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ORIGINAL RESEARCH

The perceptions of the working environment of anaesthesiologists migrating from the public to the private sector in a developing country: an exploratory, qualitative study

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Background: There is a significant disparity in the distribution of medical practitioners within the public and private healthcare sectors of South Africa (SA). This study explores anaesthesiologists' perceptions of their working environment in the public sector following their migration to private practice. Their reasons for leaving are largely unknown.

Methods: Rich pictures were applied in an exploratory, qualitative research design using Checkland's Soft Systems Methodology. Anaesthesiologists who left the Department of Anaesthesiology at the University of the Witwatersrand between 2014 and 2017 and worked in the Johannesburg metropole private sector were invited to a workshop. Participants were asked to draw a rich picture to illustrate their perceptions of the working environment in the department and to draw a picture depicting the ideal anaesthesiology working environment in the department. Explanations of their pictures were audio recorded, and deductive thematic analysis was used to analyse the data, guided by Herzberg's Motivation-Hygiene Theory.

Results: The rich data from this study foregrounded job dissatisfaction and a lack of satisfaction in the department due to Herzberg's poor hygiene and motivator factors, such as a high workload, a lack of resources, working relationship conflicts (within the department and between disciplines), inflexibility with work-life balance, and a lack of accountability regarding clinical conduct in the operating theatre and departmental administrative or managerial tasks. These factors are some of the important reasons for anaesthesiologists' migration from public to private practice.

Conclusion: This study demonstrates the complexity of interactions between individuals working together in systems that are often tense and sensitive to multiple dynamic influences. These systems are context-specific but must recognise the motivator and hygiene factors that may ultimately impact quality health service delivery and education.

Keywords: anaesthesiology, working environment, migration, staff retention

Introduction

Human resources are central to healthcare service delivery, which remains a challenge in SA. The SA 2030 Human Resources for Health Strategy acknowledges the current inequities between the public and private healthcare workforce.[1] In addition, the strategy seeks to improve the working environment for those working in the public sector.[1] The complex healthcare system affects healthcare workers through multiple dynamic influences, causing satisfaction and dissatisfaction in the working environment. Job satisfaction leads to a desirable work ethic and reduces the likelihood of employee migration.[2] In 1959, Frederick Herzberg proposed the Motivation-Hygiene Theory to describe the factors that motivate and satisfy employees in the working environment.[3]

In recent years, human resource professionals identified employee turnover and retention as an increasingly important management challenge.[4] Employees play a significant role in the sustainability of an organisation, and high staff turnover is often a sign of deeper underlying issues, such as inadequate recognition and career advancement in the workplace.[5,6] However, employee migration is also fundamental to the growth and relevance of an organisation, and it is important to find a balance between functional and dysfunctional turnover.[7,8]

The South African healthcare system is characterised by a shortage and maldistribution of healthcare workers.[9] The Health Market Inquiry reported in 2019 that "access to medical practitioners in the private sector (1.75 per 1 000) is in stark contrast to access in the public sector (0.3 per 1 000)" of SA.[10] The number of medical practitioners in the private sector has increased annually.[10] The public healthcare sector has fewer healthcare facilities but serves the majority (approximately 83%) of the South African population, who carry the greatest burden of disease and HIV prevalence.[10]

Training of South African doctors takes place in the public sector. The distribution of practitioners indicates that doctors are moving away from areas where their service is most required.[11] The poor retention of healthcare workers in rural areas has been attributed to limitations in career advancement, poor working environments, lower salaries, and a heavy workload.[12] Farham argues that retention schemes and incentives to work in the rural

areas of SA were insufficient to make up for the poor working conditions and deterioration of public health services.[13]

Health systems, such as the public sector anaesthesia environment, represent complex systems sensitive to multiple dynamic influences.[14] This study explores anaesthesiologists' perceptions of their working environment in the public sector following their migration to private practice and examines their perceptions of the ideal working environment.

Methods

This study applied rich pictures in an exploratory, qualitative research design. Checkland's Soft Systems Methodology supports the idea that "a picture paints a thousand words".[15,16] Drawing pictures may be better than prose as an effective way of depicting complex situations with multiple interacting relationships.[15] The University of the Witwatersrand Human Research Ethics Committee (Medical, M181050) approved this study.

The study was conducted at the Department of Anaesthesiology, affiliated with the Faculty of Health Sciences of the University of the Witwatersrand. The following core hospitals are affiliated with the department's training platform: Charlotte Maxeke Johannesburg Academic Hospital, Chris Hani Baragwanath Hospital, Helen Joseph Hospital, Rahima Moosa Mother and Child Hospital, and Wits Donald Gordon Medical Centre. All participating anaesthesiologists rotated through all the Wits-affiliated hospitals during their training.

The study population consisted of anaesthesiologists who left the department between 2014 and 2017 and were working in the private sector in the Johannesburg metropole. Purposive sampling was applied to the list of anaesthesiologists who had left the public service in that period and consented, and they were invited to a workshop held at a neutral venue after working hours. Two authors (MG Kolling and J Scribante) facilitated the workshop.

Participants gave written consent for participation and recording of the workshop. Demographic data (sex, marital status, years of anaesthesiologist experience, and departure date from the department) were collected. The authors introduced the study and the methodology of rich pictures. Participants were then divided into two groups, and each group was asked to draw a picture to illustrate their perceptions of the working environment in the department. Once the pictures were drawn, each group was asked to explain what they had drawn. The groups were then asked to draw a picture depicting the ideal anaesthesiology working environment in the department and explain their pictures again. The participants' explanations of their pictures were audio-recorded for practical reasons on two mobile phones (Apple S8 and Apple 10). An author (MG Kolling) took descriptive and reflective field notes during and after the workshop.

The recordings were clear and accurately accounted for the rich picture explanations of events at the workshop. The recordings were transferred to the investigator's password-protected laptop immediately after the workshop to ensure secure data storage and confidentiality. The audio recordings were transcribed verbatim, which the other authors checked for accuracy. Deductive thematic analysis was applied, guided by Herzberg's Motivation-Hygiene Theory.[3,17] The sequence of data collection and analysis events is displayed in Figure 1.

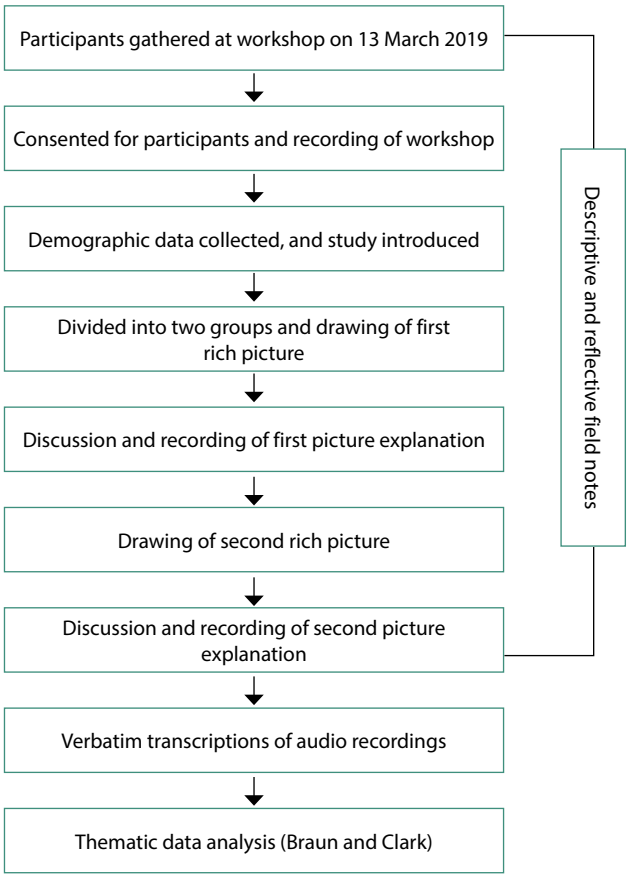

Figure 1: Sequence of events of data collection and analysis

The authors analysed the transcribed explanations and discussions of the pictures, ensuring that the study's

Table I: Participants' demographic data

Participants	Number of participants	
	Group 1	Group 2
Sex		
Male	3	2
Female	4	3
Marital status		
Married	7	3
Unmarried	0	2
Experience as a specialist (years)		
< 2	1	2
2–5	4	2
> 5	2	1
Year of departure from the department		
2014	0	0
2015	2	2
2016	2	1
2017	3	2

trustworthiness met the criteria of credibility, dependability, confirmability, transferability, and authenticity. In reporting the results, participants are referred to by the group they were in and a letter within a group system.

Results

The 12 participants (Table I) attended a three-and-a-half-hour workshop on the evening of 13 March 2019. They were divided into two groups. The rich data reflected the participants' commitment and interest in academic anaesthesiology.

The participants named their first two pictures. "The days of our lives" (a soap opera analogy) (Figure 2) was chosen by the first group to represent their experience of chaos and drama at the time of their migration.[18] Poor interpersonal and interdepartmental relationships characterised this unpleasant working environment. The second group titled their picture "War and peace – going nowhere slowly" (Figure 3). Participants described a sense of enormous effort resulting in the feeling of defeat of "going nowhere slowly".

The ideal working environments, illustrated in the pictures titled "Paradise road" (Figure 4) and "Peace in our time" (Figure 5) by the two groups, reflected efficient and effective operating room systems where mutual respect allowed individuals to feel valued as team members.

Figure 6 represents Herzberg's Motivation-Hygiene Theory. Herzberg identified two broad categories (motivator and hygiene factors) that lead to dissatisfaction and satisfaction within the working environment.[3] Motivator factors relate to the job itself, whereas hygiene factors are extrinsic to the job.

Hygiene factors

A lack of resources significantly limited working conditions, and participants found working in a resource-limited environment

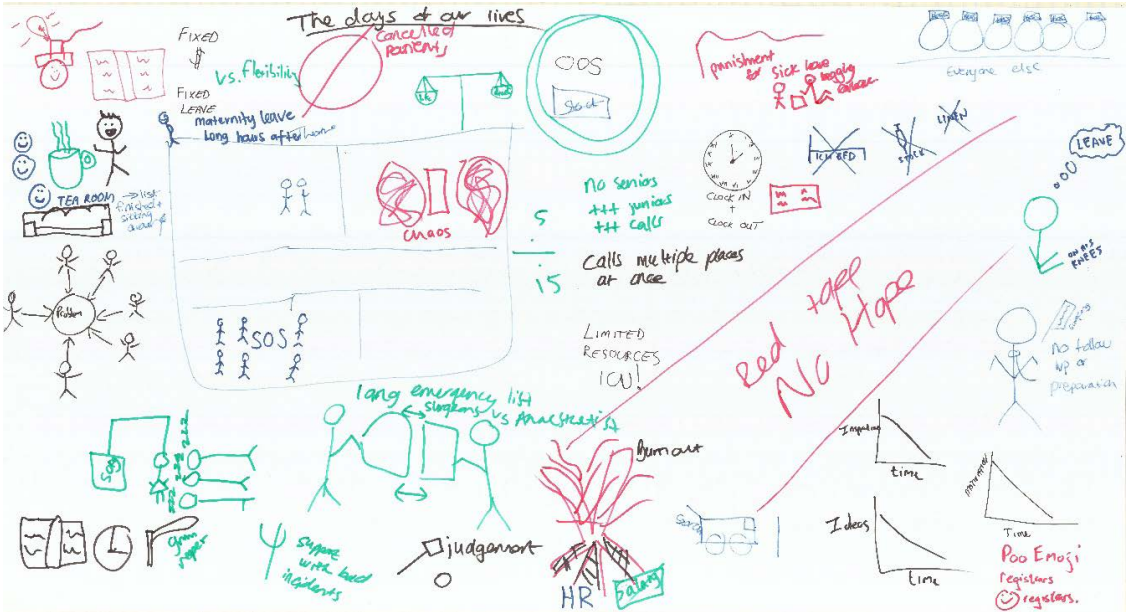

Figure 2: Days of our lives

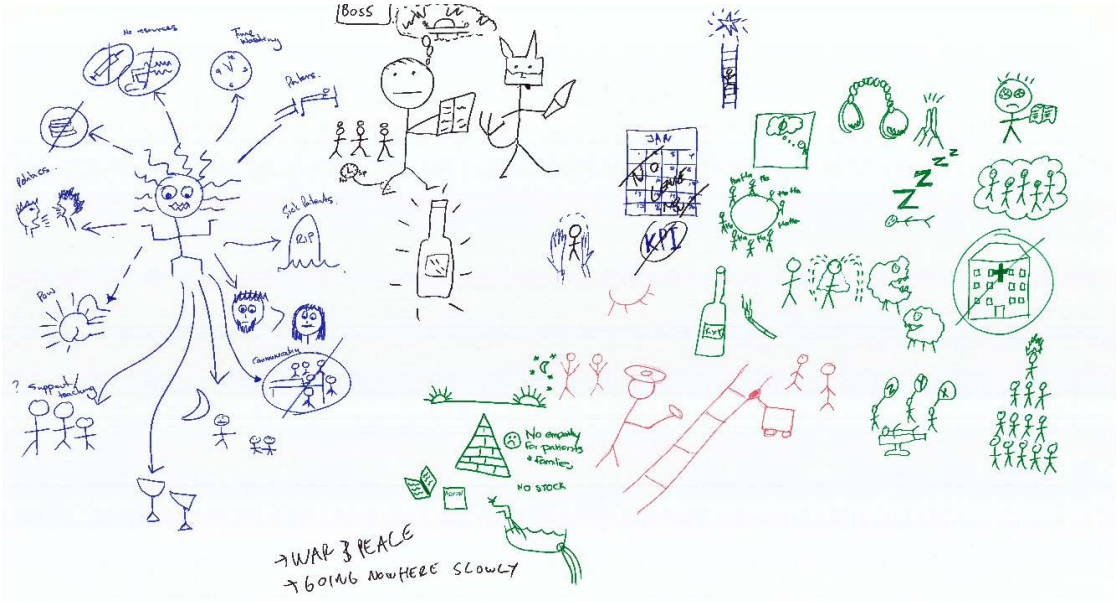

Figure 3: War and peace – going nowhere slowly

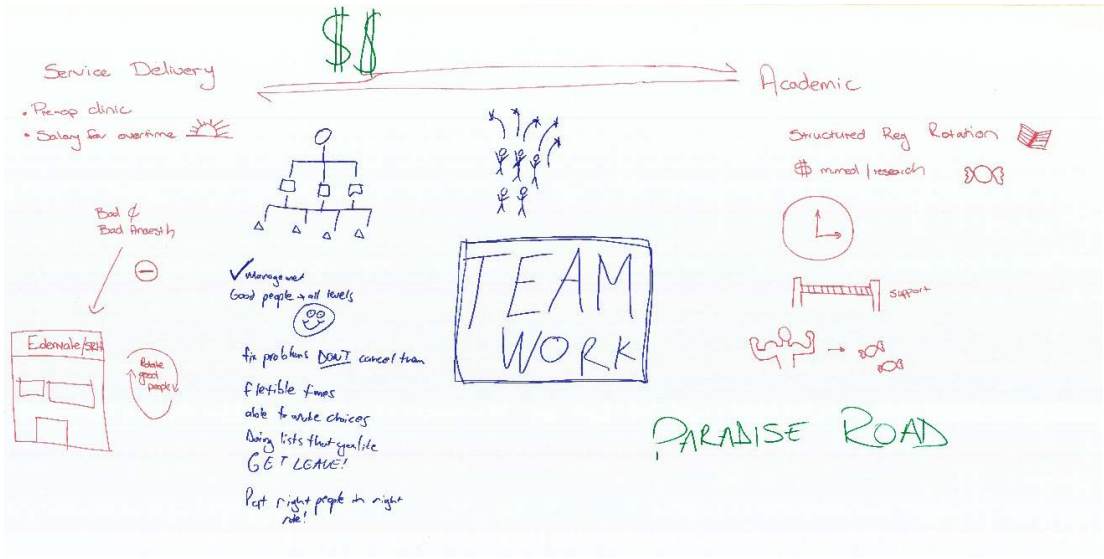

Figure 4: Paradise road

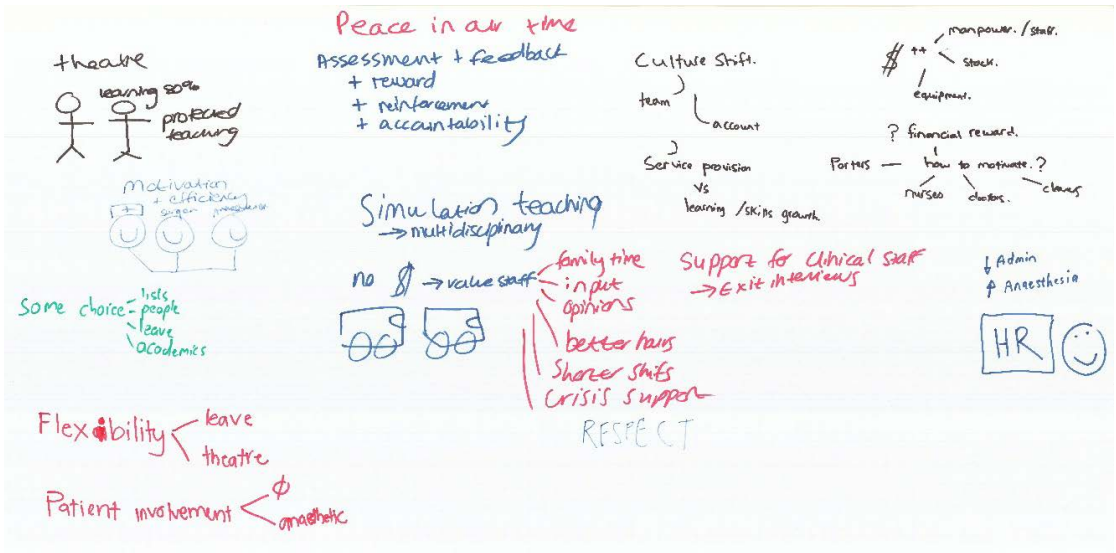

Figure 5: Peace in our time

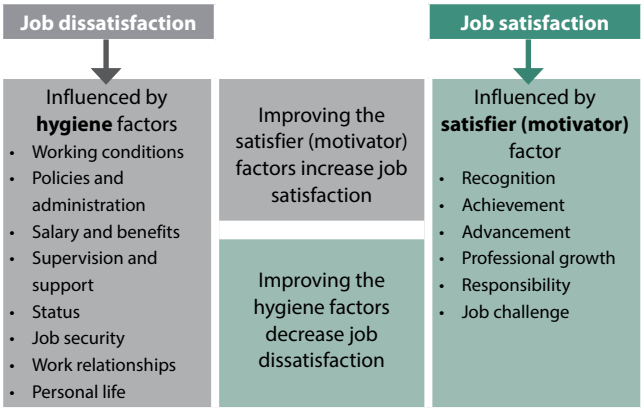

Figure 6: Herzberg's Motivation-Hygiene Theory (permission obtained and adapted from Toolshero)[19]

demotivating. "[It] just felt that there weren't enough facilities to deal with whatever we had to deal with" (2F). A participant expressed her frustration: "The time wasting, the lack of resources, linen, equipment, staff, beds, having to push patients to the wards, bring them down for a procedure because you couldn't find a porter" (2H). Replacing disposables such as gloves and syringes was challenging because they did not arrive on time despite being ordered well in advance. Participants felt that the lack of general upkeep and poor hygiene within the public healthcare sector made working conditions unpleasant: "Germs … I really feel it's very dirty" (2F).

Participants experienced a heavy workload and long hours. "The patients in [the public sector] were a lot sicker, a lot more stressful" (2H). Having to study for examinations and work long hours with a heavy workload made one participant feel "… quite fragile … sleep deprived and tired most of the time" (2F). Participants agreed that anaesthetists do not deal with stress appropriately and often participate in "risky behaviour" (2F), using substances such as alcohol as an outlet to destress.

Participants expressed dissatisfaction with certain departmental policies and felt that administrative practices could be improved. They mentioned being "treated like high school children" (1B), often having to stay despite working hard, finishing their theatre list early, and needing to report when they arrived at work and when they left. The Department of Human Resources was described as a "big pain" (1B). There was a general reflection of administrative and logistic processes of leaving being

"humiliating and irritating that you sit in a queue for an hour to leave work because they want to search your car … there's like no trust" (1A).

After qualifying as a specialist, participants initially felt inspired and motivated to improve "the system" (2F), which referred to the day-to-day functioning of the department. However, they felt less empowered to make a difference over time, with the realisation that the system was not conducive to change, primarily because of "red tape" (1A) or bureaucracy. This was illustrated by bold red tape with "NO HOPE" written across it (Figure 2). A participant made a powerful statement and drew a bathtub to illustrate her point: "You put so much effort [into the system], and it all just goes out. You're never actually filling up the bathtub with water. It's just like filling up a bath with no plug" (2J) (Figure 3). One participant drew handcuffs, demonstrating that he "felt very constrained by a lot of things, [such as] the environment, red tape, bureaucracy … constrained by the whole system ..." (2F) (Figure 3).

Scant emphasis was placed on salaries and benefits, suggesting their relative insignificance as a cause of dissatisfaction leading to anaesthetists' migration. Towards the end of the workshop, a participant mentioned, "… we earn decent salaries as registrars … we didn't think that being salaried more was an issue" (2F).

Clinical supervision was perceived as better than in other departments. A dichotomy concerning supervision and support within the department was presented. The sense of support when one was struggling was countered by "conflicting opinions from consultants …" (2F) and having little responsibility as a junior often meant that "you didn't learn from experience [because] … most of the decisions were made for you by seniors" (2F). This was termed "anaesthesia by commission" (2F) by a participant. As a senior registrar, supervising many junior anaesthetists was also very stressful, especially with sick patients.

Support during critical events also varied depending on a participant's position of seniority at the time of the event. It was acknowledged that registrars were protected and supported in the department. However, consultants carry a lot more responsibility and sometimes people are "… blamed for it in a way that's harmful to their confidence …" (1A) rather than experiencing a supportive environment with appropriate debriefing and a chance to learn from the critical event.

Participants experienced an unhealthy hierarchy. There was a sense that "you just need to know where your place is and to keep your mouth shut" (1B). Consequently, participants felt intimidated by some seniors. Participants reflected on the pressure of performance: "You needed to prove yourself … and show your worth, and after this, interaction was limited to an occasional greeting" (2F).

The lack of accountability referred to conduct amongst all disciplines crossing various professional codes and different professional roles (administrative, clinical, and managerial) within the Department of Anaesthesiology. Participants generally did not approve of the "protected employment" (1A) and job security within the department. Participants felt there was a lack of accountability due to the absence of regular evaluation of colleagues' performance. This meant that some anaesthetists were "coddled and sheltered" (2F), and "the system just made it possible for them to go through" (2F).

The working relationships among theatre staff were a prominent theme that generated intense discussion. Obstacles existed within the department, with "politics and factions" (2H) influencing working conditions unfavourably. Hard-working individuals did most of the work, literally pulling the weight of others on a pulley system while others were sleeping close by (Figure 2). Consultants described some registrars as "rotten apples" (1D) because of their poor work ethic.

An image emerged of two people pulling the emergency operation theatre list in opposing directions, depicting daily struggles between surgeons and anaesthetists (Figure 2). Participants reported poor relations with surgeons based on communication and perceived lack of competence. "We are not blameless" (1G), as anaesthetists can sometimes be obstructive and unprofessional. Some participants expressed that the public sector did not allow them to select a surgeon with a matched work ethic to work with, as they do in the private sector. Participants agreed that anaesthetists should behave professionally, and "… if we actually listen to [surgeons] and have better relationships with them, the theatre experience would be better, for everyone" (2H).

The relationships with patients made a lasting impression on participants. They sympathised with patients who were not always prepared for theatre and were sometimes "in such a state that they [were] actually past the point of resuscitation" (1A). A participant described her dissatisfaction with how patients are treated in the public sector, "probably the biggest reason why I left was like there was no empathy for patients" (2J). Patients are often not counselled regarding their anaesthetic or surgical choices, and informed consent is not always carried out appropriately. Children are mostly unaccompanied by parents, and families are seldom included in patient care. However, "the patients [in the public sector] are really appreciative" (2F), which made the work satisfying to one participant.

The balance between work and personal life was important to all participants; they felt this was largely not optimal. They described how they sometimes had to beg for leave and missed important family commitments because work was demanding and lacked flexibility. A participant drew a picture of his "wife crying", demonstrating that his marriage took much strain at times (Figure 3). Taking sick leave sometimes meant being unintentionally punished upon returning to work and given extra work to make up for their absence. However, maternity leave was described as a positive aspect of the department.

Motivator factors

Participants valued recognition for their good work ethic. However, they describe a lack of positive feedback or encouragement if cases do not go according to plan. Key performance indicators are non-existent in the department, which makes it difficult for registrars and consultants to advance personally and demonstrate professional growth. The academic culture within the department stimulates professional growth, but this is not always prioritised as anaesthetists often work in theatre and cannot attend tutorials. The high service burden is prioritised over academic engagement.

Registrars are often protected within the department and have less responsibility than consultants. Working in the department meant that participants were presented with challenging cases, which contributed to professional growth, and this job challenge led to satisfaction in the workplace. However, consultants complained of spending a lot of time "doing more portfolio [administrative] work than you do actual clinical work …" (1A). It was frustrating that anaesthesiologists spent most of their time doing work that did not directly relate to their training as anaesthesiologists.

An ideal working environment for the department

Hygiene factors

Participants reported that working conditions would improve if the hours were more reasonable and sufficient staff were available to manage the high patient load. Anaesthesiologists would be less dissatisfied if there were no resource limitations and all equipment was functional. An ideal working environment would have "enough manpower, enough staff, having enough stock and equipment" (1A). Adequately staffed peripheral hospitals and an appropriate referral system would reduce the patient load in the tertiary hospitals, ultimately improving working conditions.

Departmental policies should value autonomy and flexibility for anaesthetists. Participants felt that they should be allowed to go home early if they worked hard and finished their list in a timely manner. They desired a department where they could choose their lists, colleagues, surgical colleagues, and academic involvements. Participants felt that there should be a better structure to the registrar rotations, where "you have some seniority before you do certain stuff … [instead of being] plugged into where [you] are needed just to fill the gaps and deliver a service …" (2F).

Departmental policies should focus on adequate training and professional growth without automatic progression to the next rotation. Often, registrars "complete" a neurovascular rotation but do not necessarily receive the required training. Participants wished to be valued as staff members, have designated, subsidised staff parking, and not be searched after work. They believed an efficient and friendly human resource team could assist with administrative issues that anaesthetists do not easily manage. Participants felt that the ideal department requires managers in the right roles who are effective and willing to tackle problems head-on: "You need people that can fix problems and not just cancel them or push them on the back burner" (2F). There should be appropriate and effective crisis support if a critical event occurs. This should be an opportunity to learn instead of an environment of blame and judgment. A debriefing and a discussion of how to improve anaesthetists' practice should ensue when a similar event occurs.

The ideal working environment should foster relationships based on teamwork and respect. Having "good teamwork amongst the surgeons, anaesthetists and nurses … will make things move along more effectively" (1A) and more efficiently. Patient and family involvement was very important to participants, who felt that an environment of autonomy should exist where patients are better informed about their surgical procedures and anaesthetic options. Flexibility in aspects of their personal life was crucial to participants: "Valuing of staff, valuing family time, valuing like what you guys have after work and it's not solely about work …" (1A), and "not having to beg people for leave or being able to have flexibility around that" (2F).

Motivator factors

Participants felt that recognition for their hard work was as important as being held accountable for a substandard performance: "If you're strong and you do your job and you graft hard, you should get rewarded for that" (2F). An annual review should be performed to ensure that registrars achieve their competencies rather than allowing "automatic progression" (1A) to the next stage of their training. This gives individuals control over their professional achievements and advancement within the department. There should also be designated times out of theatre for protected teaching, with an opportunity for tutorials and simulation training, despite the public sector being service delivery oriented.

Participants felt a lack of accountability with limited consequences for detrimental actions in the public sector: "If staff are more accountable for their actions or performance, perhaps their work ethic would drastically improve, and the system will function more efficiently" (1G). Participants desire a department where they can focus on work of personal interest and have a choice regarding "what list you're on, where you work and how you want to split your time …" (2F).

Discussion

The application of Herzberg's theory has offered an important framework for the hygiene and motivator factors that informed migration from the public to private sectors for this group of anaesthesiologists. In Herzberg's theory, poor hygiene factors lead to dissatisfaction in contrast to motivator factors, which are the primary cause of satisfaction.[3] Both satisfaction and dissatisfaction are discrete and described as being present or absent across a spectrum. If a hygiene factor were absent or poor, this would lead to dissatisfaction in the working environment and may negatively affect employee retention. These factors

influence the migration of healthcare workers and can result in the maldistribution of human resources in a setting already characterised by severe shortages.[9,20] When an employee leaves an organisation, this can disrupt service delivery and finding a replacement can be costly.[21]

More than six decades after its introduction, and despite considerable criticism, Herzberg's Motivation-Hygiene Theory has proven its relevance and utility in contemporary working environments, as our study shows. These anaesthesiologists, who recently migrated from the public sector, provided rich data through their participation in the workshop. The data provide valuable and relevant insights into anaesthesiologists' perceptions of the working environment in Johannesburg's public healthcare sector. Dissatisfaction and a lack of motivation contribute to the migration of anaesthesiologists from public to private sector practice, as is evident by the department's poor hygiene and motivator factors. "Push factors" are reported to have a far greater influence on an employee's decision to leave than "pull factors".[22] In this study, important "push factors" include working conditions, relationships in the working environment, flexibility concerning work and personal life balance, and accountability.

Participants aptly named the rich pictures drawn, and the second pictures depicted contrasting themes to the first. The first pictures illustrated the unpredictable day-to-day battle facing anaesthetists in the theatre environment, as the title "War and peace" suggests. Resource constraints, poor infrastructure, and a heavy, stressful workload characterised the perceptions of the working environment in the department. These poor hygiene factors caused dissatisfaction and frustration among participants, who felt they were not adequately equipped to perform their daily duties and worked in an environment that lacked flexibility with work-life balance.

The relationship dynamics within the theatre often created an unpleasant working environment, which was not conducive to work productivity. A supportive workplace reduced employee turnover among allied health professionals in Australia.[23] Anaesthesiologists in Finland felt that a lack of recognition, poor communication between colleagues, long working hours, and organisational justice problems (related to workplace fairness) lead to dissatisfaction.[24]

The lack of accountability within the department creates an environment of job security and protected employment. Participants felt that the staff work ethic would drastically improve if everyone were more accountable for how they conduct themselves in the working environment, rather than allowing automatic progression or promotion.[25] These studies highlight similar factors recognised by participants in our research as reasons for anaesthesiologists' migration from public to private practice.

The second pictures were characterised by "paradise" and "peace", with theatre staff having shared goals in an environment based on teamwork, communication, and tolerance, which improves efficiency and productivity and creates a more pleasant working environment for everyone.[25] Relationships with patients focus on a more patient-centred approach, where anaesthetists display empathy, involving patients and families to a greater extent. The ideal department considers one's personal life and offers more flexibility regarding work-life balance.

The "role ambiguity" issue highlights the difference between what one feels the job entails and what is expected of one within the organisation.[5] The participants felt that they should be able to focus on their interests, whether it be research, clinical work, or administrative work, and that they should be able to decide what lists they do or with whom they work. The participants' roles in the department were not always clear, and they mentioned doing non-clinical work unrelated to their training as anaesthesiologists.[5] Making employee responsibilities visible by valuing employee contribution and giving constructive feedback will allow employees to feel a sense of achievement and acknowledgement that they desire.[26]

Our findings can be contrasted with similar studies conducted in different geographical and healthcare settings to better understand the impact of hygiene and motivator factors on anaesthesiologists' job satisfaction and dissatisfaction within the working environment. A 2017 study by Kols et al.[27] conducted nationally in Ethiopia found that the main factors predicting Ethiopian anaesthetists' intention to leave their employment were poor salaries and a lack of opportunities for professional development. The study explained that adequate remuneration is an important factor for anaesthetists in Ethiopia because of the relatively higher cost of living. Ethiopian anaesthetists also felt they had limited promotion opportunities and poor access to higher education.[27] Emphasis on motivator factors, which contribute to job satisfaction, was similarly important when comparing the results of our study. Our research found that participants valued professional growth and education in the work environment because it paves the way for advancement in the workplace.

A South African study by Ashmore, involving qualitative interviews in one public and one private urban hospital, found that while financial remuneration is greater in the private sector, the public sector offered some financial advantages with a state pension, paid leave, and less costly medico-legal risk.[11] Participants in our study did not emphasise financial remuneration as a reason to leave the public sector. However, like our results, Ashmore found that greater income stability in the public sector sometimes led to poor service quality provision and a lack of accountability related to clinical practice. It was also highlighted that the public sector offered a better team environment, which allowed for more predictable working hours where one could hand over the care of one's patients to colleagues. This contrasted with our research, which found that the public sector's workload and hours were much more demanding. This could partly be explained by the fact that our study population included anaesthesiologists, who can be more selective regarding working hours in the private sector

compared to healthcare workers such as surgeons or physicians. Like our study, participants found a lack of resources, equipment, and drugs in the public sector highly frustrating.[11]

A systematic review conducted in 2022 included 89 documents published between 1999 and 2021, where factors that may attract and retain health professionals in the public sector of various institutions internationally were assessed.[28] The results of this study revealed that remuneration, available resources, and working conditions were common determining factors related to the retention of health professionals in the public sector.[28] Like our study, certain articles used Herzberg's Motivation-Hygiene Theory as a framework to assess these determinants.[3] Unlike the studies analysed in this review, our research indicates that in Johannesburg, financial incentives are less influential on one's decision to migrate than other factors, such as a high workload, a lack of resources, working relationship conflicts, inflexibility with work-life balance, and a lack of accountability in various roles within the department.[28] This can be explained by the fact that South African anaesthesiologists are better remunerated than other health professionals globally, and the cost of living in SA is more favourable than in other countries, such as the United States of America, the United Kingdom, or Switzerland. While Fernandes et al.[28] emphasised hygiene factors as a reason for job dissatisfaction and migration, our participants identified and valued motivator factors such as recognition for good work ethic, professional growth, and academic achievement as equally important when considering migration from the public sector.[28]

According to Herzberg, addressing poor hygiene factors and increasing motivator factors leads to employees being highly motivated and satisfied, with minimal complaints in the working environment.[3] Identifying these factors results in a desirable work ethic and reduces migration from public to private sector practice. It is critical to address hygiene factors first, which may often lead to increased motivator factors.[3]

While it may be easier to complain about current issues within the department, it was recognised that improving working environment conditions would require a lot more thought, effort, and time. Part of the solution to SA's human rights crisis is addressing the health workforce inequities and the limited resources while valuing health worker recognition and development.[1] The well-being of healthcare workers is centred on a working environment characterised by a nurturing, enabling, and supportive culture, which positively affects morale and mental health.[1]

A limitation of the study is that it was done in a specific context and might not be generalisable in other contexts. This study was conducted in a metropolitan area affecting only one circuit of academic hospitals.

We recommend that greater attention be given to the moment of migration to understand why individuals migrate from one sector to another. It is suggested that exit interviews be conducted to understand the reasons for migration. In addition, working conditions may improve for departmental staff if resources (anaesthetic equipment, clean linen, and availability of intensive care unit beds) are better managed and readily available. Hiring more staff may assist with the high patient workload and reduce working hours in a stressful environment. Working relationship conflicts can be addressed with conflict resolution training. A regular objective assessment of clinical, administrative, and managerial conduct will reduce the lack of accountability within the department and improve job satisfaction by recognising professional growth and achievement. It is recommended that similar studies be repeated in multiple contexts to give a richer picture of anaesthesiologists' migration from the public sector.

Conclusion

This study demonstrates the complexity of interactions among individuals working together in systems that are often in tension. These systems are context-specific but must recognise the hygiene and motivator factors that may ultimately impact quality health service delivery and education. However, the complexity of the department is context-specific and cannot be applied to all settings. The results of this study demonstrate poor hygiene (high workload, lack of resources, and working relationship conflict within the department and between disciplines) and inadequate motivator factors (inflexibility with work-life balance and a lack of accountability) in the department while pointing out the relevance of Herzberg's theory in today's setting. A key process would be conducting compulsory exit interviews to understand the reasons for migration at that time and addressing these factors so that further staff migration is reduced within the department. This will ensure that communication and accountability are enhanced and the transition moment is understood. The reasons given by participants for the migration from public to private practice must be further explored to facilitate the retention of anaesthesiologists in the public sector.

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Conflict of interest

The authors declare no conflict of interest.

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Ethical approval

The authors declare that this submission follows the Responsible Research Publication Position Statements principles developed at the 2nd World Conference on Research Integrity in Singapore, 2010. Before the study commenced, ethical approval was obtained from the ethical review board of the University of the Witwatersrand Human Research Ethics Committee (Medical, M181050).

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References

1. National Department of Health. 2030 human resources for health strategy: investing in the health workforce for Universal Health Coverage. Pretoria: Government Printers; 2020.
2. Kwenin DO, Muathe S, Nzulwa R. The influence of employee rewards, human resource policies and job satisfaction on the retention of employees in Vodafone Ghana Limited. Eur J Bus Manage. 2013;5(12):13-20.
3. Herzberg F, Mausner B, Snyderman BB. The motivation to work. 2nd ed. New York: John Wiley & Sons; 1959.
4. Society for Human Resource Management. Using recognition and other workplace efforts to engage employees: SHRM survey findings [Internet]. SHRM; 2018. Available from: https://www.aresearchguide.com/wp-content/uploads/2023/08/presentation.pdf. Accessed 4 August 2018.
5. Ongori H. A review of the literature on employee turnover. Afr J Bus Manage. 2007;1(3):49-54.
6. Hassan M, Hassan S, Khan KUD, Akramnaseem M. Employee retention as a challenge in leather industry. Glob J Hum Soc Sci. 2011;11(2):9-13.
7. Hom PW, Lee TW, Shaw JD, Hausknecht JP. One hundred years of employee turnover theory and research. J Appl Psychol. 2017;102(3):530-45. https://doi.org/10.1037/apl0000103.
8. Glebbeek AC, Bax EH. Is high employee turnover really harmful? An empirical test using company records. Acad Manage J. 2004;47(2):277-86.
9. Ntuli ST, Maboya E. Geographical distribution and profile of medical doctors in public sector hospitals of the Limpopo Province, South Africa. Afr J Prim Health Care Fam Med. 2017;9(1):e1-5. https://doi.org/10.4102/phcfm.v9i1.1443.
10. Competition Commission South Africa. Health market inquiry: final findings and recommendations report [Internet]. Competition Commission South Africa; 2019. Available from: https://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf. Accessed 10 November 2023.
11. Ashmore J. "Going private": a qualitative comparison of medical specialists' job satisfaction in the public and private sectors of South Africa. Hum Resour Health. 2013;11(1):1-12. https://doi.org/10.1186/1478-4491-11-1.
12. Odhiambo J, Rwabukwisi FC, Rusangwa C, et al. Health worker attrition at a rural district hospital in Rwanda: a need for improved placement and retention strategies. Pan Afr Med J. 2017;27(168):1-7. https://doi.org/10.11604/pamj.2017.27.168.11943.
13. Farham B. Migration of health professionals. Lancet. 2005;366(9481):199. https://doi.org/10.1016/S0140-6736(05)66897-3.
14. Scribante J. The development of a framework for improvement of intensive care delivery: a systemic intervention [thesis]. Johannesburg: University of the Witwatersrand; 2018.
15. Checkland P, Poulter J. Learning for action: a short definitive account of soft systems methodology, and its use for practitioners, teachers and students. Chichester: Wiley; 2006.
16. Bell S, Morse S. Rich pictures: a means to explore the 'sustainable mind'? Sust Dev. 2013;21(1):30-47. https://doi.org/10.1002/sd.497.
17. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101. https://doi.org/10.1191/1478088706qp063oa.
18. imdb.com [Internet]. Days of Our Lives. Phillips I, Corday T, Chase A; 1965-. Available from: https://www.imdb.com/title/tt0058796/. Accessed 20 July 2024.
19. Kuijk A. Herzberg two factor theory of motivation [Internet]. Toolshero; 2018 [updated 2024 August 29]. Available from: https://www.toolshero.com/psychology/two-factor-theory-herzberg/. Accessed 1 August 2018.
20. Wildschut A. Doctors in the public service: too few for too many. HSRC Rev [Internet]. 2010;8(4):12-5. Available from: https://repository.hsrc.ac.za/handle/20.500.11910/3996. Accessed 30 January 2018.
21. Samuel MO, Chipunza C. Employee retention and turnover: using motivational variables as a panacea. Afr J Bus Manage. 2009;3(8):410-5.
22. Oberoi SS, Lin V. Brain drain of doctors from southern Africa: brain gain for Australia. Aust Health Rev. 2006;30(1):25-33. https://doi.org/10.1071/AH060025.
23. Schoo AM, Stagnitti KE, Mercer C, Dunbar J. A conceptual model for recruitment and retention: allied health workforce enhancement in Western Victoria, Australia. Rural Remote Health. 2005;5(4):477. https://doi.org/10.22605/RRH477.
24. Lindfors PM, Meretoja OA, Töyry SM, et al. Job satisfaction, work ability and life satisfaction among Finnish anaesthesiologists. Acta Anaesthesiol Scand. 2007;51(7):815-22. https://doi.org/10.1111/j.1399-6576.2007.01343.x.
25. Jack H, Canavan M, Ofori-Atta A, Taylor L, Bradley E. Recruitment and retention of mental health workers in Ghana. PLoS One. 2013;8(2):e57940. https://doi.org/10.1371/journal.pone.0057940.
26. Gupta-Sunderji M. Employee retention and turnover: the real reasons employees stay or go. Financ Manage Instit J. 2004;15(2):37-40. Available from: https://www.albertaspeakers.com/Articles/PF/FMIRetentionTurnoverEnglish.pdf.
27. Kols A, Kibwana S, Molla Y, et al. Factors predicting Ethiopian anesthetists' intention to leave their job. World J Surg. 2018;42(5):1262-9. https://doi.org/10.1007/s00268-017-4318-7.
28. Fernandes A, Santinha G, Forte T. Public service motivation and determining factors to attract and retain health professionals in the public sector: a systematic review. Behav Sci (Basel). 2022;12(4):95. https://doi.org/10.3390/bs12040095.