

**Gordon Institute  
of Business Science**  
University of Pretoria

**Impact of changes in the professional identity of doctors on their  
relationships with organisational management in the South African private  
healthcare sector**

Louise Sole  
Student Number: 441576

A research project submitted to the Gordon Institute of Business Science,  
University of Pretoria, in partial fulfilment of the requirements for the degree  
of Master of Business Administration

9 November 2015

## **ABSTRACT**

This study seeks to establish whether the doctor in the private healthcare sector sees their professional identity as being under threat and how this impacts the interrelationships within the organisation in which they work. Healthcare in South Africa is a dynamic, growing industry, in which the private sector accounts for 52% of the total spend, yet there is a disjoint in the relationship between hospital management and the doctor. To combat the trends of increasing costs, competition, customer expectations of quality care and a changing healthcare environment, the doctor and hospital need to improve this relationship.

The research involves an exploratory study in the form of twelve doctor semi-structured interviews within the private health sector. A purposive sampling strategy is used to identify doctors who are typical of the identified population so as to gain representative perspectives.

This study concludes that a professional identity threat to doctors currently exists. Insight is provided into those characteristics that doctors see as forming their identity and the sources of perceived threats to that identity. Engagement practices that can be considered by the organisational management are proposed with a view to mitigating and managing such changes to the doctor's professional identity.

## **KEYWORDS**

Doctor; Professional identity; Threat; Engagement

## DECLARATION

I declare that this research project is my own work. It is submitted in partial fulfilment of the requirements for the degree of Master of Business Administration at the Gordon Institute of Business Science, University of Pretoria. It has not been submitted before for any degree or examination in any other University. I further declare that I have obtained the necessary authorisation and consent to carry out this research.

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Louise Sole

Date: 9 November 2015

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## **CHAPTER 1: INTRODUCTION OF THE RESEARCH PROBLEM**

### **1.1 Introduction**

The healthcare industry in South Africa is of fundamental importance to the political, economic and social sustainability of South Africa. The National Development Plan (NDP) has a strategic focus for health in which the main expenditure is on improving the standard of primary health care, health facilities, prevention of the spread of the human immunodeficiency virus (HIV) and treatment and universal coverage (Theobald, 2013).

South Africa has a two-tiered system, represented by the public and private sector. One of the goals of the NDP is to make private healthcare less expensive and to formulate an integrated healthcare system. Trading Economics (2015) reflects that the total private health expenditure comprises 4.5% of South Africa's total gross domestic product (GDP) while servicing only 28 to 38% of the population when out of pocket expenditure is included (Deloitte, 2014; Mayosi & Benatar, 2014).

The government is proposing many health reform changes, exemplified by the implementation of a National Health Insurance (Department of Health, 2011a), and has initiated a market enquiry into private healthcare through the Competition Commission of South Africa (2015). There are further disruptive forces in relation to reimbursement, technology, transparency of clinical outcomes and patient satisfaction, and a push for public-private integration (Studer, 2013).

### **1.2 Research Problem**

Collaboration between the hospital and the doctor is a necessity to combat the trends of increasing costs, competition, customer expectations of quality care, the changing healthcare environment and meeting social clinical demands. The doctor plays a significant role in this market and at the core of a doctor is his/her professional identity. Surprisingly, little research has been conducted to evaluate how the professional identity of a doctor in private practice within South Africa is changing and how this is impacting on relationships with organisational management.



### **1.3 Research Scope**

The scope of this report focuses on the private healthcare sector within the Gauteng province of South Africa. It is limited to specialist doctors working in the private sector within private organisations. The private organisation selected was Mediclinic International Ltd for ease of data collection. The specialist doctor or physician is referred to as 'doctor' for the remainder of this report. Similarly, the use of masculine terminology implies both masculine and feminine, with respect to doctors of the respective genders.

### **1.4 Research Motivation and Objectives**

In the private healthcare sector, despite many initiatives, there appears to be a disjoint in the relationship between hospital management and the doctor. The purpose of this study is to improve interprofessional collaboration between doctors and organisations in the private healthcare industry. In doing so, the study aims to ascertain whether the doctor perceives their professional identity as being under threat and how this is impacting on interrelationships within the organisation in which they work.

Martinussen and Magnussen (2011) identified professional identity as core to a doctor's personality characterised by autonomy and devotion to duty. McNeil, Mitchell and Parker's (2013) exploration of professional identity threat in general suggested this could be triggered by historical conventions that have endured over time for both organisations and professionals. Further investigation into how the doctor understands and responds to the changes to their identity may alter and help improve working relationships in a changing healthcare environment (Petriglieri, 2011; Spyridonidis et al., 2015).

Healthcare organisations have identified doctor engagement as key to providing a quality-based, cost-effective service (Snell, Briscoe & Dickson, 2011). The leadership and culture within the organisation correlates with a doctor's commitment to a hospital (Gokce, Guney & Katrinli, 2014). This study aims to gain further insight from the doctor's viewpoint into whether the practices used by the organisations are enabling this interprofessional collaboration (Kreindler, Dowd, Star & Gottschalk, 2012).

This study aims, through discussions with the doctor, to assist organisational managers to understand challenges that the doctor may be experiencing in relation to their professional identity. This may assist them in fostering better relationships.

## **1.5 Structure of Report**

This report is organised into seven chapters, as outlined below.

The first chapter offers an introduction to the healthcare system within South Africa, the research problem, scope of project, the motivation and the objectives that this project hopes to achieve. Lastly, it outlines the structure of the report.

The second chapter reviews relevant literature pertaining to the identified scope. The chapter starts by putting the healthcare environment within South Africa into context. It analyses the South African economy at the time that the report was written, healthcare as an industry and its challenges. It outlines the context of the breakdown of the relationship between private health organisations and doctors. The chapter then reviews current thinking surrounding social and professional identity. Finally, it considers engagement within the workplace and specifically with doctors. This chapter frames the need for the current research.

The third chapter depicts the proposed research questions and leads into the fourth chapter which outlines the methodology used in the project. The framework relating to design, units of analysis, population, sampling, ethics, the approach to data collection and analysis, the validity and reliability of the methodology and, finally, the limitations of this study are discussed.

The fifth chapter reflects on the results obtained from the exploratory interviews from an interpretivism stance. The qualitative data are depicted using graphs and a word cloud to highlight the main findings. Chapter 6 comprises an analysis and interpretation of these results. The first research question is either accepted or rejected, while the second and third research questions are evaluated and discussed in response to the outcome of the first question.

The final chapter portrays a summary of the research findings. It provides recommendations to both the doctor in relation to their professional identity and for the organisation relating to improving engagement with doctors. The chapter concludes with suggestions for further research in this area.

## **CHAPTER 2: THEORY AND LITERATURE REVIEW**

### **2.1. Introduction**

The research problem identifies that the professional identity of the doctor may be influenced by certain threats. The theory that identifies professional identity as being at the core of a doctor's self-concept, and which governs how they practice, is therefore reviewed (Martinussen & Magnussen, 2011). The literature review also explores the South African healthcare context, professional identity and doctor engagement.

### **2.2. The South African Healthcare Context**

A review of the healthcare system within South Africa is necessary to illustrate the landscape in which the doctor and the hospital management in the private healthcare industry exist and operate.

#### **2.2.1. South African Economic Background**

South Africa has a population of approximately 54 million people (Statistics SA, 2015a), comprising of diverse religions, races and cultures. The gross domestic product (GDP) in the second quarter of 2015 had an annualised contraction of 1.3%. The inflation rate during this period was 4.7%, exacerbated by the high unemployment rate of 25% (Statistics SA, 2015a). The Gini co-efficient or index, which measures the distribution of income, for South Africa is 0.63, on a scale where a value of zero indicates the most equitable distribution of wealth in a particular country and one indicates the greatest discrepancy between rich and poor (Worldbank.org, 2015). This index puts South Africa as the fourth-highest country in the world with respect to wealth inequality (Trading Economics, 2015).

In May 2015, South Africa's credit rating was downgraded to BAA2 by Moody's, which indicated a negative outlook because this drops the rating to the second-lowest level for investment (Trading Economics, 2015). The main reasons ascribed to this downgrade were government overspending in relation to income and the deterioration in reliability of electricity supply from the state-owned utility.

The World Economic Forum ranked South Africa 49<sup>th</sup> out of the 140 ranked countries in its *2015–2016 Global Competitiveness Report* (Schwab, 2015). The financial market development pillar scored highly, together with positive impact from the influence of improvements due to internet bandwidth (19<sup>th</sup>) and innovation (32<sup>nd</sup>); however, the health- and primary education-related pillars scored poorly (126<sup>th</sup>). The categories that showed low scores in health were tuberculosis (138<sup>th</sup>), HIV prevalence (137<sup>th</sup>), infant mortality (104<sup>th</sup>) and life expectancy (127<sup>th</sup>).

The National Development Plan (NDP) is a promising policy framework outlining government's plan to improve economic growth rate by 2030. The core elements include housing, water, electricity, transport, education, social protection, employment and healthcare. A key assumption of the NDP is that the implementation thereof will be funded through economic growth at 5% p.a. through to 2030 (Theobald, 2013); however, Sparks (2015), a South African journalist, has reported that, according to the current Finance Minister, Nhlanhla Nene, the economy is actually slowing down. In the first quarter of 2015, the growth was only at one percent. Energy and water resources are vital to South Africa's economic success and the difficulties currently being experienced in these sectors are affecting all sectors. Sparks intimates that NDP goals will not be met, and this will thereby put strain on private business. The healthcare industry, which is a key element of the NDP, will continue to be strained as the economy slides further.

### **2.2.2. Healthcare Industry**

Healthcare in South Africa is a growing industry, with annual spends predicted to be R178 billion by 2017/18 in the public sector alone (National Treasury, 2015). It is a pluralistic system (Van Rensburg, 2012), with a public and private sector which each cater to different markets. The public sector is financed by the government and the private sector by payment from individuals and medical aid schemes.

Healthcare spending is slightly higher (52% versus 48%) in the private sector compared with that in the public sector, but it only services 17% of the population. This figure was, however, reported to be closer to 28 to 38% when out-of-pocket expenses are taken into consideration (Deloitte, 2014; Mayosi & Benatar, 2014). Primary healthcare is predominately provided by the public sector free of charge or at minimal cost. Tertiary treatment (comprising of specialised healthcare within a facility as an in-

patient) is undertaken by both sectors.

Marketline (2014) showed that the total value of the healthcare industry is segmented into out-patient care (31.4%), in-patient care (27%), medical goods (18.8%), collective services and capital formation (12.9%) and long-term care (10%).

When analysing the market's private healthcare providers using a five-force analysis, Marketline (2014) found that health insurance companies (medical aid schemes) and the individual user have moderate buying power. This is attributed to the price sensitivity of individuals and the focus on profit for companies. Size also plays a part because, the bigger the insurance company, the more they are able to integrate and apply pressure on the market.

Marketline (2014) conveyed supplier power as being strong in the market. The suppliers comprise the pharmaceutical companies, equipment suppliers, qualified staff and hospital groups. All have strong negotiating power due to the buyer's desire for quality products and service. The threat of new entrants and degree of rivalry are perceived as moderate due to the capital investment involved, regulations, specialised staff and the reputations of the bigger companies, e.g., Life Healthcare Group Holdings Ltd, Mediclinic International Ltd and Netcare Ltd. There has, however, been a market disruptor as more day hospitals are being opened, thereby threatening this power (Makholwa, 2014).

The threat of substitutes as a consequence of the usage of alternative medicine is also moderate. Alternative medicine in South Africa exists through therapeutic methods (e.g., reflexology), diagnostic treatments (e.g., iridology) and complementary healing systems (e.g., homeopathy) (Van Rensburg., 2012). Traditional medicine has a strong influence in certain demographic groups, due to the cultural diversity within South Africa.

### **2.2.3. Healthcare Challenges**

In a special report, Mayosi and Benatar (2014) outlined the challenges that South Africa experiences. They discussed problems relating to disease, health trends, human resources and economical and political factors. They highlighted that the high Gini index of 0.63 has repercussions with regards to diseases of poverty. South Africa accounts for 17% of the world's human immunodeficiency virus (HIV) infections. In

2015, the estimated numbers were that 11.2% of the population was living with HIV, i.e., 6.19 million people (Statistics SA, 2015a). This has had a negative effect on the incidence of tuberculosis as the frequency increased to 860 per 100 000 of population in 2013 from 253 in 2004, an increase of 240% (Statistics SA, 2015b). The limited and poorly maintained infrastructure of the public hospitals, that are generally underfunded and mismanaged, has led to further burden on disease control.

Health trends showed life expectancy to be, on average, 62.5 years, which is an increase from 53.4 years, measured in 2004 and largely due to the success of anti-retroviral programmes (Statistics SA, 2015). However, high mortality rates for neonates, infants and children younger than five years remain. The changing patterns of diseases causing premature death and disability and the emergence of non-communicable diseases (e.g., stroke, ischemic heart disease, diabetes, hypertensive heart disease and chronic renal disease) are likely to increase the burden on short- and long-term healthcare services (Mayosi & Benatar, 2014).

Research into human resources in this sector showed an on-going challenge, despite a 34% increase in doctors qualifying between the period of 2000 and 2012 (Mayosi & Benatar, 2014). The ratio of doctors per 100 000 population in 2013 has shown minimal increase since 2000 and remains at 60. Countries within the BRICS, a group of emerging national economies, with similar profiles have ratios of 70 (India), 189 (Brazil), 194 (China) and 431 (Russia) (Econex, 2015). It was difficult to gain accurate statistics of South African doctors immigrating but Econex (2015) estimates that during the years of 2005 to 2009, 17% of doctors did not register for community service which is necessary to register with the Health Professions Council Association in order to practice. Mayosi and Benatar (2014) spoke of immigration studies showing that 30% of doctors have immigrated during the periods 2000 and 2012, thereby decreasing returns on the cost of their subsidised education. Nursing numbers, according to the Nursing Council, have increased over the years, but this could be misleading because they may not all be practicing (Mayosi & Benatar, 2014). Further reports indicate that there is no capacity to train more doctors (Child, 2014). Disparity between rural and urban distribution of medical staff exists, with only 12% of doctors and 19% of nurses working in the rural areas, which service 43.6% of the population (Whiteside, 2014).

The government has developed the concept of a National Health Insurance (Department of Health, 2011a), which details a central financing system which would enable all South Africans free access to healthcare. However, lack of funding and the

shortage of professional skills are delaying implementation of this goal (Phakathi, 2014).

The Competition Commission of South Africa (2015) has recently started a market enquiry to establish whether the private healthcare industry exhibits features of anti-competitive behaviour. The pending outcome will determine the future of organisational sustainability in the private healthcare sector.

Further changes in the healthcare landscape are identified as resulting from greater influence of both the patient and the impact of medical aids. Historically, the care of patients was centred on the convenience of the doctor and the hospital, rather than on the patient's needs (Pate, 2012). Medical aids are now perceived to have a greater influence on the industry because they are seen to dictate patient treatment (Child, 2015). They have also increased the use of designated service providers, which has channelled patients to specific providers (Still, 2014). Additionally, the Department of Health will, in future, require the publishing of clinical outcomes, which will lead to greater transparency of the industry (Department of Health, 2011b).

#### **2.2.4. Private Healthcare Organisations**

The private hospital sector in South Africa has three main players, all of which are listed on the Johannesburg Stock Exchange. Their sizes are measured on the number of registered beds (Still, 2014). These hospital groups are: Netcare Limited, with 9424 beds (Netcare Limited, 2014); Life Healthcare Group, with 8418 beds (Life Healthcare Group, 2014); and Mediclinic International Limited, with 7883 beds (Mediclinic International Limited, 2015). While all these companies have international interests, only the South Africa figures are quoted. The National Hospital Network has 8252 beds, with the remaining 7315 beds available in the country made up from independent and mine hospitals (Still, 2014).

Hospital funding, as previously mentioned, originates predominantly from health insurance and the out-of-pocket spend of patients. Individual private hospitals are managed by hospital managers who have the autonomy to engage with all stakeholders, e.g., doctors and patients. The administration and procurement processes are generally centralised to allow for economies of scale (Van Rensburg, 2012). Hospitals have an employed nursing and administration workforce who render



care to patients.

### **2.2.5. Doctors in South Africa**

In 2010, the estimate of the number of doctors in South Africa by Econex (2010) was 27 431, with 70% working in the private sector (Green, 2013). Doctors practice either in private practice or are employed by the public sector. Public sector doctors, with permission, can do private work called Remunerated Work Outside of Public Service (RWOPS). The advantages of this scheme, as highlighted by Taylor and Khan (2014), are that doctors gain experience, teaching opportunities and financial supplement, while the public sector is still able to retain these doctors; however, a negative aspect is the abuse of this scheme by doctors not working their full-time quota in the public sector.

In the private sector, doctors have to apply to hospitals for admission rights and are required to go through a process of credentialing or reference checking. If available, they rent practice rooms on the hospital premises and all equipment and staff required by their practices is paid for by the doctor. Dr Coetzee, the General Manager of the South African Medical Association, South Africa's biggest doctors' union, has indicated that the average age of doctors in private practice is 58 (Kahn, T., 2014).

Doctors in the industry have always legally worked according to their qualifications obtained and their registration with the South African Medical Association. General practitioners have historically been the first line of contact with the patient prior to referring them on to the specialist, as necessary. Today, patients are also self-referred to specialists.

No contracts between the private hospital and doctor are signed, and theatre space has to be negotiated according to the operational availability of the hospital. Doctors are co-opted voluntarily onto committees to assist with operational and clinical matters that arise.

## **2.3. Social Identity Theory**

Robbins and Judge (2013) refer to social identity as the characteristics linked to self-esteem that an individual considers as important to being a member of a group.

Booyesen (2007) described social identity as an individual's classification of themselves and others into different categories. This classification is generally "relational and comparative" (Tajfel & Turner, 1986, p. 16).

Ashforth and Mael (1989) divided self-concept into two areas, i.e., personal identity and social identity. Personal identity is made up of various characteristics that allow an individual to define themselves, such as physical attributes, qualities and individual personality traits. Social identification integrates an individual into a social group, the categorisations of which could be similarity with regard to values, education or demographics, identification with a distinctive profession or status, or even the reduction of uncertainty in relation to where they fit into a situation or environment.

Tajfel and Turner (1986) argued that an individual's self-image is linked to the group that he belongs to. Individuals belong to different groups and, the stronger the identification with a certain group, the greater the effect will be on their social behaviour (Kreindler et al., 2012). There is an emotive association with the group which compares favourably to other groups according to values and characteristics. Striving for a positive social identity causes movement within groups or active improvements to further differentiate the superiority of a particular group.

## **2.4. Professional Identity**

Professional identity is derived from Social Identity Theory because members form part of an organised group that possesses distinctive knowledge and skills which have economic value in society (Pratt, Rockmann & Kaufmann, 2006). This self-reference forms an integral part of a doctor's social and professional identity (Tajfel & Turner, 1986). It guides a new member in gaining a realistic view of their chosen profession.

### **2.4.1. Formation of Doctor Identity**

Doctor identity can be described by three different, but interrelated, levels: occupation level, activity level and individual level (Andersson, 2015).

The occupation level implies that the basis of their work is related to medical science. This is cultivated during the time spent in medical schools, learning the norms and values, watching the social effect of their colleagues and role models (Goldie, 2012),

and by listening to stories (Pratt et al., 2006). The application of their learnt science to the medical problems of their patients relies on use of their judgement in different circumstances. Martinussen and Magnussen (2011) highlighted that doctors are socialised into a culture of individualism which is characterised by autonomy and devotion to duty.

Traditionally, a doctor's definition of autonomy has been seen as having freedom to decide on and provide treatment to patients using their best abilities and judgement. The well-being of their patient is their main priority (Emanuel & Pearson, 2012). However, this identity can be seen as elitism and can be counterproductive to other interrelationships. It also deters improvement in the consistency of outcomes (Smith, 2007).

The second level of doctor identity is activity-based, with differences noted due to subspecialties. Pratt et al. (2006), in their study of physician identity construction in residents, found that exposure to work changes deepened their understanding of their professional identity. Examples are the rotation of doctors through different departments learning to treat different diseases, working long hours and learning to deal with patient suffering and death. Work done by Goldie (2012) expanded on how identity is influenced more by informal curricula than by more formal teachings. This profession has strong governance, which increases the similarities between subspecialties (Andersson, 2015), because identity is continually sculpted within the systems of power and knowledge that exist in the profession (Goldie, 2012).

The third level of doctor identity is linked to the individual. This encompasses the level of experience and stage in their career, which influence perception of their identity. As a hospital resident at the start of a career, the doctor's identity is in greater flux as they go through their learning cycles. It is at this time that they develop a greater understanding of their professional role and place within the multi-disciplinary team of a hospital. Wong and Trollope-Kumar's (2014) study into the construction of professional identities showed that, during this phase of their career, influences such as role models, patient encounters and societal expectations play a pivotal role in identity development. Their discussion on contemporary constructivist theories highlights that the formation and dynamic nature of professional identity can be changed and moulded over time through exposure to different experiences and changes in environment. The more experienced or even older doctor may change his focus to research, medico-legal work or education (Andersson, 2015).

### **2.4.2. Professional Identity Conflict**

McNeil et al. (2013) expanded on work done by Chrobot-Mason, Rudermann, Weber and Ernst (2009) and explored the triggers that are attributed to professional identity conflict. The key triggers were identified as differential treatment, different values, assimilation, insult and humiliating action or simple contact.

Differential treatment can be attributed to unequal treatment in the workplace, unequal distribution of resources or perceived unequal compensation. Different values become a trigger where fundamental beliefs, and even responsibilities, are in conflict. Examples of interprofessional views regarding quality of life are given. This can be extended to the divergent views relating to medical care and costs. Joffe and Mackenzie-Davey (2012) established that, even when holding a hybrid role of doctor and manager, the professional identity remains the most robust.

Assimilation occurs when the dominant party expects everyone to behave as they do and does not tolerate professional differences. Evetts (2011) noted that, as organisations employ more professionals, a change in professionalism is occurring. Employed doctors are caught between sustaining their autonomy in regards to their patient care and capitulating to the pressures of the organisation's business cost models. McNeil et al. (2013) speak to the anxiety raised as changes to one professional group impact other interrelated professionals. An example of this could be seen when there is an unavailability of skilled nursing staff. This can lead to discord in the care of patients. Insult and humiliating action are behaviours that devalue the medical profession. Other professional's behaviour can negatively affect the doctor the doctor's identity. An example of this is the legal fraternity who have increased doctor litigation thereby increasing insurance costs by 573% and influencing specialities being chosen by medical students (News24, 2015).

Finally, the simple contact trigger in professional identity conflict refers to parties that find themselves in conflict simply by being brought together. An example of this could be seen when academic and private doctors are not in agreement due to working in different environments

Historically, the doctor has been seen as the dominant player in the healthcare industry. This raises questions of whether the changing South African healthcare

industry landscape, changes in the influence of the medical aid industry, patient enlightenment and the introduction of online identities (Decamp, Koenig & Chisolm, 2013) have triggered a conflict with the professional identity of doctors. Zikic and Richardson (2015) have shown that strong threats to a profession that has robust pre-entry stipulations—such as medicine—require further research on how best to repair or protect such threatened identity.

The abundance of information available on the internet may be causing a shift in power as the patient gains more of the knowledge of which they were historically dependent on the doctor. This leads to an enlightened patient who has the ability to interrogate doctor's recommendations and treatment plans. The internet and particular social media, has resulted in controversy relating to the line between professional and personal identities. Since social media is in the public space, it has potential harm to a doctor's professional identity if the doctor posts inappropriate content (Decamp et al., 2013).

Another aspect that has changed is the increased number of cases that are being legally publicised and which could change the perception of the public of the infallibility of the “all-healing” doctor (Weaver, 2012). Likewise, the dynamic trends in the industry, raises questions concerning how the change in focus to minimize costs and follow evidenced-based protocols also affects the autonomy of the doctor (Smith, 2007), which, as mentioned, is a fundamental aspect of their identity and value system. Finally, is the professional culture of the doctor under threat as enlightened patients, employed colleagues and hospital general managers apply pressure to their dominance in the environment?

McNeil et al. (2013) suggest that both the organisation and their professional experiences trigger different levels of identity threats to doctors. Pratt et al. (2006) identified that a mismatch between work (what they do) and identity (who they are) causes alterations to their professional identity. Additionally, Wong and Trollope-Kumar (2014) confirmed that interaction with others within their environment aided in the development and changing of their identity. These authors also suggested that the outcome was closely linked to whether the experience was positive or negative in nature.

Through an in-depth literature review relating to social identity within the healthcare industry, Kreindler et al. (2012) concluded that, in order to unite healthcare professionals and ‘unlock silos’, the acknowledgement of shared values should be

used as opportunities. Should these valued identities not be mobilised, then any changes will lead to identity threat and impede the stimulation of reshaping and/or reinterpretation of professional identities. In the private sector, doctors may not be up to date on all industry and legislative changes and this could cause a conflict, and even a lag, in the development of their professional identity.

It is important to remember that professions are made up of individuals: Petriglieri (2011) reviewed the literature for all the definitions of individual identity threat. She defined these as “experiences appraised as indicating potential harm to the value, meanings or enactment of an identity” (Petriglieri, 2011, p. 644). This is in line with the definition given by McNeil et al. (2013), as described above. Petriglieri (2011) explored responses associated with identity threats, and found that the identity either reconstructs to decrease future harm to itself or it takes a protective stance. The outcome depends on the strength, age and importance of the identity and the extent of access to the source of the threat. This study also detailed consequences of and responses that could be taken in reaction to the threats by both the individual and their associated organisations.

### **2.4.3. Hybrid Identities**

Joffe and Mackenzie-Davey’s (2012) exploration of the identities of professionals and managers within the health sector emphasised that doctors relate to their professional group whereas managers identify with their organisation. Training differs between the two groups, which directs their focus to diverging goals. The doctor’s primary goal is the patient, while the manager’s is to the organisation’s goals.

In the South African private sector, doctors are generally not employed in management positions within hospitals but are self-employed. This is, however, changing slowly. For this reason, it is important to look at the literature relating to the challenges that the international industry is experiencing. This hybrid role gives insight to both the challenges of relationships between doctors and managers, and to the changes in identities.

Literature shows that doctors who are managers still see their identity as linked primarily to their profession (Joffe & Mackenzie-Davey, 2012; Spyridonidis et al., 2015). Spyridonidis et al., (2015) identified varying degrees of acceptance of physicians to

such new roles, but concluded that all found that the exposure developed their professional identity. The first group embraced the new role quickly and incorporated it into their identity; the second group felt that acquiring a managerial identity would erode their identity as a professional; the third group, after initially resisting, were able to incorporate their new role if they redefined the role into that of a clinical leader.

In order for doctors to successfully adapt to a hybrid role, they need to either adapt to established professional norms or realign these norms to be closer to their personal principles and beliefs. McGivern, Currie, Fitzgerald and Waring (2015) suggested that there is, in fact, an element of doctors that claim senior hybrid roles specifically to maintain their professional identity. This study, undertaken in the United Kingdom, also noted that financial rewards are greater in private practice. This is also true of the South African market.

Spyridonidis et al. (2015) stated that salient shifts were crucial to understanding identity shifts during changes to the industry or organisations. This helps to understand how the identities evolve, clash or are reconstructed according to the importance of the differing roles. He also highlighted that the outcomes depended on the doctor's involvement and willingness to accept the change. In the private sector, a separation between doctors and hospitals could curtail their involvement, thereby delaying the alignment of identity change with the altering environment.

## **2.5. Engagement**

### **2.5.1. Engagement in the Workplace**

Engagement is defined as that which a person invests physically, emotionally and cognitively into their work (Bhuvanaiah & Raya, 2014; Kahn, W., 1990). Motivation is at the core of engagement and has well-described elements that are fundamental to achieving a goal (Robbins & Judge, 2013). These elements can be broken down into intrinsic and extrinsic motivators.

Intrinsic motivators are those that are driven from within the person for reasons such as interest, enjoyment, meaningfulness, self-efficacy and alignment with own values. Extrinsic factors are those motivators that come from outside the individual and which influence their behaviour and motivation. The most commonly used extrinsic factors are those of reward and punishment (Robbins & Judge, 2013).

Theorists like McClelland (Robbins & Judge, 2013) believe that the needs for achievement, power and affiliation are stronger than extrinsic motivators. Pink (2012) expands on this by saying that there is a “mismatch between what science knows and what business does”. He feels that rewards can narrow an individual’s focus and destroy creativity. He ascribes the pillars of intrinsic motivation as those of autonomy, mastery and purpose.

Ariely (2012) concurs that engagement is not solely about money, but includes other factors. In his *Ted Talk* (Ariely, 2012), he discusses studies he has done to show how other influences, such as positive re-enforcement, knowing the importance of what one does, being proud of completing a difficult task and visible proof of outcomes, increase productivity. Ariely links the feelings of being unappreciated to people wanting more money to do a job and that of being ignored to becoming demotivated. In a Gallup worldwide poll (2013), it was found that 63% of employees attributed lack of motivation as their reason for being disengaged from their job.

The performance of organisations is connected to both the engagement and satisfaction of individuals in their jobs. Vasantha and Manjunathan (2014), in their descriptive research, highlighted the top four impacts on job satisfaction as: job security; opportunities to use skills and abilities; the organization’s financial stability; and the relationship with their immediate supervisor. Manager–employee relationships are affected by the individual’s perception of autonomy. If this is low, then feedback from managers is welcomed and engagement is increased (Menguc, Auh, Fisher & Haddad, 2013). In the case of doctors, who have high autonomy, feedback from a manager may have the opposite effect.

Regardless of whether an individual’s motivators are intrinsic or extrinsic, the eventual outcome of these needs not being met is that of disengaged parties. Over the years, technology, family dynamics, social media, ways of working and individual priorities have changed; however, many organisations are still working within the same traditional rationale that considers employees’ wellness and morale as not essential to their business success. An organisation’s future success depends on closing this gap (Morgan, 2014).

Bhuvanaiah and Raya (2014, p.67) define disengaged employees as those who have “high levels of discontentment and negative opinion on organizational approach”.



Organisational costs are affected in many ways, including by declining productivity and innovation, apathy, staff turnover and absenteeism. Menguc et al. (2013) conclude that customer service is affected by the level of employee engagement and the direct impact that this has on company reputation and brand. Furthermore, their study highlighted that engagement is positively affected by supervisory support if there is a high level of perceived autonomy. In contrast, when there is a low level of perceived autonomy then feedback is more effective.

Whether positive or negative, the overall nature of employee engagement can form the foundations of relationships with other stakeholders within an organisation. In the hospital sector, the relationship and underlying principles of engagement can be extended to engagement with doctors.

### **2.5.2. Doctor Engagement**

Snell et al. (2011) recognise in their research that doctor engagement starts with the characteristics and values of the doctor. Ariely (2012) speaks to the concept of unconscious motivation, where, if an individual plays a role in the outcome of an activity, they would care more about that outcome. This can be seen in the medical fraternity, where an individual doctor's knowledge and opinion are directly linked to a patient's health.

Spaulding, Gamm and Menser (2014) speak to the concern that doctor engagement has different inferences for the doctor and the hospital. They emphasise that accountability and quality expectations by both parties underpin doctor engagement. In contrast to other countries, South African doctors are not legally allowed to be employed by private hospitals and may only work there in their private capacity (Health Professions Council of South Africa, 2008), which adds to the complexity of managing the dynamic of clinical outcome and cost control.

Clark (2012) contends that there needs to be a culture change in order for medical organisations to be successful. This requires that the non-medical manager and the doctor partner in achieving quality and outcomes-based care. Clark proposes a framework for improving doctor engagement by introducing the doctors to the idea of being part of a hospital team that has managerialist values, but which could also oppose the doctor's autonomy. Fundamentally, the framework is driven from the

primary viewpoint of the organisation. However, Martinussen and Magnussen (2011) found that doctors were divided in their opinions concerning the adoption of managerialist values, and advocated for further research to be done on hospital-specific factors that cause heterogeneity rather than hybridisation in the medical profession. Milliken (2014) concurred that doctors and organisations need to work together as a team to decrease the polarity that currently exists and thereby improve quality care for patients.

Kippist and Fitzgerald (2014) explored the relationship between hospital management and doctors in the Australian healthcare sector. In this country, the doctors have the option of being employed by the private sector. This study highlights differences in the professional philosophies of both parties and the need for a collaborative relationship to meet the challenges that go with healthcare reform. This can be translated into the South African context with respect to the various reforms and evolution of the industry outlined in Section 2.2. Kippist and Fitzgerald (2014) advocate for more research related to this topic. A study by Correia (2013) regarding the interchange between the administration manager and the medical profession also highlights the need for information so as to enable individuals to use their position and resources professionally.

Carlson and Greeley (2010) argued that the relationship that currently exists between doctors and hospitals in the United States of America is not sustainable from both cost and competitive perspectives. One can translate this into the South African setting, recognising that all medical parties are competing within a limited market. These authors give examples of ideas of how this fragile relationship can be strengthened. These encompass topics such as understanding the value propositions of both parties and sharing an aligned vision (Carlson & Greeley, 2010).

Fundamental to doctor engagement is the creation of trust. Unless this is established, doctors will not align with the organisation and are most likely to resist new initiatives or even become more uninvolved (Du Plessis, 2013; Snell et al., 2011). A literature review by Ozawa and Sripad (2013) examined trust at all levels of the health system and concluded that trust is woven into all partner relationships and its importance extends to the greater health of society and access to care. These authors advocate that more should be done to measure such trust levels.

Understanding the mutual interests of the doctor and the organisation can be the first stage in improving engagement and creating trust. Suggested mutual interests include

improving clinical quality, patient interests, and patient experience and increased market value (Du Plessis, 2013; Spaulding et al., 2014).

A survey by Whitlock and Stark (2014) investigated the elements that doctors felt were important to engagement. Fifteen items were listed, of which the five most important were: respect for their competency and skill; having their ideas and opinions valued; good relationships with their colleagues; work-life balance; and having an input into how their time is used. All doctors contributing to this study were employed. In the present work, these factors are incorporated into the study and are built on from the perspective of self-employed doctors.

A study by Taitz, Lee and Sequist (2012) identified a variety of themes that can be used to improve doctor engagement and to optimise quality care and safety. These include engaged leadership, the reasons why a doctor is practicing, financial compensation and incentives, access to data and academic promotion. This study also reflected on a consistent theme that shows how doctors have influence on their peers. A limitation of this study with respect to the current study is that the framework applied to employed doctors, but the general concepts can be applied to future studies pertaining to self-employed doctors.

There are many reasons for doctors to become disengaged. The erosion of potential engagement with doctors can be attributed to constraints of time and money. Doctors who are expected to participate voluntarily in hospital initiatives for which they are not compensated have a tendency to become disengaged (Snell et al., 2011). Organisations that do not offer positive working experiences, such as having a disengaged work force, will further increase the divide (Mache, Vitzthum, Groneberg, Klapp & Danzer, 2014; Spaulding et al., 2014).

Barriers identified to engagement also extend to the lack of physician time, an organisational culture that is not conducive to alignment, doctor autonomy, inadequate training, the cost of engagement programmes and the lack of quality improvement programmes (Taitz et al., 2012). In South Africa, the low doctor-to-patient ratio and low medical specialist numbers (see Section 2.2.3) exacerbate the time pressures that doctors experience (Deloitte, 2014).

Additional barriers to engagement include a lack of transparency between parties, resistance to adapting to the changing environment, industry competition (Burns & Muller, 2008; Carlson & Greeley, 2010), maintaining the idea that care should be

organised around the convenience of the hospital and not that of the patient (Pate, 2012) and regulatory pressures (Burns & Muller, 2008). Factors affecting individual doctors include professional fragmentation, dominance by particular doctors in the system, personal economic concerns and lifestyle preferences (Burns & Muller, 2008).

The benefits of doctor engagement and a good working relationship with the hospital management can be seen in benefits to the shaping of healthcare strategy (especially if doctors are included from the beginning), decreased conflict (if there is equal input into teams) (Beckham, Berry, Feussner & Trastek 2015), improved clinical outcomes, better cost management and reduction of errors (Milliken, 2014).

Work done by Gokce et al. (2014) found that there was a direct correlation between a doctor's commitment to the organisation and the hospital leadership style and organisational culture. Although this research was carried out in the private sector in Turkey, the doctors were employed by the hospital. Translating these learning into the South African setting, the commitment of doctors to an organisation where they are not employed is more difficult to ascertain.

Internationally private health organisations have used many practices to improve doctor engagement and South African hospitals have mimicked them. A few examples of current initiatives being used by the management of organisations are: individual meetings; increased visibility; and information sessions relating to goals and objectives of the establishment in which they practice (Du Plessis, 2013). Others are management dealing quickly with operational challenges to ensure optimal patient care; sharing credible data; and combined clinical meetings such as morbidity and mortality meetings which include nursing, doctors and management. Effective communication vehicles promoting understanding of industry and hospital specific changes through the use of the electronic and print mediums are also used.

It is evident from the above review that many studies have been done on what is required to engage doctors, but there remains little understanding of the effects of such initiatives on the changing professional identities of private doctors.

## **2.6. Summary of Literature Review Outcomes**

In order for the private hospital industry to survive in South Africa, it will need to consider all stakeholders. Historically, the primary business stakeholders were viewed

as the owners and shareholders, but this has changed to include, amongst others, the patients, doctors, medical aids, pharmaceutical companies, suppliers and the government.

The current downward economic trajectory of South Africa is having direct implications on the healthcare system, as the extents of poverty and disease exert pressure on an already overburdened system. Collaboration between the private hospital and the doctor is a necessity to combat the trends of increasing costs, competition and customer expectations of quality care.

The professional identity of a doctor is constructed over many years as they gain knowledge and skills. That of medical doctors is recognised as one of the stronger professional identities: in the South African private healthcare sector, this may be under threat. Understanding the changes to the industry and their effects on the doctor are important to both the sustainability of the private healthcare industry and to the doctor–manager relationship.

Doctor engagement has its own challenges within South Africa because doctors are self-employed, but for quality service and good clinical outcomes to continue going forward, organisational management needs to comprehend their role in what engages or disengages a doctor.

The literature review presented in this chapter was utilised to develop the research questions presented in Chapter 3.

## CHAPTER 3: RESEARCH QUESTIONS

Chapter 2 outlines the outcomes of research reported in literature relating to the profession identity of the doctor and the challenges and conflicts that affect this identity and associated relationships. The primary objective of the current research is to identify whether doctors in the private healthcare industry in South Africa feel that their professional identity is changing, and how this may be impacting on their relationships with organisational management. A secondary objective is to explore engagement strategies that would assist the doctor with adapting to and managing their changing identity and the working relationship between doctor and organisational management.

The following research questions were formulated to address the research problem in relation to these objectives.

### 3.1. Research Question 1

*Is the professional identity of the private-sector doctor in South Africa under threat?*

The aim of this question is to identify, from the doctor's point of view, if they feel that their identity as a doctor within the South African context is under threat. This question also aims to identify and establish common core characteristics of such professional identities.

### 3.2. Research Question 2

*If there are changes to the doctor's professional identity, how has this affected the relationship between the private doctor and the healthcare organisation?*

The aim of this question is to appreciate if there are changes that doctors are experiencing and whether they feel that these impact on their relationship with the management of the hospital within which they work.

### 3.3. Research Question 3

*How should the traditional engagement strategies employed by the organisational management be adjusted to meet the changing identity of the doctor?*

The aim of this question is to link perceived changes in the professional identity of doctors in the private sector of South Africa to engagement strategies currently being utilised and to foster ideas for new strategies to enhance the on-going working relationship between doctor and hospital management.

## CHAPTER 4: RESEARCH METHODOLOGY

This chapter forms the framework for the approach taken during the research. It outlines the defined population, sampling process, the collection of the data and the analysis activities. The validity and reliability of the research outcomes are addressed, and the chapter culminates in discussing the assumptions and limitations identified in the research method.

### 4.1. Research Design

Saunders and Lewis (2012) explained that it is necessary to be aware of the foundation research philosophy that a researcher will use because this will affect and guide the way the research is conducted. An interpretivism stance was applied in this case, because, by the nature of the research problem, it strove to understand whether there was change in identity and what effect this had on the doctor's role and engagement with hospital management.

An inductive approach was taken, because, although there is significant information available in the public domain on professional identity and its threats and on doctor engagement and relationships within the multi-disciplinary team, there is little information on how the perceived change to private doctors' professional identity is impacting on them and others.

This exploratory study was aimed at gaining insight into these matters and thereby assisting organisations and doctors alike in the future practice of medicine. Saunders and Lewis (2012) advocated that, for an exploratory study, the strategy of a qualitative survey should be used.

Such a qualitative approach to this study aided the interviewer in gaining an understanding of the doctors' views and perspectives in the contextual and real-life conditions that they were experiencing at the time (Vaismoradi, Turunen & Bondas, 2013; Yin, 2011). It allowed for multiple sources to assist with identifying the possible emergence of changing perceptions regarding doctors' identities and organisational engagement (Yin, 2011).



## 4.2. Unit of Analysis

The unit of analysis was the private doctors in the South African healthcare industry.

## 4.3. Population of Relevance

Robinson (2014) maintained that it is imperative to identify the sample population. This is the entire repository that qualifies for inclusion in the research study. Because this was determined by the research questions, the relevance of the population is defined by inclusion and exclusion criteria. The following criteria were identified for qualification into this study:

- Inclusion:
  - All doctors were self-employed and working in a private medical practice.
  - All doctors were required to have admitting rights to a private hospital.
  - Population parameters were set according to the geographical area of the study being conducted, i.e., the greater Johannesburg area.
- Exclusion:
  - Those doctors who work in a combination role of public and private practice, and where the public practice is their primary employment.

Selection of this homogeneous population assisted with the analysis of data as it improved the identification of meaningful themes (Robinson, 2014).

## 4.4. Sampling Strategy, Size, Sources and Demographic Data Pertaining to Interviewees

### 4.4.1. Sampling Strategy

A non-probability sampling technique was selected because the researcher did not have a sample frame: a complete list of the doctor population in the private sector was difficult to obtain. This limited the ability to randomly choose the participants.

A purposive sampling strategy was employed because the selected candidates, although not statistically representative, were typical of the identified population (Saunders & Lewis, 2012). This strategy also allowed the researcher to identify

participants within the identified population who would be able to offer different perspectives and depths of information with respect to the research questions (Robinson, 2014; Yin, 2011). The diversity of sample with regard to different specialities, age and years of private practice allowed patterns of value to emerge (Yin, 2011).

There are disadvantages to using this type of technique and care was taken to be conscious of these. They include putting undue weightings on certain data, incorrect selection of representation and researcher subjectivity. These aspects are discussed in the evaluation of validity and reliability of the results (Section 4.9).

#### **4.4.2. Sample Size**

Robinson (2014) argues that, as cited by Robinson and Smith (2010), the sample size enables cross-case generalities to be identified, but protects the researcher from becoming overwhelmed by the volume of data. Additionally, a small sample size allows for the participants to have a defined identity. In the first phase of this work, two interviews were undertaken. These were followed by a further ten interviews in the second phase. The total sample size of twelve proved sufficient, because the responses reached a point of data saturation which can be attributed to the homogenous nature of the population. Saunders and Lewis (2012) define this as the point at which no new data can be obtained by further interviews: the interviews have generated adequate breadth and depth of response to the questions posed (Cleary, Horsfall & Hayter, 2014). The first two interviews conducted, although identified as test interviews, were incorporated in the total data set because the data was of value and the interview structure was not changed in the subsequent interviews (see Section 4.7).

#### **4.4.3. Sample Sources**

Those identified for the interviews were sourced from doctors practicing in three private health-sector hospitals in Johannesburg: Mediclinic Sandton, Mediclinic Morningside and Wits Donald Gordon Medical Centre. The utilisation of three sites was intended to foster greater confidence and consistency in the data gathered (Yin, 2011). All three hospitals have different general managers, which allowed for different opinions relating to management engagement practices.

#### 4.4.4. Sample Demographic Data

In total, twelve doctors were interviewed. Table 1 provides their basic demographic data. This information has been detailed as an indication of the diversity of speciality, gender and years in practice of the interviewees, and which boosts confidence in the results because diversity of composition alleviates bias in analysis (Yin, 2011). The majority of doctors interviewed had been in practice for longer than ten years: this corresponds with statistics provided by the South African Medical Council that the average age of doctors in private practice is 58 (Kahn, T., 2014) (see Section 2.2.4). Three doctors in the early stages of their practice were also chosen to determine whether conflicting opinions were obtained from a younger cohort. The participant references and order of the interviews have been changed in Table 1 to protect the doctors' anonymity when referenced in later chapters. The demographic factors are later referenced in relation to individual perceptions.

**Table 1: Demographic Data Pertaining to Interviewees**

Participant Reference	Gender	Speciality	Years in Private Practice	Hospital
Doctor A	Female	Psychiatrist	20 – 30	1
Doctor B	Male	Paediatrician	20 – 30	1
Doctor C	Female	Gynaecologist	20 – 30	1
Doctor D	Male	Physician	20 – 30	2
Doctor E	Male	Gastroenterologist	0 – 5	3
Doctor F	Male	Urologist	20 – 30	1
Doctor G	Male	Gynaecologist	20 – 30	2
Doctor H	Male	General Surgeon	10 – 20	3
Doctor I	Male	Physician	15 – 20	1
Doctor J	Male	General Surgeon	20 – 30	3
Doctor K	Male	Orthopaedic Surgeon	5 – 10	2
Doctor L	Female	Physician	0 – 5	1

#### 4.5. Research Guide

The interview guide, as reproduced in Appendix 1, consisted of six questions that assisted the interviewer to explore the research questions. The questions comprised a combination of open- and closed-ended questions that were used within a framework to ensure that all questions were answered, but, at the same time, were used to

stimulate conversation (Saunders & Lewis, 2012; Yin, 2011).

The questions did not require altering after the completion of the pilot interviews (see Section 4.7.1). The questions generated during the conversations relaxed the interviewees so that they were able to freely impart information. The relaxed flow of each interview allowed the researcher to remain open-minded while interviewing and collecting data.

#### **4.6. Ethical Clearance**

Ethical clearance was obtained through the Research Ethics Committee of the Gordon Institute of Business Science. Because this research project was carried out in the healthcare industry, further approval was obtained from the University of Pretoria Health Ethics Committee. The project also received ethical clearance from the Mediclinic International Ltd Research Committee (Appendix 2).

#### **4.7. Data Collection Process**

The data collection process was divided into two phases: the pilot phase and the interview phase. Both phases took the form of in-person, semi-structured interviews. A semi-structured interview is a method in which the interviewer uses an interview guide that has a list of questions and/or themes that can be asked in different orders. This allows latitude for the interviewer to add or omit questions, depending on the direction that the interview takes as it unfolds. This permits participants to be more open and enables the researcher to potentially gain unexpected insights into the topic (Saunders & Lewis 2012).

All participants were initially contacted via e-mail and then by telephone. The interviews were carried out at their offices at a time suitable to them. This helped to limit inconvenience to the participants. All were informed regarding what the study entails, that it was voluntary and that their anonymity would be protected. All participants were asked to sign a consent form (Appendix 3) and consented to having the interview recorded.

All doctors approached were open to being interviewed. Initially, the doctors were not sure what the subject matter entailed and so were slightly hesitant to answer. After

explaining a brief introduction to the background and objective of the study, they began to relax and became more engaged in the conversation. The doctors were eventually happy to speak about what they felt was affecting them: it was heartening to see that they have such a passion for what they do and are willing to be part of improving their working environment and relationships.

#### **4.7.1. Phase 1 – Pilot Interviews**

It is important to test the validity and reliability of the process, hence two pilot interviews were carried out. These confirmed the best interview structure, while formulating a system that identified bias either by the interviewer or the participant because both had embeddedness in the field. The correct types of questions were identified for use. A grand narrative question was used at the beginning of the interview, followed by the use of floating prompts (Yin, 2011). This assisted in designing the qualitative instrument that ensured that the research question was answered (Saunders & Lewis, 2012). During formulation of the questions and the pilot interviews, no further limitations of the study became apparent. The research guide did not need to be altered. The two pilot interviews were initially planned to be done in a single hospital, but, due to doctor unavailability, they were completed in separate hospitals.

The time frames of the interviews were adjusted because, in response to the first two invitations, both doctors indicated that they would not be able to spare one hour for the interview due to time pressures and said that thirty minutes would suit them better. In the remainder of the interview planning, requests for thirty to forty minutes were made. This encouraged positive participation (Yin, 2011).

#### **4.7.2. Phase 2 – Interviews**

The second phase consisted of ten interviews with doctors identified as meeting the criteria set by the population as described in Section 4.3. A greater number of interviews were done at one hospital for convenience. The doctors were very open to discussion about the topic and were forthcoming with their opinions.

Table 2 lists the collection methods used for the different phases and summarises the sampling method, technique, size and source used.

**Table 2: Research Phases and Corresponding Sampling Information**

Research Phase	Aim of Phase	Data Collection Method	Sampling Techniques	Sample Size	Source and Number of Interviews
<b>Phase 1</b>	Pilot test to confirm validity and reliability of process and interview questions	Semi-structured interviews	Purposeful (Robinson, 2014; Saunders & Lewis, 2012; Yin, 2011 )	2	Mediclinic Sandton (1); Mediclinic Morningside (1)
<b>Phase 2</b>	Face-to-face interviews	Semi-structured interviews	Purposive (Robinson, 2014; Saunders & Lewis, 2012; Yin, 2011)	10	Mediclinic Sandton (5); Mediclinic Morningside (2); Wits Donald Gordon Medical Centre (3)

#### 4.8. Data Analysis Approach

Analysis of the data obtained from the interviews commenced as the interviews developed. This enabled the researcher to follow up on themes that emerged in earlier interviews and increase the depth of the information being gathered. This also allowed for probing of new topics as they arose and highlighting any future value of data gathered in the discussions because these followed a conversational format. The interview guide questions were always used to structure the interviews. This also assisted in identifying the data saturation point (Saunders & Lewis, 2012). Thematic analysis approach was used to identify common threads throughout the interviews (Vaismoradi et al., 2013).

During the interviews, when answering the question relating to suggestions for improvement engagement with organisation (Research Question 3) and where the researcher had a pre-existing relationship with the doctor, the doctor was asked to pretend that they were speaking to a trainee manager. This was intended to make the answer more objective.

The interviews were all recorded and no editing was applied to the recordings. The only time that a recording was stopped during an interview was when the doctor needed to attend to a patient matter and confidentiality need to be maintained. To minimise

participant distraction, no field notes were taken during the interviews. Recordings were used to make written notes in summary interpretations of the interviews. These summary notes were then transferred into *Excel* spread sheets per question. The themes that emerged from the interviews were visually identified as the comments were sorted and clustered together under specific topics. This proved extremely time-consuming because it required the recordings to be listened to several times.

A blind quality check of three interviews was carried out by an independent party. The intention of this was to confirm the validity and reliability of the themes identified. The independent party, who owns a research company, was given the recordings and the notes made and requested to cross check the themes that had been identified by the researcher. There was abundant overlap of the themes, thereby establishing credibility of the data reported (Appendix 4).

A force-field analysis was compiled to show the relative strength of those factors that are influencing changes within the doctors' identity. This analysis shows those factors that are driving forces and those that contribute to resisting any change (Burnes & Cooke, 2013). The 'field' represents the psychological environment in which a doctor is positioned at the particular time and place at which the interview was conducted.

Research Question 3 requested the doctors to identify three strategies that would assist engagement. The responses were self-transcribed in order for a word cloud to be developed (Stuckey, 2014). A word cloud is a pictorial representation of the common themes or phrases that occur in qualitative data. Use of this technique maintains the anonymity of the participants, while allowing for a snapshot of answers to the question to be developed (DePaolo & Wilkinson, 2014). The word cloud was created with the online use of *Wordle* (Wordle.net, 2015).

#### **4.9. Validity and Reliability**

Saunders and Lewis (2012) referred to the importance of both the validity and reliability of the research project being undertaken. Validity alludes to the use of data that have been correctly collected and interpreted and that the conclusions accurately reflect what was being studied (Yin, 2011). Reliability refers to the choice of data collection method and the analysis techniques used to ensure consistency of the findings reported (Saunders & Lewis, 2012).

Throughout this study, special attention was taken to strengthen validity and to prevent the intrusion of factors that may threaten reliability. These are discussed in detail in the pertinent sections above: a summary of the approach taken includes the following:

- There was no subject bias because the participants responded to the interviews openly and honestly. Additionally, the samples were chosen from three different hospitals so that opinions were not limited to an unrepresentative population.
- The interviewer minimised observer bias by staying close to the interview guide and permitting the conversation to follow a natural direction using only minimal floating prompts.
- Observer bias was avoided because the themes identified were triangulated by the use of an external company to verify the main themes identified.

#### **4.10. Research Limitations**

The following limitations of this study are identified:

1. The Competition Commission Inquiry (see Section 2.2.3) was taking place at the time that this study was conducted and may have made participants hesitant to be open in voicing their honest opinions.
2. Self-selection bias typically occurs during voluntary participation. This is when an interviewee agreeing to the interview, may offer different data than those that do not want to be interviewed (Robinson, 2014).
3. The interviewer had a working relationship with some of the doctors, which made it, at times, difficult to separate operational topics from responses to the interview questions.



## CHAPTER 5: RESULTS

### 5.1. Introduction

This chapter describes the data that were gleaned through the twelve interviews with doctors within the private healthcare sector. The results are presented in line with the research questions presented in Chapter 3 and which were derived from a review of current literature (Chapter 2).

The methodology, as outlined in Chapter 4, was adhered to and enabled fruitful results to be obtained. As indicated in Section 4.7, the results of the pilot- and second-phase interviews were combined and are assessed together because the only difference between the two phases was the time availability of the doctors.

As shown in Table 1, the majority of doctors interviewed had been in practice for longer than ten years, and only three doctors were in the early stages of their practice. The varied demographics of interviewees with respect to gender, age, and stage of practice were chosen to observe whether these factors gave rise to conflicting opinions with respect to the research questions posed. The results show common themes, but with differing emphasis on various elements. There were no visible trends noted as a function of these demographic differences. The most significant findings are discussed in the sections that follow.

### 5.2. Research Question 1

The first question posed in Chapter 3 is:

*Is the professional identity of the private-sector doctor in South Africa under threat?*

The aim of this question was to identify, from the doctor's point of view, if they felt that their identity as a doctor in the South African context was under threat and to identify the common core characteristics of their professional identity. Furthermore, it was important to determine their opinion as to the causes of any perceived threat.

The majority of the doctors required an explanation as to what a professional identity entailed. Once this concept had been explained, they all acknowledged that they did have a professional identity and were able to identify characteristics that made their

identity different to those of other professionals.

All interviewees acknowledged that their professional identities had changed to different degrees during the course of their careers. Such changes ranged from acknowledgement of changes in the overall identity of doctors in general (although such changes were not attributed personally) to a definite affirmative response from others. Comments from participants that support these themes include the following:

*There has been [a change in professional identity] but most likely less in this country than elsewhere... (Doctor 1)*

*There is erosion of how you would express yourself as a person or to your patient. (Doctor 2)*

*[It is] becoming harder to maintain it [a professional identity]. (Doctor 6)*

*'[There has been] no major change to my identity. (Doctor 7)*

*[Professional identity has] evolved over the years, not necessarily for the better... (Doctor 10)*

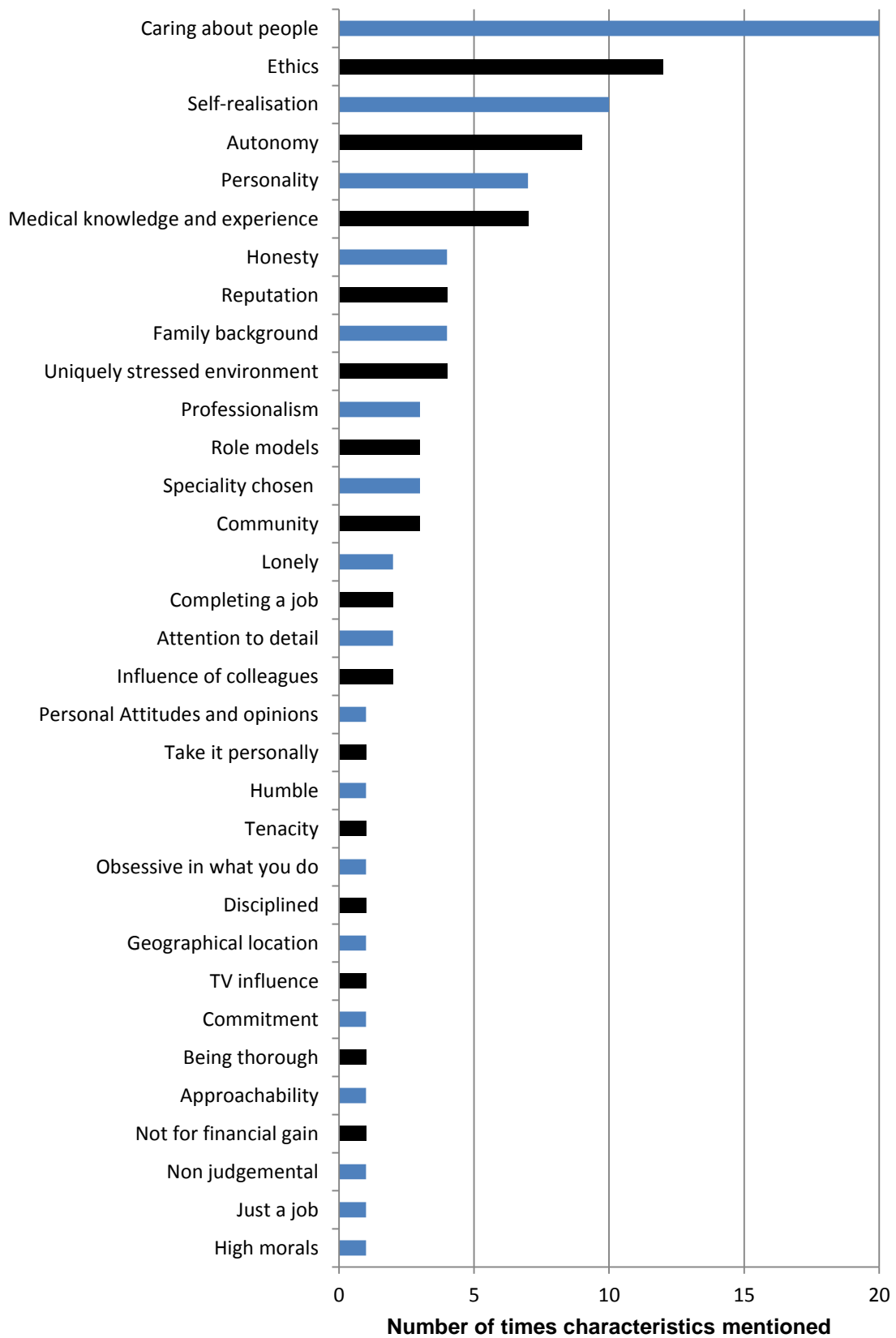
*[Our behaviour is] no longer paternal. (Doctor 11)*

Confirmation of this change in professional identity is not surprising. As the interviews continued, the reasons causing changes in this identity and in the way that doctors have to practice today were frequently expressed.

### **5.2.1. Characteristics of a Doctor's Professional Identity**

All doctors were asked for their opinion in identifying the characteristics that form the foundation of a doctor's professional identity. The characteristics identified were translated into a frequency chart according to how many times the characteristic was mentioned in the interviews: the themes were then grouped together according to subject. Figure 1 lists all major themes identified in decreasing order of prevalence.

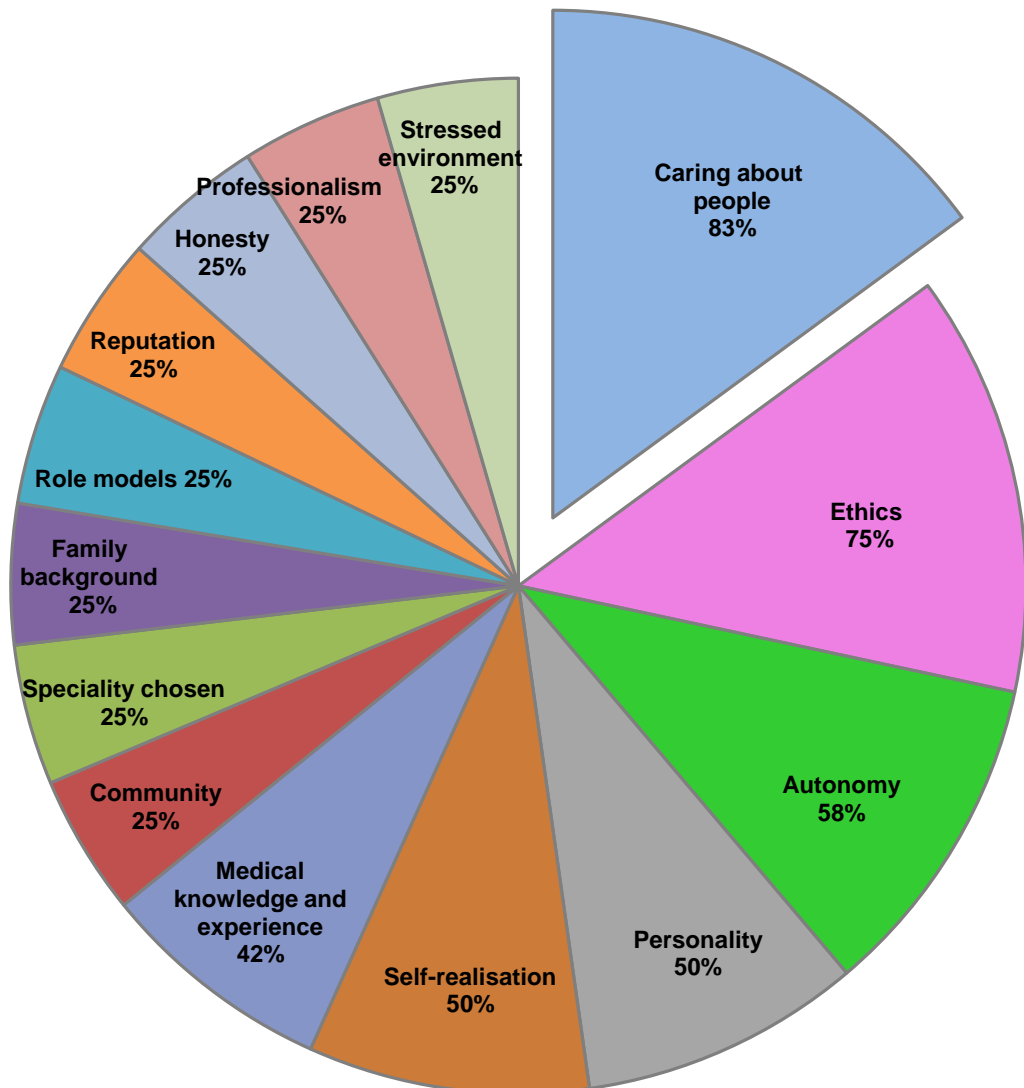
**Figure 1: Characteristics identified by doctors as forming their professional identity, arranged in decreasing order of frequency of mention in all interviews.**



The top five characteristics most frequently cited were caring for people, ethics, self-realisation, autonomy and personality.

These characteristics are compared with the number of doctors that mentioned them in order to rank their importance. The breakdown of the top fourteen characteristic themes is illustrated in Figure 2. This identifies the percentage of doctors interviewed who mentioned these themes. The remaining characteristics identified in Figure 1 as contributing to a doctor's professional identity were offered by less than 17% of the doctors and are not assessed further .

**Figure 2: Percentage of doctors who cited the top fourteen themes of characteristics relating to the makeup of their professional identity**



Caring about people and ethics ranked first and second, respectively, both in frequency of being mentioned (Figure 1) and with respect to importance (Figure 2). However, in the doctors' perceptions, the characteristics of autonomy and personality outweigh that of self-actualisation. Medical knowledge and experience rated equally in both breakdowns. Honesty, reputation, family background, stressful environment, the influence of role models, professionalism, the choice of speciality and service to the community were all mentioned and ranked in these two analytical schemes with little differentiation in order.

The theme of 'Caring for people' was the highest-ranked characteristic with respect to professional identity by 83% (ten) of the doctors. It appears from the interviews that caring for patients, keeping them safe, and having respect and understanding for them as people is considered a priority. The doctors acknowledged that they have an impact on the lives of others and it is crucial to protect them from harm. Medicine was felt to be a humanitarian profession and hence empathy forms a large part of a doctor's professional identity. A 'sense of doing good' for the community and society was remarked upon by 25% (three) doctors, which can be regarded indirectly as taking care of patients. Some remarks from the participants backing this theme are:

*Features of professional identity is [sic] based on ethics, benevolence, doing good for the patient. Doing good for the community is an indirect relationship of that. Making sure there is no harm despite interventions, quality of life preventions... (Doctor 1)*

*Be empathetic, be understanding... (Doctor 6)*

*I feel very strongly a sense of attachment to the patient...it's very intimate and close. (Doctor 9)*

*Need to make a difference in the patient's life but, [also] in the larger picture, in society. (Doctor 12)*

Ethics was the second-most commonly rated professional identity characteristic, cited by 75% (nine) of the doctors. They mentioned the fundamental importance of ethical practice for themselves and how it affects the decisions that they make and approach that they take for patients. The concepts of integrity, wanting to do right by the patient and confidentiality were all highlighted. Honesty was mentioned independently by 25% (three) doctors as important. Extracts from the interviews that speak to this theme are:

*High integrity...Just want our patient to feel they are not coming for financial reasons, they are coming to get better. You are in it for the patient not financial gain. (Doctor 5)*

*Doctors, I would like to believe, are ethical and honest...ethics forms a huge part. (Doctor 12)*

Autonomy was the third most-frequently cited characteristic identified as being part of a doctor's professional identity. A total of 58% (seven) doctors said that the independence that they had within their profession was a reality because it gave them freedom and the ability to make the correct decisions for patients. They also acknowledged that it allowed them to work in teams and obtain second opinions when and from whom they respected, when required. One doctor was against total autonomy, as he felt doctors should support one another, whether in public or private practice. Some comments from the participants supporting this theme are:

*I think it's very important but no matter how much you value your autonomy and use your autonomy, you still have to always work within a group situation. (Doctor 4)*

*One of the nice things in private practice in South Africa compared to [sic] the rest of the world is that we are autonomous, it's a pleasure to have. You can make the decisions that you think are right for the patient. (Doctor 5)*

*You can do what you want. I love the independence...not [to be] beholden to anyone. (Doctor 9)*

Their personality and self-realisation were equally rated by 50% (six) of participants as the fourth-most important factor. Those doctors who mentioned personality felt that they needed to have a strong personality and that a specific kind of personality was attracted to study medicine. Although these characteristics were not explored further, a few doctors (25%, three) mentioned that their family background, religion, schooling and other doctors in the family impacted on their identity. These characteristics may be linked to the formation of their personalities.

Self-realisation was expressed in the feelings that the doctors have as a motivating factor of why they practice medicine. Those mentioned were fulfilment, gratification, pride, feeling of being wanted and enjoyment. One participant said:

*To take people who are critically ill and save their lives [is the] greatest honour in the world. (Doctor 6)*

Medical knowledge and experience was voiced by 42% (five) doctors as a component that moulds the doctor's identity. This was the fifth-most cited characteristic, rated by a fair number who acknowledged that the moulding of their identity occurred during their medical studies, and particularly the long years of study. One doctor found that the twelve years of study was difficult and long and she felt that it had moulded her. She continued by saying that one's identity changes as one becomes older and more experienced. Doctors felt that they needed to keep up to date and be prepared for continual learning because this is a responsibility that they have towards a patient. One doctor mentioned commitment to the profession. The need for continual learning speaks to this:

*Decisions are made based on what you know or should know, and where you studied. And you keep up to date with literature...a decision should not be based on what you are feeling but on what you should be doing and what is accepted internationally. (Doctor 2)*

*I've got the experience. So I can sit back and talk to the patient, knowing that I know the majority of the stuff and don't have to rush him to go read up. So the experience kicks in. (Doctor 3)*

*[The] turning point is when you move from [being] a varsity student and then you start to work with patients: you have to act in a different way. (Doctor 8)*

These characteristics tie into the influences that role models and colleagues have on doctors as they study and work. The discipline that a doctor ultimately chooses to specialise in continues to mould their specific professional identity. Both of these factors were rated by 25% (three) doctors alike. Some comments from the participants supporting these themes are:

*[The] difference between, say, a general surgeon and a plastic surgeon and a urologist [is] the way they act and behave... (Doctor 8)*

*A lot of doctors emulate their role models. [It has] a lot to do with role modelling. (Doctor 8)*

Professionalism and reputation were rated sixth in importance, together with role models and the chosen speciality. Being both professional and having a good reputation are seen as being core to being a good doctor. The interviewees expressed pride in their profession: one doctor said that they need to work hard to maintain a good reputation; another said that she is always aware of what she does and how it affects her reputation. One doctor voiced concern that current medical students appear to have a different concept of the doctor's professionalism and that this could be changing the profession and even the doctor's identity.

*Your reputation...referral by others...indirectly impacts on your identity.*  
(Doctor 11)

Finally, three doctors mentioned the stressful environment within which they work. They felt that the constant strain of knowing that you impact lives, being seen to be ethical and making the right decisions affects their identity.

Other characteristics cited as impacting the professional identity of doctors are: having high moral standards, being non-judgemental, approachability, being thorough (even obsessive) in attention to detail, completing a job, the influence of television and radio exposure (fictional medical programmes and advertising of lawyers specialising in medical cases), the practice of medicine just being a job, and the need for self-discipline. These were mentioned by only one or two doctors. Other characteristics brought up were those of being tenacious, humble, taking their responsibilities personally, and the fact that it can be lonely in private practice.

### **5.2.2. Perceived Causes of Changes in Doctors' Professional Identities**

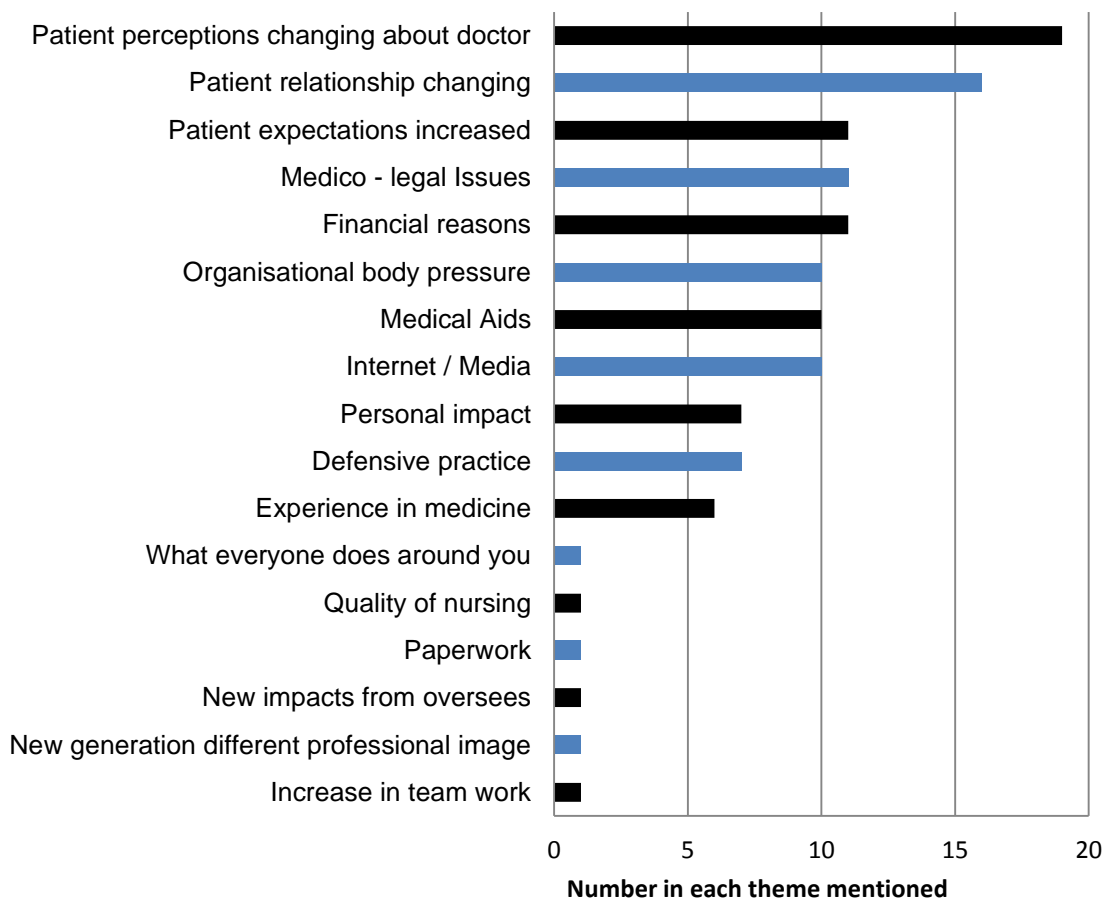
All twelve doctors were asked to identify the causes of changes that were that are affecting their professional identity. The doctors see a close relationship between the way they practiced medicine and their identity, and the majority of the changes identified result from external factors. The answers from the individual doctors were transferred into a frequency chart, and were then collated into different themes and listed from highest to lowest in frequency of citation, as depicted in Figure 3.

The top ten themes mentioned are: change in perceptions of the patient towards the doctor, the changing doctor-patient relationship, a variety of financial reasons and the increase in patient expectations. The industry influence was mentioned in relation to



medico-legal impacts, the different medical organisational bodies, medical aids, and the fact that they have had to change their manner of practice to be more defensive. Interviewees mentioned that both their experience in medicine over the years and their personal feelings have changed their identity.

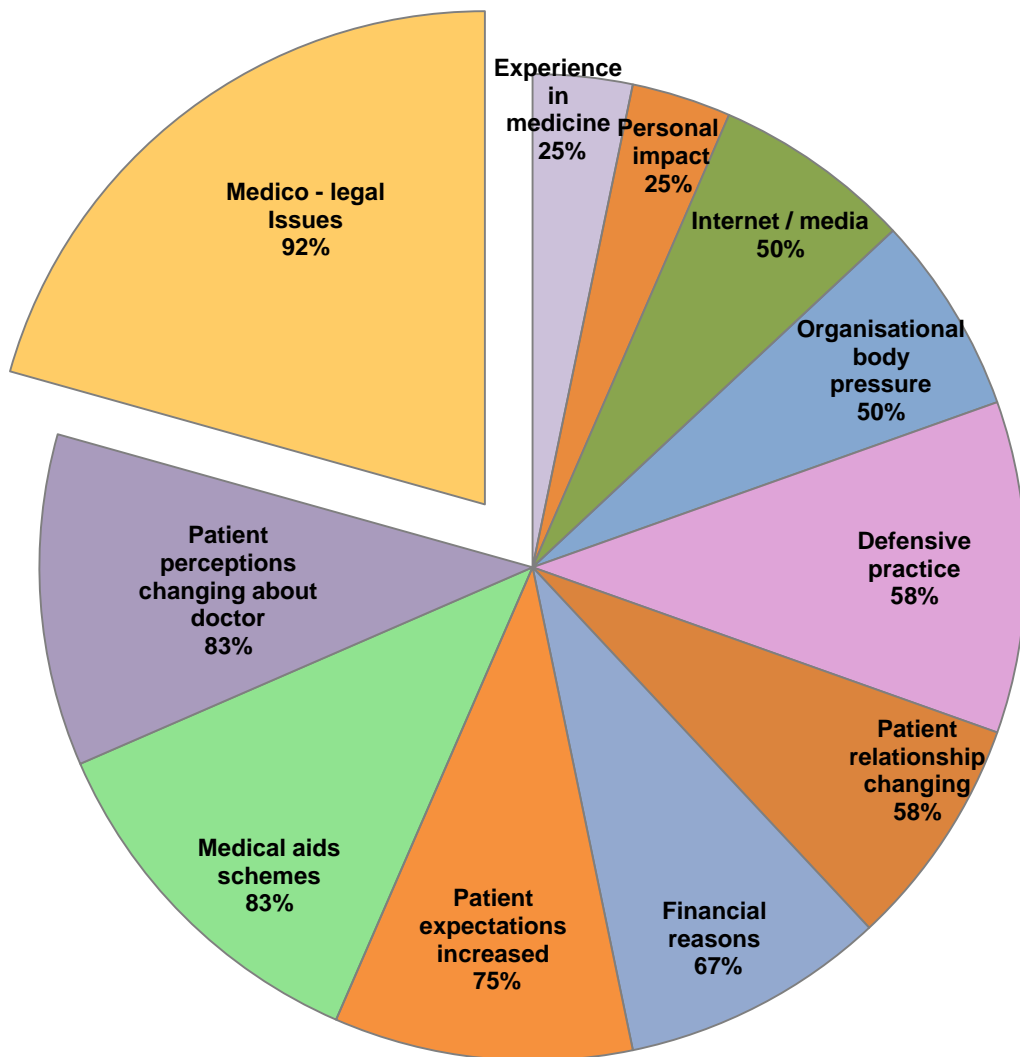
**Figure 3: Top themes of causes identified by doctors as relating to changes in their professional identity, arranged in decreasing order of frequency of citation in interviews.**



Individual doctors felt more strongly about one or other of these causes over another. To get a better idea of how these topics ranked as causes for the changes in professional identity, these themes were compared with respect to the number of doctors that spoke about them. The breakdown of the top eleven characteristic themes is illustrated in Figure 4. These are assessed in further detail. The remaining comments shown in Figure 3 were made by less than 8% of the doctors and are not discussed further.

This analysis again showed differences in the themes that were mentioned throughout the interviews with respect to how many doctors mentioned these specifically. Changing perceptions of doctors, changing relationships and increased patient expectations were mentioned most frequently (Figure 3). Medico-legal issues ranked as most important (Figure 4) as causes of change. Changing perceptions of the doctor and the effect of medical aids were rated second in the respective analyses. This was followed by increased patient expectations. Financial reasons remained in fifth place for both analyses. The remaining causes mentioned ranked with little differentiation in order.

**Figure 4: Percentage of doctors who mentioned the top twelve themes as causes for changes to their professional identity**



By far the most important reason identified as changing the professional identity of doctors, cited by 92% (11) of interviewees, reflects as a consequence of the high focus on medico-legal aspects within the industry. The doctors discussed how this has changed their views relating to how they practice and impacts areas of their identity such as autonomy and doing what is right for the patient. An underling feeling of threat came through from many participants:

*Medico-legal affects you and you need to be vigilant. (Doctor 2)*

*Medico-legal is creating a contractual relationship. (Doctor 9)*

*Autonomy is negatively impacted by litigious patients and their knowledge of litigation...won't make me more ethical but it's going to change my practice. Does change your identity as you become more self-protective. Ten years ago I wouldn't [have] be[en] as afraid of litigation. (Doctor 4)*

*It's a known fact that 70 to 80% of lawsuits are spurious. It ruins your life. It is usually spurious and colours what you do. When you get a registered letter in the mail, your heart stops, because you think this is the one. Threat of litigation is huge. (Doctor 12)*

The second most important reason for changing identity, cited by 83% (10) of interviewees, reflects the fact that patients' perceptions about doctors have changed. The doctors expressed the opinion that their patients viewed them differently: patients saw them as service providers and treated them as such. Many interviewees felt that respect for doctors in society has dissipated due to many factors, including advertising that advocates litigation and the advent of the internet. They felt that the status of their profession was decreasing and that it was no longer patriarchal. Some remarks from the participants supporting this theme are mentioned below:

*[There is the] concept that the doctor is the evil one when something goes wrong. (Doctor 2)*

*People's perception, I think, may be changing. The older perception was that doctors were more your family practitioner kind of doctor, where you could speak to them about everything. They could manage anything from a cough and a cold to an emergency. I think they had more reverence and respect for a doctor's position, where[as] now*

*doctors are seen as more service providers that are providing a service.  
(Doctor 7)*

*As communities have gotten bigger and bigger, the doctor has become less important...nowadays it is just seen as a job. (Doctor 8)*

*Previously, it was seen as a patriarchal system where what the doctor says counted, but now you have to account for yourself in far greater detail. You have to explain things to patients. It's not an autocratic relationship anymore. It's more like a consumer service provider-type relationship which has changed over the years. (Doctor 10)*

*The way patients perceive doctors and the way doctors perceive patients have changed. (Doctor 10)*

*[We are] considered money-grabbing multi-millionaires who have no interest in our patients...Purely a service provider (Doctor 12)*

Along with the change in public perceptions of doctors, the high involvement and demands of medical aids was also rated by ten (83%) doctors as an influence on them. Medical aids are classified separately here from other organisational bodies in the industry because they were mentioned independently of all other bodies and by such a high number of doctors. The medical aids are seen by some doctors as controlling and influencing their preferred treatment plans for patients. There is a positive influence relating to costs because some doctors may be exploiting the system. Extracts from the interviews that speak to this theme are:

*Medical aids' manipulation of doctors, of patients, of a situation, because they are extremely powerful. Medical aid manipulation of an environment is causing doctors to change to template billing practices to survive.  
(Doctor 2)*

*Some [doctors] are feeling that they are spending a lot of their time adhering to rules by funders and by hospitals rather than [on] what they were trained to do, which is being independent practitioner. [The medical aids are] taking their autonomy away. (Doctor 8)*

The increase in patient expectations was spoken of by 75% (nine) of the doctors. The doctors interviewed felt that the expectations of patients had risen dramatically, although they indicated that this may be related to the highly affluent and demanding population that they serve in the private sector. As previously mentioned, the perception of doctors having changed to providing more of a contractual service has added to changing doctor–patient interactions. One doctor commented that he felt that patient expectations were higher than in other countries and that at least 20 to 30% of these were unrealistic (Doctor 2). An example given was in situations where patients ask for tests or procedures to be done as in-patients (rather than as out-patients) so as to circumvent medical aid restrictions. This is seen as challenging a key component of their identity—their ethics. Two comments from interviews follow as examples:

*[Doctors] have to work harder and give more of themselves to make the patient happy. (Doctor 10)*

*Causes conflict because the patient thinks you are not prepared to help her but what they want you to do is unethical. (Doctor 11)*

A variety of financial reasons was cited by 67% (eight) of interviewees as impacting doctors in many aspects. The greatest concern was that that they were not being rewarded for the work they were doing. Some felt that the amount of time spent studying no longer equated to the reward. This factor speaks to the concepts of self-worth and recognition of what they do. There were those doctors who had the opposite view and felt that they were making an adequate living, but these responses were in the minority.

A few interviewees also felt that talking to their patients about money detracted from their relationship with the patient. During the discussions, it was apparent that they did not become doctors for financial reasons, but, with escalating practice costs and the economic decline causing an increase in prices and family responsibilities, the financial aspect had become more of a strain and focus. A related concern for the doctors surrounds the increase in healthcare costs in the industry and that they are seen as being responsible. Some acknowledged that they are a part of the source of rising costs, however, they felt that the other stakeholders were more to blame. This appears to be causing anger within the profession. Quotes from the two doctors below reflect both opinions:

*[I] can make a good living by doing good...What I find rewarding is when you are rewarded appropriately and do good for society. (Doctor 9)*

*The cost of practice has become huge. Our MPS [Medical Protection Society professional liability insurance] is R 450,000 this year... I can't recoup the costs of my practice unless I put my fees up ... so there is a lot of financial pressure. Patients believe we overcharge because the medical aids contribute very little, so there is always this financial drama with patients. (Doctor 12)*

The sixth and seventh reasons identified as causes for changing the professional identity of doctors had 58% (seven) of the doctors alike discussing the change in the relationships they are experiencing with their patients and the fact that they are practicing more defensive medicine. Both of these factors appear to stem from the medico-legal aspects, the change in patient expectations and the change in the perception of doctors discussed above.

The change in the doctor–patient relationship is linked to the fundamental characteristic of their professional identity, which is caring for people. A factor that became obvious was that patient knowledge has increased and doctors are being questioned more often. While some doctors felt that this was a good development, others felt that it implied questioning of their clinical judgement. One doctor summed up the general feeling of those doctors who mentioned the change in relationship:

*I feel very strongly a sense of attachment to the patient... it's very intimate and close...[but] adversarial relationships and the checks and balances are eroding the intimacy of the relationship between doctor and patient. (Doctor 9)*

Practicing defensive medicine appears to cause internal conflict for doctors because they are being forced to prescribe additional diagnostic tests and investigations, and thereby increase costs. Their experience and medical knowledge, which form part of their identity, is being questioned – and even threatened. Two comments from different doctors convey the general opinion of those that mentioned this factor as changing their autonomy and how they practice:

*[My practice of medicine is] certainly more defensive. When I first started, medico-legal wasn't an issue. You only scanned a patient when you*

*need[ed] to and now you scan regardless. Can't afford to miss anything, so you practice defensive medicine. Not good medicine, more expensive medicine...[You are] doing medicine for someone else, not what you want to do. (Doctor 3)*

*A lot of stuff is done that is time-consuming [and] that goes towards defensive medicine. (Doctor 10)*

Half of the doctors interviewed (six) commented on the media and the internet. These factors elicited both positive and negative opinions. Some doctors felt that these were assisting them as doctors and enabling them to access information more quickly than before, thereby augmenting their experience – a trait they felt was important to their identity. One doctor felt that it challenged him professionally by having more enlightened patients. The negative aspect of media and internet exposure is that some interviewees feel harassed by the constant questions from patients and feel that it has eroded trust in their knowledge and opinion. Social media has both positive and negative implications to their reputation, another characteristic mentioned earlier. The doctors are concerned about how their patient's opinions, whether they are right or wrong, spread quickly via social media, potentially harming their reputation and practice. Opinions from both sides are portrayed below:

*I am getting reports and journals from around the world in real time. The reverse is that patients now read up on everything and think they know it all. If all you could just read up, then you wouldn't have to do 12 years of medicine. (Doctor 3)*

*Advertising in a way changes the identity, reduces the professionalism. May be a big factor going forward ... An increasing way of advertising is going to be a web page and the internet and I think that, in a way, that changes the identity because they are kinda advertising themselves out there...that almost reduces the professionalism. Doctors are much more accessible to scrutiny by patients because it's not uncommon for a patient to arrive to your rooms having googled you. (Doctor 7)*

*Internet does not worry me. [I] have to answer more questions and consultations take longer...until they [are] satisfied with what they need. (Doctor 8)*

*I am enjoying patients becoming more and more educated. I like the fact that people are spending time on the internet...an educated patient [that] challenges me to perform better is the way to go. I want the patient to [expect] a high standard of me. (Doctor 9)*

The pressure and lack of support from external organisational bodies (excluding medical aids) was mentioned by 50% of the doctors as having a direct impact on their identity because this curtails their autonomy and erodes trust with their patients. The organisations mentioned are the Ministry of Health; particularly as it moves forward with the Competition Commission Inquiry and the National Health Insurance Act (see Section 2.2.3). The Health Professions Council of South Africa, hospitals and the South African Medical Association were also mentioned. One doctor felt that even their insurance companies are keen to just settle disputes and not fight on behalf of doctors, regardless of their innocence. It was mentioned that different speciality groups are forming individual committees to defend and negotiate with the different stakeholders to protect the autonomy of their treatment plans and remuneration. This appears to be affecting the professional identity of doctors in that there is an uncertainty to the practice of medicine in the future:

*Vested interest[s], like the medical aids and government, which is [sic] eroding the status of the doctor. (Doctor 6)*

Less-important reasons for changes in their professional identity were mentioned by 25% (three) of the doctors. They felt that their identity changed and matured as they gained more experience and knowledge by keeping up to date with scientific advances, by getting older and by becoming more experienced within their field of expertise.

Personal intrinsic motivating changes were mentioned by 25% (three) of the doctors. The impression gained was that the majority of the doctors enjoyed what they were doing. Different dynamics that were expressed as affecting their intrinsic pleasure for the profession were stress, the feeling it was becoming just a job, loneliness in private practice and the decrease in life–work balance:

*The profession is wonderful, but the job satisfaction is not. In the past, we sacrificed ourselves, our time, our health, our families and we did it because we were believing it was for a good end. (Doctor 6)*



The remaining themes listed in Figure 3 were mentioned only by individual participants. Although these build on the characteristics of professional identity, they are noted but are not discussed further.

### 5.3. Research Question 2

The second question posed in Chapter 3 was:

*If there are changes to the doctors' professional identity, how has this affected the relationship between the private doctor and the healthcare organisation?*

The intention of this question was to establish if there was a change in the nature of doctors' relationships with organisational management in relation to any change in their professional identity. The participants were asked to view their experience from the establishment within which they worked.

The responses to Question 1 (Section 5.2) showed that all doctors interviewed felt their identity changing to varying degrees, so asking this question was pertinent. Only eleven of the twelve participants were asked the question directly. There was no specific reason that the one participant was not specifically asked the question; this was only discovered after re-listening to the recordings. The responses for this question were therefore analysed based on those from eleven doctors only.

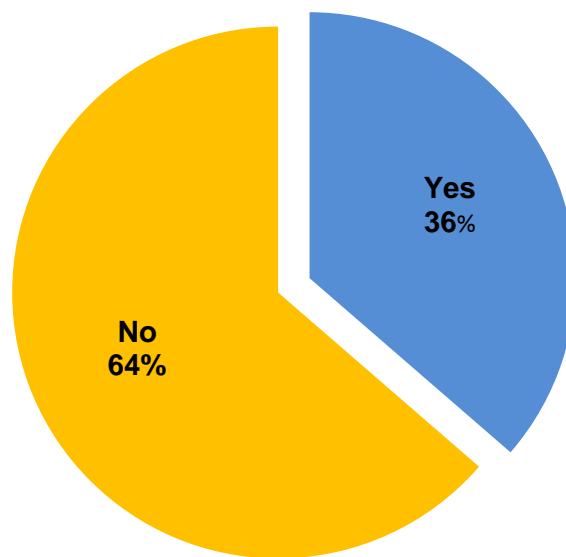
The responses reflected that 64% of the doctors felt that their relationship with organisational management had not changed (Figure 5). The remaining 36% felt that it had changed in different ways. The doctors expressed that the change manifested in a range of ways: from subtle changes, to becoming partners or allies enhancing necessary team work, or to becoming resentful of management.

The subtle changes remarked on by one doctor (Doctor 1) were predominately due the industry pressures (Section 5.2.2) that the hospital and the doctors were experiencing. It was also mentioned that the personality of the hospital manager and the manner in which operational issues were dealt with was important to fostering and supporting the relationship. Becoming allies or partners was commented on by another doctor as 'a commonality to survive' (Doctor 5) the changes that are occurring. Resentfulness was expressed as doctors perceive that they are restricted in their clinical practice due to

cost cutting measures.

The doctors that felt that there was no change to their relationship with management said it was due to: strong partnerships already formed; open communication with management; being able to understand what is occurring in the industry; lack involvement of management and realising that fundamentally a hospital is a business.

**Figure 5: Illustration of doctors' perception of change in relationship with management due to change in identity**



Some remarks from the participants supporting how this direct question are mentioned below:

*I suppose subtly, they have changed in that the hospital manager has to be more of a policeman and will have more of a difficult time dealing with outliers. (Doctor 1)*

*Has had no effect at all [on relationships]. (Doctor 3)*

*I think it makes us a bit resentful, to be perfectly honest. (Doctor 10)*

#### 5.4. Research Question 3

The third question posed in Chapter 3 was:

*How should the traditional engagement strategies employed by the organisation management be adjusted to meet the changing identity of the doctor?*

The aim of this question was to link the perceived changes in the professional identity of doctors in the private sector of South Africa to engagement strategies currently being utilised and to foster ideas for new strategies to enhance the on-going working relationship between doctor and hospital management. Responses to this question would identify if changes to current strategies need to be made in line with the perceived changes in identity.

The participants were asked firstly whether they were aware of any strategies to engage doctors in relation to quality or cost of care. Only eleven of the doctors were asked this question directly. The twelfth doctor, through the conversation, intimated that he and the organisation had had discussions previously regarding operational concerns and equipment. He acknowledged himself as comprising a 'piece of the puzzle', so, for these reasons, the interviewer felt that he could be grouped with those being aware of engagement strategies. The overall result showed that 100% of doctors were aware of different strategies.

The participants had varying experiences with management, but some found it difficult to think about specific engagement practices until the interviewer probed or made suggestions to stimulate ideas. This questioned whether current practices are effective. Different initiatives that were mentioned by the interviewees included the *Best Care Always* initiative - an international effort to improve best practices and patient safety (Bestcare.org.za, 2015), access to various clinical databases used to standardise protocols and measure clinical outcomes such as the *Apache* and *Vermont Oxford Network* databases (Vincent & Moreno, 2010; Horbar, Soll, & Edwards, 2010), meetings with management, cost-per-event statistics on all admissions into hospital, shareholding options, newsletters and memoranda.

The second part of this question probed what the different engagement strategies could entail that would improve engagement and potentially assist with managing the changes in their identities. All doctors were asked for their top three suggestions, but

the majority were happy to talk freely about their ideas and offered more than three.

The results were organised into a frequency table to collate the themes and then framed into a word cloud with the assistance of *Wordle.net*, as shown in Figure 6. As mentioned in Chapter 4, a word cloud is a pictorial representation of the common themes or phrases that came up. The words are reflected in size from the largest-size font to the smallest, depending on the number of times the word or concept was mentioned.

**Figure 6: Word Cloud representing themes identified to improve doctor engagement with organisational management.**



The top strategies suggested to improve engagement are highlighted as per the word cloud (Figure 6). The predominant strategy suggested was the use of communication – emphasized by 92% of the doctors. This was highlighted on a variety of levels: they spoke about direct communication with the hospital manager, down to that with the nursing sisters running the wards; they wanted communications concerning the vision

and strategy of the hospital in which they worked, new doctors, new developments and clinical outcomes. They acknowledged that the managers *do* talk to them, but something more formal, such as an e-mail, may re-enforce the message. Part of the communication theme, although mentioned separately, was the need to be listened to: they feel that this is lacking at times. Some remarks from the participants confirm these findings:

*So there has [sic] to be adequate channels of information spreading between the various parties involved, so that's important: between the management, between the nursing staff, between doctors. So there is always room for improvement [in] communication and continued communication and understanding why certain things are done. (Doctor 1)*

*I don't know what sort of methods of communication there are but [management need to] improve services. (Doctor 4)*

*[There is a need] to communicate first before big decisions are made on our behalf. I think one of the things that irritates me is that I see things being done but it's never really brought to my attention. Maybe it is cause I'm not paying attention or I haven't gotten the email and stuff. (Doctor 10)*

The second priority for the doctors was the level of nursing standards. They are aware that the healthcare industry has challenges, such as skill shortages and high costs of staff, but they felt that having good nursing staff would decrease their frustrations and give the patient a better experience. The doctors expressed a need for the patient experience to be improved via a focus on clinical matters, nursing standards, streamlining the admission processes and visibly spending more on this experience:

*I would want the hospital not to be skimping and scraping on nursing staff. (Doctor 4)*

*But then the bottom line, number one, is always and your biggest challenge is your nurses. And with your nurses, I accept that they are a rare commodity, they are not trained the way they were. (Doctor 6)*

The third suggestion made by 33% (four) of the interviewees was for equipment to be up to standard. They spoke to how integrated this factor was to enable them to practice good medicine. A few expressed frustrations at the fact that equipment is not always maintained as well as it could be and that requests for new equipment were denied or take a long time to be approved. Coupled with this is the need for adequate hospital facilities, expressed by 17% (three) of the doctors. They felt that this was important to both them and their patients. These points are illustrated in the quotes featured below:

*The other thing is to ensure that equipment-wise, because what we, what I do, is so dependent on equipment that there is a [need for] constant updating. I am incredibly frustrated sometimes that equipment requests are declined or [that pieces of equipment] aren't maintained.*  
(Doctor 9)

*[Hospital management needs] to give us what we need in order to care for the patients the best.* (Doctor 10)

High on the list of doctors' suggestions for engagement was greater visibility by management, especially in the theatres – commented on by 25% of doctors. Sorting out the problems of individual doctors received similar attention. Many other suggestions that emerged as the doctors responded: these are reflected in the word cloud of Figure 6.

## **5.5. Summary of Results**

This chapter presents the findings of the interviews carried out as part of the qualitative research conducted amongst doctors practicing in the private healthcare sector. Several themes emerged related to the changing professional identity of doctors and the need for these to be addressed in the doctor–hospital relationship so as to improve the professional engagement of doctors. The analysis of these results and their relationship and conformity with the results of prior studies, as reported in Chapter 2, is given in Chapter 6.

## CHAPTER 6: DISCUSSION OF RESULTS

### 6.1. Introduction

This chapter discusses the results presented in Chapter 5 relative to the research questions that were posed. The results are explored further in relation to current literature to extrapolate and highlight insights pertaining to the research questions. The chapter follows the same structural outline as Chapter 5, in which each research question is addressed individually before concluding with a summary of the findings.

### 6.2. Threats to the Professional Identity of Doctors

The first question posed in Chapter 3 was:

*Is the professional identity of the private-sector doctor in South Africa under threat?*

The data collected in this research project indicate that the doctors are aware that they have a professional identity because they were able to list characteristics that they felt were important to the foundation of this identity. Some doctors did, unexpectedly, need to have the concept of professional identity explained to them, although they did, in fact, understand the concept at a personal level, if not as a theoretical term. Concurring with literature results described by Andersson (2015), the doctors indirectly identified the three interrelated levels that Andersson outlined (occupational, activity and individual levels) through those characteristics on which they commented.

Characteristics that spoke to these different levels were analysed according to the frequency at which they were remarked on and then ranked by the number of doctors that mentioned them. These data are reflected in Figures 1 and 2.

The predominant themes relating to the occupational level are caring about people, ethics, autonomy, and helping the community. Caring for people and the effect of their profession on the community are high priorities. Martinussen and Magnussen (2011) argued that doctors are socialised into this way of thinking: this was confirmed when the doctors spoke about their role models and knowledge gained at medical school.

This socialisation is linked to the ethics of their approach directed towards the patient. They voiced that honesty, having integrity, protecting the patient and applying the correct medical approach are intertwined in the care of a patient.

Autonomy is linked to both their personal and professional identities. Doctors enjoy the independence that being in private medical practice gives them. They appreciate being their own boss and can dictate their own working hours and effort. At the same time, the doctors acknowledged the need for and importance of the team that surrounds their practices to augment their care for the patient.

The characteristics identified that relate to activity concur with those reported by Goldie (2012) and Andersson (2015): the doctors confirmed that a certain speciality, medical knowledge, experience and role models were underpinning factors of this level. The doctors discussed topics such as where they attended medical school, who their role models were, how their colleagues influenced them and even how choosing their speciality affected their outlook to their profession. A few doctors commented on how personality directs one towards a certain speciality. An example is that given by an orthopaedic surgeon, who stated that he does not mind being seen as having pursued the least-academic speciality because his focus was on attaining practical, hands-on expertise.

The final level of professional identity, according to Andersson (2015), is linked to the individual. This was identified by the doctors as they spoke about their different experiences within their private practices, the maturity of their practices and the medical experience they had gained over the years. The demographic selection of the doctors was useful in this study as it allowed for opinions to be voiced representing practitioners in all stages of their careers (Wong & Trollope-Kumar, 2014). The length of time in private practice had surprisingly little effect on their opinions relating to what formed their professional identity. One doctor did mention that experience with current medical students suggests a further evolution in identity. This is an area suitable for further investigation to determine how this will affect the profession in the future

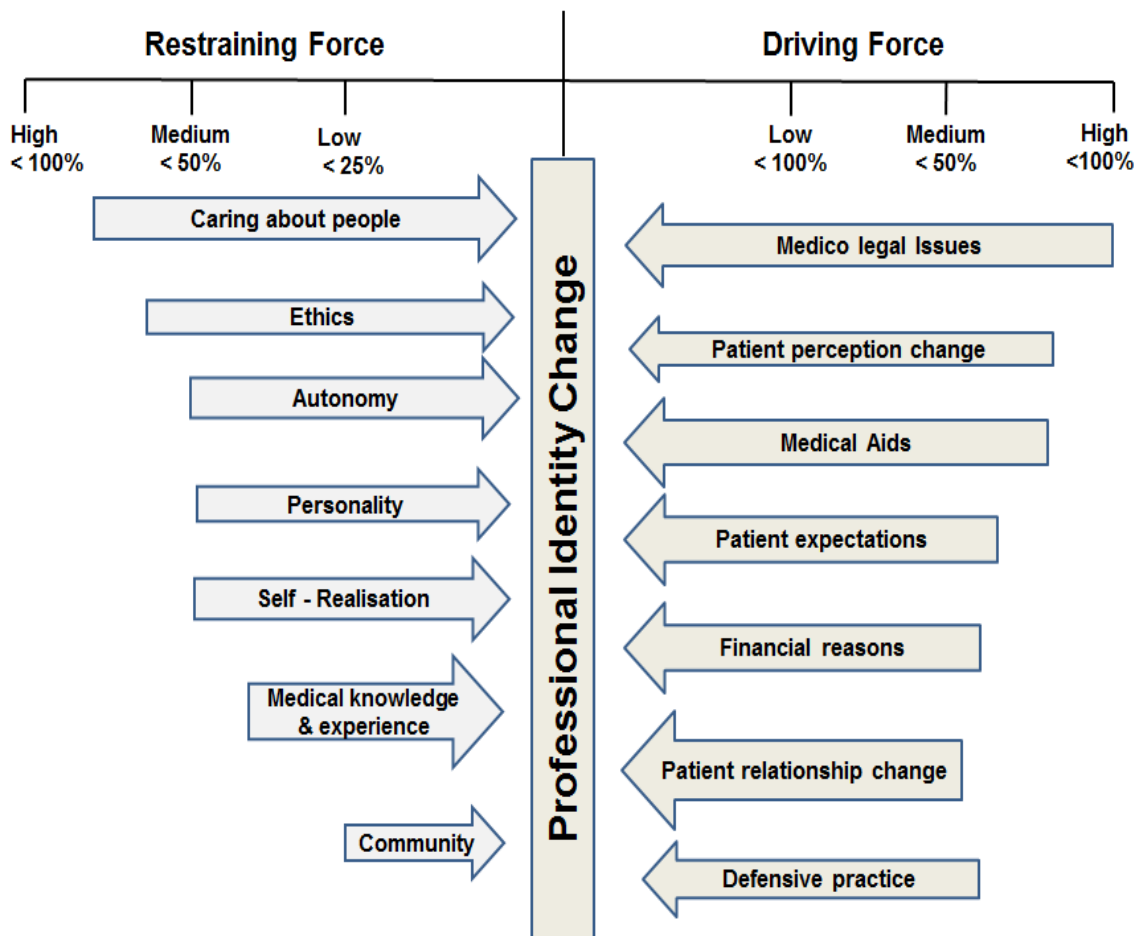
The general sentiment that emerged through the discussions was that the doctors enjoy what they do and see their profession as forming a great part of their personal self-realisation. The use of words such as *gratifying*, *honoured*, *feeling of being wanted* and *fulfilment* indicate the reasons given to why these interviewees intrinsically enjoy practicing medicine.



All twelve doctors confirmed that they felt that their identity was changing to varying degrees. Pratt et al. (2006) found that changes to an individual's identity will have varying degrees of response in relation to both their job discretion and the extent of the threat directed towards it (Petriglieri, 2011). The reasons cited by participants were ranked according to the frequency mentioned and by number of participants. These results are graphically depicted in Figures 3 and 4.

A force-field diagram, shown in Figure 7, was used to analyse the forces that are both driving a change in their identity and resisting a change (Burnes and Cooke, 2013). This diagram is discussed with respect to the triggers identified by McNeil et al. (2013) that are ascribed to causing conflict within the identity of a professional such as that of a doctor.

**Figure 7: Force-field analysis of the top themes of characteristics and causes identified by doctors relating to the change in their professional identity.**



Central to the force-field analysis is the professional identity of a doctor and the perceived change that is reported by the interviewed private doctors. On either side are the forces identified as driving the change (on the right) and those resisting the change (on the left). Restraining forces are those characteristics that are identified as key to the doctor's identity and would theoretically want to be maintained so as to preserve the profession. The driving forces are those acknowledged by the doctors as causing the greatest threat. Both forces are shown in decreasing rank of importance. It should be noted that they are not, in all instances, aligned directly with the conflicting arrow because many causes of conflict are intertwined in how they affect the identified characteristics.

The triggers to identity conflict discussed by McNeil et al. (2013) are: differential treatment, different values, assimilation, insult and humiliating action, or simple contact. Considering these triggers, it is clear from the results that the doctor's identity is under threat. The trigger that appears to be causing the greatest conflict is that of insult and humiliating action. These actions are behaviours that devalue the medical profession. The doctors (92%) expressed both anger and sadness at how the legal system is focusing on the medical industry (Weaver, 2012). The high increase in medical litigation is having a negative effect on their practices. There were 58% who mentioned that they had to practice more defensive medicine, which was increasing costs and, at the same time, undermining their knowledge. This quote speaks to the general opinions associated with litigation:

*Autonomy is negatively impacted by litigious patients and their knowledge of litigation...won't make me more ethical but it's going to change my practice. [It] does change your identity as you become more self-protective. Ten years ago I wouldn't [have] be[en] as afraid of litigation. (Doctor 4)*

Perception of the doctor is changing and interviewees felt that their status in society is decreasing. Expanding on this theme with the doctors, they see themselves as becoming more of a service provider than as a core necessity to society. In their opinion, their knowledge and experience—integral to their need to be of economic value within society—appears to have been devalued in the minds of the patients (Pratt et al., 2006). This driving force was spoken of by 83% of the doctors and attributed to the impacts of negative publicity that their industry is receiving and their consequent decrease in status and reputation in the minds of their patients. This quote reflects the general sentiments of those interviewed:

*I don't really feel it's a highly respected profession any longer. The criticism in the media of doctors, litigation of doctors, socially people put their doctors down, attitude and abuse of patients, makes me think a doctor is not such a respected profession anymore. (Doctor 4)*

Exploitation by legal companies advertising medical litigation, in the doctors' minds, is eroding patient trust and damaging the patient–doctor relationship. This relationship is emphasised as a fundamental aspect of how doctors perform medicine and even the outcomes of their patients. Doctors feel that part of the success of a procedure or a patient's journey to wellness is dependent on the trust that they have in their doctor. This appears to be causing identity conflict, because caring about people remains the strongest aspect of their identity (Figure 2). One doctor summed up this view:

*An important part of my surgical identity is the intimate relationship with the patient and I think the modern application of medicine with layers and legal is eroding it and it's a bad thing. (Doctor 9)*

Furthermore, the internet and media are also seen as triggers changing identity: 50% of interviewees mentioned these as relevant. It is noted that the responses are conflicting: those that were positive are happy for their patients to investigate their diagnosis and ask questions; those that had a negative outlook feel threatened in that their knowledge is being questioned. It appears this trigger was being dealt with in a variety of ways, because those who mentioned it acknowledged that they are working within an enlightened age due to the ubiquity of the internet. The example below reflects a negative connotation of the media:

*Especially with the media, the social media and Google and the internet so on, the patients question everything you do...It's absolutely infuriating...If the doctor agrees with Google, then the doctor's right on that point. (Doctor 12)*

This first trigger of identity conflict of insult and humiliating action also appears to be causing conflict with the doctors' sense of autonomy and personality because it affects their choice of speciality. One doctor mentioned that insurance costs were becoming so high that those qualifying shortly will choose their speciality accordingly. He gave the example of the obstetric field having the highest number of litigation cases and individual insurance costs in the medical industry. His concern for the future of this speciality was very apparent.

The second trigger that appears to be causing conflict is that of different values. As mentioned previously, ethics and the care of a patient are prominent to value creation for a doctor. The first area that causes conflict, in their opinion, is the perception that medical aids, and even other organisations, are more financially focused whereas doctors have the patient's health at the forefront of their priorities. The perceived interference of the medical aids, mentioned by 83% of the doctors, indicates a real concern at being told how to treat patients despite the doctors having the knowledge of knowing what is right. This speaks to the perceived decline in their autonomy, a characteristic identified by 58% of doctors. The historical dominance of the doctor is today being pressured by the different stakeholders in the industry. The quote below alludes to the impact of medical aids:

*At this stage, [medical aids are] giving the doctor enough autonomy but I think this is just the beginning of trying to change it and it will get tighter as time goes on. [Medical aids will] tell them [doctors] what they have to do, will change them. (Doctor 5)*

The second area related to this value trigger is an increase in expectations of patients, as mentioned by 75% of doctors. To them, this means the need to spend more time with patients to satisfy them, dealing with expectations from patients to be unethical in order to assist with patients' financial problems relating to medical aid constraints and being questioned about their clinical knowledge. The divergent preferred treatment plans between doctors and medical aids appear to be re-enforcing this trigger. This trigger directly affects what doctors hold high in their profession, i.e., ethics, self-realisation and their knowledge base.

The third trigger of identity conflict identified by McNeil et al. (2013) is that of differential treatment. This was identified in the private doctors interviewed by the fact that many spoke of their compensation being inadequate relative to their qualifications and time spent studying. Medical knowledge and experience were identified by 42% of those interviewed as being important aspects of their identity, yet 66% said that the decreasing rewards and industry cost pressures were affecting them intrinsically and they were finding it difficult to maintain their lifestyles.

Another conflict trigger is assimilation. This occurs when the dominant party expects everyone to behave as they do and does not tolerate professional differences. At this time in South Africa, it appears as if the medical aids, hospital organisations and the government have more influence on the medical care of patients than the doctor. This

can be extended to the heterogeneous opinions of the doctors in relation to how they see the impact on their autonomy and on how they practice. This trigger has the potential to cause further polarisation between doctors and organisations (Martinussen & Magnussen, 2011).

The final trigger identified by McNeil et al. (2013) as creating identity conflict is that of simple contact. This alludes to parties being in conflict simply by being brought together. This trigger does appear evident at a lower level because the stakeholders within the industry are currently being investigated by the Competition Commission (2015) and doctors are uncertain of the outcome and its consequences and impacts. The impact of the medical aids is evident with this trigger, but is more applicable to the value trigger.

Further to these triggers, self-realisation is seen as important by 50% of doctors. Although not illustrated in Figure 6 (only the top seven driving forces are depicted), 25% of doctors felt that their reasons for going into medicine and the personal impact that gave them fulfilment had declined. The increase in stress, decrease in job satisfaction, loneliness of private practice and decrease in work–life balance are contributing to these changes in their identity.

The triggers identified correlate with the force-field analysis, signifying that the driving forces for change appear to be stronger than the restraining forces protecting the doctor's professional identity. Those causes identified outside of the force-field analysis (Figure 6) but seen in Figures 3 and 4 can be added to the list of items of the future harm that could impact the identity of doctors and thereby increasing the threat to their professional identity (Petriglieri, 2011).

### **6.3. Professional Identity in Relation to Management Relationships**

The second question posed in Chapter 3 was:

*If there are changes to the doctor's professional identity, how has this affected the relationship between the private doctor and the healthcare organisation?*

The doctors admitted to varying degrees of change in their identities and were able to identify, in their opinion, different associated causes. The private doctors in South

Africa work within private organisations so this question was used to explore whether their professional identity outlook was impacting on the relationships with the management in the establishments within which they work.

The majority of doctors (64%) felt that their relationship with organisational management had not changed. The remaining 36% of doctors articulated that change had occurred, ranging in severity from a subtle change, to becoming partners or allies, or to becoming resentful of management.

This divided response described by the doctors appears to be caused by various reasons. Those who felt that their relationship with the organisation had not changed alluded to the fact that they were independent of the hospital management and, if they received what they needed, there was no need for the relationship to change. Those that felt the relationship has changed were divided into two groups: those who felt there was a positive change commented that, with the changes occurring, both the management and the doctor needed to work more closely together and those who were negative about the change were resentful of management because they saw them as unsupportive. They also felt that the organisations had more power than the doctors, which leads to the hospital imposing changes on them.

The literature revealed that doctors relate strongly to their professional group whereas managers identify with their organisation and that the training and goals of the two professions are differently focused (Joffe & Mackenzie-Davey, 2012). This could be the reason for growing resentment between the parties because there may be doctors who are trying to maintain their primary link to their profession and failing to adapt as the healthcare industry landscape changes. Alternatively, the focus on goals is still polarised (Joffe & Mackenzie-Davey, 2012; Spyridonidis et al., 2015). An extract from an interview that spoke to this theme is reflected below:

*The stumbling blocks are the different agendas. The manager is there to make sure that the hospital runs smoothly and as efficiently as possible with minimal expenses and create an income and not be a negative drain on the parent company. The doctor is not interested in that. Doctors are more interested in getting the patients better as quickly as possible and providing the best service to the patient. So there are slightly different agendas. Certainly the hospital manager has the interests of the patient at heart but has to make sure that the organisation runs properly. There are more pressures on the hospital*

*manager and that may impact on the relationship. (Doctor 1)*

Some doctors said that they had become allies or partners. These doctors may have already gone through a process of incorporating or adapting to those factors in the industry that are threatening their identity. An example could be the discovery of methods to adjust their working practices so as to neutralise the impact of the internet and thereby grow their professional identity. Another approach, as suggested by literature, is that of identifying new roles, e.g., as a clinical leader or working closely with the organisation to grow a centre of excellence and further training (Spyridonidis et al., 2015). A comment from a participant supporting this theme is mentioned below:

*This hospital—if we can make more money—can employ fellows to be trained. That’s a different thing because very little profit leaves this hospital because it goes back into it. (Doctor 8)*

The relationship between the doctor and management of organisations is constantly shifting as the industry changes and individuals experience the interactions differently according to the status of their identity (Spyridonidis et al., 2015).

#### **6.4. Engagement Strategies That Address Concerns Relating to Identity Changes**

The third question posed in Chapter 3 was:

*How should the traditional engagement strategies employed by the organisation management be adjusted to meet the changing identity of the doctor?*

Responses to the previous two questions revealed that the professional identity of the doctor in private practice is altering due to multiple causes, as identified by the participants. They reveal that the relationship with management has undergone change. The aim of this question was to establish whether the strategies currently being used are those that will align the doctor and the organisation for the future practice within the private sector and, if not, what strategies are recommended (Spyridonidis et al., 2015).

The interviews revealed that the doctors are aware of and are participating in some of the engagement strategies with their organisations. However, it was apparent from the

discussions that more could be done to improve the relationship because there remains a gap between the priorities and goals of the hospital management and those of doctors (Morgan, 2014; Spaulding et al., 2014). The willingness to give ideas for engagement practices and by suggesting practices that hospitals are already employing implies that the current practices could be improved. Being in private practice and outside the employment of the organisation was shown by Snell et al. (2011) as causing a tendency for the doctor to become disengaged. This makes it imperative to have engagement strategies that meet both parties' expectations and to bring them closer to aligning their priorities.

The responses to the first question showed that 25% of doctors voiced the finding that the impact of the professional identity changes had a negative impact on them. Ariely (2012) stated that engagement is not solely about money, but other factors also play a role: identifying strategies aligned to the doctors' intrinsic reasons for choosing medicine as a profession is therefore key to engagement.

The responses to this question highlight strategies that the doctors feel would help them going forward, both in their relationship with the organisation and in their practices. The key concepts were formulated into a word cloud to visually demonstrate their importance to the doctor (Figure 6). It is interesting that the strategies proposed are intertwined with those characteristics cited as key to their identity in response to Question 1.

Communication was mentioned by the majority of the doctors. This concurs with the literature findings of how important communication is in working together. This ties into expectations of increased visibility and contact with the management (Correia, 2013). Snell et al. (2011) recognised that knowing what the values and characteristics are is key to a doctor's engagement. It is therefore not surprising that communication features so highly, because this is paramount to knowing how doctors' identities and needs are changing:

*So communication, I think, is the biggest, biggest thing that we have to improve in the hospital. The second thing that we have to improve is availability. Management must be able to go to the wards, move across the wards so that staff and junior staff know: here come[s] the matron, here comes the manager, they're checking in the hospital, they're looking. They speak to the patients [that] they care. (Doctor 11)*



Open communication channels also improve the trust levels between the doctor and the organisation which can encourage further discourse and mutual partnerships to improve patient outcomes (Du Plessis, 2013; Ozawa & Sripad, 2013; Spaulding et al., 2014). Ethics and autonomy, both factors important to doctors, are enabled by open communication that can foster transparency and therefore trust.

*There has to be lot of communication. You are going to have to get some of the opinion leaders to buy-in first...Ok, its honesty, communication...and I think the vision of where the hospital is going. (Doctor 8).*

Nursing standards is another significant factor impacting on engagement of the doctors. They were aware of the skills base challenges that the country is experiencing, however a fundamental identity characteristic is the care of their patient, as discussed in the responses to Question 1. Having a workforce that does not meet their standards or is disengaged will further polarise the doctor from the organisation (Mache et al., 2014; Spaulding et al., 2014).

The third area of frustration was identified as that of equipment. The expectation is that all matters pertaining to the availability, maintenance and modern equipment technology need to be sufficient to the needs of doctors to practice medicine. This is considered as empowering them to use their skills and abilities in caring for the patient, and which is, again, aligned to their identity (Vasanth & Manjunathan, 2014).

The doctors expressed a need for the patient experience to be improved via a focus on clinical matters, nursing standards, streamlining the admission processes and visibly spending more on this experience.

Other factors discussed were those that foster self-realisation, including being listened to, recognition, being shown appreciation, visible support of the doctors by management and being part of the team. Being made aware of the organisation's commitment, vision and strategy and being part of future training were also indicated as important factors in enhancing engagement. This inclusiveness expressed intimates that there may be a gap that the management are not acknowledging (Whitlock & Stark, 2014). A comment that illustrates the feeling towards team work is quoted below:

*Learn to work together with team, don't be individuals. It always starts at the beginning. If you work together as a team, you learn how to be strong: if you are not prepared to pull your weight, the whole thing falls*

*apart. (Doctor 3)*

Changes within the industry concern the doctors and they would like more support from their organisations. One doctor commented that he would like the playing fields to be level in relation to all providers meaning hospital organisations, medical aid schemes and pharmaceutical companies etc. (Doctor 2). The medico-legal pressures on the industry are another area where the doctors want support and organisational objectivity:

*Going back to what I was saying about how this is a more litigious time in practicing a defensive medicine, I need to know that the hospital has my back. (Doctor 10)*

The question concerning doctor engagement was explored in a limited capacity due to the nature of this project, but it has given some good insights into the ways that organisational management and doctors can close the gap and improve engagement. It is evident that barriers to engagement remain, confirmed by the high response rate with similar themes (Carlson & Greeley, 2010).

## **6.5. Summary of Discussion**

The project results show that doctors in the private healthcare sector in South Africa are aware of their professional identity. They recognise that there are specific characteristics that form the crux of their professional identity and, through analysis, the top five characteristics were identified by the majority. The doctors admitted that their professional identity has changed to varying degrees and the majority identified similar factors that they thought were causing the threat.

The research further concludes that there is a fair impact of this threatened professional identity on relationships with organisational management. The discussion surrounding doctor engagement identifies themes that can be used to foster closer working relationships and thereby assist organisations in responding to the identity threat. A closer working relationship would contribute to sustainability of private healthcare in South Africa.

## CHAPTER 7: CONCLUSIONS

### 7.1. Introduction

The purpose of this chapter is to consolidate the results and discussions of the two previous chapters in line with the objectives of the research. Recommendations for the different stakeholders both in the business and academic arenas are included. The chapter concludes with a summary of the limitations of the research and suggestions for future research.

A snapshot of the economic environment shows a country in an economic downturn that is impacting negatively on the healthcare system. South Africa's healthcare system is already overburdened and unable to meet the country's needs. The healthcare system is divided into the public and private sectors: both sectors, catering to different markets within the population, have challenges of ever-increasing costs, lack of skilled human resources, legislative changes and changes in patient expectations.

The scope of this study was concentrated within the private sector, focusing on doctors who are self-employed and working within private hospital organisations. Key to the success of the private sector is the interrelationship between the doctor and the organisation. This study sought to understand if there was a threat to the doctor's professional identity and whether this was impacting this relationship.

The review of the literature in Chapter 2 established that doctors have a professional identity because they are a group of individuals who hold distinctive skills and knowledge that are essential to their choice of career and different traits in their personality (Martinussen & Magnussen, 2011; Pratt et al., 2006). The formation of the doctor identity was explored to gain more insight into their professional identity (Andersson, 2015). This allowed for better understanding to be gained relating to the triggers of and responses to professional identity conflict (McNeill et al., 2013; Petriglieri, 2011; Spyridonidis et al., 2015). The literature review concluded by exploring engagement within the workplace, specifically aimed at the doctor and the organisation. Both the barriers and the benefits previously identified were discussed as an introduction to understanding engagement specifically within the private sector within South Africa (Gokce et al., 2014; Kreindler et al., 2012; Snell et al., 2011). In Chapter 6, the results revealed from the qualitative research, completed by interviewing twelve doctors in private practice, were discussed with reference to prior studies and conclusions reported in the literature.

In summary, the professional identity of a doctor is an important aspect of their personality and any adverse pressures will threaten their personal identity and that of their professional group. Doctor engagement starts with understanding these challenges and assists with collaborating on common goals. The remainder of this chapter discusses the key findings.

## 7.2. Key Findings

The primary objective of this research was to identify whether doctors in the private healthcare industry within South Africa feel that their professional identity is changing, and how this may be impacting on relationships with organisational management in the institutions in which they work. The secondary objective was to explore engagement strategies that could assist the doctor with mitigating or managing such changing identity and enhance the working relationships between the doctor and organisational management.

The key findings are listed below:

- The study supports other studies in the literature in determining that the doctor has a strong professional identity and that the doctors within the scope of this project were aware of this.
- This identity is influenced through the medical school environment, interactions with role models and professional experiences.
- Many characteristics are identified as forming part of this identity: the top themes, identified by the majority of doctors, were those of caring for people and the community, ethics (from the viewpoint of doing right by the patient), and having integrity and honesty. A sense of autonomy, their own personality, self-realisation and medical knowledge and experience rounded off those characteristics cited by most respondents.
- All of those interviewed recognised an element of change to their professional identity, the extent of which ranged from minimal personal change to an indubitable change. All agreed that their professional identity is under threat.
- The doctors identified predominately external causes that are threatening and causing the change in their identity. The majority of participants identified the

greatest attack as the heightened medico-legal focus, which is leading to defensive practice of medicine. Other causes mentioned by the majority of interviewees are changes in the perception of doctors by patients and increased patient expectations. The pressure and influence in the industry of medical aids and other organisational bodies, together with the concurrent financial burden of running a practice and not being rewarded in line with their expertise, were also cited as reasons for this change in identity. One final cause worth mentioning is the polarising impact of the media and the internet, because this affects doctors on several fronts.

- The doctors expressed the opinion that their profession was being devalued as it became more a service than a humanitarian necessity.
- The majority of the doctors (64%) said that this changing professional identity had not affected their relationship with the management of hospital organisations. Both positive and negative shifts in the nature of this relationship were mentioned by those who said that it had been affected.
- That doctor engagement strategies are in place at the hospital organisations in the private sector of South Africa is evident, but there appear to be barriers and/or gaps in opportunities for fostering engagement between the parties because there was a high response and eagerness to speak about such strategies from the interviewees.
- The main themes with respect to improving doctor engagement were identified as improving communication, nursing standards, and equipment availability and maintenance. Resolving the individual problems of doctors timeously, management visibility, hospital facilities and visible recognition and appreciation of their part in the hospital environment were also frequently cited.

This study concurs with the literature results in relation to the existence and strength of the professional identity of the private doctor within South Africa. The study has added to literature the conclusion that the overall driving forces by the external causes of conflict to this professional identity appear to be stronger than the restraining forces of the characteristics making up the doctors' professional identity, thereby leading to a threat to this identity. The dynamic healthcare market within the country is likely to be an on-going influence and doctors will continue to feel more pressure to change, as evidenced by the impact already demonstrated.

There are engagement strategies currently being used by organisations which are described to in the literature; however, these are not delivering the desired outcomes. The vocalised areas for improvements to engagement strategies and understanding these findings have implications for both the healthcare environment and academia.

### **7.3. Limitations of the Study**

The limitations of this study are, firstly, that the interviewer had a working relationship with some of the doctors which made it, at times, difficult to separate operational topics from the interviews. Self-selection bias cannot be ruled out because this can occur during voluntary participation. Finally, the industry is being pressured by the Competition Commission Inquiry that was occurring at the time of the study: this may have made the participants hesitant to be more open in expressing their opinions.

### **7.4. Recommendations for Stakeholders**

The private healthcare system comprises key stakeholders that all play a significant role in the functioning of this system. This study focused only on the private doctor and the private health organisations. Recommendations derived from this study will therefore only be discussed in this context.

#### **7.4.1. Doctors**

The doctor's professional identity is under threat, as shown by this and other international studies. The doctor needs to decide on appropriate responses to this threat because the driving forces are strong and the impact is already being felt. The interviews indicated doctors are currently expressing anger towards the different causes: this derogation or discrediting of the validity of the source of threats can only be a short-term solution in protecting their identity (McNeill et al., 2013; Petriglieri, 2011; Spyridonidis et al., 2015). They may also be unable to reverse the change in the attitudes of the most challenging of those parties with whom they interact, i.e., patients, medical aids and the legal system.

It is recommended by the researcher, that doctors as a profession look at how they can meaningfully adapt their professional identity to work within the changes occurring in

the market place. Adapting this identity voluntarily will enable them to maintain more control over the importance of and the motivating reasons for this identity that forms such a significant part of their personality. This can be done by cultivating working relationships with the hospital management to achieve common goals that promote and protect their profession. Doctors in the private sector also tend to work within an element of isolation. This should be altered so that, as a group, they are able to counteract influences that they are opposed to. Clinical partnerships with the organisations that have a greater influence in the market can protect their autonomy of clinical practice.

Costs within the industry remain on the increase (Carlson & Greeley, 2010; Deloitte, 2014; Mayosi & Benatar, 2014). Doctors should evaluate the business models on which their practices are run. Currently, they typically work independently: it is advised that they look at combining practices so that operational costs can be shared. Partnering in the development of Centres of Excellence within their operating environment will assist in maintaining their reputations and re-establish the value of an appropriate reward in the minds of patients and medical aids.

The value of their profession requires an alteration in their own perception as—by their own admission—the public place them into the category of being a service provider. Embracing this change could help reverse the decline of the status of their professions in the community.

#### **7.4.2. Hospital Organisational Management**

The sustainability of both hospital management and the doctor operating within the same healthcare environment are intertwined. The private setting in South Africa is becoming more and more accountable for cost and quality outcomes. This means that the urgency of doctor engagement is becoming more crucial going forward.

The engagement strategies that organisations currently have in place are only a starting point but, as revealed by this study, there remains a divide between what the doctors see as engagement and what the hospitals are doing. The shortage of nursing and doctor skills, the focus on cost and the economic situation in the country mean that organisations need to focus more closely on doctor engagement strategies. In the opinion of the researcher, suggestions of what should be taken into consideration, as raised by the interviewees participating in this study, should be discussed.

Understanding the factors that are causing the threat to a doctor's professional identity can be the starting point of such strategy. This study highlights many aspects of concern to doctors: these can be individually assessed to determine where management can have the greatest impacts in fostering a closer relationship.

The incorporation of doctors into the organisational vision and goals by allowing doctors to give their input into clinical operations, processes and outcomes will assist with the protection of their identity and, at the same time, benefit the organisation competitively as the doctors extend their commitment to the hospital. This will also foster transparency and trust between parties, while augmenting recognition for the doctor. The aspects of commitment and recognition are both cited as being part of their identity.

Improvement of communication channels is highly significant to the success of a more beneficial partnership. The study found that 92% of respondents wanted improved communication. Doctors have the biggest impact on clinical outcomes and costs of a hospital because they decide on the treatment protocols. Communication is therefore crucial between the doctor and the management of the organisations, in order for the organisation to have any positive input in cost containment.

Nursing standards are under strain because of the skills shortage in the country. This is an area in which the hospitals can involve the doctors by encouraging their involvement in training. In the private sector, training is currently seen as predominantly the responsibility of the hospital. This study showed an inclination of the doctor towards being part of this.

Operational problems increase the stress levels of a doctor so hospital management must take care of these issues quickly and effectively, communicating with the doctor relating to the progress. Visibility of management fosters the perception that they are in control of the organisation and are willing to take the time to experience and listen to the doctor's concerns.

Hospital management needs to identify the leaders in the doctor community in their hospital. This will help to achieve buy-in of other doctors to facilitate the changes required by the forces impacting the healthcare system.

The impact of the medico-legal framework in causing a financial burden for doctors can be shared, where the organisations look to sharing or paying for doctors' insurances in specialities that are at risk of becoming scarce.



Facilitating work–life balance for doctors, to assist in combating the stress levels they currently experience, may be an opportunity for the organisations to show support. This can either be done by becoming involved in the training of doctors or by employing more doctors. Although it is not legal at this stage in South Africa to employ doctors in the private sector, this practice has been shown to be beneficial in other parts of the world, particularly as it relates to cost management, quality outcomes and decreased doctor stress.

Engagement is an on-going, evolving process and needs to be adapted to the changing environment and the needs of the doctors and organisations. The above provide a few ideas that can be used going forward to improve the relationship between doctors and private hospitals.

### **7.5. Suggestions for Future Research**

Based on the outcomes of this research, the following areas are recommended for further study:

- The identification of new personality traits in younger individuals who are attracted to medicine today, because this will influence the future of the profession.
- A study into the quality of teaching within the medical schools to determine whether the newly qualified doctor is being adequately equipped for medicine in private practice within South Africa.
- A study of ways in which doctors can adapt their profession to maintain the intrinsic feeling of satisfaction and reward that has been a key feature of their professional identity in the past.
- A study into the competencies of organisational managers in dealing with the changes occurring within the medical industry and their impact on doctor engagement.

## 7.6. Conclusions

South Africa's healthcare remains a growing industry in a country where there is a dichotomy between the public and private sector relating to service, costs and spending. The importance of the doctors working within the private healthcare industry cannot be overlooked as they play a fundamental role in this overburdened healthcare system.

This research project has explored the current professional identities of doctors working in the private healthcare sector. Important characteristics were identified by doctors as forming their strong professional identity. This project has successfully identified that doctors in private healthcare are experiencing changes to their identity. Those factors that are threatening this identity were discussed.

The study has also identified areas that could be used to improve the co-dependent relationships of doctors and the organisational management. Themes highlighted by doctors relating to engagement will further aid to mitigate and manage such threats currently being experienced.

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## Appendix 1: Interview Guide

### Interview Guide

**Date:**

**Demographics:**

**Length of time in Private Practice:**

**Question 1:** All doctors have a professional identity. Can you identify any characteristics that form the foundation for your profession?

**Question 2:** Have you felt that these have changed?

**Question 3:** What has caused the change?

**Question 4:** How has that affected your relationship with hospital management?

**Question 5:** Hospitals are trying to engage with doctors to improve quality and cost management. Are you aware of any such initiatives?

**Question 6:** With the change in the industry and doctors professional identity, what would you say are the three top strategies that management could employ?



## Appendix 2: Ethics Approval

### a. Gordon Institute of Business Science Ethics Approval



Dear Mrs Louise Sole

Protocol Number: **Temp2015-00915**

Title: **Doctor professional identity changes impact on relationships with organisational management in the private healthcare sector in South Africa**

Please be advised that your application for Ethical Clearance has been APPROVED.

You are therefore allowed to continue collecting your data.

We wish you everything of the best for the rest of the project.

Kind Regards,

GIBS Ethics Administrator

### b. Mediclinic Ethics Approval



MEDICLINIC OFFICES  
STRAND ROAD  
STELLENBOSCH  
7600  
PO BOX 456  
STELLENBOSCH  
7599  
T +27 21 809 6500  
F +27 21 809 6756  
ETHICS LINE 0800 005 316  
www.mediclinic.co.za

20 May 2015

Ms L Sole  
Mediclinic Sandton  
Cnr Peter Place and Main Road  
Bryanston  
2021

E-mail: [louise.sole@mediclinic.co.za](mailto:louise.sole@mediclinic.co.za)

Dear Louise,

**DOCTOR PROFESSIONAL IDENTITY CHANGES IMPACT ON RELATIONSHIPS WITH ORGANISATIONAL MANAGEMENT IN THE PRIVATE HEALTHCARE SECTOR IN SOUTH AFRICA**

Please be advised that Mediclinic hereby approves the application for the above-mentioned research.

Yours sincerely,

A handwritten signature in black ink, appearing to be "M S Smuts".

**DR M S SMUTS**  
**CHIEF CLINICAL OFFICER**

## c. Mediclinic Ethics Approval

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

23/07/2015

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### Endorsement Notice

**Ethics Reference No.: Temp2015-00915**

**Title:** Doctor professional identity changes impact on relationships with organisational management in the private healthcare sector in South Africa

Dear Louise Sole

The **New Application** as supported by documents specified in your cover letter for your research received on the 20/07/2015, was approved, by the Faculty of Health Sciences Research Ethics Committee on the 22/07/2015.

Please note the following about your ethics approval:

- Please remember to use your protocol number (**Temp2015-00915**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

**Ethics approval is subject to the following:**

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

**Yours sincerely**

*\*\* Kindly collect your original signed approval certificate from our offices, Faculty of Health Sciences, Research Ethics Committee, H W Snyman South Building, Room 2.33 / 2.34.*

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**Dr R Sommers**; MBChB; MMed (Int); MPharMed.

**Deputy Chairperson** of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

## Appendix 3: Draft letter of consent

### Draft Consent Document

**Study Title:** How do doctor's professional identity changes impact on relationships with organisational management in the private healthcare sector in South Africa?

Dear Doctor

I am conducting research on how changes to a doctor's professional identity impacts on relationships with organisational management in the private healthcare sector South Africa.

Our interview is expected to last about one hour, and will help us understand how your perceived changes to your professional identity affect the relationship with the manager within the organisation you work. This study hopes to identify factors to improve working relationships between doctors and organisational management. There should be no costs incurred on your part except for your time.

**Your participation is voluntary and you can withdraw at any time without penalty.** All data will be kept confidential. If you have any concerns, please do not hesitate contacting either my supervisor or me. Our details are provided below.

Researcher name: Mrs Louise Sole

Email: louise.sole@mediclinic.co.za

Phone: 011 706 2142

Signature of participant: \_\_\_\_\_

Date: \_\_\_\_\_

Supervisor name: Professor Karl Hofmeyr

Email: hofmeyrk@gibs.co.za

Phone: 011 771 4000

Signature of participant: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of researcher: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix 4: Letter from KPI Research and Strategy



15 September 2015

To whom it may concern

**Re: Quality check of theme identification for a research project done by Louise Sole**

A blind quality check was requested by a student doing her Master of Business Administration thesis at the Gordon Institute of Business Science. Random recordings of interviews and corresponding interviewer notes were analyzed.

After further discussion with the researcher it can be confirmed that the themes were consistent to with what she had found.

Yours truly

*Althea*

Althea Bacchialoni

(Director - KPI Research & Strategy)

The Square, Pinewood Office Park, Rivonia	KPI RESEARCH & STRATEGY (PTY) LTD Reg: 2011/129364/07	Tel: 011 803 4412 Fax: 086 608 5769
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