodological decisions along with their implications (Olmos-Vega et al., 2023; Walsh, 2003). In addition to the rationales provided throughout this methods chapter, I was also aware of the context of this study and how that might influence the analysis. The quantitative

data was analysed and reported first in the initial study (Soune, 2022), and I was cautious not to make meaning of the qualitative data through the lens of the quantitative results. I took the precaution of completing the quantitative and qualitative analyses one year apart, which assisted in not being immersed in both sets of data simultaneously, and analysed them in an isolated time frame.

Contextual reflexivity is concerned with situating a study within a given cultural and historical context and how these aspects may influence the research and participants (Olmos-Vega et al., 2023; Walsh, 2003). The study was conducted in South Africa where a contextually different healthcare system operates compared to other countries, particularly compared to other global studies conducted on HCWs. I made an effort to explore and research systemic and political factors of our healthcare system prior to data collection to gain a better contextual understanding of the environment my participants are immersed in. Additionally, the data was collected only recently proceeding the last significant wave of the COVID-19 pandemic in South Africa, and many HCWs may have still been psychologically recovering when responding.

Conclusion

This methods chapter detailed how the research study was conducted with rationales for methodological decisions. The ontological, epistemological, and research approaches were first described and argued to be best aligned with the Reflexive Thematic Analysis method of data analysis. The sampling, procedure, ethical considerations, and data analysis were outlined in detail to provide a transparent account of the research process. Lastly, as a fundamental aspect of qualitative research, the rigor and trustworthiness, and reflexivity of the research and researcher were described. An integrated analysis and discussion is presented in the coming chapters, with each theme dedicated to its own chapter.

Chapter Four - Theme One: South African Healthcare System

Introduction

Theme One explores how participants perceive and experience the South African healthcare system. It focuses on management by various authorities, including the Department of Health (DoH) and the government, and the urgent need for more resources in their workplaces. The analysis delves into systemic challenges, highlighting participants' frustrations with the healthcare system's structural and political aspects. The chapter is organised into three subthemes: "The whole system is broken," "Being governed by government," and "Resources! We need more."

Subtheme One: "The Whole System Is Broken" (3)

Participants express exacerbation when describing the healthcare system, higher levels of management, and political management.

Because I don't work in an academic environment there is a tendency of chronic senior medical officers to project their own insecurities onto juniors. Because, how dare I use guidelines? How dare I care? How dare I be dedicated, inquisitive and analytical. (153)

[would like] Honestly, none from my toxic workplace. I would never trust a toxic and manipulative institute to offer me support. (153)

Participants describe an environment marked by interpersonal challenges, resistance to change, and toxic workplace culture. A critical perception is shown by emotive language, punctuation, and a resentful tone. They convey a sense of frustration and defiance against the resistance faced, and this reflects the interpersonal challenges and power dynamics within the healthcare hierarchy, where junior HCWs may feel unfairly criticised or stifled. Both the expressed futility in wishing/fighting for things to change and the lack of trust and feelings of distaste towards institutions suggest a perceived barrier and lack of hope to reform or improve. Frustration and hopelessness are found to be significant contributing factors to HCW burnout (Rossouw et al., 2013) or reasons for emigrating or leaving the public sector (Fletcher-Nkile et al., 2022). A strong stance against seeking support from their institution highlights a lack of faith in the workplace to offer genuine assistance. Negative sentiments are prevalent toward management, with expressed complaints that HCW's efforts and concerns go unnoticed (Ijumba, 2002; Voget, 2017). This negative attitude toward the organisational structure was reported by Peltzer et al. (2003) to be the third highest severity of job stress in HCWs.

Longer and more detailed answers on the healthcare system suggest participants feel unheard when they voice these concerns in their workplace. This is demonstrated by one participant in their paragraph-long response to, ironically, what they would keep the same about their work:

Nothing. To be honest, I'd rather go through the shit of [public hospital] internship again and being in an academic institute and doing following best practices instead of being in a system that is blatantly and proudly negligent.

A system that silences juniors who speak out against injustices and a system that manipulates, micromanages and gaslights you with narcissistic leaders and HoDs. Flying monkeys.

The very same system that openly discourages patient transparency and discourages you to advocate for patients. The same system that has chronic medical officers in paediatrics who are anti-vaxx.

The same system that leaves palliative patients to block beds for months on end because they are essentially patients who are "quick to round on and I can go to my private practice" instead of having conversations with families sending their loved ones to die at home.

The same system that stops HIV prophylaxis in high-risk infants because the birth PCR was negative.

The same system that puts you down for improving yourself academically and professionally.

The same system that ridicules your ideas but then uses it as their own.

I hate it here. No one cares. (153)

The emotionally charged language expresses an intense dissatisfaction and anger with the healthcare system. This participant vividly details deep frustration, disappointment, and a strong need to articulate many grievances. A sense of urgency and despair marks the participant's tone in the closing remark of hating their workplace. They appear to have used this survey to vent their withheld resentment in a raw account of their experiences, which was also found by Jensen et al. (2022) whereby many HCWs expressed workplace challenges despite their interviews not being designed nor aimed to do so.

Participants' mention of increased threats and fear from management as something they would change in their work further motivates why this survey may have been used to voice concerns anonymously.

The sense of fear and demotivation resulting from administrative and interpersonal politics of senior management. (78)

Ways to raise issues with senior staff without it impacting on my career (34)

The expressed fear suggests participants may stay quiet to avoid threats to their jobs or negative consequences in the workplace, highlighting the negative impact of internal politics on the well-being and morale of HCWs. It appears participants grapple with a delicate

balance between professional advancement and apprehension when voicing concerns, and they desire an “*accessible and external (66)*” and a “*powerful investigative governing body (120)*” to report mismanagement or unethical practices without the risk of negative consequences. This suggests HCWs fear being victimised when they address concerns, and there is a lack of trusting, safe, and open channels for communication. This was publicly shown by a HCW suspended by the DoH after writing an open letter regarding the poor conditions of a public hospital in Gauteng (McCain, 2022).

Participants highlight the emotional, ethical, and existential challenges they grapple with when confronted with systemic issues. They express little trust in the system that is failing both HCWs and patients.

It has exposed my own weakness and ethical flaws. It opens one's eyes to the real human costs of the mismanagement and rotten nature of management. The inability to save or even help anyone. The way one feels powerless at times. The trauma and pain people go through. The poor mental health services. (169)

[would change] I would quit. The system is damaged and failing health care workers as it is. It is not worth it. (172)

[brings distress] Having to "fight the good fight" constantly, battling the system and other staff to do the job right, no leeway for the human side of things. (21)

Participants responded with sentiments of helplessness, exhaustion, and powerlessness in having to challenge the system, with resentment and anger at witnessing the effects on their patients. HCWs have been shown to have a strong sense of duty and responsibility towards their patients and communities who are most vulnerable and marginalised (Stodel & Stewart-Smith, 2011; Wagner & Pather, 2019), with a desire for more humane healthcare. Participants highlight the tension between professional obligations and the human aspects of healthcare, underscoring the emotional burden they carry due to mismanagement and the overall state of the healthcare system. Participants describe service as below what patients deserve, demonstrating how the healthcare system dictates the quality of service and often conflicts with their values and morals. This relentless conflict can lead some HCWs to give up entirely and quit, perceived as the only change they have power over. This has been demonstrated by the moderate to high turnover intention and emigration rates of HCWs across South Africa (Bezuidenhout et al., 2009; Bidwell et al., 2014; Blaauw et al., 2013; Delobelle et al., 2011; Fletcher-Nkile et al., 2022; George & Reardon, 2013; Sounes, 2022; Stodel & Stewart-Smith, 2011; Van Wyk et al., 2010). The willingness to quit signals a level of disappointment that

transcends mere dissatisfaction. Participants express a perception of decline, possibly in terms of resources, services, and overall quality of care, with profound concern about the trajectory of the healthcare system. They highlight the ongoing struggle HCWs face as continuous and challenging efforts to uphold ethical standards and provide quality care. Despite the struggles, Fletcher-Nkile et al. (2022) reported patriotism, hope, and belief that things would improve as motivation for some HCWs not to quit or emigrate.

Subtheme Two: “Being Governed by Government” (83)

Participants highlight the healthcare system's political and structural management aspects when answering what brings them distress and frustration or what they would change about their work. They express frustration with management practices detrimental to individuals' professional growth and the healthcare system's integrity.

Poor management practices that are so obvious. People who get into positions they are not capable of and others who never progress as they are blocked from opportunities. (38)

The politics and power dynamics of employees and the effect of this on service delivery. (187)

Participants describe management structures as corrupt, incompetent, apathetic, lacking commitment or interest, and having a core focus on the financial bottom line rather than the quality-of-care patients receive. They suggest a more profound concern about the integrity of the healthcare system and imply an enduring and ingrained challenge beyond isolated instances. The political leadership, resources and infrastructure, and accountability are complex in South Africa (Fletcher-Nkile et al., 2022), which may be why only qualitative studies on subjective experiences of HCWs have elicited explicit views on corruption. Of the reviewed literature, only Kazadi et al. (2023) also reported HCW's displeasure and concern about the DoH's trustworthiness and failures due to corruption and financial mismanagement. Other studies have reported a more implicit view that the DoH is not doing enough (Ramukumba, 2020) or merely listing corruption as a reason for emigration (Fletcher-Nkile et al., 2022). There appears to be an ‘us vs them’ view of higher management structures, including the DoH, of which HCWs feel at the mercy. Many inferences are made about how the system is built on hierarchies and bureaucracy “*that makes you feel constantly inferior (9)*”, which suggests a lack of meritocracy and fairness. Participants feel powerless against the toxic exploitative treatment from both government and management and that it hinders the provision of quality care.

The DoH structures were often named as the cause of frustration, and concerns were raised that government officials and hospital management need to understand HCWs' day-to-day work.

[would change] Consultants who are actually qualified should be put in charge at district hospitals. There would be less medical negligence and incompetence. I wish that senior chronic medical officers would embrace junior doctor's passion, energy to improve systems, patient advocacy and knowledge from internship instead of disregarding them and thus perpetuating cycles of emotional abuse (153)

[brings distress] Lack of management with accountability. Management often absent and delegate their responsibility to mid-level management with no compensation but full accountability. Poor ethical decisions mandated by consultants although never in ward rounds. (69)

Participants convey a sense of frustration and yearning for change within the healthcare system, reflecting structural concerns and the emotional toll of these issues. They imply a perceived link between leadership qualifications and the quality of healthcare delivery. HCWs feel that leaders should work as part of the team and that most managers do not know the role or function of the HCW (Wagner & Pather, 2019). The mention of emotional abuse hints at the strain experienced by HCWs who feel dismissed, disregarded and undervalued despite their dedication to improving systems and advocating for patients. Participants suggest a disconnect between decision-makers and the moral practicalities of patient care. HCWs may be grappling with a sense of powerlessness and frustration as they witness decisions that seem detached from the ethical principles they hold dear.

The disconnect between decision-makers and HCWs is further expressed through the desire for participants to feel empowered and heard within the organisational structure by having input in the decision-making processes.

[would change] Playing a much bigger part in decision making. (43)

I would like to have a say in how policies are set up (66)

Participants strongly desire increased agency, recognition of concerns, and active and meaningful participation in decision-making processes, which is common among HCWs (Ijumba, 2002; Kazadi et al., 2023; Voget, 2017; Wagner & Pather, 2019). This may be motivated by the wish to align policies with HCW's moral and value systems, which are not always represented by the healthcare system. HCWs feel very little is done to address their

challenges (Ramukumba, 2020), and the lack of complaints being taken seriously suggests a gap in responsiveness or acknowledgement for issues raised by HCWs despite them having ideas and suggestive solutions. The exclusion from decision-making that dictates how HCWs work likely adds to their negative perception of management structures as they feel silenced. Fletcher-Nkile et al. (2022) suggested that any improvement in healthcare will require extensive collaboration between the national government and HCW stakeholders.

The lack of understanding by management and their performance failures causes participants exhaustion and frustration. They describe an urgent need for systemic reforms in healthcare, focusing on addressing issues related to management, support, and the overall working environment.

[would change] Reform of the entire system-starting with the funders, and lawyers. Sadly that rot is the cause for the patient's desperation (and ultimate exploitation of doctors). We are a grudge purchase. (145)

[would like] Better management. Supportive management. We are just their toys that they play with and they sit in their offices and think of ways to make our lives more hellish (10)

Participants appear exhausted at filling managerial performance failure gaps as it places more burden and hours on their work without recognition or compensation. They express being disgruntled at higher management, earning money from their hard work while struggling to meet unreasonable demands that compromise their ethics. Participants want management practices to change and to see people being held accountable for poor performance. Words such as 'rot', 'toxic' and 'hellish' pervaded the data, indicating the frustration and perceived profoundly ingrained contamination and danger. Participants imply a sense of resentment and helplessness, emphasising the feeling of being a commodity to be transacted and exploited. Participants vividly portray a sense of powerlessness and indicate a lack of agency and autonomy while conveying hostility and pain of feeling manipulated and mistreated, with anger and perplexity found to be shared in HCWs (Kazadi et al., 2023).

Subtheme Three: "Resources! We Need More" (158)

One of the most mentioned allegations of the healthcare system was the lack of funding allocated to resources for participants to do their jobs adequately.

[brings distress] Feeling helpless in situations where scope of practice and lack of access to resources prevents me from being able to assist children. In addition, exposure to the extreme

deprivation and poverty that so many of our community are forced to live in, and not having the means to help them in getting proper help. (116)

[would change] Availability of resources we are expected to have. Improving standards, currently we watch deterioration. (77)

Frustration with the lack of resources is a common experience among HCWs (Delobelle et al., 2011; George & Reardon, 2013; Ijumba, 2002; Kazadi et al., 2023; Peltzer et al., 2003; Rossouw et al., 2013). Participants describe how they face difficulty providing medical interventions patients need due to a lack of resources with almost all expressing more resources as the most critical change they need. Participants share that they are “*expected to do a lot with a little*” (107), implying feelings of powerlessness and being unseen, dismissed and devalued. This added layer of emotional distress underscores the direct link between resource limitations and the well-being of both HCWs and patients. Participants express despair and concern as they witness a decline in the quality of care that could be mitigated with adequate resources. The lack of resources has been reported as a significant contributing factor to HCWs burnout (Peltzer et al., 2003; Rossouw et al., 2013) and reasons to emigrate (Fletcher-Nkile et al., 2022; George & Reardon, 2013) or leave their job (Delobelle et al., 2011).

In answer to what causes them distress, participants cited a veritable laundry list of necessary resources that are lacking, for example:

Basic necessities like water and electricity, furniture, proper infrastructure, a clean environment. (94)

No running water in some wards, dirty conditions, poor resources, understaffed, the amount of hours we are expected to work and still do our job properly, feeling unsafe at work. (9)

The fact that we haven't had working landlines for five weeks, no internet in my part of the clinic for three months, the hospital still hasn't been fixed since the fire in April last year. (107)

HCWs cite numerous resource challenges across the literature, (Delobelle et al., 2011; George & Reardon, 2013; Ijumba, 2002; Kazadi et al., 2023; Voget, 2017) indicating the impact of multiple problems and the endlessness of resource scarcity. Participants shed light on resource scarcity that prevents them from timeously serving their patients, including the need for more equipment, medications, porters, and staff across various levels, including laboratory and radiology departments. Participants mentioned that little maintenance is

conducted in facilities, and they are expected to work in dire conditions with broken equipment as the facility structures deteriorate. Complaints about the age of clinic buildings without upkeep were also reported by (Ijumba, 2002). Participants express a strong desire for a clean environment contrasted with the reality of “*dirty conditions (8)*”. Beyond professional challenges, there are direct consequences for healthcare facilities' operational efficiency, such as lack of electricity and “load-shedding of hospitals (17)” placing both HCWs and patients at risk.

Participants express the pleading desire for enough resources to do their job adequately, highlighting the severity of the lack of resources they are expected to work with.

Just enough resources to be enough to work. (83)

Healthcare disparity, practicing two different types of medicine in private's vs government, end up not knowing what is correct. The private way over overreacting or the government way of under-reacting because you know you don't have the resources available to even do the basic stuff. (93)

Participants convey a desire that feels out of reach, that improving the current working conditions and providing quality care to their patients feels like a far-fetched dream, leaving some HCWs disillusioned about their chosen profession (Voget, 2017). Participants indicate they are not asking for unreasonable demands but only the bare minimum to do their job. Most participants who expressed the severity of resource scarcity were in the public sector, and participants who worked in both sectors commented on the stark contrast between the private and public sectors. It is well-known that public facilities are worse and suffer from a lack of funding worldwide (Bidwell et al., 2014; World Health Organization, 2008), but this contrast is more pronounced in South Africa (Achoki & et al., 2022; Bateman, 2007; Cook et al., 2021; Econex, 2015). Participants convey a profound ethical dilemma, with the stark contrast between overreacting and underreacting, highlighting their problematic choices due to resource constraints. Notably, HCWs expressed perplexity that private hospitals had adequate personal protective equipment (PPE) resources during COVID-19 while public hospitals were recycling one-use-only PPEs (Kazadi et al., 2023).

Participants consistently emphasise the critical need for additional staff, highlighting the impact of staffing shortages on their ability to provide quality care and manage their workload effectively.

Have more staff! (115)

[brings distress] The nature of the cases. But mainly the waiting list. Too many patients need to be seen for the Human Resources available. Feeling like there are too many people to help - do I see someone for a few session shorter so I can see new referrals and risk the first patients being re referred. (17)

Honestly. Just more staff members to ease the workload. (90)

More staff is the only achievable intervention. Otherwise there are just too many irreparable systemic faults (184)

The exclamations in these statements convey a sense of immediacy and urgency as participants portray not coping with their current staff numbers. Staff shortages are described as the leading cause of unmanageable and unbearable workloads (Delobelle et al., 2011; George et al., 2012; George & Reardon, 2013; Ijumba, 2002; Kazadi et al., 2023; Peltzer et al., 2003; Voget, 2017), with the current patient-to-HCW ratio being unrealistically high and better representative of a low-income country (Cook et al., 2021; Econex, 2015; George et al., 2012). High patient volumes and HCWs' inability to serve them have been shown to cause distress, despair, and conflicts with their professional duty. The description of the dilemma regarding shorter sessions and re-referrals reveals the ethical and emotional challenges HCWs face that resource constraints force them to make. Participants demonstrate how powerless they feel to the healthcare system, as they must beg and negotiate for resources and imply a lack of optimism in ever receiving the resources they need. More staff being the most realistic change that will have the most significant impact is common among HCWs (Ijumba, 2002; Kazadi et al., 2023; Voget, 2017) and unfilled posts in hospitals are described as disturbing the whole hospital (Ijumba, 2002).

Conclusion

Theme One has illuminated the profound challenges and frustrations experienced by HCWs within the South African healthcare system. Participants described a profoundly flawed system characterised by toxic workplace cultures, mismanagement, and a severe lack of resources. The emotional and ethical burdens placed on HCWs are immense, contributing to feelings of helplessness, anger, and a sense of powerlessness. Participants' narratives reveal a critical need for systemic reforms, including better management practices, increased resources, and more significant involvement of HCWs in decision-making processes. These

insights underscore the urgent need for interventions to address the systemic issues within the South African healthcare system to improve HCW well-being and patient care.

Chapter Five - Theme Two: Working Conditions

Introduction

Theme Two explores the working conditions of HCWs in South Africa. It focuses on long working hours, increased administrative responsibilities, and perceptions of their physical workspace. The challenges HCWs face include excessive overtime, administrative burdens, and safety concerns, highlighting their working conditions' physical and mental toll and the impact on their personal lives and professional efficiency. The chapter is organised into three subthemes: "Extremely Long Hours," "Admin Staff to Do Stats Instead of Doctors," and "I Love the Space I Work In Vs Lack of Safety."

Subtheme One: "Extremely Long Hours" (143)

Participants describe significant concerns about working conditions, including excessively long hours and the distress caused by extended periods of overtime.

[would leave] Horrible, long inhumane working hours, no salary increments over the past 05 years whereas peers are earning way more than I do working normal 9-5 shifts with no overtime (172)

[brings distress] Long hours of overtime, working 30 hours without sleep and still being expected to function... (89)

Participants perceive their working hours as cruel, harsh and lacking in empathy, with one HCW arguing that sleep deprivation is a form of torture (Doctor, 2016). The dehumanising context indicates the extremity of the strain that HCWs endure, going beyond what they think is reasonable for a human being. The comparison with peers earning more while working regular 9-5 hours further emphasises the perceived inequity and dissatisfaction. Extended hours have been found as a significant cause of decreased productivity (Rossouw et al., 2013), increased job stress (Peltzer et al., 2003), emigration (Bezuidenhout et al., 2009), burnout (Naidoo et al., 2020; Rossouw et al., 2013; Stodel & Stewart-Smith, 2011), absenteeism (Nyathi & Jooste, 2008), and leaving their job (Nyathi & Jooste, 2008). This remark that participants are expected to function highlights the physical and mental toll of extreme working hours and sleep deprivation and studies have shown that excessive working hours or lack of sleep impairs cognitive efficiency in HCWs (Firth-Cozens & Greenhalgh, 1997; Samkoff & Jacques, 1991). Participants show concern for their well-being and capacity to provide safe and effective care, with HCWs having fear of causing harm due to functional impairment (Theron et al., 2021). It has been shown that at the end of a 17-18 hour period of

awakeness, performance levels were equivalent to the alcohol intoxication that many countries would deem incompatible with safe driving (Williamson & Feyer, 2000) Additionally, extended hours place HCWs at higher risk for road accidents (Kotze et al., 2020; Mak et al., 2019), particularly evident in the public outcry at the death of a junior doctor in a motor vehicle accident after a 24-hr extended shift (Doctor, 2016; Kotze et al., 2020). Doctor (2016) further argues that had the young doctor worked an 8 to 12-hour shift, she would probably still be alive.

Participants expressed frustration with the current working hours, emphasising disparities in compensation and quality of life between medical doctors and other professionals.

... there are professionals now who earn way more than medical doctors, and they get the liberty of having weekends off for family and friends, and the delicacy of going to bed every night. (172)

No consideration for personal time (going for lunch, going to the bathroom and sleeping are supposedly a luxury), unsafe working hours. (170)

Participants mention aspects of life such as lunchtime, bathroom breaks, weekends off, and sleep, which might be taken for granted in other professions, are precious and rare. This implies a harsh working environment where even essential aspects of personal well-being and self-care are compromised due to demanding and unsafe working hours. The lack of personal time has been shown as frequent job stress for HCWs (Peltzer et al., 2003) with fewer working hours as a protective factor for stress levels (Jensen et al., 2022). HCWs have been shown to value flexible working hours and appropriately compensated overtime (Fletcher-Nkile et al., 2022), while more control over their working hours predicts low burnout (Wagner & Pather, 2019). The comparison to peers suggests jealousy of the regular working hours and how the prestige that HCWs are perceived to have contradicts participants' lived experience. The status quo of these being a luxury highlights the humanness that participants are expected to put aside when they enter the profession.

Participants would like changes in their working conditions that address concerns related to long shifts and reasonable hours with breaks.

[brings distress] Unsocial hours, unfair rosters, unrealistic and unreasonable expectations from company management and patients... (184)

[would change] Lunch time always being a given. Better balance so that some aren't overworked while others relax. Reasonable expectations regarding completing work on time... (169)

Participants want a limitation to the number of overtime hours or hours worked in a row, particularly the changing of 24-hour calls, as some participants cited not wanting to be “*at work 36 hours (3)*” Participants show a strong and unequivocal stance in wanting to eliminate the current policy around shift hours with other samples, on average, working 62 hours a week (Stodel & Stewart-Smith, 2011) and 85% working overtime, with 54% working more than 64 hours of overtime a month (Rossouw et al. (2013). Unfortunately, different advocacy strategies have been employed for regulatory reform on working hours for HCWs but have had limited success as there is no regulation to prevent HCWs from working continuously for up to 36 hours (Kotze et al., 2020). Participants want mandated lunch times or “*one hour of the day where we have to be outdoors (74)*” to take a break during their workday. The description of some individuals being overworked while others relax suggests a desire for fair and equitable scheduling or workload distribution. With little flexibility for on-call duties, participants appear to be at the mercy of management scheduling, expressing frustration and lack of justice or empathy towards their work-life balance.

Participants reflect on the significant impact of their demanding work hours on their personal lives, particularly time with family.

[would leave] If I don't end up getting enough time at home in the next year (100)

[brings distress] ...Time away from my husband and son. Open endedness of working hours (101)

The willingness to leave their job suggests participants value time with family and want to prioritise this as crucial to their well-being, indicating feelings of being burdened by work demands infringing on personal family time. Some HCWs have been shown to try to separate work life from home life, but the immense workload encroaches on life at home, while others believe work-life balance is a myth (Wagner & Pather, 2019). A sense of uncertainty and strain on family relationships is expressed due to unpredictable and potentially extended work hours. Time with family is portrayed as valuable by HCWs (Fletcher-Nkile et al., 2022), and it being stolen or sacrificed causes distress (Cook et al., 2021).

Subtheme Two: “Admin Staff to Do Stats Instead of Doctors” (12)

Participants underscore the challenges and distress they experience due to administrative tasks that extend beyond their primary clinical responsibilities.

[brings distress] The admin and stats that we're expected to do beyond clinical responsibilities... (12)

[brings distress] ... excessive admin that needs to be completed while trying to do a clinical job... (184)

Participants' long hours are impacted by their workload and the amount of admin they are required to do, over and above seeing patients and their clinical work. They express the severity of the excessiveness in the expected admin tasks and suggest an encroaching of admin on their core job functions, often having to complete admin after hours, causing frustration and resentment. Excessive paperwork and workload are significant factors in HCW job stress severity (Rossouw et al., 2013), burnout (Rossouw et al., 2013; Stodel & Stewart-Smith, 2011), and absenteeism (Nyathi & Jooste, 2008). This dual demand for their time and attention highlights the difficulty of managing administrative tasks alongside providing direct patient care. HCWs find the data recording aspects of their job tedious, with far too many forms required (Ramukumba, 2020).

Participants expressed the desire for assistance with administrative responsibilities placed on them, which admin support staff can do.

[would like] More appreciation that as doctors we need to be saved a lot of the admin that we do (84)

[would like] Assistance with menial tasks as it detracts from patient interaction. (126)

Participants desire appreciation and recognition for their clinical work and perceive administrative duties as burdensome, taking away valuable time from other critical professional responsibilities. The requirement to do administration leaves participants feeling devalued as it takes time away from their actual skillset and treating patients. HCWs have also reported being more dissatisfied and feeling out of control when they cannot meet the demands placed on them (Wagner & Pather, 2019) and that administrative requirements impact the level of care deemed necessary (Stodel & Stewart-Smith, 2011). Participants expressed frustration at the lack of time for their admin. They would like admin time built into their hours, such as “a day at home for admin (60)” or “more administrative support

(109)” such as “*data captures (83)*” or “*admin staff to do stats instead of doctors (10)*” within their department.

Additionally, participants mention their frustration with paperwork and corruption within the administrative process.

[brings distress] Workload. Increasing amount of paperwork that is duplicating. (50)

[brings distress] Administration corruption (105)

[would change] If we could implement a meritocracy, and an incorruptible record keeping strategy (120)

Participants expressed futility at the redundant duplication of paperwork and suggested a continuously growing volume. They imply that unethical administration practices impact the amount of paperwork they must do and recommend “*computerise the system (83)*”.

However, they experience the management that enforces structure and protocols as reluctant or in opposition to adopting new ideas, processes, or technologies and acts as a barrier to progress. HCWs have also expressed that data storage is not ideal and security is not guaranteed (Ramukumba, 2020).

Participants further explained how external administration requirements add to their workload, which is an additional cause of frustration.

[brings distress] Medical schemes limitations, endless red tape (182)

[brings distress] ... Medical aids and motivations and applications and formularies. Reimbursement... (141)

External admin requirements, such as processes required to reimburse or comply with legal tax requirements, leave participants feeling frustrated. They imply feeling powerless and at the mercy of medical aid requirements, with a resentful expectation that this additional admin will be done free of charge despite it taking up so much of their time outside consulting fees. HCWs have reported obtaining reimbursement from medical aid as the major drawback of working in private practice (Bidwell et al., 2014). It is suggested that there are not enough resources in the public sector to meet the patient’s demands. In contrast, in the private sector, medical aid acts as a funding barrier to providing healthcare to patients. The endlessness of these requirements suggests the worsening of the never-ending external admin requirements.

Subtheme Three: “I Love the Space I Work In” (122) vs “Lack of Safety” (170)

Participants shared experiences related to their office location, safety concerns, and the impact on their daily routines.

[would keep] My offices- I love the space I work in. The people I work with. (122)

[would keep] My beautiful new location (35)

Only six participants described their workspace as pleasant regarding location, view, or workspace. “My” suggests a sense of ownership or personal connection with a positive or appreciative sentiment. However, these non-detailed responses to what they would keep the same about their work suggest that these participants may have been searching for any positive aspects of their work, no matter how small, as they only mentioned the physical workspace.

In contrast, the fear of safety emerged as a cause of distress, but only from female participants in both the public and private sectors.

[brings distress] ...lack of safety in/around the hospital (security often not present/ sleeping) ... (170)

...give us secure parking (my car was stolen because of the parking situation after the fire), give us a safe space to get to our cars - I no longer work late because it's not safe in the 15 minutes' walk to my car... (107)

[brings distress] ...Late evenings. Driving. Especially in the dark... (141)

Participants' safety concerns include security within and around the facility, with a heightened fear at night also reported by . Bidwell et al. (2014) reported that of the security incidents reported by their sample, none occurred in private facilities. However, HCWs expressed they were still exposed to security risk outside of their workplace as high crime rates, in general, have been reported as a significant cause for HCW emigration (Fletcher-Nkile et al., 2022; George & Reardon, 2013) with a considerable increase since 2004 (Bezuidenhout et al., 2009). Participants suggest that security is not perceived to be taken seriously by the organisation and that they are left to fend for themselves. This fear is described as particularly distressing as some have already been victims of crime at their workplace. HCWs have reported being exposed to incidents of violence at work, including shootings and knife attacks (Jensen et al., 2022), and being threatened by their patients or risking their lives to protect others (Ijumba, 2002). This highlights the need for HCWs to feel

safe at work (Bidwell et al., 2014) and during home visits (Ramukumba, 2020). Safety concerns influence participants' decisions regarding working late, impacting their daily routine and commuting choices. This fear links to their desire for less overtime to avoid leaving their workplace late.

Conclusion

Theme Two explored HCWs' working conditions, revealing significant challenges and distress. Long working hours, compounded by excessive administrative tasks, contribute to physical and mental exhaustion, with severe implications for personal well-being and patient care. Safety concerns, particularly among female HCWs, further exacerbate the stressful environment. The findings underscore the urgent need for policy reforms and organisational changes to ensure fair working hours, adequate administrative support, and improved safety measures. Addressing these issues is crucial for enhancing HCWs' job satisfaction, productivity, and overall quality of care.

Chapter Six - Theme Three: Psychological Conditions

Introduction

Theme Three delves into the psychological conditions experienced by HCWs in South Africa. It examines the impact of team dynamics, hierarchical structures, and the emotionally taxing nature of their work. The chapter is organised into three subthemes: "Being Part of a Brilliant, Dynamic Team Vs Lazy Co-Workers Who Don't Care," "The Hierarchy of Toxicity," and "Emotionally Taxing Work." These subthemes reveal a dichotomy in HCWs' experiences with colleagues, the detrimental effects of hierarchical structures, and the significant emotional burden of healthcare work.

Subtheme One: “Being Part of a Brilliant, Dynamic Team” (6) vs “Lazy Co-Workers Who Don't Care” (171)

Participants demonstrate a dichotomy in how they experience working with their respective colleagues, ranging from positive mentorship and teamwork to challenges and conflict. This dichotomy is shown by the extremity of the words chosen to describe colleagues, such as “amazing”, “brilliant”, “talented”, “committed”, “enthusiastic”, and “courageous” versus “lazy”, “uncooperative”, “resistant”, “toxic”, “arrogant”, “uncaring”, “unprofessional”, and “miserable”. A dichotomy of positive and negative experiences of professional HCW relationships was also found by Ijumba (2002) and Mokoena et al. (2023).

Some participants describe their team as an aspect of the work that brings them joy and fulfilment, what they would keep the same about their work, and a reason that keeps them in their job.

My co-worker is an amazing mentor. Working with her is the greatest benefit to me. I worry about how unbearable work will be when she retires in 5 years. (41)

[would keep] The courage, enthusiasm and spirit of Ubuntu I see among healthcare personalities regardless of sabotage from the government (29)

Participants describe a deep appreciation for the positive influence of immediate co-workers and admiration for fellow HCWs who persevere despite the challenges faced. There appears to be stronger communal support in the public sector (Fletcher-Nkile et al., 2022), likely encouraged by the perception that the government is sabotaging and intentionally working against HCWs who are trying to serve patients. The term “ubuntu” highlights the South African context, communal spirit, and shared values that HCWs hold. Fostering good

relationships with peers and having a friendly, supportive work environment have been reported as essential characteristics of a resilient HCW (Wagner & Pather, 2019), the key to handling work frustrations (Ijumba, 2002), maintaining job satisfaction and retention (Delobelle et al., 2011), and adding value to their work (Kazadi et al., 2023).

On the opposite side of the dichotomy, some participants describe their team as a cause of frustration and distress, what they would like to change about their work, or why they would leave their jobs.

[brings distress] ...lack of follow-through from colleagues (increased workload to try cover others not doing their work), rude colleagues (whether from burnout or otherwise) ... (170)

[would change] The people I work with and the attitudes of parents and other professionals that I have to deal with as part of my job (195)

[brings distress] large amounts of conflict and resistance from colleagues and patients (184)

Participants describe resentful frustration in dealing with the consequences of colleagues not fulfilling their responsibilities. They express having to tolerate various encounters, such as people's attitudes, without the ability to retaliate despite their desires to do so. This was further shown in how interpersonal relations between staff and patients' relatives can elicit dysphoric and depressive reactions in HCWs (Stodel & Stewart-Smith, 2011). The responses imply an agitated atmosphere where disagreements and opposition are significant and everyday occurrences. Poor team cohesion has been found to affect HCW job satisfaction and absenteeism (Nyathi & Jooste, 2008) and increase job stress severity (Peltzer et al., 2003).

Overall, the above dichotomy underscores the critical role of interpersonal dynamics and collaboration in shaping participants' job satisfaction experiences. Participants who struggle and persevere together against difficulties appear to develop a stronger sense of closeness and connectedness. Those who experience conflictual interpersonal dynamics appear to feel lonelier and distressed in fighting against the system and colleagues. These participants likely have little reprieve, with their working conditions clouded with pessimism.

Interestingly, participants were deliberate in stipulating exclusions in their responses to clarify who they were referring to, for example:

[would keep] The staff (not managerial positions) (9)

[would keep] ... Camaraderie with colleagues (fellow interns). (169)

[would keep] My team, with a few exceptions. (107)

Exclusionary language provides a more nuanced understanding as it highlights the participant's intention to differentiate and specify certain groups or individuals within the broader category of colleagues. The separation of HCWs based on hierarchy and similarity suggests an in-group and out-group perception that may arise in the workplace. The clarifying comments imply a more varied experience with different people in the workplace and a reluctance for participants to group all colleagues as 'bad'. This intentional exclusion was not found in other literature.

Participants expressed a desire for improvements in the workplace environment to enhance team dynamics and communication.

[would like]... external mediator to assist with tensions between colleagues and improve communication between different team members (119)

[would like]... More fun activities that build the team (193)

Participants who experience negative working relationships prefer conflict resolution and team building to improve the psychological working environment. The desire for more collaborative relationships may be motivated by the premise that cohesive teams ultimately serve their patients better (Mokoena et al., 2023). This is articulated by a participant who explained that a “*multidisciplinary team approach means that everyone brings their expertise and understanding of the client to the table*” (119). HCWs have suggested that building a sense of community in the workplace with good relationships and communication skills cultivates a social support network and is essential for HCWs to accomplish their work (Stodel & Stewart-Smith, 2011; Wagner & Pather, 2019). Participants describe a need for an impartial and neutral party to facilitate resolution, excluding internal mechanisms. This suggests that internal processes play a perceived part in the tension between team members and that the current methods are ineffective.

Subtheme Two: “The Hierarchy of Toxicity” (174)

Participants express concerns and dissatisfaction with the toxic aspects of workplace hierarchy. Many describe the hierarchical structure whereby the lower your position, the worse you are treated.

[brings distress] Workplace dynamics, insecure HOD, racism and hierarchical structure nonsense. Psychiatrist, medical officer, psychologist..... Being reminded of my place in the hierarchy of patient care, like, roll my eyes. My value being discredited due to my profession. I could go on and on.... (72)

... There is also a toxic culture with a hierarchy that makes you feel constantly inferior. (9)

Throughout the data, participants refer to “juniors”, “seniors”, “medical officers”, “consultants”, “managers”, “bosses”, “senior management”, and “government”, which demonstrates the various levels of the healthcare hierarchy. The expressed sentiments suggest perceived absurdity and exhaustion in the hierarchy when talking about the frustrations it causes. Participants experience the hierarchy as toxic, implying tainting and contamination, with their self-worth being made to feel inferior to those higher up. This is a common experience among HCWs (Ijumba, 2002; Jensen et al., 2022; Kazadi et al., 2023; Mokoena et al., 2023; Voget, 2017; Wagner & Pather, 2019). There appears to be a powerful “seniority complex” among HCWs, whereby hierarchical attitudes potentially lead to counterproductive actions (Mokoena et al., 2023, p. 7). HCWs have also expressed how the medical hierarchies played a vital role during Covid-19, as doctors received more PPE than other frontline workers (Kazadi et al., 2023). The desire to break down the hierarchy implies anger in wanting to destroy the structure that causes psychological harm.

Participants describe their treatment from those above them in the hierarchy as abusive and bullying and find it challenging to work under these circumstances.

My manager is a nightmare (41)

...I wish that senior chronic medical officers would embrace junior doctor's passion, energy to improve systems, patient advocacy and knowledge from internship instead of disregarding them and thus perpetuating cycles of emotional abuse (153)

[would leave] Constant pressure from supervisor and always bringing staff down (135)

HCWs in higher positions are described with animosity as mean and toxic. Strong language suggests a profoundly negative experience of distress and a desire to escape the challenging

relationship, further indicated by the wish for improvement in how juniors are treated. Along with feeling disregarded, participants also referred to the “*exploitation of juniors by seniors*” (14) and “*lack of respect (12)*” by “*uncaring (77, 87)*” seniors or people in charge, suggesting they are perceived as dangerous and untrusting. Lack of trust and respect for senior professionals underpin many interpersonal conflicts for HCWs (Jensen et al., 2022; Mokoena et al., 2023). The reference to emotional abuse implies a power dynamic whereby juniors feel victimised and helpless to the treatment by seniors. In response to what kind of support structures they would like, one participant explained:

That is a very foreign concept in medicine. From the moment you walk into a hospital as a student you are belittled and abused. If you take a sick day or holiday, you are not pulling your weight. I don't find doctors to be supportive of each other. Needing help is frowned upon (141).

Support being significantly rare implies an alien experience and the absence of it from the start of their profession. The relentless experience of being belittled indicates that HCWs are taught and mentored through humiliation without the psychological safety to ask for help. Wagner and Pather (2019) also found that HCWs hold unrealistic expectations for their resilience, which are perpetuated in the profession whereby perfectionism is praised, and those who show vulnerability are unduly judged. The lack of perceived support implies a very lonely and fearful training experience, and mentoring programs have been recommended as coping resources (Stodel & Stewart-Smith, 2011).

Although participants clearly describe the animosity toward seniors, they also appear to re-enact the hierarchy toward those perceived as below them. Some express how nurses are looked down on and on the receiving end of harshness and bullying from other HCWs.

[brings distress] Co-workers negative perception of my profession. Most people in my company think nurses are stupid and unintelligent. (44, nurse)

[brings distress] The bullying, no resources, the cattyness, the managerial bullying, broken equipment, bullying from doctors (10, nurse)

[brings distress] ... The lack of respect shown to us by senior staff. The poor training and engagement of our nursing staff. (12, registrar)

[bring distress] ... being phoned at 4am once the sisters wake up to assess 5 “corpses”, the fact that every sister does not know BLS [basic life support] particularly when you are calling for a “resus” and need assistance. (170, intern)

The data suggests that hierarchical bullying is perpetuated and reinforced as HCWs progress in their professions. Hostile stereotypes are expressed that nurses feel are unfairly attributed to them, and have also been found by Mokoena et al., 2023 reporting clinical associates felt that their qualifications were superior to nurses'. Participants reflect the potential professional level and age-related conflicts that suggest a pervasive problem in the workplace culture. They convey dissatisfaction with the preparation and development of nursing professionals and desire more involvement and commitment. This was further expressed by the critical tone to imply a perception of widespread incompetence of nursing staff and attributed blame for the patient's death. Interestingly, Ijumba, (2002) reports some nurses perceive investment in training does not add value to their quality of care, and their inadequate skills place their patients at risk. Many junior participants express a struggle to understand how seniors can be so abusive, yet they can sometimes behave similarly towards nurses and administration staff. It appears HCWs become more jaded and emotionally detached throughout their careers and might be unaware of how they perpetuate the abuse they were hurt by in their formative years or be vengeful for their own experiences.

Outside of the bluntly described bullying and abuse, participants experience their direct superiors as uncaring and unsupportive and desire a more positive and supportive relationship.

[would like] Seniors who are genuinely invested and cared about their employees as much as they are invested in and care about the patients. (143)

A new supervisor would be great. Someone who actually takes other people's opinions. (53)

[would change] ... A better culture where asking for help is not seen as a sign of weakness. More accountability for poor work ethic and helpfulness (169)

Interns and community service participants desire more support and supervision, conveying a strong desire for seniors to care about juniors authentically beyond the professional realm. This is further expressed by a participant wanting “*monthly debriefings. Seniors who ask how you are doing, seniors who appreciate your input*” (174). The desire to be asked ‘how one is doing’ implies a cold and disconnected perception of their relationship with seniors and reflects a need for empathy, understanding, and recognition of their opinions. The importance of supportive relationships has also been shown by (Cook et al., 2021) who found anxiety to be buffered by positive organisational support and supportive working environments as instrumental in helping HCWs cope with challenges. It appears that when HCWs enter the

profession, they are struck by the unsupportive hierarchical system, leaving them with a very bitter experience of being seen as weak and less than if they need help or guidance. Although supervision is beneficial in supporting HCWs, it is still perceived as one of the weakest aspects of human resource management (Delobelle et al., 2011) , as highly uneven levels of supervision and support have been found in healthcare (Jensen et al., 2022). Participants would like seniors to be held accountable for their unhelpfulness, implying these strained relationships' significant impact on their work.

Subtheme Three: “Emotionally Taxing Work” (170)

In addition to the above workplace and relationship stressors, participants are also faced with the emotionally taxing nature of their actual work in providing healthcare to patients.

[brings distress] Emotional exhaustion that goes with getting through to patients. (126)

[brings distress] Parents demands, the endless weight of responsibility (103)

[brings distress] Difficult patients, emotional stress from patients (74)

Participants imply that the draining and effortful nature of experiences with patients is a fundamental part of their job, demonstrating the inherent pressures of healthcare work. HCWs refer to both emotional (Rossouw et al., 2013) and physical exhaustion (Kazadi et al., 2023) , and overall stress suggestively impacts their resilience and emotional capacity to deal with work stressors. Burdensome feelings towards patients, shown by high scores on the depersonalisation scale of the Maslach Burnout Inventory (Moses et al., 2024; Naidoo et al., 2020; Peltzer et al., 2003; Rajan & Engelbrecht, 2018; Rossouw et al., 2013; Sirsawy et al., 2016; Stodel & Stewart-Smith, 2011; Zeijlemaker & Moosa, 2019) and increased compassion fatigue (Jensen et al., 2022), can lead to HCWs becoming detached and callous to their patients implicating the quality of patient care (Elkonin & Van der Vyver, 2011). The reference to responsibilities and expectations placed on participants being an infinite weight indicates a constant heavy burden that they likely feel overwhelmed by. Over and above feelings of overwhelm, symptoms of depression have also been found to be prevalent in HCWs (Pillay et al., 2016; Rossouw et al., 2013), with some HCWs fearing psychiatric admission due to the emotional effects of their work (Voget, 2017). Their exhaustion may contribute to toxic workplace dynamics as they cannot resolve conflict or engage in difficult conversations with other professionals. It may also contribute to bullying and abuse as their

emotional depletion likely makes them less able to connect with their humanness and, therefore, others.

One participant said they would leave their job for a “*better quality of life, not always being so exhausted that I can't live life (174)*”. At the same time, another expressed the desire for “*More consideration for the fact that we are also people. We need time to relax and deal with life*” (15). These indicate how their energy is completely depleted from their work, with no reserves left for their own life, and on the brink of survival. It has been found that HCWs' perception of and attitude towards their work significantly impacts their ability to handle their daily life challenges and overall quality of life (Elkonin & Van der Vyver, 2011; Wagner & Pather, 2019). Participants are perceived to be treated as robots that can withstand the emotional assault of their work indefinitely and plead for their holistic well-being to be recognised.

The combination of challenging working and psychological conditions leads to many participants suffering from burnout and trauma.

[brings distress] ... Emotional load of the work, difficult work environment due to burnt out co-workers. (116)

[would leave] Continued burnout (86)

[would like] Time off, time away so that we can actually tend to our emotional needs/mental health challenges. This hamster wheel-cycle destroys our mental health. There is no recovery time in between to heal from the stress/trauma.(151)

Participants express the heavy burden of their work compounded by burnt-out colleagues, highlighting burnout's ripple effect on teams and colleagues as HCWs who experience burnout perpetuate burnout in those around them (Stodel & Stewart-Smith, 2011). Burnt-out colleagues are perceived as creating an environment of overburden, which articulates the lack of empathy shown to each other. Others often persist and endure to avoid being seen as weak, a message perpetuated in the healthcare profession (Wagner & Pather, 2019). The language used implies the destruction and erosion of their mental well-being and experiencing it as worsening. A feeling of being trapped in a relentless, repetitive cycle without sufficient breaks suggests the persistent inability to escape the impact of their work, further indicating that burnout is an ongoing challenge that is difficult to overcome. This is demonstrated by the

continuing reports of high rates of burnout in HCWs, particularly in South Africa (Cook et al., 2021; Moses et al., 2024; Naidoo et al., 2020; O'Connor et al., 2022; Peltzer et al., 2003; Rajan & Engelbrecht, 2018; Rossouw et al., 2013; Sirsawy et al., 2016; Sounes, 2022; Stodel & Stewart-Smith, 2011; Wagner & Pather, 2019; Zeijlemaker & Moosa, 2019), which is a growing concern. Participants are not afforded needed time off, contrasted with their perceived emotional injury as needing urgent care and attention.

Participants mentioned the persistent deterioration of their physical and mental health as a reason they would leave their jobs, with some having already left their jobs due to a lack of support. In contrast, others wish for some time off, for example:

Not necessarily leaving, but I'd love a fairy godmother to pay my salary for 2-3 months so I can get a complete break from work, trauma etc! (117).

The reference to a fairy godmother highlights the wishful and dreamlike nature of the participant's desire for recovery time, conveying a feeling that they will never realistically be able to have this despite the urgency of this wish.

The pervasive use of "trauma" in the data highlights a significant aspect of working in healthcare: experiencing the death of a patient.

[would like] ...Psychological support after death of patients (100)

[would like] Psychological support /debriefing for loss... (101)

HCWs have been reported to be at high risk of compassion fatigue and vicarious trauma (Elkonin & Van der Vyver, 2011). The desire for support after losing a patient indicates a recognition of the challenging emotional aftermath that HCWs may experience and the critical time frame when support is needed. The loss described is poignant, capturing the profound emotional impact of these experiences. It is argued that the loss of a patient may be equated with personal failure and impacts self-esteem, particularly with a predisposition to guilt, and is the most distressing experience for an HCW, which increases the risk of depression and stress (Elkonin & Van der Vyver, 2011; Firth-Cozens & Greenhalgh, 1997). Participants convey a sense of intensity and urgency, emphasising the need for immediate and targeted assistance during highly distressing situations. The desire for support, particularly for these instances, suggests that they are left to deal with the grief and acute distress of the loss

of patients on their own. Kazadi et al. (2023) reported one HCW who witnessed so many deaths that they became significantly introverted and felt no one would truly understand the experience unless they also personally experienced the loss of a patient.

The awareness of the toll that their work takes on them is shown by the many participants who express the desire for emotional support along with suggestive solutions to what support structures they would like more of, for example:

...better emotional support, more importance placed on personal time and recuperative time (2)

Psychology counselling (135)

Support groups, mandatory debriefing, (34)

The desire for support structures implies the inadequacy or lack of emotional support participants experience, which was found to be notably lacking in the public sector (Kazadi et al., 2023). Psychologically safe and supportive spaces are expressed as lacking and perceived as unimportant and undervalued by management. Two participants noted the desire for a better quality of psychological services through *“Debriefing counselling services made more readily available and with people who actually understand” (179)* and *“Psychologists not on a telephone helpline...” (21)*. This suggests frustration at workplaces recommending helplines rather than more personalised and direct support services from professionals who comprehend the unique challenges faced by HCWs, implying that participants feel unseen and misunderstood.

Conclusion

Theme Three underscores the profound psychological challenges faced by HCWs in South Africa. The contrasting teamwork experiences, the toxic impact of hierarchical structures, and the emotional exhaustion from patient care highlight the urgent need for supportive and respectful workplace environments. Addressing these psychological conditions is crucial for improving HCWs' well-being, job satisfaction, and the overall quality of healthcare delivery. Enhancing team dynamics, fostering supportive relationships, and providing adequate emotional support are essential to creating a healthier and more sustainable work environment for HCWs.

Chapter Seven - Theme Four: Purpose and Value

Introduction

Theme Four explores the sense of purpose and value that HCWs in South Africa derive from their work. This theme encompasses the emotional highs and lows tied to patient outcomes, the importance of acknowledgement and recognition, and the joy found in teaching and professional growth. The chapter is organised into three subthemes: “Recovered Patients vs Death”, “More Acknowledgment, Reward and Recognition,” and “Research, New Patients, Unusual Diagnoses, Teaching, Publishing”.

Subtheme One: “Recovered Patients” (91) vs “Death” (152)

Participants describe a dichotomy between positive and negative patient outcomes as causes of fulfilment and distress, respectively. They describe how positive patient outcomes bring them joy and fulfilment, for example:

Seeing patients improve. Bringing new life to the world. Feeling like you are making an impact on a person's life in a positive and sometimes life-changing way. (7)

Seeing my patients progress from being acutely ill to being able to function as best as they can. Seeing my patients enjoy my sessions and getting validation that I have made a difference in their lives. (187)

However, the dichotomy emerges when participants are confronted with the reality of adverse patient outcomes which bring distress and frustration, for example:

...Mortality (36)

I get frustrated when a patient deteriorates and dies...more so with babies. (57)

...patients who show little improvement (193)

Participants express positive patient outcomes as a source of “*personal fulfilment (18)*” and why many stay in their roles. Positive patient outcomes have been found to impact HCW job satisfaction significantly (Kazadi et al., 2023). Participants express a deep emotional connection to the positive impact they believe they have on individuals and reflect a sense of accomplishment and purpose from the rewarding aspects of their profession. They describe the distress and helplessness they experience when faced with the limitations of medical interventions and the inherent uncertainties of patient outcomes. Notably, participants share more details on their experience of positive outcomes, suggesting a struggle to articulate their grief and feelings of futility when patients die. This struggle was further demonstrated with

the use of abrupt, harsh words such as “death” and “mortality”, implying an avoidance of elaboration. Responses such as *“When the patient is in so much pain and there is nothing I can do”* (54) suggest a painful and prolonged witnessing of decline with a sense of unbearable helplessness. Overall, this dichotomy is common (Ijumba, 2002; Jensen et al., 2022; Kazadi et al., 2023; Wagner & Pather, 2019; Watermeyer et al., 2020) and underscores the delicate balance HCWs must maintain between the positive aspects of their work, where they witness healing and improvement, and the emotional challenges associated with the limitations of medical care.

Participants described the experience of being needed and meeting the patient's needs as a source of joy and fulfilment.

If I make a difference in someone's life (40)

I love helping people and attending to their needs. I enjoy coming up with a diagnosis and treating it (90)

Helping patients in their time of need (106)

Participants highlight the intrinsic motivation, self-worth, and personal value they derive from making a positive impact. They suggest a personal commitment to improving the well-being of individuals with an added layer of resilience and determination. The emphasis on "time of need" underscores the significance of supporting and caring for patients during challenging circumstances and critical moments. HCWs have been found to derive a sense of value in their ability to provide healthcare to those in need, providing them with a sense of being needed (Wagner & Pather, 2019), which is particularly significant in South African HCWs (Bidwell et al., 2014).

However, meeting the needs of patients is coupled with a strong sense of responsibility for patient's well-being, which participants describe as both distressing and fulfilling. Fulfilment was described as eliciting a sense of power in the ability to change a patient's outcome, for example:

Taking care of patients & making sure they survive (104)

The ability to change the outcome of a patient with right treatment (125)

...When I diagnose a condition early enough to effect a definitive change in disease course. When I know I've actually prevented disease effectively. (145).

In contrast, distress was described when participants feel responsibility for adverse outcomes and suffering, for example:

Wrong diagnosis of certain conditions or when patients seem dissatisfied with the service we provide (14)

...The constant fear of killing somebody (141)

Hurting patients because I don't have a choice (4)

Responses imply the gravity of the healthcare profession and how participants feel responsible for people's lives. They express a sense of power to alter outcomes and the pride they experience in influencing and improving the trajectories of their patients. The feeling of pride is coupled with the distress of feeling responsible for adverse outcomes. The mention of medical errors and dissatisfied patients reflects participants' vulnerability when their decisions impact patient outcomes. The high-stakes nature of healthcare and the heavy burden HCWs carry regarding the potential consequences of their actions are articulated with a tone of fear. While the mention of not having a choice reflects the internal struggle, they may feel when making difficult choices that may result in harm. The complex tension between accomplishment and pressure is demonstrated in inconsistent burnout scores between the emotional exhaustion and personal accomplishment scales in Maslach's Burnout Inventory across HCWs (Jensen et al., 2022; Moses et al., 2024; Naidoo et al., 2020; Rossouw et al., 2013; Sirsaw et al., 2016).

Participants also grapple with the decision to stay or resign based on their sense of responsibility and commitment to the well-being of their patients. For example, one participant shared that *"I no longer work there (I resigned), but the reason I didn't resign earlier is because I felt a sense of responsibility towards my colleagues and towards my patients..." (119)*. Numerous participants described *"the responsibility I feel towards my patients..." (195)* as a contributing reason they stay in their jobs. The responsibility appears beyond professional duty and becomes a deep personal commitment (Jensen et al., 2022) to ensuring the best possible patient care, reflecting the moral and ethical aspects of healthcare work. However, it has been argued that a conflict between the working conditions and

HCWs' sense of duty sometimes results in them placing the needs of patients above their emotional health (Stodel & Stewart-Smith, 2011).

Subtheme Two: “More Acknowledgment and Reward and Recognition” (40)

Participants shed light on the emotional highs and lows they experience in their interactions with patients, from the rewarding moments of gratitude to the challenges posed by demanding or unappreciative patient behaviours. They find authentic gratitude from patients as joyful and fulfilling.

When patients feel better and acknowledge the effort we do for them (14)

The smiles on my patient's faces, the thanks and affection from their parents (107)

Some participants portray a positive and appreciative tone of absolute joy that they experience authentic patient gratitude. However, some imply an ironic tone where patient gratitude is uncommon and conveys a longing for more acknowledgment and recognition for their efforts. For example:

[brings joy] ...and when a patient actually pays my bill without the expectation of a freebie or a discount, or a “free follow up” despite it being 45mins later, or 10 other calls with specialists/funders etc... (145)

In contrast, participants experience distress and frustration when patients are perceived as difficult or demanding.

Patients who communicate to me in an angry or frustrated/negative manner, expectations of family that are unreasonable, (193)

Patients have become way too demanding, and demand so much of my time, all hours. (157)

[brings distress] Patients exploit the good nature of doctors. No good deed goes unpunished. There is zero respect or boundaries. Patients tend to think they own a doctor, should be available at every beckoned call, and that we should provide instant relief or cure every time, the first time- else it's a free follow up. (145)

Participants express a tone of emotional labour and financial dissatisfaction, suggesting they may feel undervalued and resentful. Resentment may be influenced by their desire for patients to be privy to all the stressors they endure to provide healthcare services, and their gratitude appears to be a measure of their value. Feeling unappreciated by both patients and organisations has been reported as a contributing factor for HCWs wanting to emigrate

(Bidwell et al., 2014; Fletcher-Nkile et al., 2022) or leave their profession (Wagner & Pather, 2019). The importance of appreciation, respect, and recognition has been shown to mitigate burnout (Stodel & Stewart-Smith, 2011) and increase job satisfaction (Kazadi et al., 2023). Participants experience frustration with patients who may not adhere to medical advice, which interferes with adequate care, also found by (Watermeyer et al., 2020). Responses imply a sense of overwhelm at being stretched thin and pressured by expectations on HCWs' time, including frustration about "*patients running late for their appointment*" (52). This indicates they experience their time as disregarded, building resentment, further implying the perceived expectation for HCWs to be available constantly and feeling used and abused. Some participants share a cynical perspective that their goodwill and intentions will be met with a lack of appreciation, showing the reported pervasive encounter HCWs have with perceived ingratitude (Fletcher-Nkile et al., 2022; Jensen et al., 2022). This is further demonstrated in the elaboration of how patients are perceived to take advantage of HCWs in Participant 145's sarcastic response to what brings them joy. The sarcasm implies a complete lack of pleasure or fulfilment-inducing experiences. In contrast, Ramukumba (2020) reported the majority of the community HCW sample felt that patients showed appreciation and understanding that their work was not easy.

The reference to patients' perceived hold over participants was further expressed in the distress they experience with patient power, particularly over their reputation with legal action.

...Threat of litigation" (96)

"the litigious nature patients have adopted" (142).

... or getting sued. Or badmouthed on social media or a complaint at the HPCSA. [...] Having to pay MPS in case you get sued. Are there even positives? (141).

Participants underscore the legal and ethical challenges they grapple with in their profession. Responses suggest a pervasive anxiety and fear among HCWs regarding legal actions and imply an experience where they desire gratitude but are instead met with being sued or reported. The number of medical malpractice claims appears to be rapidly increasing in both the public and private sectors, both in the number of claims and size (Pepper & Labuschaigne, 2011) , with the size of claims being argued to be unreasonable (McQuoid-Mason, 2022). In 2008, 90 HCWs in South Africa were found to be guilty of unprofessional

conduct, while in 2011, 895 patients were in the process of negligence claims, with a further 1000 awaiting assessment (Pepper & Labuschaigne, 2011). The closing rhetorical question demonstrates how some participants find it challenging to find reasons that their profession brings them joy or fulfilment under the fear of being reported.

Participants described their remuneration and benefits package as another measure of feeling valued or undervalued. Most of them expressed their remuneration as a cause of distress.

...The amount of overtime we do which is well beyond the amount we get compensated for. (12)

Low remuneration for a high demand job... (92)

Not being paid enough. I feel like my salary does not reflect my value. (134)

The topic of financial remuneration pervaded the data, mainly as a cause of distress and an aspect participants would like to change about their work. They express dissatisfaction with their financial compensation concerning their salary not reflecting their value in a primarily matter-of-fact tone. The terms “poor pay” and “not paid enough” were cited by numerous participants, suggesting the perception of a significant disparity between the highly demanding workload and the low remuneration received. Many HCWs are dissatisfied with their remuneration (Bezuidenhout et al., 2009; Delobelle et al., 2011; George & Reardon, 2013; Jensen et al., 2022; Mokoena et al., 2023; Peltzer et al., 2003) and struggle to balance their passion and desire to help patients with their desire and need to make a “*decent liveable income (13)*”. Many participants referred to a better salary as a reason they would leave their role, with only eight participants listing their financial remuneration as bringing them joy or an aspect of their work that they would keep the same. Bezuidenhout et al. (2009) reported financial reasons as the most significant motivation for South African HCWs to emigrate, yet Bidwell et al. (2014) found this not to be the case. Overall, participants' satisfaction with their financial remuneration appears to be a very scarce experience.

Subtheme Three: “Research, New Patients, Unusual Diagnoses, Teaching, Publishing” (107)

Participants share a positive aspect of their profession, particularly the joy and excitement of learning and professional growth.

[brings joy] ...explaining the topics that excite me to patients, challenging myself with new topics (33)

[brings joy] Status, learning a new skill, being innovative and creative (21)

[would keep] My job is actually the easy part, every aspect of it- yet the most complex in every way. I would not change a thing about it. I still learn something new every single day. It's everything else that is the problem. (145)

Participants used words such as “excite”, “challenging”, “interesting”, “creative”, and “stimulating” to describe both their academic endeavours and actual work, conveying a sense of passion and genuine engagement in professional development and learning. Challenges of their work include “*solving medical problems*” (102), “*managing complicated cases*” (168) and figuring out “*complex pathology*” (167), which were expressed as bringing joy and fulfilment, demonstrating the intellectual and learning dimensions of their profession. HCWs commonly welcome mental stimulation and learning opportunities from complex and uncertain diagnostic cases (Erumeda et al., 2023; Wagner & Pather, 2019). Advancing through healthcare training is a long process, and HCWs are unlikely to progress without an intrinsic motivation to learn. This inherent desire for new information suggestively motivates HCWs to study, specialise and attend ongoing training. This was further shown as the desire to emigrate was significantly influenced by HCWs' intention to seek further training and specialisation opportunities abroad (George & Reardon, 2013).

The importance they placed on learning opportunities and developing skills in their profession was further demonstrated by their reference to it as a deciding factor in leaving or staying in their job and something they would like more of.

[would leave] Lack of opportunity for promotion, growth. (77)

[would leave] If I get in a position to be able to specialise (83)

I would also like to be able to have more time to work on self-development in the workplace and broaden my skills so that I am able to provide a better service. (116)

Responses suggest frustration with the current limitations on career advancement and imply the perception that opportunities are not easily accessible. Lack of opportunities has been reported as a factor causing the most severe job stress in HCWs (Peltzer et al., 2003). The desire to specialise indicates an aspiration for professional expertise and may cause further frustration at the lack of perceived opportunity, which is viewed as a barrier to this. The desire for professional growth also motivates HCWs to emigrate to broaden their experience or stay in the public sector with academic aspects (Fletcher-Nkile et al., 2022). This is further shown by 90% of a HCW sample intending to proceed with post-graduate medical studies (Van Wyk et al., 2010). Participants expressed frustration that training feels like a tick-box requirement instead of being driven by purpose and meaningful learning that facilitates growth. They further describe skill development as essential to improving healthcare service to patients and for a sense of personal accomplishment. Two participants expressed their “*hunger to improve skills*” (148) and “*...Keeping up with the latest new knowledge*” (195) as what they would keep the same about their work, both conveying a continuous and positive never-ending motivation to not fall behind the rapid advancement in medicine.

Upon progression in their career, participants find joy and fulfilment in sharing their knowledge with more junior HCWs, as expressed by senior established participants below:

[would keep] The help/assistance/guidance I give to students. [brings joy] ...I enjoy seeing the joy in students, when I have provided them with useful new information. (19)

[would stay] Significant experience and also fulfilment of being able to teach students and younger colleagues to hopefully be better equipped for being a doctor in the harsh society we live in. (78)

Numerous participants mentioned “*teaching (20, 84, 93, 40)*” as bringing them joy and what they would keep the same about their work. Responses suggest satisfaction in contributing to the professional development of others and convey a personal investment in the success of the next generation of HCWs, with a particular mention of equipping future HCWs for the profession. These experiences contrast with the many instances previously mentioned in the data of senior HCWs being uncaring and unsupportive, suggesting HCWs invested in mentorship are scarce, with few preferring to spend “*more time to teach students (166)*” than consulting patients. This contrast was also reported by Erumeda et al. (2023) who found contradicting perceptions between registrars and supervisors in the lack of availability to observe role modelling and learning opportunities on the job. Teaching and supervising

appear to be perceived as a professional progression, adding value and highlighting participants' self-worth in serving others over and above their patients. It has also been reported that teaching and supervising provide ongoing learning opportunities for established HCWs (Erumeda et al., 2023).

Conclusion

Theme Four emphasises the profound emotional experiences that shape an HCWs' sense of purpose and value in their profession. The joy of positive patient outcomes and gratitude from patients starkly contrast with the distress of adverse outcomes and lack of appreciation. Additionally, the intrinsic motivation for learning and teaching underscores the importance of professional growth in maintaining HCWs' sense of fulfilment. Recognising and addressing these emotional dynamics is crucial for supporting HCWs in their roles, ensuring their well-being, and ultimately enhancing the quality of healthcare delivery in South Africa. Providing adequate acknowledgement, opportunities for growth, and emotional support can help sustain HCWs' commitment and passion for their vital work.

Chapter Eight - Theme Five: Feeling Stuck and Trying to Cope

Introduction

Theme Five delves into the emotional experiences of HCWs and their perceived sense of agency within their roles. It explores the various coping strategies they employ to manage their stress and their significant challenges in finding effective coping mechanisms. The chapter is organised into three subthemes: "Fears and financial obligations," "Job security concerns," and "Coping strategies: healthy vs unhealthy."

Subtheme One: “Fear of Risk and The Unknown” (141)

Participants express a sense of apprehension and reluctance to change jobs due to concerns about potential adverse outcomes.

I once changed jobs and my new job was worse than my old. I'm worried that if I change again the same could happen (184)

[would stay] ...The grass may not be greener on the other side. It's hard to change. (94)

[would stay] The fear of the unknown and being judged by family and friends. Feeling like I quit because I'm a failure. (9)

The fear of the unknown and the possibility of experiencing a worse situation in a new job is evident. Additionally, the fear of judgment from family and friends and the perception of quitting being associated with failure adds emotional weight to the decision-making process. Participants may consider similar working conditions in any role under the DoH due to the pervasive systemic challenges. Bidwell et al. (2014) found many of their HCWs sample have moved from the public to the private sector to address systemic factors. However, responses convey a perceived fear of running a private practice as riskier, with additional business management demands. Fletcher-Nkile et al. (2022) reported that HCWs no longer find private practice appealing due to the saturation of the private sector, particularly in urban areas, and high economic costs such as income tax, which require longer working hours to make a decent living. Interestingly, HCWs have reported that working in both sectors allows the experience of the best aspects of both, particularly the well-resourced private workplace and the collegial support in the public sector (Fletcher-Nkile et al., 2022).

Participants express a sense of stuckness in their profession when asked what reasons keep them in their job.

Where else do you go? What else do you do? It's not easy moving abroad and then having to establish yourself again, trusted collegial relations, proving competence etc all from scratch. I certainly don't have the energy to embark on this all over at this moment. (145)

No other option (85) (93)

Responses indicate a perceived lack of alternatives or a feeling of being trapped. Overall, the tone conveys challenges and limitations to change, with a sense of resignation to their circumstance. HCWs have described the scarcity of public sector posts as being due to older HCWs being unwilling to move on and the private sector becoming progressively saturated (Fletcher-Nkile et al., 2022). With the extended period and resources dedicated to training, some participants feel trapped by “*The amount of time that I invested into it already*” (176) and “*Finishing what I started*” (179). This suggests that participants find it more challenging to leave their jobs the more qualified they become, while some report staying in their roles to finish training requirements. George and Reardon (2013) reported HCWs planning emigration shortly after graduating with the perception that they would be able to repay training fees sooner when earning money abroad. However, the high costs of emigration, including examination fees to acquire professional registration in destination countries, act as a barrier to many HCWs actualising their emigration plans (George & Reardon, 2013).

Financial obligations and the need for a stable income are significant factors keeping participants from leaving their jobs.

I need the money to take care of my family (168)

I wouldn't have food to eat if I quit (20)

FINANCIAL RESPONSIBILITIES (191)

Many participants responded that financial commitments and obligations keep them in their jobs. Responses reflect practical and immediate concern for basic needs, which is experienced as a compelling reason to stay in their current employment despite potential challenges or dissatisfaction. Their choice of formatting and straightforward language underscores the gravity of the situation, emphasising that the need for income is not just a preference but an essential aspect of meeting basic life requirements. Notably, more participants listed financial obligations than positive work experiences as the reason for keeping them in their jobs. This further implies the experience of feeling trapped in how they

link their professional choices directly to the well-being and sustenance of their families. The desire for higher salaries and more financial security and safety for their families motivates HCW's consideration of emigrating (Fletcher-Nkile et al., 2022; George & Reardon, 2013).

Participants underscore the significance of job security as a significant factor influencing their decisions to remain in their current positions.

The benefits and the fact that I have a job, especially in the current economic state we are in. (61)

Job security (149) (197)

Some participants also mentioned leaving only if they received a secure job offer elsewhere.

Corporate-I would leave clinical medicine altogether if the offer was worth it (a very sad reality) (145)

If I got another offer I'd consider taking it (184)

If I had a good offer at another institution I would definitely leave (53)

Participants convey a pragmatic perspective in acknowledging the value of having a stable position with gratitude, particularly in the South African economic climate. The mention of moving for other offers introduces a conditional aspect to the commitment to their current workplace. This reveals that while job security is perceived as crucial, there is a willingness to entertain the idea of leaving and escaping their current environment for a similar offer. Responses demonstrate the desire to leave healthcare altogether and imply the experience of being an HCW can be so severely taxing and painful that they have no other option but to leave the vocation. Some participants appear to be looking for new opportunities, suggesting they have one foot out the door, as they cite only staying in their job because of “*not getting another job*” (65). One participant articulated how the “*niche skill set acquired doesn't open many doors, competitive hiring environment* (75), suggesting that HCWs are waiting for opportunities to arise to leave their jobs, which are perceived to be very scarce. This fear of scarcity is supported by the current crisis in South Africa, whereby hundreds of qualified doctors cannot secure employment (Majavu, 2023). The Minister of Health, Joe Phaahla, recently commented that the shortage of posts is due to budget constraints and that they are attempting to address this (‘Health Working Around the Clock to Absorb Unemployed Doctors - Minister Phaahla’, 2024).

Subtheme Two: “Self-Care” (141)

In response to how they deal with the distress caused by their work, a complex dichotomy emerged between the number of different coping strategies participants implement with the hope of helping. Some describe very many strategies they employ, for example:

I see a psychologist once every 2 weeks, speaking to my husband who is also a healthcare worker helps because he can relate to a lot of the frustration that I experience, also being outdoors and exercising has helped a lot. (14)

Discussing issues/ debriefing with colleagues, having morale-boosting events and team building, personal mindfulness and prayer, use of humour (18)

Take antidepressants, antacids, commiserate with colleagues, complain to my family, laugh, sleep a lot, overeat, cry, distract myself with games, watch tv (94)

While others describe very few, for example:

Gym (3)

Watch TV (26)

Reading (93)

Alcohol (63)

Participants highlight a spectrum of coping strategies, ranging from professional mental health support and personal lifestyle choices to the use of substances, reflecting the multifaceted ways in which they address the challenges and stressors. The use of many strategies described as helpful implies that some participants are coping well. The use of excessiveness when referring to eating and sleeping and the need to distract themselves or “cry (83, 137, 145, 178)”, suggests one strategy provides insufficient relief to emotional stress and turmoil they experience. Crying has been expressed as an effective outlet for bottled-up emotions and enables HCWs to move on and face another day at work (Voget, 2017). The most common healthier strategy participants cite is physical exercise in various forms, the use of exercise to release stress and increase endorphins as a positive coping strategy to decrease psychological stress and anxiety in HCWs (Cook et al., 2021). Other healthier methods included creative hobbies and activities, also reported by (Wagner & Pather, 2019), likely provide HCWs space to be immersed in an activity unrelated to their work and give a sense of joy and value outside their professional identity. More spiritual and mindfulness strategies were cited, suggesting some HCWs use spirituality to seek comfort

and solace. Spirituality is common among HCWs, who report their belief system provides meaning to their life and contributes to their sense of resilience as a significant help to their work strain (Kazadi et al., 2023; Pillay et al., 2016; Wagner & Pather, 2019). Less healthy coping strategies cited by participants include the use of substances and excessive screen time. It has been suggested that alcohol may be perceived as a successful way to maintain psychological health, particularly in younger doctors (Firth-Cozens & Greenhalgh, 1997), and other substances that have been reportedly used by HCWs in their lifetime include tobacco, cannabis, sedatives, cocaine, stimulants, inhalants, hallucinogens, and opioids (van der Westhuizen et al., 2019). Although a growing concern for the prevalence of substance misuse in HCWs has been reported, Van Der Merwe et al. (2023) found substance use is the least used mechanism of coping in their sample of HCWs. However, they acknowledge that participants may have been under-reporting due to fear of consequences from employers.

Participants demonstrate complex ways of combining both healthier and less healthy strategies, for example:

I mostly internalise it, which just isn't efficient but I've started talking to colleagues and if they feel the same way I talk to my immediate superior. That has been more fruitful (7)

Gym most days but if not alcohol (178)

These participants imply that healthier strategies feel more effortful, for example, going to the gym or talking to colleagues. The first participant referred to internalisation as their primary coping strategy, which provided insufficient relief. The second participant refers to using alcohol when they are unable to attend the gym as their more immediately available relief strategy. Voget (2017) also found that HCWs implement coping mechanisms that provide short-term relief. The term “but if not” indicates a tone of irony whereby participants try to channel their stress in healthier ways but sometimes fail. This highlights the individual experiences that HCWs have in their choice of coping mechanisms (Kazadi et al., 2023) and how the continuous change in demands may place HCWs at a higher risk for resorting to more unhealthy coping mechanisms (Van Der Merwe et al., 2023).

Many participants cited their own therapy and psychiatric care as coping strategies, for example:

I see a psychologist once a week (106)

I'm on strong medication, antidepressants and anxiolytics. I do spinning for exercise. (120)

I went to see a psychologist and psychiatrist and I am on meds now (190)

I have a psychologist and psychiatrist. I talk to friends who can relate. Learning coping mechanisms and ways of framing to help me cope. Overall I am coping well (169)

Seeking the help of psychologists and psychiatrists indicates a commitment to mental health and emphasises the importance of processing and discussing work-related challenges.

Numerous participants cited being in therapy with psychiatric medication and described these as being helpful in their coping. The use of mental health-related treatment and medication is not uncommon in HCWs (Kazadi et al., 2023; Rossouw et al., 2013; Wagner & Pather, 2019). Although these medications are used as part of the management of depression, anxiety, and stress, it is unclear if the nature of their work causes these mental health challenges.

However, based on the data, it is suggestive that participants' working environment is a perpetuating factor of their mental health challenges. Only two participants expressed that they are coping well or “*don't have stress*” (112), implying most participants do not feel they are coping well or managing their distress successfully. Additionally, untreated symptoms of mental health-related issues, such as depression, will inevitably affect the care that HCWs can provide (Firth-Cozens & Greenhalgh, 1997).

Outside of formal therapy, informal forms of talk therapy were mentioned by many participants as coping strategies.

Express concerns to family and friends (17)

Venting to fellow colleagues or partner (64)

I take a deep breath calm myself and take Stress-Away if need be. Or I talk to my husband about it to get rid of frustrations. (113)

Participants demonstrate the importance of interpersonal connections and social support in their workplace and personal lives. It has been found that HCWs who do not have enough social support are likely to adopt less healthy coping strategies (Cook et al., 2021).

Participants use various ways to describe informal talk therapy, such as “talk”, “vent”, “debrief”, “speak”, and “express concerns”. Sharing concerns with family and friends indicates a reliance on personal relationships for emotional support and involves verbally expressing stressors and seeking comfort in trusted individuals. HCWs have reported to

prioritise relationships outside of work as they feel it is a vital contributing factor to their well-being and influences their health (Kazadi et al., 2023; Voget, 2017; Wagner & Pather, 2019). The term “*venting* (31, 57, 106, 120, 160, 162, 170)” was commonly cited and suggests expressing negative feelings or frustrations. Venting to colleagues indicates the importance of workplace relationships, as “*commiserating* (83)” appears to be bonding and forming connections through joint suffering. This implies that sharing with colleagues who relate and understand provides relief against feelings of loneliness in their experiences, which links to the previously mentioned importance participants place on team cohesion and connection. However, emotional support and venting are attributed to Approach and Avoidant coping styles, respectively, on the Brief Cope Inventory, suggesting the former is adaptive while the latter is maladaptive (Engelbrecht et al., 2021; Van Der Merwe et al., 2023). This contradicts the value that this study and Voget's (2017) participants place on venting to colleagues as helpful. During COVID-19, HCWs found it particularly detrimental when they were required to isolate and were unable to use their social support as a coping strategy and found the isolation to exacerbate their psychological strain (Kazadi et al., 2023). Participants rely on trusted individuals in their personal lives, and although they find them supportive, this implies taking work stress home. One participant explained, “*My wife supports me, but I need to acquire better habits of dealing with stress* (58)” suggesting not only the struggle to maintain clear boundaries between their professional and personal life but also that the lack thereof may feel unhelpful.

Subtheme Three: “Struggling with That at The Moment” (192)

Despite implementing various strategies, some participants were honest in their struggle to cope, with the persistence of emotional challenges underscoring the need for ongoing support and coping mechanisms.

I see my psychologist weekly. I have a psychiatrist. I'm on High doses of antidepressants. Learning to set boundaries. But it's still shit. I cry on my way to work every day (153).

I struggle a lot but talking and engaging in healthy leisure (192)

Exercise, talking to others and trying not to bring it home but the stress is always there :((195).

The language used in these quotes is poignant and reflects a deep emotional struggle. The description of crying by many participants carries a heavy emotional weight, emphasising the significant impact of the job. The mention of high doses of antidepressants suggests a severe

attempt to manage their emotional well-being. However, responses convey an ongoing sense of difficulty and challenges in coping with their distress despite seeking help, showing the complexity of the emotional burden HCWs carry. Concerning rates of anxiety and depression have been reported in HCWs (Naidoo et al., 2020; Pool et al., 2024), and high levels of stress in HCWs increase their risk of suicide, psychiatric morbidity, drug use, and family disruption (Stodel & Stewart-Smith, 2011). Participants show a proactive willingness to address their mental health but also indicate that finding effective coping mechanisms is still a work in progress, particularly with the concluding statement expressing a poignant reality of the persistence of detrimental effects of stress despite efforts to cope.

Some participants report getting stuck in escapism strategies and how they struggle to implement healthier ways of coping.

Try to forget. Bury myself in literature sometimes. Or just space out on the xbox. (126)

Urbanol mostly. Also mindlessly scrolling through tiktok while binge watching series on Disney while I should try and sleep or at least do something useful. Unfortunately did not pick up any spectacular coping strategies through the years (141)

I have seen myself binge drinking over the weekends (157)

Poorly. Self-care is shocking in our medical training, and in the established medical culture- despite the attempts at putting it into the curriculum. It needs to start at the top and move down. (145)

Participants expressed a desire to escape or temporarily distance themselves from work-related stress but were not always successful. Responses suggest a coping mechanism that involves consuming excess to unwind or cope without always realising it at the moment. These also demonstrate an avoidant coping style (Engelbrecht et al., 2021; Van Der Merwe et al., 2023); self-distraction is the most frequently used mechanism by other HCWs (Van Der Merwe et al., 2023). Other participants acknowledge not having good coping strategies, indicating a more reflective self-awareness of the lack and need for more effective coping mechanisms. Responses bluntly communicate the participants' experience of inadequacy in the current status quo of self-care. It indicates a sense of maladaptation in the system with emphasis on the experienced need for a fundamental shift in how self-care is approached within the medical profession, along with a call for systemic change.

Some participants expressed a sense of helplessness and stuckness in how they struggle to implement coping strategies.

Try and forget about it. (9)

Sleep as much as I can (91)

I don't really- just carry on. There's no time for deep reflection and stress processing anyway (184)

I don't : (193)

The brevity and tone of these quotes convey a feeling of stuckness and helplessness in the shutting down of their reflection and thinking in the face of overwhelm. Numerous participants cited sleeping and forgetting as their way of coping, implying their attempt to put aside or suppress distressing thoughts or stressors consciously. Other participants abruptly cited their way of dealing as “denial” (139) and “ignore it and carry on” (76), further indicating their desire to distance themselves from the impact of distressing feelings as they experience a continuation of responsibilities without time to address or process their stress actively. The use of denial demonstrates an avoidant style of coping, which has been reported in other HCWs and been associated with PTSD symptoms (Engelbrecht et al., 2021) and was reported as the least used mechanism in a sample of HCWs (Van Der Merwe et al., 2023). The final statement conveys a sombre tone, indicating some participants struggle with coping and feeling helpless about how to start addressing this struggle to cope.

Overall, denial or avoidance strategies also suggest feeling helpless in finding a more proactive approach. However, this can lead to negative consequences for HCWs as their distress may find relief in unfortunate ways, for example:

Swearing. Venting. Fighting. Internal rage. (181)

I snap. I have yet to find the time to develop coping mechanisms. (151)

Detached myself or attack back (128)

I don't. I'm a ticking time bomb. (131)

Responses suggest a release of intense emotions and may both indicate a symbolic struggle against the stressors and an aggressive approach to handling difficulties, possibly as a way of regaining a sense of control or agency in the face of overwhelm. Participants convey a tone of

harshness, suggesting an experience of a sudden, intense emotional reaction as the final breaking point under pressure. They reference limited time, indicating a lack of internal resources for self-care, with the metaphor of a ticking time bomb implying the experience of being in a constant state of alertness and impending emotional eruption. This metaphor indicates a sense of urgency and vulnerability and suggests that anyone nearby may be a casualty of their explosion, causing damage to themselves and others. This gives some insight into how HCWs may become unpleasant and difficult to work with, lashing out due to pent-up distress being expressed as anger.

Conclusion

The emotional aspect of HCWs' work experiences highlights a profound sense of being trapped and overwhelmed by systemic and personal challenges. While some HCWs find solace in professional help, social support, and healthier coping mechanisms, many need help with the effectiveness and consistency of these strategies. The pervasive feeling of stuckness, coupled with financial and job security concerns, underscores the need for systemic changes and better support structures to alleviate the emotional burden on HCWs.

Chapter Nine - Conclusion

Introduction

This chapter synthesises the study's findings, highlighting the main themes and their implications for the South African healthcare system. It also discusses the study's limitations, policy and practice implications, and future research recommendations.

Summary of Findings

This study used a qualitative research design within an exploratory, descriptive phenomenological framework. It provides a comprehensive understanding of the lived experiences of 177 HCWs across eight of nine provinces in South Africa. By focusing on qualitative data, this study delves deeper into the subjective experiences of HCWs, offering insights beyond what quantitative data alone can reveal.

This study confirms that the South African healthcare system is marked by a critical shortage of HCWs and a pronounced disparity between the public and private sectors. The literature review underscores the limitations of applying global studies to the South African context and highlights the necessity of locally conducted research. Through five key themes, a comprehensive understanding of the systemic, occupational, psychological, and emotional landscapes that shape the daily lives and professional environments of HCWs has been demonstrated.

Results revealed the multifaceted challenges faced by HCWs within the South African healthcare system, emphasising their deep frustrations and emotional burdens. Participants expressed a pervasive disillusionment with the healthcare system, citing systemic flaws such as mismanagement, bureaucratic inefficiencies, and severe resource shortages that hamper effective healthcare delivery. These systemic issues are compounded by a toxic workplace culture, where poor management practices and political interference further exacerbate HCWs' difficulties. The demanding working conditions, marked by excessively long hours, heightened administrative burdens, and significant safety concerns, have a profound impact on HCWs' physical and mental well-being. Many HCWs reported experiencing physical exhaustion and burnout due to excessive overtime, while the administrative load detracted from their clinical duties and added to their stress. Safety concerns, particularly among female HCWs, further intensified their anxiety, highlighting a dire need for improved security measures within healthcare facilities. Psychological strain is a prevalent theme, with HCWs

experiencing considerable emotional and mental distress. The dynamics within healthcare teams varied widely, with some participants praising positive mentorship and collaboration while others lamented conflicts and the lack of support from colleagues. The hierarchical nature of the healthcare system often perpetuates abusive behaviours from superiors, contributing to a toxic work environment. The emotionally taxing nature of healthcare work, particularly in dealing with patient suffering and death, added to the psychological burden, underscoring the necessity for better emotional and mental health support for HCWs. Despite these substantial challenges, HCWs derived a profound sense of purpose and value from their work, mainly through positive patient outcomes and expressions of gratitude from patients. These moments of fulfilment were vital in sustaining their commitment to their profession. However, the joy of positive patient interactions was often contrasted with the distress caused by adverse outcomes and unappreciative patients. Additionally, the intrinsic motivation for continuous learning and teaching played a crucial role in maintaining HCWs' sense of professional growth and fulfilment. Many HCWs expressed a feeling of being trapped in their roles due to financial obligations and job security concerns, which limited their sense of agency and exacerbated their stress. The struggle to find effective coping mechanisms was evident, with some HCWs managing their stress through professional help and social support while others resorted to less healthy strategies. The pervasive sense of being stuck highlights the need for systemic changes and better support structures to alleviate the emotional burden on HCWs and enhance their overall well-being.

The findings underscore the urgent need for comprehensive reforms within the South African healthcare system. Improving management practices, increasing resources, ensuring fair working conditions, and providing adequate emotional and mental health support are critical steps toward enhancing HCWs' well-being and the quality of healthcare delivery. Addressing these issues is essential for creating a more sustainable and supportive work environment for HCWs, ultimately benefiting HCWs and patients in South Africa.

Limitations

This study has several limitations that should be considered when interpreting the findings. While the study achieved a larger and more diverse sample than previous qualitative studies, the poor representation across demographic factors such as race and province, particularly the larger female, Gauteng, and Western Cape sample majority, limit the generalisability of findings to the broader South African context. The study's cross-sectional design provides a

snapshot of HCWs' experiences at a single point in time, and the findings may only apply to the time the data was collected. The reliance on qualitative data means the findings are based on the participants' self-reported subjective accounts. While this provides insight, it may also introduce bias. Response bias may also have occurred because respondents may have perceived the survey as an opportunity to voice their grievances in the hope of addressing their complaints. An online survey was used to collect data, which could have been accessed by anyone who had seen the study's advertisement. Attempts to mitigate against this were demographic filter questions on the professional designation and the exclusion of participants who did not meet the inclusion criteria or left demographic questions blank. The sample could have been susceptible to selection bias because HCWs who were more burned out or under psychological stress may not have had the capacity or willingness to participate. Using online open-ended questions is a limitation, given that the questionnaire does not allow probing and clarification where necessary; therefore, the responses are less detailed than those collected in face-to-face interviews.

Implications for Policy and Practice

The findings of this study have several important implications for policymakers, healthcare organisations, and the South African government. There is a critical need for more equitable resource allocation between the public and private sectors and across different regions and settings within South Africa. Implementing robust support systems for HCWs, including mental health services and professional development opportunities, is essential to mitigate the psychological toll and reduce turnover intentions. Recognising and appreciating the hard work of HCWs can significantly improve their job satisfaction and psychological well-being. This includes both formal recognition programs and everyday acknowledgements.

Future Research Directions

Future research should focus on several key areas to build on this study's findings and further improve the South African healthcare system. One area is conducting longitudinal studies to track the experiences of HCWs over time and better understand the long-term impact of their working conditions. Another is exploring the effectiveness of various interventions to reduce burnout and improve job satisfaction among HCWs in South Africa. Lastly, the experiences of HCWs in different regions and settings within South Africa should be compared to identify specific factors contributing to better or worse outcomes. By addressing these areas, future research can contribute to a more comprehensive understanding of the challenges faced by

HCWs and inform the development of targeted interventions to improve the South African healthcare system.

Recommendations

Based on the findings of this research, several recommendations are proposed below to address the challenges faced by HCWs in South Africa and improve the overall healthcare system.

Systemic Reforms in Healthcare Management - The pervasive structural and political issues within the South African healthcare system demand urgent reform. Improving management practices by establishing more explicit guidelines, accountability measures, and transparent decision-making processes is crucial. This should include restructuring management hierarchies to foster a more supportive environment that values input from HCWs, allowing them to actively participate in policy formulation and workplace improvements.

Enhanced Resource Allocation and Support - Participants highlighted the dire need for more workplace resources, including medical supplies, staffing, and infrastructure. It is recommended that the Department of Health and other relevant authorities prioritise resource allocation to underserved healthcare facilities. Thorough needs assessments should guide this to ensure resources are distributed equitably and effectively, and administrative tasks should be considered for redistributing to dedicated staff. These will allow HCWs to focus more on direct clinical work and patient care.

Improving Working Conditions - Long working hours, excessive administrative burdens, and safety concerns significantly impact HCWs' well-being and job performance.

Recommendations include implementing policies to regulate working hours, provide adequate administrative support, and ensure safe working environments. Employers should also invest in protective measures, particularly in and around facilities.

Addressing Psychological Conditions and Emotional Support - The emotional and psychological burden on HCWs was evident, with many reporting feelings of burnout, anxiety, and emotional exhaustion. It is recommended that healthcare institutions develop and provide accessible mental health support services, such as counselling, peer support groups, and stress management programs. Additionally, creating a more collaborative and respectful

work culture can help mitigate the negative impacts of hierarchical toxicity and improve team dynamics.

Recognition and Professional Development - Acknowledgement and recognition were highlighted as crucial factors influencing HCWs' sense of purpose and job satisfaction. Healthcare institutions should implement formal recognition programs to celebrate HCWs' achievements and contributions. Providing opportunities for ongoing professional development, such as training, workshops, and mentorship programs, can help maintain HCWs' motivation and foster a culture of continuous learning.

Support for Coping Strategies and Reducing Feelings of Stuckness - Many HCWs expressed feeling trapped due to financial obligations, job security concerns, and challenges in finding effective coping mechanisms. To empower HCWs to manage stress, healthcare organisations should offer career development pathways, financial planning resources, and resilience training. Moreover, establishing clear career progression opportunities can help reduce the sense of stagnation and improve overall job satisfaction.

Policy Advocacy and Stakeholder Collaboration - The findings underscore the need for greater collaboration between government bodies, healthcare organisations, and HCWs to drive policy changes that reflect the realities of those on the frontlines. Advocacy efforts should focus on addressing systemic challenges, improving working conditions, and ensuring that the voices of HCWs are heard and considered in policy-making processes.

These recommendations aim to address the multifaceted challenges experienced by HCWs in South Africa, fostering a more supportive, efficient, and sustainable healthcare system that prioritises the well-being of its workforce. Implementing these changes is crucial not only for improving HCWs' working conditions but also for enhancing the overall quality of care provided to patients across the country.

Personal Reflections

The research process has brought to light the remarkable resilience, dedication, and unwavering commitment of South African HCWs, who continue to provide essential care despite facing overwhelming challenges. Their experiences reflect the urgent need for systemic change and the extraordinary strength and compassion they bring daily to their roles. This study serves as a heartfelt acknowledgement and deep appreciation for all they endure and contribute, highlighting the importance of supporting and valuing these incredible individuals who are the backbone of the healthcare system in South Africa.

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Appendices

Appendix A: Participant Discipline Categories

Table A1

Sub-Classifications of Discipline Factor

Discipline	<i>n</i>	Sub-Classifications
Musculoskeletal	12	Physiotherapy, Chiropractic, Podiatry, and Orthopaedics
Critical	20	Emergency Medicine, Casualty, Intensive Care, and Internal Medicine
Surgery	8	Surgery, Specialist Physician, and Anaesthesiology
Medical Science	8	Pharmacy, Radiography, Clinical Research, Pathology, and Infectious Disease
Occupational Therapy	19	Occupational Therapy and Speech Therapy
General	20	General Practice, Family Medicine, Nursing, Dentistry, Oral Hygiene, and Geriatrics
Paediatrics	38	Paediatrics, Neonatology, and Obstetrics and Gynaecology
Student	21	Medical Student, Intern, and Community Service
Mental Health	20	Counselling, Clinical, and Educational Psychology, Lay Counselling, and Psychiatry
Public Health	10	Occupational Health Nursing, and Public Health

Note. N=176

Appendix B: Informed Consent Form



Researcher: Daniela Sounes

Please tick the below options and click submit to give informed consent to participate in this study.

1. I agree to participate in this research project, the research has been explained to me, and I understand what my participation will involve.
☐ YES
☐ NO
2. I agree that my participation will remain anonymous.
☐ YES
☐ NO
3. I agree that the researcher may use anonymous quotes in their research report.
☐ YES
☐ NO
4. I agree that the information I provide may be used anonymously by other researchers following this study.
☐ YES
☐ NO

Appendix C: Ethical Clearance for First Study



SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE:

PROTOCOL NUMBER: MAPSYC-22-11

PROJECT TITLE:

Investigating the prevalence of burnout and turnover intention in South African healthcare workers, a mixed methods study.

INVESTIGATOR

Sounes Daniela (607236)

SCHOOL/DEPARTMENT OF INVESTIGATOR

SHCD/Psychology

DATE CONSIDERED

26 May 2022

DECISION OF THE COMMITTEE

Approved unconditionally

RISK LEVEL

Low Risk

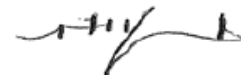
EXPIRY DATE

31 December 2024

ISSUE DATE OF CERTIFICATE

19 July 2022

CHAIRPERSON _____



(Dr Nkululeko Nkomo)

Cc Ms Enid Schutte (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and ONE COPY returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.



Signature

Date

27 / July / 2022

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix D: Ethical Clearance for Current Study



SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE **CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)**

CLEARANCE CERTIFICATE

PROTOCOL NUMBER: Mclin/23/08W

PROJECT TITLE:

Subjective Experiences of Working as A Healthcare Worker in South Africa: A Qualitative Study.

INVESTIGATOR

Sounes Daniela (607236)

SCHOOL/DEPARTMENT OF INVESTIGATOR

SHCD/Psychology

DATE CONSIDERED

16 May 2023

DECISION OF THE COMMITTEE

Approved unconditionally

RISK LEVEL

No Risk

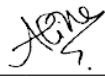
EXPIRY DATE

31 December 2025

ISSUE DATE OF CERTIFICATE

23 May 2023

CHAIRPERSON


(Dr Aline Ferreira Correia)

cc: Prof. Carol Long (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure as approved, I/we undertake to submit an amendment of the protocol to the Committee.



Signature

Date

24 / May / 2023

Appendix E: Participant Information Sheet



Dear prospective participant/healthcare worker,

My name is Daniela Sounes, a current Masters student in Research Psychology at Wits University in Johannesburg. As part of my studies, I am investigating the current state of mind of South African healthcare workers.

As part of this project, I would like to invite you to take part in answering a self-administered questionnaire survey. This activity will involve four sections and will take around 15 - 20 minutes to complete.

By participating in this survey, you will not receive any direct benefits, nor will there be disadvantages or penalties for not participating. You may withdraw at any time or choose to not answer any question. The online survey will be confidential and anonymous and will not be asking for your name or any identifying information, and the information you provide will be held securely and not disclosed to anyone else. I may use anonymous quotes, to represent your responses, in my final research report.

If you experience any distress or discomfort, you may stop the survey at any time. If you need any support or counselling services during or after the survey, these are available free of charge:

1. The healthcare workers care network which includes 24-hour healthcare workers care network helpline (0800 21 21 21 or SMS 43001), monthly support group sessions, and online mental health resources. <https://www.healthcareworkerscarenetwork.org.za>
2. SADAG's 24-hour helpline 0800 456 789
3. SADAG's 24-hour suicide crisis helpline 0800 567 567
4. National Medical Frontliners Counselling 24-hour Hotline WhatsApp: 079 513 7015

If you have any questions about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the Wits university library website.

If you have any queries, concerns, or complaints regarding the ethical procedures of this study, you are welcome to contact the Wits University Human Research Ethics Committee (non-medical) by telephone + 27(0)11 717 1408 or by email: Shaun.Schoeman@wits.ac.za

Yours sincerely,

Researcher: Daniela Sounes
607236@students.wits.ac.za
0842547896

Supervisor: Enid Schutte
Enid.Schutte@wits.ac.za
0117174521

Appendix F: Demographic Questionnaire

Please answer the below questions as they apply to you.

1. How old are you?
2. Which gender do you identify as?
 - ☐ Male
 - ☐ Female
 - ☐ Other
3. Which race applies to you?
 - ☐ Black
 - ☐ Coloured
 - ☐ Indian
 - ☐ Asian
 - ☐ White
 - ☐ Other
4. Which South African Province do you currently work in?
 - ☐ Eastern Cape
 - ☐ Free State
 - ☐ Gauteng
 - ☐ KwaZulu-Natal
 - ☐ Limpopo
 - ☐ Mpumalanga
 - ☐ Northern Cape
 - ☐ North-West
 - ☐ Western Cape
5. How long have you been working in the healthcare services for?
6. What area of discipline do you currently work/practice in? Please be as specific as possible. *E.g. Geriatric nurse in a residential home, medical officer in an oncology hospital unit, etc.*
7. Which sector do you currently work/practice in?
 - ☐ Public
 - ☐ Private

Appendix G: Qualitative Questionnaire

Please answer the below questions in as much detail as possible:

1. What aspects of your work bring you joy and fulfilment?
2. What aspects of your work bring you distress and frustration?
3. What kind of support structures would you like to see more of in your work?
4. What would you change about your work?
5. What would you keep the same about your work?
6. What reasons keep you in your current role?
7. What reasons would make you consider leaving/changing your role?
8. How do you deal with distress caused by your work?

