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TITLE PAGE

**Should I migrate or should I remain?
Professional satisfaction and career decisions of doctors who have undertaken specialist
training in Fiji**

**Thesis Submitted by
Kimberly Marie OMAN MD (USA), MPH, FRACP, FAFPHM
in August 2007**

**For the degree of Doctor of Philosophy
James Cook University
Townsville, Queensland
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3 August 2007

Signature

Date

Statement on the contribution of others including financial help and editorial help

This PhD was supervised from August 2001 until early 2004 by Professors Richard Hays and Craig Veitch, both from the School of Medicine at James Cook University (JCU) in Townsville, Australia. In early 2004, Professor Rob Gilbert from the School of Education at James Cook University took over as principal supervisor, and he continued in this role until the end of my candidature, including after his move to the School of Education at the University of Queensland in October 2006. Professor Kim Usher from the School of Nursing Sciences at James Cook University was an associate supervisor from April 2004 until October 2006, when she took on a shared role as principal supervisor with Rob Gilbert until the end of my candidature.

I have not received statistical support, editorial assistance (other than feedback on drafts from my supervisors), or research assistance. I have not entered into any research collaborations during the course of writing this thesis. I have not made use of infrastructure external to JCU, or made use of infrastructure external to the Schools of Medicine, Education or Nursing Sciences within JCU, with the exception of minor administrative support from the Fiji School of Medicine during my fieldwork visits.

Because of my position as a Senior Lecturer at James Cook University, I have not been required to pay tuition-related fees during my PhD candidature, and in this regard have been fully supported by the university. I have received overall logistical support from the School of Medicine, and have funded some of my travel and miscellaneous expenses through a professional development fund that has been made available to me through the School. This fund ranges from \$3000 to \$5000 per year and was also accessed for non-PhD related activities. In addition, I have had access to the following sources of funding:

Year	Source of funding	Comments	Amount
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2006	Faculty of Arts, Education and Social Sciences	Grant – Graduate Research Scheme	\$1086

I have acknowledged the important contributions of others in the acknowledgement section. Additionally, I have co-authored a paper with a number of colleagues from the Fiji School of Medicine (see Appendix K). The reference for the paper as well as the contributions of the co-authors are as follows:

Reference: Oman K, Bale S, Baravilala W, Malani J, McCaig E, Rodgers E, Moulds R. Donor countries may unintentionally become major beneficiaries of their own aid: the case of postgraduate specialist training at the Fiji School of Medicine. *Fiji Medical Journal* 2006;27(2):11-18¹.

Contributors: K Oman was responsible for combining and analysing data, for statistical analysis and for primary authorship of the paper. R Moulds made major contributions to writing and revising the paper. S Bale, W Baravilala, J Malani, E McCaig and E Rodgers provided and verified information, and kept track of the whereabouts of the postgraduate enrolees. They also reviewed the drafts of the paper and provided input on accuracy, content and interpretations.

Declaration on Ethics

The research presented and reported in this thesis was conducted within the guidelines for research ethics outlined in the National Statement on Ethics Conduct in Research Involving Human (1999),

the Joint NHMRC/AVCC Statement and Guidelines on Research Practice (1997), the James Cook University Policy on Experimentation Ethics. Standard Practices and Guidelines (2001), and the James Cook University Statement and Guidelines on Research Practice (2001). The proposed research methodology received clearance from the James Cook University Experimentation Ethics Review Committee (approval number H1743). The proposed research methodology has also received clearance from the Fiji National Research Ethics Review Committee (approval number 005-2004).

Kimberly Oman

6 August 2007

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Abstract

Introduction

Fiji is a Pacific Island nation that prior to the mid-1990s relied mostly on expatriates for its specialist workforce, and few Fiji doctors who obtained overseas specialist qualifications returned home to work. To address this problem, regional specialist training for the Pacific was established at the Fiji School of Medicine (FSMed) in 1998, and it was assumed that local training along with a non-exportable specialist qualification, would lead to improved retention. After several years, it became apparent that many doctors who started training resigned from the public service, with most migrating. While this accelerated around the time of the coup of 2000, it has continued since then. This coincided with a worldwide increase in the migration of health workers. The purpose of this study was to determine why doctors who undertook specialist training at FSMed chose to migrate or stay, with a focus on the issues of professional satisfaction and dissatisfaction. It was hoped that a deeper understanding of the situations of these doctors would suggest interventions that could improve their retention and overall satisfaction.

Methodology

The research was carried out as a mixed method, though predominantly qualitative study. The study focused on the “case” of the establishment of postgraduate specialist training in Fiji. Altogether, 47 Fiji doctors were interviewed, including 36 of 66 doctors who attained an FSMed Diploma or higher. Doctors in the public sectors, in private practice, as well as migrants were included. Semi-structured exploratory interviews were carried out between 2004 and 2006 and were taped, transcribed, coded and analysed using a constant comparative method, with the identification of emerging themes from the interview data.

Results

The results are presented over 3 chapters exploring professional satisfaction, migration, and career pathways. A model of professional satisfaction was developed that included three major elements of professional growth, service and recognition. Professional dissatisfaction could be conceptualised as the absence of or the blocking of the elements of professional satisfaction. Dissatisfaction was particularly directed at the Ministry of Health, and a failure to reliably provide

basic medications and supplies, as well as problems with career advancement, were frequently mentioned. Of the 66 doctors, 20 had migrated permanently and the 7 who were interviewed cited family security (mainly related to the coup of 2000) or spousal career or family issues as being central to their decision-making. Fijian but not Indo-Fijian doctors also cited the contributing factors of limited career advancement opportunities, low salaries and poor working conditions. Nine of these doctors entered private practice in Fiji. The four who were interviewed generally cited desires to spend more time with their families and gain control of their working lives, though frustrations with career advancement were also mentioned. No doctor who resigned cited higher salaries or improved training opportunities as the predominant factors in their decision-making. The doctors who remained in the public sectors usually mentioned a service ethic, often grounded in religious belief, as well as close attachments to family, extended family and culture. Overall, while many spoke positively about postgraduate training, most cited significant stress from managing their academic loads on top of very busy public hospital postings. Some trainees, mainly in the procedural disciplines, complained about inadequate clinical supervision. Of the 42 doctors who left training with a Diploma as their highest qualification, only 13 have remained in the public sectors. Family issues predominated as reasons for leaving training, especially time pressures for female doctors, and difficulties in supporting families on low salaries for male doctors, though some resigned in order to migrate. Of the Masters graduates, 18 of 21 (plus three current students) are still in the public sectors, some of whom still remain at the lowest career grades. Overall, doctors complained of unpredictable career advancement, with a Masters or Diploma seeming to have little impact, as well as bottlenecks from limited numbers of senior postings.

Discussion

A constructivist approach to these interviews suggested that overall these doctors saw public hospital work as an expected “norm” that offered many satisfying career aspects, while other career options were to some extent compromises. One of the few “justifiable” reasons for leaving the public system seemed to be family welfare. The blocking of professional development and advancement was cited by doctors who considered resigning, but by fewer who actually resigned. This suggested a centrality of the professional values of service, patient welfare and treating patients regardless of their ability to pay, and these values overlapped considerably with the elements of professional satisfaction. The findings from this study fit with and expand on previous research from Fiji, and also fit well with the world literature, where there was agreement on the frustrating elements of lack of infrastructure support (especially drugs and supplies), difficult

working conditions, staff shortages and problems with career advancement. Salaries in Fiji are modest though arguably “liveable”, and were less of an issue than elsewhere. This study expanded somewhat on satisfying aspects of medical practice, including camaraderie, mentoring, being of service and making a difference. While health worker motivation is widely mentioned in the literature, there was at best an uncomfortable fit with existing theories, possibly related to much of the literature being focused on worker alignment with organisations, while health workers are more likely to be aligned to their professions. This study was limited by having studied only specialist doctors from a small country, and this may limit applicability elsewhere. Overall, the study suggested that retention in Fiji could be increased through improved provision of basic medications and supplies as well as through the development of transparent career pathways, through tying advancement to postgraduate training, and through trying to make workloads for trainees more tolerable in order to increase Masters completions. While in other countries the provision of a liveable wage may be more important, these interventions may also prove to be effective elsewhere in the world.

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Abbreviations, definitions and timelines

Abbreviations

Abbreviation	Description
FSMed or FSM	Fiji School of Medicine (“FSMed” introduced in 2006 to replace “FSM” in order to avoid confusion with the Federated States of Micronesia – also abbreviated as “FSM”)
MOH	Ministry of Health (Fiji)
CWM	Colonial War Memorial Hospital, Suva (the capital of Fiji) This is the main teaching hospital for the Fiji School of Medicine
Masters or MMed	Master of Medicine awarded by the Fiji School of Medicine
Diploma	Postgraduate Diploma (in Anaesthesia, Child Health - Paediatrics, Internal Medicine, Obstetrics and Gynaecology, or Surgery) awarded by the Fiji School of Medicine
HRH	Human resources for health (sometimes called health resources management)
WHO	World Health Organization
JLI	Joint Learning Initiative
MDGs	Millennium Development Goals
BMJ	British Medical Journal

Abbreviations - Fiji Civil Service career grades for doctors

Abbreviation	Career grade (highest to lowest)	Comments
Consultant	Consultant	Senior grades / postings (consultant-level roles)
CMO	Chief Medical Officer	
PMO	Principal Medical Officer	Mid-level grades / postings
SMO	Senior Medical Officer	Junior grades /postings
MO	Medical Officer	

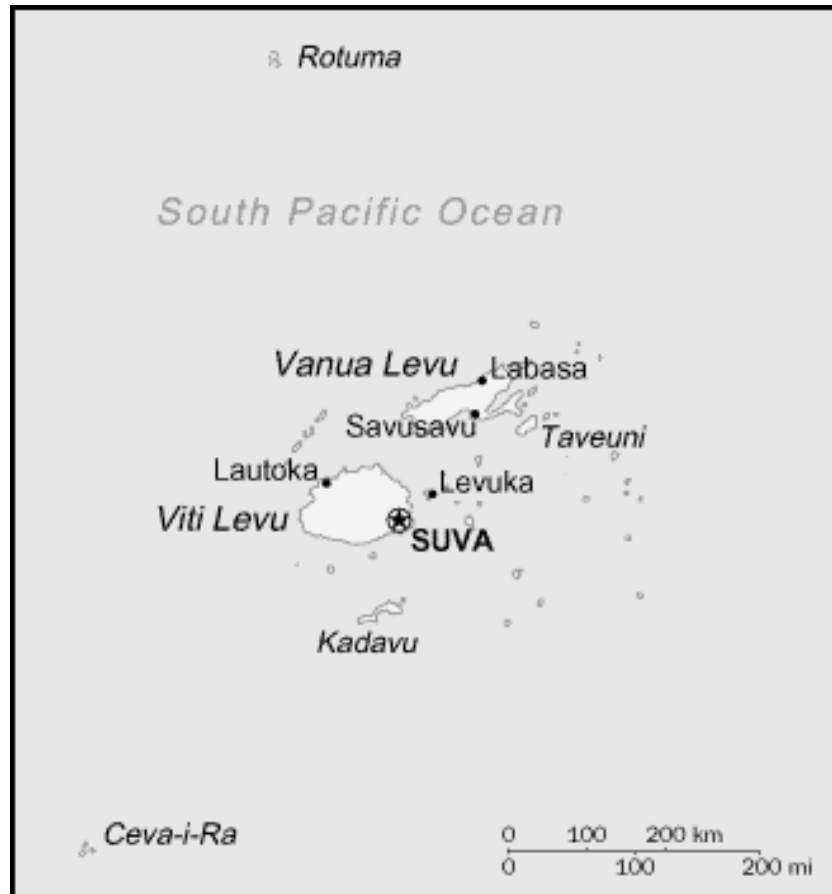
Definitions

Term	Definition
Public system	Working for the Fiji Public Service Commission (PSC) under the Ministry of Health, in a hospital or other public facility
Public sectors	Working in the public system, for the Fiji School of Medicine, or for the United Nations. These are considered to be “preferred” working locations for Diploma or Masters graduates as they facilitate service to all of the population in Fiji, regardless of ability to pay
Fiji doctors	Doctors who are citizens of Fiji or permanent residents (usually spouses of Fiji citizens), regardless of race
Fijians	Individuals of indigenous Fijian ethnicity
Indo-Fijians	Individuals who live in or are from Fiji whose ancestry is from the Indian subcontinent
Others	Individuals from Fiji who are neither Fijian nor Indo-Fijian (such as Europeans, Chinese, and other Pacific Islanders)
Regional	Refers to other Pacific Islands other than Fiji
Diploma cohort	The year that Diploma training was completed. For doctors who undertook their Diplomas through other programs, the cohort year is the year before they entered the first year of Masters training (in other words, the year they would have entered Diploma training had they undertaken it through FSMed and entered Masters training without interruption).
Motivation (organisational context)	An individual’s degree of willingness to exert and maintain an effort towards organisational goals. (This thesis discusses or proposes other definitions for doctor motivation related to professional values.)
Health reform	A restructuring of health services characterised by decentralisation, contracting out of services, and promotion of diversity and competition in the provision of health services ² (this approach is particularly promoted by the World Bank)
Professionalism	While there are a number of definitions, a general definition is used here, and refers to putting patients first, maintaining a good standard of care, showing respect, being honest and trustworthy, and keeping up-to-date with knowledge and skills. ³

Timelines before and during thesis

Event	Dates
Fiji independence from the United Kingdom	1970
Fiji coups	1987 (2), 2000, 2006
Establishment of postgraduate specialist training in Fiji	1998 (1996 for anaesthesia)
Diploma cohort years included in study	1997 - 2004
My employment at the Fiji School of Medicine	1998-2001 (3 years)
PhD candidature (part time)	August 2001 to August 2007
Confirmation of candidature seminar	12 November 2003
Visits to Fiji	Consultancy work: 4/02 and 10/02 Fieldwork: 4/04; 9-10/04; 8-9/05; 8-9/06
Presentations at the Fiji Medical Association Annual Meetings	August 2005 and August 2006
Pre-completion (exit) seminar	14 December 2006
Cut-off date for quantitative data collection on whereabouts and highest educational attainment	31 December 2006
Dates of main (comprehensive) Medline-based literature reviews	September 2003; February 2007
Cut-off date for ongoing literature review	16 April 2007

Map of Fiji



Main Islands: Viti Levu and Vanua Levu

Main cities: Suva (capital), Lautoka, Labassa

Source: Central Intelligence Agency: The World Factbook⁴

This image is in the public domain.

Chapter 1. Introduction

This study revolves around the establishment of postgraduate specialist training in Fiji to serve the English-speaking Pacific Islands, and the challenges that these programs have faced. More importantly, it revolves around the professional aspirations and career decisions of the doctors who undertook this training.

1.1. Background

In the mid-1990s, specialist services in Fiji were mainly provided by expatriates, as few of the doctors from Fiji who undertook overseas specialist training returned home to work. Using the best logic of that era, a decision was made to establish in-country and regional training that would not only be locally appropriate, but would not require trainees to live for long periods in developed countries, where they could become adjusted to a different lifestyle and style of medical practice and therefore less inclined to return home. This, along with the awarding of non-exportable specialist qualifications, was expected to make migration of specialists graduates much less likely. It was therefore surprising to many that by the time that the first group of specialist (Master of Medicine) candidates graduated in 2001, the resignation or migration of doctors who had undertaken some specialist training in Fiji was already well-established, and was felt to threaten the viability of the postgraduate training programs. In view of this, the overall aim of this study was to determine why doctors who undertook specialist training in Fiji remained within the public sectors, or left the system to enter private practice or to migrate. The study question was approached through a particular focus on professional biographies and career decisions as well as on the factors that led to professional satisfaction and dissatisfaction for these doctors. While the overall aim of the study was exploratory, it was hoped that the findings would suggest interventions that would increase the retention and overall satisfaction of these doctors.

Fiji is the most populous Pacific Island nation outside of Papua New Guinea, with a population of 849,000⁵. Fiji became a colony of Great Britain in the late 1800s, and its early history was marked by the importation of migrants from the Indian subcontinent in order to provide labour. Independence was granted in 1970, and the time since then has been marked by four coups in 1987, 2000 and most recently in 2006, with racial issues generally playing an important role. In 2006, the population consisted of 55% indigenous Fijians (“Fijians”), 37% ethnic Indians (Indo-Fijians) and 8% other races⁶.

Fiji is a developing nation, but with a gross national income of \$US3280 per capita is economically more advanced than the countries in the “least developed” group of nations⁵. Fiji spends \$US104 per person each year on health, which is 3.7% of its gross domestic product⁷. From a health standpoint, Fiji has entered into a transitional period where the impact of infectious diseases is still important but less than in other developing countries, but where diseases of lifestyle such as diabetes, hypertension, cardiovascular diseases and stroke are becoming increasingly prominent, constituting a “double burden” for the health system. While HIV / AIDS occurs in Fiji, it has not yet had a major impact on the health system, unlike in other developing countries. Overall health statistics are reasonably good by developing country standards, such as an under 5’s mortality of 18 per 1000 live births (121st highest in the world), an adjusted maternal mortality of 75 per 100,000, and a life expectancy at birth of 68 years⁵.

Undergraduate medical training has been available in the Pacific for over 100 years. The Fiji School of Medicine (FSMed) was established in 1885 as a “native practitioner” course that trained Fijians to administer smallpox vaccination and provide basic health care. Over time, the length and scope of the course increased, and in 1982 an MBBS course was established⁸. FSMed provides undergraduate medical education for the English-speaking islands of the Pacific, except for Papua New Guinea (PNG), which has had its own medical school since 1964^{9, 10}. The Pacific Basin Medical Officers Training Program (PBMOTP), formerly based in Pohnpei State of the Federated States of Micronesia and administered by the University of Hawaii, also trained 62 new Micronesian doctors between 1987 and its planned closing in 1996¹¹, after which Micronesian medical students attended FSMed.

Postgraduate specialist training in the Pacific was first established in PNG in 1972, and these programs have been described in the literature^{9, 10, 12-16}. Up until the mid-1990s, however, there was no formal postgraduate specialist training in the Pacific outside of PNG, other than a number of stand-alone externally-run diplomas in Obstetrics (1994 and 1996) and Paediatrics (1996) that were offered in Fiji. Specialist training had to be undertaken overseas, most often in Australia or New Zealand. While accurate figures on overseas specialist training are not available, anecdotally, failure rates, especially in the primary examinations of the specialist colleges, were high, and successful trainees often did not return to the Pacific to practice¹⁷. For example, it has been estimated that 25 FSMed graduates have attained their Fellowships through the Royal Australasian

College of Surgeons over the past 2 decades, but only one is known to have returned to practice in a Pacific Island country¹⁸.

1.2. The establishment of postgraduate specialist training at the Fiji School of Medicine

In March 1995, a meeting of health ministers and permanent secretaries / directors from many English-speaking countries in the Pacific met on Yanuca Island in Fiji to discuss health issues, including human resources. The “Yanuca Declaration” produced as a result of this meeting agreed “to introduce postgraduate training at the Fiji School of Medicine to complement the existing postgraduate training programmes at the University of Papua New Guinea”¹⁹. Postgraduate training was established at FSMed in 1998, supported by an AusAID grant administered by the Royal Australasian College of Surgeons. These training programs led to Diploma and Master of Medicine (MMED) qualifications in Obstetrics and Gynaecology, Internal Medicine, Child Health, and Surgery²⁰ with a previous Anaesthesia Diploma established in 1996 “rolling into” the FSMed Masters and Diploma programs²¹. The intention was to provide specialist training in the Pacific relevant to the Pacific, producing graduates who would be more likely to remain in the Pacific¹⁷⁻¹⁹.

All specialty programs were developed by a local specialist, assisted by one or more “external advisors” who were supported by outside funding for 3 years in Fiji, and for 2 years of follow-up visits thereafter. All programs started with a one-year Diploma¹⁷. At the end of this year, an exam was taken, and students who attained a “B+” or higher were eligible to enter the Masters program for a further 3 years¹⁸. At the end of the second year of the Masters program, another exam was required. Clinical training in the specialty in an “apprenticeship” style was required of all students throughout the course, and students in all disciplines undertook combined coursework in basic sciences, public health and research methodology, and all were required to submit a research project. While most training took place at the Colonial War Memorial Hospital in Suva, Fiji (the main teaching hospital for FSMed), some distance training at the Diploma level was allowed. Aspects of these programs have been described in more detail in the literature^{17, 18, 20, 22, 23}.

In 2000, which was the third year for the programs, a coup took place in Fiji, and a number of students resigned from the public system around that time. Even over the next few years, as the political situation stabilized, doctors who had undertaken specialist training continued to resign, with most of these migrating.

1.3. The author's connections to the Fiji School of Medicine and choice of a PhD topic

At this time, it is useful to outline my own involvement with the postgraduate programs at FSMed. I am an Infectious Diseases physician and a qualified Public Health physician with a Masters of Public Health (MPH). I took up a position at FSMed in 1998 and over the next three years taught as well as provided clinical services as a consultant in Internal Medicine at the main teaching hospital in Suva (the capital of Fiji). I have therefore experienced firsthand the frustrations but also the fulfillment of working as a specialist in Fiji. While I have been involved with clinical supervision and occasional formal teaching sessions for the postgraduate programs almost since the outset, I was appointed as a long term advisor for the last 16 months of my stay in Fiji in order to work full time helping to set up the program in Internal Medicine alongside my clinical work. My family and I experienced the Fiji coup of 2000, which was a particularly uncertain time and was disruptive to teaching, even to the point of threatening the viability of both undergraduate and postgraduate courses. When I left Fiji in early 2001 at the expiry of my contract, I came to James Cook University (JCU) in Townsville, Australia as a Senior Lecturer, and enrolled in a PhD by mid-year. JCU has close informal ties with FSMed, and I welcomed the opportunity to carry out a study that could potentially be of value to my colleagues and former students in Fiji. I was particularly interested in the most effective approaches for institutions in developed countries as they supported medical schools in developed countries, and I envisioned a study where I would be exploring how to support continuing professional development for the graduates from the courses. By the time I returned to Fiji in 2002 for a follow-up visit, however, I learned that my senior colleagues were most concerned with the high rates of migration of former students who had taken part in the courses, as they felt that this threatened the future of postgraduate training. Based on this, I shifted my focus to migration and retention issues. I also became increasingly aware of the professional frustrations of the Fiji specialists and former students, and therefore chose to approach the issue of retention from the standpoint of professional satisfaction and dissatisfaction.

1.4. Global context

The increase in migration of former specialist trainees from Fiji was similar to what was happening in other developing countries throughout the world at that time, and my PhD candidature from mid-2001 to mid-2007 has coincided with a number of shifts in focus in the approach to health-related issues at an international level. This is discussed in greater detail in the literature review. In 2000, the Millennium Development Goals (MDGs), at least three of which pertain directly to health, were

declared, accompanied by broad-based support along with additional funding, increasingly from a number of large organizations, of which the Bill and Melinda Gates Foundation is probably best known. Within a few years it became clear that even with funding increases, the main “bottlenecks” in making progress towards the MDGs were a lack of infrastructure and in particular a serious shortage of health workers. A minimum number of health workers per capita that was required in order to make reasonable progress towards the MDGs was defined, and based on this and other data, it was calculated that there was a worldwide shortage of 4 million health workers. While these shortages were particularly acute in the poorest countries, a number of English-speaking developed countries, most notably Australia, Canada, the United Kingdom and the United States, became increasingly aware of their own workforce shortages related to failures to train sufficient health workers in previous years. Their recruitment of doctors and nurses from developing countries accelerated, along with an overall lowering of the barriers to migration. The lowering of barriers in Australia and New Zealand was felt to have the greatest impact on the health workforce in Fiji.

At an international level, following many years of what was described as “protracted neglect”, there was a shift in focus towards the plight of health workers in developed countries and their need for support. Over the course of my PhD candidature, the literature shifted from an emphasis on drawing attention to the problem, often through editorials and letters to the editor, along with a few single-country statistics, to the commissioning of research including the publication of useful summary articles, and the establishment of the online journal “Human Resources for Health” as a freely accessible venue for the publication of articles focusing on health workforce issues. The focusing of the entire World Health Report for 2006 on human resources for health (HRH) issues, as well as the proposal of a decade of focus on HRH from 2006-2015 to coincide with the remaining years allocated to achieving the MDGs, is particularly indicative of this shift in focus.

1.5. Choice of research approach

In spite of the current global focus on HRH issues, original research on doctor migration is very limited, and the exploratory nature of this PhD study may be particularly welcome at this early stage of addressing HRH issues. In terms of the study itself, I initially approached the study design with strong skills in quantitative research, given my medical background and my MPH studies, but found that none of these “tools” seemed to be particularly relevant to this study. In particular, I attempted early on to design a questionnaire survey, but found that I really did not know what the

“real issues” were for the Fiji doctors, and did not think that a questionnaire, even with room for comments, would lead me to what was really going on. I consider it fortunate that in my early candidature I was encouraged to read broadly, and through this early exploration I became aware of qualitative research methods, which seemed to hold great promise in exploring complex issues such as career decision-making and migration, about which little was known. With little original research in the literature to guide me, I came to believe that the key to the approaching the difficulties that these doctors faced, as well as determining what sort of interventions would help them, lay in understanding their lives and careers at a deeper level, and I eventually approached the study questions through in-depth interviewing of 47 specialists, specialist trainees and former trainees during four trips to Fiji and three within Australia spread over 2004, 2005 and 2006.

To have gone from a strong quantitative background to using mixed method research with predominantly qualitative approaches that I barely knew existed at the start of my PhD candidature has been daunting, to say the least. Nevertheless, the rewards have been great. In particular, while the interviews were very informative and even enlightening, I found all of the interviews, without exception, to be inspiring as well, whether the doctors had remained in the public sectors or entered private practice or migrated. I am also surprised and humbled by how little I understood at the outset, even after having worked in Fiji for three years, about the pressures and challenges that my Fiji colleagues were facing. I am deeply grateful to the doctors who gave up their time to be interviewed, and it is my hope that through the process of this research, possible interventions will become apparent and that their implementation will be of benefit. It is also my hope that the experiences of the Fiji doctors will be enlightening and of some relevance to health workers in other countries.

1.6. Brief thesis overview

The following chapters begin with a review of the current literature (Chapter 2) related to medical migration, first in a global context, then in the Pacific. Motivation theories of relevance to HRH issues are also presented. This is followed by a chapter outlining the methodological considerations underpinning the research and the methods that were used in carrying out the study (Chapter 3). The study results are presented over three chapters that are mainly qualitative in focus, with quantitative findings interspersed to provide additional context. The first results chapter (Chapter 4) explores issues of professional satisfaction and dissatisfaction for these doctors. The second results chapter (Chapter 5) focuses on migration and retention decisions. The third results chapter (Chapter

6) outlines the career stages of the doctors who undertook specialist training, and explores the rewards and frustrations of postgraduate training at FSMed, the impact of training on family life, decisions to complete or drop out of training, and career pathways following training. The chapter proposes a number of career stages where doctors may be more likely to leave the public system, and suggests interventions that may improve retention. Finally, a discussion chapter (Chapter 7) presents a constructivist approach to the study results that focuses on the professional values of these doctors and the interplay between professionalism and decisions to resign or remain in the public sectors. The study findings are then positioned in a global context. This is followed by a number of proposals for improving retention of these doctors in the public service in Fiji, as well as the possible relevance of these findings to other developing countries.

Chapter 2. Literature Review

The literature on medical migration of doctors from developing to developed countries has expanded significantly over the past 5 years. Despite this, original research on medical migration, whether qualitative or quantitative, is still quite limited. The overall aim of this literature review is to present the current global context of doctor migration, as it has considerable relevance to what is currently taking place in Fiji.

This literature review will begin by addressing medical migration and human resources for health (HRH) issues on a global basis. Evidence on the current numerical extent of medical migration will be reviewed. Thereafter, major summarising reports from the World Health Organisation (WHO)⁷, the World Bank²⁴, and the Joint Learning Initiative (JLI)²⁵ will be discussed in some detail, followed by a review of other summarising articles in the literature. Then original research from developing countries on medical migration, professional satisfaction / dissatisfaction, burnout and coping mechanisms will be presented, with some mention of the impact of health reforms. Following this, the relevant literature from Fiji and the Pacific will be presented. The review will then explore theories of workforce motivation and other related concepts that are mentioned in the HRH literature.

2.1. Search strategies

The literature on human resource issues in developing countries is somewhat difficult to search. My initial approach to this literature took place between 2001 and 2003 through Medline searches, which were not particularly productive. This was probably related to a number of factors. Firstly, much of the human resources for health (HRH) literature, especially key summary documents, did not appear in the Medline searches. Secondly, the literature has expanded significantly in recent years, and many of the articles and reports that I have found to be most useful have been published since my original literature review was written in 2003. Thirdly, while I used a number of Medline search strategies, I found that any particular search term seemed to be “hit or miss”, and as far as I was able to determine, there were no major subject headings that incorporated most of the literature on medical migration. The field of “human resources for health” was not listed as a separate MESH

term, and the closest MESH term, “health manpower” did not prove to be particularly useful as a search term. Even in searches for literature on developing countries, I found that the term “developing countr*” missed many articles, and necessitated expanding the search to include different regions or even individual countries in the developing world. The search strategies that were used in various combinations with variable success and that were carried out in August 2003 and then repeated in February 2007 are listed in Table 2.1.

Table 2.1. Search strategies used (8/03 and 2/07)

Pacific Islands: ("Pacific Islands"[MeSH] OR "Pacific Islands" OR "Melanesia" OR "Micronesia" OR "Polynesia" OR "Papua New Guinea")

Developing countries: ("Developing countries"[MeSH] OR "developing countries" OR "Middle East"[MeSH] OR "Middle East" OR "Africa"[MeSH] OR "Africa" OR "Caribbean Region"[MeSH] OR "Caribbean" OR "Central America"[MeSH] OR "Central America" OR "South America"[MeSH] OR "South America" OR "Asia"[MeSH] OR "Asia")

Migration and satisfaction / dissatisfaction issues: ("Job Satisfaction"[MeSH] OR "Burnout, Professional"[MeSH] OR "burnout" OR "brain drain" OR "Emigration and Immigration"[MeSH]) AND ("physicians" OR "doctors")

Human resources for health: “health manpower”[MESH] (used 2/07 only)

Limits for all searches: human, English

The search strategy that eventually proved to be the most fruitful started with regular reading of major medical journals that have consistently shown an interest in developing country issues. The most useful journals in this regard were The Lancet²⁶ and the British Medical Journal (BMJ)²⁷. The editorials and news items in these journals referred to other articles and websites, which led to finding additional references. These journals also discussed major activities in the HRH field such as the Joint Learning Initiative (JLI)²⁵, as well as alerting readers to the yearly report of the World Health Organization (WHO) for 2006⁷ which focused on human resource issues. Through a “snowball” approach, the ongoing search strategy eventually included receiving e-mail notifications of the table of contents for a number of journals (see Table 2.2), accessing “promising” articles, and doing a manual search of the reference section for additional “promising” articles. A repeat of my

Medline search strategies plus a search on the MESH term “health manpower” carried out in February 2007 failed to list a number of key original articles that I had found to be particular useful, suggesting that the “snowball” search strategy that I had developed was probably more effective than Medline-based search strategies.

Table 2.2. Journals for table of contents notification

The New England Journal of Medicine ²⁸
The Lancet ²⁶
British Medical Journal ²⁷
Medical Journal of Australia ²⁹
Journal of the American Medical Association ³⁰
Annals of Internal Medicine ³¹
Bulletin of the World Health Organization ³²
Human Resources for Health (online journal) ³³
Social Science in Medicine ³⁴
Academic Medicine ³⁵
Education for Health ³⁶
Medical Education ³⁷

2.2. Global literature on medical migration and human resources for health (HRH) issues

2.2.1. Evolution of the world literature

The literature on medical migration has expanded greatly since the start of my PhD candidature in 2001, and it is important to be aware of the evolution of the world literature during years that this study was being carried out. The literature has evolved in its focus from “scattered” editorial-type articles and calls for action to journal articles summarising various aspects of the human resources literature¹ to major documents published by globally-based organisations that are heavily referenced and draw together existing evidence, which, as described above, is scattered across the Medline and non-Medline-referenced literature that in some instances would have otherwise been difficult to

¹ Many of these appear in the online journal “Human Resources for Health” which was established in 2003 and is freely available on the World Health Organization website at <http://www.human-resources-health.com>

learn about or find. These summary resources greatly simplified the process of writing a literature review for this thesis, though it should be noted that many references were not published until the middle to late stages of carrying out the research and write-up, and therefore did not have an impact on the early study design.

Earlier writings on medical migration could be described as mainly drawing attention to the problem and describing its impact on developing countries, as well as raising moral issues related to wealthy countries not training enough doctors and other health care workers for their own health workforces, and then “poaching” the shortfall from poor countries whose medical workforces were inadequate to begin with. Much of this literature has consisted of editorials, news items, letters to the editor, or longer summary articles illustrating the problem and presenting research carried out by others. A considerable number of these sorts of articles have appeared in major journals such as *The Lancet* and *BMJ*³⁸⁻⁶⁷, and would have had wide circulation and therefore considerable impact on drawing attention to the problem.

Several events contributed to expansion of the literature and probably the knowledge base on medical migration. In 2000, 189 countries made a commitment to eradicate extreme poverty and improve the health and welfare of the world’s poorest people within 15 years, by 2015⁶⁸. Eight “Millennium Development Goals” (MDGs) were agreed to, three of which specifically addressed health issues: reduction of child mortality (goal 4), improvement of maternal health (goal 5) and combating HIV/AIDS and other diseases (goal 6). The WHO annual report for 2006 described how increased funding had become available to support MDG-related activities⁷, including both government aid and private sources, most notably the Bill and Melinda Gates Fund, the Global Fund to Fight AIDS, TB and Malaria, and the Global Alliance for Vaccines and Immunization⁶⁹.

Despite the increased attention to health issues and the increased availability of funding, a WHO report from 2005 described uneven progress towards the MDGs, especially in the poorest countries, many of which were making slow progress or falling behind in health⁶⁸. It had become apparent that a major barrier to making progress towards the MDGs was a lack of skilled health workers and health managers “on the ground” to carry out MDG-related activities in many countries, or to even absorb the funding that was available⁷. WHO has identified a threshold in health care worker density below which it is unlikely that a country can meet the health-related MDGs, and has identified 57 countries with critical shortages that are below this threshold⁷. As one report states, “at a time of opportunity to redress outstanding health challenges, there is a growing awareness that

human resources rank consistently among the most important system barriers to progress” and that “while more money and drugs are being mobilised, the human foundation for all health action, the workforce, remains under-recognised and under-appreciated”²⁵. Medical migration has been cited as a major contributor to workforce shortages in developing countries.

In response to these challenges, the Joint Learning Initiative (JLI) was established early in this decade. This is a group of more than 100 “global health leaders” with HRH expertise who worked together to identify strategies to strengthen the workforces of health systems. As the preface to a major JLI report states, “The JLI was launched because many of us believed that the most critical factor driving health system performance, the health worker, was neglected and overlooked”²⁵. The work of the JLI took place in three phases. In 2002, recruitment was carried out and an agenda was planned, followed in 2003 by literature reviews with more than 30 consultations as well as over 50 commissioned research papers carried out throughout the world. In 2004, a major report entitled “Human Resources for Health: Overcoming the Crisis” was prepared on the basis of an analysis and “distillation” of the evidence gathered²⁵.

The WHO has also played an active role in acknowledging and calling attention to the global “crisis” in the health workforce. A report from 2005 cited strengthening of health systems as the first challenge in achieving the MDGs. The entire WHO annual report for 2006 was devoted to HRH issues⁷. Of relevance to Fiji, AUSAID (the Australian Government’s overseas aid agency) has also shifted its focus to strengthening health systems⁶⁹.

The knowledge base of what works in strengthening HRH, especially in developing countries, has been described as being limited. In April 2003, the WHO established an online journal, Human Resources for Health, as a forum for publishing original research as well as summary articles on HRH issues, as well as making these articles freely available³³.

2.2.2. The numerical extent of medical migration

While medical migration from developing to developed countries (as well as within-country migration from rural to urban areas and from the public sector to the private sector) is generally agreed to be extensive and to have major impacts on health delivery in the “source” countries, the full extent of such migration is not known^{7, 25, 70}. One of the most useful original research articles

on the numeric impact of medical migration on developing countries looked at the numbers and source countries of doctors working in the United States, the United Kingdom, Australia and Canada⁷¹. This study demonstrated that between 23 and 28 percent of doctors working in these countries were international medical graduates (in other words, they obtained their undergraduate medical degrees outside of the country they were currently working in) and of these, between 40 and 75 percent were from “lower-income” countries. The article computed an “emigration factor” for 120 countries of origin with domestic doctor workforces of more than 1000 (which excludes Fiji and all other Pacific Island nations). This factor represented the percentage of a country’s doctor workforce that was employed in these 4 recipient countries, with higher emigration factors representing a greater impact on the doctor workforce in the source country². While the leading source countries numerically were India, the Philippines and Pakistan (the first two of which are reported as producing an oversupply of doctors for “export”⁷¹), the emigration factors were higher for other nations. Of the 20 countries with the highest emigration factors, six were in sub-Saharan Africa and 3 in the Caribbean, and overall, the emigration factors for these regions were 13.9 and 8.4 respectively. These numbers are likely to be underestimates of the losses of doctors in developing countries, as they do not include doctors still living in these countries who have left the public system to either enter private practice or leave medical practice altogether, or doctors who have migrated to other developed or developing countries. Despite these limitations that would lead to underestimates of migration percentages, this article documented a major numerical impact of migration on the workforces of many developing nations that had small medical workforces to begin with.

Interestingly, this article presented evidence that of the remaining 26 nations in the Organisation for Economic Cooperation and Development, all except three³ had less than 10% of their medical workforces consisting of international medical graduates. This indicated that failure to train and / or retain sufficient numbers of doctors was far from universal in developed nations. Other articles have also suggested that reliance on international medical graduates is particularly prominent in English-speaking countries^{52, 55, 63}. Of special relevance to this study, 26.5% of the medical workforce in Australia graduated overseas, and 40% of these doctors are from developing countries⁷²⁻⁷⁴.

² This emigration factor was calculated according to the formula $[A/(A+B)]$ where A was the number of doctors from the source countries practicing in these 4 developed countries and B was the number of doctors practicing in the source country.

³ These 3 are New Zealand (34.5%), Switzerland (17.8%) and Norway (12.7%).

In many developing countries, accurate data on health worker numbers and in particular migration numbers is limited⁷⁵. Both the WHO and the JLI have published estimates of the numbers of doctors, nurses and other health workers for most countries, and both have called for more accurate data on health worker numbers and movements as an important step in approaching the problem of health worker migration^{7, 25, 76}.

A key study on health worker migration was carried out from 2001 – 2002 in 6 countries in sub-Saharan Africa⁷⁵ (Cameroon, Ghana, Senegal, South Africa, Uganda and Zimbabwe). This study provided limited data on trends in overall workforce numbers as well as numbers employed in the public sector, numbers of new graduates per year, and estimates of migration numbers from these countries. This report is also one of the few that explores reasons for migration as well as retention through interviews and surveys (including some data from migrants), so is of relevance to the current study. Of concern, between 26.1% and 68.0% of the doctors interviewed who were working in these countries declared intentions to migrate. While this study admitted to the limitations of scanty, incomplete data, it concluded that the tempo of migration to other countries or to private practice was increasing, particularly in the case of nurses. The report stated that most migrants were young “upcoming professionals” for whom heavy investments in training had been made, but who had not yet fully “repaid” through service to their countries. The report described how the investment in their training was lost when they migrated, leading to a situation where poor countries were subsidising the health workforces of wealthy countries. The losses of health workers were described as extending to skilled health managers as well as health educators, which limited the ability of these countries to respond to crises in health worker numbers through improved health resource management practice or through expanding (or even maintaining) basic health worker education. Downward spirals were described where resignations led to heavy burdens on remaining health workers leading to stress, de-motivation, and further resignations. The report emphasised that in countries with less than one million people (which includes almost all Pacific Island nations), the loss of even one skilled health worker is significant.

The larger studies presented in some detail here have helped to document that medical migration from developing to developed countries is a significant problem on a numerical basis, even given the limitations in available data^{7, 25, 71, 75}.

2.2.3. Summary literature

In this section, three major reports on human resource issues will be reviewed in some detail: the 2004 Joint Learning Initiative report entitled “Human Resources for Health: Overcoming the Crisis”²⁵, the World Health Organization annual report for 2006 entitled “Working Together for Health”⁷ and a World Bank report from 2006 entitled “Disease Control Priorities in Developing Countries”²⁴. Additionally, a number of summary articles looking at existing HRH research will be reviewed. These reports are relevant to Fiji and the Pacific because worldwide trends in approaches to human resource issues, especially policies and approaches promoted by major organisations such as the World Bank and the World Health Organization, have had an impact on Fiji and undoubtedly will continue to do so in the future.

Two major reports from the JLI²⁵ and the WHO⁷ were similar in their approaches and messages and will be reviewed together. Both documented a severe global shortage of health workers, estimated at 4 million. This shortage was described as having arisen due to “gross and protracted neglect” of the workforce²⁵. The contributing factors cited included investments in health workers being replaced by neglect, the globalisation of the market for health workers, and the impact of HIV/AIDS in increasing the workload on health workers, many of whom ended up dying of AIDS themselves, particularly in countries that were least able to absorb these losses. Both reports called for immediate action and for at least 40% of global aid for health being devoted to strengthening health systems and workforces, and emphasised that the cost of inaction would be devastating to the health of the populations of world’s poorest countries. Both reports called for a “decade of action” (2006-2015) on HRH issues to coincide with the remaining years allocated to working towards achieving the MDGs.

These reports described how many developing countries that had small health workforces to begin with were losing these workers through migration to wealthier countries, with some countries described as having only a fraction of the health workers they had trained remaining in their workforces. This overall situation of increasing migration was referred to as “fatal flows” of health workers because of the potential for collapse of weak health systems that were increasingly unable to cope, or even make use of available external aid^{7, 25, 77}. A number of “push” and “pull” factors with regards to migration were identified (see Table 2.3).

Table 2.3. Migration of health workers: push and pull factors⁷ (p.99)

Push factors (away from developing countries)	Pull factors (towards developed countries)
Lack of promotion prospects	Better remuneration
Poor management	Upgrading qualifications
Heavy workload	Gaining experience
Lack of facilities	A safer environment
Declining health service	Family-related matters
Inadequate living conditions	
High levels of violence and crime	

The messages of these 2 reports could be described as being “worker-centred”. Health workers were presented as crucial investments to be nurtured and developed rather than as costs to be minimised. Remaining health workers in developing countries were presented as often working beyond the call of duty under difficult working conditions with poverty-level (or even unpaid) wages. As the WHO report pointed out, “even in countries in crisis, many professionals work tirelessly and often without salaries”. Many of these workers were described as collapsing under the strain and “losing the fight”²⁵, leading to resignations and increasing workloads for those who were left, which often led to downward spirals of further resignations as remaining workers were even less able to cope. The losses extended to skilled health managers, with many countries experiencing “dire” shortages of public health specialists and health care managers⁷. This was described as further diminishing the extent to which weakened health systems could address or even comprehend these critical problems. As the WHO report stated, “that major stakeholders have such poor knowledge of their own situation underscores the lack of connection between the acuteness of human resources problems and a coherent policy response”. The report described many national health systems as being “weak, unresponsive, inequitable – even unsafe”⁷.

These reports identified, as an immediate priority, the stemming of the loss of health workers, advocating that “we have to work together to ensure access to a motivated, skilled and supported health worker by every person in every village everywhere”⁴, and emphasised the importance of “putting workers first”⁷.

⁴ LEE Jong-wook, Director-General, World Health Organization, High Level Forum, Paris, November 2005

These reports identified a number of “threats” to retaining health workers at policy or employer levels. While the motivation of health workers was seen as being of major importance, and while professionalism was identified as a source of motivation even in difficult circumstances, the WHO report described that “the professional self-regulation model is also showing signs of strain because employers increasingly override it”. The WHO report described how many countries “rely on a command-and-control approach: the use of hierarchy and administrative rules to govern the health workforce” which no longer worked when the health system was underfunded or near collapse or when the legitimacy of the state was questioned⁷. Rather than a “command-and-control” approach, these reports advocated treating health workers as partners rather than as “just employees”²⁵. The JLI report described health workers as highly adaptable and active agents, rather than passive commodities, whose motivations were multifaceted, ranging from financial self-interest to heroic social self-sacrifice. Health workers were further described as “free agents who act in not fully controllable ways, and whose actions can change the playing field for others”²⁵, and yet whose responses to proposed policy changes were often not taken into consideration⁷.

These reports advocated a number of approaches to support health workers. They encouraged listening to health workers, rather than silencing them²⁵. As the WHO report quoted⁷, “When looking for ways to improve performance, we have found that nothing works so well as talking to health workers themselves. Their ideas are just amazing. They will tell you what to do”⁵. Calls were made for salary support, improvement of infrastructure and supplies (which was believed to be likely to lead to rapid improvements in the quality of care) and support of continuing professional development through improved career paths, feedback, mentoring and secondment⁷, as well as the overall creation of a positive working environment that does not stifle learning and initiative²⁵. Management approaches that were advocated included a clear sense of vision and mission, making people feel recognised and valued, listening to staff, encouraging teamwork, mentoring and coaching, encouraging innovation, encouraging a culture of benchmarking and comparison, providing transparent and fair opportunities for career advancement, feedback, and fair and consistent sanctions for poor performance. The reports emphasised that technical approaches alone would be insufficient, and the WHO report specifically advocated a “bundle” of interventions rather than uncoordinated single ones⁷. Despite the limited evidence of what interventions actually work in improving the motivation and retention of health workers, these reports insisted on immediate action while encouraging further research, monitoring of interventions and sharing of findings^{7, 25}.

⁵ Director of Human Resources from Africa

While the JLI and WHO reports reviewed above appeared to present a “worker-centred” approach to the retention and support of health workers^{7, 25}, a major document published by the World Bank in 2006, “Disease Control Priorities in Developing Countries” arguably presented an “employer-centred” approach to workforce issues²⁴. While it is beyond the scope of this literature review to describe this lengthy report (1300+ pages) in detail, two chapters will be briefly mentioned here, “Health Workers: Building and Motivating the Workforce” (Chapter 71)⁷⁸ and “Strengthening Health Systems” (Chapter 3)⁷⁹.

While the chapter on health workers⁷⁸ approached workforce issues from a number of aspects, this literature review will focus on the assumptions that seem to be made about health workers and their motivations as suggested by the language that is used. The WHO and JLI reports presented a picture of individual health workers as often working in weak health systems, struggling under difficult conditions to work according to their professional values. The World Bank chapter, however, appeared to address a “management” audience, presenting a view of health workers as mainly “economic actors”.

Economics predicts that employers will employ workers as long as the additional value of their services is at least as great as the cost of employing them, and workers will work if the rewards are of greater value than those accruing to other uses of their time⁷⁸.

Workers will invest in training if they value higher future incomes and more interesting work above the costs of income lost during training and of fees paid for training programs⁷⁸.

According to the World Bank report, the overall goals of health systems at national levels (and below) should include providing high quality care in an efficient manner while sustaining high levels of coverage that reach the poorest and most vulnerable. The “health workers” chapter presented workers as being only partially committed to the goals of the organisations they worked for, stating that “although health workers are normally somewhat motivated to pursue health policy goals, their own interests can conflict with those goals”. It can be argued that the language used in this chapter (see Table 7.4) painted a picture of health service organisations as having “correct” goals and therefore needing to undertake measures to get (often reluctant) health workers to behave in accordance with these goals, with health workers being presented, to some degree, as “objects to control”.

Table 2.4. Health workers as objects to control? Quotes from Chapter 71:“Health Workers: Building and Motivating the Workforce” (World Bank 2006)⁷⁸ (*italics added*)

- The World Health Report 2000 defines incentives for health workers as “all the *rewards and punishments* that providers face as a consequence of the organizations in which they work...”
- The challenge is to establish an optimal mix of financial and non-financial incentives that *generate the desired behavior* of health workers.
- *Aligning* health worker and system objectives is difficult. The aim is to have satisfied health workers who are motivated to work harder”.
- The challenge is to *find payment combinations that motivate providers* to provide desired volume and quality of services while containing costs.
- For new payment systems to work well, health workers *must be governed by effective managerial authority*.
- In a competitive environment, *contracts are a useful tool for aligning health workers’ behavior* with organizational and system objectives.
- (on health reform) Providers are given more managerial autonomy and are *controlled* by means of contracts and regulations.
- Strengthening systems will entail developing self-sustaining systems for the supply, *use* and retention of health workers.

It should be noted, however, that the quotes that appear in Table 2.4, are presented in “stand alone” fashion, and are, to some degree, presented “out of context”. While it is beyond the scope of this review to present a comprehensive overview of World Bank activities, it is useful, in order to provide some context, to briefly look at the role of the World Bank in financing health services over the past few decades, as well as the evolution of the “philosophy” of the World Bank over this time, especially in regards to “health reform”, which is often mentioned not only in the World Bank report but in other summary and original research literature as well.

According to Segall⁸⁰, the international health agenda in the late 1970s and early 1980s was centred around the policies of primary health care and “Health for All” as set out in the Alma Ata Declaration of 1978. These policies were based on a philosophy of cooperation between the “actors involved in the production of health” and were based on an assumption that health workers would be motivated by a sense of professional duty to serve their patients and communities. Shortly after

this declaration, however, a prolonged worldwide recession took place, leading to “macroeconomic crises” in many developing countries, leading to policies of “structural adjustment” and resulting decreases in spending on health and other social services, and a fall in the real value of the salaries of health workers.

In the setting of ongoing fiscal constraints in many developing countries, the World Bank, in consultation with the World Health Organization, published “Investing in Health” in 1993², which promoted goals that were arguably in keeping with the spirit of the Alma Ata Declaration, and included increasing health spending on a package of highly cost effective public health interventions and basic services, with a special focus on reaching the poorest communities. The World Bank proposed mechanisms for achieving these goals, including eliminating government support for more expensive clinical services, and cutting funding for specialist training and tertiary hospitals (which were often important venues for health worker training). Further mechanisms included decentralisation, contracting out of services, and the promotion of diversity and competition in the provision of health services. A health reform “movement” related to these ideas has been taking place at least since the 1990s, by which time the World Bank had become the world’s largest health sector lender⁸¹. In many cases, aid funding was tied to the implementation of reforms⁸⁰.

Countries that are willing to undertake major changes in health policy should be strong candidates for increased aid, including donor financing of recurrent costs. An increasing number of donors, among them the World Bank, are now supporting this kind of broad sectoral reform².

By 2006, the World Bank admitted that such reforms had focused “almost exclusively on financing and organisational changes, largely neglecting the question of whether improved health outcomes have been achieved”. A review carried out in 2004 and described in the 2006 report, presented outcomes of such reforms as being “mixed at best”, with only 29% of civil service reform projects supported by the World Bank rated as satisfactory. Calls were made for further research to be carried out in view of a lack of information on which interventions were successful in strengthening health systems²⁴. As an article on health reform in Latin America stated, “even the World Bank, which promoted the reforms, has finally recognised that the neoliberal strategies are not having the desired impacts”⁸¹. Another article pointed to a lack of evidence for the effectiveness of the principles of health reform, and contrasted this with the confidence with which statements supporting the principles of health reform have been made.

The policies have been promoted as universal economic truisms without the need apparently for testing or piloting ... this promotion has been pursued despite the frequent lack of feasibility of implementing the policies or even evidence on their desirability⁸⁰.

Negative impacts of health reform have been described, including the adding of additional destabilisation to working environments⁸². According to these reports, while decentralisation was intended as a means of overcoming the limitations of “rigid” central bureaucracies through devolving decision-making to the local level, this was described as often taking place without adequate training and support, and managers at local levels were often not prepared for their new and expanded management responsibilities⁸³, including the management and oversight of contracts with private providers⁸¹. The administrative aspects of decentralisation in some settings proved to be expensive⁸¹. Decentralisation was also described as leading to problems of financial management and corruption at the local level, with lack of accountability and concerns over the quality of services. The introduction of “flexible contracts” and a fall in the number of permanent contracts was described as leading to a reduction in employment security⁸⁴, which could lead to workers being less inclined to show loyalty to an organisation that could make them redundant during restructuring⁸⁵. Decentralisation, in some instances, also made it more difficult to structure “career ladders”, and as central control weakened, problems such as “patronage and political domination” could be exacerbated⁸¹. An article on health reform in Latin America saw this as being particularly problematic in politically unstable regions, where “civil service tenure was necessary to maintain an efficient, productive and loyal workforce”⁸¹. The decreased security of employment in the public sector along with the emphasis on an expanded role of the private sector led to health workers having more than one employer, with divided loyalties and in some cases, public sector duties were neglected⁸¹. As these reforms led to decreases in staff numbers, the workload of those who remained increased, along with a deterioration of working conditions⁸⁴.

One of the most problematic aspects of health reform that was cited in the summary literature was the conflict between the stated and actual values of the reformers. While the stated intentions of most health reforms were to improve “equity, efficiency and quality”⁸³, Lethbridge proposed that “health sector reform has often aimed to restructure organisations to reduce costs and the power of the workforce”⁸⁶. Rigoli stated that in individual country studies, health workers have been able to easily perceive the non-alignment between the stated and actual aims of reforms⁸³.

Of particular concern in the summary literature was the pressure that health reforms put on the professional values of health workers. Several authors described how those who had internalised an “ethos of public service” could end up resisting the drive towards efficiency and cost cutting if it clashed with their own value systems⁸³, and that “the misalignment between values of the workers and those of the reformed system are very detrimental to the workers’ motivation”⁸¹.

Health workers, in particular doctors and nurses, have been described as tending to be loyal to their profession and patients first, rather than to their employer⁸⁷. Ethical behaviour in health workers has been described as the “jewel in the crown” of health services, and Segall emphasised the need for health system policies to nurture a professional service ethic⁸⁰. A “psychological contract” has been described as existing between organisations and their employees, which for many health workers includes “an intrinsic belief that their work will give them a fulfilment ... it concerns self-actualisation, a sense of achievement, recognition, responsibility and the quality of personal relationships in the workplace”. These sources of personal motivation, however, have been described as not being explicitly considered in health reform policies⁸⁸, and such reforms were felt to be potentially detrimental to professional values. Several authors suggested that a market system not only does not nurture a service ethic, but actually encourages self-serving behaviour^{80, 81}. Rigoli stated that one of the impacts of health reforms has been that the “new professional roles and new working conditions break the psychological contract between health institutions and their workforce”. He described the older ethos of hard work, security and permanence of work as being replaced by a greater emphasis on the protection of employee self-interest in the absence of long-term guarantees of employment⁸³. Lethbridge described the discomfort of health workers moving from an accountability to public service and their profession to accountability to commercial employers (or commercialised public employers) with performance-related pay and conditions, which could lead to tension between professional standards and pressures from the commercial employer⁸⁴.

These summary articles on health reform for the most part described health workers as being guided by professional ethics (which was presented as being desirable), with these ethics serving as powerful motivating factors. Health workers could, however, be pressured by health reforms into behaviours that were self-serving, and the tension between actual employer values (as compared with stated values) and professional values could be demotivating. Dussault stressed that health policies have failed to take these human resource issues into account, and that “in many instances, health workers are treated as mere production tools, such as when financial incentives are

introduced to increase productivity, without taking into account other dimensions of work. As a result, these measures regularly fail to produce the expected results”⁸⁵. In some cases, incentive schemes that tried to modify the behaviour of doctors led to paradoxical and unexpected results, suggesting that “physicians are capable of autonomous reactions, other than those predicted by economic theory”⁸³. Dussault emphasised that “unlike other assets, the potential value of human capital can only be fully realised with the cooperation of the person” and that attention to human resource issues can be viewed as “human capital investments from which returns can be derived”⁸³.

It can be argued that the language used by the World Bank continues to encourage an approach to health policy that views health workers as “objects” or “production units” to be controlled. Nevertheless, there is evidence that on a worldwide basis, a shift is taking place, at least in some of the literature, to take into account the “human” aspects, in particular the motivation of health workers, as evidenced by the WHO⁷ and JLI²⁵ reports. An article on the “Global Fund to Fight AIDS, Tuberculosis and Malaria” described an increased recognition that current shortages in health workforces served as “bottlenecks” in achieving health goals, and described how successive funding rounds have demonstrated some degree of openness to supporting overall health workforce strengthening (as compared with specific project funding)⁸⁹. Of particular relevance to the Pacific, an AUSAID (the Australian Government aid organisation) report from 2005 emphasised building stronger health systems through a “sector-wide approach” and “investing in people” (as opposed to stand-alone projects) as a unified theme for Australian aid, with a focus on direct support for health worker training along with capacity building in workforce management and finance issues⁶⁹.

The literature summarised in this section leaves some unanswered questions related to migration. Health reform, which was presented as being problematic and with unintended outcomes that may have been particularly detrimental to motivation and professional values, has been a dominating force in health sector planning throughout the world at least since the early 1990s, and some aspects of “health reform” have been attempted in Fiji. Health reform has often taken place in a setting of profound fiscal restraints and cost cutting, and it is difficult to separate the impact of these two factors. The underlying philosophy of health reform may have been flawed in not taking into account the professionalism and overall “humanness” of health workers, but on the other hand, the severe resource constraints may have been the overriding factor leading to negative impacts on health workers. Nevertheless, it is possible that otherwise dedicated health workers have decided to migrate or enter private practice not only for economic reasons, but because, in the setting of health reforms, their service ethic was no longer supported by the public systems they worked for, leading

to diminished job satisfaction. The extent to which this is the case is unclear from the summary literature. For doctors who have remained in the system, it is difficult to speculate to what degree their professionalism has been damaged by policies related to health reform and replaced by self-interest, and if this has occurred, whether such professionalism can be regained.

Some time has been spent in this review on the concepts of viewing health workers as valued professionals to be supported and nurtured as opposed to viewing them as “units of production” or as “ongoing costs”. This is because the concept of feeling “valued” within one’s health service features prominently in the interview data for this PhD study, and it is useful to be aware of global trends in how health workers are viewed (see Chapter 4). This literature review has also spent considerable time on the topic of health worker professionalism, with a focus on the concept professionalism being under threat in the face of global trends. The reason for this focus is because the analysis of the interviews conducted for this thesis identified professional values as being particularly relevant to the career decision-making of Fiji doctors (see Chapter 7). When proposing interventions to address HRH problems in Fiji, it is important to consider the impact that such interventions would have on professionalism, based on previous worldwide experience. Overall, the findings in the interview data from Fiji are closely reflected in the “worker-centred” orientation of the WHO and JLI reports, and this “worker-centred” orientation may, over the past few years, have become more prominent on a global basis.

2.2.4. Original research

Medical migration

Overall, little original research, either quantitative or qualitative, has been done on the reasons behind medical migration. A number of studies have been carried out looking at motivation and professional satisfaction and dissatisfaction issues, as well as coping mechanisms for health workers facing financial difficulties, and to some extent, these studies may serve as proxy approaches to the issues that would lead health workers to migrate or remain in their home countries. Some of these studies are reviewed in the next section below, as they contribute to an understanding of the pressures facing doctors in developing countries, of whom a considerable number migrate or contemplate migration.

Of the studies that specifically addressed health worker migration, the most comprehensive study available on the reasons for migration is by Awases. This study presented a combination of quantitative, survey and qualitative interview data on migration from six African countries (Cameroon, Uganda, Zimbabwe, South Africa, Ghana and Senegal)⁷⁵. In addition to gathering data from health workers still employed in these countries, this study presented data from both migrants as well as health workers who had returned from overseas. The metrics of migration presented in this study were discussed above, and indicated that in these countries, between 26% and 68% of surveyed health workers stated intentions to migrate. The main reasons varied from country to country but were mainly economic, including a desire for better remuneration and living conditions. In the work place, heavy workloads and poor working conditions (lack of facilities and declining health services) were cited, with 50% of doctors in Cameroon mentioning poor management of health services as a contributing factor. Overall economic decline and feelings that “there was no future” in the home country were also mentioned. For Cameroon, concerns about safety and lack of promotion opportunities coupled with a desire to upgrade qualifications and gain experience in developed countries were particularly prominent, with a higher percentage citing some of these factors than economic issues. The factors cited that would motivate health workers to remain in their home countries or return included better / realistic remuneration (67.8-90%), conducive working environments (36-80.7%), continuing education and training (29 – 66.9%) and better management of health services (29 – 70.1%).

A quantitative study by Vujicic looked at the level of health worker migration and the size of the wage differential between the source and the destination countries and found little correlation. The authors concluded that the wage differentials were so large overall, that small increases in wages in developing countries would be unlikely to significantly slow migration, and that non-wage interventions might be more effective⁹⁰. A survey study carried out among doctors still working in Colombia, Nigeria, India, Pakistan and the Philippines (but not including migrants) identified a number of factors that they felt encouraged their colleagues to migrate, including increased income, greater access to technology, general security and stability, and improved prospects for one’s children.

Several qualitative studies on migration using focus groups with or without individual interviews were carried out in Ghana, Nigeria and Lebanon. Doctors in Ghana, where 61.6% of health workers admitted to considering migration⁷⁵, cited lack of job satisfaction, poor career and professional opportunities, and frustrations with the government bureaucracy⁹¹. In a study carried out in Nigeria

and Ghana, doctors in academic settings were interviewed individually and as part of focus groups. In this study, almost all students and residents spoke of a strong desire to leave Africa, at least to obtain more training, and it was stated that “it would be very difficult to find a trained senior medical doctor who has not been abroad for at least some number of years during his or her career”, with doctors who had extensive experience abroad serving as role models. Local specialist training was available, especially in Nigeria, but was described as being “frustrating”. Interview participants mentioned not having a set time to take exams but needing to be deemed “ready” by a supervisor, which could prolong training by many years, along with “fairly arbitrary” criteria for determining what eventually constituted a passing grade. Completion rates were as low as 30%, and it was felt that the economic necessity of undertaking outside private practice interfered with exam preparation. Overall, the authors described a “culture of migration” where medical school faculty members not only did not discourage migration, but judged their own success as teachers by whether their students were able to practice in the competitive medical environments of the US and the UK. As one specialist said, “we are proud of our graduates who have left”. As for other factors, these doctors favoured adoption of strategies for improving retention which included better financial remuneration, improvement in local postgraduate training opportunities, and improvement of their standing in their communities⁹². A study from Lebanon included interviews and focus groups with medical students who had stated intentions to go abroad for training. Factors both contributing to or discouraging intentions to train abroad were found to fall into personal, social, professional and political dimensions, and were listed in the study, though not described according to their relative contributions to migration decisions. In addition to push factors (from Lebanon) and pull factors (from developed countries), “repel” (from developed countries) and “retain” (in Lebanon) factors were identified. Again, a culture of migration was described⁹³.

Although these studies may be only somewhat relevant to Fiji, they are presented here in some detail because so few studies on migration itself have been carried out.

Motivation and job satisfaction / dissatisfaction

Because of the scarcity of original research on the reasons for health worker migration, it is useful to review the literature on motivation and job satisfaction and dissatisfaction, even though it does not directly address the issues of migration. It is probably reasonable to infer that satisfied health workers are more likely to remain in their home countries, that dissatisfied workers are more likely

to migrate, and that the factors that lead to dissatisfaction and de-motivation are likely to contribute to decisions to migrate. While motivation / demotivation and job satisfaction / dissatisfaction are not synonymous, they are quite similar, and these concepts will be considered together in this section for the sake of simplicity.

Overall, the main factors identified in the literature as being motivating or making work more satisfying included financial factors, personal characteristics of the individual health worker, support of the working environment, good supervision, training opportunities and being valued by the health system and the community. Franco studied health worker motivation in Georgia and Jordan using interviews and questionnaires that included attention to individual psychological characteristics as well as workplace factors⁹⁴. Her study suggested that motivation was associated with self-efficacy, pride in one's workplace, management openness, support and availability of resources, worker values and motivational job properties (jobs that allow for achievement, challenge, a variety of skills, advancement and security). She stated that these characteristics were not "immutable" aspects of individuals but could be influenced by good human resources interventions. Although Franco noted that health workers felt that financial factors were very important to motivation (as was also found in regards to stable employment and income in Viet Nam⁹⁵), she and other authors also stressed the importance of non-financial factors⁹⁴⁻⁹⁶. In Mathauer's qualitative study on non-financial incentives for health workers in Kenya and Benin, health workers were asked, "What would have to happen so as to boost their spirit and increase (your) willingness to perform?", and was told of the high importance of having the materials and means to carry out one's work, as well as training and increased supervision. While some approaches to supervision were described as being demoralising or counter-productive, workers expressed a desire for supervision that provided a feeling of being cared for and appreciated, with personal needs and concerns being taken seriously. Mathauer also stressed the overall importance of making health workers feel cared for, and cited a study carried out in remote areas in Zimbabwe where high levels of motivation to perform were found despite low salaries and hard working conditions, with motivation being attributed to good leadership and supportive management⁹⁶. Vietnamese health workers also mentioned the importance of appreciation by managers, colleagues and the community⁹⁵.

Mathauer's study also suggested the importance of building on the existing "professional ethos" of health workers through addressing professional goals such as recognition, career development and

further qualifications⁹⁶. Being offered training opportunities was also found to be important to Vietnamese health workers⁹⁵.

More studies addressed the aspects of professional dissatisfaction and de-motivation. A questionnaire survey of doctors at a teaching hospital in Nigeria found that 54% of participants were either dissatisfied or very dissatisfied with their jobs, though the reasons for this were not explored⁹⁷. Among resident medical staff interviewed and /or surveyed at a teaching hospital in Nairobi, Kenya, high levels of psychological stress were identified, with 62% describing being at least moderately affected physically by work-related anxiety, and with 58% considering leaving the practice of medicine altogether. Of these doctors, 82% admitted to meeting the definition of “burnout” (described as “a cumulative process leading to the loss of physical and mental energy, and to emotional exhaustion and withdrawal”), 32% met the criteria for post-traumatic stress disorder, and 48% met the criteria for major depression⁹⁸.

The demoralising impact of HIV / AIDS on the motivation of health workers in Africa was described in a number of studies, and was emphasised by the WHO⁷. In addition to leading to an increasing workload and contributing to a sense of hopelessness where life-saving antiretroviral medications were unavailable, health workers mentioned not being supplied with the means to protect themselves from becoming infected by their patients. In some countries, the loss of health workers through mortality, often due to AIDS, was described as exceeding the losses related to migration^{61, 99}.

Low salaries were frequently mentioned as being sources of dissatisfaction, and in the case of Africa, many health workers described not making a liveable wage and needing to undertake various “coping mechanisms”, some of which were considered to be marginally ethical or even unethical, in order to survive. These coping mechanisms are described in more detail below.

Poor working conditions, including a lack of “means and supplies” such as drugs and equipment were cited as major contributors to dissatisfaction^{95, 96, 100}, with the knowledge that one was unable to provide an acceptable level of care being described as particularly painful. Health workers in Ethiopia complained of knowing that they were delivering poor treatment or inadequate service because of excessive workloads, inadequate facilities and a lack of materials¹⁰¹. The study on resident doctors in Kenya found that the knowledge that one was providing “inferior care” was particularly distressing, as was the knowledge that one had, in the setting of very high patient

volumes, committed errors, especially when patients were felt to have been harmed or to have died unnecessarily. As the authors stated, “the individual physician’s capacity to provide timely and life-saving interventions ... is compromised by lack of access to medications and equipment necessary for curative treatment, as well as by the sheer impossibility of managing the ever-increasing volume of patients with life-threatening medical conditions”⁹⁸.

While good supervision was described as being desirable, workers overall complained of poor supervision, with many feeling neglected by their seniors and by health administration^{96, 100}. Supervision, when it did take place, was described as being irregular, top-down, centred on criticism and shortcomings, and as being demotivating, especially when carried out in front of patients⁹⁶. Health workers interviewed in Vietnam described supervision as a tool for control, with appraisals carried out for administrative purposes rather than for improving performance⁹⁵. On a day to day basis, workers complained about inadequate communication and bad treatment by supervisors⁹⁶, and in Kenya and Benin, 57% and 80% of health workers respectively described feeling they could not participate in decision making at their facilities⁹⁶. Resident doctors in Kenya described a lack of commitment by senior physicians and nurses as second only to lack of drugs, and greater than the impact of HIV / AIDS, as a source of discontent, and they complained of a lack of accountability by their seniors, an overall lack of support, and being ridiculed. This study also described how “lack of respect outside of the medical community as well as inside the medical community contributes to an individuals’ sense of shame”⁹⁸.

A number of studies described a lack of promotion and career development opportunities, with health workers often feeling that training was not allocated fairly on the basis of merit^{96, 100}. Health workers in Vietnam likewise felt that the criteria for further training were unclear⁹⁵.

Health policy, including “health reform”, was also described as being problematic. Kenyan resident doctors were described as “feeling underpaid and undervalued, they bear the burden of a medical system that is unable to financially reimburse or morally support its practitioners”. In Ethiopia, favouritism and unfair policies that were lacking in transparency were described as being exacerbated in the setting of “health reforms”, leading to a “fend for yourself” attitude related to loss of trust in the health system. In the private sector in Ethiopia, health workers complained of a profit motive as well as pressure to engage in unethical practices including the provision of unnecessary services. In Kenya and Benin, health workers were described as viewing health policies as attempts to override professional ethics⁹⁶. In Uganda, health workers reported that

decentralisation led to less employment security, inequity between staff, lower income, and fewer training opportunities. They also described how decentralisation could lead to economic disaster for health workers in districts with poor managers, plagued by debt and corruption¹⁰². Another qualitative study from Africa concluded that “these reforms have not only failed to improve health services and the health of the population but arguably have been the key factor behind their deterioration”¹⁰³.

Overall, there are many similarities between the aspects of professional satisfaction and dissatisfaction as reported above in the literature, and the causes of satisfaction and dissatisfaction for the Fiji doctors that were interviewed for this study (see Chapter 4).

There is a great deal of literature on doctor satisfaction and dissatisfaction from the developed world, including an extensive literature on stress and burnout, but only a few large surveys and editorials in major journals are presented here for the purpose of providing limited comparison to the literature from developing countries. The Physician Worklife Survey, a study of over 5000 doctors which was carried out in the United States between 1995 and 1998¹⁰⁴⁻¹⁰⁷, suggested that satisfaction was most strongly associated with clinical autonomy, working in an environment where it was possible to provide high-quality care, having sufficient time to spend with patients, and ongoing relationships with patients and colleagues. Income was also related to satisfaction, as was working in an academic environment¹⁰⁸. Stress and burnout were related to increasing expectations, decreasing work control and decreases in perceived support. Another study of over 12,000 US doctors between 1997 and 2001, the Community Tracking Study¹⁰⁹, has documented some increases in dissatisfaction over time that have been related to threats to autonomy, ability to manage time and patient interactions, and perceptions of ability to provide quality care, as well as to specific local practice-related factors. Income had less effect on satisfaction¹¹⁰.

Three editorials on doctor satisfaction in major journals are of particular interest, one from the New England Journal of Medicine (USA)¹¹¹ and two from the British Medical Journal^{112, 113}. While these are not research articles, they are valuable in presenting what may be a shared consensus on “what is wrong with medicine today”. The first British article cited anecdotal evidence of increasing unhappiness, and mentioned, as the most obvious cause, feelings of being overworked and undersupported, with doctors feeling as though they were battling the system rather than being supported by it. The article pointed to a sense of diminished control, more change, and an increasing disparity between what patients expected and what could reasonably be delivered¹¹².

The second BMJ article also referred to declining morale among doctors related to reductions in medical autonomy and increases in accountability, which many doctors perceived as a loss of control over their professional lives¹¹³. The USA article, while citing factors of particular concern in the US (including managed care and the malpractice “crisis”), cited a number of trans-national themes, such as disparate expectations, lack of time, and doctors’ roles as double-agents (having to divide their loyalties between their patients and organisations to which they answer)¹¹¹. The article described a “shared theme of unhappiness caused by profound disparities in expectations” between what medical science can deliver, the high expectations of patients, and the limits imposed by bureaucratic ‘tangles’ in wealthy countries or the poverty of a developing nation”. The article stated that “the greatest single problem in medicine today is the disrespect of time” and that “doctors’ anguish seems to come from violating every day what they know they ought to be doing. The pain is from the degree to which they still espouse values but can’t live up to them”. Finally, the article cited conflict with organisations that “remove authority” and force “adherence to conflicting allegiances”. “Complaints about medicine ... bombard the physician at every turn ... Our fuzzy science isn’t scientific enough, and our awkward art is not artful enough ... The real world in which they function fails to support the inner sense of dedication which many doctors feel”, and “doctors who disappoint themselves...will inevitably disappoint their patients too”. In summary, doctor dissatisfaction in the US and UK, according to these editorials, seemed to come from time pressures as well as from an inability to live up to their own professional values, with doctors feeling unable to deliver the quality of care that they believed they should be providing, often because of pressures from the organisations they worked for or answered to. These articles from the USA and the UK are presented in some detail here because the themes are strikingly similar, though different in degree, to the dissatisfaction that doctors from developing countries experience when their health systems do not support them in the practice of a good standard of medicine that is in accordance with their professional values. Professional values were also found to be central to the satisfaction and to the decision making of the Fiji doctors interviewed in this study, as described in Chapter 7.

Coping mechanisms

A number of qualitative studies based on interviews and / or focus groups^{100, 102, 114-116}, as well as a few descriptive articles^{103, 117}, described how health workers, especially in Africa, struggled to get by financially. Roenen described how salaries for many African doctors were “blatantly

insufficient” to live on, and were sometimes delayed for months¹¹⁴. Health workers in Cameroon, who in the early 1990s were described as having the purchasing power of their salaries fall by 70% within a year due to salary cuts and currency devaluations carried out as part of structural adjustments, described their financial situations as “disastrous, deplorable, frustrating and very painful”, and attrition rates of health workers at that time were noted to be high¹¹⁶. Nevertheless, most health workers did not migrate, and perhaps surprisingly, many remained within the public sectors even though they could earn more in private practice. Public work was described as offering opportunities to manifest social responsibility, self-realisation, professional satisfaction and prestige¹¹⁷, job security, credibility and social contacts¹¹⁴, and a high profile identity and respect from the community¹⁰².

Health workers in Africa whose salaries were described as being too low to provide an acceptable standard of living undertook various “coping mechanisms” to get by. While some of these approaches were felt to be acceptable, others were viewed as being “predatory” or “unethical”.

Health workers in Malawi related trying to save money through missing meals and walking to work. Some requested to work in rural areas where the cost of living was believed to be cheaper, or near their home villages so that they could run farms¹⁰⁰. Ugandan health workers also reported engaging in agriculture¹⁰². Other health workers preferred to work in urban areas where opportunities to earn extra income were perceived to be greater⁷.

Many workers reported undertaking employment in addition to their public sector duties. These activities included moonlighting and private practice as well as running businesses^{100, 116, 117}. Whether officially allowed or not, workers described such activities as leading to increased lateness, absenteeism and reduced working hours¹¹⁶.

One of the more “acceptable” means of making extra money included outside teaching, consulting for development agencies, secondment to donor projects, and undertaking sponsored training. This often involved attending meetings held by donor agencies and collecting per-diems and allowances^{100, 114, 117}, sometimes described as “seminaritis”¹¹⁴. While these activities were seen as being possibly useful, they could lead to decreased time on the job, to fatigue, and to less time being available to engage in public sector activities, with disruptions in services at the local level.

While the above coping mechanisms interfered with health services through decreased availability, other activities that were described involved blatant misappropriation and “predatory behaviour”. For clinicians, these activities included under-the counter fees, running private practices during business hours, pressuring patients to attend private consultations, stealing drugs, and the sale of drugs that were supposed to be free. Managers had fewer options for earning extra income, but were described as becoming involved in corruption and misappropriation^{114, 116, 117}. These sorts of activities were reported as increasing in recent years¹¹⁷, but nevertheless were viewed negatively by health workers^{100, 101, 114, 116, 117}, though one article reported a feeling of futility that the health system itself was responsible for the creation of an environment in which corrupt practices were possible¹⁰⁰. While in one study “the core of the professional identity of these doctors” was described as being “the role image of the public servant”, the article concluded that “it would, however, be an illusion to expect the tenuous barrier of ethics to hold against increasing economic hardship in the absence of mechanisms ensuring that practitioners’ behaviours remain in line with wider societal interests”¹¹⁴.

The situation described above is different from that in Fiji, where salaries were generally described as modest but liveable (as described in Chapter 5). It is important to keep in mind that many developing countries are much more economically depressed than Fiji, as this may limit the applicability of the findings from Fiji to other settings.

2.2.5. Professionalism and health worker motivation: a discussion based on the literature

In this section, the relationship, as described in the literature, between health worker motivation (which is related to professional satisfaction and dissatisfaction) and professionalism is explored. This has particular relevance to the current study because professionalism was identified as a central issue for the Fiji doctors interviewed, and was also closely related to their concepts of professional satisfaction and dissatisfaction (see Chapter 7).

Some of the literature reviewed suggested that a major motivating factor for health workers is their sense of “professionalism”, and that their loyalty is mainly to their professions rather than to their employers. Professionalism has been summarised as putting patients first, maintaining a good standard of care, showing respect, being honest and trustworthy, and keeping up-to-date with knowledge and skills³. At its best, this professionalism is manifest through selfless dedication to

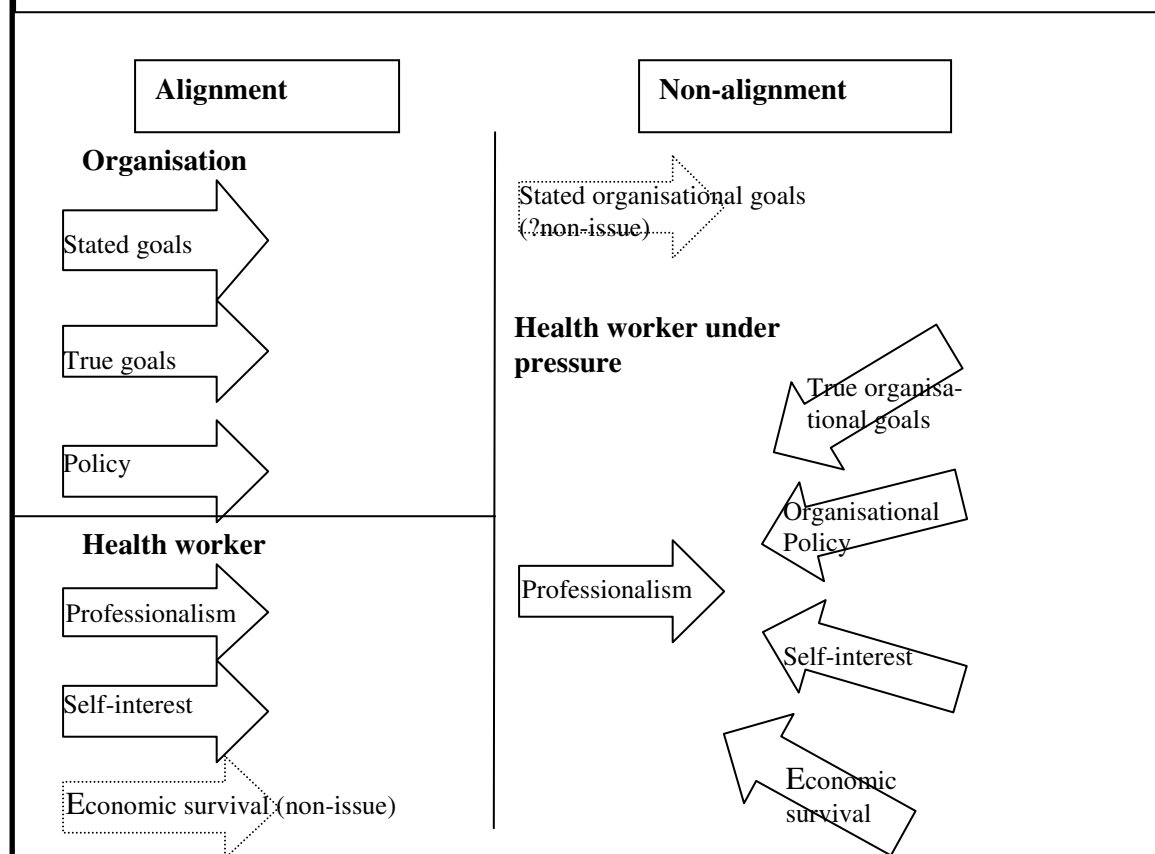
the welfare of one's patients, often in spite of the difficult circumstances that are frequently encountered in developing countries⁷. Some of the research articles described how health workers could experience dissatisfaction, demotivation and distress when the health systems they were employed by did not support their professional values. Such lack of support included a failure to provide medications and supplies that would enable health workers to provide good patient care and optimally use their training, lack of opportunities for further and ongoing training, and lack of clear career pathways and promotions criteria. Of particular concern, especially in Africa, was the failure to pay health workers a wage that covered the cost of living, and this has been described as leading to both ethical and even unethical coping mechanisms. Overall, the literature suggested a “clash” between health workers, many of whom were motivated by professional values, and health systems that did not support the realisation of professional values. As mentioned above, there were some similarities to literature from developed countries where doctors described being dissatisfied because they could not practice medicine as they felt it should be practised, often because of the interference of health organisations that were supposed to be supporting them¹¹.

The World Health Organization proposed that health workers should be “motivated, skilled, and supported”⁷. The 2006 report, however, did not specifically define motivation. A number of definitions and approaches to the concept of worker motivation have been proposed. Some sources arguably take an “organisation-centred” approach to what can be done to improve motivation and retention of workers, and while such vantage points are quite reasonable, given that well-functioning health organisations are vital to supporting the work of health workers, some assumptions made in the “organisation-centred” literature can be problematic. For example, some articles use a definition of motivation in an organisational context as “an individual's degree of willingness to exert and maintain an effort towards organisational goals⁹⁴”. It could be argued that one problem with this definition of motivation is that it seems to assume that the goals of the organisation are “better” than those of health workers, who need to replace their own “lesser” goals with the goals of the organisation. In some instances, however, while health care organisations have “stated” goals that health workers can easily agree to, such as providing equitable, efficient, and high-quality patient care, health workers may come to see themselves as struggling to remain true to their own professional values in spite of working for organisations that, through their lack of logistical support for patient care, demonstrate that they do not truly embrace their own stated goals. While organisations may fail in their support of health workers due to varying degrees of dysfunction or indifference, organisations may also have “unstated” or “true” goals that a health worker may have particular difficulty aligning with, such as slashing health funding and services

and gaining more control over the health workforce through making employment less secure. Some organisations may be widely perceived as being mainly self-serving, and as an example, it was stated about a health service in Nepal that “the purpose of the District Public Health Office is to create incomes for its staff, not to deliver services”¹¹⁸. Organisations, in addition to having “stated” and “unstated” goals, try to achieve these goals through particular “policies” (such as decentralisation, contracting, and the introduction and encouragement of competition as part of “health reform”). Health workers, even if they accepted the stated goals of their organisations, might be reluctant to align with specific policies if they clashed with professional values, especially if such policies were felt to be likely to interfere with patient care, or were unlikely to work, or would lead to further deterioration in employment conditions.

Figure 2.1 proposes two models, a model where there is full alignment between organisational goals and policy, and health worker professionalism and interests, and a second model where there is non-alignment. In the aligned system health workers who acted in accordance with their professional values would be rewarded, not only through recognition and professional advancement, but through greater work satisfaction. In an aligned system, salaries would be sufficient to live on and should be somewhat of a “non-issue”. In such a health system, it would be reasonable to expect health workers to be aligned with their organisation’s goals which are in turn aligned with professional values. In non-aligned systems, however, health worker professionalism may be placed under pressure by health policies, and by “true” (but perhaps unstated) organisational goals. Policies may have created situations, perhaps through flawed incentive systems, where acting in one’s self-interest, or in a spirit of competition, would violate professional values. Unliveable salaries would put further pressure on professionalism. In such health systems, aligning with organisational goals would require a compromise or abandonment of professional values by health workers, and therefore “true” organisational goals and policies would be much less likely to be internalised or aligned to.

Figure 2.1. Alignment and non-alignment of an organisation with health worker professionalism



In light of Figure 2.1, it is worth mentioning the relationship suggested in the literature between “health reform”, motivation and health worker professionalism. While change often involves an element of reform, “health reform” as carried out at least since the 1990s (involving privatisation, contracting out of health services, decentralisation, and encouraging competition) has been problematic, and may have contributed to the deterioration of health services as well as to increasing migration levels in some developing countries. It is beyond the scope of this review to carry out a detailed critique of the successes and failures of health reforms carried out in various countries. Nevertheless, the literature reviewed here suggests that some of the shortcomings of “health reform” may have been related to a lack of attention to the human elements of reform, failing to take into account the humanness and professional values of health workers¹¹⁸. Health workers have been described as being viewed as “part of production chain”⁹⁶ who were expected to behave as “passive actors”^{101, 102} in health reform. It may have been assumed that money was a key motivator, and that workers acting according to economic self-interest could be controlled through incentives and “interventions “designed to stimulate certain kinds of worker behaviour”, as was

suggested in the use of language found in a report by the World Bank (see Table 2.4). In reality, however, such “interventions” were sometimes found to lead to unexpected behaviour reflecting a lack of internalisation of reforms¹¹⁸. As Franco stated, health reforms “often embody values contrary to those held by health workers”¹¹⁸.

Health reformers may have assumed that health workers would not only do as they were told, and respond to incentives as expected, but that they would still maintain their basic sense of professionalism, even if the reform process made the expression of professionalism more difficult for individual health workers. It could be argued that even if some health reformers recognised the centrality of professionalism to health workers, these values may have been viewed as either something that could be taken for granted, or even perhaps as something to be exploited. In Ethiopia, for example, a qualitative study described how it was assumed that health workers were “passive actors” that “are both competent and motivated to serve the public” but were found (surprisingly) to have behaved purposively, often out of self-interest, in response to changing circumstances¹⁰¹. As Franco stated, “The implications of health systems reforms for health worker motivation should be examined prior to implementation of reforms”¹¹⁸.

In addition to arguably “organisation-centred” definitions, the literature alluded to other possible definitions of motivation. An indirect approach to the concept of motivation asserted that “worker performance is also dependent on workers’ level of motivation stimulating them to come to work regularly, work diligently, be flexible and willing to carry out the necessary tasks”¹¹⁸. Other behaviours such as not migrating and remaining in one’s job could also be viewed as being indicative of health worker motivation. Motivation, however, has been described as being complex and multifaceted⁹⁴, and coming to work could be indicative of a lack of other employment options¹¹⁶, or because the job was seen as being useful to facilitating outside employment (or stealing drugs)¹¹⁷, or “ideally” as due to “an intrinsic state of willingness and pleasure to do one’s work”⁹⁶. Interestingly, an article based on interviews with health workers in Kenya and Benin mentioned avoiding the use of the word “motivation” altogether in favour of “boosting one’s work spirit” or “work morale”⁹⁶.

While the above literature can be interpreted in a number of ways, one possible interpretation is that it may be more useful to approach the issue of increasing health worker motivation through supporting the work of health workers in ways that facilitate rather than interfere with adherence to professional values. As Mathauer states, “there is a different angle to (motivation) when we take

high professional commitment as the starting point for a strategy of improving motivation”⁹⁶. On the other hand, it is probably unhelpful to expect health workers to align with “organisational values” when the manifestations of organisational practice interfere with or override professional values, which is described as happening all too often⁷.

The world literature points to a need for “motivated, skilled, and supported” health workers. Motivation is complex but is often related to professional values, which are sometimes put under considerable pressure (rather than being supported) by health organisations, perhaps especially in the setting of “health reform”. The impact that demotivation and dissatisfaction (often related to an inability to work according professional values) have on migration in a global setting where health workers now have many options is unclear, but intuitively, workers may be more likely to migrate if they believe that their health system no longer supports them in the manifestation of their professional values.

Given the shortcomings of health systems throughout the world, especially in developing countries where these systems have been described not only as “weak” but “unsafe”⁷, changes need to be made, but many sources from the summary literature admit that the best way forward is not known, and that further research needs to be carried out, along with sharing of successful and unsuccessful interventions^{7, 24, 25}. The available literature suggests, however, that “worker-centred” approaches based on assumptions of underlying professionalism may hold particular promise.

2.2.6. Summary of the review of the world literature

The original research literature on the reasons that health workers migrate or remain in developing countries is limited, though this is somewhat compensated for by major international reports and summary-type journal articles published over the past few years. Numerically, it has been established that from a global standpoint, medical migration is a major problem. The health systems in many developing countries have been weakened through losses of health workers. This in turn has threatened the ability of national health systems to improve or even maintain services, even in a setting of increasing availability of global funding for health initiatives in developing countries. Reasons for satisfaction and dissatisfaction of health workers in developing countries is likely to be related to the reasons for retention and migration. While salaries and working conditions were mentioned as being important sources of dissatisfaction, threats to health worker

professionalism were also found to be sources of discontent. Focusing on the issues of professional satisfaction and professionalism may be a promising approach towards improving health worker retention. Many of the issues mentioned here are also reflected in the interviews carried out with the Fiji doctors as part of this study, and the current study is compared to the world literature in section 7.3.

2.3. Medical migration and human resources for health issues in Fiji and the Pacific

Overall, while the world literature on medical migration is limited, a number of studies have been carried out in the Pacific. A major report by Connell, supported by the World Health Organization, has been published on skilled migration of health personnel from Fiji, Samoa, Palau, Vanuatu and Tonga¹¹⁹. This report, which was first circulated in draft version in 2001, was finalised in 2004, and provided not only a particularly useful summary of a number of studies that had previously been carried out, but also included the collection and analysis of additional interview data about the reasons for the migration and retention of doctors and other health workers¹²⁰⁻¹²⁴.

According to Connell¹¹⁹, a shortage of doctors in Fiji first became evident in 1977 when graduates from the Fiji School of Medicine were allowed to enter private practice. Nevertheless, he states that up until 1987, the availability of skilled health workers was not a particular problem until the situation deteriorated after the two coups in 1987, a time which was also associated with overall resignations of skilled workers and economic difficulties.

A number of studies on doctor migration were carried out in the 1990s before the coup of 2000. The statistics presented are somewhat hard to interpret because of the admitted lack of denominator data in many instances, especially for the numbers and characteristics of doctors who remained in the civil service. Exact numbers from these studies are also not necessarily in agreement but point to the same trends. According to Connell, between 1984 and 1994, Fiji was reported as losing 586 doctors to emigration¹¹⁹ (to put this into perspective, there were 406 established posts for public sector doctors in 2006)¹²⁵. According to Azam¹²¹, 205 Fiji doctors resigned between 1987 and 1996 representing a 65.3% turnover. Of these, 108 resigned in 1987 or 1988. Azam reported that in 1996, 112 of 353 posts were filled by expatriates with 39 posts remaining vacant. Tora looked at data on 252 doctor resignations from the public service in Fiji between 1987 and 1999¹²². Of the

doctors who resigned during this time, the average annual number of resignations was 19 per year, of whom 78.2% were Indo-Fijian and 16.7% Fijian. Most who resigned were aged 36-45 (154 out of 252), compared to a median age of 34 in Naidu's study¹²⁴. Tora was particularly concerned about resignations of doctors in the older age cohort as they already had many years of experience, but he also noted that the doctors who resigned in 1997/98 were somewhat younger and postulated that this could represent a downward change in the age at resignation. He concluded that young Indian doctors were overall most likely to resign and recommended training more indigenous Fijians as doctors, removing promotion barriers which he felt were inappropriate and demoralising to young doctors, improving services conditions such as salaries and allowances, and providing more opportunities for career advancement and achievement of professional goals. A Ministry of Health (MOH) survey described by Connell¹¹⁹ which covered the same years as Tora's study, found that while most doctors who resigned were between 28 and 37, 65% had left before completing 5 years of service (which was also probably before their required period of bonding following their undergraduate medical training was completed). The majority of these doctors were in the middle and lower grades in the civil service. It was felt that these resignations of more junior doctors were the result of limited career structures, unrealistic promotions criteria, increased workload and lack of recognition of the long hours that doctors worked. This report emphasised that loss of doctors to migration had created problems for the health system. This was addressed in the short term through the hiring of expatriate doctors, but this approach was overall uneconomic, both due to the loss of investment in doctor training at the Fiji School of Medicine (FSMed), and through the extra cost (\$US1,400,000) of hiring expatriates over and above what it would have cost to employ local graduates. By 2006, little progress had been made. Out of 406 approved positions, 341 were filled and 65 were unfilled. Ninety positions were filled by expatriate doctors of whom 26 filled the top- and mid-level positions of consultants, chief medical officers and principal medical officers¹²⁵.

A number of studies looked in more detail at the reasons why doctors were dissatisfied, as well as why they were considering or had actually resigned. Some data is also available on why doctors were satisfied or chose to remain in Fiji. Connell summarised Naidu's 1996 study¹²⁴, which found that 1/3 of doctors who had migrated cited poor working conditions in the public hospitals, followed (in descending order) by political instability, low salary, inadequate facilities and limited postgraduate specialist training. A few doctors were reported as perceiving the root cause of their decisions to migrate as being the "low calibre of administrative personnel in the headquarters of the Ministry of Health". Naidu quotes one doctor as saying that "the Ministry of Health, its Ministers, the Permanent Secretary and most of HQ staff show a level of incompetence which is remarkable

even by government standards”. This doctor also argued that good jobs were allocated according to chiefly status rather than according to ability or training. Many of those who stayed, however, pointed to job satisfaction as being most significant, followed by “lifestyle” issues, while others spoke of feeling too old to move, or cited family reasons or “a fear of the unknown”. Even during this relatively stable period, one quarter of the doctors surveyed had already lodged applications to migrate, while one quarter reported keeping their options open.

Brown and Connell carried out a study of 251 doctors and nurses from Tonga, Samoa and Fiji, including migrants, returned migrants, and health workers who had never left¹²⁰. Included in this study were 29 Fiji doctors, including 10 current migrants, 11 non-migrants, and 8 returned migrants. They proposed a predictive model for migration which took into account the interaction of personal characteristics, material conditions, family/kinship situations, and “unobserved” country-level conditions. In their interviews, which took place in Sydney, Auckland, and the capitals of the three island nations, they gathered data on age, house ownership, business ownership, whether the health worker was living apart from a spouse or whether they had a parent who lived overseas, whether they had pursued a health career for income reasons, and whether financial considerations were the most important factors in their current career situation. The data for doctors from all three countries was presented together. Almost half of the current doctor migrants (45.83%) and return migrants (42.86%) gave income as the primary motivator for entering into their current working situation, and the study concluded that income had a major influence on decisions to become doctors or nurses, and that it was also a key reason for migration. The study also mentioned that dissatisfaction with government work was an important contributor to migration, but only partly because of income, with other problematic factors including lack of an evident career structure, limited promotion opportunities, training opportunities and access to modern technology. The study also mentioned the “embeddedness” of international migration in an extended family context, with migration decisions representing household goals at least as much as individual goals and aspirations. These issues, however, were not directly explored in the study.

Azam reported on the results of a questionnaire distributed to Fiji doctors in the public service exploring the issues of salaries, benefits, chances of promotion, the link between work effort and benefits, and intentions to resign. This study was carried out in 1996 before the establishment of postgraduate training, using a stratified random sample of doctors in the civil service, with a response rate of 22 out of 50¹²¹. Of these doctors, 2 out of 22 were satisfied with their pay. Only one doctor agreed that their pay would be increased as a reward for hard work, and only 8 agreed

that they had a good chance of being promoted. Seven doctors stated that they intended to resign, six stated that they planned to remain in the public sector and 9 were uncertain in regards to their plans. The leading reasons given for wanting to resign were poor or low salary (55%), poor working conditions (41%), and lack postgraduate training (27%), with most Indo-Fijians planning to migrate abroad (8 of 14) and most Fijians planning to enter private practice (5 of 6). He concluded that existing compensation and benefits in the civil service not only did not serve to motivate doctors, but were a likely cause of doctor resignations. He suggested that the civil service recognise the skills and training of doctors and reward them appropriately, and he also proposed a productivity-based reward system.

A survey of 20 Fiji doctors was carried out in Suva in 2000 as part of Connell's report¹¹⁹. While 4 of these doctors planned to migrate permanently (for higher salaries, better research facilities or political stability), and 6 planned short-term overseas placement, another 12 stated that they had no intention of leaving Fiji, citing the wish to be close to family and friends, the overall enjoyment of their work, a sense of duty, and a feeling that "Fiji is home". These doctors did complain, however, about pay structures, and about administration and management, particularly in regards to slow and inefficient delivery of medication and supplies. Of particular concern was the promotions process, which was described as being related to length of service and "who you know" or "who you are" rather than to quality of work. These doctors mentioned particular frustrations at local doctors being passed over for senior positions that were then given to expatriates. As part of this survey, nine Indo-Fijian doctors and nurses were interviewed in Sydney, all of whom reported being motivated to migrate out of concern about the future of their children, with two stating that they would have stayed in Fiji if there had not been political unrest. None reported migrating for superior employment opportunities or because work in Fiji was unsatisfying or inadequately paid, and none of these doctors reported plans to return permanently to Fiji.

Connell's study concluded that there was an "extraordinary consistency in general explanations of migration, including low remuneration, long hours, a lack of training facilities and continuing education, and a poor working environment with shortages of supplies and equipment, with loss to migration being "most serious for doctors, especially young and good ones". He made a number of suggestions for addressing migration, including maintaining a database on resignations from the health service supplemented by exit questionnaires, systems of bonding to repay training, flexible career structures that supported rural doctors and enabled promotions for those who were talented and committed, expansion of mid-level practitioners along with provision of career pathways,

extension of the retirement age of doctors, improvement of working conditions, and facilitation of return migration. Connell particularly emphasised that “it cannot be overstressed that in-country education, with locally focused curricula, is more effective than out-of-country education”, and he further emphasised that in-country graduates are less likely to migrate. He additionally pointed out the implications that this has on the need to strengthen regional institutions. He also stressed the importance of recognising locally trained graduates, and giving them equal status compared to overseas graduates in regards to promotion and career advancement¹¹⁹.

While the MOH in Fiji would need to play a central role in making changes that could lead to increased doctor satisfaction and retention in the health service, the Ministry and its policies has come in for some criticism in the above reports. Pande has published a working paper on “Retaining Pacific cultural values in modern health systems”¹²⁶ where he looked at the interaction between Pacific culture and bureaucracy. He described some features of bureaucracy as fitting comfortably into Pacific culture, such as a “clear-cut hierarchy of legitimate position and chain of command, the defined roles for specific clans or individuals, the rules that govern conduct in the performance of rituals or in fulfilling obligations, and reverence for and uncritical acceptance of the established institutions”. On the other hand, he described features of bureaucracy that potentially clashed with Pacific culture including “separation of workers’ organisational roles from their private lives, ownership of material resources by an organisation rather than by people, loyalty to the organisation before people and the need to process everyone the same way”. Pande described health bureaucracies as combinations of “professional organisations” and “managerial organisations” where the distribution of power and authority could not be sharply defined. He described how “doctors claim that managers are there to support them, while managers claim doctors are to provide services according to managerial constraints”, which has the potential to lead to considerable misunderstanding. Pande postulated that the dual sources of authority and power in health bureaucracies could lead to mismatched priorities, haphazard development of services and a multiplicity of goals, rules and standards with a resulting creation of opportunities for manipulation, misunderstanding and confusion. Intriguingly, the concept of a “mock bureaucracy” was described, where “rules are neither enforced by management or obeyed by workers, there is little conflict between the groups and the joint violation and evasion of rules are buttressed by the informal sentiments of the participants.” Pande asked, “Is it possible that our hospitals and health ministries are actually ‘mock bureaucracies’ with some of the worst features of old bureaucracy such as impersonality, stasis, blind adherence to rules and regulations, but also with the unstated objective of satisfying the goals of the employees rather than the goals of the organisation?” Nevertheless,

there is no objective evidence that the MOH in Fiji is “any different” or “any worse” than health departments in other developing countries (as illustrated in the review of the world literature presented above) or than health departments in developed countries for that matter. As mentioned above, the WHO emphasised that health systems throughout the world are problematic and need strengthening⁷.

Overall, there is already a considerable amount of literature on doctor satisfaction, dissatisfaction and migration issues for the Pacific, and for Fiji in particular. The findings of the current study are compared to the existing literature in section 7.3.

2.4. Motivation theories and related theories of relevance to health worker migration

In this section, some major concepts and theories of motivation in work settings will be briefly reviewed, though it is beyond the scope of this literature review to provide a comprehensive overview. The reason for reviewing these concepts is that they may have relevance for understanding and approaching the current worldwide human resources crisis in the health field, and may help to put the current world literature as well as this study into a theoretical perspective.

Before looking at the various motivation theories, it is worthwhile to review some definitions of workplace motivation that have been used. Motivation is often defined in the HRH literature as a worker being aligned with his or her organisation. As discussed above, this definition may be problematic where health departments are dysfunctional or where they seem to show little concern for patient welfare or for the professional values of health workers. I would like to propose an alternative concept of “professionalism-based motivation”, which incorporates working diligently in accordance with one’s professional values. This may be a more useful concept in the HRH setting. Since some motivation theories also address performance, it is also worthwhile to consider what performance means as well. An employer may be more interested in “measurable performance”, and in “motivating” workers to work harder, perhaps even using rewards (and punishments) to encourage specific desired tasks to be carried out. “Global performance”, on the other hand, incorporates less measurable aspects, such as showing compassion and concern for patients, supporting colleagues, being a good leader, strengthening clinical services, and taking a longer-term

view. Ironically, in systems that are more interested in measurable tasks, workers who focus on increasing their measurable outcomes (and who may therefore have less time for or inclination towards less measurable or unrewarded tasks), may be perceived as outperforming workers who sacrifice “through-put” to some extent to focus on more important, though less measurable, bigger-picture aspects of performance. Global performance, however, is generally more closely related to concepts of “professionalism-based motivation” than is “measurable performance”, and is probably ultimately of greater value to an organisation.

Most theories on work motivation have been developed based on workers in developed countries in the business and manufacturing sectors, and have been extrapolated to the health sector and to developing countries. It is unclear whether such extrapolation is justifiable. Dolea has extensively reviewed the limited data on motivation in health care workers with a focus on workers in developing countries¹²⁷. Table 2.5 lists the factors that she has identified that serve as motivators to health workers.

Table 2.5. Motivating factors for health workers in developed and developing countries (from Dolea and Adams) ¹²⁷	
<p>The work itself</p> <ul style="list-style-type: none"> • Autonomy at work • Meaningful and challenging work <p>Relationships at work</p> <ul style="list-style-type: none"> • Recognition • Appreciation by colleagues and superiors <p>Workplace conditions</p> <ul style="list-style-type: none"> • Availability of resources • Working hours and workload 	<p>Opportunities for personal development</p> <ul style="list-style-type: none"> • Opportunities for training and getting new skills <p>Pay / rewards</p> <ul style="list-style-type: none"> • Levels and mode of remuneration • Pay differentials • Non-financial incentives <p>Management practices</p> <ul style="list-style-type: none"> • Supervision, leadership, teamwork <p>Organisational policies</p> <ul style="list-style-type: none"> • Organisational culture, pride • Job security

In preparing this review, work-related motivational theories were identified through a manual review of the table of contents or motivation chapters of a number of HRH texts (previously called “health services management”) from the local university library. A number of theories appeared in most sources. This overview has drawn heavily from two of these textbooks^{128, 129}, as well as from

Dolea's extensive review of motivation theories as they applied to health workers. The original works that presented these theories were generally not reviewed and are only cited where they were actually used as sources. Of the theories identified, the ones that were most frequently referred to in the HRH literature or that eventually had the most relevance to the current study have been reviewed. The fit between the current study and the motivation theories presented here is discussed in section 7.3.

There are a number of theories about what motivates workers, arguably none of which provides a comprehensive framework¹³⁰. In this discussion, theories that relate to the factors that motivate workers will be presented first, followed by a review of some models drawn from research on HRH that incorporate the issues of both motivation and performance^{118, 127}. Then organisational commitment theory will be presented and discussed. Following this, some comments will be made on the applicability of theories developed in industrialised countries to developing countries.

2.4.1. Workplace motivation theories

Herzberg's motivation-hygiene theory^{127, 131, 132} was developed using a critical incident technique, asking about a time at work when workers felt particularly good and also particularly bad. He identified satisfying aspects of the job, or "motivators", and found that these were "intrinsic factors", such as achievement, recognition, the work itself, responsibility, advancement and growth. He also identified dissatisfying aspects of jobs, or "hygiene factors", which were mainly extrinsic and included company policies, salary, working conditions, interpersonal relations, administration and supervision. Herzberg proposed that eliminating causes of dissatisfaction would not lead to satisfaction, but would lead to a neutral state of absence of dissatisfaction. Satisfaction and motivation would only occur if the "motivators" were present, and would lead to higher levels of motivation and performance^{127, 130, 133}. Herzberg's theory is notable in making a case that money is not the strongest motivator at work, and that managers and supervisors must pay attention to intrinsic factors such as opportunities for achievement and recognition¹³⁰. According to Dolea, Herzberg's framework has been used in six of the twelve studies of health worker motivation that she reviewed, and these studies seemed to support his theory to some extent.

Equity theories propose that while people are concerned with the rewards they receive, they also compare themselves to others, and are concerned about whether rewards are given out fairly and

equitably¹³¹. According to these theories, justice is important to workers, as most people believe that in the long run, they are more likely to profit from a fair system than an unfair system¹³⁴. Employees are usually willing to accept an unfavorable outcome as long as they perceive that the outcome has been arrived at fairly^{135, 136}. **Organisational justice**, an equity-related concept often referred to in the motivation literature, and has been divided into “distributive justice”, which deals with how resources are allocated¹³⁵, “procedural justice”, which involves development and enactment of specific policies and procedures that are seen to be fair¹³⁶, and “interactional justice”, which has to do with perceptions of the quality of the interpersonal treatment an individual receives from an authority during the enactment of justice-related procedures¹³⁵. A perception of inequity can create tension in an individual worker, who will be motivated to do something about it, such as appealing, working less, being “neglectful” or “destructive”, or resigning^{127, 137}. The qualitative research on health workers in developing countries reviewed above supported the concepts of organisational justice. These studies suggested that a perception of unfairness, favoritism or lack of transparency in the workplace (such as in making working assignments and in awarding promotions and opportunities for training) as well as the witnessing of coworkers getting away with “predatory behavior” can be very disheartening.

In addition to written contracts which generally focus on remuneration and other terms and conditions, the literature proposed the existence of “**psychological contracts**”¹³⁸⁻¹⁴⁰, which have been defined as “an individual’s (unwritten) beliefs regarding the terms and conditions of an exchange agreement between themselves and their organisations” consisting of “certain rewards in return for the contributions that they make to the organisation”¹⁴¹, such as career development, job content, financial rewards, social atmosphere, and respect for private life”¹⁴². Violations of psychological contracts were described as leading to negative outcomes such as decreased job satisfaction, reduced trust in the organisation, increased turnover, a decreased sense of obligation to one’s employer, a decreased willingness to participate in organisational citizenship behaviors and decreased work performance^{135, 138, 141}.

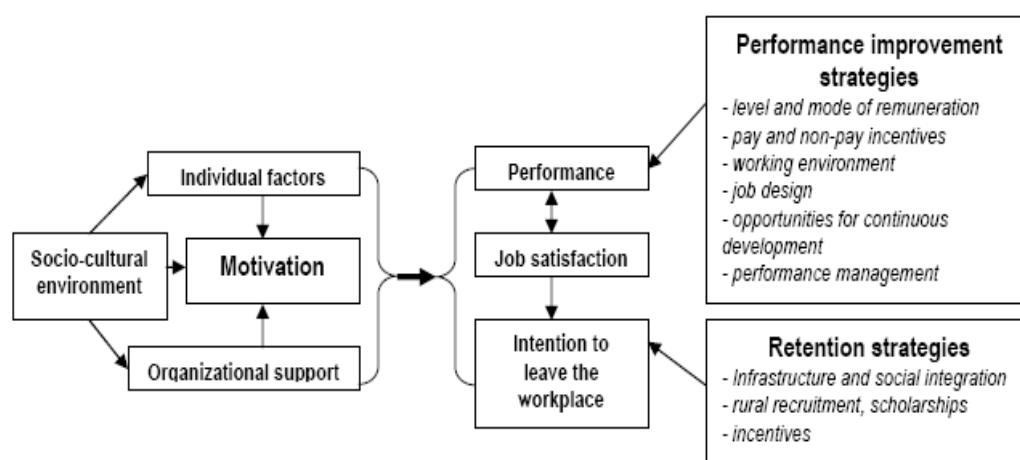
The eventual result of the violation was related to how the employee and employer dealt with the violation, and Rousseau proposed that four options were available¹³⁸. “Voice” involved trying to resolve the violation through discussion and negotiation. Where resolution does not take place, workers who remained in their jobs could either become “silent”, or could engage in “neglect or destructive behaviours”. “Exit” was most likely where others were exiting, and / or where other job options existed.

The degree to which psychological contract violations have contributed to health worker dissatisfaction, demotivation and resignation is unclear from the literature, though given the increasing opportunities to migrate, a doctor who has experienced a violation may now be more likely to resign than to silently accept the situation. Psychological contracts were occasionally mentioned in the human resources for health literature^{83, 88}, and may be of particular relevance to developing countries.

2.4.2. Combined motivation and performance theories

The above theories have looked at motivation, with limited focus on performance. Franco, based on quantitative and qualitative research on over 500 health workers in Georgia and Jordan, has proposed a useful model linking organisational, social and individual factors (including the beliefs, feelings and motivation of individual workers) with performance. Dolea, as shown in Figure 2.2, has built on Franco's model to produce a comprehensive and simplified model that incorporated motivation, job satisfaction, performance and retention¹²⁷.

Figure 2.2. Relationship between motivation, performance, intention to leave the workplace, and motivation strategies (from Dolea and Adams^{a)})



^aDolea C, Adams O. Motivation of health care workers - review of theories and empirical evidence. Cahiers de Sociologie et Demographie Medicale 2005;45(1):135-61.

2.4.3. Organisational commitment

While motivation is a useful concept in trying to understand how to increase the retention of health workers in developing countries, individual workers may be motivated to remain in their jobs for a number of reasons, whether out of a sense of personal fulfillment, out of a sense of professional obligation, or grudgingly out of a lack of better alternatives. Theories of “organisational commitment” offer an approach to the retention of workers that take these factors into account.

While the literature on organisational commitment is not reviewed extensively here, the following discussion is mainly drawn from a text by Meyer and Allen¹³⁶. They state that commitment is usually thought of as something that “binds an individual to the organisation” with committed employees being more likely to remain with their employers than uncommitted employees, though there are many reasons for commitment. They propose that commitment falls into three major categories:

- **Affective commitment** refers to the employee’s emotional attachment to and identification with the organisation (“**wants to**” remain with the organisation). From an employer standpoint, affective commitment is the most desirable.

- **Normative commitment** reflects a feeling of obligation to continue employment (“**ought to**” remain with the organisation)
- **Continuance commitment** refers to an awareness of the cost of leaving the organisation (“**needs to**” remain with the organisation). These employees are most likely to leave when other opportunities become available.

Organisational commitment theory, through taking into account the various types of commitment, some of which are more desirable than others and more likely to lead to worker retention, may provide a more useful framework in approaching the problem of medical migration than the more complicated frameworks provided by motivation theories.

2.4.4. Workplace motivation in developing countries

As mentioned previously, most research and theory development on motivation has taken place in developed countries and has generally not focused on health care workers, and it is therefore difficult to determine the relevance of these theories to health workers in developing countries. Hofstede proposed that management theorists are strongly influenced by the culture they grew up in, and that there is no such thing as a “universal management theory” (of which motivation theories are a part)¹⁴³. Kanungo proposed that in many developing countries, cultural values placed an emphasis on workers who were collectivist, hierarchical, and harmonious, and who may prefer to be passive, moralistic (as opposed to pragmatic) and authoritarian, and that organisational cultures were more likely to place an emphasis on fate beyond one’s control, fixed human capabilities, the importance of the past over the future, and a focus on short term goals¹⁴⁴. This suggests that motivation theories based on research in developed countries cannot be automatically assumed to apply to developing countries, and that they should be applied cautiously (if at all) in such settings.

2.4.5. Summary of motivation – related theories

Motivation is closely related to job satisfaction, performance and retention. Of the motivation theories, Herzberg’s theory and the concepts of organisational justice and psychological contracts appeared to have the most relevance to developing countries. Franco’s model⁹⁴ (along with Dolea’s

modification¹²⁷), which was developed through research on health workers in developing countries, provided useful frameworks that combine individual, organisational and societal issues, and incorporate performance and even resignation issues.

Worker motivation is a complex concept with “positive” and “negative” aspects. Give this, organisational commitment theory, through its attention to the reasons (both positive and negative) why workers remain with their organisations, and through its focus on the nature and strength of workers’ commitments, may provide a more useful and perhaps simpler framework than the various motivation theories for understanding why health workers remain in their jobs, and what it would take for them to migrate.

2.5. Closing comments on the literature review

The literature on workforce issues and challenges in developing countries has expanded greatly during this decade. Despite recent initiatives to summarise and make the literature more accessible, there remain many uncertainties about how best to approach the issues of health worker migration.

The issues related to medical migration cut across many disciplines, including the clinical disciplines, health professions education, public health, human resources for health, management, health economics and organisational psychology, and few individuals possess wide-ranging expertise across of these disciplines. Most of these disciplines were touched upon in this literature review, though not necessarily in depth.

Research on medical migration and other workforce issues is complex, and is likely to be enhanced where researchers move cautiously out of their “comfort zones” in order to broaden their outlook and be enlightened by insights from disciplines outside of their own. Useful insights may end up arising through the interaction and cross-fertilisation between a number of disciplines. This is likely to increase the chances of uncovering novel insights that may contribute to new understandings and solutions to the problems of health workers in developing countries. In this spirit, this study has attempted to take a broad, cross-disciplinary approach to understanding and putting into a wider context the working lives and career decisions of the Fiji doctors that were interviewed.

Chapter 3. Methodological considerations and methods used

This study was initiated with the underlying purpose of learning how to support the professional careers of specialist doctors who trained in Fiji. As described in the introduction, the initial research interest centered around how best to facilitate continuing medical education for these doctors, but it became evident fairly early in the study that the greatest problem faced by the postgraduate training programs was the unexpected rate of loss of specialist trainees and former trainees to migration, as well as to the private sector in Fiji.

The study came to focus on the phenomenon of the career decisions of doctors especially in regards to migration and retention, as well as the phenomena of professional satisfaction and dissatisfaction. These phenomena were explored within the bounded context of doctors who undertook, contemplated or were involved with specialist training through the Fiji School of Medicine (FSMed) between 1996 and 2004. Because of this “boundedness” in time, place and study population¹⁴⁵ (p. 444), the research was carried out as a case study, and for pragmatic reasons, mixed quantitative and qualitative approaches were used, with quantitative data helping to define the context, and qualitative approaches allowing for exploration of an area where little research has been done.

In the first major section of this chapter (3.1), methodological issues are discussed. The case study approaches used in the research are described, followed by comments on how mixed-methods approaches were incorporated. Theoretical underpinnings are discussed, and a general overview of the adaptations of grounded theory that were undertaken is presented. Quality indicators and ethical considerations are also discussed. The Methods section (3.2) of this chapter describes how the research was carried out while the final section (3.3) presents some data about doctors who were selected as interview participants.

3.1. Part one: Methodological considerations

3.1.1. Case study methodology

Yin, in his textbook on case study research, stated that “a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident”¹⁴⁶ (p.13). While some texts provide guidance in regards to carrying out case study research^{146, 147}, there is no “one” case study method. Stake explained that “case study is not a methodological choice but a choice of what is to be studied ... By whatever methods, we choose to study *the case*”¹⁴⁵ (p.443).

The overriding purpose of this study was to carry out research that would increase the understanding about what the doctors undertaking postgraduate medical training in Fiji were experiencing, as well as to understand the career decisions that they were making, particularly in regards to migration. A major aim of the study was to ultimately be of benefit to these doctors and to the Fiji health system in general. Stake described this sort of approach as an “intrinsic case study”¹⁴⁵ (p. 445), and he stated that “most case study work is done by people who have an intrinsic interest in the particular case itself”¹⁴⁵ (p. 450). He contrasted this with an “instrumental case study” where cases are selected to provide insight into a particular issue, or where a major purpose is to use findings from the case study in order to generalise.

Indeed, if a researcher were to choose a context in which to study medical migration (rather than choosing a context in advance, as was done in this study), they might be unlikely to choose Fiji, especially if the aim of the study was generalisation or theory building. This is because Fiji is unlikely to be either a “typical” case, or an “extreme” case, which are two criteria that Yin has suggested for choosing single case studies. Nevertheless, this case may represent a “revelatory case”, which Yin described as occurring when “an investigator has an opportunity to observe and analyze a phenomenon previously inaccessible to scientific investigation”, or a “longitudinal case”, which refers to “studying the same single case at two or more different points in time” (p.42). As a researcher, I was in a position to observe the Fiji situation through four field trips over a 2-1/2 year period, but my active involvement with FSMed dates back to 1998, giving perhaps an unusual degree of longitudinal exposure for a case study researcher. Because of my previous work in Fiji, I also had a reasonable understanding of the context even before starting the study. What may make this case somewhat “revelatory” in comparison to other studies, was that I was able to approach fieldwork and especially interviews as a “semi-insider”, and as a specialist-clinician colleague. This is likely to have facilitated access to interview participants and other sources of information. These two factors of longitudinal exposure and semi-insider status may have allowed for a depth of

insight into the Fiji context that may not otherwise have been possible, though being as close as I was to the case was potentially problematic in terms of the risk of bias (this is discussed further in Chapter 7).

Yin described how case studies can take either an exploratory, a descriptive or an explanatory approach¹⁴⁶ (p.3). At the time that this study was designed, (and even up to the present), original research on medical migration was limited (though reasons for migration have been proposed in a number of publications, most notably the World Health Organization Report for 2006⁷). Therefore it was felt that an exploratory approach was needed in order to uncover the reasons for both migration and retention, particularly in the Fiji context. Eisenhardt proposed that case study research is “particularly well-suited to new research areas or research areas for which existing theory seems inadequate”¹⁴⁸ (p. 32), and that case studies could be particularly useful for generating novel insights¹⁴⁸ (p. 29).

While there are few specific methods for case studies, a process of approaching the case through multiple sources and methods, or “triangulation” has been suggested^{145, 146, 148}, looking for convergence or differences between the sources of information. Mixed methods research may therefore be particularly appropriate for case study research. While this study was centered around qualitative interviews that were usually taped and transcribed, limited use has also been made of documents, archival records, direct observation and participant-observation (as suggested by Yin – p. 83¹⁴⁶) to collect both quantitative and qualitative data.

Several authors described an overall flexible and open approach to case study research. As Eisenhardt described, “a key feature of theory-building case research is the freedom to make adjustments during the data collection process” (p. 16). Yin encouraged case researchers to “think of yourself as an independent investigator who cannot rely on a rigid formula to guide your inquiry”¹⁴⁶ (p. 63). Stake encouraged ongoing openness, and reminded researchers that issues that seem particularly important at the start of a study may later seem to be of little consequence¹⁴⁵ (p. 456), and that “the caseworker needs to anticipate the need to recognize and develop late-emerging issues”¹⁴⁵ (p. 453). This study was characterised by a flexible approach over the four field trips, with a few changes in direction and modifications along the way.

When it comes to analysis, there is no “one” method particular to case studies. While Yin suggested exploring rival explanations as part of the analysis process¹⁴⁶ (p. 112), Eisenhardt

recommended an analysis process that includes a constant comparison of theory to data, assessing each case to see how it fits with any emerging constructs¹⁴⁸ (p. 20). She suggested that “the likelihood of valid theory is high because the theory-building process is so intimately tied with the evidence that it is very likely that the resultant theory will be consistent with empirical observation¹⁴⁸ (p. 29). This would fit in well with the aspects of the current study that are drawn from grounded theory methods, in particular the use of the constant comparative method as described below.

According to Eisenhardt, case studies can be carried out to provide description, to test theory or to generate theory¹⁴⁸ (p.9), and that building theory from case studies can take place at a number of levels including the development of concepts, conceptual frameworks, propositions, or possibly mid-range theory¹⁴⁸ (p.27). While the main purpose of this study was to explore the Fiji context and ultimately lead to local benefit, some attempts at generalisation and a cautious development of conceptual frameworks are made in this study, which is probably justifiable, given the lack of research on medical migration and its importance on a worldwide basis. Stake described this taking of both a local and a wider view as a “zone of combined purpose”¹⁴⁵ (p.445). He went on to explain that “In the intrinsic case study, researchers do not avoid generalization – they cannot ... They expect readers to comprehend their interpretations but to arrive, as well, at their own” (p. 450). In case studies, “naturalistic generalisation”¹⁴⁹ (p. 179) (similar to Yin’s concept of “analytic generalisation”¹⁴⁶ - p.32) is carried out. This is a process where findings are taken from one study and applied to understanding another similar situation¹⁴⁹ (p.179). Stake further suggested that in order to facilitate generalisation, researchers should pay close attention to defining and describing the nature of the case, particularly its activity and functioning, its historical background, its physical setting, other contexts, such as economic, political, legal and aesthetic factors¹⁴⁵ (p.447). Attention to defining and describing the context of this study in order to facilitate generalisation is an important aim of this research. “Statistical generalisation” (from a representative sample to a population), on the other hand, is often neither possible nor relevant in case studies¹⁴⁶ (p. 32), and is not attempted here.

3.1.2. Mixed methods approaches

As described above, using several different methods to collect data is recommended in case study research, and therefore mixed method approaches may be particularly appropriate. In the current

study, it was felt that while insights which were derived from the analysis of interview data would form the major portion of the study, quantitative data on the entire group of doctors studied would help not only with choosing which doctors to interview, but with understanding the overall picture of the career choices actually made by this group of doctors as a whole. As Creswell described in his textbook on mixed methods approaches, “in mixed methods research, investigators use both quantitative and qualitative data because they work to provide the best understanding of a research problem”¹⁵⁰ (p. 12).

Creswell described several approaches to mixed methods research, and suggested a number of criteria for choosing a strategy¹⁵⁰ (p. 210-213). First of all, a decision needs to be made about the sequence of carrying out qualitative research. In this study, qualitative data and quantitative data were collected at each visit after the preliminary field trip. While the quantitative data was almost complete after the second interview visit and was used to select interview participants, it was updated at each visit and through e-mails between visits. Secondly, Creswell suggested that a weighting, or priority, needs to be assigned to each form of data collection. In this study, the qualitative interview data was “dominant”, with other approaches deemed as being “supportive”. Thirdly, integration needs to be taken into consideration. In this study, “mixing” of the data took place throughout the study, and in general, the quantitative data served as a framework or a “backdrop” for the interview data, putting it into an overall context. Finally, Creswell recommended giving consideration to a theoretical framework, which is discussed below.

Six strategies were proposed for mixed-methods research, and the current study follows a “concurrent nested strategy”. In this case, a smaller quantitative study was “nested” within a larger qualitative study, but data was collected concurrently. With other strategies, qualitative and quantitative data can be collected sequentially, or can have more or less equal weighting¹⁵⁰ (p. 213-220). Details of how both qualitative and quantitative data were collected and analysed are discussed below (section 3.2).

3.1.3. Qualitative approaches and theoretical underpinnings

While the current study uses a number of research approaches, the major focus is on the qualitative analysis of interviews. In this section I discuss how my approach to the interviews has been influenced by my own epistemological leanings. I also discuss how I have drawn heavily from

grounded theory. The epistemological approaches of the different versions of grounded theory are presented, with an emphasis on those that support my own constructivist / interpretivist leanings. In the following section (Section 3.1.4), I also discuss how I incorporated grounded theory methods from Strauss¹⁵¹ and Charmaz¹⁵², as well as how I deviated from these methods.

Approaches to qualitative research are underpinned by a number of epistemological assumptions, in other words “different philosophical views about “how or whether (in the case of poststructuralism) it is possible to obtain certain or objective knowledge about the world”¹⁵³ (p. 9). These philosophies are categorised in a number of ways in different texts. Travers proposed four perspectives¹⁵³: “positivism” (a view that “it is possible to describe the world objectively from a scientific vantage point” – other authors mention “postpositivism” which advocates similar research approaches but also proposes that absolute truth can never be found¹⁵⁰ – [p.7]); “interpretivism” (a belief that the “objective of sociological analysis should be to address how members of society understand their own actions”); “realism” (which is similar to the “critical theories” mentioned by other authors¹⁵⁴ and involves “looking behind appearances to discover laws or mechanisms that explain human behavior” and to “reveal a reality concealed from ordinary members of society”); and “poststructuralism” (which is sometimes used interchangeably with the term “postmodernism” and challenges the “assumption that it is possible to obtain valid knowledge about the world”, or to represent “social reality”). Lincoln and Guba (and others) proposed an additional major category of “participatory action frameworks”, which describes research that is carried out collaboratively with participants and is oriented towards their empowerment¹⁵⁰ (p.6),¹⁵⁴ (p. 220). Among researchers who claim to use grounded theory, positivist^{151, 155}, constructivist¹⁵⁶ and postmodern¹⁵⁷ underpinnings are described or advocated.

Of particular relevance to this study is the epistemological position of constructivism, which, according to the classification above¹⁵³, is an interpretivist approach. According to Burr, who uses the term “social constructionism”, “what we regard as ‘truth’ (which of course varies historically and cross-culturally), ie. our current accepted ways of understanding the world, is a product not of objective observation of the world, but of the social processes and interactions in which people are constantly engaged with each other.” She goes on to describe that “we construct our own versions of reality (as a culture or society) between us ... within social constructivism there can be no such thing as an objective fact”¹⁵⁸ (p. 4-6). Symbolic interactionism is a related concept that has played a significant role in the development and evolution of grounded theory (which has been described as a “more rigorous, scientific version of symbolic interactionism”¹⁵⁹ - p. 41). The Blumer-Mead

model of symbolic interactionism, which is most closely associated with the “Chicago School” (University of Chicago), is also in the interpretivist tradition and proposes that humans act towards others in their environment on the basis of the meanings that these things have for them, that these meanings derive from social interactions between and among individuals, and that these meanings are established and modified through an interpretive process¹⁶⁰ (p. 124).

My own epistemological position has evolved over the course of this study. As a practising specialist in internal medicine, I teach “evidence-based medicine”¹⁶¹ and try to incorporate its principles into my approach to patient care. This lends itself to a “post-positivist” perspective, where the “truth” of the best approach cannot be known with certainty, but should be approached through “scientific” inquiry. It has been argued that “medical doctors believe that their field is founded on scientific knowledge where knowledge is defined as facts that can be empirically verified by the biomedical method”¹⁶². Nevertheless, I also view medicine as an “art” and understand the limitations of an “evidence-based” approach, which include major gaps in evidence, considerable biological variability in response to treatment, and patients who need to be understood as individual human beings rather than as “biological entities”. I view the entities of compassion, empathy, and human understanding as essential parts of successful medical practice, but these factors cannot be “controlled, measured, counted or analysed by statistical methods”. It has been argued that “the medical research tradition lacks strategies for the study of interpretive action, its dynamics and its consequences” and that “in an attempt to escape all interpretive subjectivity, medicine has threatened to expunge its primary subject – the living, experiencing patient”¹⁶².

As a doctor, I am comfortable with taking a simultaneous “evidence-based” along with a “human” approach grounded in “wisdom” (rather than “research”) in my own approach to patient care. As a researcher, however, I faced the challenge of a research problem that, while being quantifiable to some degree, required an approach that took into account “that most powerful of all threats to conventional objectivity, feeling and emotion”¹⁵⁴. The “scientific methods” that I had been taught to use as a doctor could tell me “what” was happening with the Fiji specialists, but not “why”, and therefore I turned to qualitative methodology.

As I started exploring qualitative research traditions in 2002, I was attracted to grounded theory, perhaps because, on the surface at least, it seemed more “scientific” than other methods. As Greckhamer states, “Grounded theory has protected itself against many critics by establishing detailed procedures to ensure validity and scientificity. It grounds its analysis in data yet focuses on

theory development. This means that grounded theory draws from both qualitative and quantitative inquiries by staying open to data while aiming to produce theory and arguments logically and systematically”¹⁶³ (p.731). At the time I started my study, the 1998 Strauss and Corbin text seemed most accessible to a “beginner”, and the detailed coding and analysis procedures provided a “welcome” degree of specific guidance. I was particularly attracted to the idea of “grounding” research findings in the data itself using established procedures. Early on, given my biomedical background, I had few concerns about epistemological issues. In any case, the epistemological positions of Strauss and Corbin were not clear to me at the time, and it has been said that “in the case of grounded theory developed by Glaser, Strauss and Corbin, the philosophical stance has to be inferred from the literature, given the lack of explicit discussions thereof”¹⁶³ (p. 736).

As I started actively planning my study in 2003, in retrospect, I believed that the interviews that I would be carrying out (and my analysis) would be different from the interviews and results that other researchers would have obtained, even with the same interview prompt, the same overall procedures, and the same participants. I believed, for instance, that my “insider” status would give me access to some information and understandings not available to others, but that I would perhaps lack the “fresh” approach of an outsider. These pre-existing impressions eventually resonated with the writings of Charmaz^{152, 156, 164}, which became increasingly available during the course of this study. According to Charmaz, “a constructivist approach ... sees both data and analysis as created from shared experiences and relationships with participants and other sources of data”¹⁵² (p. 130). She also proposed that interviews are not “objective data”, but “reconstructions of experience, they are not the original experience itself”¹⁵⁶ (p. 258). This reinforced my own pre-existing, though (at the time) unstated understandings of the interview research process.

According to Charmaz, Strauss and Corbin’s stance differed from her own (and my own stance as well) in that it assumed the existence of one external reality waiting to be discovered and aimed towards unbiased data collection through a set of technical procedures (even though their descriptions of methods were focused on analysis and did not have much to say about actual data collection techniques)¹⁵⁶ (p. 250-251). Glaser even claimed that his version of grounded theory was “... discovered, not invented. It is a sure thing for researchers to cast their fate with”¹⁵⁵ (p. 21). This suggests that he viewed grounded theory itself as having always existed as an objective reality even before it was “discovered”.

I had concerns, however, about my own ability to be a truly “objective” researcher, relating to the possibility that bias could be introduced through my own pre-existing views and experiences, especially in regards to my own experiences of professional satisfaction and dissatisfaction. While “objectivist” grounded theory has been described as making the assumption that an authoritative expert would bring an objective view to the research¹⁵² (p. 132), leading to pre-existing theory emerging from the data through the use of correct procedures, I was not certain that I could be truly “unbiased”. Charmaz, on the other hand, described the researcher as being integral to research findings, and stated that “the theory depends on the researcher’s view; it does not and cannot stand outside of it” (p.130). She explained that “constructivists attempt to become aware of their presuppositions and to grapple with how they affect the research”¹⁵² (p. 131). Throughout the data collection and analysis process, I worked to identify my own “issues” and presupposition through contemplation, written memos, and discussions with others, including my supervisors. These active efforts at self-awareness were intended to both avoid interference with the analysis due to unexamined presuppositions, and to consciously and cautiously use pre-existing knowledge and experiences to bring new insights into the interview and analysis processes.

From the start of the study, I also believed that not only would my findings be very much related to context of my study, but that I had a responsibility to use my research to try to “give voice” to the participants and to bring benefit to them, which is also very context-specific. Charmaz similarly proposed that “any analysis is contextually situated in time, place, culture and situation”¹⁵² (p. 131), This suggests that Charmaz would be likely to view case studies as being particularly appropriate contexts for grounded theory research. Both Charmaz and Strauss also stressed the social responsibility of grounded theory researchers, both to participants and to society at large^{164, 165}. Strauss wrote that “We who aim at grounded theories also believe (as do many other researchers) that we have obligations to the actors we have studied: obligations to “tell their stories” to them and to others – to give them voice – albeit in the context of their own inevitable interpretations ... We do have an obligation also toward “society”, at least to those social worlds toward which we have commitments”¹⁶⁵ (p. 174). My own context-specific approach and philosophy of social responsibility through research differed from Glaser, who proposed that “the goal of GT is conceptual theory abstract of time, place and people”¹⁵⁵ (p. 11).

Overall, among the grounded theory approaches, Charmaz’ theoretical underpinnings were closest to my own. Additionally, her approaches were attractive in allowing for a pragmatic approach where “grounded theory strategies can be used with sensitizing concepts from other perspectives”¹⁵⁶

(p. 256), and that “researchers can draw on the flexibility of grounded theory without transforming it into rigid prescriptions concerning data collection, analysis, theoretical leanings, and epistemological positions”¹⁵² (p. 178). There seemed to be no contradiction in adapting and modifying her methods and incorporating them into case study and mixed methods approaches.

3.1.4. Adaptation of grounded theory methods

It has been argued that rather than being a methodology, “grounded theory may be best understood as a method – a set of techniques or procedures designed to produce a certain kind of knowledge”¹⁶³ (p. 729), and it is mainly as a method that I have drawn on it. As stated above, my own approach to data gathering and data analysis drew heavily from the principles of grounded theory, though there were significant deviations. I particularly used Strauss and Corbin’s 1998 Basics of Qualitative Research text¹⁵¹, though Charmaz’s 2006 text, Constructing Grounded Theory¹⁵² became available as I was starting my analysis. I have found these texts to be useful and to some degree complementary, and have drawn from both of them.

The texts outline a number of major principles of Grounded Theory research including:

- Simultaneous data collection and analysis (from the first interviews)
- Theoretical sampling
- Use of constant comparative method
- Strategic use of coding procedures to approach the data
- Use of memos
- A process of analytic induction
- Development of theory grounded in the data

In this section I will discuss my own approach to data collection and analysis in general terms and compare it to the approaches suggested by these texts, pointing out areas of concordance and deviation. I will provide more details of how I adapted these methods to this particular study in the Section 3.2 of this chapter (see below).

Grounded theory studies generally use interviews for data collection, though other sources can be used. While I chose to use interviews, and was familiar with Strauss and Corbin’s Basics of

Qualitative Research¹⁵¹ and its detailed guidance on grounded theory analysis prior to entering the field, this book gave limited guidance on interview techniques. My own approaches to interviewing were similar to those described in Charmaz' Constructing Grounded Theory¹⁵², but this book was not published until my field work was nearly complete, and therefore reflected rather than guided my approach. According to Charmaz, intensive interviewing allows interviewers to go beneath the surface, explore a topic in detail, seek clarification, recheck for accuracy, return to earlier points, shift the topic, validate the participant's humanity, and express gratitude that they have participated¹⁵². Charmaz also outlined some of the limitations of research using interviews. While she presented interviewing as being particularly suited to exploratory research, where one of the objectives is to identify novel insights, she described how interviewing is limited by being a 'snapshot at a moment in time'¹⁶⁴ (p. 529), as well as a construction of experience rather than the experience itself¹⁵⁶ (p.258). Additionally, Charmaz reminded that "what people say may not be what they do"¹⁶⁴ (p. 529). Although as a researcher I faced these limitations, it should be mentioned that in this study, the collection of quantitative data about workplace location and educational attainment and progression over several years, as well as participant-observation and "gossip" heard during "corridor conversations" served as a limited cross-check between the words and actions of interview participants.

The analysis process in this study was influenced by a number of authors, including Strauss¹⁵¹, Charmaz¹⁵² and Denzin. Denzin¹⁶⁶ has outlined a six part approach to "interpretation" which includes:

- Framing the research question
- Deconstructing and analysing critically prior conceptions of the phenomenon (in this study through a process of personal reflexivity which is described above plus a review of the existing literature)
- Capturing the phenomenon, including locating and situating it in the natural world and obtaining multiple instances of it (in this case mainly through the interview process)
- Bracketing the phenomenon, or reducing it to its essential elements and cutting it loose from the natural world so that its essential structures and features may be uncovered (in this instance through the coding process)
- Constructing the phenomenon, or putting the phenomenon back together in terms of its essential parts, pieces and structures
- Contextualising the phenomenon, or relocating the phenomenon back in the natural world

Strauss also described a process of “shattering” and “reassembling” data¹⁵¹, as does Charmaz¹⁵². Overall, analysis in this study followed a process of dividing up the data and bringing it back together, and was influenced by these authors.

In grounded theory, early analysis is meant to guide the subsequent selection of interview participants, and further interviews are conducted with a view to refining the emerging categories and the developing theory. This is called “theoretical sampling”. My approach differed from this in that I selected interview participants according to educational attainment (such as Masters graduates, Diploma graduates, or current Masters students) working status (public sectors, private practice or migrant), with an aim to achieve a balance by race, gender and specialty, which is a more “demographic” (though not strictly statistically representational), or perhaps a “purposive” approach to sampling as compared to theoretical sampling to fill out emerging categories. Because the doctor subgroups were potentially quite different, I planned from the outset, especially after the initial “preliminary” field trip, for the interviews to be as similar as possible in structure to each other, and to cover the same topics. Although I reviewed and in some cases coded transcripts between trips, I was concerned that early analysis, especially of more senior doctors in the public service, could lead to early incorrect impressions and less openness to the issues brought up by younger doctors and those who had left the public sectors, who were generally interviewed later. Therefore, I was comfortable with and preferred the idea of leaving the bulk of the analysis until near the end and felt that in view of the relatively large numbers of interviews that I did (54), the risks of “premature closure” were greater than the risks of incomplete development of the categories and the emerging theory. This delay of the analysis until after most data was collected is also a significant deviation from grounded theory methods, where data collection and analysis are meant to be carried out simultaneously.

While I did not engage in detailed analysis of interview data from the outset, my overall approach to the data was through a “constant comparative method”, where comparisons were made between data, codes, and categories as a means of advancing conceptual understanding through grounding in the data¹⁵² (p. 179). Charmaz described the constant comparative method as “(a) comparing different people (such as their views, situations, actions, accounts and experiences), (b) comparing data from the same individuals with themselves at different points in time, (c) comparing incident with incident, (d) comparing data with category, and (e) comparing a category with other

categories”¹⁵⁶ (p. 259-260), and she proposed that the constant comparative method plus the engagement of the researcher are at the core of grounded theory (p. 178-179).

In grounded theory, the “constant comparative method” is approached through coding procedures, which are well described in texts^{151, 152}. Strauss proposed initial line-by-line and even microscopic coding to “open up the data”. This is a practical approach where only a few early interviews are available for coding, but for logistical reasons had to be modified when, as in my study, large numbers interviews were analysed together at the end. I approached coding through reading the initial interviews from the first field trip, developing a few dozen codes, and using them (with some later modifications) to divide up my interview data into manageable sections as a first step to analysis (see Section 3.2.4). Charmaz described a similar process of “focused coding” where the most significant or frequently used codes from earlier line-by-line coding are used to sift through large amounts of data in order to condense data and provide a handle on it (p. 57-59).

Once the data were coded into more manageable sections, I used two main approaches to further analysis, which are described in general terms here and in detail in Section 3.2.4 below. For some groups of codes (such as those related to professional satisfaction / dissatisfaction), I reviewed the interview data and created long lists of “sub-codes” in a process similar to Strauss’ “line by line” coding. These sub-codes were regrouped to create a number of major categories, similar to Strauss’ “axial coding”¹⁵¹ (see Appendix E). This led to a number of “models” of professional satisfaction which are presented in Chapter 4. While Charmaz also encouraged line by line coding, she questioned whether and to what extent the use of axial coding provided a more effective technique than careful comparisons (p. 62-62). For other groups of codes, I was guided by Charmaz’ techniques of comparing incident to incident (in particular for migration and other career decisions) (p. 53). This was facilitated in some instances by setting out summary data in table form, where “findings” were grouped by career and / or migration status¹⁶⁷ (see Appendix D). I also carried out some quantification of findings where I felt it was useful or appropriate. Whichever approach I used, I frequently returned to the data to check out impressions and emerging concepts. I also used memos, or reflective notes, to record my impressions as I analysed the data, as recommended by both Strauss¹⁵¹ and Charmaz¹⁵².

The overall goal of my research was to provide some benefit to my Fijian colleagues through not only giving them voice, but through a more complete understanding of them and their situation. One of my goals was an attempt at theory building, or at least the proposal of conceptual

frameworks, where theory would be derived from the data through a process of analytic induction (analysing data in order to “induce” or “come up with” theory), facilitated by a constant comparative method.

To summarise, in this study I have drawn from many aspects of grounded theory, including coding procedures, use of memos, grounding conclusions in the interview data through the constant comparative method, and attempting some degree of theory-building. I have, however, deviated in major ways, including, most importantly, leaving analysis until most interviews had been collected, and through sampling by “demographic categories” rather than “true” theoretical sampling carried out in order to advance developing theory. Barbour has criticised the approach of citing strict adherence to a well-accepted method such as grounded theory as an “approving bumper sticker” to claim academic respectability, rather than as a useful description of a strategy of analysis¹⁶⁸. While I have been strongly influenced by grounded theory methods, I cannot claim strict adherence to any particular method, and am not in a position to unequivocally claim that I have carried out a “grounded theory” study.

3.1.5. Quality indicators

As Barbour states, “in medical research the question is no longer whether qualitative methods are valuable but how rigour can be ensured or enhanced”⁸⁵. Frustratingly, quality indicators for rigour in qualitative research are not particularly well-established and differ between different authors and texts, with seemingly little uniformity, even in terminology. Unlike with quantitative research^{169, 170}, there are no widely-accepted quality “checklists” or procedures for critical appraisal of qualitative articles. The Lancet and the British Medical Journal, however, have published useful and comprehensive lists of quality indicators for qualitative articles aimed at doctors and other health workers (see Appendix G)^{171, 172}.

Table 3.1 provides a summary of quality indicators in qualitative research drawn from a number of sources^{152, 172-175}. These indicators centre around the issues of “reflexivity”, “validity” and “relevance”, and this section will briefly discuss how the current study addresses these issues, though more detail is available in Section 3.2 below.

Table 3.1. Summary table of quality indicators in qualitative research				
	Aspects		Major terms	Other terms
Researcher as an “instrument”	Theoretical & personal perspectives	Reflexivity ^a	Reflexivity ^a	
The study itself	Research question	Validity ^{a,b}	Internal Validity ^a	Credibility ^c
	Data collection		Descriptive validity ^c	
	Data Analysis			
	Quality of the write-up		Internal Validity ^a Interpretive Validity ^c	Resonance ^{c,d} Rhetoric ^d
Beyond the study itself	Description of the study context		Generalisability ^{b,e}	Transferability ^a Applicability ^d
	Positioning the study in the literature		External Validity ^a	Theoretical validity ^c
Within & beyond the study itself	Expanding knowledge	Relevance ^{a,b}	Relevance	Originality ^c Usefulness ^c
	Possible interventions			Empowerment ^d

^aMalterud (2001)¹⁷² ;^bMays & Pope (2000)¹⁷³ ;^cCharmaz 2006¹⁵² ;^dLincoln & Guba¹⁷⁴ ;^eMaxwell (2002)¹⁷⁵

One of the most problematic, though perhaps unavoidable aspects of qualitative research is that the researcher him or herself acts as an “instrument”. Previous beliefs and experiences may interfere with these “researcher as instrument” processes, however, especially when such issues are unexamined, such as may be the case for qualitative researchers who claim objectivity. Preferably, qualitative researchers will have reflected on their own leanings and declared them, taking care to separate their own “issues” from what they are discovering through the research process. The quality indicator that is promoted to take this into account is termed “reflexivity”¹⁷², or in other words, a reflective and disclosing process on the part of the researcher. As Malterud states, “Preconceptions are not the same as bias, unless the researcher fails to mention them ... however the investigator should take care not to confuse knowledge intuitively present in advance, embedded in preconceptions, with knowledge emerging from the inquiry of systematically obtained material. This situation can be avoided by declaration of beliefs before the start of the study”¹⁷². As discussed above, in this study, I do not claim objectivity, and have approached the issue of reflexivity through describing my background in Fiji and my relationship to the research

participants in Chapter 1 (Introduction), through declaring my own constructivist “leanings” (Section 3.1.3), through consciously and actively undertaking a reflective process (Sections 3.1.3 and 3.2.1), and through discussing the implications of my semi-insider status in Chapter 7 (Discussion).

A second quality issue, often called “validity” or “internal validity”, has to do with the quality of the study itself, in other words, how it is planned and carried out, as well as throughout the analysis process. Because “replicability” or “reliability” between different investigators is problematic in qualitative research, the criterion of “validity” has been described as being a more useful quality indicator in the planning, data collection and analysis stages. This study has approached validity in a number of ways, including the development of a clear research question^{172, 173}, and through clear descriptions of how the research was actually carried out (see Section 3.2).

The issue of the validity of the analysis process can be particularly puzzling to quantitative researchers, and as Belgrave states, “if our (qualitative) strategies for selecting research participants and collecting data are somewhat unfamiliar to quantitative reviewers, our means of analyzing data verge on the incomprehensible”¹⁷⁶. This is related to the fact that the analysis and its associated creative process goes on, to a great extent, within the researcher’s own head. As Barbour describes, “uncritical adoption of grounded theory can result in explanations tinged with ... “near mysticism” ... a sleight of hand produces a list of “themes”, and we are invited to take it on trust that theory somehow emerges from the data without being offered a step by step explanation of how theoretical insights have been built up”¹⁶⁸. In my own study I have sought to avoid this “analytical mysticism”, and have adopted a number of strategies from Yin, including triangulation (use of a number or approaches to data collection), “chains of evidence” (where the reasoning behind the findings and conclusions presented in the thesis can be traced back to the original data), and the creation of a “case study data base” to document these chains of evidence¹⁴⁶ (p. 97-105). An example of a major “link” in one chain of evidence in this study is documented in Appendix E, where the development of a satisfaction and dissatisfaction model from reassembled subcodes is presented. Validity was also addressed through the presentation of preliminary findings at the Fiji Medical Association Annual Conferences in 2005 and 2006, where opportunities for feedback were available (see Appendix H).

The issue of “relevance” in qualitative research is not dissimilar from quantitative research, where the publishability of a quantitative study relates not only to its adherence to quality indicators, but to

how useful and applicable the findings are. In my own case study, “relevance” has to do with the value of this study both to the health care system in Fiji, but also to the extent to which the study can be generalised (also known as “external validity”) to other settings. Specifically, I have approached the issue of generalisability through describing the setting in Fiji in detail in Chapter 1, and then through positioning this study in the world literature in Chapter 7. Another element of relevance is whether or not readers feel a subjective element of “resonance” that the study has some applicability to their own context, and overall “rings true”. It is hoped that this study will have “resonance” to readers outside of Fiji, but this remains to be seen.

3.2. Part two: Methods used in the study

This section describes the actual methods that were used to carry out this study. Because I did not choose one particular methodological approach and strictly follow it, a detailed description of what I actually did is presented here.

3.2.1 Preparation for fieldwork and the preliminary fieldwork trip

Research question and context

As stated above, this study focused on the reasons behind the career decisions of Fiji doctors undertaking local specialist training, especially in regards to migration and retention, as well as the phenomena of professional satisfaction and dissatisfaction as experienced by these doctors. The reasons behind choosing this group to study, as well as the reasons why the particular research questions were chosen, are presented in detail in Chapter 1. Details about the Fiji context in which the research was carried out are also presented in detail in Chapter 1, and previous research carried out in Fiji is presented in the literature review in Chapter 2.

Preparation before the first field trip

The preparation carried out during the planning phases of the study before I started data collection involved thinking through my own relationship to the study along with potential sources of bias (reflexivity), as well as deciding on a research approach. My relationship to the research participants and my “semi-insider” status are described in detail in Chapter 1. In addition to declaring this background, I have carried out an active process of examining my own views and experiences in regards to professional satisfaction, dissatisfaction and personal decisions to keep or change jobs. Where I have felt that my previous experiences could potentially bias the research process, especially during the interview and analysis stages, I have tried to consciously minimise bias through an active reflective process which has included identifying my own “issues”, and separating them from the issues of the Fiji doctors, using the techniques of contemplation, written memos and discussions with supervisors and other supportive colleagues.

In order to gain understanding of the “worlds” of these doctors, I chose to carry out in-depth interviews. While prolonged participant-observation as the main method of data collection was technically an option, it was impractical to spend the required amount of time in the field, and it could be argued that the three years that I had already spent at the Fiji School of Medicine as a “participant” gave me a reasonable understanding of the setting.

One of the limitation of using interviews as a study method is the skill of the interviewer. While my medical background gave me extensive experience in medical interviewing in the context of patient care, research interviewing presented different challenges, and my own preparation for fieldwork included attention to refining my own skills as an interviewer as well as giving considerable thought to how to obtain the most useful interview data. I decided to carry out semi-structured interviews, and to use an approach where certain topics would be covered in all interviews but where the overall structure would remain relatively loose, allowing for spontaneity. The original interview prompt was developed over a number of meetings with one of my supervisors, and represented my understanding at the time of the major elements impacting on professional satisfaction, dissatisfaction, and career decisions for this group of doctors. I was also “coached” in composing non-directive questions.

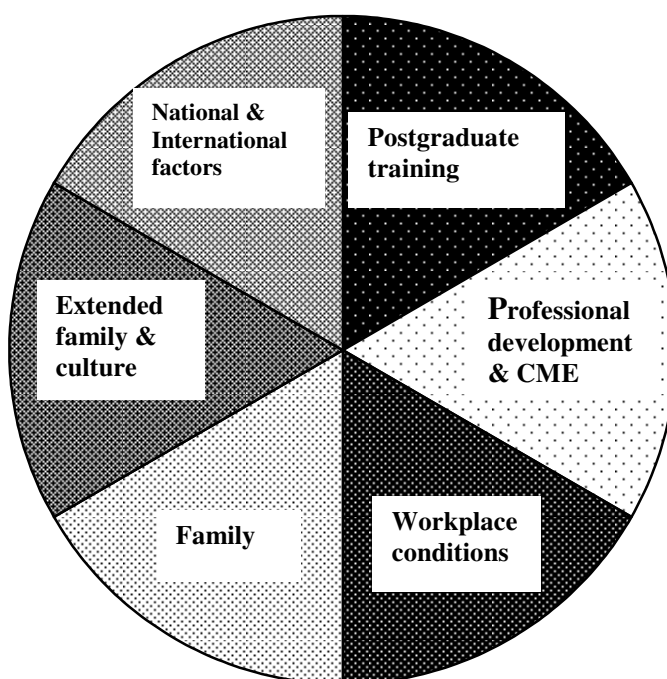
In addition to interviews, I also planned to carry out limited participant-observation, including informal interviews and corridor conversations (which were documented in field notes). As described below, a quantitative “arm” was added during the second interview trip with a dual purpose of identifying doctors to interview as well as defining the demographic characteristics,

overall educational attainment and working locations of the entire group of doctors who undertook specialist training in Fiji.

The preliminary field trip

The first field trip in April 2004 served as a “preliminary” trip. A key purpose of the trip was to enlist support for the study from senior specialists at FSMed, as well as to determine the most important issues to address, to improve my understanding of the situation, and to test and receive feedback on the interview prompt. A few early interviews were transcribed in the field and led to “refinements” in interview techniques (such as interrupting less) both during the first interview trip and in subsequent trips. After the first field trip, one of my supervisors reviewed and commented on the audiotapes and transcriptions, and this plus my own review of the early interviews led to a less directive and more balanced approach during subsequent interviews with a focus on “positive” well as “negative” issues. On the basis of these pilot interviews, the initial interview prompt was modified slightly (see Figure 3.1), and it was decided that in subsequent field trips, the focus would shift from what was happening with other doctors in general, to individual experiences and professional autobiographies.

Figure 3.1. Modified interview prompt used in main interviews: areas to cover



It should be mentioned that one focus group interview was carried out with three doctors, and thereafter it was decided to limit the study to individual interviews. This was both because of logistical difficulties of getting several busy doctors together at the same time, as well as because of the relatively “safe” and “careful” comments that were made in comparison to the “openness” in the individual interviews that had been carried out.

3.2.2. The main fieldwork trips

Definition of study population, quantitative data collection, and sampling approaches

The second, third and fourth field trip took place between September 2004 and September 2006 and included interviews at both the main teaching hospital in Suva (Colonial War Memorial Hospital - CWM) and the second major teaching hospital in Lautoka. Additionally, three trips within Australia to interview migrants were undertaken during this time.

Table 3.2. Number of interviews carried out (excluding regional doctors)					
	Fiji trip #1 4/04	Fiji trip #2 9-10/04	Fiji trip #3 8-9/05	Fiji trip #4 8-9/06	Australia 12/04 - 5/06
# of interviews (53 + focus gp)	13 + focus group	15	13	6	6

It was decided that the main “study population” to be interviewed would be defined as doctors who were permanent residents or citizens of Fiji and who had undertaken specialist training through FSMed between 1998 (1996 for anaesthesia) and 2004. Doctors were included if they had obtained at least a Diploma through FSMed (in other words had passed a Diploma exam after one year of specialist training), or who had undertaken at least some Masters coursework through FSMed if they held diploma qualifications from elsewhere (in the case of obstetrics and gynaecology (OBGYN) and paediatrics, where externally-run stand-alone diplomas had been offered locally in 1994 and 1996). A list of all doctors who met the study definition was compiled using FSMed enrollment records, an AUSAID report¹⁷⁷ and graduation programs. Students who had dropped out during the Diploma year or had not passed their exams were not included because the records available did not allow for the accurate identification of all such students. The specialist coordinators reviewed and corrected the list, and provided additional information on the country of origin, gender, race, years of enrollment, and current whereabouts. This information was updated

during and between each subsequent field trip. This information was used to document the demographics of the trainees and allowed for the identification of “sub-groups” of doctors according to race, gender, educational attainment, and working location. Additionally, the data guided “purposive sampling” during the interview process, and care was taken to interview representatives of the major sub-groups in a balanced though not a strictly statistically representative manner. The characteristics of the entire group as well as the characteristics of the doctors interviewed is presented below in Section 3.3.

While data was collected on both Fiji and regional trainees, including interviews of a number of regional doctors during the first two Fiji trips, it became apparent during these interviews that each Pacific nation had its own particular local issues, and that it would be very difficult to disguise the identities of regional interviewees due to the small numbers of doctors in countries outside of Fiji. Therefore, for logistical reasons and to ensure anonymity, a decision was made to focus on the situation in Fiji itself.

The main interviews

As compared to the “preliminary interviews”, for the main interviews, the focus shifted from the situation in general to the stories of the individual interview participants themselves. Interview participants were informed that the purpose of this study was to learn about their own professional satisfaction and dissatisfaction, as well as to explore the reasons why they remained in the public service in Fiji, or entered or considered entering private practice, or considered migration, or had migrated. The interviews for most Fiji trainees began with a description of their upbringings and the development of their careers, as well as their career plans over the next 5 to 10 years. These narratives usually included positive as well as negative aspects of their careers. The interviews were allowed to flow naturally into the areas of postgraduate training, continuing education, workplace conditions, family and cultural factors and national issues. The interview prompt that had been refined after the first field trip (see Figure 3.1) as well as a list of areas to “probe” was used as needed in order to make sure that all topics of interest were covered for each interview participant. The brief introduction by the interviewer as well as the biographical focus was meant to encourage participants to speak honestly about their own lives and careers, rather than to satisfy an agenda or “theory” of the researcher. An additional purpose of the “loose” design of the interviews was to allow opportunities for unexpected comments and insights to arise.

Table 3.3. Topics specifically “probed” for with all main interview participants if not covered spontaneously

Postgraduate training
Continuing medical education
Workplace conditions
The most satisfying aspects of their work
The least satisfying aspects of their work
Views about the career structure
Immediate (nuclear) family issues
Cultural issues and commitments
How they were affected by the coup
Salary and remuneration
Thoughts about migrating themselves
For those who had not migrated, why they had chosen not to migrate when others had
Race issues for Indo-Fijians
Gender issues for women

The decision to end the interview process was reached because of a combination of pragmatic and theoretical factors. Pragmatically, four trips had been carried out, and it was difficult to justify further trips for data collection due to limitations in both time and funding. From a methodological standpoint, Strauss and Corbin advocate starting analysis with the first interview, and continuing until the categories that emerge through the interview process are well developed and “saturated”, with minimal new insights coming out of subsequent interviews¹⁵¹. I deviated from this process and so cannot claim that saturation was reached in the way that it is defined in grounded theory. I did not start detailed analysis until I had completed three fieldtrips to Fiji as well as the migrant interviews in Australia, though I did review all transcripts between interview trips and carried out some preliminary coding. Just prior to the fourth field trip to Fiji in August / September 2006, I analysed the issues of professional satisfaction and dissatisfaction in preparation for a presentation at the Fiji Medical Association annual meeting (see Appendix H). At that time, I felt that the categories that had emerged were well-developed. I could have justified stopping interviewing at that point, but decided to continue because a number of specialist trainees who had undertaken placements in developed countries and had returned to Fiji temporarily or permanently were available to be interviewed. This is a group from whom I had little previous information for logistical reasons. These final interviews added little to the professional satisfaction model that had

been developed, suggesting that “saturation” had been reached already. On the other hand, these interviews provided new insights into career decision-making that were related in part to changing situation in Fiji over time. It became clear that the situation in Fiji in regards to career decisions would continue evolving, and therefore it was unlikely that there would either be a time when new insights stopped arising, or a time when these categories would become truly “saturated”. This made it justifiable to stop the interview process at an “unsaturated” point, given that the study could not continue indefinitely.

3.2.3. Data handling

All interviews were carried out in person and were audio-recorded. Six were transcribed verbatim by the researcher, and the rest professionally. The accuracy of the professional transcriptions was personally verified. Altogether, all sections of text were read at least 3 times, once during the transcription process, once during the coding process, and at least once during the analysis. Of the 54 Fiji interviews transcribed, two were of problematic audio quality, with some gaps limiting interpretation, and one was lost altogether and partially reconstructed within 2 hours of the interview.

Some passages that were chosen for inclusion in the written report were edited. While the original meanings were retained, changes were made to make the texts more grammatical or more concise, and some changes were made to conceal identities. Transcription practices for passages quoted in this study were as follows:

- Where words were added to clarify the meaning but were not actually spoken, they appear in brackets, such as [at this hospital] - where this clarifying information may have been mentioned several sentences earlier.
- Where words were inserted in order to further de-identify the data but were not actually spoken, they appear in brackets, such as using [my boss] to replace a proper name or [spouse] to replace “husband” in order to disguise the gender of the speaker.
- “Actions” appear in parentheses and italics, such as (*laughter*) or (*sigh*).
- Clarifications and explanations appear in parentheses, such as (Fijian doctor) or (in regards to racial issues)

- Where up to a few words were omitted, three “full-stops” were used, whereas six “full-stops” were used for longer gaps.
- Utterances such as um, ah, er, or repeated use of “you know” or using a word twice in a row were excluded without using full-stops to indicate that they had been removed.

3.2.4. Data Analysis

The overall approach to analysis was guided by both Strauss and Charmaz, who are within the grounded theory tradition. After the first field trip, the transcribed interviews were reviewed and provisionally coded, with a view to identifying up to a few dozen broad coding categories in order to sort the data for easier handling¹⁵². The transcribed interviews were then entered into the QSR N-6 software programme¹⁷⁸ and were coded using preliminary interview codes. These codes were adjusted slightly into “main interview codes” that were used with the second and subsequent rounds of interviews (see Appendix B), and the preliminary interviews were recoded using these “main interview codes”. Many passages were placed under more than one code. These codes derived from the interview data lent themselves to categorisation into three major topics, each of which is analysed in a separate chapter (see Appendix C).

1. Professional satisfaction and dissatisfaction (Chapter 4)
2. Migration / retention decisions (Chapter 5)
3. Biography and career development (Chapter 6)

Other codes (such as race, gender, generational issues, family life, culture, remuneration, and the coups) cut across several areas and are included in one or more of the above chapters.

The approach to the analysis of satisfaction / dissatisfaction codes was drawn from Strauss and Corbin’s descriptions of “open coding” and “axial coding”¹⁵¹, and took place through a process of subcoding and reassembly. Interview passages coded under the major topic of “satisfaction and dissatisfaction” (see Appendix C) were reviewed and long lists of sub-codes were created. The sub-codes were then grouped and regrouped until a small number of main categories emerged (see Appendix E for the full list of sub-codes and the main categories and subcategories that they were regrouped into). A similar process was carried out for the analysis of “migration of others” and is summarised in Appendix F.

The codes relating to personal migration decisions as well as to career development explored actions and decisions by individuals. While the analysis of professional satisfaction / dissatisfaction grouped all of the doctors together, the analysis of migration and career pathways was carried out by dividing the doctors into “subgroups” based on their working locations and educational attainment (see Table 3.4 and Appendix D). It was felt that participants who had made different career decisions or were in different stages of career development could have different insights, and that these might be obscured if all interviews were analysed together.

Table 3.4. Subgroups of interview participants (mutually exclusive for analysis purposes despite some doctors belonging to two categories) – see also Appendix D.	
Abbreviation	Description
Senior informants	Senior specialists not trained at FSMed
Masters graduates	Masters graduates working in the public sectors
Masters students	Masters students working in the public sectors
Temporarily overseas	Doctors who are or have been temporarily overseas for at least a year and who have returned or declared intentions to return
Diploma, in public sectors	Diploma graduates not undertaking further studies but still working in the public sectors
Private Fiji	Doctors in private practice
Permanent migrants	Permanent migrants

The interview transcripts coded under the major topics of career development and migration decisions (except for the code of “migration of others”) were divided up according to the subgroups of the interview participants. Cross-cutting codes (such as family, culture, race and gender) were sometimes analysed by subgroups and sometimes not (if the amount of coded text was limited). The “layout” for this subgroup analysis by codes or coding families is summarised in Appendix D. In the analysis process, the transcripts were reviewed, and key passages were highlighted. Annotations were made in a large margin, and summary points for each doctor were also listed. This allowed for some degree of quantification. In some instances, summary points were listed in table form in order to assist with the analysis. This approach was adapted from Charmaz¹⁵² and Miles¹⁶⁷.

The analysis process for both the professional satisfaction / dissatisfaction and career decisions was carried out using a constant comparative approach that linked emerging concepts and insights to the

data itself^{151, 152}. During the course of the analysis of the interview data, findings and insights arose, and were cross-checked against other interview data, and this process was repeated through successive levels of abstraction¹⁵² (p. 178). Additionally, the process was supported by the use of memos to record reflections and evolving reasoning¹⁵² (p. 72-95).

As a mainly qualitative interview study, this study analyses and summarises hundreds of pages of interview data, most of which cannot be made generally available due to both ethical and space considerations. As recommended by Yin and as described above, chains of evidence have been documented, and a case study database has been created¹⁴⁶. This allows for justification of the findings in this study through tracing reasoning from the arguments in the written report back to summary documents, and then to the original texts as they have been divided up and annotated and summarised as part of the analysis.

In this study, “reconstruction” can be done through the N-6 qualitative software files¹⁷⁸, as well as through “case study database - quantitative” and “case study database – qualitative” folders on my computer desktop (which is password-protected). The qualitative software files contain the full interview texts, coding, and derivation of new codes that were used in the analysis process. The qualitative folders on the computer desktop trace the analysis back to the original data, while the quantitative folders support the derivation of the quantitative data, which was analysed using Epi-Info¹⁷⁹. It should be mentioned that while nearly all items in the “case study data base” are de-identified, access to the full data base would require ethical approval.

3.2.5. Ethical considerations

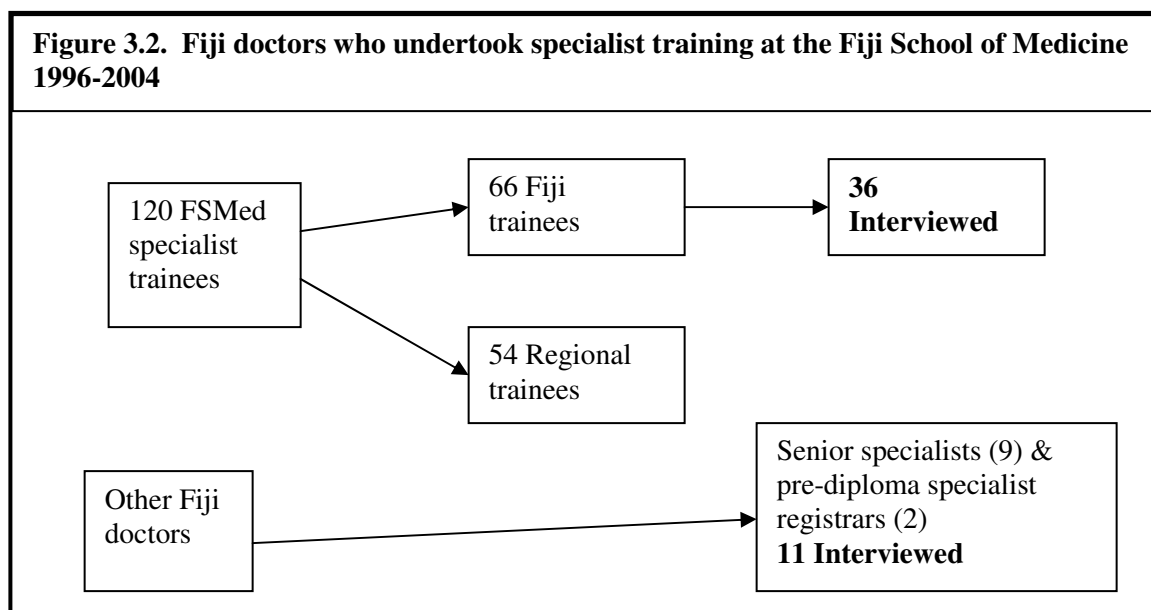
The main ethical concerns in this study were related to maintaining the confidentiality of the respondents. Fiji is a small country, with only a few hundred doctors. All of the study participants were “known” to senior doctors and other officials in the Ministry of Health (MOH), which plays a major role in placements, promotions and awarding scholarships for postgraduate training. Career pathways within the public sector depend on the MOH, and career options outside of the public sector are limited compared to countries like Australia. Even for doctors who have entered private practice or migrated, it is important from an ethical standpoint not to write anything that would preclude them from returning to Fiji or to employment in the public sectors.

For this reason, great care was taken to safeguard the data and to de-identify the quotations from the doctors who were interviewed, in some cases by making slight alterations to wordings (while preserving the overall meanings) in order to disguise gender, locations or race. For 38 out of 47 interview participants, quotes to be included in the thesis were reviewed and permission to use them was given either verbally or in writing. For the other 9 interview participants (some of whom were not able to be contacted), the quotes used were felt to be extremely unlikely to be linked to the speaker. Other precautions included removing names from interview transcripts, storing all data including electronic recordings in a password-protected computer, using password-protected back-ups especially in the field, and through not printing hard copies of the interview transcripts.

This study received ethical clearances from James Cook University as well as from the Fiji National Research Ethics Review Committee. As a condition of the Fijian committee, a local psychiatrist was nominated who agreed to be available to see any doctors who became distressed by the interview process.

3.3. Part three: Characteristics of interview participants

Forty-seven Fiji specialists or specialist trainees were interviewed between April 2004 and September 2006, including 36 of 66 who had trained through FSMed between 1996 and 2004, nine senior consultants who had trained overseas, and two specialist registrars who were thinking about enrolling in an FSMed Diploma. While most (34) doctors were interviewed in Suva, 7 were interviewed in Lautoka, the second major hospital in Fiji, and six were interviewed in Australia. For the 53 individual interviews carried out, 42 doctors were interviewed once, 4 were interviewed twice and one was interviewed three times. The repeated interviews were generally carried out with doctors who were in a process of career transition.



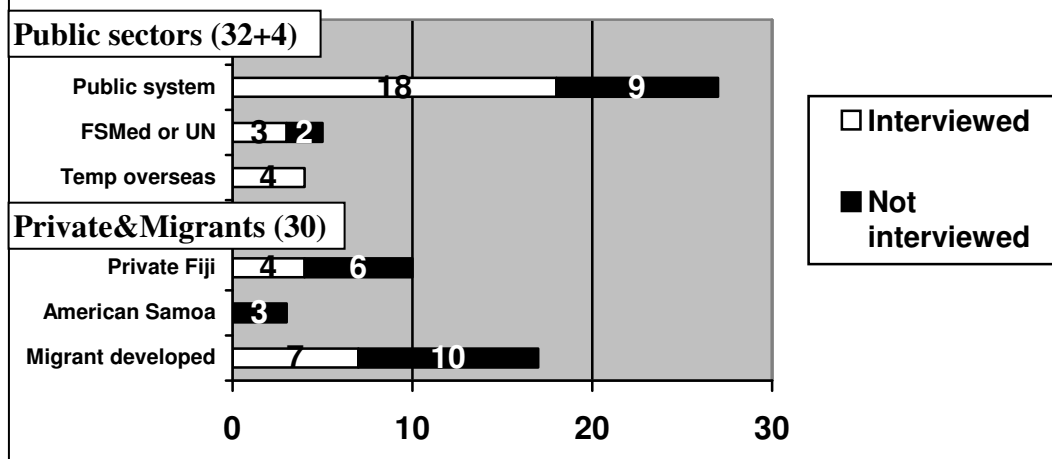
Sampling was carried out on a “purposive” basis in order to represent all doctor subgroups, as described above. All groups of trainees were well-represented, with the exception of doctors who had moved to American Samoa on a long-term basis, none of whom were interviewed. Active efforts were made to “balance” interview participants on the basis of race, gender, educational attainment, and working location (see Table 3.5). Proportionally, there was some under-representation of doctors who had only obtained a Diploma or who were believed to be permanent migrants (these doctors were more likely to be in scattered locations throughout Fiji or overseas).

One of the major concerns in Fiji was the loss from the public sectors of doctors who had undertaken specialist training. The term “public sectors” includes working in the “public system” (for the Fiji Public Service Commission in a public healthcare facility, usually a hospital), or for FSMed, or for the United Nations, all of which are considered to be “preferred” outcomes, given that these sectors serve all potential patients in Fiji regardless of income, and also given shortages of all doctors, including specialists, especially in the government sector. Of the 66 specialist trainees, 32 were in the public sectors (including 27 in the public system), 30 had left the public sectors to enter private practice or to migrate, and 4 had stated that they were temporarily overseas (see Figure 3.3). Six were interviewed in Australia.

Table 3.5. Characteristics of Fiji School of Medicine specialist trainees 1997 – 2004 (Fiji doctors only, excluding regional trainees)			
	All Fiji Specialist Trainees	Trainees Interviewed	% interviewed
Total	66 ^a	36	54.5%
Gender			
Males	39	22	56.4%
Females	27	14	51.9%
Race			
Fijian	41	23	56.1%
Indian	20	10	50.0%
Other	5	3	60.0%
Specialty			
Anaesthesia	11	6	54.5%
Medicine	12	8	66.7%
Obstetrics and Gynaecology	14	6	42.9%
Paediatrics	18	9	50.0%
Surgery	11	7	63.6%
Highest educational attainment (9/06)			
Diploma	42	14	33.3%
Masters or MMed student	24	22	91.7%

The quantitative data shown here is presented in order to define the characteristics of the doctors that were interviewed and to give some indication about the representativeness of the sampling that was carried out. In the next three chapters, the focus will turn to the analysis of the qualitative interview data, though the quantitative data presented briefly here will be reviewed and expanded in order to provide additional information on context in order to support the interpretation of the interview data.

Figure 3.3. Work situations of doctors undertaking specialist training at FSMed 1996 - 2004 (as of 9/06)



Chapter 4. Results Part One: Professional Satisfaction and Dissatisfaction

The results from this study are presented over three chapters. The current chapter, which is the first results chapter, looks at the concepts of professional satisfaction and dissatisfaction for these doctors. The analysis of these concepts is presented first because they had a major impact on the career decisions that these doctors ended up making. In this way, the current chapter sets the stage for the following two chapters that focus on events and decision-making in individual lives. The second results chapter (Chapter 5) looks at the special issue of migration decisions, as well as decisions to remain in the public sectors or enter into private practice. This particular aspect of career decision making is of particular interest to the health system in Fiji, so it is presented as a separate chapter. The third results chapter (Chapter 6) looks at career decisions overall, and also provides some insight into how these doctors felt about their postgraduate training, the career pathways available to them, as well as how their careers were affected by issues of race and gender. The focus on career pathways in this chapter provides additional insight into how difficulties at different career stages affected decision making, including decisions to exit or remain in the public system.

In this chapter and in the next two chapters, the interviews of all 47 Fiji doctors are analysed, including doctors who had undertaken specialty training at the Fiji School of Medicine (FSMed) (36) or were considering such training (2) as well as senior specialists who had trained elsewhere (9). The analyses included both preliminary interviews of mostly senior doctors that focused on the “situation” in general, and the main interviews that focused on the lives of the individual interview participants.

The first major aspect of professional life that was analyzed in this study was these doctors’ views about professional satisfaction and dissatisfaction, both in general terms and in terms of events in their own lives and careers. The approach to the interview texts discussing these concepts took place through procedures related to “open coding” and “axial coding” described by Strauss and Corbin¹⁵¹. The details of how coding and analysis actually took place in this study are described in detail in Chapter 3.

This chapter begins with a description of the major aspects of professional satisfaction and dissatisfaction that emerged from the analysis, illustrated through quotations from the interviews

themselves. The interview data is then reflected upon and models of professional satisfaction and dissatisfaction are proposed based on these data.

4.1. The components of professional satisfaction and dissatisfaction

4.1.1. Professional growth

Interview participants, in the course of talking about their lives and careers, spontaneously mentioned many aspects of job satisfaction and dissatisfaction. Additionally, doctors were specifically asked about the most satisfying as well as the least satisfying aspects of public hospital work in Fiji, even if they had resigned.

Many interview participants spoke of their desire for professional growth. In the interviews, the desire for professional development was expressed as a continuum, present throughout doctors' careers, and continuing to be expressed even (and perhaps especially) after formal training had been completed. Having opportunities for professional development was described as a source of great satisfaction. On the other hand, many doctors mentioned barriers to achieving professional development that were sometimes viewed as an inherent part of the health system and could become a source of considerable frustration.

All doctors were asked to discuss their feelings about the FSMed postgraduate programs, both positive and negative, and postgraduate training is explored in greater depth in Chapter 6. Doctors often expressed satisfaction at having the opportunity, since 1998, of being allowed to undertake formal specialist training, and were pleased at the professional growth that it facilitated, but some expressed a conviction that this growth was not recognised at the level of the Ministry of Health (MOH).

Well as I said I'm generally very appreciative that they have started the postgraduate program...for me it has broadened my horizons. It allowed me to see more ... to look for more issues than that which I was concentrating on. And once the realisation came about it allowed me therefore to gain more satisfaction from my work, because I knew for every problem there was a solution.

The depth of internal medicine that you go onto, I mean you couldn't get that anywhere else ... and that is so attractive, the fact that you feel so secure in the ... knowledge that you can fall back on ... but the main issue here is [the] Ministry actually recognising that you've gone through, my guess is that they're really quite ignorant of what we are actually doing ...

The supervision that we got from overseas ... trainers who came in and lecturers – it was good – but then when they left we were always ... stuck with no one having to supervise us, and then we had local supervision which was not up to the par of postgraduate supervision that we would require.

...sometimes you ...are made to feel guilty that you were training ... a few times I had to miss classes because as a registrar ... I had those responsibilities on my head, and sometimes it was ... contradicted [by] my supervisors from the school because they saw it as a ... lack of ... appreciation of their supervision. But in fact it wasn't - it was because of my responsibility as a civil servant and a registrar. It was very difficult and I guess a lot of people had bent under that.

While formal training was viewed as being important, doctors at all career stages also valued a working atmosphere that facilitated learning. The main teaching hospital, Colonial War Memorial (CWM) Hospital in the capital Suva was viewed by many as a rich learning environment due to the wide variety of patients and conditions that were treated there. Doctors mentioned valuing the intellectual stimulation of interactions with their colleagues, especially when they discussed particularly interesting or challenging cases. Individual support from mentors and teachers was also valued, and being mentored was described as a very satisfying aspect of professional growth that was missed when it wasn't there. Mentoring and good supervision were also viewed as practical manifestations of being valued by senior colleagues.

I've got this much experience, I know this much because of this place, if it wasn't this place, I wouldn't have known all of those...this place is also very important to me...don't take me wrong that I'm all frustrated, no, this place can be really good.

I left CWM with a lot of regrets ... it's a goldmine for learning...

I miss that ... [we] would just walk in and say 'hey there's a case' and ... everybody would sit down and go over it and I miss ... the biggest part is the academic programs, the ongoing learning.

There was one I particularly liked ... and I particularly liked going with him because he really taught me the best that I've ever come across. Unfortunately ... during the coup he had to leave., and after...I could not find really find someone I could attach myself to ... Somehow [after that] my interest sort of was not there because I was not getting taught well...I found that what was lacking was a mentor or someone to guide you along.

In Fiji, formal specialist training takes place over four years, with a Diploma being awarded after satisfactory completion of the first year, and a Masters after completion of an additional 3 years. The Masters degree usually makes doctors eligible for specialist registration following a further 2 years of satisfactory clinical work. Most doctors who completed training to the Masters level related how they felt that their training had made them better doctors, and they enjoyed the recognition of their accomplishments by others.

I've got a Masters degree. I've got a certain standard and work ethic that I've learnt for the past few years and I'm gonna go there and do it ... and it's not because I need to prove myself to anybody... I'm going to do it because that's what I've learnt.

... finally [Doctor #] treats me like a colleague. You know, I think [there has been] a change of attitude of the mentor's around us ... I think the other thing is that the locals, the junior registrars ... they really look up to you when you have a Masters. Even though ... the policymakers may not ... share the same sentiments."

Specialist trainees and graduates were often (but not always) given the opportunity to move into senior roles that extended beyond basic patient care, and these could prove to be a source of great satisfaction. These doctors saw many challenges in their working environments, and welcomed the opportunities to address and overcome these problems. Focusing on patient care itself, these specialists described working on expanding their own knowledge and clinical skills, and introducing new services and procedures, some of which they had learned in overseas attachments. Some focused on improving the quality of patient care in their departments through audits and through working for positive changes in the delivery of care. Some moved into roles beyond

patient care itself, such as contributing to the running of a good department and promoting morale. Some doctors particularly enjoyed teaching and mentoring, while others focused on wider public health issues related to their discipline, or on community empowerment.

I managed to go to [overseas] ... doing ultrasound, and that was very, very helpful. So it's helping us now in terms of prenatal diagnosis and stuff. We can't do the full prenatal screening ... like I said, it's cost factors again, so it's just with what we have with ultrasound, it's doing heaps for us.

Actually, I quite enjoy working with medical students. I always have quite a few ... on the rounds ... unless and until I'm trying to teach somebody or something, I don't know how much I really don't know about a subject.

I'm trying to mentor my students. I had the privilege of having just one or two people take an interest in me over the years and those one or two people make such a difference. And there's not a whole lot of that that goes on.

What I have done is ... getting the team together in the last two years, our department has ... not had a good record in terms of our service provision to the other specialties, and it came from a lot of staff morale [problems], and to do this I had to really get the team together, start to develop good attitudes, also [a] good perception of themselves internally as a team ... and once we did that ... our department started to get better and improve.

To me these are the kind of things that give me satisfaction. The fact that I can direct my mind and look at ... the macro picture every now and then. But what that allows me to do, though, is to spread my wings a bit further and look laterally and appreciate what's happening around me ... That's one of the nice things that I find about working here ... it just gives me a more global view of what's happening ...

I do radio talk shows also ... trying to promote reproductive health.

While some doctors were able to move into senior roles in a timely manner after Masters training, this was not true for everyone. Doctors mentioned a lack of certainty about the value to the health system of their Masters qualification, to the point of believing that their Masters was seen as a

“lesser” qualification compared to overseas specialists qualifications. As one graduate stated, “... our Masters is being [seen as] just an infant Masters compared to a Masters from India or somewhere else.” There was even less certainty about the worth of a Diploma, apart from being a required first year of Masters training.

As mentioned above, entering into higher-level roles was described as a source of professional satisfaction, and promotion to senior postings was seen as a major step towards being allowed to move into these roles. As one Masters graduate who continued working at a junior level related, “... you know when you want to make changes but ... you have to be in that position to make changes, not working as a registrar”. The promotions process itself was viewed as being problematic. In some instances, the number of senior posts were said to have remained static for many years despite increases in patient numbers and the complexity of services. Some doctors, despite having specialist qualifications, described being held at junior postings for many years due to “bottlenecks” from older doctors and expatriates filling the few available senior postings. Even when senior posts had been established, the promotions process was described as taking place slowly, with many unfilled vacancies and long, sometimes seemingly inexplicable delays in filling them. Doctors also mentioned instances of witnessing promotions made on the basis of seniority rather than on merit. When these blockages to promotions occurred, some graduates were limited to continuing in junior roles. Other doctors were given senior roles without senior postings, which represented only a partial solution and has led in some instances to frustration and resentment. Other doctors were appointed to “acting” senior posts, but found this to be an insecure situation. At least one interview participant told about being replaced by an expatriate doctor after acting in a consultant post for a number of months. Overall, the lack of clarity about the meaning of local specialist qualifications, as well as the lack of certainty about career paths, were major sources of dissatisfaction, and it was felt that this should be addressed by the MOH.

The career structure ... it's quite variable ... which is what is dictated by the Ministry ... there has been ... unfair promotions and stuff like that ...

...there just isn't any career path for ... paediatricians, we tried [and] we collected all the statistics and ... wrote papers and all that but it's a mindset of the Ministry. I think they're not ... equating all the work and the work flow, if we look [at] the workload ... we run two intensive care units. So there's that discrepancy ... the posts and things were done such a long time ago there's never been a review ...

...yes, the lack of recognition, that's the main thing ... we feel so limited ... we've graduated but then there's only like four posts and that's it, you basically just function at the level you were at even when you studied and you just continue to function in that post until somebody actually leaves the system.

It is quite distressing still because ... I'm a medical officer, but when I look at what I'm doing I'm doing a job description of a chief medical officer, yes, so I felt that ... the system is not really fair on that.

When I came, [I had to] ... run the department ... I hadn't had my specialist registration [at that] time and last year that was not the most important thing, the most important thing was you learn how to ... lead. So [the specialist registration] was delayed and because it was delayed the ministry hired a [specialist from overseas] to come in. At the moment I'm acting consultant. When [the consultant] left ... now [I'm] back in the acting position. But when she was here I was back to my principal position.

... one reason why I actually left the system, because I knew I was getting nowhere ... I felt ... I had the sense of getting nowhere and I felt six, eight years down the line and I'm still gonna be just a registrar.

While professional satisfaction had a great deal to do with being able to move into expanded professional roles, many doctors reported great satisfaction in the intellectual stimulation of the clinical work itself quite apart from the aspects of a job well done. On the other hand, a number of doctors expressed frustrations with the clinical setup, and felt that they could not use the full extent of their training in Fiji.

Now working here ... I don't think I'd ever be able to leave, I like how we practice medicine here, I didn't like the way they practiced it [overseas], I think it's too specialised – if you're doing cardiology you can never touch somebody who has a stroke ... the little bits and pieces of something instead of a whole person ... here we do everything ... to manage the person as a whole. I think our way of looking after patients is much better.

Yeah, sort of like just coming back to the clinical work was equally good because ... theory's one side and then when you get thrown back into the clinical you have to marry the two, so that's ... what I love doing right now.

...our practice...I can go right down to the nitty gritty but there is only a limit to how much ... I can implement and carry forward, otherwise ... [clinically] I have to repeat the same thing over and over again. I can't go into any depth about it because Fiji does not have the resources.

To summarise, opportunities for professional development were a source of professional satisfaction, and this continued even after specialist training had been completed. Professional development included, in addition to formal continuing medical education, being able to move into roles that had an impact beyond immediate patient care, and this was usually facilitated through being awarded a senior posting. Uncertainties about the value of a local specialist qualification and about career progression were significant sources of dissatisfaction.

Overall, though professional growth was satisfying in itself, there was much overlap with the “service” aspects of work, which could be carried out better as doctors grew in their skills and capacities, and especially if they were recognised through promotion. Finally, being given access to opportunities for professional growth helped doctors to feel that they were “valued” by the health system.

4.1.2. Service and patient care

A second important factor that doctors mentioned as a source of professional satisfaction was the undertaking of a service role, centred around patient care. Many spoke of the rewarding nature of striving to provide the best care that they could for their patients, even in a setting of limited resources, and they described a willingness to work long hours and make sacrifices for the sake of their patients.

The satisfaction of treating very sick patients and seeing them recover was mentioned frequently as a source of satisfaction. Doctors working in the public hospitals in Fiji found satisfaction in knowing that in a difficult working situation, their presence made a difference. Some particularly

mentioned obtaining satisfaction from serving their own people, and from treating patients regardless of their ability to pay. Some doctors mentioned particular pride in being a part of the clinical work that was being done in their hospital.

... [with] intensive care patients ... it was really nice the way they used to come in sick and you see them going out of hospital.

I believe you can do a lot more in Fiji ... if I go and work in Australia, they really don't need me, they have so many good people out there that can look after their children, but if I leave here then a lot of people here would miss out on my services ... I suppose I'm needed, and that's why, I think it made me want to stay here.

I'm satisfied working in the hospital and I enjoy [it] just because most of these women are mothers ... they're not from a good socioeconomic background, so just the satisfaction of being able to help them and ... make a correct diagnosis for some things that some other people had missed, makes me happy during that day, and just the completion of the work.

...most of the women that we have, you know, just speaking the local language itself ... So just trying to go through that thing in Fijian in a way that we can explain in 100 sentences compared to one or two English words, just to try and get them to understand them is, I think it's been one of the few conquering things that I love Yeah, just to get that message across to them.

We see 200,000 people a year go through that hospital. Maybe 25,000 admissions. And the satisfying thing is that there's a lot of good work done. Lot's of frustrations in between time. But bloody hell there's a lot of good work. The odd person dies ... but we've still got 6000 new deliveries ... A lot of people do work hard across the way. A lot of people have put the problems of administration behind them.

These doctors viewed the services they provided as being of value, and expected that the MOH would provide them with the structure and resources they needed to look after their patients properly. Nevertheless, most doctors mentioned difficult working conditions, and found it frustrating when they felt that they were not adequately supported by their health system, with some even mentioning that they felt that conditions were getting worse. Essential medications were

described as frequently being out of stock, and essential supplies were not available or needed to be hunted for in many wards, leading to an inefficient working environment. These shortages and “stock-outs” were mentioned as interfering with the ability of doctors to provide an acceptable level of care to their patients. Doctors in the private sector mentioned relief at not having to deal with these limitations and shortages.

... we have all these administrators, but no one with the mandate to make a decision ... [it's] hell on earth, hell on earth ... For the last month or so, we've only had two sizes of gloves to operate on, 6-1/2 or 8-1/2. We have no gowns to operate with. Why? Because there's been no money to buy the diesel to run the motors to sterilise the gowns, to run the steam to sterilize our equipment. So the frustration is the administration and their failure to respond to the needs.

The co-operation that you get [at Suva Private Hospital], the team spirit that you have and then the availability of the resources that you need for any particular patient can be obtained in a short time, and people, they listen ... not just brushing aside your ideas, that people understand ... that we, you have a job to do... and whenever you need something it has to be provided because ... that's what you require for your job and that's the thing that ... I find quite satisfying ...

Staffing shortages were particularly discouraging, exacerbated by ongoing resignations of doctors and nurses. Senior doctors expressed discouragement over heavy workloads due to losses of experienced trainees and subsequent reliance on junior staff. This was exacerbated by the frustration of spending time training doctors and nurses and then having them leave. It was particularly frustrating to many doctors that little seemed to be done to address the problems of resignations of doctors and nurses. As discussed above, even where posts had been established and there were qualified doctors who could fill the posts, they remained unfilled, sometimes inexplicably, for long periods of time, further increasing the workload of those on the ground.

The frustration basically is across the whole of the medical services. And you know what the frustration is all about, the shortage of doctors, the shortage of nurses, the shortage of what we work with every day and the continuous resignation of the nurses.

The other thing is, you know, the staff turnover. We've had, for us now, all our registrars, all our local registrars have only had a maximum of 18 months [specialty] background. So it means that ... for the three of us doing consultant call, also we've got to be extra vigilant all the time, check up things. And not just the doctors, its the nurses that leave as well ... it's quite frustrating because you teach them skills and then they get really good at it and then they leave.

I know a lot of things have been written about the frustrations and deficiencies, in that service in this country now is almost, more than 50% or close to 50% of expatriate doctors. That doesn't mean that we don't have the doctors, that we don't have the qualified doctors in this country. It's been an issue for years of people leaving and no one seemed to take notice about it ... I think our health centre is getting crippled.

I mean see our unit here, we have a post for ten registrars ... at the moment we only have four registrars ... post holders ... people ask and we ask and request for people to come in and there is always all sorts of excuses coming up ... I have been fighting [for eight months] ...

These staff shortages led to fatigue due to long hours, overwork, and understaffing. Some doctors, including older doctors, experienced health problems related to overwork. Younger doctors in particular related interference of their work with family life.

... I feel that there's a balance to the amount of stress you have and what is a positive stress that makes you move forward and what is a negative stress is that when you do not perform to your capability. And I feel that the negative stress is more here, especially over the last year or so ... the workload, the patient admission rate is the same, or even more ... but the number of people doing the work is less, I mean it's, it's double the load from what was in 2002.

There were times when I was really stressed out. There were times where it really showed up physically and I started to develop, you know, very prone to getting infections, abscesses – ah that's the worst part of it, I think so, and that really showed how much I was stressed out.

... people were leaving and [for] whoever was left behind ... the load was not going to shrink. It was still the same so you found going home you were more tired, not speaking to the kids right, you're sort of you know, explosive almost, do this, get a rap on the ear and things like that. And I said, 'This is not how we're going to bring up our kids.' And so by then I had already decided, we won't be staying until retirement in the public system.

Some doctors mentioned discouragement about falling standards, and a lack of focus on quality in patient care, and some attributed these factors, at least in part, to low staffing levels. As one doctor stated, "We need to audit our work, we need to see what is really getting done and what is not really getting done you know, and I think that priority [is not] patient care ... they were not looking at the suboptimal patient care that, people were dying with infection ... the priority I think was wrong.

Many of the doctors directed their frustrations at the hospital administration and at the MOH, as they felt that not only were many of the problems avoidable, but that administration at all levels was unresponsive to complaints or even unaware of the problems that existed. Clinicians felt that they were not supported in their patient care roles by head office. Approaching the Ministry in order to make even small changes was seen as being very difficult.

And that's what irritates me, then the Ministry officials are saying there's no problem. In their ivory tower they say there's no problem and they keep denying things. I don't know which land, which planet they're from.

... I think the biggest frustration is ... the total lack of answerability by the managers. No one's responsible. OK, so if we have problem X ... the administrators really don't know who to turn to. It's the manager's problem, it's the general manager's problem, it's corporate services', or the clinical director's problem. But we've got new computers!

... when you're on the ground you know what we need to do ... But you don't seem to get the necessary action from those above you. Even if they do not wish to take action at least it should be transparent as to why ... you know why in the big balance of the universe, why this one cannot be prioritised as high as this one. But no it doesn't happen.

While the working environment in the public hospital was difficult, many doctors described a powerful "ethic" of service which they felt kept them going. This is described in greater detail in

Chapter 5. Interestingly, although interview participants were not specifically asked about their religious beliefs, a number of doctors spontaneously mentioned a centering of their working lives around their religious convictions. These beliefs were described as sustaining them in difficult times.

I think that this idea of a higher purpose really has stemmed from the point that I feel that the kind of work we do requires such long hours to work under conditions that are not ideal, and for me I felt a long time ago that in order to sustain myself under these conditions I needed to feel that I was doing something that is truly useful to God. (a Christian doctor)

To me, you know, doing something for my God is more important than doing for myself. My interests come second, society's interests come first. And I think with that thing in mind, I don't see any problem, you know, the problems are there but I don't see them as problems, I see all of them as challenges to me. Because, you know, it's my duty. I see everything as my duty, you know? That somebody has to do it and why not me? (a Hindu doctor).

Overall, many satisfying aspects of working in the public sector in Fiji were mentioned. There were also many frustrations that were attributed not just to the relative poverty of Fiji, but to failure to manage the health system as the doctors felt it should be managed. Nevertheless, it is important to note that while many doctors who started specialist training left the public system, many remained, and through their frustrations continued to find satisfaction in their work.

4.1.3. Recognition and being valued

A third factor that doctors frequently mentioned as a source of professional satisfaction was being recognised and valued in their roles as doctors. This included being appreciated by patients, by one's peers, by one's clinical departments and department heads, and by the health system in general. On the other hand, doctors were dissatisfied when they became convinced that they were not valued, and this lack of being valued was usually described as taking place at a hospital level or higher.

On a day-to-day working level, appreciation by patients, positive interactions with colleagues, and good leadership within a well-run department were mentioned as sources of satisfaction. Doctors

described how the appreciation of their patients kept them going through frustrating times. Others spoke warmly of the sense of camaraderie that they experienced with their closest colleagues.

I do get pleasure out of treating these poor people also ... even when I do clinics they seem very happy, and they come and thank me that they are so happy and maybe, I don't know, that's ... only keeps me going.

... the comradeship ... that unity, that gang thing ... I see there was such depth in our relationship out there, because [there was] a lot of respect.

A few doctors, however, expressed frustrations that some doctors were not pulling their weight, and others complained of the apathy of their colleagues.

I wish every person was ... hard working and committed, every single person ... but I just see that ... some of my colleagues need to be kicked in the butt ... to get them into shape because if everyone did their part it would help in whole picture.

I think basically what it comes down to really is we are not in a real culture of caring or showing a sustained high level of concern for anything. I think our culture has ... well it's not the fault of the people who work in the unit, I think what has happened is over the years, people have shown concern for something, but that concern is not shared by others ... once you have pushed your concern through you end up carrying your concern right up until the very end ... and that is frustrating ...

While interactions with colleagues at the same level of seniority were important elements of professional satisfaction, departmental leadership was also mentioned as being very important. Some doctors praised their leaders, but others expressed discouragement, feeling that they were not supported by their departmental heads.

... I like my boss ... yeah I think a lot of people complain about him but I like him because he knows when to sort of kick our butt ... and he can be generous at times and I think that's one of the other reasons I stayed on because he's a good person to work under and I like the people that I work with so that kind of helps ...

... those in leadership and those looking out for you don't seem to come around us at the time where you really need them ... sometimes it can be demeaning as well and especially when you are trying to achieve something. You want someone backing you up most of the way ... but the bottom line was that it was very difficult to actually get a consistent backing, and that environment created for you to actually improve, and also to support your training. And that was the most difficult thing.

Overall, the doctors interviewed felt valued by their patients and colleagues, and often (but not invariably) within their departments, and they experienced this as being very satisfying. On the other hand, most doctors felt that they were not valued or appreciated by administrators at senior levels of the health system, particularly at the level of hospital administration or the MOH. As mentioned above, doctors mentioned not being supported in their clinical roles or in their professional development. A number of doctors mentioned how they did not feel valued as members of a profession. Practical physical needs, in particular the need for affordable housing, was described as not being supported. A few mentioned a lack of consideration of themselves as individuals, and described times when they had encountered difficult personal circumstances and were not treated with compassion by the MOH. This particular point is discussed in detail in Chapter 5. Some doctors expressed that the particular working situations of doctors, such as their unusually long training, the 24-hour nature of medical care, and the long working hours of most doctors, were not taken into consideration in public service-based conditions of employment.

There is this lack of commitment to our employees from [the] Ministry of Health and that is demotivating so there's no real interest in us pursuing professional development further.

There's no incentive given to work in terms of your ... family being looked after and cared for in their needs like housing and, you know, loans and all that ... our graduates still have to fend for themselves and look after their families. There's no support from the Ministry or from the health sector in the family support and family welfare.

I think not only monetary but just time and condition of service ... I think the ... public service treat[s] everybody the same, but everybody doesn't work the same hours, all work different hours, different time[s] of the day, so they should be different also in the treatment of those people.

... I felt like ... I compared myself like the... in a supermarket, those cashiers, they all take the packet of milk and, and type it on and next, next, next kind of issue. And ... we're treated like you were not an intellect but someone there to just do the job of looking after people ... so you did not feel valued.

Overall, doctors experienced considerable satisfaction through being valued, and while they generally felt that their closest colleagues and their patients appreciated them, many felt that at the level of the health system, the value of their professional roles was hardly recognised at all.

4.2. A model of professional satisfaction and dissatisfaction for specialists in Fiji

As mentioned above, the interviews of these doctors revealed a few central categories of professional satisfaction, which included opportunities for professional development, service through patient care, and an awareness of being valued. Individual aspects of dissatisfaction were more numerous, but also fit into these central categories, but as opposites, being manifestations of the absence of satisfying elements, or even as actual barriers to the realisation of satisfaction. These three main categories of professional satisfaction were not discreet, but overlapped considerably.

While the categories of professional development and of service proved to be conceptually straightforward, the issue of recognition was rather more complex. As described above, the issue of recognition encompassed being appreciated and valued, and extended to relationships and interactions with patients, colleagues, supervisors, and up to officials and other employees within the MOH itself. In the original professional satisfaction model presented at the Fiji Medical Association annual meeting in 2006, the title for this “recognition” category was tentatively set as “interpersonal”, but after further analysis and reflection it became clear that being recognised involved more than just interactions at an interpersonal level. Being valued (recognition) could also be experienced in a practical, “enabling” sense through one’s professional development and service roles being supported by a well-run health system, quite apart from the support of any individual doctor. Within a health system, lack of enabling support either at an interpersonal or a structural level could be interpreted as a lack of valuing of doctors, either as individuals or as members of a skilled profession, or even a lack of valuing of the actual work that doctors do in looking after their patients. Frustrations with the lack of an enabling health system cut across all aspects of

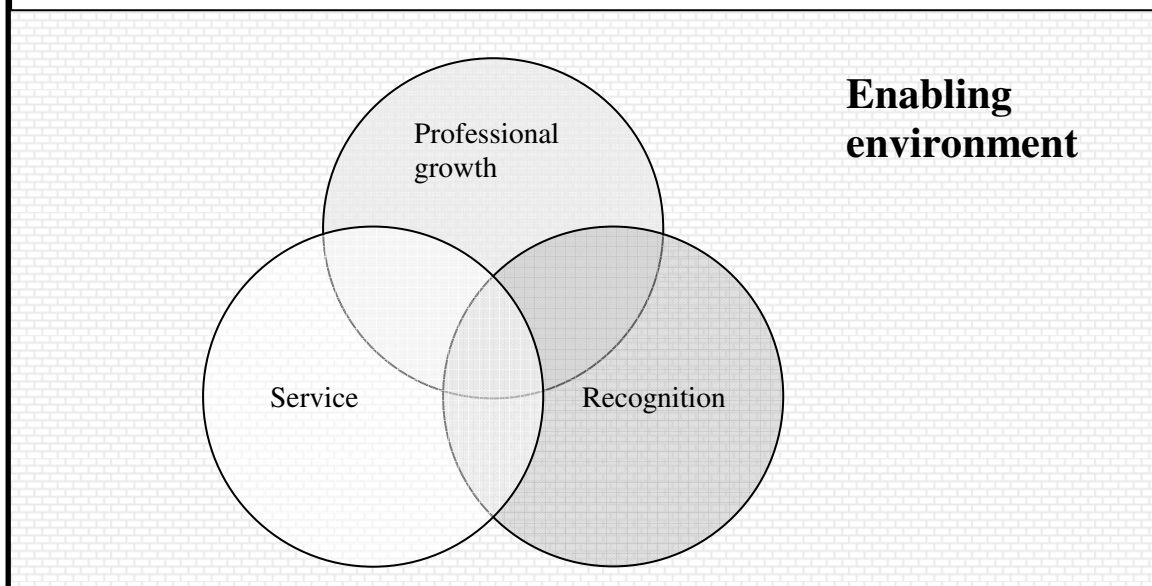
professional satisfaction through blocking both professional development and the capacity to serve one's patients well, as well as through leaving doctors with a sense of not being valued.

This early model was then revised, with the most important revision being a rethinking of where to place the “structural” elements (as compared with the “interpersonal” elements) that could lead to a sense of being valued. To illustrate what is meant by “structural” elements, the situation in an “ideal” health care system, and then the situation in Fiji, will be described. In a well-functioning, “well-structured” health system, professional development would be readily available to all and specialist training would be available to the most qualified. Promotions to higher roles would take place in a timely manner and according to merit. The patient care roles of doctors and nurses would be supported by a reliable supply of basic medications and equipment (at a level appropriate for a developing country). Workforce recruitment would take place in a timely manner in response to need in order to avoid significant staffing shortages, and turnover due to dissatisfaction would be minimised. Individual doctors in such a system could focus on developing themselves to the best of their abilities, and could count on support for their efforts at development. Individual doctors, supported by a well-functioning support system, could focus on providing excellent and locally appropriate care to their patients.

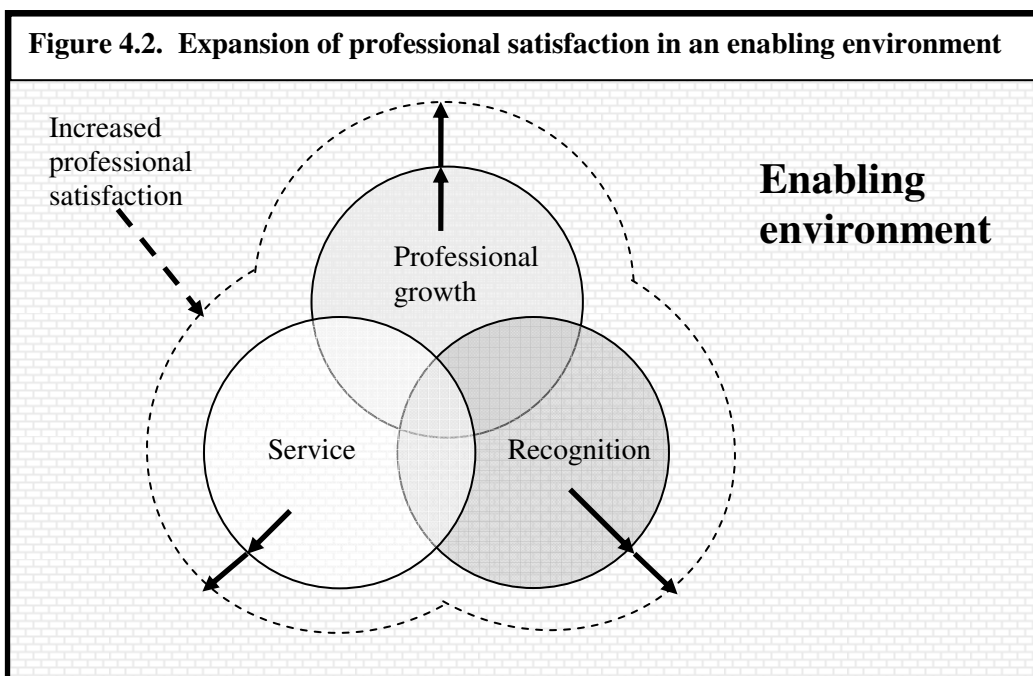
In Fiji, however, the interview participants described a system where some were enabled in terms of promotions and opportunities and some were not. There were not clear, transparent systems in place for career development that applied to all, and some doctors were enabled (“got lucky”) and some weren't. Doctors often felt appreciated by their colleagues and patients, but seldom by the health system. The disempowering effects of workplace shortages on patient care affected everyone.

Based on the above factors, the model of professional satisfaction presented in Figure 4.1 includes three individual “spheres of professional satisfaction” of “professional growth”, “service” and “recognition” that overlap on a background “scaffolding” of a well-structured, enabling health system.

Figure 4.1. Model of the elements of professional satisfaction in an enabling environment



As shown in Figure 4.2, the growth of these “spheres” of professional satisfaction is facilitated by effort from individual doctors as well as “structural” and “specific” enabling by the health system. “Structural” enabling includes, as an example, the availability of high-quality postgraduate training along with a just and transparent promotions policy. To follow on from that, “specific” enabling would be manifest by a worthy individual being given the opportunity to undertake such training. Individual efforts to grow in the elements of professional satisfaction (through pursuing professional growth, through dedication to service, and through working hard to be worthy of the appreciation of one’s patients and colleagues) are represented as arrows within the “spheres of satisfaction”. Enabling from the health system is represented as arrows attached to the outside of the spheres of professional satisfaction. In this model, as a result of individual efforts in an enabling environment, professional satisfaction expands. This is an ideal situation, where supported doctors strive to reach their full potentials to serve their patients and the wider health care needs of their nation.



On the other hand, if an individual in a disabling environment where the elements of professional satisfaction are absent or blocked, professional satisfaction may diminish. While it is conceivable that individual efforts might decrease under such circumstances, none of the Fiji doctors described withdrawing their efforts under difficult circumstances (other than through resigning altogether), but rather described working hard to maintain their standards. In other developing countries, however, engaging in absenteeism, dual employment, demanding of informal payments and overall underperformance has been described^{7, 117}.

If conditions are particularly unfavorable, professional satisfaction may shrink considerably, and doctors may begin to actively weigh up whether it is worth it to continue, especially if, as is discussed in later chapters, their work impacts on their personal lives. If other employment options are readily available, they could choose to migrate or enter private practice.

The models of professional satisfaction and dissatisfaction presented here may have value as frameworks for understanding what these doctors want from their working environments, and may be of value in helping to design interventions that would increase their overall professional satisfaction and retention.

Chapter 5. Results Part Two: Migration and Retention

One of the major aims of this study was to address the problem of unexpectedly high rates of resignations from the public system by postgraduate specialist trainees at the Fiji School of Medicine. These resignations were followed by entry into full time private practice in Fiji, or relocation to American Samoa, or by migration to developed countries, mostly Australia or New Zealand. These resignations had major impacts on the public hospital workforce in Fiji, especially on the workloads of the doctors who were left behind. In the interviews, doctors spoke about the migration of others, and described their own personal decisions about whether or not to migrate.

The analysis methods used in this section are described in detail in Section 3.2. Processes related to “open” and “axial” coding (in the case of “migration of others”) or coding and subgroup analysis with some quantification (in the case personal migration decisions) were used. Quantitative data on the whereabouts of all graduates is integrated into the presentation of the qualitative findings.

This chapter will start with the interviewees’ impressions of the historical evolution of migration decisions prior to the establishment of specialist training in 1998, followed by a description of events since then that have had an impact on migration, again, mostly from the perspective of the interviewees. Then the reasons cited for “migration of others” will be presented, followed by a discussion about personal decisions to remain in the public sectors, to enter private practice or to migrate. Finally, the reasons for migrating or not migrating will be summarised and a number of models will be presented.

5.1. Migration decisions from independence to the present

5.1.1. Migration before the establishment of postgraduate training in Fiji

Fiji achieved independence from the United Kingdom in 1970. Since then, coups have taken place in 1987 and 2000, which have had considerable impact on doctor migration (the impact of the coup of 2006 on migration is not yet clear). According to the senior specialists interviewed, doctor migration from Fiji has been taking place at least since independence. Part of this migration was

felt to be related to the lack of availability of specialist training in Fiji. Fiji doctors who wished to formally train as specialists were required to undertake specialist training overseas, most often through “fellowship” programs in Australia, New Zealand or the United Kingdom. Even in the 1970s and 1980s, many “fellowship holders” did not return to Fiji. A sufficient number did return, however, so that by the mid-1980s the main hospital in Suva (Colonial War Memorial Hospital - CWM) was described as being mostly self-sufficient in terms of filling specialist posts with Fiji doctors. After the 1987 coups, however, doctors witnessed high levels of migration of their colleagues, mainly of Indo-Fijian doctors, and since then, Fiji has relied heavily on expatriates to provide specialist services. As one senior consultant described, “... I can just go back to before the ‘87 [coup] and I realise that the CWM was far better [off in terms of] skill of specialists ... oh yes, absolutely, than what we have now. We had specialist microbiologists in the lab, we had specialist hematologists, I mean these were all fellowship holders ... in here and we had specialist general pathologists and you name it, we had it here at CWM. But now we don't even have any.”

Even in the relatively stable period between the coups of 1987 and 2000, few fellowship holders returned to Fiji. Fellowship holders who tried to return faced major barriers in obtaining posts. Of those who did return, most were described as becoming frustrated and leaving after a few years.

A lot of those that went to do their postgraduate abroad, you can basically count by your fingers the numbers that came back to serve the country again.

I was tempted to [stay away] but it was basically because I didn't get any response from the Ministry of Health when I started writing, to say that, you know ‘I'd finished my specialist training, if there was a job I'd like to come to it’ and they didn't respond for eight months ... my story isn't unique, man, a lot of people report this story ... I suppose I persisted a bit longer than others but it was just matter of two weeks, if that letter hadn't come, two weeks later I would have taken up a job in England as a consultant. (senior consultant)

We don't create positions for people who come back. And I think, just an example. There's a young man ... who's just got his fellowship in orthopedics. OK and I should have his letter on my table someplace. And he's just written saying he wants to come back in June of the year 2005. And this is a copy to, it's copied to me, it's a letter to the Minister, the CEO. And I have no doubt the CEO in his wisdom would have this letter filed someplace. He'd not create a position for him. He'd say to himself, “well, I've heard this all before and he's

probably not going to come back”, and so he’s faced with problems when he does come back. There’ll be no position for him. (senior consultant)

There were a few well before the coup, they just came and ... well ... they just felt frustrated ... under the same working conditions as they were in when they left, when they came back ... with new ideas, they want to change this, so, they just can’t ... change ... the bureaucracy is rigid, and they come back with their new ideas ... and maybe after maybe two or three or four years they just get, well ... ‘there’s no point, there’s no point fighting this, let’s go’. (senior consultant)

Those who stayed longer, however, described satisfying aspects to their careers. As one senior doctor related, “As a specialist and a consultant you have political clout, yeah? And that’s important to a lot of people. You’re members of committees, you’re consulted when people want to do new things, they want to change things so it makes you feel important, that makes you stay.” Nevertheless, as of September 2006, only six doctors from Fiji, out of the estimated dozens who were overseas fellowship holders, were working in Fiji.

5.1.2. Migration of postgraduate specialist trainees after 1998 – an overview

By 1998, doctors still had the option of going overseas for specialist training, but many chose to enrol in the newly established specialist training programs in Fiji, leading to qualifications that would be recognised only in the Pacific. It was felt at the time that a “non-exportable” qualification would discourage or even prevent migration in many instances. As a senior consultant stated, “Well, they’ll stay in the Pacific if they’ve got a qualification that can’t be exported ... OK? So it’s a professional barrier.” Nevertheless, within a few years it became apparent that the migration of doctors who had undertaken postgraduate training was occurring at unexpected and worrying rates. The extent of this loss within the first 7 years of postgraduate training is described in detail in Chapter 6. While the coup of 2000 had considerable impact on migration, and is discussed below, other factors also were seen as contributing to migration. A particularly important factor was seen to be the opening up of opportunities for doctors from developing countries to work in Australia and New Zealand, which had been more difficult to come by in previous years. As a senior consultant explained, “In ‘87, Australia and New Zealand had their doors closed to professional acceptance. But by the year 2000, Australia and New Zealand had already opened

their doors to accepting ... doctors, engineers, lawyers, skilled labours. So Australia and New Zealand had their own factors playing within their system that actually allowed them to open their system to professionals abroad and guess who ... it's Fiji!"

While job opportunities overseas were opening up, some believed that the Australasian orientation of the training at FSMed played a role in preparing doctors for overseas practice by making them more marketable. As one senior consultant said, "Well I, I don't want to be sarcastic but I think the postgraduate program now, having been around for a few years basically [is a] preparatory program for people to go abroad." Some doctors felt that their colleagues were starting to see postgraduate training as a stepping-stone to positions overseas, as "a ticket to get out of the Pacific".

Another factor that was felt to be a bridge to migration was overseas attachments. A number of specialty departments had traditions, even before 1998, of sending registrars for a year or so to Australia or New Zealand for training, with the expectation that they would return and use their newly-acquired skills locally. It was felt that doctors not only gained confidence through working overseas, but "tasted" all that developed countries had to offer.

Fijians are now leaving also, not all, but a lot of them are leaving ... And we're giving them the opportunities ... we're giving them an attachment overseas and I've always said that the attachment overseas just gives them that added experience and gives, just whets their appetite a little. (senior consultant)

... it's very few, those that have tasted the life there, the type of work they do there, very few want to come and those that want to come are probably not that well welcomed by the Ministry.

Doctors who worked for a number of years overseas but without obtaining an overseas specialist qualification were viewed as facing significant barriers to returning, even greater than for returning fellowship holders.

... I don't think they see it as ... going and not coming back, they just think 'oh, I'll just stay another year, another year, better, let's stay another year and another'. It gets to a point where ... when do you go back, and then you have all that anxiety about 'if I go back, what am I going

to do? And where do I fit in?' ... and seriously if they came back after three or four years they won't fit in, so that's another issue that they have to contend with. I mean if you came back as a specialist or something like that, that's different ... the big specialist who's been away ... yes, that's right, but if you came back and you're still the same as when you left, but you've just been away for a few years earning more money, you're back to square one ... so there's not any enticement for them to come back at all ... there's a disincentive in fact for them to come back.

(senior consultant)

Overall, the combination of reduced barriers to migration in developed countries, the “bridging” aspects of specialist training towards Australasian practice, overseas attachments and challenges faced when returning from overseas provided background conditions that facilitated migration after postgraduate training was established. In the public hospitals, where working life was difficult with few rewards, the decision to remain was increasingly one of full and free choice, given that there were fewer and fewer barriers to hold doctors in Fiji.

5.1.3. Difficult times and “unpredictable” events

As outlined above, even during “normal times” there was little to keep doctors in the public sectors. After 2000, a number of arguably “unexpected” or “unpredictable” events took place, and their impact on the medical workforce could be interpreted as uncovering the fragility of the systems in place for retaining doctors.

The May 2000 Coup

Many comments were made about the impact of the coup of 2000 on the migration of other doctors. It was generally felt that the loss of doctors following the coup of 2000 was greatly facilitated by the openness of many developed countries to migrating doctors. As a senior consultant described, “In ‘87, Australia and New Zealand had their doors closed to professional acceptance. So it fell right into Australia's plan that ‘here we are, there's a coup in Fiji, our doors are open’, and they just accepted our doctors with open arms.” Some doctors attributed much of the migration to the coup itself, while others minimised its overall impact. Other doctors, while acknowledging the impact of the coup on the accelerating rate of migration, emphasised the complexity of what was going on.

I think the bottom line is that people have attempted to put a simple explanation to why people leave. ... Yes there was an increased flow at the time of our political upheavals, but everyone else left. We lost after 1987, 5000 people a year left from the country, and they were doctors, lawyers, teachers, and so certainly the politics is an issue. And I think it was a major issue during those peaks in 1987 and the year 2000. (senior consultant)

But I think the ones who left were probably always going to leave, that's how I always look at it ... The coup happened, it was a good excuse.

Indo-Fijian migration was seen as being greatly influenced by political events and security considerations, whereas some saw Fijian migration as being influenced by a desire for "greener pastures". Others, however, related that many educated Fijians embraced democratic values, to the point of seriously considering migration for the sake of their children's futures when such principles were threatened.

The main reasons [for migration] are the two coups, OK, in 1987 and 2000, and so we lost a lot of our Indo-Fijian specialists, for one, and then as a consequence of 1987, it's been extremely difficult for Indo-Fijians to progress up the career path - OK? And you can call it nationalism, racism whatever, but I think that definitely put a barrier in the way of the progression of Indo-Fijians through the health system ... that's been a major, major determining factor in driving them away. (senior consultant)

That's when a lot of our, I guess, instability and confusion and really, not really knowing what the future was like for them... so that's when many of them left that were already in the program ... for the Indians, instability probably has an impact on them, on their decision to leave. For the Fijians, no, it's really just trying to make life better for themselves because they're not getting the ... kind that treatment they should be getting here. (senior consultant)

... yes, very many doctors, especially ... Indian doctors but not exclusively ... there are Fijian doctors too who see the effect of instability on general development and ... the social development and what kind of place their children are going to grow up in ... that is a big factor, most of them don't mind it for themselves but they are concerned about their children. (senior consultant)

And so [Fijians] actually fall into a similar section as the Indo-Fijians ... so I think for an educated Fijian who believes in democratic rights and believes in equality, who believes in fairness, and to couple that with their lack of attachment to their cultural tradition, you can see how they can make those decisions to go away or to stay away without much difficulty.
(senior consultant)

Overall, while many more doctors resigned after the coup than would have been expected during “normal” times, the doctors who were interviewed did not agree on whether the coup directly “led” to migration, or was a “tipping” factor for doctors already inclined towards migration.

The opening of Suva Private Hospital

In 2001, Suva Private Hospital was opened a short distance from the main teaching hospital. Prior to its opening, general practice and limited outpatient specialty practice was well-established in Suva, but inpatient private specialty practice was much more limited. Private patients were admitted to a “paying ward” at CWM Hospital, and were looked after by public hospital specialists, and the most complicated specialty patients were generally looked after in public outpatient clinics. Public sector doctors were only allowed to undertake outside private work if they were registered as specialists with the Fiji Medical Council, which required a recognised overseas specialist qualification or a local Masters plus, in most cases, two years of post-Masters experience.

The opening of a private hospital in Suva in 2001 opened up the possibility of private inpatient specialty practice, and had a mixed impact on staffing at the teaching hospital. In the early years, the impact seemed to be negative. Some public doctors, including registered specialists, resigned to work at Suva Private, but some admitted that this option had actually held them back from leaving Fiji altogether.

Perhaps surprisingly, the evolution of the private hospital may have changed the outlook for specialist trainees in positive ways. Early specialist trainees saw their futures as being linked to the public hospital system. Many expected career advancement when they obtained their Diplomas and Masters, and when this didn’t happen for some, there were few options for those who wished to work as specialists other than “waiting it out patiently” for a senior posting to open up in the public

sector, or migrating overseas. Financially, doctors “stuck” at junior grade salaries could only look forward to a modest though “livable” public salary when they were eventually promoted, or to supplementing income by doing occasional locums such as in American Samoa. By 2006, however, a number of Masters graduates who had obtained specialist registration described earning “lucrative” incomes through supplementing their public hospital salaries with private specialist work. The impact of the opening up of this possibility on retaining current students or encouraging enrolments is unknown, but may end up being positive.

Doctor industrial action: the “work to rule”

In 2002, another event took place which may have contributed to the migration of some Fijian doctors.

During 2002, many doctors had become increasingly frustrated with working conditions and their terms of their employment in the public sector. By this time, the postgraduate specialist training programs were in their fifth year, and the first Masters candidates had graduated. To add to the frustrations of public sector doctors, many had expected that undertaking postgraduate training would lead to faster career advancement, but by 2002, many felt that this had not eventuated. A group of doctors, mostly hospital specialist registrars at junior grades, called for improved working conditions. When they were unsuccessful, they decided to take industrial action, but described being unwilling to strike because of their professional ethics. The decision was made to initiate a “work to rule”, where they decreased their working hours, meeting only the exact terms of their employment. This led to considerable disruption to hospital services. The industrial action took place over several months and was felt to lead to an unsatisfactory outcome. A number of doctors mentioned that this probably contributed to an accelerated loss of Fijian doctors at that time. As one doctor explained, “I would say that ... all these resignations happened mostly after the 2001 and 2002. There was a work to rule that happened ... and straight after our issues were pushed through ... and most of the issues did not happen ... and that’s when ... all those people ... most of them left after that, the general discussion then was that ‘ok, we’ve done this, we’ve gone this far, we even went to the President of Fiji ... with our proposal ... we’ve tried this once, it’s not going to happen so, why ... stay?’ ... I mean I personally observed it ... because straight after that there [were] 18 resignations or something from the Ministry ... we counted that.”

“Turning on the tap” and “opening the floodgates” – specialist departments in crisis

When doctors resigned from the public hospital system, this had considerable impact on those left behind. This led to heavy workloads, and times of particular difficulties. As discussed above, this process was set in motion or accelerated around the time of the 2000 coup. Doctors who remained were afraid that very few of their colleagues would be left to share the workload. Some felt as if a “tap” had turned on, with more and more of their colleagues flowing out of the system.

I thought everyone was going to leave ... yeah, it looked like everyone was leaving, but I guess for most of them [postgraduate training] was a step up to go abroad, if not immediately, later down the line ... they eventually left.

... so people were going to leave irrespective of the coup, I think that what has happened is just somebody’s turned the tap on, in the beginning it was slowly and now it’s a full run on and everybody [is] ... going to hop onto that pipe and just flow through that thing.

In some instances, overstretched junior doctors were concerned about losing patients due to the necessity of cutting corners and “missing things” in the face of an unmanageable workload.

Vicious circles seemed to have been set in motion where the loss of doctors led to unmanageable workloads which led to the resignations of more doctors who no longer felt they could cope with the workload. As a senior consultant described, “I think they felt there were a lot of deaths and morbidity that could have been prevented if they were just more vigilant, were there more of them ... and we have a few who’re very dedicated ... but there are some things that will break you ... because there’s a lot of guilt on them.”

The staffing shortages had considerable impact on postgraduate training. Overstretched trainees had less time to study, and this may have led to some of them being unable to score highly enough on their Diploma exams to qualify to continue on to the Masters course. Some doctors were reluctant to continue with Masters training, as they were concerned that they could not do it justice given their workload. Other doctors did not pursue Masters training because they were not convinced that supervision would be adequate. As one Masters graduate described “... they knew from the beginning that we were not keen on continuing with the Masters program, we had to tell them like ‘it’s going to be hard, it’s going to be busy and we may not perform as expected of us as

well then' ... and I know I did, I didn't do well with my school, in the classroom than I would have had I had time ... because I just focused more on my responsibility here at the hospital ... than trying to keep up with the work here."

While workload difficulties and staffing shortages took place throughout the public hospital system, individual specialist departments experienced times of particular crisis. In Fiji, specialist departments consist of a number of consultants, as well as senior and junior registrars, with interns rotating through for a few months at a time. Newly recruited specialist registrars undertake a year of on-the-job training, then are eligible to enter formal specialist Diploma training, and after that Masters training if their performance is satisfactory. Within a department, at any given time, not all registrars are undertaking postgraduate training, giving a mix of trainee or non-trainee registrars. In addition, regional specialist trainees contribute to the staffing of the department during the academic year. Expatriates are recruited when insufficient numbers of local staff are available. While the specialist departments and the specialist training programs are separate, a well-functioning and well-staffed department is invaluable for enhancing specialty training, and steady numbers of local and regional trainees contribute significantly to the staffing of the department.

By the time this study commenced in 2004, all specialist departments had experienced difficult staffing situations exacerbated by low numbers of remaining Fiji medical graduates, and only partly compensated for by employing expatriate doctors. Much of the information on departmental difficulties was obtained through casual conversations with a number of individuals over the course of the four visits to Fiji, and to a lesser extent through interviews themselves. The seriousness of the staffing shortages in each specialty varied between October 2004, when data on trainee whereabouts was collected, and September 2006 when the final field trip took place. Between these dates, the situation of some departments improved considerably, while it deteriorated or remained problematic in others.

The obstetric and gynaecology department, by early 2001, experienced a serious shortage of senior doctors which ironically opened up opportunities for some early Masters graduates to be promoted more rapidly. By 2006, all four Fiji Masters graduates remained in the public system.

The department of medicine was experiencing serious staffing shortages by 2004, illustrated vividly by a group picture of the department taken in 2001. By 2004, nearly half of the doctors in the photo had left the public system with minimal new recruitment. Of the first three Masters candidates who

graduated in 2002, two had migrated to Australia and one had entered full-time private practice in Fiji. The loss of these experienced doctors was commented on by a number of doctors, usually sympathetically, though their departure contributed to the heavy workloads for those remaining.

Well I certainly know that among some who've left, they didn't get the posts they should have got or they were kept waiting a very unreasonable length of time, I mean one chap who got his Masters in Internal Medicine was still on a substantive post of medical officer when he got it ... and the Public Service Commission had held over his strongly recommended promotion to principal medical officer for over a year and it came through the day he left I think. (senior consultant)

They've been stuck in terms of their promotion, they have been doing the amount of work or the work they are doing [is] actually even at a higher level, but they haven't been promoted and they have been told lies in that sense they have been just promised without being fulfilled, those are the reasons, those, sometimes it gets very frustrating and even more worse when you see people who are not of that calibre being promoted and people of ... who have that potential remain to be pushed down and those things sort of make you feel 'is it really fair or justice, is justice being done?'

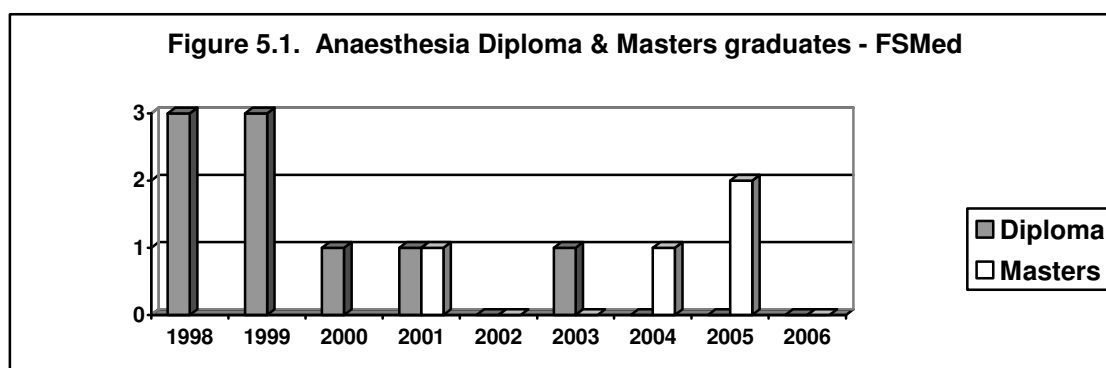
By 2006, however, the situation had improved considerably. Two more internal medicine trainees had received their Masters and were appointed to senior posts. New recruitment took place into the department, and staffing was further helped by a number of regional medicine trainees.

The department of surgery, by 2004, had also been short-staffed for a number of years. By the start of 2005, two Masters graduates and one Masters student were away from Fiji, undertaking subspecialty surgical training in New Zealand. When doctors undertake overseas placements, rumors often circulate about whether or not they are coming back, and some feared that temporary placements would become permanent. Nevertheless, by early 2006, all three had returned to Fiji, though one left again for additional overseas training later in the year.

... the department's running very well ... I mean ... the last decade I've seen the department drop to it's lowest ... lowest it's ever been ... the lowest point was when we had a lot of staff turnover ... at both consultant and registrar level ... with our general surgeons' turnover, at one stage it was like [a] bus emptying it's contents every ... I think what people forget is that

... there's always a light at the end of the tunnel ... what anaesthesia's facing now is what we faced seven years ago ... and we gritted our teeth and said 'we'll come out of this' ... the push should be within the department itself ... people in the departments have to grit their teeth, knock on everyone's door, you know do whatever [it takes]. I think it will come right, it just needs time ... and that's the way to do it.

One of the problems reported as contributing to staffing shortages in specialty departments, in addition to the resignations of doctors, was not being allowed to recruit local graduates, even into established posts. This was particularly a problem for anaesthesia, as illustrated in Figure 5.1. In 2004, the situation in the department of anaesthesia was somewhat stable, and the training program had three Masters enrollees from Fiji, though there had been no Diploma enrollees from Fiji in either 2003 or 2004. By early 2006, local recruitment into the anaesthesia department still had not taken place, and by then, four years had passed without a Diploma intake of Fiji trainees. It was described how some doctors who wanted to train as anaesthetists became discouraged after no one was offered specialist registrar positions for a number of years, and some ended up going into other specialties instead, with 2 resigning to enter private practice. In early 2006, the department of anaesthesia was experiencing severe staffing shortages, leading to cancellations of operations, and in the opinion of some, an inability to support some of the new surgical skills that Masters graduates had acquired during placements overseas. Anaesthetists in Fiji also cover the adult intensive care unit, and staffing shortages had considerable impact on ICU care, especially on the workload of the remaining ICU registrars. A number of new anaesthesia trainees were urgently recruited in response to this crisis in early 2006, and were expected to be eligible to enter training in 2007.



The situation in the paediatrics department was much more problematic and complex, with a combination of factors that together may have led to an unusually high number of resignations. At a structural level, in early 2000, paediatrics had relatively few established senior postings compared

to other departments, with only one consultant post, one chief medical officer post and two principal medical officer posts, which were filled at the time and unlikely to open up. Some doctors mentioned that the low number of senior postings in the department was surprising, given that the paediatric unit ran two intensive care units (paediatric and neonatal), which required high levels of skills. Many experienced paediatric registrars at that time faced the prospect of remaining posted at junior levels for years to come with few opportunities for promotion. Additionally, many experienced registrars had taken part or planned to take part in a year-long placement in a neonatology department in Newcastle, Australia. Therefore, by the time of the coup, a large pool of relatively senior registrars with limited prospects for promotion were already aware of their marketability in Australia. After the coup in May 2000, paediatric registrars started to migrate. By 2004, ten experienced registrars had left the department, with most migrating permanently overseas. As one consultant described, "... after the coup for [a] year or so that's when ... all our registrars left, senior ones ... all just gone, one after the other ... like opening the floodgates ... and you just get junior people coming in." As more and more registrars left, the remaining registrars faced very heavy workloads, which led to more resignations, often of registrars who were felt to have been relatively less likely to resign, but whose long working hours and high levels of stress impacted negatively on their families and made undertaking of formal postgraduate training almost impossible. As a senior consultant explained, "They used to tell us of their frustration and then it came to a time when ... we were left with three ... they were running one in three 'on calls' ... we said 'look, close either the outpatients or close the intensive care', and I was opting that we should close the intensive care units because we cannot manage, you cannot manage two intensive care units plus the whole hospital, the wards, that's two major wards and outpatients with three doctors". Some recruitment of more junior registrars did take place, but they required closer supervision, placing a heavy burden on senior staff, who no longer had experienced registrars that they could rely on. Even by 2006, the department has not yet fully recovered from the high losses to migration, and no Masters students have been enrolled since 2002. The reasons behind the unusual difficulties in paediatrics may relate to a "perfect storm" of high levels of overseas training, lack of career prospects in Fiji, and working conditions that became increasingly difficult as more and more colleagues resigned, one after the other.

In summary, all specialty departments have experienced staffing difficulties. The combination of a perception of lack of career prospects plus poor working conditions plus additional stresses such as the coup or the "work to rule" were felt to be contributing in some cases to downward spirals of resignations, increasing workloads, and even more resignations.

5.2. Migration of others

5.2.1. The multi-factorial nature of migration decisions.

During the interviews it quickly became clear that the doctors viewed the decision to migrate as being complicated and “multifaceted” and not due to one dominant factor only, despite the occurrence of a disruptive coup in 2000. Moreover, the decision to migrate was seen as a profound decision that could not be taken lightly.

I think the bottom line is that people have attempted to put a simple explanation to why people leave. OK or whether it's, Indians have left Fiji simply because of the political scene. I think it's certainly very complex and it's not just politics. People who are leaving left way before politics. (senior consultant)

It all boils up before a person decides to move ... to move from one country to another is not a small decision and whoever decides it thinks about it many times by looking at the consequences, and multiplying, dividing, adding, subtracting before they finally make a decision to move, and it's not only one reason that pushes a person to leave a country ... being born in a country we have pride in our nation, and to kill that pride needs a lot of input to suppress that and to decide 'OK I'm not going to serve my country' and move on, move forward and I think ... it's a multi factorial thing.

5.2.2. The impact of professional factors

A number of professional factors that affected migration decisions were identified. These included workplace factors, career pathways, and salaries. While training opportunities were identified as being important, formal continuing professional development (such as the availability of journals, local meetings and support for overseas conference attendance) was generally not described as a major area of difficulty.

Some doctors felt that workplace problems contributed significantly to decisions to migrate. The difficult working conditions that doctors faced are outlined in detail in Chapter 4. As one doctor described, “I think that the greatest, main determining factor I’ve seen here with the locals that have left is the dissatisfaction of the working in the system, in the health care [system] in Fiji. I think people have come to believe that after their training they've achieved so much, the system is still lagging behind in measuring up to the level of training that they've undergone ... in terms of materials, in terms of instruments and all that we've learned to use to improve our level of care for patients ...”.

Frustrations with career pathways (described in more detail in Chapter 4 and especially Chapter 6) were also believed to play a role in decisions to migrate, and some saw this as the central factor in discouraging retention in postgraduate training and in the public service. Senior postings were seen as being central to improved working conditions and a more comfortable salary, which could lead to retention. When promotions were not forthcoming despite having undertaken postgraduate training, this was felt by many to make migration more likely.

I think that in this setup here, not having the post is really the most important factor that people leave here. And getting that post will enable one to and enjoy what comes with it, conditions, pay, working hours ... A lot of my colleagues have left, those who have been in the program and those who haven't been in the program and those who've been in the program and not finishing the program, they've all left because of the postings. I think ... the postings, really that's the major issue, you know, one feels that maybe you could get more satisfaction if you get that post, plus ... what comes with it.

... but even when they're getting into their senior years, you know, two years into the Masters, it didn't change their status. And we think that is wrong. I think that's part of the reason why they leave. I know this for a fact. Some of them even completed their Masters and still didn't get promoted. I mean that's shocking. I mean I would be the first to jump up and down and complain about it and what can we do. We don't do the promoting. That's the main reason why they leave. (senior consultant)

Overall, not only day-to-day working conditions, but a lack of certainty that promotions would be forthcoming as a reward for undertaking postgraduate training, were seen as contributing significantly to migration decisions.

5.2.3. The impact of financial considerations

The doctors who were interviewed had mixed views about whether or not financial issues were central to migration decisions. While salaries for doctors in the public sectors in Fiji were low compared to developed countries, or to what could be earned in private practice in Fiji, or elsewhere in the Pacific, such as in American Samoa, many doctor felt that in general, salaries in Fiji were modest but livable, and that while remuneration was higher overseas, so was the cost of living. As one doctor stated, “You’re not gonna be rich being a specialist in Fiji, ok, you’re not going to be super rich, but you’re not gonna be poor”. Many, however felt that money was an important or even central issue in migration, and a few commented on the increasing materialism of their colleagues. Some doctors expressed optimism that increasing salaries, even modestly, would lead to decreased migration.

Salaries are kind of listed in the same bracket as ‘my wife wants to leave because her family is overseas’. Salaries are a major factor. (senior consultant)

I think the whole lot who left ... because of frustration and money. Money was always an issue ... people who will sit during internship and said ‘we’ve worked, I’ve studied for 6 years and then the guy who was two years behind me in school is driving around in a car when I’m catching a bus’.

And also the remunerations are not good. I think that has been one of the major factors in colleagues, in fellow doctors leaving that they see that nurses are better off in pay, they're paid by the hours that they work whereas we work extra hours, after-hours, and still almost get the same flat rate of pay. There's no incentive given to work in terms of ... your family being looked after and cared for in their needs like housing and, you know, loans and all that, we ... our graduates still have to fend for themselves and look after their families. There's no support from the Ministry.

... before the 87 coup, people would work hard for the sake of the country ... they'd work hard, long hours for the sake of the country. But people now are very money oriented.

Because that's also a change of our culture ... people realise that ... at the end of the day, you've got to provide for your family. (senior consultant)

I would change the remuneration, what I'd pay specialists ... their package ... I'd give them more money ... I'd give each of them ... every two years entitled to one overseas conference, OK? I'd make sure that in the hospital departments they got their choice of three important journals in their discipline, yep, and I'd give them two weeks of professional development leave each year. (Interviewer: OK, is that affordable?) Well I think it is, if you look at the consequences then of filling, of bringing in an expatriate to fill that position, it's a lot more expensive ... it's a lot cheaper to just pay that money. You could spend an extra 15% over and above their salary to provide these packages and you'd have a much happier person. (senior consultant)

Some doctors commented that, while the salaries attached to senior postings were adequate, this was not the case especially for doctors held at junior postings for extended periods, and it was felt that the impact of higher salaries as an inducement to migrate or enter private practice was more important to these younger doctors. Other doctors felt that working conditions and other frustrations were more important than money in decisions to migrate.

One of them you know they, he couldn't cope with his two children and his wife was a nurse and he had just bought a house ... for them to be able to look after their financial commitments they needed, both of them needed to work, true. But they had two small children. So then they decided, you know, it wasn't going to work. They wanted to bring up their children properly, so his wife, he didn't want his wife to work, just to sort of stay home and look after the children ... That was the main reason he left. (senior consultant)

Money is not the main issue ... it's not the top priority ... whether increasing the salary and leaving the working conditions as they are I think people would still leave ... money is one ... of the issues but it is not the only one.

People left for money, but at least my friends, so many have left, hardly I think anyone left for money ... like look at me, hardly I manage ... it's just that people were too frustrated ... it's so many other things ...

While most experienced the migration of their colleagues as a significant loss to the health system in Fiji, a few doctors mentioned that government officials had actually told them that migration of doctors was not necessarily a bad thing because of the remittances that migrant doctors send back to Fiji. As a senior consultant described, "... and somebody from Finance says 'well, no that's not negative, they're bringing in such a lot of money' and I said 'well what about the effect on the health services', 'oh yes but you can get other doctors in can't you?' you know, and then the same people would say if they were sick themselves 'well why hasn't Fiji got this that and the other?' ...". None of the doctors interviewed saw remittances as making up for the loss of skilled doctors, and overall, the opinions about the importance of money in migration decisions were mixed, with some focusing on working conditions and others seeing financial issues as central.

5.2.4. The impact of family and culture

The interview participants spoke about family and cultural factors which were viewed as being very important or even central to migration decisions. Nuclear family issues were seen as being particularly important. As one senior consultant stated, "... eventually, it comes down to right inside their homes that decisions are made ... I think that's where the most potent driving forces [are]". He went on to explain that "Professional dissatisfaction can be translated at various levels right into their household, you know their wife unhappy about them coming late, and then not enough money to support their family, eventually, they're going to make a decision on behalf of their household." Spouse issues were seen as being especially important, and some described situations they knew about where doctors had migrated in order to facilitate a husband or wife's career or family responsibilities. Doctors also migrated or stayed back out of concern for the welfare of their parents. As a senior consultant explained, "... I mean what pushed us back, well, our parents were getting a bit older ... and we knew at some stage we're going to have to look after them ... especially for [my wife] because she comes from a two child family, ok? So that was really important for her ... and also for me, it was important for my parents that I come back here to work".

Doctors were seen as migrating in order to promote family welfare, especially the education of their children. Family issues were also seen as being behind decisions to enter private practice, a step which was viewed as being undertaken in order to spend more time with one's family, in addition to earning more money.

... they certainly felt very bad about leaving, and they said they had to look into the future and with their children, their family, you know, what's there for the children? I think especially in our culture, it's not so much self, well I guess it's self indirectly, but we are brought up to bring up our children ... and children are important. You provide the best you can for them ... and they see that staying in Fiji is not the best way to do that ... and if they can do it elsewhere, they go elsewhere to do it ... so, even if they have very strong obligation to stay ... they would sacrifice that if they thought that their children would have a better future if they went. (senior consultant)

It was felt that given the political situation in Fiji, Indo-Fijian doctors were more likely to migrate out of desire for security and stability for their families whereas Fijians were more often viewed as migrating in search of material benefits. As a Fijian doctor explained, "Fijians no, security wise not a problem, not a problem, they just ran for the greater attractions abroad ... for the Indians yes, that is a major problem ..."

The impact of extended families and culture in holding doctors back from migration was seen as being more powerful for Fijians than for Indo-Fijians. Most Indo-Fijian families had experience the migration of family members. In some instances, very few family members remained behind in Fiji.

... [with] Indian people ... it's a very sad thing to see them having three or four generations built up and extended and then they may emigrate, one to Canada, one to USA, one to Sydney and once again it's the family shattered like that, then on the other hand if they all immigrate to the same place, then they may be in for another sort of tension with the older generation trying to maintain the authority of the younger generation lot, so once again ... they do pay quite a serious price for immigrating. (senior consultant)

... her husband's family [was] all here but then her own family started leaving one by one ... for various reasons, and she was very close to here mother and her sister ... so when they left she was having problems with family ... life and her family support was gone ... so she said, 'What the heck why am I staying here?' ... she goes where the family support is. (senior consultant)

In the past it had been viewed that cultural issues could be counted on to hold Fijians back from migrating, and such issues were still viewed as being important. Some doctors cited the centrality of a sense of cultural belonging in keeping doctors in the Pacific. Other doctors cited the friendliness of Fiji and the laid-back lifestyle compared to overseas.

I think you have to understand the Fijian. The Fijians thrive in this cocoon of family love and care, and when they're out of it, they feel really really lonely and isolated. And I guess that's what brings them back. Family, wherever they are they would always be contributing to stuff and coming back and you'd never find a Fijian who will stay away forever and not come back at any stage. (senior consultant)

Nevertheless, it was felt that the impact of culture in keeping doctors in Fiji could no longer be taken for granted. Some doctors cited a generational change, and felt that some younger doctors no longer had a “sense of belonging to their culture” and were more likely to leave. Others described how some doctors felt burdened by heavy cultural demands and could even experience overseas attachments and migration as a “release”.

I don't believe that family holds people back, it's the lure of having family, the extended family as we know it in the Pacific ... is not as strong as it is before.

I don't think [being held in Fiji by cultural attachments] works anymore now. I think it really depends on you, the oldies are now staying, but the younger ones are moving out and I don't think they have any more sense of belonging really, because there's nothing to belong to. I think they've been let down by their Ministry of Health. I think that's exactly what's happening.

A whole bulk of people that have moved abroad really have gone because they need breathing space ... because tradition can really choke you ... it really shuts you down and pulls you back because in our community ... your achievements, what you gain in as far as if you're obligated to the community you are ... community property ... what you gain, what you acquire, what you achieve belongs to the community and people actually just sort of get away from it all, they really go abroad just to have a life of their own. It gets sort of suffocating and chokes you.

Even in Australia or New Zealand, maintaining communication with family and relatives in Fiji was described as being much easier than it had been in the past. Moreover, a sense of cultural belonging even while overseas was greatly facilitated by the existence of growing overseas Fijian communities in major cities in Australia and New Zealand. As a senior consultant explained, “It’s a huge [overseas Fijian] community. In Sydney, everywhere. Huge communities and I see this when we go on rugby tours and I mean we are well and truly entertained by Fijian communities everywhere. We’ve got our own churches, community halls, there’s no problems with adjusting, none whatsoever. Most of us feel at home when we go overseas.”

In conclusion, it was generally viewed that in the decision for doctors to migrate or remain, nuclear family and in particular spouse issues were central, and could act in either direction. Cultural ties were seen as being much weaker for Indo-Fijians, related to high levels of prior migration by Indian family members. Cultural factors were seen as being more important in keeping Fijians from migrating, but were also seen as weakening. While cultural and family commitments could hold a doctor in Fiji, the presence of an active private sector meant that they could not be held in the public sector.

5.2.5. Summary of views about the migration of others

Overall, the Fiji doctors presented the migration decisions of their colleagues as being multifactorial, related to a combination of working factors, financial considerations, and personal factors including family, extended family, and cultural matters. Since the establishment of specialist training in Fiji, all of these factors played out in a setting of increasing and perhaps unprecedented opportunities to migrate to developed countries. In addition to this, a number of events have taken place in Fiji that were very likely to have encouraged migration or at least resignations from the public system. The multiple and varied reasons for migration that emerged from the analysis of subcodes that were derived from the interview data on the migration of others are presented in Appendix F.

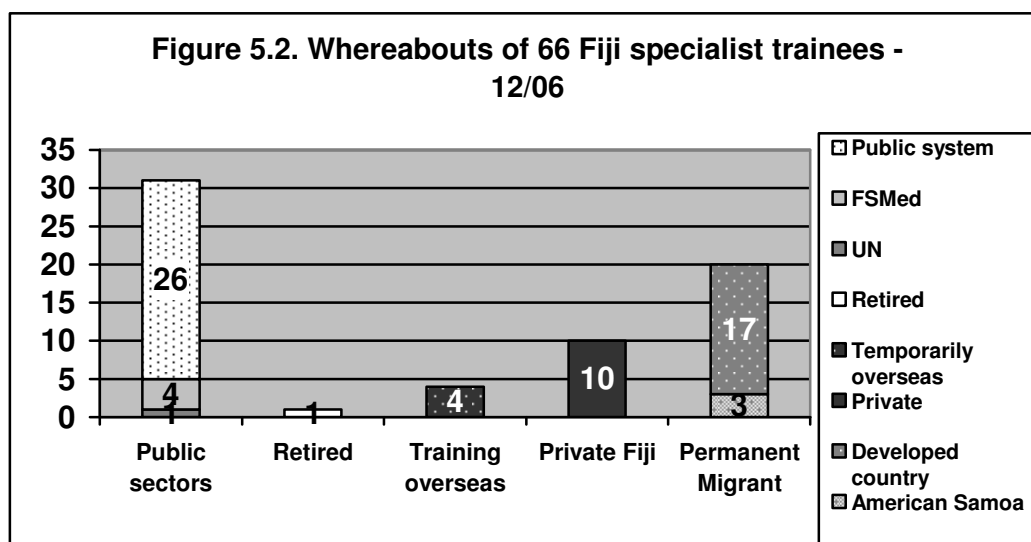
While this section details what is likely to represent the “conventional wisdom” about why Fiji doctors have migrated, it is important to explore not only individual decisions to migrate, but also to determine why, in spite of the difficulties, many doctors have remained in the public system. The

next section explores the career decisions of the doctors who undertook specialist training in Fiji in regards to migration, entering private practice, or remaining in the public sectors.

5.3. Personal decisions about migration

5.3.1. Introduction and background quantitative data

Of 66 Fiji doctors who undertook postgraduate training at FSMed at least through Diploma level, only 26 were still working in the public system by December 2006 (including 3 current students). Ten were working in private practice in Fiji, and twenty were believed to have migrated permanently (see Figure 5.2). Of the 66 doctors, 36 were interviewed, and all were asked about their own personal decisions to remain in the public sectors or resign. These decisions will be discussed in this section.



It should be mentioned that many interesting, enlightening, and even inspiring stories were told about individual decision-making, but presenting these stories here could lead to the identification of the individual involved. Therefore, individual stories have been omitted because of confidentiality issues.

5.3.2. Permanent migration

Of doctors interviewed, seven were believed to be permanent migrants. The permanency of migration is sometimes difficult to judge. To illustrate this, while 25 doctors who had undertaken postgraduate training were believed to have migrated permanently by early 2005, by September 2006, three had returned to Fiji and two who were still overseas were reclassified as being temporarily away based on new information, leaving 20 permanent migrants, of whom 7 were interviewed in person, and three more contacted briefly by phone. None of the three doctors living in American Samoa were interviewed.

Of the 20 permanent migrants, 13 lived in Australia, one lived in Canada, two lived in New Zealand, and one was rumored to be New Zealand (but this was not confirmed), and three were living in American Samoa. For the doctors who had moved to Australia, working status was obtained through interviews or phone calls, or from publicly available state medical board registries, which gave practice locations for those with temporary or provisional registrations. By December 2006, four of these doctors were believed to be working in general practice or were in GP training, and nine were working in hospital settings, often within their specialties.

Of the seven migrants who were interviewed face-to-face, four were Indo-Fijians and three were Fijians, with representatives from all specialties. All were working in public hospitals at the time of their interviews.

Migration decisions for these doctors were multifactorial and complex, but generally there were two predominant reasons, either spouse commitments or security concerns. Two Indo-Fijian doctors left predominantly because of their spouses' career aspirations or family commitments. One of these doctors described the evolution of a decision to extend a temporary stay into a permanent one because it was "better for the kids". For the other five doctors, including all of the Fijians, migration decisions were described as being either directly due to, or heavily influenced by the 2000 coup. In particular, these doctors were concerned about raising their children in a politically unstable environment, although they were also concerned about their children's education and employment prospects.

I think, well, something I didn't mention was my kids, yeah. I would consider myself as a family man. And ... I wanted a ... good future for them and I can't find it back home, given the political situation that has happened. I was sort of brought up, I'd say, in an average

family. And I think I could see the struggles that they went through. I think the reason why I got into university quickly was that because the Government was quite stable at that point in time ... I think those that were coming behind me, I've seen the struggles they have gone through, especially the kids, trying to get scholarships and ... ending up going a different career path than what they had wished. So, I just thought to myself ... 'I don't want my kids to go through this'.

And then, also the other thing is the political climate that was going on ... after the coup in 2000. You know, things were unsettled. Those were the things that sort of pushed me to leave ... then in November they had this [mutiny] ... like things were getting worse ... and I had to sort of think about my future and my son's future. So that sort of led me to sort of leave - think about leaving."

The Indo-Fijian doctors who described leaving because of the 2000 coup had been old enough during the 1987 coups to make conscious decisions not to migrate at the time. In 2000, however, they started arranging migration almost immediately, usually leaving Fiji within a year. An Indo-Fijian doctor related his thinking in 1987. "Well, I looked at it this way, 'This is my country, I was born here, I've got more rights here than any other country so why leave? And if I leave they'll...', like I knew there was nobody else to fill those shoes, so, and I said 'No ... I would stay and work and treat my own people, postgraduate or no postgraduate.'" By 2000, his thinking had changed. "I said to my wife, 'Our main concern now is our kids' education.' So my kids were now big, so that's why it dawned to me now, 'OK, this is second coup. This is different, now I'm in a different situation.' "

Unlike the Indo-Fijians, the Fijians waited longer to migrate, and described going through a time of hoping that things would get better.

It was based on my daughter's future really, we didn't want her to be staying there and if this was to happen again, we didn't want the repetition of what happened with her ... for her children to go through because we weren't really sure what was going to happen ... the way we looked at it ... we thought about moving, I mean at the time it was a half hearted decision. You know, we weren't really sure that we really wanted to go then ... which, that's why it took us almost a year to get out of there.

Yeah, I had made up my mind. I would say I was 70% sure that I was going to leave at the end [of the coup], but I think ... the reason why I didn't have a complete sort of decision to leave is that I wanted to wait and see whether things would change. I still had that 30% hope that things would change later on, but I think that didn't eventuate, so ... I chose to leave, and not only because of political - I mean, I think most of the things were related to the political situation in Fiji because there was a lot of unfairness within the health department ...

The migrants did not report any difficulties in finding work in Australia, and most of those interviewed were working within their specialties, though none were eligible for specialist status. As one migrant stated, "I would only want to do [my specialty], if there's no [specialty work] I would rather stay back in Fiji ... that's my passion." A few had attempted or passed the Australian Medical Council (AMC) exam, which opened the way to improved employment prospects, and some were considering or had entered specialist training, though others had held back because of family responsibilities. Migrants who wished to pursue specialist training not only faced the hurdle of the AMC exam, which covered all specialties, but often needed to work for a few years in non-training posts before being offered formal specialist training, which then required many additional years of training as well as the requirement to pass difficult specialist exams. Therefore, migrants faced many more years of training in Australia in order to obtain a specialist qualification as compared to in Fiji, though Australian qualifications had the advantage of being recognised in Fiji as well. This posed a significant challenge and perhaps a barrier to older migrants. On the other hand, some GP practices could be entered into immediately through "area of need" temporary registration, and formal GP training could be completed in as little as 2 years. Interestingly, none of the migrants interviewed cited a desire to undertake formal specialist training as a motivation to migrate. This may not be typical of other Fiji migrants, for a number of reasons. All migrants were relatively experienced in their specialties before leaving Fiji, and had chosen to undertake specialist training in Fiji. All of them had families as well. Younger migrants, on the other hand, may have been motivated by the opportunity to undertake specialist training in Australia after obtaining some postgraduate training in Fiji (perhaps as a "bridge to migration"), though this strategy was not described in any of the interviews. Doctors who had migrated early in their careers before undertaking any local specialist training were not interviewed, and may have migrated mainly for professional reasons, but again, that could not be addressed as part of the current study.

Most of the migrants spoke of having enjoyed their work in Fiji. Some related anecdotes about their work with a sense of pride and fond remembrance, and admitted to sometimes missing aspects

of their former positions. For a few, however, problems with career structure and difficult working conditions contributed heavily to migration decisions.

(Interviewer: Do you think that if they improved ... conditions ... there, better paid, better hours, do you think that would have kept you?) Um, maybe I would have considered it, but I still don't think I would stay because the political situation is not settled.

We were just sort of squashed with work, we had to do clinics, we had to do calls, we had to do procedures and I think the work pressure was at (optimum - *unclear*) and I said 'I'd better get out of this place, otherwise, you know, there's going to be a lot of pressure ... It's not good to our health'. ... No policies in place in the Ministry for sort of further[ing] ... a career ... I think the biggest factor [in my leaving] was just my frustrations with the Ministry. Yes. I mean, they are not sort of treating locally trained people fairly, that's what I thought.

Just as feelings about the work in Fiji were mixed, so were feelings about Fiji itself, with both Indo-Fijians and Fijians reporting continuing fondness for and attachment to Fiji, as well as deep bitterness. An Indian doctor related having heard a speech by the prime minister around the time of the coup, and believing from that time onwards that there was no future in Fiji and that there was no choice but to leave. A Fijian doctor, when asked what it would take for him to go back, stated "one million bucks"! Another Fijian stated "...I mean, even the death of a sister wouldn't keep me there. I would just attend the funeral and I'll come, because it was, I mean for me the feeling was so strong that I wanted to leave." Nevertheless, other doctors, both Indo-Fijian and Fijian, and even some who had left because of the coup, maintained close ties and felt strong affection for Fiji.

I think we still go back every year, since we [came] here ... if anything I keep calling Fiji 'home' and I get corrected by all the Australians around me ... 'been here for so many years, how come that's still "home"? I said 'come on ... you weigh up 30 some years against 4', I said 'forget it, that's still home.'

The Fijian migrants were mixed in their feelings about cultural obligations. While all continued to maintain cultural attachments in Fiji, for some, these attachments remained strong, but for others the cultural ties were weaker in general than for doctors who had not migrated.

My family's all there [in Fiji], and I think that given the fact that I was educated there, I probably should contribute a bit more to the community ... and ... feeling guilty [about] the fact that I sort of abandoned them and then just took off when I'm just thinking more of my family and myself at the moment.

... my extended family. Um, the only thing that I miss is the food! Yeah ... I do get in touch with them on the phone and on the internet, so I'm still in contact with them ... my mum usually rings me up and says 'Look, this is your traditional thing, you have to send me money', and I still do. So I haven't escaped from these ... traditions ... I've been back to Fiji twice since I came here so, I mean, it's not that far.

Living in the country where relatives are basically an important part of your living, it's quite difficult. Because we live in ... an extended sort of family where your money belongs to your uncle as well, and with \$10 in your pocket left after a fortnight's pay, it is very difficult to share those things and I mean, if you don't share your things and if people come and ask you for a bus fare or taxi fare and you don't have it, you are looked upon as a sort of, you know, you're not Fijian, you're an Indian! ... Yeah, as I said, most of the things that we own [are] not only yours, it's other people and I think the difficulty about living in that kind of environment is that you don't get to have your own family unit, you know, functioning together. The kids are everywhere and your focus is on the relatives and you forget about your own progress and most of the time your focus is, you know, away from your family and I think, while coming here I will be able to be with my family ... and have a direction for them and yeah, I think in that sense I am happy to be away from home ... I still have a very soft spot for Fiji, I mean, I see myself as a Fijian. I have to go back home some day, so, but not now, later on.

All migrants were asked if they would consider returning, and all were open to the idea except one, who stated he would only return to work in Fiji if something "drastic" happened, such as a being fired. None, however, expressed a wish to re-enter the public hospital system unless they had obtained Australian specialist qualifications. Others were interested in short-to-medium term attachments, or in undertaking mentoring roles with "expatriate" status, or working in private practice, especially once their children's education had been looked after.

... let me think ... I would go back and work if I finished ... my formal [specialist] training, and I'd prefer to do that here and finish up and then go back as a qualified [specialist] and work there.

Lots of options there, go back to Fiji ... if I want to earn a bit of more money, go back to American Samoa and work for 3 months or 6 months ... or go to Marshall Islands ... I'll go to Fiji, do some service work because there's a lot of things going on as well ... look, I've got nothing against ... political things in Fiji. I can go back anytime and work and because my registration is still up to date there ... I wrote a letter to ... the manager for Fiji ... private hospital. He wrote a letter saying 'any time ... you can come' ...

Migrants were asked about the impact of the salaries available in Australia, and none of the migrants cited money as a principal reason for leaving. At least one hesitated about starting over in a new country relating that "I guess if there wasn't a coup we'd still ... be working in Fiji. So it was going to be basically starting from scratch all over again, so, I mean, those were the things that we were weighing up ... to see whether it was a good idea to move or not". All of the Indo-Fijians interviewed described themselves as having been financially comfortable in Fiji.

Money is not an issue for me, because I, let me tell you, I took a pay cut when I came here.

... but no, I haven't had negative experiences in that way. As far as the money thing goes, I don't think money is was a driving factor. We were pretty happy at home the way we were.

All Fijians, however, described being unhappy with their salaries in Fiji, and cited money as a contributing factor in their decision making.

... I'd be lying if I said [money had no influence on our decision], but I think in a small way it did. But I don't think our decision was based mostly on that, I think my daughter had a lot to do with our decision to move ... but, yeah, I guess when you come and work here and you see the amount of money you earn then you think 'oh well, I think I made the right decision to move'.

I think the bigger factor for my moving here was as I mentioned before (security and future of children) and money was one of the factors as well, that sort of kept that in the distance ... I think it was the second biggest factor, to be honest.

To summarise, most (but not all migrants) interviewed cited as their major reason for leaving Fiji a concern for the futures of their families in a politically insecure environment. For the most part, both Indo-Fijians and Fijians mentioned a sense of affection for and ongoing connections with Fiji, although doctors of both races described some bitterness. While migration decisions were made despite a strong personal sense of attachment to Fiji, some welcomed having some distance from cultural attachments and their attendant financial responsibilities, which had been hard to manage on their low salaries. None of these migrants mentioned having been motivated by professional development issues, such as a desired to undertake fellowship training.

5.3.3. Private practice in Fiji

By 2006, ten doctors who had undertaken specialist training had entered into private practice in Fiji, and all were believed to still be in Fiji. Of these, four were interviewed, and again, because of the low number of doctors in this category, some interesting details are left out as they could identify the interview participants.

Each doctors had a predominant reason for leaving the public sector, along with related, contributing factors. Two doctors left the public sector primarily because working conditions interfered with family life. They were experienced specialist registrars when they left, and had been faced with increasing workloads as their colleagues left and were replaced, if at all, by junior doctors new to the specialty. As one doctor explained, “At that time I was so frustrated! Why I left was, my number one thing was for my family ... I thought I wasn’t giving enough time. I have [children], so that was my main reason leaving ...”

The other two doctors left primarily because of dissatisfaction with administrative aspects of working in the public sector, which limited their autonomy and led to an overall sense that they were not valued. Three doctors also mentioned that they believed that their own promotion prospects in the public sector were limited due the career structure, though it was somewhat unclear what role this played in their decision-making.

I was getting fed up with ... the administration ... I'm no longer needed and so ... that's when I decided to move out. And that's when I came to Suva Private ... it took me a year to make up my mind ... What would have kept me there? Well, if they had listened to what I suggested to them ... then maybe yes I would have stayed on.

There was no incentive for us to stay and there were so limited posts and ... we were so confined in the way that we could practice out there as compared to when I've actually come out of the system. I have a liberty to practice and people actually respect the decisions that I make ... I just practice so freely ... It's just so much more rewarding, once I've actually left the government system.

Interestingly, none of the doctors left in response to a particular event in either their working or personal lives, and unlike some of the doctors who remained in the public sectors (see below), none reported episodes of being treated insensitively as an individual. All left the public sectors at times of overall frustration, and all took time to consider their options. Two had not actually considered private work, and had looked into migrating or taking time off, but were approached and allowed to "ease into" private work, which they found to be a good option at that time in their lives, providing an alternative to migration.

... and at that time I had never thought of private practice ... so my main decision was to take time off for my family and from there I would decide what to do, but ... you know people in Fiji they know what's happening really, so ... I got offers from everywhere.

It's weird, I look at it and it's ... find an alternative which ... for my situation actually came off, you know like private hospital ... because otherwise I would have been out of here. I would have gone abroad ... It's just that, this is just such an ... opportunity and ... there's really so much that pushes you away ... I was already applying into Brisbane ... into Queensland.

Work in the private sector was reported as being satisfying, especially in that it allowed doctors to control their hours. It was much more lucrative, but this was not mentioned as the main motivation for any of the doctors. The doctors valued being able to spend enough time with their patients, enjoyed the autonomy of their practices, and liked having available all that they needed to provide

good care, but they did not like the fact that patients were charged for all aspects of their care. The main trade-offs mentioned about private work were that it did not offer opportunities for further specialist training, and that the working environment was not as “rich” and varied as it was in the public hospital.

The work here ... you can't compare it with CWM Hospital, but I like it because I can see my patients with my own time.

The most dissatisfying thing over here is that ... you wish you could just serve people like what we are doing in the Government sector where we didn't have to worry about the money. Somebody else worried about that ... just whatever investigation ... we thought was necessary in treatment and everybody got their turn eventually, but over here you have to think, 'the patient has to pay for all this', and not everybody is insured, or not all the insurance covers all the things...

... right now, looking back ... making about five times more than what I was making in the hospital. But ... I think every doctor would like to further develop [him/herself]. If [there] was the opportunity there ... I probably would return, but given the shambles? And what you hear, I am fearful to return.

In general, private practice offered good working conditions conducive to family life, and for doctors who had not made a decision to migrate, offered an alternative that would allow them to stay in Fiji. Most of the doctors, however, had considered, and had not ruled out migration in the future.

5.3.4. Remaining in the public sectors

Of the 36 specialist trainees interviewed, 25 were either working in the public sectors in Fiji (21) or were in specialty / subspecialty training positions in Australia with a stated intent to return (4). All 18 of these doctors who had obtained a Masters degree by December 2006 were interviewed. One current Masters student as well as six of 14 diploma graduates who were either in Fiji or planning to return were also interviewed.

In the interviews, doctors were asked why they had chosen to remain in the public sectors, and whether they had ever seriously considered migration. Answers given were spontaneous with minimal prompting. Doctors cited a “service ethic”, family considerations, or a sense of attachment to Fiji and/or Fijian culture as the main reasons for not migrating, with most citing more than one reason.

Nineteen of the doctors spontaneously described a “service ethic” of wanting to serve their patients in Fiji, either when specifically asked about not migrating, or elsewhere in the interview. Although this was occasionally expressed as overall satisfaction with one’s work, service in the public sector was often associated with many frustrations, and service took place in spite of these frustrations. While six doctors did not spontaneously describe a “service ethic”, this does not mean that they were not motivated to some degree by a desire to serve, and all doctors described being conscientious in their work.

I had intentions of leaving, but I guess my philosophy of medicine is really based on the care that I can give to people and it is not based on finance ... I think I am happy – what I am content with is the type of care and the level of care that I give to people, and just to see the results. I think ... that’s what motivates me every day ... It may not be in the best conditions, but you know it’s the type of care that you give and in the way that you give it that will make the difference.

And then part of it was, there’s so many specialists [in Australia] and even if I did specialise there, I would be just another specialist among so many, whereas, if I came back I would have skills that I could offer, a lot more applicable.

The role of religion was not specifically asked about in these interviews, but of the 19 doctors who described a service ethic, eight spontaneously volunteered that their medical practice was powerfully motivated by a belief in God. Sometimes this belief was expressed as an underpinning of their day-to-day service, and in other instances it was described as something to be turned to for comfort and guidance when life became difficult. Interestingly, only one doctor in the private sector and no migrants discussed the role of religion in their lives or medical practices. Still, it cannot be assumed that religion was not important in the working lives of the doctors who did not spontaneously mention it, as people vary in their willingness to discuss their beliefs.

I think it depends on me trusting in God to take me through a lot of these situations ... I see situations change where there seem to be demeaning, where there seem[s] to be ... a lack of vision, God begins to give you the abilities to move forward and also see those situations change and also provide a way to be able to walk through. So it's based on those Christian principals that I have been able to make a lot of my decisions and also walk through some of the difficult times, and under stress and duress, it has really been God giving me my strength and refuge and just being a position of solace just to gain my inner strength to move forward, and I think it has contributed greatly to me maintaining the balance between my family, workplace and other ... commitments, traditional and social.

When we first got married we actually toyed with the idea of taking time off and working as missionaries, to do some mission work, but then actually the children came along and we thought again about that and decided that maybe our mission was to stay, just to be here.

All doctors were specifically asked about their cultural commitments, and for 21, culture was very important to them, with 14 specifically citing it when asked about whether they had considered migrating. "Culture" was experienced in a number of ways. Many, including Indo-Fijians, described a feeling that "Fiji is home", or an appreciation for the laid-back lifestyle and friendliness in Fiji, or a sense of commitment to Fiji. Others, mostly Fijians, described extended family commitments as well as taking part in various cultural events. Many doctors mentioned the attraction of raising their children in an environment that would expose them to Fijian culture. Of the 19 doctors who described a service ethic, sixteen viewed culture as important, while three others had made a conscious effort to "draw back" to some extent from Fijian culture. Five doctors described "culture" as the major or only factor keeping them in Fiji, and these doctors did not spontaneously describe a "service ethic". While nuclear family issues were important to all doctors, and were often closely related to or inseparable from cultural factors, only one doctor volunteered that spouse employment was the only factor keeping them in Fiji.

We actually talked [about migrating] quite a lot, especially the first year when we went away ... [but we] felt that we really couldn't just up and leave ,and I think after that as we've gotten more children, we find that in Fiji it is probably easier for us to, I guess, control the type of input that our children are getting, and because we also belong to an ecumenical Christian community, we also sort of have teachings on family life and rearing your children and being responsible for what they are exposed to and things.

... but the main reason [for staying] is security ... you feel foreign if you are the only one in the family there ... in the midst of millions of thousands of people who don't know you ... and ... you can't go to ask for local help, to socialise, like you feel that 'ok we go to auntie this one, to uncle this one, to grandparents here' ... It's the lifestyle, the way people live and work and do things there that is probably not the kind of life that I want to live.

Overall, the doctors who remained in Fiji were held there by positive factors, especially by an ethic of service and a sense of belonging to the culture or to the nation. Nevertheless, many doctors described negative factors and events that had caused them significant unhappiness and in some cases had led them to seriously consider migration.

Fifteen doctors mentioned unhappiness with their own career progression, or pessimism about their promotions prospects. Of these, two had been offered contracts overseas but had not taken them up, and four had actually worked overseas, though two had returned and the other two stated their intentions to return. Interestingly, for a few who worked overseas and later returned, the time spent away was described as one of rededication, refreshment and renewal. Two doctors who had been offered overseas contracts commented:

Yes, and I suppose there are people like me who will probably, despite the odds and the ups and the downs, will probably still decide to remain and to work here until, like I said, they get to the boiling point and then decide enough is enough and pack up and work somewhere else. (about not being promoted)

... so, I mean, you are not rewarded for it, but you are made to work and ... pressured to work ... and sometimes I don't feel good about it. Sometimes I ... think whether I should just also follow my colleagues kind of thing ... and step out of the system ... and of course like currently we know we are marketable. We think of our options that's not only for us but for our wife, family and children, things like that ... Sometimes you really feel bad about how you're treated.

On the other hand, ten doctors were satisfied with how their own personal promotions process had gone, and of these, three stated that their career progress had been expedited by high levels of migration around the time of the 2000 coup. While the minority of these doctors felt that

promotions would come to those who deserved them and that their colleagues should be patient, most felt that although they themselves had personally done reasonably well in the promotions process, they were “lucky”, and that the promotions process needed to be more fair, and that more posts needed to be created.

Many doctors, including those in the public system and those who had left, described “bad treatment” in general, which was impersonal and mostly related to heavy workloads. Seven doctors, however, related one or more episodes of “bad treatment” directed at them personally. They described episodes of extremely insensitive handling of the promotions process (4), not being treated with respect in a serious way (2), insensitivity to serious financial difficulties (2), and unreasonable denial of leave (3). Details of these episodes cannot be related for confidentiality reasons, but had considerable negative emotional impact on the doctors involved, leading three of the seven to actively seek out other employment opportunities. The other four described seriously considering leaving, but did not get to the point of specific planning. All seven described a process of revisiting their core values and making an active decision to continue on in spite of what had happened.

...so I just can't believe this stuff because I don't like being lied to and ... they don't write it down ... so, you can't, so that was the other reason I nearly left.

... but when that happened the beginning of this year, I accepted for the first time I really seriously considered going ... then I thought, 'oh, they won't appreciate me'. It's not that I want to be appreciated but I thought, you know, I'm someone that wants to stay here and this is how they treat me, so it was a very difficult time for me ... and I ... seriously contemplated leaving and applying for, and I thought, okay, I'll stay on, I'll give it a year and if things didn't work out perhaps that would be where I'd be looking at going ... You question that maybe that wasn't the right decision, you know, stay on and work here, but I love this place you know, I love the work, I love the people and I love the atmosphere here.

... but I stayed because my grandfather spoke to me ... and sort of convinced me, but I think deep down I really didn't want to leave, I was just, I felt hurt and just to get back at the Ministry I thought I didn't like the way they were treating me ... I agree with what my grandfather says, like if we all left, who's going to look after our people? That's my main kind of thinking.

In addition, two other doctors considered leaving at the time of the coup, one to the point of actively seeking employment and making plans to “start over” by enrolling in a fellowship in Australia.

Just as we were about to go my wife got offered better things and so we ended up staying back because she has a certain amount of job satisfaction now ... I think I came pretty close ... I mean one of the most important things that sustains you when you're away is ... that I have faith in the fact that I am here for a purpose and the coup actually to some extent ... I almost felt as if my faith was pushed in the wrong direction.

Of the 25 doctors, ten could be classified as possible “near misses” if one counts doctors who considered resigning after “bad interpersonal treatment” (7) or any others who actively sought out alternative employment due to the coup or frustrations about the promotions process (3). It is perhaps worrisome that almost all of these doctors who were “near misses” described powerful ethics of service. This suggests that in the future, even the most dedicated may be vulnerable to giving serious consideration to resignation in the setting of political upheaval or insensitive treatment.

Overseas placements have been described as “whetting” the appetite of trainees, increasing the likelihood of migration. Whether or not this is true, doctors who have undertaken overseas training successfully are no longer held back from migrating by doubts about being able to fit into medical practice in developed countries, and their experiences would have given them valuable connections and made them more marketable. Nevertheless, discouraging or not allowing overseas placements in the hope that this will keep doctors from migrating is no longer a viable option. Overseas attachments are now very common, and had been undertaken by 17 of these 25 doctors. Only four of the interviewed Masters graduates had never done an overseas placement and two of these may be undertaking placements in 2007. While it is difficult to determine who will come back and who will eventually migrate permanently, the four doctors who were overseas in 2006 stated that they would return, and several doctors have already returned from overseas training.

Overall, of the twenty five doctors interviewed who are still working in the public sectors or have stated intentions to return, almost have expressed strong ethics of service, cultural commitments or, in most cases, both. Nevertheless, all are marketable overseas, whether elsewhere in the Pacific or in developed countries, and most have undertaken overseas attachments. A significant number have

described serious consideration of migration in response to political unrest, frustrations with the promotions process or insensitive and upsetting interpersonal treatment, some to the point of actively seeking out alternative employment. Overall, this group appears to be relatively attached to Fiji through culture or through dedication to their work, but it cannot be assumed that they would not migrate in the future, especially if treated unfairly.

5.3.5. The special case of monetary issues for doctors who have remained in the public sectors

As described above, monetary issues were mentioned as motivating factors in leaving the public sectors, though most doctors who spoke about salaries in general felt that public sector salaries were adequate, though not generous. When doctors who had enrolled in specialist training were asked about whether their own salaries were livable, their answers were related closely to their own seniority and life situations, as indicated in Table 5.1. In general, doctors who were more senior described own salaries as being adequate, but requiring careful attention to budgeting. Again, these doctors, many of whom had worked overseas, mentioned that “all is relative” given the lower cost and standard of living in Fiji.

Part of our concern was that if we went to Australia we would both have to ... work quite long hours, because we would then be starting over and both of us would have to pursue our careers actively, in which case the children would be left to somebody else, whereas here, the cost of living, ... the advertising is not so strong ... so we can quite happily say, ‘oh well, we don’t really need that’ and just make do with what we have.

I think I make enough, considering Fiji’s standard of living. If we compared ... our standard of living like in Australia, it’s not enough. But our standard of living’s much lower than Australia and the west and ... so I think for us, it’s enough ... and I like the way we practice medicine and also, I seriously am not in it for the money.

... at the moment with one child I think I can live on my salary ... but, you know you’re denied the chances of trying to find ... more expensive entertainment and all that sort of thing ... like going on a hotel holiday or something ... You’re not talking about a Mercedes or something ... basic essentials you can live on that salary.

A few who had obtained specialist registration mentioned that doing outside private work allowed them to earn more than when they were overseas. As one doctor related, “I’m happy and, probably with my private work making the same or even more money here than I made in New Zealand ... so, income-wise ... I’m happy here.”

On the other hand, doctors at junior grades had much more difficulty getting by on their salaries, with some citing major financial pressures. In general, single doctors felt that they could get by, but that they would not be able to manage if they were married. Some doctors felt that they were only able to have a comfortable living because of the salary of a spouse. Married doctors with families struggled, particularly in Suva where housing was not provided and rents were relatively high. Those with mortgages described struggling the most.

I think at present with the current post, it’s not bad, but the only difficult thing is when you have a commitment like mortgage ... and you know that can chew up ... your salary ... our day to day livings [are] not that much

I think it was just enough to sort of survive ... just enough to survive. It wasn’t enough to save for maybe a trip overseas or ... to buy, even though we were able to get a good house, buy things. It was mainly for day-to-day sort of things – and not for the future.

I’m able to cope. I am still single so I don’t know whether that will change after I have my own family.

At the moment salary-wise I wouldn’t say it’s good, but because my husband is there he’s earning much better than me ... so I’m alright ... Other people who’ve got children, some of them are struggling ... if only one person is earning ... and they’ve got children what is a doctors salary, it’s nothing ... ‘this is a clerk’s salary’ my dad used to say.

... sometimes you feel bad ... you know bad comes to worse. I’d rather stay home ... rather than you know with this kind of salary ... and get frustrated here there’s no point ...

As described above, most of the doctors who entered private practice commented on their increased salary, though none cited financial considerations as reasons to leave the public sectors, mentioning instead working conditions, family considerations, or lack of appreciation. As mentioned above,

none of the migrants mentioned financial considerations as the main reason to migrate either, though they played some role in the decision making for the Fijians who were interviewed.

Table 5.1. Financial situations as self-reported by Fiji doctors working in the public sector or on temporary overseas placements intending to return (n=25)			
	Number	Highest 3 grades (PMO or above)	Lowest 2 grades (SMO or below)
Satisfactory financial situation (12)			
Can earn very well due to opportunities to do private specialist work	2	9	3
Comfortable but modest	10		
Financial situation unsatisfactory or satisfactory only due to family situation (13)			
OK because spouse is working	4	2	11
Getting by because single	3		
Struggling to get by	6		

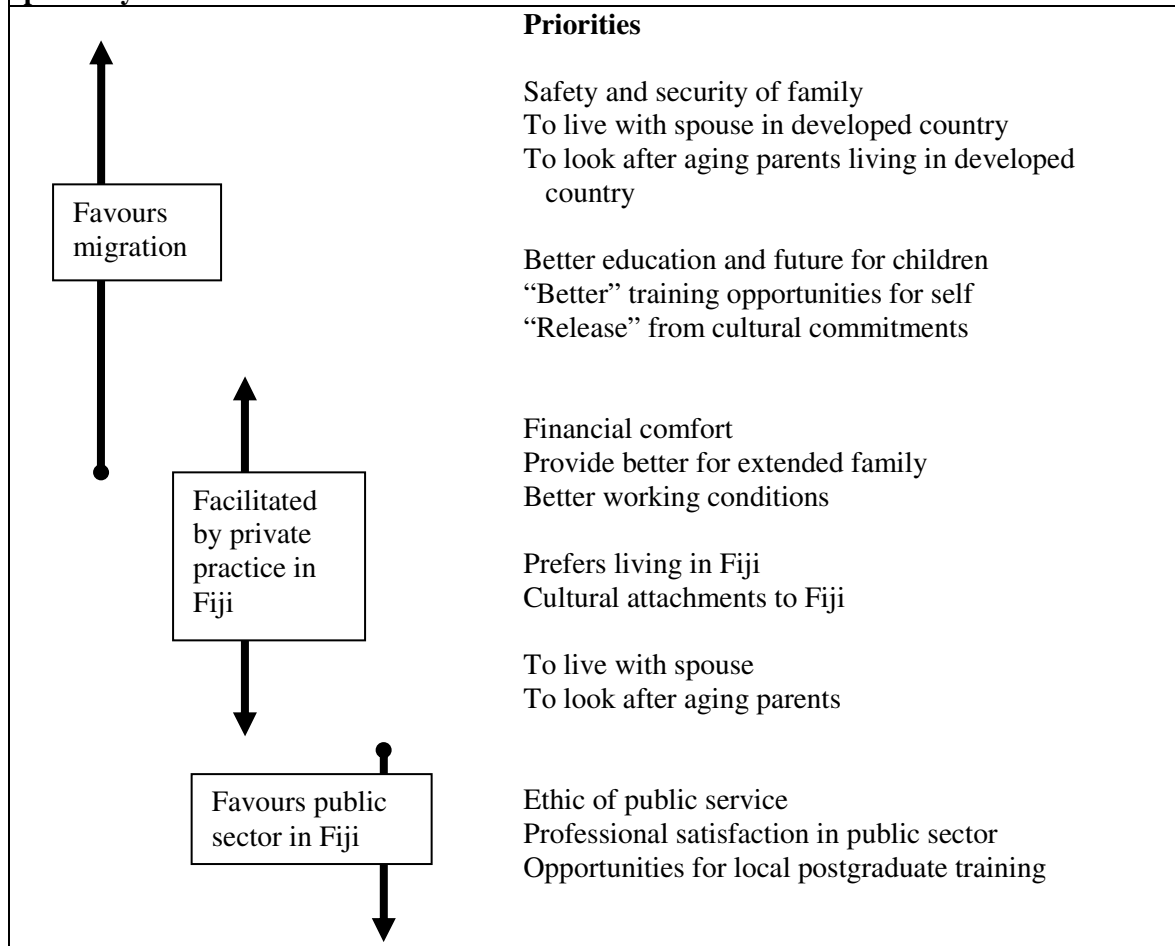
Overall, Fiji specialist trainees could eventually expect a livable salary if they remained in the public sectors, but this was tied into promotion and career advancement, which in practice was not guaranteed, with many doctors remaining at junior postings and their associated low salaries for as long as a decade or more, which coincided with the years when they married, had children, took out mortgages, and often wanted to get by on a single salary. This is explored in more detail in Chapter 6. As one senior doctor stated, “I think salary has to be linked into the post progression, the career progression basically ... even if you don’t do any studies you should progress and it’s very demoralising to stay an MO (medical officer) for fourteen, fifteen years.” Younger doctors therefore could find themselves in significant financial difficulties, and if they stayed in the public sectors, relief was many years away, with no guarantees over the timing of future promotions. For some families, immediate financial relief was needed, and while this could be obtained through migration or through locum work in American Samoa, lucrative salaries could also be earned by leaving specialist training and entering private general practice in Fiji. Nevertheless, for doctors who decided to migrate, and especially for those who entered private practice, money was definitely not cited as the main reason.

Of note is that by mid-2006, several Fiji Masters graduates who had obtained specialist registration described doing some private work to supplement their public incomes, and they found this to be particularly lucrative. Ironically, two were still at the second lowest grade (senior medical officer) despite having undertaken subspecialty training overseas. While the slowness of their career progression may have been discouraging to younger doctors considering whether to enter postgraduate training or complete their Masters, on the other hand, younger doctors may have been encouraged through realising that they themselves, even if they chose to remain in the public service, would eventually be able to earn a very good income once they obtained specialist registration (which was generally available 2 years after Masters graduation), even if career advancement was not forthcoming. Whether opportunities for limited private practice will have an impact on retention or even recruitment into postgraduate studies remains to be seen.

5.4 Keeping doctors in Fiji

As outlined in Chapter 4, working as a specialist in Fiji can offer many opportunities for satisfaction, but can also be enormously difficult, and enormously frustrating. A number of factors helped to keep these doctors in Fiji, especially the work itself, a sense of attachment to Fiji, and family issues. While these factors may prevent overseas migration, they cannot necessarily keep doctors in the public sectors in Fiji when there is such an active private sector. Figure 5.3 describes the priorities of individual doctors that favour public sector work, private practice or migration.

Figure 5.3. Priorities that favor migration, private practice in Fiji, and retention in the public system



Retaining doctors in the public sectors can potentially be helped by addressing the reasons why doctors leave and why they stay. From the standpoint of the Ministry of Health (MOH), some factors are “passive” in that, at least in the past, they could be counted on to keep doctors, if not in the public sector, then at least in Fiji. “Active” factors are specific policies and interventions that a health department is potentially able to undertake consciously in order to keep doctors.

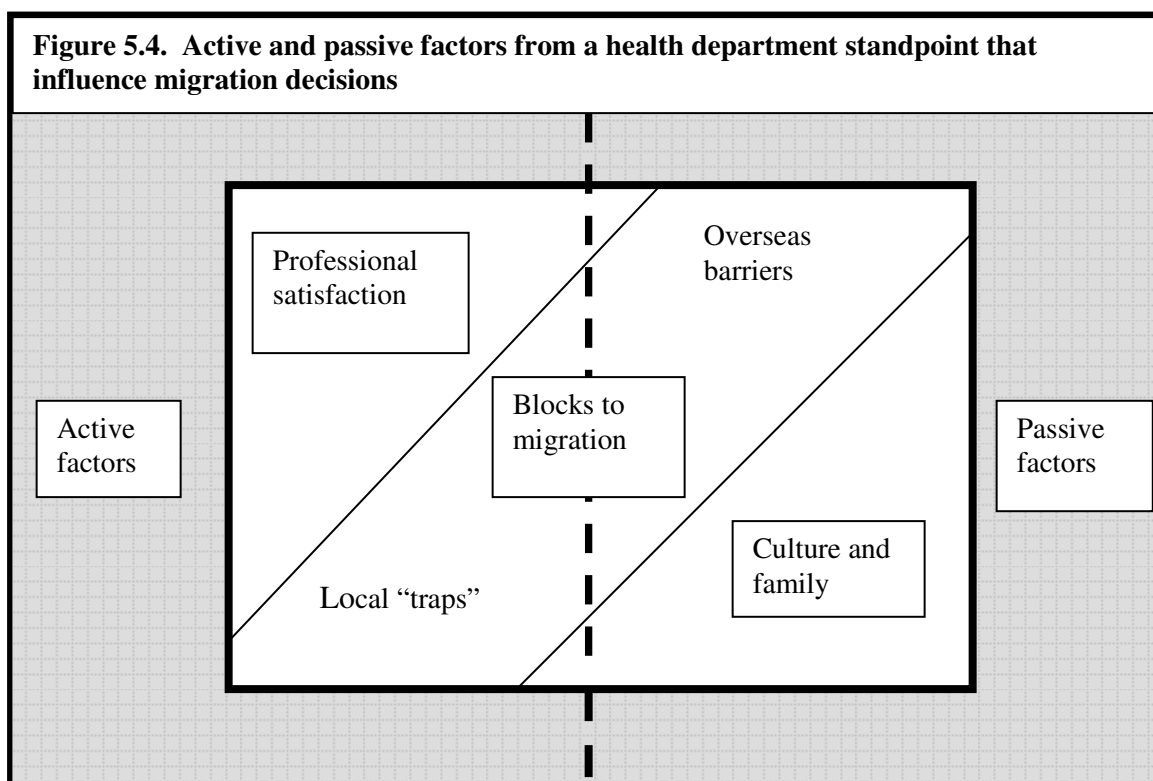
Cultural attachment is a “passive factor”, from the standpoint of the MOH, and is still very strong for many doctors, including some Indo-Fijians, but probably cannot be counted on to retain doctors to the degree that it has been in the past. For some doctors, a sense of cultural attachment seemed to be almost inseparable from a sense of dedication to serving the people of Fiji, and this could keep a doctor in the public system. On the other hand, moving into private practice may have allowed some of these doctors to be in a better position to spend time and money on cultural roles and

obligations. Some doctors have even described needing to “override” cultural attachments to some extent in order to migrate, though they also described continuing to keep in touch through e-mail, phone, visits home and remittances.

Nuclear family issues were extremely important “passive factors” in migration decisions. Spouses accommodated to each other’s professional and family responsibilities. Parents migrated for the safety and futures of their children, or remained in Fiji in order to bring their children up in their own culture. Other doctors remained in order to look after welfare of aging parents. Again, doctors who remained in Fiji for family reasons still had the option of leaving the public system in order to work in private practice, as this often allowed better incomes and more time to devote to family life.

“Blocks to migration” can be either passive “barriers” that other countries set up to limit the intake of overseas doctors, or active “trapping” through deliberately setting up conditions in Fiji that discourage migration, or make it more difficult. The overseas “barriers” to migration are much weaker than they were after the 1987 coups, and most English-speaking countries in the developed world have lowered their barriers to accepting overseas doctors. The “inner” barrier of doctors not feeling confident enough to work overseas is much diminished as well, and most have either undertaken placements overseas, or have observed the successes of their colleagues. If they have any doubts in their abilities, they now have the opportunity to use Diploma training as a “bridge” to developed country standards. Active “traps” have not been particularly successful in keeping doctors in Fiji either. The “trap” of a non-transportable qualification has not kept doctors from leaving. While Fiji could have opted for the “trap” of providing “inferior training” for specialists in order to discourage migration, no one wanted this, either at the time specialty training was set up, or now. Given the openness to migration of Australia and New Zealand, it is doubtful that this would be much of barrier in any case. The “trap” of not allowing doctors to undertake specialist placements overseas is no longer feasible, because over time, such training has practically become the norm. The denial of placements could even backfire by leading to resignations. Formal “bonding” arrangements for sponsored undergraduates attending FSMed exist (currently approximately one year of service for each year sponsored), but a number of doctors related that enforcement was variable and didn’t seem to apply to some. Whether formal bonding for sponsorship of postgraduate training would discourage migration is unclear, and it could again backfire by acting as a disincentive for doctors to enter training.

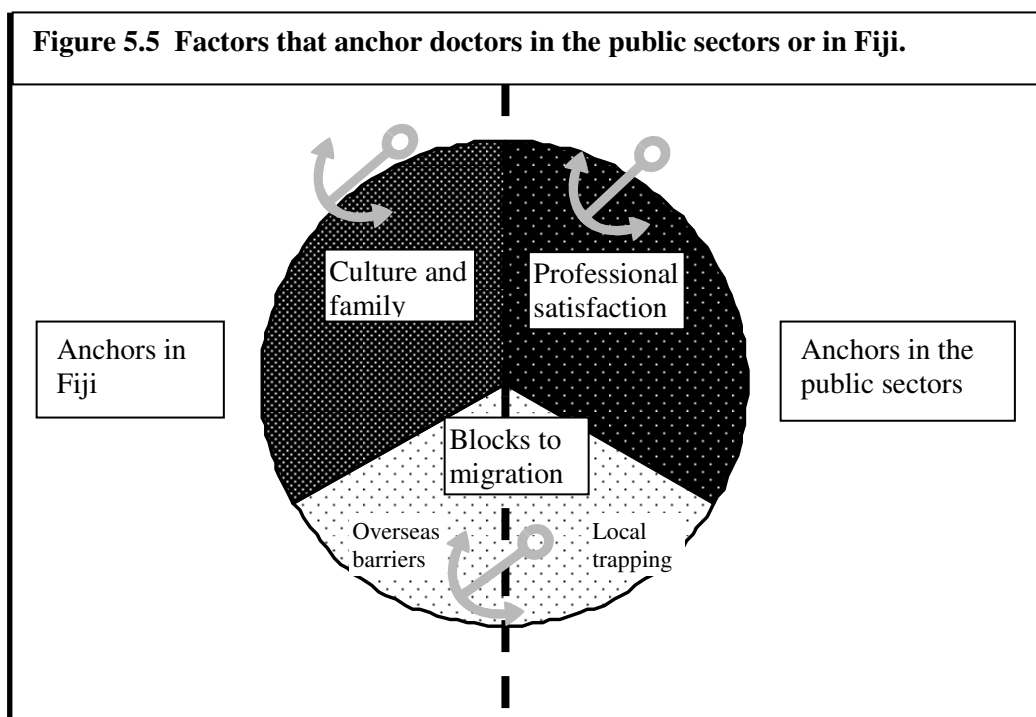
While cultural factors generally would help to hold doctors in Fiji, though not necessarily in the public sectors, and while “blocks” to migration, especially from outside of Fiji, are no longer as effective in retaining doctors as in the past, the factor of job satisfaction can be actively enhanced through interventions by the MOH. Some elements of “job satisfaction” could be considered as being “passive” from the standpoint of the MOH, and many interview participants described a sense of dedication to public service grounded in professional and personal values, perhaps in spite of whatever they felt about the MOH. This cannot be counted on by itself to keep doctors, however, and many otherwise dedicated doctors have left or seriously considered leaving, citing professional dissatisfaction as a major or contributing factor. As discussed in the model introduced in Chapter 4, professional satisfaction was described by the interview participants as consisting of opportunities for professional growth, opportunities for service, and being recognised and valued, on a background of a well-structured health system. Dissatisfaction was related to the absence of professional satisfaction, or, in some cases, the blocking of professional satisfaction. The main dissatisfying factors mentioned were unclear career pathways and difficulties with promotions, inadequate logistical support of the working environment, and lack of appreciation, often manifest as poor interpersonal treatment of doctors, either in a general sense or as individuals. The relationships between the active and passive factors that impact on migration decisions as outlined above are illustrated in Figure 5.4.



From a health department standpoint, the interview data suggested strongly that the most reliable “anchor” available to prevent resignations is through making efforts to facilitate professional satisfaction for doctors in the system. This could be addressed in a number of ways. Clear career paths as well as just and transparent policies for promotion could be developed (this is discussed in more detail in Chapter 6). Workplace conditions could be improved through making sure essential medications and supplies are provided and through making efforts to fill vacant posts in a timely fashion, especially in under-staffed departments, in order to prevent resignations due to fatigue and interference with family life. At health department, hospital and departmental levels, doctors should be treated as valued members of medical teams, and it should be recognised that insensitive interpersonal treatment of many doctors has taken place in the past, and should be carefully avoided in the future.

The interview data suggested strongly that it is no longer justifiable to assume that doctors will stay in the public system no matter how they are treated because of “dedication”, strong “cultural attachments”, or because of not having other employment options. While doctors differ in their propensity to stay in the public service in Fiji, even those who are unlikely to leave can be driven to do so by fatigue or by poor interpersonal treatment. Figure 5.5 shows the factors that “anchor” doctors in Fiji, whether in the public sector or in the country itself. The strength of the attachment

of doctors to Fiji can be seen as related to the size and number of the anchors that the doctor has set down. In this model, a strongly “anchored” doctor can “weather” most storms that come along, but for a doctor with a single small anchor, or no anchor at all, it wouldn’t take much for them to be “blown away”.



Doctors often expressed the opinion that some of their colleagues were more likely to leave than others, and in particular that some who left at the time of the coup were going to leave anyhow. One of the Masters graduates who wanted very much to stay felt that efforts should be taken to address the concerns of the many doctors who “could go either way”.

... the ones that we would have kept, ... the view that you have, one end of the scale you have hundred percent ‘I’m leaving, not coming back’ ... the other end of the scale you have the one percent where they say ... ‘I’m going to stay in Fiji’, but there’s a whole group that are in the middle ... they’re in the forty to sixty percent ... forty percent is towards they’re staying and sixty percent is towards they’re leaving ... and I think we don’t do enough to entice people in that middle group to stay ...

Political instability is not under the control of the MOH, nor is the openness of most developed countries to the migration of doctors. In the future, some doctors may migrate in the face of political events even if their work is satisfying. On the other hand, doctors who are otherwise satisfied with their work and with their career prospects may be willing to “wait out” political events before making a final decision to leave or stay. Many doctors in Fiji have experienced frustrations in their working environments, and after the coup of 2000, not only Indians, but most Fijians as well, have probably considered migrating and have made an active decision to stay, while remaining conscious of migration as a viable option. This could be seen as a “pre-priming” towards migration, allowing a more rapid decision to leave to take place in the future, as happened with Indians in 2000, who left Fiji quickly. Additional “pre-priming” may take place when doctors who are otherwise unhappy professionally start to think about leaving, and a coup could be the “tipping factor” in their decisions to resign. If enough doctors are ready to make a rapid decision to migrate, unpredictable events can lead specialist departments to become rapidly depleted, setting up downward spirals of resignations as even the most dedicated doctors can no longer cope with the workload. The interview data suggested that the health system would be wise to pay particularly close attention to facilitating professional satisfaction for doctors in stable times, as this may help the health system to weather difficult times with fewer resignations.

Overall, the doctors who were interviewed (including many of those who had resigned) described the public hospitals in Fiji as places where desires to serve could be made manifest, and where a rich learning environment in itself could facilitate professional growth. These professional values can potentially serve as powerful “anchors”, which is reassuring at a hospital and health system level, but cannot be taken for granted. Adverse conditions and events have overridden these values in the past and are likely to do so in the future, and overall, given the same circumstances, some doctors are probably more likely to migrate than others. As one doctor described:

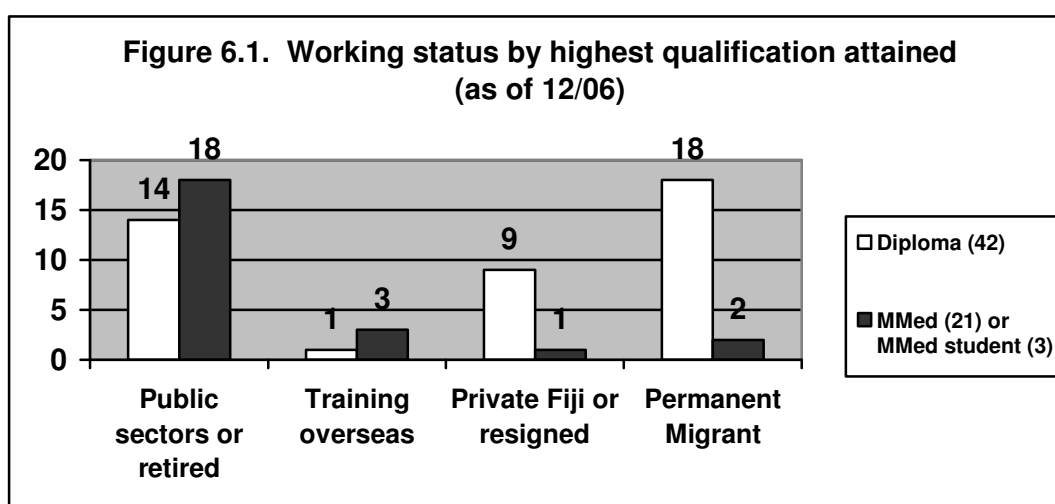
... very early on in the piece I found that ... my possibility of going was lower than most others ... and I knew that the capabilities of those people in ... the huge group of people wanting to go, I knew there were a lot of bloody good doctors in that group and ... I knew there was a lot of people in that group they were going to be very useful to the country ... and not only useful to the country, they were going to be recognised throughout the Pacific for their work in medicine, especially in tropical medicine ... and I knew that if they stayed it would have really ... boosted the hospital, boosted the medical school, it would have boosted the young people coming up, [the] young consultants and ... I tried very hard to be able to

persuade the authorities to improve the conditions so that these people can stay ... I recognised very early on in the piece that I was in the twenty percent ... that at the end of the day ... if everybody else left, then I was probably ... going to be one of the last ones to go and it had to be something very, very nasty to make me go.

The current global environment is very challenging to health departments in developing countries. Medical migration is a problem throughout the developing world, exacerbated by the failures of developed countries to train enough health workers to meet their own needs. Many developing countries experience difficult times, often related to political instability. All of these issues, which are outside of the control of health departments, need to be addressed. Nevertheless, in the face of these challenges, at least for Fiji, these interviews suggested that there are active interventions, related to the facilitation of professional satisfaction, that can be taken in order to lessen the impact of otherwise uncontrollable factors and events.

Chapter 6. Results Part Three: Career Decision

While Chapter 5 looked specifically at decisions to migrate, enter private practice locally, or remain in the public sectors, the current chapter looks at career pathways, especially in regards to the decisions that Fiji doctors have made about their own local postgraduate training. The decision about whether or not to complete training to the Masters level may be particularly important because most doctors (42 of 66) left the training programs with a Diploma as their highest qualification, and these doctors had much lower retention in the public system than those who completed a Masters (see Figure 6.1).



The importance of completing a Masters may be greater in Fiji than elsewhere in the Pacific. In regional Pacific Island nations, populations and medical workforce numbers are small, and sparing even a single doctor for four or more years while they are training as a specialist in Fiji can be quite burdensome to health systems. Some regional doctors who were only supported to train to the level of a specialist Diploma have been able to return to their islands with valuable skills and have been able to carry out senior roles. For some nations, it may be debatable whether their small populations can justify fully-trained specialists, and in such places, Diploma-level training is potentially of considerable value. On the other hand, the population of Fiji is much larger than those of its neighbors. The Ministry of Health (MOH) runs three major hospitals that provide specialist services, and these are generally staffed with fully qualified specialists (often expatriates). Before local Diplomas and Masters became available, doctors who did not train as specialists overseas had the option of working in specialty departments in Fiji with the possibility of obtaining

specialist status after 15 or so years. Now, the Masters in Medicine (MMed) has been developed as the local route to specialist status. Fiji doctors who left postgraduate training with only a Diploma would have gained valuable knowledge and experience, but this has not generally led to career advancement. The option of remaining in the public service for many years and automatically becoming a specialist may no longer exist, making the future career prospects of “Diploma-only” doctors in the public service unclear. While working in district hospitals and using skills acquired in training is potentially an option, it has rarely been taken up.

While this chapter explores the career stages for these doctors as well as the career choices that they have made, a number of other issues are addressed. The impact of gender and race on decisions to leave or to continue training are discussed. Additionally, this chapter is, to some extent, an evaluation of an intervention in medical education (the establishment of postgraduate training in Fiji), especially in regards to its arguably most important outcome, which is whether or not the goal of training a local specialist workforce that would stay in Fiji over the long term is likely to be realised. Part of this discussion includes the views that these doctors have about the quality of their postgraduate training. This is more than just “program evaluation” because the strengths and weakness of local specialist training had the potential to impact on whether or not doctors felt it was worth their while to continue their training.

6.1. Decision-making before the start of specialist training

6.1.1. The process of entry into specialist training

The Fiji specialist trainees who were interviewed mostly undertook their undergraduate medical training at the Fiji School of Medicine (FSMed), though some had studied in India, Pakistan, or Australia. Upon graduation from FSMed with an MBBS degree, the doctors were assigned to do a one-year internship at one of the three major hospitals. Throughout medical school, students were told that after internship, in return for government support of their medical training, they would be required to work up to six years in public system (though provisions were made to allow doctors to leave earlier if they repaid the cost of their education for the years not served). The students were also aware that part of this public system work would include placements for a number of years in the “periphery” outside of the major hospitals, often in a smaller town or rural area. Some doctors,

however, were invited immediately after internship to join a specialist department at one of the main hospitals. Overall, while requests could be made, these doctors generally had little ultimate control over where they were assigned, and in a few instances, the placements led to husbands and wives being separated, though this was usually avoided.

As the required years of rural service came to an end, these doctors faced a number of career options which included leaving the public service to either migrate or enter private practice in Fiji (which in some instances required bond repayment), or remaining within the public service. Doctors in the public service generally had the option of continuing to work in a general practice / public health capacity, usually outside of the three major cities, or applying to come to a major hospital to be specialist registrars. All appointments were ultimately dependent on Ministry of Health approval. The prerequisites for starting specialist training included completing an internship (1 year), two required “service” years, and one year of working as a specialist registrar. The minimum time from MBBS graduation to earning a four-year Masters degree was therefore 7 years.

This study looks at career decisions of doctors who undertook specialist training in Fiji. By definition, all of the doctors interviewed (with the exception of the senior specialists who trained elsewhere) had made a decision to pursue specialist training in Fiji, had been allocated a specialist registrar position by the Ministry of Health, and had either obtained their Diplomas (36) or were eligible to enter Diploma training the following year (2). This study does not explore, however, the issue of health care delivery outside of the major hospitals, which is at least as important on a national level as specialist services. Most FSMed graduates have not pursued specialist training, and this study can only speculate about their careers. One Masters student provided some insight into the career decisions of his pre-2000 graduating MBBS class when he listed his 17 classmates on a blackboard along with where they were currently working. All six Indo-Fijians had migrated, one immediately after graduation, and five soon after the coup of 2000. Of the 11 Fijians, 5 were still in the public system, one was a tutor at FSMed, four were in private practice in Fiji, and one had migrated. In addition, he related that two of the Fijian doctors still in the public system had come close to resigning. This Masters student attributed the migration of his Indo-Fijian classmates to security concerns, and the resignations and near-resignations of Fijians to overall frustrations with salaries and working conditions, which he described as being heightened around the time of the “work-to-rule” industrial action in 2002 (see Chapter 5). As he explained, “... [the] whole lot who left work, left because of frustration and money ... money was always an issue. I would say that ... all these resignations happened mostly after the 2001, and 2002 there was a “work to rule”

that happened ... and straight after our issues were pushed through ... and most of the issues did not happen and I think half of these people left around that time.”

The careers of the five (out of 17) doctors still in the public sector were of particular interest. Despite the fact that over seven years had passed since graduation, which allowed enough time for completion of specialist training, only the doctor who was interviewed had even entered formal specialist training at FSMed. One classmate was training informally in pathology in Suva, and two other classmates who were working as specialist registrars had not yet entered the training programs. Only one was working in the public sector outside of the major hospitals. Whether other graduating classes had similar outcomes was not addressed in this study.

The lack of timely advancement into specialist training was of concern to staff at FSMed. During the final fieldwork trip in September 2006, three senior specialists spontaneously and independently mentioned their concerns about a lack of transparency in how doctors were selected for specialist training, or for any career path in the public system, for that matter. One of these specialists expressed concerns about how new medical school graduates were assigned by the Ministry to internships and service postings, often seemingly without concern for individual interests and inclinations. Others also wondered if doctors who were interested in specialist training but were stationed in the “periphery” were worried about being left in their posts and “forgotten about”. The FSMed specialists explained how potential specialist trainees had to be appointed by the MOH to a specialist registrar position in order to become eligible for training, and after that they needed to be selected for sponsorship by a government scholarship (except for a few self-sponsored private students). These requirements meant that specialist coordinators at FSMed were only able to play a minor role in recruiting and selecting trainees. From the FSMed standpoint, it was also unclear how many, or even which students approached, or were approached by the Ministry to start down a specialist career pathways, or by what criteria the actual selection processes for the entry-level specialist registrar posts took place. If this process was unclear to FSMed specialist staff, it was undoubtedly even less clear to the potential trainees themselves, and these senior doctors wondered whether the lack of clarity about how to pursue specialist careers led to frustration, lack of hope and eventually to resignations.

The FSMed anaesthesia specialists were particularly concerned about the lack of recruitment of pre-training anaesthesia registrars. This was reflected in a dramatic drop-off in the number of anaesthesia students, with only one Fiji doctor entering (and later leaving) anaesthesia training since

2002, and with no Fiji doctors training in Anaesthesia at any level in 2006. This was believed to be a major contributing factor to the anaesthesia staffing crisis in early 2006 (as discussed in Chapter 5). One of the FSMed specialists related frustration at being told by the Ministry that there was a lack of interest in anaesthesia training, despite being personally aware of and having copies of letters to the Ministry from interested applicants.

A second decision that medical graduates had to make in order to pursue specialist training involved the requirement to relocate to Suva. While training to the Diploma level was available at Lautoka Hospital, Masters training was only available in the capital. In Suva, doctors at junior grades were expected to find their own housing in an expensive rental market on the same salary that they would have earned while working as specialist registrars at the main hospitals in Lautoka or Labassa, where highly subsidised housing was also provided by the MOH. This, in addition to personal and family considerations, was felt to discourage some doctors from undertaking training.

... and so salaries in Lautoka certainly go much further than salaries in Suva. I think this is one of the factors in which, you know ... we've got a young couple who work in [the periphery]. And I think they're, sounding like a clinician, I think they're too good to be working in a small district hospital. They said they're comfortable. They've got two salaries ... goes far further than two salaries in Suva. Rent's high in Suva, and so, why come to Suva? And then spend time doing the postgraduate course to be abused by seniors when they're their own bosses in the district. (senior consultant)

... because the other thing too is people are worried to ... make a move to come across to Suva, there is so much expenses you're going to need for traveling and moving and families and adapting and, you are not sure what is ahead of you or for the program whether, you know they will improve your salary or whatever ... in order to make up for the losses for you to come ... so I think that's basically a fear that people sort of have ... yes, I think it was very difficult to come across.

On the other hand, senior doctors at Lautoka Hospital felt that they were disadvantaged in recruiting specialist registrars. They believed that most doctors who wanted to become specialists preferred to start training in Suva, where entry into postgraduate training would be pretty much automatic after their pre-training year. For specialist registrars in Lautoka, however, continuing on into the Masters program would require obtaining permission to relocate to Suva, and this could be delayed for a

year or more due to staffing considerations. As one doctor from Lautoka explained, “This is our problem. We have ... a lot of difficulty getting our own people from out in the district to come in and join some subspecialty ... so we can feed them into the training program ... and the way I see it, most of them, when they get back in, they prefer to go to Suva straight away ... because once you are based there, then they can apply and then they go straight into this training.” Of the 6 doctors who undertook some postgraduate training by distance in Lautoka, 3 eventually came across to Suva for Masters training. Overall, it is difficult to tell to what degree the requirement to move to Suva was a deterrent to entering postgraduate training, or whether, perhaps, the establishment of training in Suva had an even more detrimental effect on specialist registrar recruitment in Lautoka and Labassa.

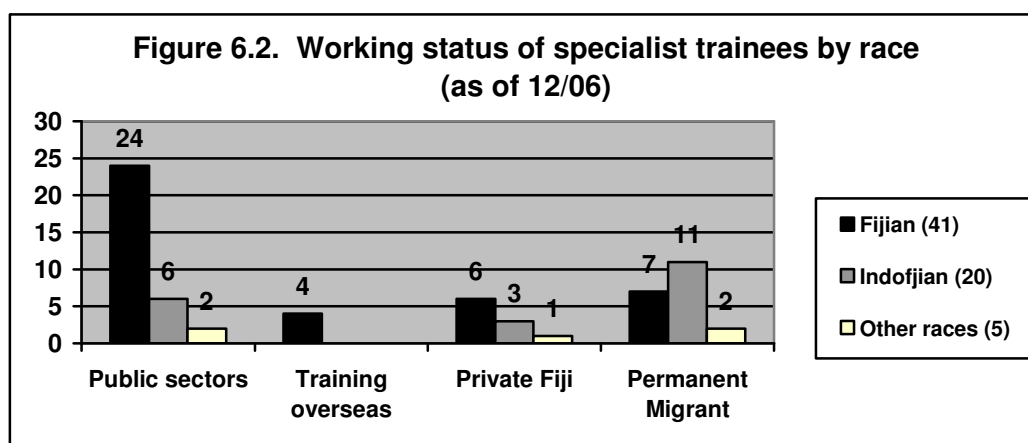
Overall, the pathway from medical school graduation into formal specialist training was characterised by many uncertainties. The process was viewed as lacking in transparency with unclear criteria for selection, and with no assurances about whether or when doctors who wished to become specialists would actually be able to enter training.

6.1.2. Should Indo-Fijians enter specialist training? Experiences of those who did, and implications for other Indo-Fijians

In Fiji, Indo-Fijian doctors have migrated at higher rates than Fijian doctors, as discussed in Chapter 2. This has been especially apparent since the coups of 1987, with peaks of migration during 1987 / 1988 and after the coup of 2000. While this study looks at Indo-Fijians who actually chose to enter local specialist training, these represent a minority, and for other Indo-Fijian doctors, the decision faced was not only whether to enter postgraduate training, but whether to remain in Fiji at all. Indo-Fijian doctors who did not undertake specialist training were not interviewed, so their experiences cannot be presented here. Nevertheless, the experiences of Indo-Fijian doctors who did undertake specialist training may shed some light on the reasons why many of their colleagues did not pursue specialist training, and it is therefore worth reviewing their experiences here as a part of a discussion on the decision making of Fiji doctors in regards to entering training.

Of the 66 Fiji doctors who undertook specialist training, 20 were Indo-Fijians, 41 were Fijians, and 5 belonged to other races. Nine out of the twenty Indo-Fijian doctors who had undertaken postgraduate training were interviewed, including five of nine who were still in Fiji, along with four

of eleven migrants. Two other Indo-Fijians were interviewed, including a senior department head and a junior specialist registrar who had not yet started formal training.



Indo-Fijian doctors who contemplated undertaking specialist training in Fiji had to take into account not only the overall security and political situation in Fiji, but whether discrimination within the public system would prevent them from attaining their professional goals. After the coups in 1987, many watched their Indo-Fijian colleagues migrate, and some described subsequent professional discrimination, not only impacting on Indo-Fijians in general, but on their own medical careers as well.

As a consequence of 1987, it's been extremely difficult for Indo-Fijians to progress up the career path, OK? And you can call it nationalism, racism, whatever, but I think that definitely put a barrier in the way of the progression of Indo-Fijians through the health system ... that's been a major, major determining factor in driving them away. (senior consultant - Fijian)

... and I think I was fortunate to be one of the people that came through the system after the first coup...where the new intake to the medical school was 50/50 in terms of the Indians and ethnic Fijians ... because when I compare my grades ... to my Indian colleagues they had far better marks and grades... (Fijian doctor)

... 'cause they're native Fijians, and I know that they were not that good in school! ... but they're still going further compared to where we are, me and ... some of my other colleagues, except for the ones who ... finally decided to go abroad and ... they're doing quite well ... (Indo-Fijian doctor)

Indo-Fijian doctors who chose to stay in Fiji after 1987 described barriers to obtaining training, especially overseas training, and a few described this as being especially distressing. One doctor who particularly wanted to undertake specialist training described his own efforts to deal with the professional blow of being denied opportunities. He described how "... in those days there was a thing called positive discrimination ... and it has to be given to a Fijian ... and I missed [an] opportunity again ... that one really hurt me ... still..... I went to the interview, the question is 'you are an Indian' ... this is from PSC (Public Service Commission) ... 'What guarantee can you give us that you will return to Fiji and continue working?' I said 'I'm born here, I'm a... and a' ... so that was it, that's the only part that I failed in the interview ... but on the racial line, it's all to do with ... I keep saying it, positive discrimination ... so, you just have to work 100, 103%, 105% ...".

Before 1998, specialist training had not generally been available locally, other than a few stand-alone Diploma programs in obstetrics and paediatrics. By time of the startup of local postgraduate training, the numbers of specialist registrars who had not undertaken any postgraduate training or who wanted to advance to the Masters level had built up. This may have been especially true for Indo-Fijians who, as mentioned above, described being discriminated against when training spots, especially those involving overseas placements, were allocated. Even with local training, some Indo-Fijians felt that their entry into training was unfairly delayed compared to their Fijian colleagues. As one Indo-Fijian doctors describes, "... a few of my colleagues were outspoken, they did question why this particular person you know 'why I wasn't taken and other people were not taken', but as you know, most of the things are not answered here."

Initial intakes into the training programs, particularly in 1998 and 1999 were relatively large, and by the time of the coup of May 2000, 13 out of 28 enrolees were Indo-Fijians. These doctors had personally experienced the coups of 1987, had spent various numbers of years serving as specialist registrars, and had actively decided to remain in Fiji, although some described experiences of discrimination during those years. After the coup, many of these doctors decided to migrate. By 2006, only 4 of these 13 doctors remained in Fiji, of whom two worked in private practice, while the other two went on to complete their Masters, thereafter remaining in the public service. Of the other nine, one went to American Samoa and the rest moved to developed countries and were presumed to have migrated permanently. The overall impression was that the Indo-Fijians who left departed quickly, and indeed, the migrants who were interviewed and had left for security reasons described seeking out opportunities to migrate almost immediately after the coup. Migration rates

of Indo-Fijian doctors who were not undertaking postgraduate training may have been even higher, though this was not assessed in the current study. As described above, a Fijian doctor had seen all six of his Indo-Fijian MBBS classmates migrate, mostly soon after the coup. Another graduating class had a similar experience. As one Indo-Fijian doctor described, "...when I graduated (in the late 1990s) ... we had eight Indo-Fijians who graduated with me ... and six of them have migrated ... and one is migrating this year ... so there is only me ... I have tried to encourage or sort of ask people to stay but I've never succeeded."

Between 2001 to 2004, seven other Indo-Fijian doctors enrolled in postgraduate training, and of these, four are still in the public service, one has resigned but is still in Fiji and two others are living overseas. Given the "lack of openness" in the selection process of doctors for postgraduate training that is described above, it is not possible to tell if these lower numbers of Indian trainees reflected lower numbers of applicants (due to intentions to leave the public system or to beliefs that it wasn't worth applying because they were unlikely to be sponsored) or whether the low numbers were due to active discrimination against Indo-Fijians who actually applied. One doctor described how it was being actively discussed at a policy level whether it was possible to retain Indo-Fijians at all, especially males, and whether that justified discrimination, including at the undergraduate level. Another doctor described wondering if it was even possible to keep Indo-Fijian doctors in the public service.

... the Public Service Commission looked [at] how can we keep people here by looking at the intake, OK. Who leaves? And ... the Indian male is the most likely person to leave and they looked out without telling anybody they said 'Why don't we just stop the intake of Indian males?' So that was another avenue which they looked at. OK, instead of having a 50-50 intake, well maybe we should increase the Fijian, ethnic Fijian intake and so they're now looking at that ... I think our standard will drop because certainly the Indian male, he enters at a higher level ... but this is another issue they're looking at. If we look at, say, the Indian male, is 90% likely to leave, why do we accept him? (senior consultant – Fijian)

I feel that many of my Indian colleagues have a focus in life that is towards getting bigger and better things as you grow older ... I think it is all part of their own culture, that when you are born again you are supposed to be born a better person, so the whole thing is just geared towards getting better and better and better and better ... they would have less problems migrating and going and doing something outside of the country if it's going to give them something better ...

that is probably the way they are brought up, and ... I don't think there is anything wrong there ... But from a job satisfaction point of view in terms of how we can retain people by giving them satisfaction, that group of people will never be really retainable. They are not people you can detain." (Fijian doctor)

Overall, of the ten interviewed Indo-Fijian doctors who had undertaken local postgraduate training, six reported feeling disadvantaged compared to their Fijian colleagues on at least one occasion. One described entry into training being delayed, and five others described not being sponsored for other local or overseas training. Additionally, two related that they had not received scholarships and had paid their own postgraduate course fees. Some Indo-Fijian doctors who remained after 2000 generally described feeling that discrimination was ongoing and at times even more open than before, while others noted the loss of their colleagues. Some doctors, while acknowledging support from within their own departments, commented pessimistically on the future of Indo-Fijian doctors within the health system.

I have had no problems with racism in terms of my unit or my colleagues, but on the whole, for the country there is a lot of problems being an Indo-Fijian and being a Fijian in terms of the policies of the government, getting scholarships, getting into further education ... and then in terms of our children, in the future, the policy of the country is ... very racist in terms of giving scholarships to only a particular group of students or group of individual[s] or particular ethnic groups and not the others ... It was the same in my time when I went into [medicine], lucky to have the scholarship but a lot of my friends couldn't. So this thing at a national level is really something that doesn't make you happy to be in this country. (Indo-Fijian doctor)

... [the coup] didn't really make much difference except there's a lot of racist people here in this hospital ... I like my boss because I think he's the most unracist person that I know ... because he just treats you equally ... really nice, but then like you see some of the political influence and nurses suddenly they're not smiling so much at you or they're being rude, downright rude ... I think very small minded, then there's some of them that I find stupid ... but the doctors are good actually, they were very good this time ... like everybody was treating everybody equal you know they didn't care about race and stuff like that. (Indo-Fijian doctor)

... and, it was actually one of the [Fijian] senior registrars there who made me think about it... [he] sort of said to me, 'I think you should go and find out because you've been here longer and

you're not being given the chance' [to go overseas], so I went actually up and asked about it ... and was told that they didn't think that I needed it ... I was sort of reassured that no, I wouldn't have benefited from it and all that stuff, so I thought 'oh, why is that, I mean everyone else has gone, why can't I go?' ... it was no big deal eventually, then I sort of thought about it [and] ... I remember ... saying 'I wonder if that's because I'm an Indian ... and everyone else isn't' ... because every time I got a different answer ... (Indo-Fijian doctor)

[My supervisors] changed [their] mind[s] about sending me on attachment and then the year after that they said 'oh maybe you should go now' and then they said 'oh no we're short of staff you shouldn't go', and then the very same year [two Fijians] both went and so [we were] very short of staff, instead we were [doing the] work of 3 people. (Indo-Fijian doctor)

... that discrimination, the victimisation is just terrible, and nowadays I think it's just open. (Indo-Fijian doctor)

... I remember there used to be so many ... [Indo-Fijians] in some of the departments, [now] there's nobody. (Indo-Fijian doctor)

All of these doctors worked in Fiji after the 1987 coup, and doctors who have since migrated as well as those who have remained in Fiji described developing coping mechanisms to deal with racial issues. Of the migrants interviewed, all described varying degrees of discrimination in Fiji that had impacted on their careers, but despite this, they had developed their own strategies to deal with the situation that enabled them to keep working in Fiji at least until 2000. Eventually, migration decisions were described as being made based on either coup-related concerns about family security, or on spouse needs and preferences not related to the coup. None of the migrants described leaving Fiji due to professional discrimination. While these doctors seemed to have accepted or coped with discrimination directed against themselves, they may have felt differently about their own children, and most cited the overall benefits of migration to their children's future (see Chapter 5).

Some doctors described not being affected at all by racism, or only to a minor degree. They discussed the importance of hard work and / or having the right upbringing or attitudes. Others described trying actively not to focus on racial issues.

It hasn't affected me in any way. It hasn't affected me at all. Again, it depends upon your outlook. It depends upon how you look at things, you know? For example, as I've said to you many times, you know, I've got a role to play in this world and that's all I want to do. We have got a lifespan here ... we are not going to live here forever, we're all going to die at some stage. Let me, during that time while I live in this world, let me play my role. And let me do it well. So again, I'm trying to tell you it's a lot of problems are in our mind and in our thoughts ... you change your attitudes towards the way you see things and a lot of things will become easier for you. (senior consultant – Indo-Fijian)

...I don't think I've had any major negative impact at all ... it's just probably because I've had good friends ... I think ... probably makes a difference in the people you meet [who] surround you and who you've had around ... but yeah I feel sorry for those people who feel so negative about it ... it's interesting but everyone gets affected differently.

(Interviewer: Have you personally been disadvantaged in your career by being Indo-Fijian?). (pause) I don't think so. I have never tried to feel that way.

Some doctors, while describing a feeling of security in their own inter-racial relationships as well as adopting an overall approach of trying not to dwell too much on race issues, would relate that there were times when they would start to "wonder" about the racial situation.

(Interviewer: Overall how much racism do you think that you've experienced?) ... at work itself, no, the admin yes, but then I don't know whether they're racist or they're just ... inefficient.

... but what I did find a bit scary though ... it made you think ... when you had ... like the boys in my class, when they started thinking along racial lines ... then you sort of think, 'Gee, these are the people ... who have acquired this level of ... integrity, education ... awareness of what society is all about and yet they're thinking like what those brainwashed grassroot people are thinking!' ... that used to get me worried ... because then you sort of think, 'My God, you know, is this what they really are?' ... so ... that got me a bit ... not concerned but just sort of opens your eyes to, you never know a person ... no matter how much you think you know them at that point.

Well I'm a different kind of person, even I, I don't think much about these things, (*sigh*) but sometimes when you really think about it more, it hurts you more.

Other doctors actively acknowledged the problems that existed, but described some degree of acceptance or perhaps resignation. Some described focusing on self-development in spite of the problems they faced.

I mean it's alright like I can understand if they want to discriminate ... to one race of people ... like OK ... let's, instead of like your Masters if you put one Indo-Fijian, three Fijians, it's all right ... can accept that, there's so many things we've come to accept over the years.

... there are people who think 'Oh, that's not fair!' ... and true that's not fair ... but that's how we live.

... see I did not sit down and cry and say 'they did not give me so I will not' ... I educated myself, I kept doing it, didn't stop ... [my wife] helped me as well to ... she knew that I'm not getting the opportunities ... for training and she could really see the frustration ... so ... I never look[ed] back, I just educated myself to the hilt.

... and I was kind of like a bit discouraged because ... some of my colleagues were asked to stay in the hospital while I ... went out, probably that's the baddest factor that I've felt, why they had discriminated [against] me. I'm using these words because some of my colleagues who had actually left this country, had actually given me one of these as one of their reasons so at that time, I thought that I had been discriminated upon ... however, when I went out in the periphery I found out that I ... have learnt a lot.

Among the migrants and those who remained in Fiji, a few of the doctors described considerable frustration with the racial situation. One doctor, who had been prepared to spend his career working in Fiji, described how a particular speech made by a senior politician during the coup led him to believe that as an Indian he was no longer welcome and no longer had a future in Fiji. Another doctor related the responses of Indo-Fijian colleagues who had left the system, describing how "Indo-Fijian doctors who are outside, they have phoned me up [and] ... they told me 'Why are you frustrated, we've all been through it, you'll never get anything, why you are stuck in the hospital, why [are] you not coming out in private practice, you know you... there are enough people who

want you, why don't you come out?' like they said, 'What's new if you getting discriminated? We all got discriminated - that's why we left.' ”

The interviews with the Indo-Fijian doctors brought up a number of issues. From a health service standpoint, Indo-Fijians have been more likely to leave Fiji after medical school, and have, at least in the past, been more likely to migrate after receiving postgraduate training. Nevertheless, in the interviews, the doctors currently in the system expressed an overall desire to stay in Fiji, and among the migrants, some had not ruled out returning to Fiji at some point. Attempts at policy levels to severely restrict Indo-Fijians from entering postgraduate training, however, could lead young Indo-Fijian graduates, who otherwise wanted to stay in Fiji, to consider migrating because they may believe that overseas training represents their only hope of becoming specialists.

And even my parents during the year 2000, when we had the coup, people were very upset and then my father told me, 'If you want to go abroad, you can.' But I have never felt like migrating.

...I think the only thing at this point [keeping us from returning to Fiji] is we just want the [children] to sort of ... I could always send them away to study, but you'd rather have them under your nose when they're starting as teenagers ... well, like I said, if I did go through the training program [in Australia] I wouldn't mind going back to work there ... actually finishing and going back ...

From a historical standpoint, the Indo-Fijians who entered training before May 2000 had left medical school at a time when it was relatively more difficult to migrate. All doctors who migrated, including Fijians, described a process of “starting over”. Years of specialist practice made the passing of the Australian Medical Council exams that were eventually required for unrestricted medical licensure more difficult. In Australia, “area of need” requirements often restricted the areas where migrants were allowed to practice. Migrants who wished to continue in their specialties often needed a few years of local experience before they were accepted into specialist training programs, and local graduates were often given preference. The amount of recognition of previous experience was variable, often leading to a need to undertake additional basic specialist training, in addition to the requirement to pass difficult exams for all specialist trainees. Parents, especially mothers, found these requirements very challenging, and some commented on how this process would have been much easier at a younger age.

Given that migration is probably easier during earlier stages in doctors' careers, when there are fewer family responsibilities and less need for backtracking, and given the easing of barriers to migration even for recent medical graduates, it may be that after 2000, Indo-Fijians interested in migrating may have chosen to bypass local postgraduate training altogether. Therefore, those Indo-Fijians who have sought to train locally since 2000 may be much more committed to staying than their earlier counterparts. Nevertheless, it is difficult to predict what the impact of future political instability, including the coup of December 2006, will have on Indo-Fijian doctors, or Fijian doctors for that matter. Whether it is worth re-looking at the situation and considering improving training opportunities for Indo-Fijians in an effort to improve overall retention of doctors may merit further discussion at a policy level. For Indo-Fijians who currently wish to remain in Fiji, however, the individual decision to pursue postgraduate training locally is currently a difficult one, with few certainties.

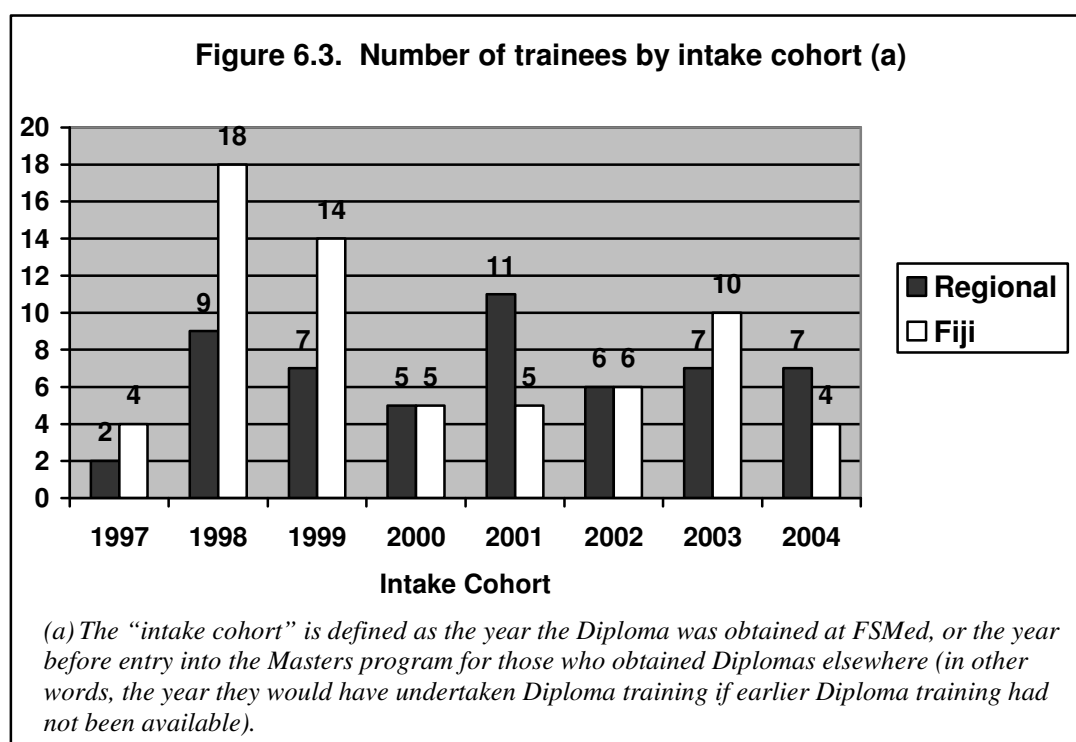
6.2. Postgraduate training at the Fiji School of Medicine

6.2.1. Views of trainees about their training: positive aspects and frustrations

As discussed above, local postgraduate training was established in order to improve the retention of Fiji doctors who undertook specialist training. Doctors who left training with a Diploma were more likely to leave the public sectors compared to those who completed a Masters. Before looking at separately at these two groups of doctors, however, it is worthwhile to review the early years after the establishment of the postgraduate programs as well as the overall views that these doctors had about their training. While a number of personal factors certainly contributed to some decisions to leave or stay in training, doctors also described both satisfaction with their postgraduate training as well as major frustrations that contributed to their decision making. Exploring these views about postgraduate training may not only help with understanding the decisions that individual doctors made, but may also suggest interventions that could improve retention in training.

As discussed in Chapter 1, postgraduate specialist training was established at FSMed, beginning in 1996 for anaesthesia, with the first six Diploma students graduating in 1997. Training in internal medicine, obstetrics and gynaecology, paediatrics and surgery was established in 1998, with all programs sharing similar overall structures and regulations.

Between 1997 and 2004, 120 students trained to the Diploma level or higher, of whom 66 were from Fiji (“Fiji students”) and 54 from other Pacific countries. During the first three years, one or more expatriate specialist doctors, or “Long Term Advisors”, from Australia or New Zealand were funded to work in Fiji, helping to establish the specialist training programs. Earlier years were characterised by larger intake cohorts of Fiji doctors, and this was most likely related to pent-up demand for local postgraduate training.



By the time the coup of 2000 took place, students not only faced political uncertainties, but they faced concerns about, as well as difficulties with the courses themselves. Though some expressed appreciation that as early-cohort students they had access to the extra staffing provided by the expatriate advisors, by mid-2000, only two Diploma courses had been run, and Masters students in particular mentioned feeling like “guinea pigs” in a course that was still in the process of being developed. By mid-2000, it was becoming apparent that the Masters required a heavy time commitment, but there were still many uncertainties about exactly what lay ahead, in terms of assignments and workload. Students were also unclear about what professional benefits they would gain from completing a Masters, either in terms of knowledge or professional advancement. By this time, students had become aware that obtaining a local Diploma did not lead to any additional

recognition or career advancement. As discussed below, many students chose to leave the course around this time, either because they decided to migrate, or because they could not devote the time required (usually because of family considerations), or because of reservations about the overall value of the course. It is difficult to determine the impact of the coup on the decisions that students made given the overall uncertainties in the postgraduate courses themselves, and it is unclear what would have happened if the political situation had been stable.

After 2000, postgraduate students faced additional challenges. While the courses were more established, the local specialist coordinators no longer had the on-site support of the long term advisors, and faced serious staffing shortages at FSMed. Many experienced specialist registrars left the public hospital sectors after 2000, leaving heavy workloads and on-call schedules for those who remained. This was felt to have a negative impact on the capacity of doctors to devote themselves to specialist training. Each specialist department went through difficult times in terms of staffing during these years (this is outlined in more detail in Chapter 5).

By the time that the interviews for this study were undertaken (2004 – 2006), Masters students had graduated and the Diploma courses had been run a number of times in all disciplines. By the end of 2006, the 66 Fiji doctors who trained between 1997 and 2004 included 21 Masters graduates, 3 Masters students and 42 doctors who had left training with a Diploma as their highest qualification. Of these, 36 were interviewed including 14 Diploma graduates, six doctors who were Masters students at the time of their interviews and 16 who at interview time were Masters graduates. Nine senior specialists who had not trained locally (“senior informants”) were also interviewed. All of these interview participants were asked for their views about postgraduate training, and except for some probing about the strengths and weaknesses of the courses, the specific issues they brought up arose spontaneously. During the analysis, the interview data were divided up and analysed according to the educational and career status of the interview participants at the time of the interviews. In general, interview participants spent the most time focusing on their current career stage and on recent events. For example, current Masters students and recent graduates often spoke at some length about the problems they had encountered in their training, while earlier graduates cited problems but tended to be more reflective about the benefits of undertaking training. Nevertheless, the doctors cited similar problems regardless of their career stage or educational attainment.

Postgraduate training included both an academic component, which was coordinated by FSMed, and a practical component, which involved providing clinical services in a public hospital as employed public servants. These two aspects of training were run independently, with variable levels of coordination. In particular, the clinical workload demanded of trainees was not under the control of FSMed, nor was the quality or participation of the consultants who supervised the trainees in the hospitals. The academic aspects of the program were often, though not invariably, commented upon favorably.

So I think this is the best thing that has happened, but it will be only good if people who are qualified from FSM, they stay here ... (senior consultant)

... you know, you train these people and then have a look around now and they're taking over your job (*laughter*)! ... overall their training is really good ... some of them really good, very impressed, very impressed with their work ... at one stage they were like young children but now they've, now they're even better than you! (senior consultant)

I liked everything about the Masters – everything. I can't see anything I didn't like except I wish we'd a lot more time ...

Some graduates and students spoke about being intellectually stimulated by the formal academic teaching they received, and the most positive comments were in regards to how the course had helped them with their reasoning skills.

(Interviewer: What [were] the most satisfying things about the course?) ... being able to think on your own about cases that you're faced with ... instead of just going with the flow ... and just thinking the work is there, but like this time it's like you have a new level of thinking, you've gone one up, so to you, every case you come across you're challenged with that case, so that's the exciting bit and it's still doing that to me, until now.

Oh yes, I must say the postgrad program for me myself has really developed me as a doctor. I feel so much more solid, and background knowledge to fall back on and skills to fall back on and I've very much sort of felt more secure in the level I've gotten to, and not only that, it's given me a bit more of an incentive to sort of explore more and I'm sort of not satisfied at the level - I want to go more into, it's sort of opened up a whole new horizon for me and I feel that

I'm not just going to stop in this. I'm going to move on, just carry on in continuing medical education ...

The academic content varied between specialties from more to less structured, with different emphases on exposure to “western” aspects of medicine. Preferences for structured or self-directed learning or the balance of local as compared to “western” content varied from student to student.

... so you get to learn more about a certain topic than just what you're given, so that was good, it was done in a problem-based way and I really liked that. I find that that's more useful ... because I trained in the old program where, you know, didactic learning and I thought, 'What a waste of time!' ... the evidence-based medicine was really emphasised, so that was great.

I found the postgraduate training good. I think it was ... more relevant to my working in Fiji ... initially my fear was that it would all be too simplified and too much tropical medicine, nothing completely about western-type diseases, but it wasn't, and I was glad ... And I found it surprisingly, I think it was a good program ... I really have learned a lot afterwards from the program and ... now that I'm an acting consultant ... it has helped me a lot ... I never knew I'd fall back on my studies, but when you get to a position like this, I find that it had really given me a good background for my cases ...

I think the program has to ... get towards enabling us to be more matured in terms of decision makings, why we do what we do on the bedside ... and [that was] sort of lacking because ... in the real world that's basically what we'll be making decisions ... rather than ... just throw ... out a, b, c and this and this and this.

I found it very interesting ... I had all these jig-saw puzzle [pieces] and when I came [overseas] it just all fitted into a puzzle, everything, all the missing puzzle [pieces]. So basically what that did, that training, was that it trained us to come and work [overseas].

Trainees also mentioned negative aspects to the academic part of the training. A number of doctors spoke favorably about their FSMed tutors, and while none were directly critical, some related that they felt that the workload on the tutors limited their ability to devote themselves to the courses as much as the students wanted them to. Some trainees felt disadvantaged by a lack of resources to support their learning.

Dr # was a really good mentor for me ... at the end of my Master's [he said] that ... 'Fiji needs people like you who are going to really contribute to learn how to teach other people.' ... that's sort of the other positive thing about the Masters ... that take-home sort of message.

When we had the postgraduate training, our coordinator was Dr #, and I think it was very good, but at the moment I don't know, I mean ... it's not like what it was in our time ...

Anyway, it was a challenge in that aspect, and as far as the staff was concerned we ... didn't have many lecturers ... as they are having this year ... we only had [one tutor] ... it's kind of better to have a number of resource people that you can always go to.

... then after that I started the Masters ... because sometimes when we pay the money and then half the time there's no tutor it's ... a typical FSM thing, it's very frustrating so ... and then this year was the first we were working under supervision and paying for it, but obviously in fact it doesn't happen ... I meant [our tutor] ... there's only one of him and he can't do everything.

I guess we need people with, you know, experience and qualifications to sort of uplift, not uplift but to sort of be in par you know with whatever training is going on. So I guess therefore we should have more staff specialists ... in [our specialty] to make sure that the course really is on par foundation-wise with places outside of Fiji.

...academic standpoint, in Masters I feel probably ... in terms of us as students, I think we need to read a lot, and one thing I should like to probably complain about ... Fiji School of Medicine is they take \$9,000, \$9,000 as the yearly fees ... so, most of the students have question[ed], 'What are we getting in return? ... we [are] not given any written material, whenever we go the computers are not working or somebody is there or somebody is using the resource ... room, we're not given any textbooks, we're not given anything ... and from the hospital you don't get time to go and study.'

The Diploma year was generally described as being more organised than the Masters years, and some doctors in the early years of the course, especially at the Masters level, spoke about their frustrations at the disorganisation they had to deal with due to the course being developed as they were taking it.

It was so exciting in the Diploma because I had ... the teacher from Britain and all, and visiting one from New Zealand. [the Masters] was just... not very interesting for me ... because I did not [have] someone ... who taught me the right things ... I was even told that I am doing the wrong thing by some visiting surgeons ... but some who came were quite encouraging and said 'You're doing a good thing' ... and so I found that what was lacking was a mentor or someone ... to guide you along ... so it was quite frustrating because you want to do something better ... and you're not sure whether it's the right thing or not.

... and the Diploma program was so, it seemed so ... formatted and well programmed ... but the Masters just wasn't coming on ... that well at that time ... so there were some days where we had really good sessions and then sometimes you felt that people were just not doing all the work ... there were days where it was ... so bland like because obviously no-one had read or done anything ... I felt that it needed a bit of structure at that point ...

It was very basic. ... went back to basic science again ... good stuff so that you rekindle your ... but ... I think ... they were struggling to come up with the course ... so they thought 'Oh, initially we'll just do basic science and then we'll come up with the...', you know, it was a year by year thing ... so they may have improved by now ... and I think they were cash-strapped as well.

... I guess for me that was just ... getting ... some stimulation again in terms of ... to work for a goal which I thought was quite interesting. Also, partly because we were going to be the guinea pigs for the Masters program ... It was quite good being a part of that initial cohort, but it was quite distressing to see the numbers fall away so quickly.

Within the hospital itself, many doctors in training mentioned being unhappy with the overall level of support and supervision that they were receiving. A few trainees mentioned a need for more feedback.

Probably I would make [the Masters] more structured ... the main leader in there ... for every staff you need to keep a record and say 'Ok, she's done this, she's done that, you know, where else can I ... improve this person?', because sometimes I feel they just leave you on your own. Sometimes I feel your supervisors need to talk to you, which we never get that ... you know I

always think there needs to be a feedback program ... which we don't have, right? And they, they never ask you ... 'What else can we do to help you?'

Trainees from all disciplines commented on a need for improved levels of clinical supervision. Inadequacies in clinical supervision were described as being particularly problematic in procedural specialties such as surgery, anaesthesia and to a somewhat lesser extent in OBGYN. Trainees described both being left on their own too early in their training, but also commented on not being allowed to do some of the cases themselves because senior clinicians did not seem to have time to teach, which takes longer.

I guess they've been happy, reasonably. The only thing I know they've been unhappy about is lack of supervision of senior people across the road. We've got good resources, we've helped them with training with our lectures ... they like lecturers that come from overseas. But, supervision is really just left to just one or two people. And they feel, and I agree, that they are just being used for service, they don't really [get trained to do things – *unclear*] ... you can't really do that when there's a lot of cases to go through. They are the ones that are really propping up the [specialist] department here, the trainees ... that's mainly it. (senior consultant)

I think ... the clinical training is OK, certainly in [my specialty] my trainees are unhappy about the lack of clinical supervision from my academic staff, they're very unhappy about that.”
(senior consultant)

I mean we can't even have our procedural skills registrars, which is one of my, you know my favorite bit. And for the last couple of years we haven't been able to run that procedural program because we just don't have enough registrars. (senior consultant)

... in most of the instances it was me who was doing most of the senior work, when ... my superiors weren't around I was responsible for doing work that is supposed to be done by consultants, and these are difficult cases ... which is very difficult because there [were] no people around with suitable background to actually help us with supervision. And that was lacking, and until this year when we had about two expatriates who came in, and that ... really made it more comfortable for me and I had wished that it was last year.

... you're just left on your own, and you're not taught this, you're not taught that, I mean basic, basic surgical procedures that they need to teach you, what happens here is if ... as long as you're able to do a caesarean section they'll leave you on your own, you can do everything ... which I think is not right.

... lot of room for improvement ... like supervision in theatre ... this is one of the common complaints from even the regional students that come ... that they come to learn, but what they're left to do is to run your theatre alone and they're used as part of the workforce, and nobody's there to teach anything new so you continue doing the same old stuff, and every once in awhile maybe a tutor will come in and help you, you know, go do... a new technique or help you perfect your other techniques or something, but most of the time you're left to your own devices so you don't really learn anything.

Many specialist posts were filled by expatriates, and while some were described as being excellent, a few doctors mentioned a preference for Australasian-trained consultants, and they generally expressed less faith in the teaching of consultants from other developing countries. Procedurally-based specialist trainees in particular mentioned the value and importance of overseas visitors both because they took the time to teach and also because they gave an indication as to whether or not the trainee was on the right track.

I was very disappointed when they always tried to look at the dollar value of a person ... for instance they would go to places, initially I thought, you know, pick up people from India and China who's clinical practice is not similar to ours, different from Australia and New Zealand, and bring them. You know, you have to have a respect for the person and confidence in the person's management to be able to let yourself learn from them.

We have the general surgeons which are trained in India ... so their way of training is different. We would have preferred if we had more Australasian trained surgeons ... general surgeons ... that's not the case so we rely on ... these visiting surgeons to come in probably at interval between 3 or 4 months, then one comes ... so, as a whole I would say that it's been good in the sense that we have visiting surgeons.

A major source of discontent with the training programs was related to the very high workloads in the public hospitals, and most doctors spoke of the dilemma of doing justice to the heavy clinical

demands of their public service appointments and how that limited the time that they were able to devote to their academic readings and assignments.

I think there is great potential, but there are a lot threats to that potential ... see a lot of the threats is firstly, this is from the students themselves ... that they see themselves as being extra labour ... they're not valued by the hospital ... they're given the training but they're overworked, they don't have time to study, they don't have time to optimise their learning ... they're just so overworked ... certainly the quality I'm getting from the students is hardly, barely above medical student level at this point in time. (senior consultant)

There were so [many] people coming in that it was more like we were trying to get the load off ... get the people treated and sent back home ... it became almost an automatic process for me ...and sometimes I question myself again whether ... 'Am I doing the right thing?', though I may have had teachers, but most of the time because they are busy themselves and [I was] left on my own to ... manage these things ... so it went on like that the whole year, it was quite tiring ... you really had to fight, much late at night to study ... so, it was like a lot of tiredness and study ... and so I was just sort of hanging on, kind of study just enough to get into my head but I knew that was not good enough because I really wanted to know [my discipline] very well.

I think there are a lot of ups and downs in the training program. The difficult part about the training program was that we had to do, still fulfill our 100% commitment to the Government ... service to the hospital and do ... 100% of the training program. It was a difficult thing to do ... to tie the two together and ... try and work things out ...

One of the aspects of training which was described as causing particularly high stress for many doctors was the clash between the need to attend classes and to look after patients.

Some doctors mentioned in particular a lack of coordination between the hospitals and FSMed.

It was hard in the sense that we had to sort of try and fit in your tutorial and ... lectures with work and obviously for a doctor that works in the government ... your patient care is first priority, so many times you have to ... miss things because, you're [on call?] and you just have to be [there] ...

What used to happen is classes were scheduled at two o'clock in the afternoon and then there's a whole waiting list in theater ... you know, patients fasted the whole day, and things like that and you had to choose between going to classes and canceling cases or doing the cases and canceling your class. And so that went on a bit ... you had to jostle the senior registrars or even the consultants, you know, 'Can you do this case so that we can go to classes?'

... it would contribute a great deal for me actually performing, because sometimes ... you are made to feel guilty that you were training, and I think those type of attitudes that people need not to feel, especially in their postgraduate training they need to feel like, you know, they're supported, when they are in, they do their work, when it's time for their classes they go out without having so much responsibility on their hands to accomplish.

... number one, as I always say, communication is the biggest problem ... in here ... there is one thing I would want to do is, the hospital people, FSM people need to sit down ... and they need to discuss 'OK we've got ... these many students and these many regular staff and what we need to do, ok this person has done these many operations, ok, but this person hasn't done it, so why don't we try to do this or bring her into this?' ... you know this kind of arrangement ... because these people are not in taking turns so they don't know what's happening, these people don't know ... at what stage of learning we are at, you know I think there's always a conflict in there, probably if that gets sorted out, it I think it will solve most of the problem ... if both parties work together.

In general, trainees in non-procedural fields such as medicine and paediatrics had more to say about the academic aspects of training, and strengthening these aspects could potentially have more impact of overall satisfaction for these courses. On the other hand, trainees in procedural fields such as anaesthetics and surgery were much more concerned about problems with clinical teaching and supervision. While there were not many complaints about the academic teaching in these programs, any strengths in coursework did not seem to make up for supervision problems. For OBGYN, trainees commented more evenly about coursework and clinical supervision. Coordination between the hospital and the school was mentioned as a way of improving training and reducing stress levels for all disciplines. Overall, doctors who undertook postgraduate training had mixed feelings about their training, and most chose, for various reasons, not to complete Masters training. These decisions to leave training without completing a Masters are discussed in the following section.

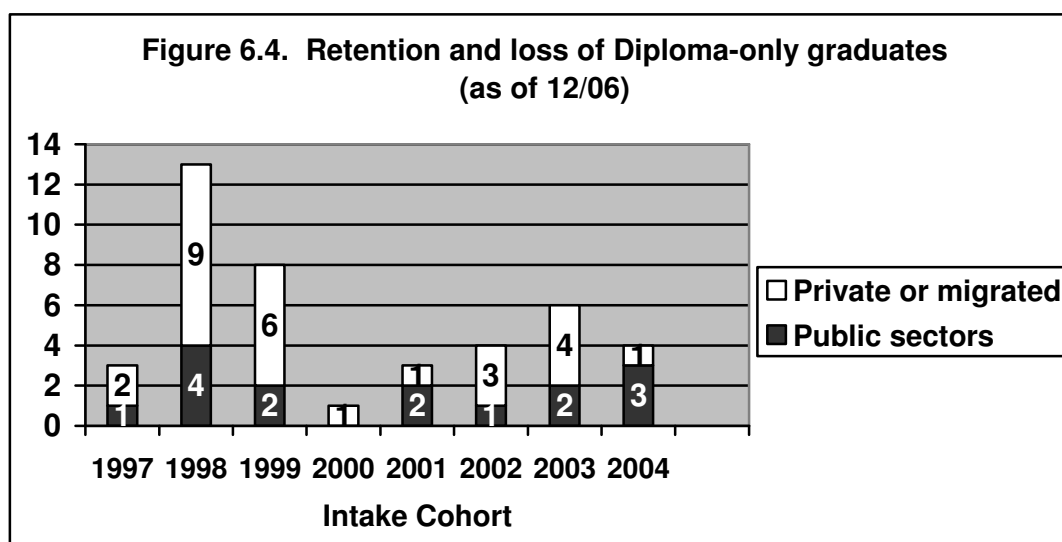
6.2.2. Leaving training with a Diploma as the highest qualification

At the end of Diploma training, postgraduate students faced the decision of whether or not to continue onto the Masters level, and those undertaking the Masters course had to decide whether to continue on to graduation. Overall, 42 of 66 postgraduate students left training with a Diploma as their highest qualification⁶, and as shown in Figure 6.1 above, their retention in the public sectors was much lower than for Masters graduates. Of particular note, only 14 of 42⁷ have remained in the public sectors, compared to 18 of 21 Masters graduates (including 3 who are currently training overseas and have stated intentions to return).

For most Diploma graduates who have not gone on to Masters training, career options in the public sectors have been limited. The option of using the skills learned in a year of specialist training in a district setting has generally not been pursued. Career progression for those who continued to work in public hospitals as specialist registrars without undertaking Masters training may also prove to be limited, as discussed above. For doctors working as problem-based learning tutors at FSMed, options for career progression may also be somewhat limited at this time. For the majority, a Diploma by itself has more often than not served as a step along a pathway to private general practice or migration, and, as indicated in Figure 6.4, this trend has continued even after 2000. No doctor that was interviewed, however, described consciously using a Diploma as a “steppingstone” to leave the public sectors, and the Diploma may have served as a way to “try out” specialist training before fully committing.

⁶ Of these, 14 had attempted some Masters work, including 5 who had Diplomas from other programs. Twelve of the Masters “dropouts” were from pre-2000 intakes when the nature the Masters courses were not yet clear to the participants, and it is possible that some of those who chose to remain in Fiji might not have attempted Masters training had they been aware of the difficulties ahead. Since 2000, all except two Fiji doctors who started a Masters have completed or are still in training.

⁷ The impact of Diploma-trained doctors on public hospital services is even more limited than the 33% retention figures would indicate. Of the 14 retained in the public sectors, 3 are working as part-time PBL tutors at the Fiji School of Medicine, and are not currently doing clinical work. Another three are senior clinicians, one of whom has recently retired, for whom postgraduate training arguably would have made little difference in their careers. Of the remaining eight, six continued on in the roles they had before training at one of the three major hospitals and two others are working in outlying hospitals. Only two of the eight are known to have made plans to repeat their Diploma exams in order to qualify to enter the Masters program.



This section focuses on the decision-making of doctors who chose to leave postgraduate training with a Diploma as their highest qualification. Of the 42 Diploma graduates, 14 were interviewed, including 6 of 16 who were living outside of Fiji in developed countries (all permanently except for one training in Australia with stated intentions to return). Three of nine Diploma graduates in private practice along with 5 of 14 in the public sectors were also interviewed. None of the three doctors working on a long term basis in American Samoa were interviewed. The decision-making of these doctors in regards to migration or retention within the public sectors was discussed in detail in Chapter 5. Overall, Diploma graduates were relatively underrepresented in the interviews compared to Masters graduates, which is related to the fact that they were geographically more scattered, both in Fiji and overseas.

Of the 23 Diploma graduates currently living in Fiji, eight were interviewed (four men and four women) and were asked about their decisions not to pursue Masters training. Some mentioned finding it difficult to compete with the multiple demands on their time. In the earlier years of the postgraduate courses in particular, intake cohorts were relatively large, but numbers dropped off rapidly, which some attributed partly to the difficulties of postgraduate training becoming apparent.

They all seem to be like 3rd or 4th year out from medical school whereas initially it was that rush factor because everyone was just waiting to do some postgraduate work, and when it happened you know people rushed into it and didn't actually think about how much it would take out of their life and things and then withdrew and moved on and stuff like that...

And I think, once the program started ... I think it created a lot of enthusiasm amongst graduates. But as graduates went into the program, I think ... they probably feel that what they were expecting may have not been what they got. They had to work harder, they felt that probably the Ministry was not supporting them in manpower resources, they were working long hours and you can feel, you can know the dynamics that we went through, they were complaining about the hours, and probably the curriculum, there were other issues that made them unsatisfied ... (senior consultant)

And so yes, it was difficult ... I think the demands and expectations by the school and its staff were certainly more than, for example, my Fellowship training So some people did drop out because of many reasons, mainly ... because they couldn't commit the time... (senior consultant)

One reason why doctors did not continue training was that while they passed the Diploma exam, their score made them ineligible to enter the Masters training. This was probably related, in many cases, to the difficulty of finding time to study with a very demanding job, though it was sometimes attributed to academic ability.

It was difficult to find the time to even go to a library to do all sorts of things because we had this procedure going on ... some emergency and we were always checked upon to do all our work ... and it was difficult ... to really put in everything ... do your best and maybe it can come down to the fact that we were not committed enough to ... find the time to do all those things, but I found it very tiring ... and as far as the learning process it was geared towards mostly self training ... whatever we found I suppose was sufficient but not good enough to make our professors happy, I suppose, to give us good grades ...

While the available data on how many doctors were ineligible to continue training is incomplete, two diploma graduates were known to be planning to reattempt the exam in 2006 (of whom one obtained a score that has allowed her to apply for Masters training). It is not known how many who passed with an ineligible mark decided to leave training or the public service altogether.

Other doctors expressed uncertainties about the value of the training itself. Some doctors in the earliest intakes were very experienced in their specialties, and though they had not been given

opportunities to undertake formal specialist training, there was some questioning of the value of training at their current career stage. Other doctors questioned the value of the training programs altogether, and disappointments influenced their decisions to resign. Some cited family concerns as a principal or contributing reason for leaving training.

I don't know whether I can say that we're getting old, whether there is such a thing as being too old to get back into study. But the other thing that we should have looked at is what exactly do we gain ... by getting through the training program? Is it just an extra degree ... or is it really going to improve our knowledge and our practical skills in terms of what and how much we can do in here? That's the other big question we needed to ask. What exactly would that Masters prove?

I think I fell into that middle third. If conditions were better, I would ... let's just say if you had this atmosphere in a teaching hospital in Australia here in Fiji, we could improve staffing, I would have gone through with my Masters and at the completion of the Masters, I would have been bound, not by laws or anything but by ... myself ... I would stay back and work here. I might, another 10 years, or for the rest of my working career. I would, I would have.

I started doing [the Masters], but somehow my interest sort of was not there because I was not getting taught well ... it was not fair for me, so... it was for me just like I have to do the case so they get well and they go home ... because of the load I did not have time to ... keep up with my knowledge, and then in the middle of the year we decided to have another child ... he came along ... but even before that I was losing interest.

In addition to these factors related to the courses themselves, one of the major contributors to the decision to leave training, as well as the public service in many instances, was the impact that training had on family life, which is discussed below.

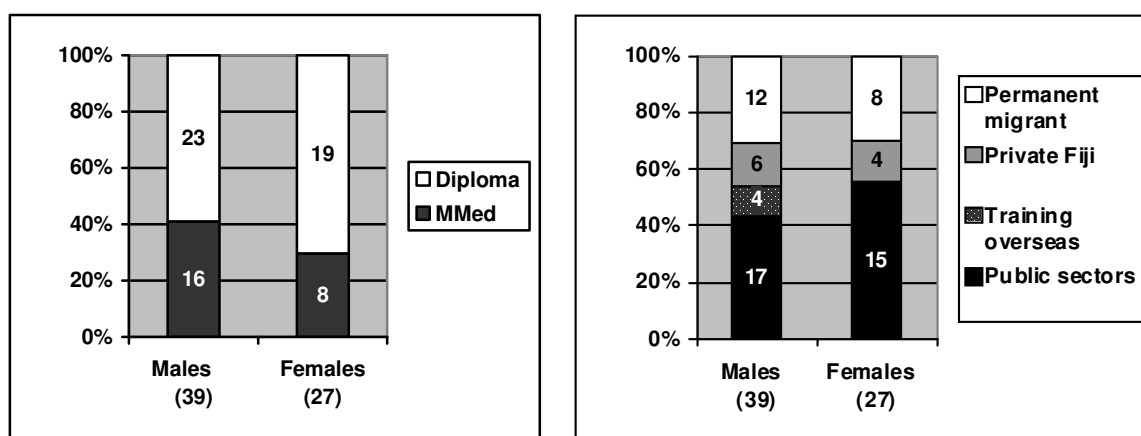
6.2.3. Gender issues and their impact on postgraduate training: “biological clocks” and “family clocks”

While family issues were cited as being very important in their contribution to decisions to leave training with a Diploma, these issues continued to have an impact on doctors who proceeded on to

the Masters level. Family matters certainly impacted greatly on female doctors who undertook postgraduate training at all levels, but they also impacted on the decisions that men made about their training. While this section follows on from an exploration of the issues behind leaving training before a Masters level has been reached and focuses the impact of gender issues on decision-making for these doctors, the impact that gender and family issues had on Masters students and graduates is included as well.

While 27 of the 66 Fiji doctors who undertook postgraduate training to the Diploma level or higher were female, fewer women completed Masters training, though retention rates in the public sectors were similar (see figure 6.5).

Figure 6.5. Highest qualification earned and work status by gender - 12/06



Family issues were discussed with all interview participants. While women were generally assumed to carry out the principal role in raising their children, as well as being expected to be more likely to stop work or move in order to support their husbands' careers, many of the interview participants were part of two-career and often two-doctor couples. Men described making sacrifices to enable their wives to train. On two occasions, wives described supporting their families after migration while their husbands established careers. One husband described migrating in order to accommodate his wife's family commitments as well. Interview participants often described a shared decision-making process, with husbands not necessarily prevailing over wives. There were also reports of both male and female doctors being delivered "ultimatums" by their spouses.

I know my wife wants to be a specialist too, so I know that if we are to go ... I can further my career but it would be at a loss to us ... living in Fiji we have a lot of family support ... and they can support us to be able to, and they would encourage my wife to also pursue her dreams to become a specialist, so that's the reason why I'm staying.

... she was selected [for overseas training] so we spent a year there, in which year she worked as a registrar ... and I was the house husband ... it was an experience! I got some insight into how it's actually more difficult looking after kids at home than going to work ...

... in terms of my ... work ... I had just come back from [overseas] so I didn't think I would have a problem, the only thing we were worried about was my husband trying to get work here, so I think that was one of the things that held us back [from migrating] a little bit longer ... was deciding whether he would accompany us or not and if he would, then what's going to happen in terms of finding work for him ...

... I have never thought of leaving this country until I had got ... married, my wife is ... [an overseas resident] ... both her parents died and her uncle and aunt they sponsored ... so she migrated ... along with two of her siblings ... both of them who are younger than her ... she's the one who looks after both of them ... so she has managed to get a job at one of the hospitals ... and she's still doing her studies there. I would have continued to do my Masters if this [problem] had not arisen.

I think, and I know a lot of the spouses find it very difficult. One of our candidates ... she almost didn't complete and that is just the Diploma and her husband said 'Okay, you can complete your Diploma but no more studies after that and ... either you stop working in the hospital or we get a divorce.' It's that bad, it's because of time. (senior consultant)

... I've told him, 'it's either you choose between whether you want a family or you want to stay [in a rural area]', so he just wrote letters to [the] Ministry ...

Nevertheless, for women in particular, the combination of the long hours demanded by public hospital work presented particular challenges, which were made even more burdensome by attempting postgraduate training. Six of eight women who completed Masters degrees were mothers, along with all six of the interviewed women who left training with a Diploma. These

women described the challenge of balancing family, clinical work and academic training as being difficult. Women (and men as well) described themselves, and were described by their tutors, as having difficulties in finding the time to study enough to pass exams, at both Diploma and Masters levels. For women who wanted to become specialists but wanted to limit their working hours, temporary maternity leave was available, but part time work in the public sector was not an option. While some worked for FSMed as tutors or entered private practice, none who made these choices had resumed specialist training as of 12/06, suggesting that these two career options are likely to lead to permanent withdrawal from the specialist workforce.

... because a lot of ours ... they are young, they are women and they have young children ... and priority has to bring your kids up first ... so, that's the reason why we actually haven't had many entering into the Masters project I mean how many ... people really go through ... an intensive postgraduate program with three young children, I mean women, you know ... they must have very supportive husbands. (senior consultant)

... that time I was so frustrated, why I left was, my number one thing was for my family ... I thought I wasn't giving enough time. I have three kids ... so that was my main reason leaving, leaving with the service I'm not that ambitious, but ... the main thing is that I have to get my children started off and then see my husband do something, [then] for myself. (female doctor)

I hope they have changed the rule by now ... because if not then ... it will be no option for me because I really can't do it full time ... yeah, flexi hours would be good and controlling [hours] you can study too ... to really do a good study here you really need the time out ... I mean I could go and do other things but that's the reason why I'm doing tutor because it gives me the flexi hours I need to [have a family with] ... so that will be probably the main reason why I came out of the Masters program. (female doctor)

Male doctors also faced particular difficulties. Of the 14 (out of 16) male Masters graduates or students interviewed, 11 were fathers, along with all seven male Diploma graduates interviewed. In addition to the long working hours in the public sectors and the additional workload from postgraduate training, which limited the time they were able to spend with their families, many doctors reported remaining on low salaries at junior grades for many years, often with no clear idea of when or if they would be promoted. This became particularly difficult as children were born,

especially if, as a couple, they wanted the mother to stay home, leaving the family to rely on one income. Fathers whose families were in financial difficulties described being distracted from their studies.

It was hard ... if I had to change things around I would probably do it ... as a single man ... rather than as a married man ... because you have so many commitments that you have to look after and on top of that trying to do your best in your postgraduate training ... and on the other side of it, when I think about it sometimes, I have my wife to depend on ... to look after the things for me while I just concentrate on my work, but I think at the end of the day, yeah it was hard ...

I couldn't complete, I couldn't concentrate mostly ... in my postgraduate training ... it's just because you have to look after your family, your wife and your kids and then focusing on your training at the same time.

So after that year we said no, let's enjoy another year before we try the Masters ... we said, you know, we'll enjoy the kid growing up, you know, doing all those stuff with babies. And so [we] decided, we were still working, in the civil service, but decided that we won't do any studies, formal studies. (male doctor)

Family concerns continued to impact on career decision as children grew older. The focus turned to their children's educations and futures, with doctors reporting making career choices where they put aside their own training and professional development in order to focus on the upbringing and development of their children. This sometimes involved migration.

I've got another two years until my children are ultimately finished high school. Once they are at universities ... so I think in the next five years I will probably really be more of sort of managing the situation, rather than my own development to the very best level. (male doctor)

... so if things don't work out well [in Australia] ... my main concern is ... my last son must cross the hurdle ... complete his first degree so ... he's in second year now, third year he'll finish ... so that's my mission accomplished ... and then, I'm looking at oh, there's lots of ... options there ... (male doctor)

While 2 male doctors (and one female doctor) who remained in the public sectors described undertaking temporary placements in American Samoa to earn extra money, entry into private general practice also offered a quick solution, not only to financial problems, but also allowed fathers to spend more time with their families. Interestingly, despite the shifting gender roles in Fiji, some men described considerable anxieties about their roles as breadwinners, while women didn't bring this issue up. A few women worked because their income was required, but others reported feeling able to remain in the public sectors despite their low salaries because of their husband's income.

... but then I should have gone away and ... resigned and ... get a \$100,000 or \$200,000 [private practice] job and cover for both of us, but then I didn't do it, why, I don't know. I just, probably I was too greedy [to give up becoming a specialist] on my part, I don't know ... and I didn't want to let them close ... the door of my dreams. (male doctor)

One of them ... he couldn't cope with his two children and his wife was a nurse and he had just bought a house ... for them to be able to look after their financial commitments ... both of them needed to work, true. But they had two small children. So then they decided, you know, it wasn't going to work. They wanted to bring up their children properly, so his wife, he didn't want his wife to work, just to sort of stay home and look after the children, and that was the main reason he moved to American Samoa. 'Because I could do that over there.' And he earned enough to support him. And pay off his house as well, the money was good. That was the main reason he left. (senior consultant)

We never planned it this way but, you know, [my husband] going into private practice was probably the best thing that ever happened to us, 'cause otherwise I would have jumped out too! ... That's probably why I'm still happy with my ... pay, 'cause my husband gets the bulk of it!

A few doctors mentioned how helpful it would have been for their own professional development and that of others to start down a specialist career path soon after graduation from medical school.

... you know, I would have loved to do postgraduate training immediately after internship ... I had gone out to public health. I think looking back now we have to select our specialty well before doing the three years ... the idea that we had after internship was that ... you have to do

three years rural attachment before you come back to the hospital. Somehow that applies to some but does not apply to others. But I think we need to push ... to identify people from internship the first year out and say 'you need to go here and here'. And then get the career ... identified very early on rather than leaving it towards the end, you know when you're supposed to have specialised and you're starting your postgraduate training.

I think they really should line us up properly and we'll graduate from medicine from MBBS to internship, and [then] ask us what we want ... and then line us up in [the] areas of specialising ... and take us there, put us there ... they should value the ... intellect that they have here, the human resources. Doctors are very highly qualified in the mind, isn't it such a waste if they don't do that? They just seem to think that doctors are just there to do the work ... so a lot of intelligent people they have, such a waste.

The interviews suggest that in Fiji, both female and male doctors face a "biological clock", or perhaps a "family clock" that has implications on their ability to complete postgraduate training. Students who enter FSMed as undergraduate medical students after high school graduate in their mid 20's. The minimum time from MBBS graduation through internship and compulsory service through to postgraduate training and receiving an MMed qualification is 7 years, plus two more years to be recognised as a specialist. In most cases, even more time has been required. Newly registered specialists will be at least in their mid-30s, even with ideal career progression. In addition, there are no guarantees of promotion even with specialist qualifications. By their mid-30s, many doctors will have started families. While women still described the greatest need to spend time with their families, male doctors often had working spouses and not only wanted to but often needed to devote considerable time to their families as well. Doctors whose spouses stayed home with the children could face serious financial pressures in addition to time pressures at a time when they were on low salaries. These pressures could lead to both male and female doctors exiting the public sectors in order to gain some control over their time and finances.

Overall, doctors whose highest qualification was a Diploma were unlikely to remain in the public sectors. The experience to date suggests that the most effective way to retain Diploma graduates is for them to enter into Masters training. The interviews suggest that in addition to the complex issues associated with migration, family considerations are an important factor leading both male and female doctors exiting the system before obtaining a Masters.

6.2.4. Obtaining a Masters in Medicine

A minority of doctors who entered postgraduate training went on to finish a Masters, and as mentioned above, their retention in the public sectors was considerably higher than for doctors who left with a Diploma. This section will look at the difficulties that these doctors faced during their training, why they continued, and decisions that they made after their graduations.

Of the 24 doctors who had completed a Masters (21) or were still in training (3) as of December 2006, 22 were interviewed. Of these, six doctors were Masters students at the time of their interviews, four were within the first year after graduation, and 12 had graduated more than a year previously. As mentioned above, all except three were still employed in the public sectors, though another three were temporarily overseas undertaking further specialist training.

There was a general consensus among the Masters graduates that postgraduate training required high levels of discipline and time management, as well as determination and sacrifice. Many doctors commented on the difficulties of their own postgraduate training, and some spoke of colleagues who had not been able to finish.

... it's the workload ... and also time management, I think ... I mean a lot of people just think they can just slip into a program and everything else carries on the same ... Well, that doesn't happen! ... they've got to make adjustments for their family, they have to sacrifice ... it's a big sacrifice ... (senior consultant)

I can hack anything now ... I mean nothing surprises me, nothing bothers me now, I can handle it... it sort of made me a better person because I have been through the mills, just studying and having family and then working and then trying to study at the same time ...

... it's a big challenge for Fiji people because we have our social life. You know, at one stage I had 20 people in my house, yeah? But ... I extended my house from a three bedroom to four bedroom and added in a small study, so I had, already had a PC at home so that study was - the door to it opened to my bedroom, so I could keep all the people around home but I had to study, I had to discipline myself.

... with regards to the supervision that we got from overseas trainees who ... came in and lecturers, it was good, but then when they left we were always, you know, stuck with no one having to supervise us, and then we had local supervision which was not up to the par of postgraduate supervision that we would require ... those things sort of contributed to, you know, my dissatisfaction with the program, but being determined to stride forward and get through I ... told myself I had to ... be determined to get through. So I think it was the last year - I was really determined, so I ... got myself together and really went forward to complete my studies, and that's why I was able to complete all my exams last year and again this year. Again one thing that we also saw with the training program is the lack of supervision even for our projects, and just close supervision ... someone just to be there to push us through, checking on us, making sure we are doing it, and that would have been something beneficial for us.

I must admit I was a very bad student ... grossly immature, I had no idea of what it meant studying ... my Diploma in 1996 I was just sort of like beginning to have some idea of what was required and by the time I got into the Masters program I sort of had a fairly good idea of, you know, how to make life a bit more purposeful and that is probably why I ... stuck it out more strongly ... There were others probably who were more ... I know that I had one guy who was ... relatively young compared to me ... and he has some problems trying to come to grips ... with the maturity required to go through the program, and the other two guys ... had been trying for the program for such a long time, but by the time they started they were quite well senior in their ages ... And it was really difficult for them to get started in with the basic science and stuff ... yeah, so I probably hit it just about the time when I was more or less ready for it.

It was very difficult and I guess a lot of people had bent under that, a lot of our registrars ... because of a lack of commitment from our local counterparts, our local supervisors and our local consultants ... what I mean by bent under, is they just can't cope with it, the stress is too much. They've just given up because they haven't found a way out and probably the only way out is get out of the system so that the system doesn't destroy you.

A few of the senior clinicians who developed the Masters course as well as the Masters graduates were asked about whether the course needed to be as difficult as it was. The underlying issue was whether a course that was less demanding would lead to increased retention. The dilemma from an academic standpoint was balancing the need to maintain standards in the setting of very heavy clinical loads and the demands of family life. The students who commented on this issue varied in

their opinions about whether too much coursework was required. Many, though not all students, while accepting the need for the assignments in their specialties, voiced objections to the heavy workload from the required public health subjects. This was also a point of disagreement between the course coordinators. Overall, many Masters graduates and students, as outlined above, described struggling with large clinical workloads, insufficient or less-than-satisfactory clinical supervision, and a lack of coordination between the hospital and FSMed, all of which were described as adding to the difficulty of undertaking a Masters, perhaps making it unnecessarily or avoidably difficult.

... no we couldn't make it easier. We couldn't be giving a degree that was seen to be lesser than whoever, whether it be a Fellowship in Australasia or a Masters in Timbuktu, we couldn't be seen to be 'anyone can get ... that Masters degree', couldn't be seen to be doing that. (senior consultant)

... the load was quite big but manageable ... the question here was really time management ... how could we juggle between like work, family, extracurricular activity and studies, but it was good ... so well structured, [if] you ... didn't get through the program it was really your own fault because we had time to do everything and we had procedures, a stack to read and it was pretty straightforward ... I must say very informative, very enlightening and very thorough ... it's quite good. Anyone that actually goes through [the] program I'd say they would make a very good doctor.

It's just too much! They've got assignments from public health, assignments from us and then continuous assessment. I mean exams every, twice a year, it's just overloading them ... I've seen if they drop in the examination result from their core curriculum, I think ... I can blame it squarely on to too much and not enough time that they're studying. I agree they have to ... organise their time better, but it's the volume of the work. I think it's just too much. (senior consultant)

But you really had to just work hard. So at some stage I was studying ... just straight five hours, nonstop, in the night. That's when everybody's asleep ... but I still feel that we, FSM still has to readjust this Masters program and I think it's not the workload that should be reduced, it's all these tutorials and all these lectures. Has to be rearranged, because I feel that ... [the] department at CWM has never been good since the Masters started. The relationship has not been good, because of this pull of study plus the work. With the people doing the postgraduate

... are the people actually preparing the work ... And I find if they don't improve then they'll make a lot of people frustrated.

Last year we were told that the public health was compulsory ... for our postgraduate training ... so I had actually devoted about sixty to seventy percent of my time studying public health ... and forty to thirty percent studying surgery ... I really think that it should have been optional ... for us to do public health ... it shouldn't have taken that much of my time during the program. I think I would have done a bit better ... if I had devoted more time reading about surgery especially during my exams ...

... on the part of the department, ensuring that you don't have any disasters or anything, so I had a lot on my hands, and it is amazing that I was able to cope through that and on top of that I had to prepare for exams ... And it was quite a, quite a big stress. And I guess that is one of the big contributing factors to – and then the atmosphere surrounding you which means that those in leadership and those looking out for you don't seem to come around us at the time where you really need them.

While the doctors who completed were able to cope with the difficulties, many more dropped out, and as discussed above, it is likely that the difficulties faced in completing the courses contributed to decisions to leave training, especially when family life was felt to be compromised.

A few doctors described giving some thought to leaving the system during their training, but made a decision to finish the Masters in order to keep their future options open in Fiji.

Yeah, I had made up my mind, I would say I was 70% sure that I was going to leave at the end, but I think, on the other hand, I still hadn't completed the Masters program and ...the reason why I didn't have a complete sort of decision to leave is that I wanted to wait and see whether things would change because I had done ... almost three years and I said 'Why not just finish it and leave?' because it would all be just a waste of effort ...

...I thought I'm not gonna get up and go and what if I don't get the salary and I'm left with nothing and I thought 'I don't want that to happen', and I thought 'Let me finish my Masters first and if this doesn't work out then perhaps maybe I should go' ... I thought, [to be on the safe side?] 'I'll finish with [the] Masters and at least you've got something and then, you know, if

you wanna go you can always come back' ... it's more an escape type for me as well as, you know, still wanting and loving the work here.

At the time of graduation, doctors faced another decision point. The granting of the MMed and the public service posting that doctors hold are separate issues, and most Masters students continued on in their same posts immediately after graduation, which was described as a source of considerable frustration. They were generally required to work 2 additional years in order to be recognised as specialists, which would allow them to undertake private practice in addition to their public hospital work, but again this is a separate issue from postings and promotions. One doctor described these two years after graduation as the “gap years”, where doctors were of indeterminate status, not technically “specialists”, but not receiving formal training either. These years were of particular interest as three Masters graduates left the system during this time, and others considered leaving. Some undertook subspecialist or fellowship training overseas, which in addition to helping them acquire valuable skills, would also lead to them becoming more marketable in developed countries. During overseas placements, their services were also temporarily unavailable in Fiji.

Since I got my Masters [last year] I continued with the same thing, that's another big bone I had to pick ... because I found it very unfair like after I got my Masters ... I still got to stay as a registrar, taking the same number of calls ... not even an acting consultant ... like what [others] used to do as soon as they finished ...

... but once the exam was out of the way, and the graduation was out of the way, then I realised that there was a, sort of like a gap there. You finish your Masters, doing things, training and then after you finish your Masters then there is nothing else to do ... I was a bit depressed earlier on, but then I said 'Okay ... I'll make the full use of the year' and just calmed down and started working and all of a sudden it's October and what I've done is ... to apply for a senior registrar job in New Zealand ... and basically saying, 'Look, if it's gonna be two years post-Masters, then, I've trained here for the past seven years, then if I need to learn something again for another year, maybe it's time to go and learn it in a new environment.'

In examining the career paths that took place after graduation, the interviewed doctors fell in 2 groups, a group of 11 doctors who received their Masters in 2001 or 2002, who were generally older at entry into training than later cohorts, and eleven doctors who either graduated from 2003 onwards or were still students.

All 11 doctors from the first two graduating MMed classes were interviewed more than a year after graduation. Of these, eight were working in the public sectors as of 12/06, including one each at the Fiji School of Medicine and UNICEF. When it came to promotions, doctors in earlier cohorts had generally fared better than later graduates, and had settled into higher-level work by the time of the interviews. Five of the six employed at public hospitals described working at senior levels, either as consultants or chief medical officers (CMOs), though in some cases still in an acting capacity.

While most had undertaken overseas placements before entering the Masters or for a few months during their final year, only one, who has since returned, extended his overseas training after graduation. All eight doctors described taking on broader career roles that were probably facilitated by the status associated with their senior postings. As discussed in Chapter 4, these new roles went beyond routine patient care to areas such as expanding the range of patient services available, introducing procedures learned while overseas, quality assurance, teaching, mentoring, management and community empowerment. Many doctors spoke passionately and at length about these roles, which they described as sources of professional satisfaction (this is discussed at length in Chapter 4).

... I think the heart of managing the hospital is really for the patient ... you know the patient should get the best possible care ... so I didn't want to go straight into that on my first day ... because I thought my feeling was that, doctors are frustrated, nurses are frustrated, they won't care less about how you want to improve them, they'll just continue the same so I wanted to provide a happy environment for them to be happy to improve. (on management roles)

... one of the tasks that we as a Department set for ourselves was reviewing the guidelines ... not just for the hospital, but so people in peripheral health centres will know what to do in different circumstances ... I think that's something that if we structure it well, even a person right in the nursing station should be able to do things before they refer it on to the next level and the next level to refer on to us. Well, that's the aim but whether it comes out as that ... and we want to make it evidence-based which is why it's really slow getting off the ground ...

I feel the need to move into more of what we call [the] 'reproductive health' part of obstetrics ... that is where I feel there is a greater need ... I got myself a few small jobs lined up just to sharpen my ability to carry out reproductive health issues ... the day to day stuff in this unit is not so easy to manage when you realise there are bigger issues that have not yet been sorted out.

Three other graduates in this group had left the system, with two migrating to Australia and one entering private practice in Fiji. All described not having been promoted in a timely manner, and not having confidence that they would be promoted in the future.

I had the sense of getting nowhere and I felt six, eight years down the line and I'm still gonna be just a registrar ... it's going back and forth and yet the Ministry was not even recognising the program itself, so I said 'Hey I've just got to get out of this!'

If they had offered me like, two or three months before my graduation, then I could probably just stay on. Like I said, you know, they had all the power and authority to make changes. They were just sort of playing around. So, like I said, I'd learned from the two other graduates, my senior colleagues, you know four, five years senior than me and how the Ministry had sort of made promises, but not kept them.

For the 10 doctors who received their MMed qualifications from 2003 - 2006, two were acting in senior posts within a year of graduation, and these postings have since been formalised. Both have remained in the public system with plans to pursue a year or more of overseas training as soon as departmental staffing allows it. The other eight had not received promotions to senior posts by 9/06. Five of these had undertaken or planned to undertake overseas specialist training within a year or so of graduation, of whom three were currently overseas (as of 12/06) and one has recently returned. The other three graduated in 2005 or 2006 and are currently working in the public system. While overseas training was seen as a way of enhancing skills rather than continuing to just work at the same level, it was also seen by some as a time of refreshment and release.

I spent six months over in [New Zealand], we had a lot of chats [with a mentor] and, we discussed things like what we are discussing now ... and from that discussion we both felt that it was because of the indignity of these two years, that we're talking about, the years post-Masters ... these are the two years you are waiting to become a specialist. These are the two years where a lot of people who finish their Masters leave Fiji ... the waiting period for your ... specialist recognition ... and he suggested maybe it's a good idea for, 'you've been in CWM for seven years. Why don't you come over to New Zealand, you know? Come over and work under a totally different boss. And maybe you won't learn anything new ... maybe all the things that you need to learn, you've learnt it in Fiji, but it's just the, being away for a year will probably

recharge your batteries, take a year out of that period ... probably lessen your frustration ... You will get a bit money ... let your wife stay at home and look after the kids and ... a short term loss will be a long term gain.' And he said, 'maybe if we do that for a year, or maybe if you really need to, you can stay for an extra year, two years. But whatever it takes, so that you will be good and hungry to work as a consultant.'

The lack of promotions was more than just a matter of not being made full consultants or given consultant level posts (CMO or above) immediately upon graduation, which is something that a number of senior doctors described as inappropriate. An even more problematic issue from the standpoint of some doctors was prolonged junior postings, with their postgraduate training seeming to have no impact on their career status. A number of doctors described receiving their Masters and still remaining posted as medical officers, the lowest career grade. Some even described the preferential promotion of doctors who were less advanced in their training. There was no written policy in place about the impact that successful completion of postgraduate training would have on career progression. Some graduates were promoted and some were not, and for individual doctors undertaking training, there were no assurances that their training would help their career advancement.

... but I understand was there was an agreement that if you finish your Diploma you automatically become a senior medical officer ... and once you completed your Masters you qualified to go up as chief medical officer ... but because of the fact that we have a lot of expatriates ... who were brought in and occupying the higher posts ... and the posts are all occupied so you still have to settle with the medical officer post.

... before we did the Diploma we were promised that we would, as soon as we completed the Diploma postgraduate scheme, we would be given a senior medical officer post. (Interviewer: did they actually promise you this?) Yeah ... the Ministry ... said that, but not in writing ... it was just verbal ... because they said well if you wanted the SMO then you have to pass the Diploma first ... but that didn't happen 'til two, three years later. (Interviewer: Ok, so they actually made a promise to you ... directly to you and they didn't keep it?) Yes. (Interviewer: ... so it was a proper broken promise?) Yes ... and it's almost the same thing saying that for us once we finished the scheme with a Masters program ... you will be given a post ... well that's not happening ... so, I mean those little things like that, that's what... because I remember talking to those two ... before they left they said just the frustration of still doing the same thing,

same type of work now that you've finished the Masters program, nothing is there for you to come back to, so they left.

One doctor described being posted at the second lowest grade (senior medical officer) despite having a Masters and three years of overseas subspecialist training. He returned to Fiji in 2006, was not promoted after 8 months, and left again to pursue further overseas training. He related how "... when I was in Auckland I told myself that I'll come here for 6 months ... and if nothing happens after 6 months, I'm going to leave ... and 6 months came nothing has ... now we're still waiting for the job interview regarding the consultants post and they should have done that from last year ... so if it has taken them another extra 6 months of us being physically here and not getting a post I thought, 'Well I can go and wait for a post somewhere else', ... I said 'Look, I'm back and if you want me to stay then give me the post, if not ... probably best that I go.' "

All Masters graduates who were overseas or planning to go overseas for training stated an intention to return to Fiji, and none described seeing themselves as migrating permanently. On the other hand, eight expressed varying levels of interest in doing a fellowship (a formal specialist qualification in Australia or New Zealand), including one who was actually undertaking a fellowship and two who were planning to look into it over the next several months. Compared to the one-to-two year overseas placements that most Masters graduates were undertaking, fellowship training could take up to 5 or 6 years or more plus exams, depending on the recognition of previous training.

(Interviewer: ... how important would it be to you to have a fellowship?) Politically, very important ... the last thing that I want to happen to me is in 10 years down the line I have someone younger coming along ... and said 'look, even though you've done the training, you don't have the fellowship, I have the fellowship', so politically if I'm going to work for the school I need the fellowship ... my focus at the moment is to, if I can ... somehow get the fellowship, I'll go for it ... I would still come back, with the fellowship ... and even if I don't get the fellowship I'll still come back.

Masters graduates who have trained overseas, or plan to train overseas in the future, already have, or will in the future, need to face the decision about when or whether to return home, though upon return most should be eligible for specialist status, promotion to a consultant-level positions, and access to specialist private practice, unlike doctors who have worked overseas but do not have

formal qualifications. Encouragingly, four of six doctors who have undertaken formal overseas training after graduation have returned to Fiji, though one has since left to continue with more overseas training, as described above. In the past, few overseas fellowship holders who have returned to Fiji have stayed for more than a few years, and therefore it is uncertain what will happen to Masters graduates who train overseas and try to return, especially if, like fellowship holders in the past, they face significant frustrations in the public system with either obtaining senior postings or using their new skills.

Overall, the retention of Masters graduates has been encouraging. Graduates have gone on to develop into expanded senior roles, especially those in the first two graduating classes. All Masters graduates in later classes are still officially in the public sector, though their promotion status has been variable. Many have trained or plan to train overseas. It remains to be seen how many of these will return to Fiji and remain after their overseas placements have been completed.

6.3. Keeping doctors in the system: what can be done locally?

Fiji is not currently self-sufficient in terms of specialist medical services, and despite nine years of local postgraduate training, still depends on expatriates to fill many specialist positions. In order to reach self-sufficiency, and in order for the postgraduate programs to fulfill their potentials, it is important that young doctors choose to remain in Fiji, enter specialist training, stay with the programs until graduation, and remain in the public sectors. Fortunately, Masters graduates have had relatively high retention levels to date. The Masters course is challenging, however, and is carried out in conjunction with heavy public hospital workloads, and to date, most doctors who have entered specialist training have not completed. In spite of the availability of postgraduate training, over the past decade many doctors, both Fijians and Indo-Fijians, including those who have undertaken local postgraduate training, have chosen to migrate from Fiji, and for those who have stayed in Fiji, not enough have been retained in the public service to meet the medical needs of the population.

Given that many public hospital posts are vacant or filled by expatriates, it is not in the best interests of Fiji for so many aspiring specialists to leave training programs that favor “survival of the fittest”, especially when most doctors who leave training end up leaving the system altogether.

These losses are exacerbated by global trends of increasing opportunities in developed countries for Fiji doctors that have taken place since the establishment of postgraduate training, and are outside of the control of the MOH. Nevertheless, developing an understanding of why doctors do and do not complete Masters training may point to interventions that could enhance overall retention of postgraduate trainees, especially where such interventions can be implemented locally and are independent of global workforce issues. The above analysis of the career pathways and decision-making of these doctors pointed to a number of findings that should be kept in mind as interventions are considered and planned:

- Doctors who complete a specialist Masters are more likely to remain in the public sectors in Fiji than doctors who leave training with a Diploma, (and probably as compared to doctors who have not undertaken specialist training, though the current study did not collect data on this issue).
- Public hospital work is very demanding, even when training is not being undertaken.
- Specialist training is particularly demanding as it takes place on top of an already difficult and time-consuming public service job. While completing a one year Diploma is difficult enough, the three additional years to complete a Masters is particularly challenging, and this is related to the overall workload and probably to the duration of training as well.
- Both public hospital work and specialist training have considerable, and sometimes detrimental, impacts on family life, especially parenting, for both male and particularly female doctors.
- Career progression to senior grades leads to higher salaries and usually better working conditions and call schedules as compared to junior career grades, and this can have a positive impact on family life.
- Many doctors who have undertaken training were not certain whether completion of postgraduate training would lead to career progression, and a number described remaining at junior career grades after graduating with a Masters.
- Given the above, some doctors described giving serious consideration as to whether the benefits that would occur as a result of training would be enough to offset the sacrifices that they and their families were called upon to make. This was cited as a reason for resigning by some.
- Doctors may be particularly prone to leave the public service at or after times of transition in training status, and interventions at these times may lead to increased retention. These

times include graduation with a Diploma, graduation with a Masters, and possibly returning from overseas post-Masters training.

This section will elaborate on these points, with a particular focus on family issues, training issues, and transition times. It should be mentioned that individual doctors have undoubtedly entered training with their own personal characteristics and strengths, including how much they desired to become specialists, their overall “hunger” for learning, their capacity for work, and their time management skills (though the interviews were not designed to assess these strengths). The interviews suggested that if one wants to understand how to help as many of these doctors as possible to succeed in their training, it should be kept in mind that they enter training not only as individuals but as members of family units and that these doctors need to take into account the needs of their spouses, including spouse careers, their children’s upbringings and their role in extended families as well.

One of the themes that emerged in the decision-making process for the doctors who had undertaken postgraduate training in Fiji was the concept of the “family clock”, in other words, the major impact of starting and raising a family on career decisions for both men and women (though even single doctors faced significant demands from being part of a families and extended families). “Biological clocks” are often spoken of as a “women’s issue” related to the actual timing of childbearing, in particular the impact of delaying the start a family, usually for career reasons. The interviews of these doctors, however, suggested that both the men and the women had to take into consideration the impact on their careers of starting families. Both women and men described considering the career ambitions and desires of their spouses as they decided whether or not to remain in the system and whether to undertake training, with sacrifices being made both ways.

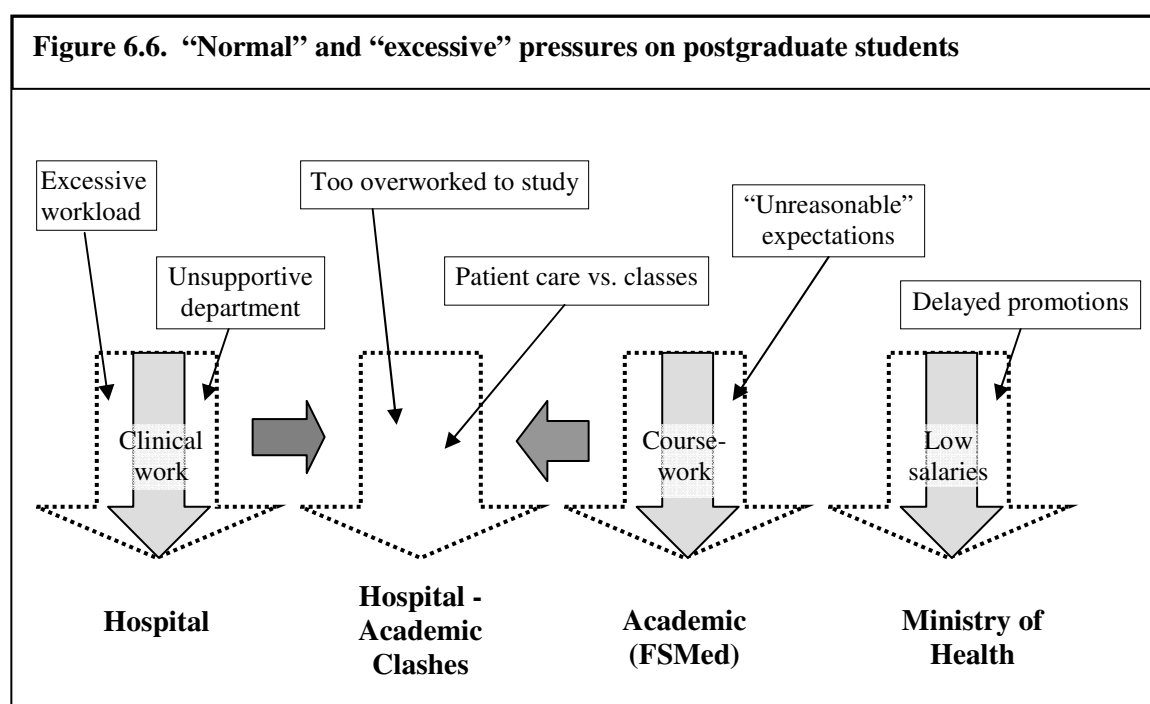
From the standpoint of deciding when to start a family, the lengthy training required to become a specialist was described as being problematic for both men and women. The minimum time from secondary school graduation to the completion of specialist training would leave most doctors in their early-to-mid-thirties. As discussed above, actual entry into specialist training was usually delayed beyond the minimum times. Even after receiving a Masters, the process of gaining specialist status and promotions to senior postings, along with the associated benefits of improved working hours and salaries, took even more years, and the timing of such career advancement was unpredictable. Given these factors, delaying having children until a senior post was obtained was not usually done, and many doctors started families before or during their training years. Women

especially struggled with balancing work, training, and family life. Men were more likely to report feeling burdened by the financial difficulties of raising a family on a limited salary, in addition to frustrations with not being able to spend more time with their families.

The demands that careers placed on individuals impacted on family life, and doctors described times of particular pressure, due to time or financial issues, or sometimes to an overall build-up of frustration. Both men and women described addressing these demands by laying aside specialist career ambitions either temporarily, or permanently. Some doctors described temporarily stepping outside of the public system in order to deal with these pressures. In particular, short term locums in American Samoa served as “safety valves”, providing relief both from the difficult working conditions in Fiji as well as providing lucrative salaries to help out with financial difficulties. For other doctors, temporary placements in developed countries provided new environments and opportunities for learning as well as higher salaries. The option of part-time work in the public sector was mentioned by a few doctors as a possible way of dealing with time pressures while remaining in the system, but this was not allowed. Other career choices that offered relief from the time pressures in the public hospital sector have so far served as “one-way” valves, constituting permanent exits from the system. Three female doctors with young children have chosen to work as tutors at FSMed. Others have entered private general practice, which not only provided a quickly-arranged exit from the system, but paid well and allowed for control of working hours, which was valued by both men and women. Nevertheless, in Fiji, specialist training is only available in public hospitals. While there is technically no reason why doctors in private practice or at FSMed could not re-enter specialist training, exits from the public hospital system for this group of doctors have so far been permanent.

In addition to family pressures, it should be kept in mind the clinical and academic workloads that these doctors face. Specialist trainees described facing heavy and sometimes conflicting pressures from the hospital, from FSMed and from the Ministry of Health, as shown in Figure 6.6. Some pressures were probably an inherent and expected part of training (and are represented by the gray arrows in the diagram), such as looking after patients and academic assignments, along with getting by on modest public service salaries. At times, however, these doctors described the pressures as being excessive, sometimes avoidably and sometimes not (as represented by the “dotted” arrows). Pressures at work were sometimes described as being made worse by unsupportive departments or supervisors. Resignations of colleagues led to heavy workloads for those who were left. In the school, “unreasonable” expectations, lack of support or feedback, and coursework that was time-

consuming but seemed irrelevant added to pressure. A particular source of stress was the conflict between academic and clinical roles.



While the interviews suggested a picture of Masters graduates as “survivors”, the circumstances that individual trainees faced, including workload, clinical supervisors, and academic requirements, varied from year to year, and those who left may have experienced particularly unfavorable circumstances compared to those who stayed. Family circumstances were also unique for each trainee, and family issues may have become more complicated as more children were born or as children grew older. From the interviews, one cannot say that those who stayed in training were “stronger” or “more determined” than those who left, though some who completed seemed to describe particular tenacity under difficult circumstances. Still, some who left the system described strong desires for professional growth and advancement along with disappointment at letting go of specialist ambitions when demands became more excessive than what they or their families were willing or able to bear. In considering how to increase retention, it is important to determine whether any of the burdens placed on postgraduate students are excessive and can be removed, or at least attenuated.

Doctors in training in many countries, including developed countries, also face heavy pressures, but in some countries, the pathway to specialisation is well-defined and predictable, and trainees are

aware that if they are able to hold out for a certain number of years (and meet all requirements), they will not only be awarded a specialist qualification, but will have improved options, which involve higher salaries, hours that are more conducive to family life, or more satisfying work. One of the major differences in postgraduate training in Fiji compared to many developing countries such as Australia is the lack of clearly defined career pathways, including pathways to specialist practice. In Australia, for example, young doctors can usually start their specialist training soon after internship. The nature of the training, the required projects and examinations to be passed, and the number of years to the awarding of a fellowship are well established. The available training jobs are advertised each year and a formal applications process for these jobs is generally carried out, with the most attention in the selection process being paid to previous accomplishments and merit. After a fellowship has been obtained, doctors are recognised as fully-qualified specialists and can undertake employment as consultants, though competition for highly sought-after positions may require additional studies. For doctors who wish to start families, they can often plot out in advance “stopping points” where they can take time out, or in some cases train part-time, or they can make an informed decision about whether they can “hold off” until the (predictable) time when training is completed.

The situation in Fiji is not like this. Doctors, while able to request particular placements, are assigned to postings after graduating from medical school. All are supposed to undertake rural service, but this is unpredictable, with some doctors seeming to bypass this requirement, while others who want to do specialist training remain in rural areas for three years or more. While doctors may request specialist registrar postings, these positions are not openly advertised for a competitive applications process, and it is not clear on what basis these posts are allocated. The start of formal specialist training is delayed compared to Australia and cannot be undertaken until doctors have completed three years of training after medical school graduation. For those who become specialist registrars, and particularly for those who wish to start families, the time to promotions, with their associated “relief” in terms of salary increases, and the time to the more senior postings with their improved call schedules, better working conditions and higher salaries, is unpredictable and differs greatly between doctors for seemingly little apparent reason. Promotions are believed by many to take place on the basis of seniority, luck, and perhaps who you know, rather than on merit or qualifications earned.

Doctors who undertake specialist training in Fiji face not only ongoing pressures from their work, their studies and their family life, but they may be particularly vulnerable to leaving training, or to

leaving the public sector altogether, around or after “transition points”. In the interviews, it was suggested indirectly that the years between medical school graduation and eligibility for entry into specialist training were such a time, though very few doctors were interviewed before entering training. The completion of Diploma training was another point in time where the majority of doctors with Diplomas chose not to continue on to Masters training, with most of these eventually leaving the public system. Another potentially vulnerable time that was identified was the two years between Masters graduation and being granted specialist status. While a few resigned at this time, a number of Masters graduates, especially those who remained in junior postings, planned or undertook overseas placements within a year or two after graduation. These doctors will be faced with the decision of when or whether to return to Fiji. Time will tell what will happen to Masters graduates when they return from overseas training, but given past experience with returned fellowship holders who seldom “lasted” more than a few years, it is reasonable to assume that this may also prove to be a time of vulnerability. Encouragingly, as described above, four Masters graduates have returned from overseas placements, though one has temporarily left again.

While more specific interventions will be addressed in the Discussion section, in general, providing structured, transparent and predictable career pathways leading to specialist practice may help to ease the frustrations of young doctors, and may help individuals and families to “hang in there” during times of particular pressure, especially if rewards for effort are something that can be counted on. This is something that is within the scope of the Ministry of Health to do, and may even be cost-neutral or ultimately cost-saving, as well as of considerable benefit to the delivery of health services Fiji, if such measures lead to improved retention of Fiji doctors and lead to less reliance on expatriates.

In summary, doctors in specialist training face considerable pressures from their clinical and academic work and from family life. More often than not, these doctors do not complete their training. This is a considerable loss to Fiji, especially since few doctors who leave training remain within the public system. While possible interventions for Fiji are addressed in Chapter 7, in general it is useful to keep in mind not only the pressures that these doctors face in their early careers, but also the value of these doctors to the health service in Fiji, and the considerable advantages to be gained to the public sectors from making the most of their dedication and skill.

Chapter 7: Discussion and Future Directions

7.1. Introduction and brief summary of results chapters

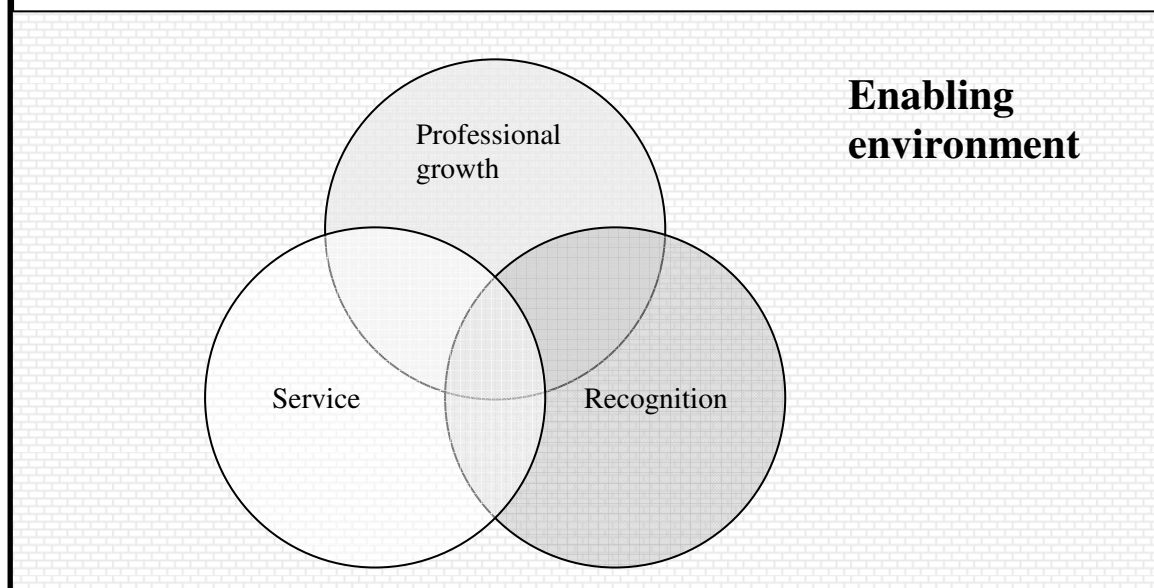
Over the past three chapters, the findings from the interviews with doctors who undertook specialist training in Fiji have been presented, with Chapter 4 focusing on professional satisfaction and dissatisfaction, Chapter 5 focusing on the special case of migration, and Chapter 6 focusing on career pathways through specialist training and beyond. In this discussion chapter, the findings from these results chapters will be summarised briefly. Then the interviews will be approached and interpreted from a constructivist standpoint, exploring how these doctors, through the interview process, “constructed” their professional biographies. This exploration provides insight into some of the underlying values of professionalism that these doctors share, and builds on the findings from the results chapters, as well as providing some degree of integration of the study findings.

Then these findings will be discussed in the context of the literature. Firstly, this study will be compared to existing literature about doctor migration and dissatisfaction in Fiji. Then the findings will be compared to what is known about medical migration and related issues from other developing countries, followed by a discussion of the study findings in the light of work-related motivation theories, a number of which are mentioned in the human resources for health (HRH) literature. After reviewing the fit of this study with the literature, the strengths and limitations of the study will be outlined, followed by a discussion of implications of the study for Fiji as well as some possible directions forward, based on the study findings and the world literature. Finally, it will be briefly discussed whether and to what extent the findings from this group of Fiji doctors can inform approaches to improving retention and supporting health workers in other developing countries.

This study included three results chapters. The first (Chapter 4) explored the factors that constitute professional satisfaction and dissatisfaction for these doctors. Three central aspects of professional satisfaction emerged from analysis of the interviews. These aspects were professional growth, service and recognition, all of which should be facilitated by a well-functioning health system, as illustrated in Figure 7.1. On the other hand, professional dissatisfaction initially seemed more complex and multifaceted, but further analysis suggested that dissatisfaction could be viewed as the

absence of or the blocking of the elements of professional satisfaction. A major element of dissatisfaction for these doctors was in regards to the Ministry of Health (MOH), which many doctors described as not supporting or even working against the realisation of professional satisfaction.

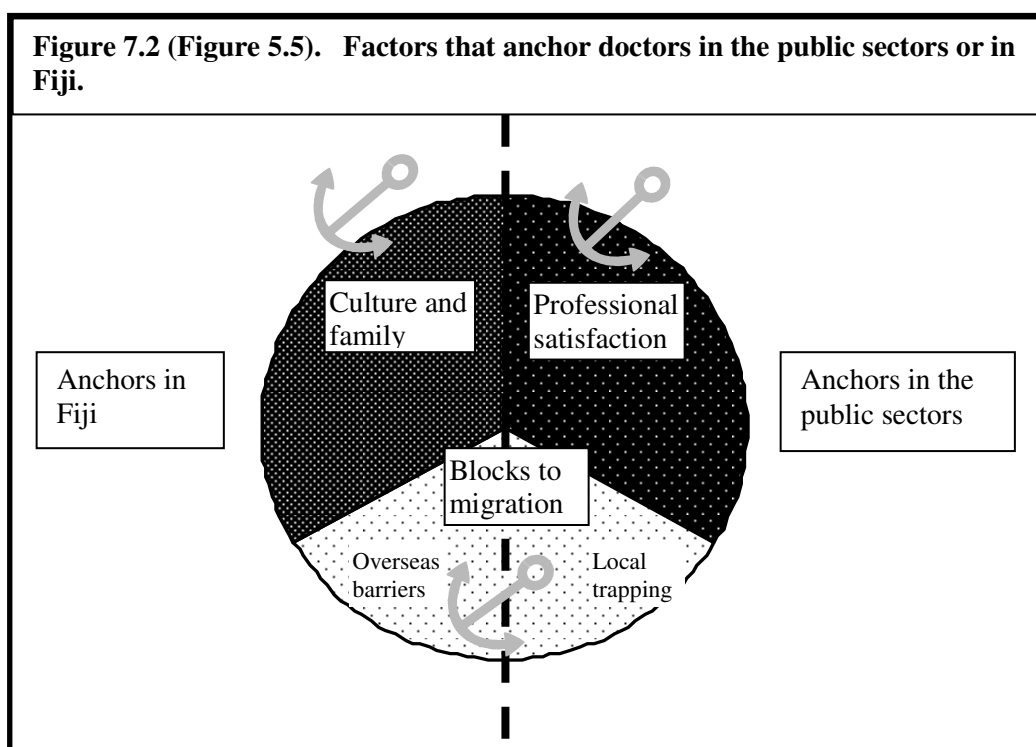
Figure 7.1 (Figure 4.1). Model of the elements of professional satisfaction in an enabling environment



The second and third results chapters looked at career pathways. Chapter 5 looked at the specific decisions of remaining in the public sectors, or resigning in order to migrate or enter into local private practice. These decisions were of particular interest to the doctors in Fiji because of the high rate of loss of colleagues from the public service since the initiation of local specialist training. This chapter presented the decisions to leave the public sectors as complex and multifaceted, but with family welfare being a dominant factor. Family welfare for migrants was usually focused around the issues of safety and stability, though in some cases migration was undertaken because of spouses' career and family issues. Fijian, though not Indo-Fijian migrants, also cited frustrations with working conditions, and in most cases career progression, as contributing factors to migration decisions.

For doctors in private practice, the control of working hours in order to allow more time with families was mentioned as a prominent factor in their decision-making, though a few cited frustrations at not being able to make full use of their specialist skills in the public sector as being a

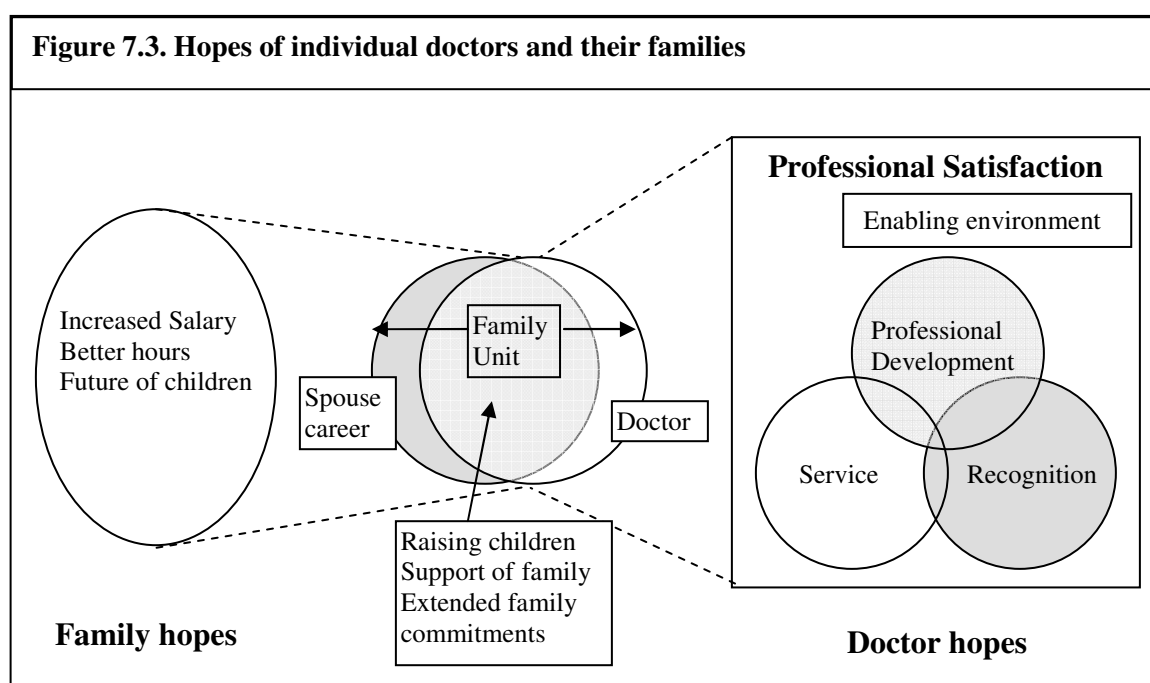
more dominant issue. Doctors who remained in the public sectors (as well as some who left) usually spontaneously described a “service ethic” and eight spontaneously discussed their religious beliefs as a basis for this service ethic. Most also described feelings of attachment to Fiji, which were usually manifest as a commitment to culture and extended family, or as a sense that “Fiji is home”. Nevertheless, a number of these doctors had seriously considered leaving the public service, including some who had received offers of employment from overseas. Some of these doctors described instances when they felt as if they had been treated particularly unfairly. A model was presented which suggested that while cultural issues could “anchor” a doctor in Fiji, professional satisfaction was the major factor that could “anchor” a doctor in the public sectors (see Figure 7.2)



The final results chapter (Chapter 6) explored career pathways before, during and after specialist training, with a focus on times of career transition when decisions to leave the public sectors may have been more likely to take place. For the study participants, these times included the completion of Diploma training and the early years after the completion of Masters training, especially if promotions to more senior roles were not forthcoming. The study also suggested, based on the experiences of returning doctors in earlier years, that if Masters graduates who returned from overseas attachments were not promoted into roles that allowed them to fully use their skills, they

could become vulnerable to resigning as well. It is still too early in the evolution of postgraduate training, however, to tell if this is will eventually be the case. The study also suggested but was not designed to demonstrate that the time before acceptance into specialist training may also be a time of vulnerability to exiting the system.

A factor that was particularly prominent in this chapter was a lack of clarity about career pathways for doctors graduating from medical school who wished to undertake specialist training, especially in regards to how long it would take and whether it would lead to career advancement. For example, some doctors seemed to be “favoured” with exemptions from rural service, acceptance and support for postgraduate training and/or timely promotions, but some were not, and an individual doctor who wanted to enter specialist training had no certainty about whether or according to what criteria they would be accepted into training or how long it would take to start training, or when they could anticipate promotions or advancement into senior roles. This was especially problematic because most doctors chose to start families during or even before training, and the associated financial and time commitments could make training difficult or impossible, especially if there were no certainties about how long they would have to “hang in there” before relief arrived in the form of higher salaries or the better conditions associated with senior postings. Figure 7.3 illustrates how doctors enter training, not just as individuals with their own professional aspirations, but as parts of family units with family aspirations.



7.2. Professionalism and Fiji doctors: a discussion from a constructivist perspective

There are many pressures on doctors working in the public system in Fiji, and there many job opportunities for doctors who wish to leave the system. It is perhaps not surprising that many doctors have migrated, but it is perhaps surprising and also fortunate for the MOH that many doctors have stayed.

This section of the discussion will explore the contributing role of professional values to the career decisions of these doctors through taking a constructivist approach to the interpretation of the interviews. According to constructivist frameworks, the interviews that I carried out with these doctors, as social processes and interactions, led to agreed-upon “constructions” of “reality”. The interview participants were given the opportunity to “construct” their professional biographies, and through the interview process they were given an opportunity to “make sense” of their medical careers and their career decisions.

It is important to keep in mind that the Fiji doctors and I entered the interviews with a wealth of shared experiences from having worked in specialist capacities in Fiji. By the time I started data collection, I was known to many of the doctors that I wanted to interview, and was probably viewed as somewhat of an “insider”, which presented both opportunities and challenges that are discussed further under “Strengths and limitations” (section 7.4). Although I could not completely divorce my background from these interviews, and very much brought my own experiences into the interview process, I worked hard to convey an openness to whatever stories and viewpoints they wanted to relay to me, and I also tried to avoid the impression that I had preconceived viewpoints or agendas, other than that of trying to determine what was going on in the working lives of these doctors in order to be in a position to propose interventions that would be likely to be helpful.

Before starting this discussion, it is also useful to think about the characteristics the doctors who were interviewed, and how these characteristics may have had an impact on their professional values. All have worked in specialist departments in public hospitals in Fiji, and most have undertaken their specialist training through FSMed to the Diploma level or higher. Most entered into their specialty out of personal interest and desire to become specialists, rather than being assigned to training. With the opening up of employment opportunities for doctors in countries such

as Australia and New Zealand, many, especially after 2000, would have watched both Fijian and Indo-Fijian classmates leaving the public system, both to migrate and to enter private practice, thereafter experiencing varying degrees of career success. They would have been aware that migration earlier in a career offered a number of advantages, such as allowing overseas specialist training to commence at a younger age or at a time when family responsibilities were less. Nevertheless, the interviewed doctors had made all made active choices to pursue local specialist training despite other options being potentially open to them. Therefore, they may be a group that, at least initially, was unusually interested in staying in the public sectors, with the ultimate goal of becoming locally-trained specialists, and this public service ethic may have been a more central aspect of their professional values than for other doctors in Fiji. Nevertheless, a substantial number ultimately left the public service.

It is also helpful to explore in advance one of the more likely criticisms of this study, and of this discussion in particular. In the literature about medical migration, financial issues are generally presented as being much more prominent reasons for migration than seems to be the case for the Fiji doctors. The Fiji interviewees described financial concerns as sometimes contributing to their own career decisions, but not as a central factor. One could argue rather convincingly that “Of course these doctors wouldn’t admit to doing it for the money!”, and that the interview participants would “naturally” be presenting themselves in the best possible light. One could even question whether individual doctors were “telling the truth” about themselves, especially given that some doctors believed that financial motivations were central to the migration decisions of their colleagues. One approach that was taken in this study to address such criticisms was the undertaking of a large number of interviews, including doctors who had made different career choices, as this would allow more chances for divergent opinions and “pragmatic” motives to arise. Another approach was to explore “outliers”, looking in particular for doctors who were “brave” enough to admit to being motivated primarily by financial concerns. Interestingly, no such “outliers” were encountered among the 47 interview participants, though some doctors described their colleagues (but not themselves) as being motivated primarily by money.

Going back to the interviews themselves, there were many commonalities among them. The interview participants, as they discussed their lives, often described the interaction of two competing discourses. The first was a discourse of medical professionalism, with its demands for selfless dedication and self-sacrifice for the welfare of one’s patients. The second was a discourse

of family welfare, which in these interviews could justifiably overrule the demands of professionalism.

These interviews suggested that for these doctors, shared professional values are strong and prevalent. In the interviews, staying in the public sector was presented as a “norm” that required little justification, and the “most virtuous” course of action was generally described as remaining within the public service despite the sacrifices involved. Leaving the public sector, however, required justification. Public sector work was described as offering the possibility of professional fulfilment through opportunities to manifest a service ethic (sometimes based in religious beliefs), and this ethic revolved around putting the welfare of one’s patients first and serving one’s own people regardless of their ability to pay. This was particularly reflected in the most widespread complaint about postgraduate training, which was the dilemma of looking after one’s patients properly, which often conflicted with classroom attendance or with having the energy to study properly. Hard work was presented as something that was expected of doctors, and difficult working conditions were seen as “par for the course”. Within this professional ethic, personally choosing to seek out “greener pastures” or to earn more money was not sufficient justification in itself for leaving the system (though some doctors felt that this motivation was justified for others). Lack of career progression, long hours and difficult working conditions, while constituting “understandable” reasons for others to leave the public service, were also not usually presented as sufficient justifications in themselves for individual doctors to decide to leave the public system.

On the other hand, these factors were often described as having a negative impact on family welfare, and most doctors who chose to leave the public sector (including all of the Fijians) acknowledged the contribution of working factors, and the pressures they placed on family life, to their decisions to leave. Nevertheless, all except two cited family rather than work considerations as the principal reasons for resigning, whether this was related to the future of their children (especially their security or education), or to the need to devote more time to family life. Migrants, in particular, cited family welfare and security as predominant reasons for migration, and Indo-Fijians, interestingly, barely mentioned working conditions as reasons for migration. While many who left the public service mentioned professional frustrations, most also mentioned missing, to some extent, both the stimulation and the service aspects of their public service jobs. These doctors presented themselves as dedicated professionals devoted to the welfare of their patients, but also as dedicated parents or family members, with their decision-making taking place as an interplay between these factors.

Although family issues (and occasionally personal health issues) were usually cited as predominant reasons for leaving the public system, a few doctors described frustrations at not being able to make full use of their training within the public system. This suggests that the desire for professional development is also an important element of the professional values of these doctors to the point that its blockage is often used to justify thoughts of resignation, though it is less often cited in retrospect as a primary reason for leaving the system. Professional growth and development, whether through postgraduate training, continuing medical education, or through undertaking the complex “big picture” roles that open up with promotions, was a central aspect of professional satisfaction to these doctors. Many expressed a strong desire for their own professional development in parallel with their service work, and in this regard, public sector work in Fiji after 1998 had a lot to offer. This included the possibility of specialist training, which was not available in the private sector, and if undertaken in developed countries could take many years (if one was even accepted into such training).

While the overall professional ethic of service has probably been stable over time in Fiji, there is some suggestion that the value of professional development for individual doctors has become stronger, and the willingness to sacrifice one’s self-development has become less common. A few doctors alluded to how the “old” doctors used to “just take it”, and would “work work work” for the good of the country. Among the older doctors interviewed, some described experiences of being disappointed when they were passed over (sometimes repeatedly) for training or promotions, but despite that, they described continuing in the public service and not seeking other career options. Commitment to the point of sacrificing one’s professional development may be part of a professional ethic for some, but not for others. It is difficult to determine if there has been a generational change in this particular ethic because there are few older doctors left in the public hospitals, and those who were still around and described such an ethic may have been particularly committed to public service.

The professional values described above are hard to live up to in the difficult working environment of public hospitals in Fiji, and require self-sacrifice as well as family sacrifices. While interview participants alluded to professional values which favoured public service as they “justified” their career decisions, many still left the public service, which is probably not surprising. For these doctors, “accepting whatever the Ministry of Health did to them” did not seem to be part of shared professional values. While doctors generally accepted the need to work hard, they also described

feeling that their work was harder than it needed to be because the health system not functioning as it should. Doctors, as expected, faced high patient loads, long hours, and hard work, but also had to contend with limitations in the medications, supplies and facilities that were available to help them meet the demands placed on them. While these doctors were able to accept that Fiji could not offer the same resources as a developed country, they expected that the health system would appreciate their hard work and would support them to care for their patients to the full extent possible, allowing for the resource limitations in developing countries. They found it difficult that in exchange for their hard work and dedication, their work was not supported logistically, nor did they feel that there was a reasonable certainty of being promoted in a timely manner in recognition of their dedication, sacrifice and hard work. Those who had completed postgraduate training described finding it difficult to accept that they were expected to remain in the same professional roles, unable to make full use of the skills that they had gained through the higher-level roles that promotion would open up. All of these factors may represent violations of “psychological contracts” that these doctors may have believed existed between themselves and the MOH (this concept of “psychological contracts” is discussed in more detail later in section 7.3.3 and in section 2.4 in the literature review). Nevertheless, most of the doctors who resigned did not cite professional frustrations as the predominant factor in their decision making, except where such frustrations interfered with family life.

It should be mentioned that it is likely that each doctor would have had a sense of the “dominant” professional values for specialists in Fiji. In many cases, individual doctors would have personally embraced these shared values, and would be trying to live up to these values, with varying success. In other cases, doctors would be aware of the predominant professional values among Fiji specialists, and while as individuals they may have chosen not to fully embrace such values, they may have wanted to present themselves as doing so, thereby appearing in a “good light” to myself as an interviewer, or perhaps to themselves as well. While I may have had a “feel” about which doctors, through the interview process, were trying to make sense of their careers in reference to their own professional values, as compared to which were more interested in “trying to please” or in presenting themselves favourably, this is not something that, as a researcher, I could “prove” or be certain about. Nevertheless, the finding that certain professional values were frequently alluded to using during the interviews as doctors made sense of or “justified” their careers, is useful in that it suggests that such values are widely acknowledged among this group of doctors.

The most straightforward interpretation of the above findings is that family issues are the predominant factor in career-decision making for these doctors. At first glance, it could be concluded that there is little that can be done to retain doctors who make decisions principally because of family concerns. An alternative explanation is that while doctors in the public service are frustrated at their working conditions, the shared values of professionalism and service ethic may be so powerful that even in the face of great difficulties, family welfare may be the only acceptable reason at a personal and collective level that can override the shared values of commitment to public service. At first glance it may seem puzzling why working factors in themselves would be insufficient reasons for these doctors to justify leaving the public sector. Why wouldn't it be considered OK to resign if you were working long hours under difficult conditions for low pay when opportunities for good conditions at greatly improved salaries were readily available? Why wouldn't it be totally acceptable to resign if you were still at the lowest career grade for over a decade or after you had obtained your Masters? Why would anyone expect you to remain in a system after you had been treated badly or extremely insensitively? Why, unless perhaps there were powerful shared values of professionalism at work, or unless public hospital work offered great opportunities for professional fulfilment? If these values are indeed at work among Fiji doctors, as the interviews suggest, then the power of these shared values is of great value and could represent a potent ally to the MOH. Nevertheless, these values have not by themselves kept doctors in the system.

The concept of professionalism in general, and for the Fiji doctors in particular, had considerable overlap with aspects of professional satisfaction. Professionalism for doctors has been defined in the literature in a number of ways, and can be briefly summarised as putting patients first, maintaining a good standard of care, showing respect, being honest and trustworthy, and keeping up-to-date with knowledge and skills³. In the interviews, professionalism as a concept was not explored directly, though much was spontaneously said in regards to professional values, and interestingly, the shared aspects of professionalism alluded to in the interviews corresponded surprisingly closely to the professional satisfaction model that was also derived from the interviews with these doctors. There is a particularly close fit between the ethics of "service" (putting patients first, maintaining a good standard of care) and "professional growth" (keeping up-to-date with knowledge and skills). Only slightly modifications were needed in order to fit with the concept of "recognition", which can be reconceptualised, from the standpoint of professionalism, as being worthy of the respect of one's colleagues, patients and employers through honesty and trustworthiness, and through one's service and striving for professional excellence. This suggests

that there may be little difference between the concepts of professional satisfaction and being able to manifest professional values for this group of doctors. This study suggests that while these Fiji doctors have a strong sense of shared professionalism, this cannot be taken for granted by their employers, and retention strategies need to focus on family welfare as well as on the active enabling of professionalism.

7.3. Positioning of the study in the literature

7.3.1. Positioning of the study in the literature from Fiji

This study fits is well with other studies that have already been done in Fiji about doctor dissatisfaction and resignations from the public sectors. The literature has established that the resignation of doctors from the public service is an important problem in Fiji^{120-122, 124, 180}. While one study cited by Connell suggested that the resignation of doctors was a particular problem in the first five years after medical school graduation, the current study indicates that resignation is a significant problem even for more experienced doctors who have chosen to undertake local specialist training.

Connell's report emphasised the importance of in-country training in the retention of doctors¹¹⁹. This study indeed demonstrated that the local specialist workforce in Fiji has increased significantly with the graduation of 21 Masters candidates (as of December 2006), 18 of whom of whom have remained in the public sectors in Fiji or are training overseas with stated intentions to return (as compared to the 5 or so returned overseas fellowship holders currently working in the public sectors in Fiji). On the other hand, for the majority (42) of doctors who left training with a one-year Diploma as their highest qualification, the undertaking of local training has not prevented the resignation from the public sectors of all except 14⁸, with 18 others having migrated (see Figure 6.1). So to some degree, this study supports Connell's emphasis on local postgraduate training as a means of retaining doctors, but also suggests that the availability of postgraduate training by itself,

⁸ Of these 14, 3 are tutors at FSMed, one has retired, and only 10 are providing clinical services in public hospitals.

without other changes in the health system, will not be sufficient to hold doctors in the public system.

Previous studies have looked at the reasons behind resignations of doctors from the public service. These factors included limited career structures, a lack of sufficient opportunities for promotion, lack of training opportunities (especially prior to the establishment of postgraduate specialist training), poor working conditions, heavy workloads, and a lack of recognition in civil service pay structures of the long hours that doctors work^{119, 121}. In addition, Azam cites the lack of a perceived link between hard work and rewards as a source of frustration. For the most part, the doctors interviewed for this study also mentioned encountering these frustrations in their working lives¹²¹. One study in particular emphasised high levels of frustration with the Ministry of Health¹²⁴, and this was certainly encountered in the current study.

In regards to migration, in one study, the responses of Fiji doctors were combined with the responses of doctors from Tonga and Samoa, and for this group, financial factors were cited as being important in decisions to migrate¹²⁰. In another study of Indo-Fijian migrants in Sydney, however, none cited working conditions or training opportunities as being central to migration decisions, citing instead concerns over family safety and welfare¹¹⁹. In the current study, family issues, particularly in regards to security, were central to migration decisions for both Fijians and Indo-Fijians, with financial issues having a contributing role to decision-making for Fijians, but not for Indo-Fijians.

What this mainly qualitative study adds to the existing literature is a sense of the complexity of the career decisions of these doctors. This study proposes three major elements of professional satisfaction (service, professional growth and opportunities for recognition) that are potentially or perhaps especially available through working within the public system. This supports Naidu's findings that job satisfaction was the most important element that kept doctors in Fiji, (along with issues of "lifestyle", fear of the unknown, and feeling too old to migrate)¹²⁴. The current study suggests the existence of a powerful shared ethic of professionalism that overall favours retention in the public service, and is central to career decisions of individual doctors as they weigh up many factors, including the satisfying elements of public hospital work along with the many frustrations, and the demands of family and cultural roles.

7.3.2. Positioning of the study in the world literature

This study generally complements and also adds a number of dimensions to the current world literature, and this will be discussed in this section. It is one of only a small number of qualitative studies on doctor migration, but also contributes to the understanding of why doctors remain in the public sectors in developing countries, which is less often addressed, even in the existing qualitative literature. The study also adds to the limited though related literature on motivation, satisfaction, dissatisfaction, “burnout” and coping mechanisms of doctors and other health workers in developing countries, with somewhat more focus on the satisfying aspects of medical practice than other studies. Additionally, this study adds insight into the impact of the establishment of in-country postgraduate training on migration and retention.

Before looking at the similarities between this study and studies from elsewhere in the developing world, it is useful to review how Fiji differs from other countries. Much of the literature on health worker motivation and migration is focused on Africa, which overall is much more economically depressed than Fiji. African health systems are also heavily burdened by the impact of HIV / AIDS, which has only had a minor impact in Fiji. In Africa, public sector wages for health workers were generally described as being inadequate to get by on, and health workers were described as needing to earn outside income in order to survive economically. The purchasing power of public sector wages in many countries was described as having fallen, sometimes dramatically, in response to economic hard times and structural adjustment programs. While Fiji has faced difficult economic times, generally related to coups in 1987, 2000 and 2006, it has not experienced major structural adjustments on the scale that has been described elsewhere. While many Fiji doctors were dissatisfied with their wages and described them as being barely adequate, especially at junior levels, promotions could lead to modest though comfortable remuneration at the more senior grades. In general, most doctors were able to get by on their salaries and did not undertake outside employment, apart from occasional locums and limited private work that was allowed by their terms of employment.

Likewise, while the literature from other regions (including the former socialist states, the Middle East, Africa, and Latin America) described extensive health reforms consisting of decentralisation, privatisation and the promotion of competition as having been undertaken, often with negative impacts, reforms were described as being much more limited in Fiji. While this study did not explore in detail the health reforms undertaken in Fiji, these were generally described by health

workers as being limited to decentralising of responsibility but not of authority, leading to additional layers of bureaucracy, delays, unclear lines of accountability, and an overall deterioration in the support of health facilities, especially in regards to the availability of drugs and supplies. Health reform in Fiji did not significantly alter terms of employment or job security, and was not felt to do away with seniority-based (as opposed to merit-based) promotions. Overall, while the few doctors who mentioned health reforms had mostly negative views, the reform process was not as “disruptive” as that described in other countries.

The Fiji doctors, like many of their colleagues in other countries, were unhappy about a lack of transparency in the appointments and promotions process. For example, while exemptions from rural service and appointments to specialist training were described as being related to some extent to “who you knew”, with “race” being described as having a considerable impact in appointments, the Fiji doctors complained more often of “rigid” civil service structures where seniority was viewed as being more important than merit. They did not describe widespread “nepotism” and “corruption”, as was mentioned in some of the literature from Africa and elsewhere. Likewise, the Fiji doctors, unlike some of their African colleagues, did not describe the occurrence of “predatory” behaviours by co-workers (such as ghost workers on the payroll, stealing drugs, demanding under-the-table payments, or neglecting public sector duties in favor of private practice).

Overall, despite the differences between Fiji and many other developing countries, there were many similarities between the findings from this study and the world literature. While there was close agreement on the frustrating aspects of working in developing countries, the study expanded somewhat on the satisfying aspects of such work, and added additional insight into reasons for migration as well as on the impact of establishing local postgraduate training.

Based on the literature from Fiji as well as from the interview data, there is no question that the doctor workforce in Fiji has been greatly affected by migration. Both local and global factors have contributed to this, and outside of Fiji, “brain drain” has become a major problem for many developing countries, particularly those with English-speaking colonial backgrounds⁷¹. Even though Fiji is wealthier than many other developing countries, this study suggests that the impact of migration on the doctor workforce has probably been of comparable magnitude to elsewhere. In a recent comprehensive study on migration from countries with over 1000 doctors in their workforces (which excludes Fiji), the percentages of doctors educated in these countries that were registered in the United States, the United Kingdom, Canada and Australia were reported as “emigration

factors”⁷¹. Of doctors who undertook specialist training in Fiji, 19 (or 28.8%) were working (though sometimes temporarily) in these countries as of 12/06 (not including 2 doctors in New Zealand and three in American Samoa). While figures for the entire medical workforce in Fiji are not available, the overall emigration factors for specialist trainees was greater, though not strictly comparable, to the reported emigration factors for all doctors of 13.9% for sub-Saharan Africa, 10.7% for the Indian subcontinent, and 8.4% for the Caribbean.

The world literature and the Fiji data corresponded well in terms of health workers reporting overall frustrations with their health systems, in particular feelings of being “let down” and “unsupported”. Health departments were described as not providing logistical support to health workers, lacking in clear and / or fair access to career pathways, lacking in appreciation and not valuing health workers, seeing health workers as “units of production” rather than as valued professionals, not listening to nor responding to health workers, and neither recognising the severity of nor addressing serious workforce problems^{7, 25}.

In regards to public hospital work, data from Fiji corresponded well to the difficult working conditions reported from elsewhere, and included long hours, heavy workloads, low staffing, and not being provided with the means to carry out one’s work, especially in regards to drugs and supplies. Downward spirals were described both in Fiji and elsewhere, with resignations of colleagues resulting in increasingly heavy workloads that left remaining staff less able to cope, often leading to additional resignations.

Doctors in Fiji, along with health workers in other countries, complained about a lack of transparency in the allocation of postings (whether urban or rural). Frustrations with a lack of transparent career pathways were also mentioned, especially as manifested in the awarding of postgraduate training positions, and in the promotions process. Training was also described as being difficult or even demoralising, often with insufficient support and mentoring⁹⁸. Within the health service itself, Fiji doctors, like their colleagues in other countries, described being frustrated that promotions were not given out according to merit, and overall, doctors complained that they did not feel that they could count on being rewarded for their efforts either monetarily or through career progression.

Interestingly, while the lack of availability of continuing professional development has been described as being a major problem in the world literature, especially in rural areas⁷, the Fiji

doctors, who were based in larger cities with reasonably reliable electricity and telephone services, felt that they had reasonable access to medical journals and other sources of information through the internet and other resources, with the limiting factor being lack of time to keep up. Overall, continuing education issues were not cited as major sources of dissatisfaction.

There were also somewhat fewer similarities between the Fiji doctors and the world literature descriptions of interactions with clinical supervisors, colleagues, and patients, and this may represent a general lack of focus on these areas in the world literature. While clinical supervision during training that was felt to be either inadequate or disappointing was mentioned in both Fiji and Kenya⁹⁸, a number of Fiji doctors were somewhat more positive, mentioning how valuable and satisfying good mentors and role models had been to their career development. Fiji doctors also mentioned how they derived great satisfaction from being respected and appreciated by patients and colleagues, as well as the very positive contribution that a sense of camaraderie made to their day-to-day work.

In Fiji, satisfying aspects of work were often spoken about, much more so than in literature from elsewhere, which may reflect the somewhat different and overall exploratory focus of this study. An interesting finding from the Fiji specialists was that public sector work, even with its significantly lower remuneration, was depicted by most doctors as a preferred “norm”, with other options such as private practice and migration presented as being, to some extent, compromises that were being considered, or were undertaken because of family considerations. In Fiji, this seemed to be related to the varied and sometimes fascinating nature as well as the service aspects of public sector work. The world literature also presented a number of reasons why health workers remained in the public sector, including opportunities to manifest social responsibility, self-realisation, professional satisfaction and prestige¹¹⁷, job security, credibility and social contacts¹¹⁴, and a high profile identity and respect from the community¹⁰².

This study also provides additional insight on the impact of the establishment of local postgraduate training. The study, to a major extent, represents an exploration of outcomes from an intervention in medical education from both a qualitative and quantitative perspective. In the world literature, the establishment of in-country or regional postgraduate training, with the awarding of non-exportable specialist qualifications, has been proposed as a mechanism for retaining doctors in developing countries¹¹⁹. While other studies described postgraduate specialist programs that have been set up in developing countries^{9, 10, 16, 181-183}, this study adds to that literature through providing a

thorough exploration of the establishment of regional specialist training in Fiji during an era of increasing doctor migration, and may be of interest to other countries that are anticipating setting up such training. With almost complete ascertainment of the whereabouts of trainees from the first 7 years of the course, the quantitative data from the study was able to demonstrate that local training and non-exportable qualifications do not, by themselves, prevent migration. Additionally, while political instability and the opening up of overseas opportunities have undoubtedly impacted on retention, the programs also struggled because of lack of support by the MOH at policy and practical levels as well as because of pressures and some lack of support from hospital clinical departments. Potentially, these factors can be addressed locally in Fiji and elsewhere.

In addition to adding to the literature about postgraduate training, the study adds insight into the reasons for migration itself. Much of the existing literature explored related concepts such as motivation, satisfaction / dissatisfaction, professionalism, performance, and coping mechanisms. Original research on the reasons for doctor migration was very limited. A few in-country interviews and surveys have looked at intentions to migrate as well as why others have migrated^{75, 91-93, 184}. Little research has been done on migrants or returned migrants^{75, 119, 120}. Research carried out to date suggests multiple reasons for migration, with financial factors being dominant. The current study, while limited in its focus to Fiji doctors who have undertaken specialist training, provides an in-depth exploration of the career decisions of doctors who have remained in the public sectors, entered private practice, migrated, or planned to undertake temporary overseas training or returned to Fiji after such training. The findings in this study contribute additional insight to the world literature through their depiction and analysis of the complex and multifactorial nature of career decisions for these doctors, and perhaps surprisingly, the importance of non-financial factors and concepts of professionalism to their decision-making.

In general, the findings from the current study on doctor migration, retention, satisfaction and dissatisfaction in Fiji fit in well with the world literature, and negative factors fit in well with “push” factors towards migration that have been identified elsewhere. One of the outcomes of the current study that may add a different perspective to the world literature is the proposal of a model of professional satisfaction, with the major components of satisfaction being service, professional growth, and recognition, in the setting of an enabling and supportive health system. This model, along with descriptions of aspects of practicing medicine in Fiji that are satisfying or even highly fulfilling, may start to approach the puzzling question brought up in reports from the World Health Organization and Joint Learning Initiative reports of why, despite the very great pressures on health

workers in developing countries, many not only do not migrate, but continue to come to work and carry out their duties conscientiously in spite of not being supported by their health systems, or in some cases, even paid on time. These reports do not “explain” why this should be so, but call for such health workers to be supported as they are at risk of “collapsing under the strain”^{7, 25}.

Such “selfless dedication” may not only seem inexplicable, but may appear as well to contradict economic theories, where individuals are expected to act according to their economic self-interest²⁴. For many health workers, however, higher motivating factors are likely to be at work, and this study suggests that dedication to professional values and in some cases religious faith may provide that higher motivation. The current study identifies a number of widely held professional values in Fiji, such as dedication to a service ethic, which includes service to one’s own people and service to those who are unable to pay for their care. In other developing countries, “inexplicably” dedicated health workers may have very similar motivations to the Fiji doctors, and the findings from Fiji may be a starting point or may make some contribution to the understanding of motivation in health workers in other developing countries.

To explore this issue of professionalism further, it is worth considering that while the interviews in this study explored professional satisfaction rather than professionalism per se, it was found that as the doctors constructed the stories of their medical careers, that they justified their career decisions on the basis of their professional values that were only described as being overridden when family welfare was at stake, suggesting a centrality of professional values to these Fiji doctors. This adds an interesting dimension to existing literature. In the literature review, the importance of professional values to health workers in other developing countries was also discussed, and even in the few articles cited from developed countries, the violation of professional values that took place when doctors felt blocked from providing the care that they knew they were capable of providing was presented as being central to their dissatisfaction¹¹¹.

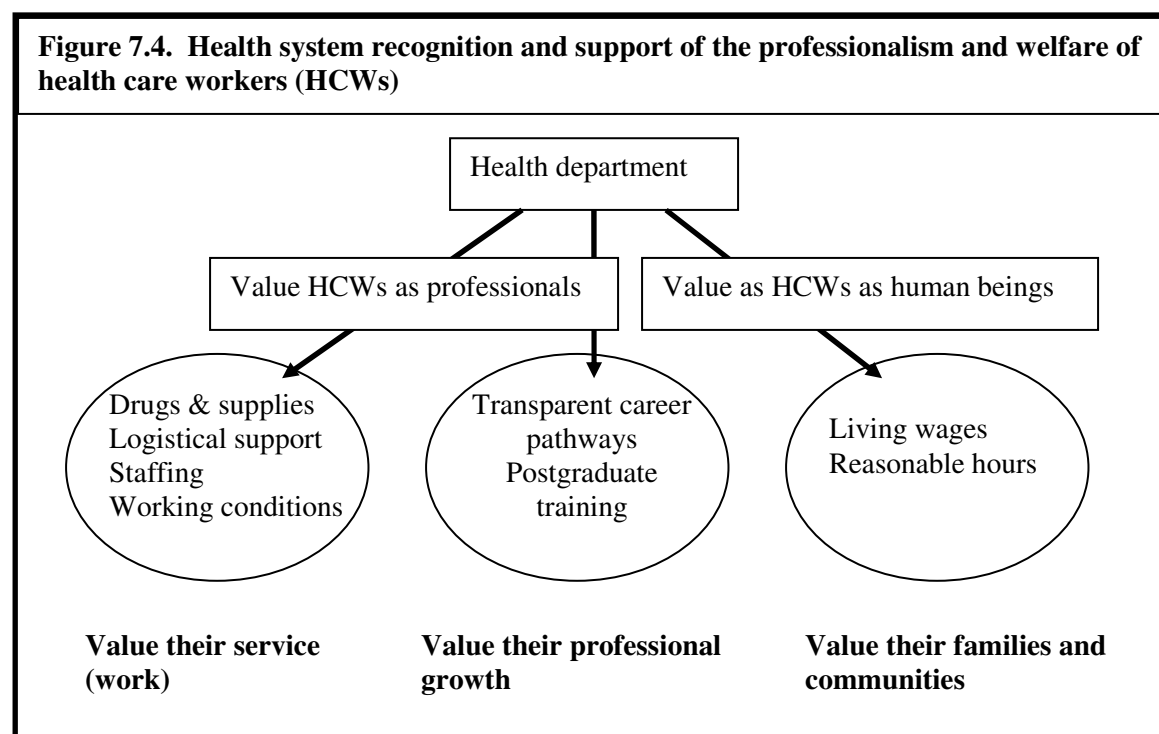
The literature review and the interviews suggested that when professional values are overridden, this may have a much more profound impact on professional satisfaction and dissatisfaction than job aspects that are mainly “frustrating”. For example, long working hours in themselves may be experienced as dissatisfying, but when an extreme patient load leads to doctors believe that they are no longer able to give compassionate care, or when they believe that they have harmed or even “killed” patients because they were too rushed to make a correct diagnosis, this may represent a particularly painful challenge to their own sense of professionalism, as suggested by literature from

Kenya⁹⁸, as well as from Fiji where a number of anecdotes about doctors “breaking” under the strain of losing patients due to overwork were cited. Likewise, not being supplied with adequate drugs and equipment has been described as being frustrating, but may lead to a violated sense of professionalism if health workers find themselves unable to provide the care that they know they are capable of providing, or if they feel shame based on their communities viewing their facilities negatively and even as “last resorts” that are unable to provide an acceptable level of care. This is probably best described in qualitative research from Kenya and Ethiopia^{98, 101}. In Fiji, it could be argued that the issue of promotions was also interpreted in the light of professional values, where senior postings were seen as means of expanded growth and service through facilitating development into being able to undertake important and valuable “big picture” activities that could make a real difference (such as teaching, leadership and expanding clinical services), while denial of access to senior roles after training may have represented a violation of these doctors’ professional values of self-development and service to the best of their ability. In Fiji, disappointments with the promotions process were cited as important contributing reasons to leaving the public sectors or to consider resigning.

From a health service standpoint, adopting a framework of supporting health workers to carry out their work according to their professional values may be a particularly important element in promoting professional satisfaction and retention, and there is support for this concept both in the literature review and in the data from Fiji. This would involve both supporting day-to-day work as well as facilitating, enabling and rewarding professional development (which was particularly important to the Fiji doctors). Likewise, dissatisfaction and resignations may not be so much a “rational” weighing up of the benefits of staying compared with various negative “push and pull” factors, but may in some instances be driven by health workers reaching a painful realisation that due to health policy and lack of support, they are no longer able to work and develop according to their professional values, and that therefore the sacrifices of hard work and low salaries that are involved in public service are no longer worth it. While the discussion in the following section on psychological contracts may provide some insight into this issue, further research is needed to clarify the link between violations of professional values and subsequent resignation and migration,

The professional satisfaction model that was developed for Fiji corresponds closely with the values of professionalism identified in the world literature. As discussed above, professional growth and service are elements of both job satisfaction and professionalism, and the professional values of striving to be worthy of trust and respect from one’s patients, colleagues and employers correspond

well to the “recognition” aspect of satisfaction. It may be useful to rework the satisfaction model slightly, as has been done in Figure 7.4. This model takes into account both Fiji data and other literature, and proposes an approach where health systems aim to increase the satisfaction (and retention) of their workers, through supporting the manifestation of professional values as well as the welfare of the workforce.



7.3.3. Positioning of the study in the motivation literature

The issue of motivation has received considerable attention in the human resources for health (HRH) literature, and is central to the World Health Organisation’s (WHO) goal of “motivated, skilled and supported” health workers⁷. One aspect of the literature review for this study was a brief exploration of widely-cited motivation theories, and this section will explore which theories are supported by the current study.

One of the first tasks before positioning this study in the motivation literature is to clarify what is meant by motivation, which is a complex term used in many ways. Motivation can be “positive”, based on satisfaction or even joy, or negative, based on fear, feeling “trapped”, economic necessity, lack of options, etc. The most widely used definition of workplace motivation in the HRH literature

relates to alignment of workers to organisational goals. For reasons discussed in the literature review and below, this may not be a particularly useful definition, and a definition of “professionalism-based motivation” that was proposed based on the literature review as “a sense of satisfaction and fulfilment gained through working diligently according to professional values” may have more relevance to Fiji, and perhaps to other developing countries. The discussion below will approach motivation from this positive angle.

Motivation can be approached through the feelings of workers about their jobs, or can be inferred through observing performance (including the “act” of migration). This study did not directly study motivation, but approached motivation issues through using a lens of professional satisfaction and dissatisfaction to explore career decisions, particularly the decisions to migrate or remain in Fiji. There was no attempt to specifically address or verify performance issues in this study, with the only measurable aspect of performance being whether or not the doctors had completed postgraduate training, and whether they were working in the public sectors or had resigned. Therefore, motivation theories that addressed feelings about work seemed to have the most relevance to this interview-based study, while theories more directly related to performance issues seemed to be less relevant.

Of the motivation-related theories, the concepts of organisational justice and psychological contracts were well-supported by this study, as were aspects of organisational commitment theory. There was some support for Herzberg’s Motivator-Hygiene theory, though with important modifications. These theories will be discussed below.

As mentioned above, motivation theories based mainly on performance issues did not have particular relevance for this study because performance was not specifically addressed. Two performance-related frameworks that merit a brief mention are Franco’s model¹¹⁸, which was developed through research on health workers in developing countries and integrates the complex aspects of individual and community characteristics, job satisfaction, workplace support, and performance, and Dolea’s model¹²⁷ (see Figure 2.2), which simplifies Franco’s model somewhat and adds in the factor of retention. These models were supported to a considerable degree by the complexity and richness of the interviews carried out in this study and are valuable additions to the HRH literature because of their taking into account many aspects of motivation. They included a major focus on performance, which, while being important, was not one of the issues that was

particularly focused on or explored in this study. Therefore, these models will not be discussed further.

Motivational theories related to “**organisational justice**” seem to be supported by the interview findings from this study and have particular relevance to the process of making civil service appointments, awarding promotions, and allocating postgraduate training positions in Fiji. According to these theories, justice is important to workers, given that most people believe that in the long run, they are more likely to profit from a fair system than an unfair system¹³⁴. While issues of “distributive justice” (which deals with how resources are allocated¹³⁵) were occasionally mentioned by the Fiji doctors, “procedural justice”, which involves the development and enactment of specific policies and procedures that are seen to be fair¹³⁶, seemed to be of particular relevance. Fiji doctors expressed discontent over the lack of transparency in career pathways, especially in the “hit or miss” nature of the appointments and promotions process, where some doctors seemed to get lucky, while some were passed over or disadvantaged, and where good performance or completion of postgraduate qualifications, rather than being predictably rewarded, seemed to have little relevance. The Fiji doctors especially mentioned discontent with the favoritism that they described as being given to expatriate doctors over those who were locally trained. Problems with “interactional justice”, which has to do with perceptions of the quality of the interpersonal treatment an individual receives from an authority, were also mentioned by a number of doctors, and some described instances of “poor treatment” from individuals in the MOH to the point where these interactions contributed to decisions to resign or considering resigning.

A concept that has been described in the HRH literature that also seems to be of particular relevance to the Fiji doctors is the “**psychological contract**”, which has been defined as “an individual’s (unwritten) beliefs regarding the terms and conditions of an exchange agreement between themselves and their organisations” consisting of “certain rewards in return for the contributions that they make to the organisation”¹⁴¹. From the interviews, it is likely that most of the Fiji doctors believed that a psychological contract existed or should exist between themselves and their employer. The contract is probably along the lines that doctors agree to work according to their professional values, putting in long hours and being dedicated to the welfare of their patients, as well as working hard to improve their skills and knowledge, often through undertaking of or being willing to undertake rigorous postgraduate training. In exchange for their efforts, they expect logistical support, especially through the reliable provision of drugs and supplies, optimisation of working conditions (within the constraints of a developing country), a liveable wage, and

opportunities for professional development and promotions according to merit. This study suggests that this contract was viewed as being violated by almost all doctors in the case of infrastructure support, and by many doctors in the case of career pathway issues.

According to Rousseau¹³⁸, psychological contract violations can be dealt with in a number of ways (see Table 7.1), and these approaches generally fit in with what was described in Fiji. In Fiji, doctors have described using “voice” to try to rectify psychological contract violations (up to the point of meeting with the prime minister) with varying levels of success. This was particularly evident in a doctors’ “work to rule” industrial action in 2002, where better working conditions were collectively sought after, and where an overall outcome that was generally considered to be unsuccessful was followed by a large number of resignations. While a reluctance to speak up was sometimes described in Fiji, doctors did not specifically describe being personally punished for activism. For doctors who experienced either collective “violations” or individual “violations” of psychological contracts (usually related to the promotions process), some described speaking up without success and some chose to remain silent, with a number of doctors describing a period of questioning and discontent where they may have appeared to enter a state of “silent loyalty”. Some, after a period of soul-searching, decided to remain in the public sectors, while others eventually chose to resign. The option of neglect and / or destructive behavior was not described in Fiji, and this may be due to the wide variety of options open to the Fiji doctors outside of the public service.

Table 7.1. Responses to psychological contract violations - adapted from Rousseau¹³⁸ (p.135)		
	Constructive	Destructive
Active	Voice	Neglect / Destruction
Passive	Loyalty / Silence	Exit

Another somewhat more comprehensive theory that is supported by the interview data from Fiji is the concept of “commitment theory”, as it seems to have some explanatory power in regards to retention and exiting the public system. Meyer and Allen¹³⁶ described organisational commitment as something that “binds an individual to the organisation”, with committed employees being more likely to remain with their employers than uncommitted employees, though there are a number of reasons for commitment. They proposed that commitment falls into three major categories, as outlined in Table 7.2.

Table 7.2. Commitment theory: levels of commitment to organisations¹³⁶		
Meyer & Allen terminology¹³⁶	Description	Proposed terminology for Fiji
Affective commitment	refers to the employee's emotional attachment to and identification with the organisation (" wants to " remain with the organisation)	Fulfillment-based (?heart-felt) commitment
Normative commitment	reflects a feeling of obligation to continue employment (" ought to " remain with the organisation)	Duty-based commitment
Continuance commitment	refers to an awareness of the cost of leaving the organisation (" needs to " remain with the organisation)	State of "weighing up"

This model has reasonable fit with the overall situation in Fiji, where doctors described a service ethic based on professional values. In general, for the Fiji doctors, public hospital work, especially if adequately supported in a logistical sense, best allowed for this service ethic to be expressed, and this led to commitment to the public service as an outcome of personal alignment to professional values, though not necessarily alignment or identification with the Ministry of Health itself. Many doctors, especially those who had been promoted or who were undertaking senior roles, described varying degrees of fulfillment and satisfaction and even joy from their work, though during difficult and particularly frustrating times, doctors described continuing to work out of an underlying sense of duty. For some doctors, a build-up of frustrations or a particular event (such as a particularly frustrating incident at work or an outside event such as the coup of 2000) could lead to a period of discontent characterised by a process of "weighing up" whether it was worth continuing in the public service. These seemed to be a particularly vulnerable times for resignations, though even doctors who resigned described continuing to carry out their work conscientiously according to their professional values until a final decision to exit the system was reached. Sometimes external factors improved (such as through a promotion being granted or through the recruitment of coworkers to relieve some of the workload) or an internal process of reflection, often based in religious belief, which led to a rededication to the public sector and a return to a more "settled" state. While Meyer's commitment model also described workers who remained in a state of "weighing up" because they did not have better employment options, increasingly in Fiji and other

developed countries, alternative employment is readily available, and fewer workers would feel “trapped” in their jobs that in previous years.

Arguably, a “commitment” model may be more useful than some motivation theories for approaching the issues of workplace retention or alignment with employer values. It provides a relatively straightforward framework of differing levels of employee commitment, as well as a predictive model for who is likely to stay. It also provides a potential explanation for the recent acceleration in migration as an opening up of opportunities to a workforce that has probably been generally unhappy or in a state of “weighing up” for quite awhile, but not previously able to exit the system quite so easily. This model also suggests that an effective approach to retention lies in paying attention to interventions that would make the work more fulfilling, which fits with the “support of professionalism” model depicted in Figure 7.4, but also through giving attention to making it less likely that workers would enter into a state of “weighing up”.

Another potentially useful motivation theory is Herzberg’s Motivator-Hygiene theory. This theory, which was developed using a critical incident technique, proposed job “motivators”, which were mainly “intrinsic factors”, such as achievement, recognition, the work itself, responsibility, advancement and growth, as well as dissatisfying job aspects, and “hygiene factors”, which were mainly extrinsic and included company policies, salary, working conditions, interpersonal relations, administration and supervision. Herzberg proposed that eliminating causes of dissatisfaction would not lead to satisfaction, but would lead to a neutral state of absence of dissatisfaction. Satisfaction and motivation would only occur if the “motivators” were present, and would lead to higher levels of motivation and performance^{127, 130, 133}. While the current study was not designed to test Herzberg’s theory, and specifically did not use a critical incident technique, there is some support for the concept of “hygiene” factors, but less support for or perhaps a different overall concept of “motivators”. In Fiji, salaries, basic working conditions, administration issues and policies seemed to be “hygiene” factors, where problems could cause considerable discontent, but where a “good enough” situation seemed to be acceptable. For example, modest salary increases were described as leading to a resolution of dissatisfaction, and while the higher salaries associated with private or overseas work were welcome, they did not in themselves lead to high levels of satisfaction. Again similarly to Herzberg’s theory, “motivators” could lead to higher levels of satisfaction, but on the other hand, this study suggested that their absence could lead to considerable dissatisfaction to a similar or perhaps even a greater extent than the absence of hygiene factors. For Fiji, interpersonal factors such as a sense of camaraderie with colleagues, good clinical supervision and mentoring

(especially within a specialty department), served as powerful motivators, but also led to considerable unhappiness when they were absent. Likewise, opportunities for career development and advancement, as well as being able to serve through the work itself were described as highly motivating, while the absence of these opportunities were described as contributing to decisions to resign or consider resigning. Interestingly, while appreciation by patients was described as being highly motivating, lack of appreciation was not often mentioned as being a source of dissatisfaction. Herzberg's theory is useful in correctly predicting that for this group of Fiji doctors, money by itself would be unlikely to lead to higher levels of motivation, and that these doctors need "motivators" in order to be truly satisfied with their work. On the other hand, the finding that these doctors were very dissatisfied, sometimes to the point of exiting the system, when "motivators" were absent suggests that Herzberg's theory may need some modifications if it is to be used as a model for health workers. The terminology might need to be adjusted to reflect the possible existence for health workers of "hygiene factors" and "motivators – demotivators" (as opposed to just "motivators").

The fit between this study and existing motivation theory has been discussed because health worker motivation is frequently mentioned in the HRH literature, but nevertheless, the fit is at best somewhat forced. Motivation theories are mostly written from the perspective of organisations or management, and the literature as well as this study suggest major differences between the "worldviews" and mutual expectations of health workers and the health services that employ them.

The interviews and the world literature suggest that doctors (and other health workers) are generally aligned to and try (with varying success) to live up to professional values that include putting patients first, maintaining a good standard of care, showing respect, being honest and trustworthy, and keeping up-to-date with knowledge and skills³. For many health workers in developing countries, professional values extend to providing care for one's own people, regardless of their ability to pay, and this was certainly the case in Fiji. For Fiji doctors oriented to such values of public service, employment by the MOH is practically "the only game in town", and these doctors described a willingness to put up with a lot from their employer in order to fulfill their own personal ethics of service, but only up to a point (which was undoubtedly different for each doctor). These doctors were not looking to their organisation as something to "align to", given that their alignment was first of all to their professions. They nevertheless looked to and depended on the MOH to support them so that they could get on with their work and be facilitated in their development as

professionals, as well as to provide pay and working conditions that allowed them to support their families properly. All too often in the interviews, they described how they felt “let down”.

Based on the HRH literature that has been written mainly from a management and health service perspective, there seems to be a big gulf in understanding between health workers and their employers. While “motivation” has been defined in terms of alignment of workers to the goals of their organisations, this concept would likely be puzzling or even seem to be “nonsense” to the Fiji doctors, or perhaps to health workers elsewhere in the world. It is unlikely that these doctors would be able to envision themselves compromising their professional values in order to “align” with a dysfunctional health department that, in spite of lofty stated goals or mission statements, seemed to demonstrate by its day-to-day functioning that it had little overall care for patient welfare or the welfare of its workforce.

Some of the assumptions from an organisational standpoint that appear in some of the HRH literature could be interpreted as being not only “off the mark” but frankly offensive to health workers, and could contribute to misunderstandings, dissatisfaction, and perhaps even resignations. As an example, for an organisation to expect health care workers to align to its goals implies that it views its own organisational goals as being preferable or even “superior” to the existing values of health workers, arguably devaluing closely-held professional values. Depictions of health workers as being principally “economically rational” self-interested actors who can be reliably controlled by incentives may also be offensive, as would language that depicts health workers as objects of production to be controlled or “motivated” to work harder. The world literature as well as the interviews from Fiji depicts not only a gulf in understanding between health workers and their employing health systems, but perhaps even an anger at the organisations that do not support them, do not seem to value them either as professionals or as human beings, and moreover look down on, take for granted or even override the professional values that they hold as precious. While health workers are willing make sacrifices to serve in the public sectors in developing countries, they may ask why they should continue to serve if they are not supported to even function as professionals, especially if their organisations, through their policies and actions, show disregard or even contempt their professionalism. Acknowledging that this gulf in understanding is likely to exist between health workers and their employers, and that this may be contributing to health worker discontent and even to migration, may lead to shifts in understanding and interventions that could help bridge the gulf or at least lead to more mutual respect and more functional working relationships. Perhaps it needs to be accepted that while the professional values of health workers are powerful allies to a

health service, health workers are unlikely to see themselves as “organisation men” or “women”, and alignment to a health organisation is unlikely to take place unless the organisation is also truly aligned with professional values. It may be that health workers (and other members of the helping professions) may be sufficiently different from other workers, such as business workers and factory workers, that management theories derived from the study of these groups cannot be automatically extrapolated, and that major modifications or even new theories need to be developed.

7.4. Strengths and limitations of this study

The next section of this discussion will look at the implications of this study for Fiji and for other developing countries, but first the strengths and limitations of this study will be outlined.

To review, this study was carried out as a case study exploring the career decisions of doctors who have undertaken specialist training at the Fiji School of Medicine. A major focus was on decisions to migrate or to remain in the public sectors, and the exploration was undertaken for the most part through a “lens” of professional satisfaction and dissatisfaction. A major strength of this study is in the large number of interviews that were carried out, with 47 specialists, trainees, and former trainees being interviewed. Of the 66 Fiji doctors who undertook specialist training between 1996 and 2004, thirty-six, or over half, were interviewed. Purposive sampling led to a representative mix of males, females, Fijians, Indo-Fijians, Masters (MMed) graduates, and doctors who left training with a Diploma only, as well as migrants, doctors in private practice in Fiji and doctors still in the public sector. Permanent migrants were interviewed, as well as doctors who were temporarily training overseas, or who had returned to Fiji after undertaking such training. In spite of some overrepresentation of Masters graduates and under-representation of migrants and Diploma-only graduates, all groups were well-represented. With the quantitative aspect of the study, the whereabouts of almost all graduates were confirmed and the extent of migration and retention was able to be accurately determined. The qualitative in-depth interviews allowed for a deep exploration of issues where little original research has been done, and also allowed more chance for novel insights to be uncovered than would have been the case with survey data. From the interview data, models were derived that may serve as useful frameworks for understanding the issues of doctor satisfaction, dissatisfaction, migration and retention, and a strength of this study is the grounding of the models in the interview data.

Arguably, a particular strength of this study was my “semi-insider” status as an interviewer. I worked as a specialist in Fiji for three years, and along with my family, experienced the coup of 2000. My involvement in the postgraduate programs has been ongoing since 1998, with 1-1/2 years spent full-time in setting up postgraduate training in internal medicine. This has probably given me an unusual degree of insight into, access to and hopefully trust of the doctors who were interviewed.

There are a number of important weaknesses to this study as well. The narrowness of this study may limit generalisability, and this is discussed below in the sections on possible directions for Fiji and the rest of the world.

The interview approach to this study limited what could be learned to an exploration of the attitudes and feelings of the doctors studied, and could not verify their actual behaviour, other than where they were actually working and whether or not they completed training. Stated intentions may or may not be reflected in future actions, though over the 3 years since data collection began, there have been no major discrepancies between what interview participants stated they would do career-wise and what they actually did. Additionally, while doctors could present themselves in interviews as skilled and dedicated professionals, this is again something that could not be directly verified other than to a limited degree through informal conversations with others. Nevertheless, major problems with competence or breaches in professionalism, such as the “predatory” behaviours described in some of the literature from Africa and elsewhere, were rarely described, though they were not specifically asked about.

My own status as a “semi-insider” may have led to limitations as well. There may have been some issues, in particular criticisms of the postgraduate programs, that the interview participants would have been reluctant to raise. Additionally, my status as an academic and former “authority figure” may have led students and former students to present themselves in a more positive “light” than they might have otherwise done. Beyond these considerations, as a “semi-insider”, in some instances I may have felt that I understood situations where in reality my understanding was limited, and an “outsider” without such assumptions may have been able to uncover insights that I “too experienced” to be open to.

Perhaps one of the greatest potential criticisms of this study is that no formal interviews were conducted within the MOH, and contact with the MOH was limited and informal. Specifically,

while doctors made many complaints about the MOH, these were not formally verified, and in particular, for ethical reasons, individual instances of “poor treatment” could not be brought up in order to learn the “other side of the matter”. One reason for this “omission” was that the scope of the study of the Fiji doctors was already very extensive, limiting the capacity to analyse additional data, though admittedly interview data from individuals within the MOH may have provided useful insights. Additionally, this “omission” of MOH data could be justified as being somewhat outside of the scope of a study that focused on why doctors made the choices they did rather than on management issues. From the standpoint of this study, the doctors interviewed had developed impressions of the MOH that were remarkably consistent and widely shared among their peers, and these doctors felt and acted based on their own as well as shared impressions, whatever the viewpoint or “reality” was from the standpoint of the MOH.

This leads to another important limitation to this study, which is its highly cross-disciplinary nature. My own expertise is limited to being a specialist clinician who has worked in Fiji, an experienced medical educator, a qualified public health physician, and a PhD student who has gained skills in qualitative medical research. While this has been useful in carrying out and analysing the interviews, there are many other disciplines that are relevant in exploring migration decisions, such as international-level health policy, health economics, management, and organisational psychology, none of which I have expertise nor have had supervisory support in. Nevertheless, I have attempted to tentatively link the study findings to the literature in these fields (with which I have an incomplete familiarity and limited understanding) as I believe that such cross-disciplinary approaches are useful in approaching the complex and important issues addressed in this study, as long as my own limitations in expertise are understood and taken into account.

7.5. Future directions

7.5.1 Improving retention in the public service: possible directions for Fiji

Migration of doctors and other health workers from developing countries has accelerated in recent years, and many developed countries have not only failed to train enough doctors to serve their own populations, but can also offer salaries that are many times greater than those available in developing countries. Ethically, it is problematic for wealthy countries to encourage the migration

of doctors who were trained in developing countries, and this has been written about at length in the medical literature and needs to be addressed. Fiji can (and should) appeal to Australia and New Zealand to address their own health workforce shortages rather than recruiting from and weakening the health systems of Pacific neighbours. In particular, it merits pointing out the morally problematic issue of Australia having helped to set up postgraduate training in Fiji and then becoming a major beneficiary of the services of its graduates.

Ultimately, however, the Ministry of Health (MOH) in Fiji has little or no control over the recruiting practices of health systems in Australia or New Zealand or any other developed country. Therefore, the health system in Fiji cannot wait for outside help, but should ultimately make whatever local interventions it can to retain its workforce, and, as a pragmatic necessity, that will be the focus of this discussion. While outside funding to support interventions to strengthen the health system in Fiji would be helpful and may be more likely to become available than in previous years given the recent shifts in the focus of aid support by Australia⁶⁹ and elsewhere⁷, receipt of such funding cannot be guaranteed, and the impact of the 2006 coup is likely to make less money available for health spending rather than more.

While some of the discussion arising from this study may seem at times to be critical of the MOH in Fiji, health systems throughout the developing (and developed) world have been described as being problematic, and the finding that Fiji doctors are highly critical of their health system is neither surprising nor exceptional from a global perspective. While this study suggests that health policies in Fiji have led to dissatisfaction and have contributed to resignations and migration, it cannot be said that the health bureaucracy in Fiji is any “better” or “worse” than in those in other developing countries, or developed countries for that matter. In particular Australia, New Zealand or other developed countries should not justify their recruitment practices by blaming Fiji and other developing countries for bringing their workforce problems onto themselves. The fact that a developed country needs to recruit doctors from overseas suggests serious deficiencies in that country’s health bureaucracy, the main difference being that wealthy countries are in a better position to “buy” their way out of problems using temporary fixes as compared to poorer countries.

While many potentially useful approaches to increasing retention have suggested in the literature (often based on limited evidence), the approaches mentioned here will be limited to those supported by or arising out of the interview data. This study suggests that the MOH in Fiji is in a position to adopt policies that may have some impact on doctor satisfaction and retention, and that these

potential changes do not depend on outside support or cooperation, nor do they depend on large increases in health funding. Before discussing these policies, it is useful to review the strengths and advantages that the MOH has to work with. First of all, it is reassuring that the Fiji doctors overwhelmingly made reference to their professional values as they described their professional lives in the interviews, suggesting that such values are widely shared and are “the norm” in Fiji. Moreover, predatory behaviours such as abuse of private practice and stealing drugs and supplies are likely to be notable exceptions to the rule. This is a very great advantage from the standpoint of the MOH. Secondly, this study has proposed a model of professional satisfaction based on the interview data, and the knowledge that these doctors particularly value being supported in their service roles, being given opportunities to develop professionally, and being recognised and appreciated for their work may serve as useful starting points as interventions are planned or considered.

Based on the interviews, a number of proposed interventions fall into three categories, as described in Table 7.3.

Table 7.3. Proposed interventions to improve professional satisfaction and retention	
Category	Central interventions
Supporting the work of doctors	Ensuring the availability of essential drugs and supplies (and other infrastructure support)
Supporting professional development and career advancement	Predictable availability of training opportunities according to merit Linking professional advancement to the completion of postgraduate training Transparent promotions process based on merit Expedited specialist registration
Valuing and supporting doctors as members of families, extended families and communities (financial and time-related issues)	Predictable career advancement to better working conditions and higher salaries – limit time spend at lower career grades (Ideally – increase salaries at lower career grades)

Supporting the work of doctors. Firstly, one of the major sources of dissatisfaction, and a major contributor to complaints about poor working conditions, were problems with the availability of

essential drugs and supplies related to shortcomings of the health infrastructure. Shortages and “stockouts” were described as being particularly demoralising and had considerable impact on the quality of care that these doctors were able to provide. This problem should be addressed as a matter of urgency not just for its negative affect on doctors trying to maintain their professional values, but for many other reasons mostly related to the adequacy of patient care. It is likely to be hard to convince doctors that the MOH is genuinely concerned about patient welfare if this problem is not actively addressed.

Supporting professional development and career advancement. One of the greatest frustrations described by the Fiji doctors was the unpredictable nature of career advancement, where some seemed to “get lucky” and some didn’t. Excellent performance and the completion of local specialist qualifications did not seem to be taken into consideration, and Masters graduates often remained at junior career grades, even after returning from overseas training. Additionally, the promotions process to fill vacant senior (as well as entry-level) posts was described as taking place very slowly, and expatriates were described as being preferentially given senior postings. Frustrations with the career structure were particularly described as contributing to decisions to resign or consider resigning.

An intervention that may address this problem would be to adopt a policy of automatic promotions tied in to the completion of postgraduate qualifications, which could be justified on the basis that the awarding of such qualifications is dependent on satisfactory performance as well as meeting externally-assessed standards. For example, Diploma and Masters graduates could be given automatic senior medical officer or principal medical officer postings respectively, or alternatively, a one-grade promotion. Consideration should be given to granting Masters graduates immediate specialist registration rather than requiring a 2 year “observation period”, given that they have already been closely observed and rigorously assessed during their training. While there is some additional cost associated with automatic promotions, there may be overall cost savings if doctors are retained and if fewer expatriate doctors need to be recruited.

Another complaint that was encountered was that doctors who wished to return to Fiji after undertaking additional specialist training overseas, or even after having earned formal specialist qualifications, were not offered promotions or senior postings in a timely manner (if at all), and incidents were described where frustrated doctors decided not to return. Doctors with overseas experience are potentially of particular value to Fiji, and it may therefore be of great benefit to

formally keep in touch with doctors undertaking training overseas and to prepare senior postings in advance of their return, even to the point of allowing overlapping posts for a year or so if an expatriate on contract already filled the post and could not be redeployed. This additional temporary cost would likely lead to cost savings if it makes the difference in retaining a local specialist who might otherwise have stayed overseas.

A transparent promotions process that has been developed in Namibia and has been described in the literature may be of some interest to Fiji¹⁸⁵.

Valuing and supporting doctors as members of families, extended families and communities (financial and time-related issues). All doctors interviewed were closely involved with their families and extended families, and many had spouses and children. Family commitments require both time and money. Many doctors who were interviewed described making enormous sacrifices in terms of the time they were able to spend with their families as they undertook postgraduate training, as well as financial sacrifices. Doctors who left training without a Masters often described financial and especially time considerations as contributing to their decisions. It should be mentioned that little is known about the career decision-making of recent graduates who had not yet entered specialist training, with only two of these doctors being formally interviewed. Therefore, what is said below about non-specialist or pre-specialist doctors is of necessity extrapolated from the interviews with the doctors who undertook specialist training.

Fiji doctors who contemplate undertaking specialist training may also be in a position to consider migration and local private practice, which pay well, offer good working conditions and often allow for more control over working hours. Specialist training, however, requires many more years of long hours at low salaries, and based on the experience of previous graduates, there are no guarantees of timely promotions that would offer the relief to struggling families in the form of salary increases. Additionally, intakes of doctors into the pretraining specialist registrar positions that are prerequisites for Diploma training have in the past been irregular and unpredictable, and the appointment process by the MOH is viewed by many as being non-transparent with no clear criteria for how appointments will be made. Therefore, new graduates cannot predict how long it will be before specialist training can even be started, never mind how long before such training will lead to senior postings with their improved conditions and higher salaries. This is a particular problem for doctors who wish to start families, especially for females, but for males as well. While the current study does not specifically explore this issue, it is possible that a predictable career pathway with

transparent and fair entry criteria for specialist training followed by regular career advancement might encourage young graduates to “delay gratification” and undertake the considerable sacrifices to themselves and to their families that postgraduate training requires. Flexible hours and part-time work may also help to keep doctors (especially female doctors) with young families in the system. Overall, a salary increase in the junior grades may help with retention, but may or may not be affordable.

Postgraduate training. As for postgraduate training itself, the interviews with the Masters graduates described a “survival of the fittest” type of system, which is not in the best interests of Fiji. This is because doctors who complete to the Masters level are much more likely to remain in the system than those who leave training with a Diploma as their highest qualification. The interventions mentioned above may help to keep more doctors in training through offering more certainty of benefit. Retention may also be improved by addressing the difficulties of training itself especially through addressing the conflict between patient care and academic activities. From the standpoint of the academic programs themselves, standards need to be maintained, but attempts should be made to lessen the burden or redistribute the workload wherever possible, such as the cutting back of the heavy emphasis on public health teaching that took place a number of years ago. Faculty at the Fiji School of Medicine may need to play a more active advocacy role than they have in the past in increasing the acceptance of these qualifications and in increasing overall support for students undertaking training.

Racial considerations. Finally, while Indo-Fijian doctors who have undertaken postgraduate training have been noted to have higher rates of migration, it is unclear how much of this is related to health policy and discrimination towards doctors who otherwise might have stayed. The loss of so many Indo-Fijian doctors, especially after coups of 1987 and 2000, has had considerable impact on the health system in Fiji. Nevertheless, the interview data suggested that there are Indo-Fijian doctors who wish to remain in Fiji, and it would be a loss if they were not allowed to develop to their full potentials, or if they reluctantly decided to migrate because they saw no future for themselves, or more importantly, for their children. Given that globally there are very few barriers to Indo-Fijian doctors who wish to migrate, it may be that many of those who are still left prefer to remain in Fiji, and it is possible that their retention could be improved through ensuring that training and promotions are genuinely available to them.

Summary comments. In summary, the retention of doctors who have undertaken specialist training, or are considering such training, is likely to be increased through improved support of the work of doctors, especially through attention to the reliable supply of drugs and essential supplies, and through the establishment of clear, predictable career pathways, with transparent criteria for entry into training and for promotions, and with rewards for completing postgraduate qualifications.

There are a number of limitations in the applicability of this study to doctors in Fiji. Importantly, the study only addresses specialist training. District health care, which involves expanded general practice and public health, is equally important to Fiji, and while such doctors were not interviewed, it is likely that their career paths and training also need attention. Nurses were also not studied, nor were private general practitioners or overseas migrants who had not undertaken local specialist training. Additionally, no medical students and very few recent graduates were interviewed, though anecdotally many may be considering migration, possibly related to the frustrations and uncertainties they have observed for their senior colleagues who have undertaken specialist training, along with an increasing awareness of colleagues who have migrated successfully. If a “culture of migration” is starting to exist for both Fijians and Indo-Fijians, as described in other countries^{92, 93}, that would have serious negative implications for the health system in Fiji, so the views of this group of young doctors and medical students would be very important to ascertain.

Despite these limitations, it is likely that these proposed interventions would have some impact on doctor satisfaction and retention. This cannot be proven in advance, however, and it could be argued that in a setting of decreased barriers to migration, worldwide shortages of health workers, and enormous salary differentials, little can be done to “stem the flow” of migration. Nevertheless, the cost of inaction would be great, and would be likely to include continuing or even increasing losses to migration of doctors and other health workers. As the WHO report indicates, the best approaches to retaining health workers are not known, but this is not an excuse for inaction. Fiji could make a considerable contribution to global health through undertaking interventions based on research presented here and by others^{119-121, 124}, through thoroughly documenting the baseline situation as well as subsequent workforce flows, and by sharing any positive or negative outcomes with the world community.

7.5.2 Possible implications and directions for other developing countries

It is somewhat daunting to discuss the implications for elsewhere in the developing world based on a study carried out on a limited group of doctors who have undertaken specialist training in a small island nation that differs in many ways from other developing nations, apart from having a medical workforce that has been greatly affected by medical migration. Nevertheless, the original research, especially qualitative research, in this field is so limited that it is probably justifiable to attempt to relate this study to the rest of the world to some extent.

An important implication is that while Fiji is not a least-developed nation and has more financial resources than many other countries, and unlike many countries, pays doctors arguably liveable, (though low) wages, this does not prevent significant migration. This suggests that salary increases by themselves will not prevent migration, but that other workplace factors must be addressed as well. An alternative explanation, that wage differentials between Fiji and the developed world are still so huge that they continue to drive migration, is not supported by the interview data.

Health systems in developing countries throughout the world are interested in understanding how their workforces can be retained, and frameworks for understanding what “drives” or “motivates” health workers are potentially useful. A factor that was particularly prominent in the interviews of the Fiji doctors, and that was supported by literature from elsewhere, was the centrality of professional values to these doctors as they described their careers, and the particular dissatisfaction that was experienced when these values were undermined. While this study and the literature suggest that professional values are a powerful ally to health systems, and that support for the manifestation of professional values by health systems may have an impact on satisfaction and perhaps even retention, the literature also suggests that as compared to Fiji, professional values may have weakened among some health workers in other developing countries. Countries outside of Fiji may need to assess the intactness of professional values, and work may need to be done in some countries to facilitate the re-establish these values, especially where they have been undermined by previous health policies.

Additionally, from this study a model of professional satisfaction was proposed that is closely related to underlying professional values and is based on the principles of service, professional growth and recognition, supported by an enabling health system. The model is consistent with other literature but also expands understanding of positive factors somewhat (which are less prominent in the literature than negative factors). From a health system standpoint, it may be easier conceptually to focus on promoting a few central satisfying aspects of the work of doctors and

eliminating barriers to satisfaction rather than trying to address numerous negative “push” issues. This framework may be of some use in other countries.

The disappointment and even anger that the Fiji doctors expressed towards their health system was reflected in the world literature, and overall suggests a “gulf” of understanding between health systems and health workers. The language used in some of the literature even suggests underlying attitudes of managerial superiority and control, as reflected in the widely-used definition of motivation as alignment of workers with organisational goals. This contrasts sharply with the strong identification of doctors in Fiji and health workers elsewhere with their professions, and their views of their health departments as entities that should support them in their technical work rather than as something to “align to”. This clash of expectations between public service management and technically-skilled workers may underlie much health worker dissatisfaction, and may shed light on why “rationally thought-out” policies imposed on health workers often either do not work, or do not lead to the expected results. This possibility merits further exploration.

In terms of motivation theories, this study supported some concepts, such as psychological contracts and organisational justice, but the overall fit with motivation theories was not particularly close. While this study was never intended to formally test existing motivation theories, it suggests that these theories may need to be adjusted or rethought as they apply to health workers. One theory that seemed to provide a good explanatory framework in Fiji was related to organisational commitment, where levels of commitment from “heart-felt” to “duty-based” to “weighing up” (or “no better option”) seemed to fit with the interview data. Commitment theory is probably more conceptually straightforward in approaching migration issues than are motivation theories in general, and may serve as a useful framework for understanding health worker propensity for migration and retention in other countries.

The main interventions suggested for improving the satisfaction of the specialist workforce in Fiji may have relevance for other countries. The two major approaches suggested by the data from Fiji were improved infrastructure for the support of the work of doctors (especially in regards to drugs and supplies), and the establishment of clear career pathways, with opportunities and advancement awarded in a transparent process according to merit. It has been postulated that these approaches would work at least in part through the support of professional values. In more economically depressed countries, increasing salaries up to a livable wage is probably more important than it is in Fiji, though, as mentioned above, probably not sufficient in itself.

As for specialist training, the experiences from Fiji suggest that the impact of such training can be undermined by migration, and that the awarding of a non-exportable qualification does not prevent migration. In Fiji, a number of factors particularly undermined the impact of training. One was the lack of recognition, in practice, of the local specialist qualification, as manifest by their failure to reliably lead to, or even be taken into account, in career advancement. Another was the lack of support of trainees by hospital clinical services, where very heavy workloads and clashes between clinical and teaching activities led to an undermining of academic aspects of the program. This arguably resulted in a “massively” overloaded “survival of the fittest” situation, where dropouts, who were unlikely to remain in the system, outnumbered doctors who completed their Masters. The experience in Fiji suggests that other countries that are looking to set up specialist training should pay particularly close attention to ensuring in advance that these programs will be recognised and supported, and that overall workloads for trainees, while maintaining academic rigour, are bearable.

Perhaps the most important criteria for transferability of the concepts described in Fiji is whether or not they “ring true” to health workers and health administrators from other countries. Concepts that seem to have merit could be tested locally. Overall, it would be most useful if researchers and policymakers in other countries would comment on how these findings relate to their own situations, and in particular, if interventions based on these findings are successful or even partially or unsuccessful. As this study draws together many disciplines, cross-disciplinary discussion and input could lead to refinements or expansions of the concepts presented here that could potentially be of considerable use globally to improve health systems and overall health status in developing countries.

The candidature for this PhD study began in mid-2001, which was a time characterised by “protracted neglect” of the health workforce, but also a time when a renewed focus accompanied by increased resources were being directed at health issues in developing countries, especially through commitments to the Millennium Development Goals. This study approached the problem of addressing high levels of migration of a group of doctors who had started specialist training in Fiji through attempting to reach a deep understanding of their lives and careers. As this study was being planned and carried out, the Joint Learning Initiative and the World Health Organization began to focus at an international level on the need to support health workers, and began to emphasise the centrality of health workers to the delivery of health care and overall health status. This shift in

focus culminated in major reports being published in 2004²⁵ and 2006⁷ respectively. These reports have called for research into how best to support health workers, and it is hoped that the study presented here, through its focus on deeper understanding health workers and its cautious suggestion of interventions based on that understanding, will contribute to learning how to improve the situations of health workers in other countries. It is in the spirit of the renewed focus on the health worker at an international level that this study has been carried out and is being presented.

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Appendix A. Definitions Used in Coding and Data Analysis

Term	Definition
Codes	Groupings derived from or applied to interview transcripts.
Preliminary Interviews	Interviews carried out during the first field trip to Fiji in April 2004. These interviews focused on learning about the overall situation, mostly through senior consultants (informants).
Preliminary interview codes	Codes derived from analysis of the preliminary interviews. Based on an initial reading of all of the preliminary interviews, codes were derived. These codes were then applied during a second reading of the preliminary interviews.
Main interviews	Interviews carried out during the second, third and fourth field trips to Fiji in September / October 20004, August / September 2005, and August / September 2006. These interviews focused on individual experiences and professional biographies.
Main interview codes	Codes derived from adjusting the preliminary interview codes after reading through the first few main interviews. These codes were then applied to all of the main interview texts. The preliminary interview texts were also recoded using the main interview codes.
Coding “families”	Groupings of related codes created in order to facilitate analysis.
Major topics	Three broad groupings derived from the codes: “Professional satisfaction and dissatisfaction”, “Migration decisions”, and “Career decisions”. In addition, a number of “Cross-cutting issues” impacted across all of these broad groupings.
Sub-codes	Numerous codes derived from detailed analysis of a code or a coding family.
Derived categories	These are categories derived from the regrouping and reassembly of sub-codes.
Analysis by subcoding and reassembly	Developing long list of subcodes from codes or coding families, then rearranging and reassembling them in order to develop “derived categories” (related to “open” and “axial” coding as described by Strauss and Corbin ¹⁵¹).
Subgroup analysis	Analysis of codes and / or coding families by doctor subgroup.

Appendix B. Development of Main Interview Codes from Preliminary Interview Codes

Main interview codes	Preliminary interview codes	Comments about codes
Satisfaction and dissatisfaction codes		
Professional satisfaction	Workplace conditions	
Patient care – comments about	Workplace conditions	Usually positive
Camraderie & interactions with co-workers	Nil	Usually positive
Individual	Individual	Philosophy of life with implications for medical practice - secular
Religion	Individual or culture	Philosophy of life with implications for medical practice - religious
Workplace conditions	Workplace conditions	Usually negative
Professional dissatisfaction	Workplace conditions	Comments on dissatisfaction with work
Activism and the “work to rule” - 2002	Nil	Includes comments about doctor industrial action in 2002
Promotions & career structure	Promotions & career structure	Usually negative
Policy – health & other	Policy – health & other	Usually negative
Career development / biography codes		
Biography before medical school	Nil	
Medical school	Nil	
Employment before training	Nil	
Choice of specialty	Nil then professional satisfaction	
Postgraduate training	Postgraduate training	
Regional training issues	Regional training issues	Issues for trainees at FSMed from countries outside of Fiji
Attachments in non-Pacific countries	Continuing professional development or postgraduate training	As part of training, usually Australia or New Zealand

Main interview codes	Preliminary interview codes	Comments about codes
Employment in Fiji after graduation	Nil	
Future career plans	Nil	
Continuing professional development	Continuing professional development	
Migration codes		
Migration of self	Migration	
Migration of others	Migration stories or Migration	
Not migrating	Not migrating	
Private practice	Migration	In Fiji
American Samoa and other Pacific	American Samoa	Comments about working in American Samoa or other Pacific Islands
Working in a developed country	Nil	By permanent migrants
Returning or considering returning	Returning or considering returning	
Guilt	Nil	
Salaries	Nil	
Remittances	Remittances	
National & International issues	National & International	Globalisation-type issues (coup and security issues now coded separately)
The Coups & security	National & International	Cross-cutting code analysed mainly under migration
Cross-cutting codes		
Family	Family	
Spouse career issues	Family	
Culture	Culture	Includes extended family
Gender issues	Women's issues	
Indo-Fijian race issues	Indo-Fijian race issues	
Generational issues	Nil	

Main interview codes	Preliminary interview codes	Comments about codes
Other race issues – prejudice	Nil	Prejudice other than against Indo-Fijians
Other codes		
Regional issues	Regional issues	Other Pacific Islands

Appendix C. Hierarchy of Codes

Analysis method used	Major topics derived from codes	Codes or coding “families” used during the analysis	Main interview codes included
Subcoding and reassembly	1. Professional satisfaction and dissatisfaction	Professional satisfaction	Professional satisfaction
			Patient care – comments about
			Camaraderie & interactions with co-workers
			Individual
			Religion
		Professional dissatisfaction	Workplace conditions
			Professional dissatisfaction
			Activism and the “work to rule” - 2002
		Promotions & career structure	Promotions & career structure
		Policy – health & other	Policy – health & other
Subgroup analysis (codes or coding families analysed by subgroups of interview participants)	2. Migration decisions	Migration of others	Migration of others
		Migration decisions	Migration of self (developed country)
			Not migrating
			American Samoa and other Pacific
		Returning	Returning or considering returning
		Private practice	Private practice
		Salary issues	Salaries
			Remittances
		Coups & security	Coups & security
		National & International issues	National & International issues
	3. Career development	Pre-postgraduate	Biography before medical school
			Medical school
			Employment before training
			Choice of specialty
		Postgraduate training	Postgraduate training
			(Regional training issues)
		Overseas placement	Attachments in non-Pacific countries (during training)
		After training	Employment in Fiji after graduation
			Future career plans
			Working in a developed country (migrants)
			Attachments in non-Pacific countries (after Masters graduation)
		CPD	Continuing professional development
	(Cross-cutting issues)	Family and Spouse	Family
			Spouse career issues
		Culture	Culture
		Indo-Fijian issues	Indo-Fijian race issues
		Gender issues	Gender issues
Analysed together	(Miscellaneous)	Generational issues	Generational issues
		Miscellaneous codes	Regional issues, guilt, prejudice–other races

Appendix D.2. Subgroup definitions (mutually exclusive groups; as of September 2006)

Subgroup	#	Definition
Senior informants	9	Senior consultants who undertook specialist training overseas, most of whom were involved with teaching and supervising in the postgraduate training programs at FSMed.
Masters graduates	10	Had obtained an MMed at the time of their interviews.
Masters students	4	MMed students at the time of their interviews.
Temporarily overseas	6	FSMed Diploma or Masters graduates or Masters students who at the time of their interviews had trained, were in the process of training, or subsequently undertook training in a developed country for at least a year, with stated intentions to return.
Diploma, in public sectors	7	Students who left training with a Diploma as their highest qualification who were still working in the public system or at FSMed. The two pre-training interviewees were also included here because their numbers were too small to merit a separate subgroup.
Private Fiji	4	FSMed Diploma or Masters graduates who were working in private practice.
Permanent migrants	7	FSMed Diploma or Masters graduates who are likely to have migrated permanently (no specific plans to return).

Appendix E. Professional Satisfaction, Dissatisfaction, and Health Policy Codes
 Subcoding and Re-assembly into “Derived Categories”

Legend of fonts and abbreviations used	
(see Appendix A for definitions and Appendix C for explanation of codes and coding families)	
Bold	Derived categories (categories derived from reassembly of subcodes)
<i>Italics</i>	<i>Subcodes derived from codes and coding “families” (groups of related codes)</i>
(D)	subcode from interview texts coded under Professional Dissatisfaction “coding family”
(S)	subcode from interview texts coded under Professional Satisfaction “coding family”
(CP)	subcode from interview texts coded under Promotion and Career Pathways code
(HP)	subcode from interview texts coded under Policy: Health and Other code

Appendix E.1. Professional satisfaction and dissatisfaction sub-codes

(arranged by major derived categories: Professional Development, Service, and Recognition)

Appendix E.1.1. Subcodes relating to professional development

I. Professional Development through the Work Itself	
I.a. Fascination of the work itself	I.a. Limitations in the range of work
<i>Fascination of one's specialty (S)</i>	<i>Work is repetitive (D)</i>
<i>Playing a general role rather than a sub-specialized role (S)</i>	<i>Range of work limited (D)</i>
<i>Medicine as a mystery (S)</i>	<i>Limited in what you can do (D)</i>
<i>Marrying theory and clinical work (S)</i>	<i>Do not want to practice "lesser medicine" (D)</i>
<i>Interesting cases (S)</i>	<i>Not being able to use training (D)</i>
<i>Making a correct diagnosis that others missed (S)</i>	<i>Can't do what you are trained for (D)</i>
<i>Seeing every case as a challenge (S)</i>	<i>Can't go into depth with one's profession (D)</i>
<i>Love of clinical work (S)</i>	<i>System lagging behind what you are trained to do (D)</i>
<i>Challenging work (S)</i>	<i>"You're a professional. You quickly get up to the limit." [of what you are actually capable of doing compared to what you are able to do in this setting] (D)</i>
<i>Travel to health centers – (variety, intellectually satisfying) (S)</i>	<i>Not really tertiary care (D)</i>
<i>Doing procedures (S)</i>	<i>Training kills itself off [leads to migration] (D)</i>
<i>After all that work, can't quit medicine (S)</i>	<i>Highly skilled trainees migrate (D)</i>
II. Having opportunities to develop	
II.a. Opportunities for formal training	II.a. Problems with postgraduate training
<i>Getting their dream back [allowed to go into the specialty that they want to] (S)</i>	<i>Balancing work and study (D)</i>
<i>Longing for development (S)</i>	<i>Conflict: training and service (D)</i>
<i>Many opportunities available now (S)</i>	<i>Stuck in outer islands and not allowed to come in and join the training (D)</i>
<i>Hands on – developing as a professional (S)</i>	<i>(Problems and frustrations with postgraduate training are more fully explored in Chapter 6.)</i>
<i>Achieving a certain work ethic and standard (S)</i>	
<i>Setting professional goals for oneself and working towards them (S)</i>	

<p>(II.a. Opportunities for formal training - continued)</p> <p>(Positive aspects of postgraduate training are more fully explored in Chapter 6.)</p>	
<p>II.b. Availability of continuing medical education (CME)</p>	<p>II.b. Problem with availability of CME</p>
<p><i>Access to articles (S)</i></p> <p><i>Having access to academic programs and xray sessions (S)</i></p> <p><i>Having work needs looked after at FSMed: internet, IT, office, e-mail – [enabling of ongoing learning and service roles] (S)</i></p> <p><i>Attending conferences and being given time off (S)</i></p> <p>(Positive aspects of CME are more fully explored in Chapter 4.)</p>	<p><i>Professional isolation (D)</i></p> <p><i>No hospital library (D)</i></p> <p><i>Lack of being able to go to CME meetings (D)</i></p> <p><i>Not being able to go overseas for conferences (D)</i></p> <p>(Frustrations with CME are more fully explored in Chapter 4.)</p>
<p>II.c. Support by individual mentors, colleagues, and the overall learning environment</p>	<p>II.c. Lack of support by mentors, colleagues and the overall learning environment</p>
<p><i>Being mentored, having a mentor (S)</i></p> <p><i>Mentors and role models (S)</i></p> <p><i>Availability of senior colleagues (S)</i></p> <p><i>Good consultants to support you (S)</i></p> <p><i>Discussion of cases with colleagues (S)</i></p> <p><i>This place is a rich learning environment (S)</i></p>	<p><i>Senior roles without having back-up (D)</i></p> <p><i>Poor supervision (D)</i></p> <p><i>Consultants not helpful (D)</i></p> <p><i>Not enough supervision from seniors (D)</i></p> <p><i>Not consistent backing (D)</i></p> <p><i>Not creating an atmosphere for learning (D)</i></p> <p><i>Uplifting in Melbourne, stifling here (S)</i></p> <p>(Appendices E.1.2 and E.1.3 also include subcodes related to how negative aspects of the hospital environment and interactions with others impact on the learning atmosphere.)</p>

III. Higher level work	
III.a. Autonomy (with higher postings)	III.a. Lack of control
<i>Autonomy at work (S)</i> <i>Flexibility (S)</i> <i>Being allowed to do private work (S)</i> <i>Practice freely [in private sector] (S)</i>	<i>Working with hands tied behind back [due to poor working conditions] (D)</i> <i>Patient complaining to doctor, but out of doctor's control, all comes back to the clinician (D)</i> <i>Confined in the way they could practice (D)</i> <i>Feeling of oppression (D)</i> <i>Not in control of yourself as a professional (D)</i> <i>"...only way out is to get out of the system so the system doesn't destroy you" (D)</i> <i>Not allowed to do private work [for finances and for professional reasons] (D)</i>
III.b. Wider role beyond routine patient care	III.b. Barriers to taking on wider roles
<i>Being a consultant opening up possibilities to do more than just routine (CP)</i> <i>Wider role beyond patient care (S)</i> <i>Higher level work (S)</i> <i>Satisfaction through problem solving (S)</i> <i>Being able to work on projects: infection control and antibiotic prescribing (S)</i> <i>Setting up hyperbaric services (S)</i> <i>Mixed and rewarding roles: teaching and patient care (S)</i> <i>Management roles: acquiring knowledge, disseminating it to decision makers, trying to make a big impact (S)</i> <i>Motivated by need to get local people to run the department (S)</i> <i>Community education (S)</i> <i>Empowerment of women (S)</i> <i>Research – encouraging each other (S)</i>	<i>Don't like administration work [takes time from other roles] (D)</i> (Appendix E.2.1 explores how limitations in taking on advanced roles were often related to not being promoted into senior postings.)

Appendix E.1.2. Subcodes relating to service

I. Capacity to make a difference	
I.a. Able to making a difference	I.a. Lack of support of clinical work makes it harder to make a difference
Being needed <i>Making a difference (S)</i> <i>Knowing that your presence makes a difference (S)</i> <i>Treating patients who can't afford private (S)</i> <i>You are needed a lot more in Fiji than in Australia (S)</i> <i>Job satisfaction from doing something significant (S)</i> <i>Challenge of working in a difficult environment (S)</i> <i>Target the passionate (S)</i> <i>I have a future here (S)</i>	Staffing <i>Lack of staff (D)</i> <i>Staffing shortages (HP/D)</i> <i>Shortage of doctors (D)</i> <i>Resignation of nurses (D)</i> <i>Doctors leaving and no one taking any notice (D)</i> <i>Staff turnover (D)</i> <i>Crippled by resignations (D)</i> <i>You spend time teaching skills then people leave (D)</i> <i>Not enough people to do procedures (D)</i> <i>Having junior registrars [due to seniors leaving](D)</i> <i>Same retention problems as New Zealand (HP)</i>
Treating one's own people <i>Satisfying because it's home (S)</i> <i>Serving one's own people (S)</i> <i>Useful to the community (S)</i> <i>Explaining things in Fijian (S)</i> <i>Knowing the language as a positive thing (D)</i>	Lack of resources. <i>Working conditions not too terrible (D)</i> <i>Fijian thing: survive with whatever you're given (D)</i> <i>Shortage of what we work with (D)</i> <i>Lack of retrievables (D)</i> <i>Lack of resources for little things (D)</i> <i>Lack of basic things (D)</i> <i>Poor maintenance (D)</i> <i>Frustrated with working conditions after working overseas (D)</i> <i>Things getting worse over past few years (D)</i> <i>Never had these shortages before (D)</i>
Higher roles <i>Making a difference in staff relations and morale as a manager / running a department (S)</i> <i>Making a difference through teaching (S)</i> <i>Would like to do research (S)</i>	

	<p>(Lack of resources – continued)</p> <p><i>Shortages to extent of wanting to quit (D)</i></p> <p>Inefficient working environments</p> <p><i>Doing a procedure and hunting all around for the equipment (D)</i></p> <p><i>Time wasted walking from one building to another (D)</i></p> <p><i>Decreased capacity of the theatre to operate (D)</i></p> <p>Lowering of standards.</p> <p><i>Standards going down (D)</i></p> <p><i>Focus on quantity rather than quality (D)</i></p> <p><i>If you do it wrong, it doesn't matter (D)</i></p> <p><i>No audits to check for quality (D)</i></p> <p><i>Doing low quality work in clinics because not enough doctors (D)</i></p> <p><i>Losing patients when not vigilant because of overwork (D)</i></p> <p><i>Unable to do safe practice (D)</i></p> <p><i>Knowledge level of nurses limited [a limiting factor in patient care] (D)</i></p> <p><i>Deterioration of services in the public sector after s/he left to go into private (D)</i></p> <p>Health administration</p> <p>(Appendix E.2.2 explores the lack of responsiveness of the health system as a barrier to making a difference.)</p>
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II. Patient care	
II.a. The satisfaction of patient care itself (including private practice facilitating good patient care)	II.a. Fatigue issues decrease the satisfaction of providing patient care
<p>All settings</p> <p><i>Patient care (S)</i></p> <p><i>Care of patients: giving good care and seeing the results (S)</i></p> <p><i>Patients doing well at the end of the day (S)</i></p> <p><i>Recovery of really sick patients (S)</i></p> <p><i>“Relating to patients on the level of respect” (S)</i></p> <p>Private practice</p> <p><i>Availability of resources (S)</i></p> <p><i>Private work: more professional (S)</i></p> <p><i>Private work: more holistic view because not bogged down in numbers (S)</i></p> <p><i>Service ethic (S)</i></p> <p><i>Letting go of civil service mentality (S)</i></p> <p><i>Private work: manageable workload, financially rewarding (S)</i></p>	<p>Heavy workload</p> <p><i>Balance between positive stress and negative stress: stress here is negative (D)</i></p> <p><i>Extra work (D)</i></p> <p><i>Overworked (D)</i></p> <p><i>Underpaid for hours of work (D)</i></p> <p><i>Very long hours (D)</i></p> <p><i>Long hours still going on after 10 years (D)</i></p> <p><i>No one to give relief (D)</i></p> <p><i>“I think you just get used to it” (long hours) (D)</i></p> <p><i>Need for part time work (HP)</i></p> <p>On-call</p> <p><i>Understaffed, too many calls (D)</i></p> <p><i>Feel bad when on call (D)</i></p> <p><i>Not being able to sleep through the night when on call (D)</i></p> <p><i>Not able to give your best after 24 hours (D)</i></p> <p><i>Night shifts (D)</i></p> <p><i>Shift work is better [recent positive change] (D)</i></p> <p>Seniority issues</p> <p><i>Very hard work at senior level (D)</i></p> <p><i>High burden on consultants (D)</i></p> <p><i>Juniors doing all the work (D)</i></p> <p>Physical health and mental health</p> <p><i>Too many roles – affected physical health (D)</i></p> <p><i>Work bad for health (D)</i></p> <p><i>Broken by overwork (D)</i></p>

	Family life <i>Getting stuck with night calls, really a problem with small children (D)</i> <i>Family suffering due to overwork (D)</i> <i>No personal life (D)</i> <i>Hard to take leave (D)</i>
III. “Higher calling” (religious or personal philosophy about work roles)	
III.a. “Higher calling” as a positive factor	III.a. Negative aspects of “higher calling”
<i>Satisfaction in doing one’s duty (S)</i> <i>Rewards come from doing good (S)</i> <i>Playing one’s role in this world (S)</i> <i>You need to do something truly useful in order to sustain yourself (S)</i> <i>At peace because I am maintaining my own work ethic (S)</i> <i>Satisfaction in doing the work of God / religious motivations (S)</i> <i>Doing God’s will (S)</i> <i>Sustained by religion (S)</i> <i>Christian principles help one to be patient (S)</i>	None mentioned.

Appendix E.1.3. Subcodes relating to recognition

I. By patients	
I.a. Valued and appreciated by patients	I.a. Not valued or appreciated by patients
<i>Appreciation by patients (S)</i> <i>Treated as a God by one's patients (S)</i> <i>People remember you in the street years later (S)</i>	<i>Dealing with high expectations medically of those who have been abroad (D)</i> <i>Patient complaining to doctor, but out of doctor's control, all comes back to the clinician (D)</i> Lack of appreciation by patients in not mentioned.
II. By colleagues and other hospital staff	
II.a. Camaraderie, good morale and friendly working atmosphere	II.a. Difficulties with colleagues and other staff, poor morale, negative working atmosphere
<i>Staff interactions (S)</i> <i>Friendliness of staff (S)</i> <i>Sharing stress together (S)</i> <i>Helping one another (S)</i> <i>Ideas valued by others (S)</i> <i>Respect of juniors because you have a Masters (S)</i> Overall, camaraderie and positive relationships with colleagues outweighed frustrations with colleagues.	Colleagues not pulling their weight <i>Clinicians not doing their jobs (D)</i> <i>Doctors who call in sick (D)</i> <i>Others not pulling their weight (D)</i> <i>Surgery not starting on time (D)</i> Colleagues not caring enough <i>Not a culture of caring or sustained high level of concern about anything (D)</i> <i>Doctors not giving the simple care that they ought to (D)</i> <i>Lack of commitment to betterment of the patient (D)</i> <i>Need for caring about poor people (D)</i> <i>Clinicians need attitude of improvement (D)</i> <i>You are concerned about something, others aren't (D)</i> <i>The sense that you are trying to change things and no one else seems to care (D)</i> <i>Can't do everything myself (D)</i>

	<p>Inconsiderate colleagues</p> <p><i>Condescension of other consultants when you are trying to get something done (D)</i></p> <p><i>Colleagues not prioritizing their requests when he is busy (D)</i></p> <p><i>Treated like shit (D)</i></p> <p>Other hospital people</p> <p><i>Maids not cleaning (D)</i></p> <p><i>People treat each other as numbers, yet this is a friendly country (D)</i></p>
III. Through Departmental Leadership	
III.a. Good leadership	III.a. Lack of good leadership
<p>General</p> <p><i>Being valued (S)</i></p> <p><i>Respect (S)</i></p> <p>Departmental leadership</p> <p><i>Good departmental leadership (S)</i></p> <p><i>An organized department (S)</i></p> <p><i>Good supportive boss (S)</i></p> <p><i>Support from seniors (S)</i></p> <p><i>Being treated as a colleague rather than as a student (S)</i></p> <p>Morale and teamwork</p> <p><i>Good morale (S)</i></p> <p><i>Work on improving staff morale (S)</i></p> <p><i>Team building and happiness at the change (S)</i></p> <p><i>Being a team leader and seeing an impact (S)</i></p>	<p><i>Supervisors in hospital departments: good and bad aspects (HP)</i></p> <p><i>Struggling with high expectations from department head (D)</i></p> <p><i>Department leaders not strong enough (D)</i></p> <p><i>Leaders not there when you need them (D)</i></p> <p><i>Poor sense of foresight from seniors (D)</i></p> <p><i>Lack of communication between departments (D)</i></p> <p><i>Meetings: same things brought up, nothing done (D)</i></p> <p><i>No sense of belonging, no sense of worth, leaves you under no sense of obligation (D)</i></p>
By Health Administration	
IV.a. Support by administration	IV.a. Lack of support
<p><i>Private practice: not having one's ideas brushed aside (S)</i></p> <p>This is not mentioned as a source of satisfaction in the public sector.</p>	<p>Major issue</p> <p>(Explored in detail in Appendix E.2.2)</p>

Appendix E.2. Health administration sub-codes

(arranged by major derived categories: Professional Development, Service, and Recognition)

Note” “Health Administration” includes the Fiji Ministry of Health (MOH), the Public Service Commission (PSC) and hospital administration. The following subcodes mainly reflect the dissatisfaction of Fiji doctors interviewed.

Appendix E.2.1. Subcodes relating to professional development (overall lack of support of professional development)

I. The process of promotion itself	
Promotions went well	(Problems with the promotions process – continued)
<i>Fast promotions (CP)</i>	
<i>Just reward for hard work (CP)</i>	<i>Very senior people in very junior positions (CP)</i>
<i>Wait for your chance, prove yourself (CP)</i>	
<i>Grateful for promotion at this time (CP)</i>	<i>Ministry doesn't allow progression – (D)</i>
<i>Luckier than others (CP)</i>	Frustrations of doctors at promotions process
<i>Vacancies due to migration (CP)</i>	
<i>Promotion helped by coups (CP)</i>	<i>Being stuck [career-wise] (CP)</i>
<i>More concerned with learning than promotion (CP)</i>	<i>Waiting for things to get better (but it didn't happen!) (CP)</i>
<i>Not that concerned about postings (CP)</i>	<i>Resentment about current posting (CP)</i>
Problems with the promotions process	<i>Disappointment with clinical bosses not standing up for doctors (CP)</i>
<i>Restrictions and red tape in the civil service (CP)</i>	<i>Doctors at the “boiling point” over promotions issues (CP)</i>
<i>Bottlenecks (CP)</i>	
<i>Delays in appointments and in filling vacant posts (CP)</i>	<i>“Personal promotion stories” (CP)</i>
<i>Lack of positions / posts (CP)</i>	<i>Tales of colleagues who left due to frustration (CP)</i>
<i>Not enough senior postings (CP)</i>	<i>Promotion held up then offered on the day of resignation (CP)</i>
<i>Need to create posts (HP)</i>	
<i>Long wait for promotion (CP)</i>	
<i>Years and years at Medical Officer position (CP)</i>	

(I. The process of promotion itself - continued)	
Inequity in promotions / unfair promotions / injustice	Comments on promotions policies
<i>Discrimination against locals (CP)</i>	<i>Policy suggestions (CP)</i>
<i>Fijians promoted ahead of Indians (CP)</i>	<i>Need for designated career paths (CP)</i>
<i>Overseas people promoted ahead of everyone (CP)</i>	<i>Need for a professional to look at human resource issues (CP)</i>
<i>Public health doctors advantaged career-wise (CP)</i>	<i>Career structure policy can be improved a thousand-fold (CP)</i>
<i>Unfair promotions (CP)</i>	<i>Migration levels may force government to do something (HP)</i>
<i>Decisions need to be based on merit (D)</i>	
<i>Less qualified promoted ahead of more qualified (CP)</i>	
<i>Progression based on years of service, not competence (D)</i>	
<i>Concern about justice to other applicants (CP)</i>	
<i>Perverse incentives: sometimes a consultant can make less money for the same work due to remuneration policies (CP)</i>	
II. How the promotions process impacts on postgraduate trainees (considerable overlap with “Recognition”)	
“Consideration” as an individual	(Promotions and postgraduate training - continued)
<i>Need to make doctors feel valued [in the context of promotions] (CP)</i>	<i>Lost interest in joining the program due to uncertainty (CP)</i>
<i>Treated “like you don’t have feelings” [in regards to a held-up promotion] (CP)</i>	<i>Lack of recognition of qualifications (D)</i>
Promotions and postgraduate training	<i>No recognition for diploma (CP)</i>
<i>At least the opportunities are there now (CP)</i>	<i>Masters not recognized (CP)</i>
<i>Promotion helped by postgraduate course (CP)</i>	<i>Masters not rewarded (CP)</i>
<i>Program did not give them what they expected (CP)</i>	<i>Promotion by years of service not postgraduate training (CP)</i>
<i>Lack of support of training by the Ministry (HP)</i>	<i>“Training program could collapse without recognition by the Ministry” (CP)</i>

(II. How the promotions process impacts on postgraduate trainees - continued)	
(Promotions and postgraduate training - continued)	Two gap years (years between being awarded an MMed degree and being eligible for specialist registration)
<i>Need for leadership – what Masters means and career paths for MMed grads (CP)</i>	<i>2 year wait is good idea to gain maturity (CP)</i>
<i>Lack of clarity in what an MMed is so lack of appreciation for having undertaken training (HP)</i>	<i>Inappropriate to become a consultant immediately after graduation (CP)</i>
<i>Policy suggestion: automatic reward for completing postgraduate training (CP)</i>	<i>Suggestion: provisional consultant role (CP)</i>
<i>FSMed has not stood up for graduates (CP)</i>	<i>“Tales of the gap years” (CP)</i>
<i>No commitment from within FSMed to make changes (HP)</i>	<i>“Indignity of these two years” (CP)</i>
Further training	<i>Being viewed as an “infant” Masters compared to Masters from elsewhere (CP)</i>
<i>Unfairly overlooked for further training (CP)</i>	<i>Being in limbo [after graduation] (CP)</i>
<i>Missed out on overseas training (CP)</i>	<i>Ambiguous period (CP)</i>
<i>Need for post-MMed training (CP)</i>	<i>Problems with getting specialist registration (CP)</i>
<i>Need for conference leave (HP)</i>	Acting positions and senior roles without senior postings
<i>Need for career nurturing (HP)</i>	<i>Nice to be recognized with acting position, extra money is nice (CP)</i>
<i>Need to develop doctors in the system (HP)</i>	<i>Satisfaction of consultant role but less satisfying without the posting (CP)</i>
<i>Suggested policy: bonding after overseas training (HP)</i>	<i>Frustration of acting position: no security, no recourse (CP)</i>
	<i>Loss of acting post to overseas appointee (CP)</i>
	<i>Monetary loss at acting consultant level due to on call payments, perverse incentives (CP)</i>
	<i>Frustrations of senior responsibility without senior posting (CP)</i>
	<i>Doing extra when you aren’t paid for it (D)</i>

Appendix E.2.2. Subcodes relating to service (lack of support of clinical environment)

I. Structural problems	
Problems with the system itself	Lack of accountability
<i>Rigidity of system (HP)</i>	<i>Ministry making bad decisions (D)</i>
<i>Poor communication by administration (HP)</i>	<i>Ministry tolerating deficiencies (D)</i>
<i>Poor communication overall (D)</i>	<i>Lack of answerability by managers (D)</i>
<i>Need for teamwork (HP)</i>	<i>No accountability in hospital (D)</i>
<i>Teams not functioning (D)</i>	<i>Lack of accountability (HP)</i>
<i>Need to set priorities (HP)</i>	<i>Mismanagement of a country [Regional] (D)</i>
<i>Problems with health reform (D)</i>	<i>Fragmentation of medical superintendent role</i>
<i>Health reform hasn't done any good and has made things worse (HP)</i>	<i>leading to uncertainty about who is responsible for what (HP)</i>
<i>Global forces beyond local control (HP)</i>	<i>Broken promises by Ministry (HP)</i>
	<i>Administrators as failed clinicians (HP)</i>
	General injustice and inequity
	<i>Suva gets first pick of everything (D)</i>
	<i>Public health people are privileged (HP)</i>
	<i>Favoritism of foreign doctors (HP)</i>
II. Failure to support clinical work	
Lack of logistical support	Lack of awareness of problems
<i>Clinicians are adaptive (D)</i>	<i>Lack of understanding of clinicians by the Ministry (D)</i>
<i>Clinicians are worried about little things (D)</i>	<i>Faceless managers (D)</i>
<i>Need more backup from the Ministry (D)</i>	<i>Managers not coming around to check on conditions (D)</i>
<i>Workplace shortages (HP)</i>	<i>Administration is clueless (HP)</i>
<i>Other people not pulling their weight (D)</i>	<i>Denying there's a problem (D)</i>
<i>Clerks and head office people not doing their jobs (D)</i>	<i>Ministry in ivory tower, think there isn't a problem (D)</i>
<i>Lack of support by administration and other staff (D)</i>	
<i>Run out of things and keep having to remind people (D)</i>	
<i>People who are responsible not ordering drugs (D)</i>	
<i>The problems just continue (D)</i>	

(II. Failure to support clinical work – continued)**Lack of responsiveness**

*Support people need to respond to needs of
doctors (D)*

*You know on the ground what needs to be done
and there is no action from above (D)*

Hard to make changes [stock-outs] (D)

*Frustrations with setting up (specialist)
services (D)*

Not allowed to fill registrar posts (D)

*Unsatisfactory outcome of the “work to rule”
(D)*

Appendix E.2.3. Subcodes relating to recognition (not valuing doctors)

I. Lack of Appreciation issues	
Not enough done for “our people” [health workers](D)	No one gives you recognition and the problems just continue (D)
Lack of recognition of work (HP)	Not consulted about policy [therefore views not valued] (D)
Lack of appreciation (D)	
Treated like a cashier at the supermarket: just processing patients (D)	Moved on because [treated as if] not needed (D)
Never heard (D)	Offered expertise for free then knocked back (D)
Never get anywhere (D)	
II. Injustice towards individuals	
It isn’t fair here (D)	(Racial issues and how they impact on how one is treated by health administration are discussed in Chapter 6.)
Seeing injustices done to other people (D)	
Specific incidents of workplace injustice / traumatic stories (D)	
III. Lack of concern for physical and family needs of doctors	
General issues	Salary issues
Public Service Commission doesn’t take into account special needs of doctors (HP)	Salary too low (D)
Clerks have too much power (HP)	Couldn’t cope with salary reduction (D)
Lack of attention to physical needs (D)	Colleagues elsewhere[other health care settings] get allowances but we don’t (D)
Lack of concern about individuals (HP)	Low salary for high level work compared to a private GP
Spouses split up in posting (D)	
Families and housing not looked after (D)	
Make people feel as if they are needed by addressing their living conditions (HP)	(Salary and remuneration issues are explored in detail in Chapter 5.)
Not given housing (D)	

**Appendix F. Reasons for Migration of Others:
Derived Categories from Interview Subcoding (see Chapter 5)**

Multifactorial nature of migration decisions

Historical and contemporary contexts

Historical migration issues

Migration before the establishment of postgraduate training (1998)

Migration for better training

Difficulties in returning (overseas - qualified specialists)

Changing times with the establishment of local postgraduate training

Still some migration for better training

Impact of undertaking postgraduate training

Impact of overseas attachments

Difficulties in returning (non-specialists)

Impact of the opening up of opportunities in developed countries

Migration as human nature / global trends

Impact of events

Coup of 2000

Opening of Suva Private Hospital, 2001

“Work to rule” by hospital doctors, 2002

Crises at departmental levels

Boiling over, opening of floodgates, vicious circles

Impact on those left behind

Observing migration of others

Feelings about those who have left

Feelings about Indo-Fijian migration

Feelings about Fijian migration

(Impact on those left behind – continued)

Generational issues

Ongoing professional and personal issues*Professional and job-related factors*

Salaries

Postgraduate training

Working conditions

Promotions

Continuing professional development issues (apart from formal training)

Family and cultural factors

Spouse issues

Nuclear family / parent issues

Children's education

Children's security

Cultural issues

Appendix G. Guidelines for Authors and Reviewers of Qualitative Studies

Appendix G.1. Guidelines for authors and reviewers of qualitative studies – from Lancet 2001;358:485¹⁷²

Aim

Is the research question a relevant issue?

Is the aim sufficiently focused, and stated clearly?

Does the title of the article give a clear account of the aim?

Reflexivity

Are the researcher's motives, background, perspectives, and preliminary hypotheses presented, and is the effect of these issues sufficiently dealt with?

Method and design

Are qualitative research methods suitable for exploration of the research question?

Has the best method been chosen with respect to the research question?

Data collection and sampling

Is the strategy for data collection clearly stated (usually purposive or theoretical, usually not random or representative)?

Are the reasons for this choice stated?

Has the best approach been chosen, in view of the research question?

Are the consequences of the chosen strategy discussed and compared with other options?

Are the characteristics of the sample presented in enough depth to understand the study site and context?

Theoretical framework

Are the perspectives and ideas used for data interpretation presented?

Is the framework adequate, in view of the aim of the study?

Does the author account for the role given to the theoretical framework during analysis?

Analysis

Are the principles and procedures for data organisation and analysis fully described, allowing the reader to understand what happened to the raw material to arrive at the results?

Were the various categories identified from theory or preconceptions in advance, or were they developed from the data?

Which principles were followed to organise the presentation of the findings?

Are strategies used to validate results presented, such as cross-checks for rivaling explanations, member checks, or triangulation.

If such strategies are not described in this section, they should appear as validity discussions later in the report.

Findings

Are the findings relevant with respect to the aim of the study?

Do they provide new insight?

Is the presentation of the findings well organised and best suited to ensure that findings are drawn from systematic analysis of material, rather than from preconceptions?

Are quotes used adequately to support and enrich the researcher's synopsis of the patterns identified by systematic analysis?

Discussion

Are questions about internal validity (what the study is actually about), external validity (to what other settings the findings or notions can be applied), and reflexivity (the effects of the researcher on processes, interpretations, findings, and conclusions) addressed?

Has the design been scrutinised?

Are the shortcomings accounted for and discussed, without denying the responsibility of choices taken?

Have the findings been compared with appropriate theoretical and empirical references?

Are a few clear consequences of the study proposed?

Presentation

Is the report easy to understand and clearly contextualised?

Is it possible to distinguish between the voices of the informants and those of the researcher?

References

Are important and specific sources in the field covered, and have they been appropriately presented and applied in the text?

**Appendix H. Powerpoints Presented at the Fiji Medical Association Annual Conferences in
2005 and 2006**

1. Oman K. Where are they now? 7 years of postgraduate specialist training at the Fiji School of Medicine (conference presentation). Fiji Medical Association Annual Conference August-September 2005; Suva, Fiji¹⁸⁶.

2. Oman K. Professional satisfaction and dissatisfaction in Fiji: What are the specialist graduates saying? (conference presentation). Fiji Medical Association Annual Conference August - September 2006; Suva, Fiji¹⁸⁷.

H.1. Fiji Medical Association Annual Conference 2005¹⁸⁶

Slide one

Where are they now?

7 years of postgraduate specialist training at the Fiji School of Medicine

Dr. Kimberly Oman
James Cook University, Townsville, Australia

With thanks to: E McCaig, E Rodgers, J Malani, S Bale, W Baravilala, R Moulds

Slide two

Inclusion criteria

- Enrolled FSM postgraduate programs 1997 - 2004
- At least a diploma (excludes diploma dropouts)
- Includes diploma elsewhere and any FSM masters coursework

Slide three

Data collection

- FSM graduation programs
- RACS documents
- Enrolment records – FSM
- List of names generated
- Verified by specialty coordinator
- Data collected
 - Gender
 - Country of permanent residency at enrolment
 - Highest attainment
 - Current whereabouts as of 1 February 2005
- Independent verification: medical board public records for migrants (Australia and New Zealand)

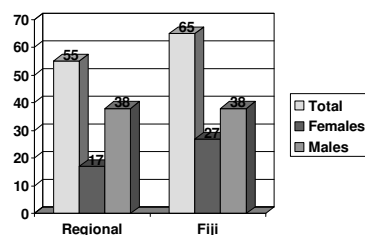
Slide four

Ethics

- Data collected as part of larger qualitative study on specialist satisfaction, dissatisfaction, migration and retention
- Approved by Fiji National Research Ethics Review Committee and James Cook University Ethics Committee

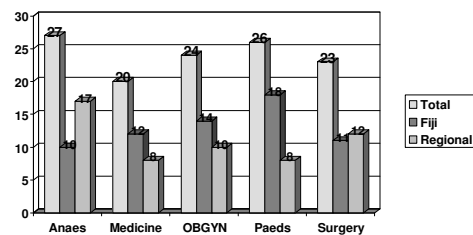
Slide five

Enrolment: total and by gender



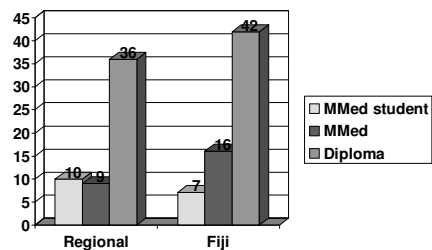
Slide six

Numbers by specialty



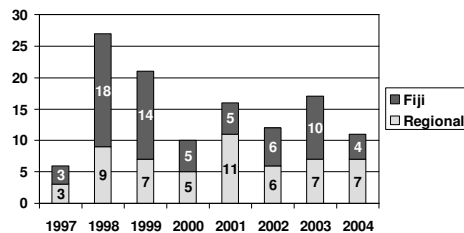
Slide seven

Highest educational attainment



Slide eight

Numbers by year

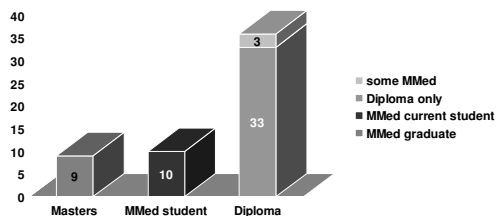


Slide 9

Regional Graduates

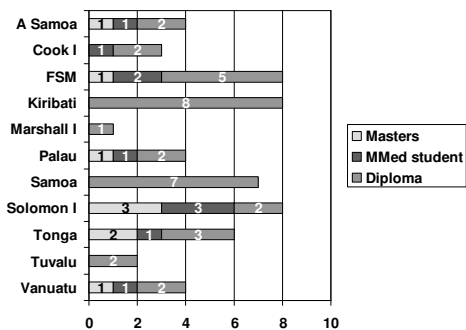
Slide 10

Highest educational attainment - Regional



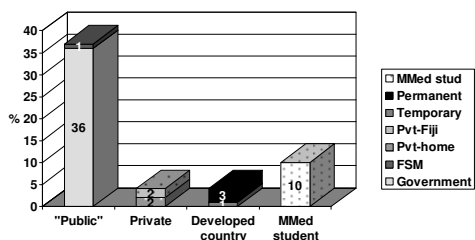
Slide 11

Regional by country



Slide 12

Whereabouts – Regional

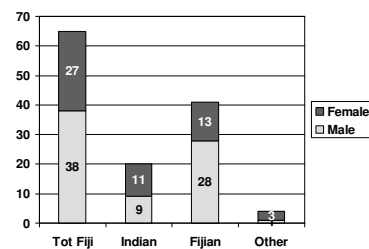


Slide 13

Fiji Graduates

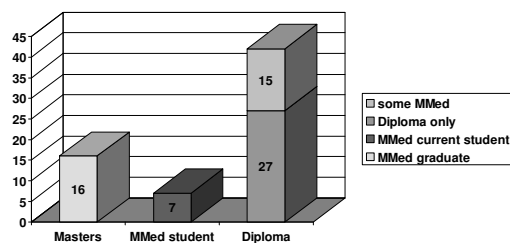
Slide 14

Enrolment by gender and race - Fiji



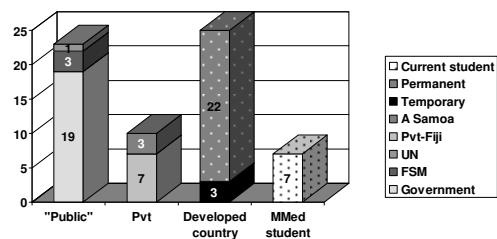
Slide 15

Highest educational attainment - Fiji



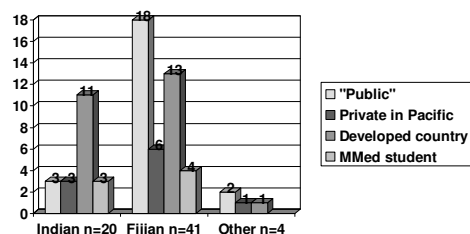
Slide 16

Whereabouts of graduates – Fiji



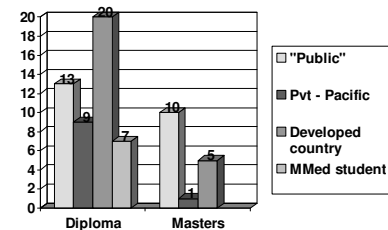
Slide 17

Whereabouts of Fiji graduates by race



Slide 18

Whereabouts by highest educational attainment - Fiji



Slide 19

Conclusions

- Regional
 - Promising retention rates to date
- Fiji
 - Ten additional qualified specialists currently in public sectors (MMed)
 - Overall low retention in public sector
 - Worrying levels of migration
 - All races
 - Both genders
 - Has continued in post-coup years
- Limitations
 - Early years of program
 - Doesn't address reasons for professional decisions

Slide 20

Action needed

- Developed countries - “**pull factors**”
 - Train enough doctors
 - Ethical recruitment
- Pacific Islands (especially Fiji) - “**push factors**”
 - Address areas of specialist dissatisfaction

H.2. Fiji Medical Association Annual Conference 2006¹⁸⁷

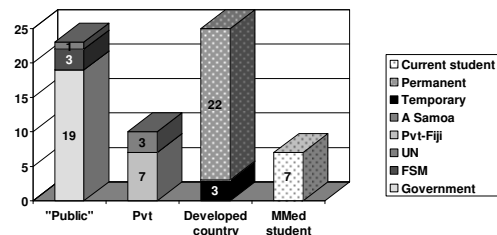
Slide 1

Professional satisfaction and dissatisfaction in Fiji: What are the specialist graduates saying?

Dr. Kimberly Oman
Senior Lecturer in Medicine
James Cook University
August 2006

Slide 2

Whereabouts of graduates – Fiji
February 2005



Slide 3

What are the reasons behind the numbers? – study design

- Semi-structured **qualitative** interviews, ½ to 1-1/2 hours
- Preliminary interviews 4/04
- Main interviews 10/04; 9/05; (9/06)
- Migrant interviews 2004 - 2006
- Tape recorded, transcribed, reviewed

Slide 4

Acknowledgement

- I want to express my deepest gratitude to all who agreed to be interviewed for this study, and for all who provided advice, insights and support. I could never have done this study without the support I received from so many people!

Slide 5

Areas explored centered on professional satisfaction / dissatisfaction



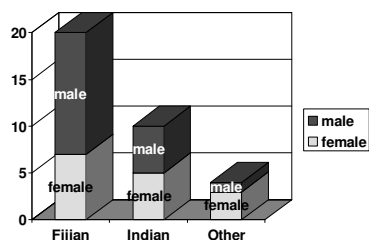
Slide 6

Interview participants (Fiji only)

- 33/65 FSM postgraduate trainees or graduates
- 1 contemplating postgraduate training
- 9 specialist clinicians trained elsewhere (all Fiji citizens)
- Total = 43 (all included in analysis)

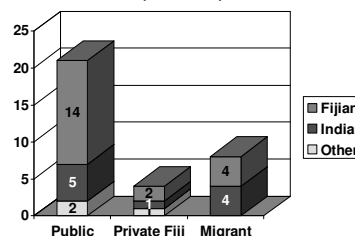
Slide 7

Postgraduate interviewees by race and gender (n=33)



Slide 8

Postgraduate interviewees by employment at time of interview (n=33)



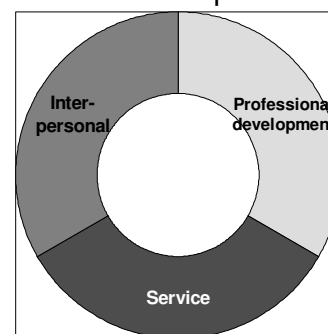
Slide 9

Results: Important points

- These findings are preliminary and need to be confirmed or adjusted based on feedback and further reviews of interviews
- Focus on what can be done in Fiji (no control over recruiting countries)

Slide 10

Professional satisfaction Centered around patient care



Slide 11

Professional development – aspects of satisfaction

“Mature” roles (usually consultant level)

- Autonomy
- Excellence in patient care
 - Improving one’s own clinical excellence
 - Introducing new clinical services
 - Improving quality
 - Making positive changes in delivery of care
 - Addressing and overcoming problems
- Roles beyond patient care
 - Contributing to the running of a good department
 - Promoting morale
 - Teaching and mentoring
 - Public health roles and focus
 - Consultancies
 - Community education and empowerment

Slide 12

Professional development – aspects of satisfaction (2)

- Opportunities for development
 - Formal specialist training
 - Rich learning environment
 - Support of individual mentors and colleagues
- Intellectual stimulation of the work itself
- **Being able to develop professionally as a doctor leads to great satisfaction**

Slide 13

Professional development – aspects of dissatisfaction

- **Lack of formal career structure** –more about this later
- Resource limitations do not allow practice to the limits of one's abilities (variable)
- Limited access to CME
- Informal career support
 - Lack of support and mentoring by seniors
 - Lack of atmosphere of learning

Slide 14

Service – professional satisfaction

- Patient care itself as a source of immense satisfaction
- Providing the best care one can (a particular attraction of overseas and private work)
- Making a difference
- Looking after all patients, especially poor patients, without regard to ability to pay
- Fulfilling religious and philosophical beliefs; "serving God" (Hindus and Christians)

Slide 15

Patient care – professional dissatisfaction

- Not being able to provide the care one believes ought to be available
- Lack of staff (migration, unfilled posts)
- Patient load too heavy
- Lack of resources
 - Running out of essential drugs
 - Basic equipment not available
- Inefficient working environment – running all over the place to find things

Slide 16

Interpersonal - Satisfaction

- Appreciation by patients
- Camaraderie with colleagues
- Good department

Slide 17

Interpersonal – dissatisfaction with clinical colleagues

- Clinical colleagues (sometimes)
 - Not pulling weight
 - Being a "lone battler" – no one else seems to care about problems
- Not a culture of caring for patients
- Lack of leadership at department level

Slide 18

Interpersonal – dissatisfaction with the Ministry (1)

Lack of appreciation as manifested by:

- Lack of support of professional development
- Lack of support of patient care
- Lack of support of physical needs of doctors
- **Lack of consideration as human beings**
- Lack of consideration for particular needs of doctors
 - Long training
 - 24-hour nature of medical care
 - Lack of appreciation of hard work of doctors

Slide 19

Interpersonal – dissatisfaction with the Ministry (2)

- Lack of accountability
- Lack of responsiveness
- Incredibly hard to make changes, even if “revenue neutral”
- Broken promises
- **Lack of basic awareness of problems**
 - Distant managers
 - Lack of consultation with front line staff
 - “Head in the sand”

Slide 20

Career pathways – a **HUGE** issue (1)

- No guarantees of any reward for postgraduate training
- Lack of guarantee of a clear career path; great uncertainty
- Promotions
 - Lack of postings
 - Bottlenecks, red tape, delays in promotions
 - Promotions often based on seniority, not on merit
 - Inequality and capriciousness

Slide 21

Lack of clear career pathways – a **HUGE** issue (2)

- Prolonged junior postings and roles can be demoralizing
- Senior roles without senior postings can be unsatisfying and feel exploitative
- Uncertainty of acting position: an expat can suddenly be given your acting job
- Demoralizing “Gap years” (between getting an MMed and getting specialist status)

Slide 22

Results of unclear career pathways

- Encourages consideration of migration by MMed and Diploma graduates due to lack of certainty about their future careers
- Hypotheses:
 - Younger doctors discouraged from joining up
 - why do all that work for nothing?
 - Encourages early migration – why hang around if a reward is far from guaranteed?

Slide 23

Fatigue

- Contributing factors
 - Inappropriately extended postings at junior levels
 - Inefficient working environments
 - Not enough colleagues to share the work with
- Very hard work - Long hours
 - Threatens family life (younger)
 - Threatens life and health itself (older)
- Can lead even the most dedicated to
 - Resignation
 - Early retirement
 - Can even stop those with “spiritual callings”

Slide 24

Fatigue (2)

- **Much emotional upheaval for those who love their jobs but for health or family reasons shouldn't continue**
- Hard work and fatigue harder to accept if:
 - Ministry felt to be contributing to failure to retain doctors
 - Poor running of health facilities leads to fatigue due to high levels of inefficiencies
 - Problems felt to be preventable

Slide 25

Money

- Money is seldom the principal reason to consider migration for interview participants, but extra money is always nice

Slide 26

Professional satisfaction and migration		
	Professionally Satisfied	Not professionally satisfied
Not migrating	BEST	DO SOMETHING HERE!!!!
Migrating	Leaving for mostly non-professional reasons	Too late?

Slide 27

Summary –my beliefs based on interview data

- Valuing doctors is likely to improve retention
- Valuing is manifested by clear career paths with justice and equity
- Valuing is manifested by supporting the patient care role of doctors
- Excess fatigue should be prevented
- **Doctors are human beings with feelings, and overall have good values centered on the well-being of patients**
- **Career satisfaction is entirely possible in Fiji**

Slide 28

What CWM Hospital has going for it?

- Fascinating clinical problems
- Lots of patients to see with a great variety of conditions
- You do a lot of good
- Very important work
- A chance to serve poor people
- A chance to serve one's people and one's nation
- Your presence can REALLY make a difference
- Chances to problem-solve and be creative
- No end to what you can do **as long as you aren't blocked**

**Appendix J. Poster Presented at The Network: Towards Unity for Health Annual
Conference, November 2005.**

**Postgraduate training in the Pacific: early mixed results in meeting specialist workforce needs
(poster abstract)¹⁸⁸**

Author: Kimberly Oman, Senior Lecturer in Medicine at James Cook University; former
Postgraduate Advisor in Medicine at the Fiji School of Medicine, 1999-2001

With thanks to: Sereima Bale, Wame Baravilala, Joji Malani, Elizabeth Rodgers, Eddie McCaig and
Rob Moulds

Context Migration of health care workers from developing to developed countries, is increasingly
recognized as a major barrier to improving health status in poor countries.

Setting Postgraduate specialist training was established at the Fiji School of Medicine in 1998 in
order to address the shortage of specialists in the small developing island nations of the Pacific.
Previously, specialists usually trained in developed countries, and most failed to return home.

Objectives This study reviews the outcomes of these programs as of December 2004.

Subjects Data on 120 doctors trained to the one-year diploma level or above, 65 from Fiji (“Fiji
enrolees”) and 55 from 11 other Pacific Island nations or territories (“regional enrolees”), has been
analysed by gender, race, highest qualification awarded, and current working location.

Results Of the 120 enrolees, 65% have left training with a diploma, the remainder having either
completed or are currently studying for an MMed qualification. Of 58 Fiji enrolees who have left
training, only 39.7% are employed in the public, academic, or UN sectors, compared to 82.2% of 45
regional graduates. While only 3 regional graduates (9.4%) have migrated permanently, 37.9% of
Fiji graduates are believed to have done so. Migration from Fiji has taken place in all racial groups
and during times of both political instability and relative stability.

Conclusions Early success with retention of graduates suggests that regional specialist training
may be a better option than developed country training for small countries without specialist

training programs of their own. For Fiji itself, high loss to migration is of great concern. Australia and New Zealand, while being major contributors to setting up postgraduate training in the Pacific, have become major beneficiaries from the medical services of its graduates, and need to address their own recruitment practices and shortages of doctors.

Appendix K. Article Published in the Fiji Medical Journal – 2006

Oman K, Bale S, Baravilala W, Malani J, McCaig E, Rodgers E, et al. Donor countries may unintentionally become major beneficiaries of their own aid: the case of postgraduate specialist training at the Fiji School of Medicine. *Fiji Medical Journal* 2006;27(2):11-8.

Lead Article

Donor countries may unintentionally become major beneficiaries of their own aid: the case of postgraduate specialist training at the Fiji School of Medicine

Kimberly Oman^{# §}, Sereima Bale^{*}, Wame Baravilala, Joji Malani^{*}, Eddie McCaig^{*}, Elizabeth Rodgers^{*}, Robert Moulds^{*},

[#] Senior Lecturer in Medicine, James Cook University School of Medicine, Townsville, Australia 4811. [§]Corresponding author kimberly.oman@jcu.edu.au. ^{*}Fiji School of Medicine, Private Mail Bag, Suva, Fiji

Keywords: Developing countries, Education, medical, postgraduate, Human resources for health, Medical migration, Pacific Islands

Abstract

Introduction. The small island nations of the Pacific, like most developing countries, suffer from a shortage of specialist doctors. Postgraduate specialist training was established in Fiji in the late 1990s, supported by aid from the Australian government (AusAID). Anecdotal evidence suggests that loss to migration of graduates from the Fiji postgraduate programs has been substantial.

Methods. By January 2005, 120 trainees, 65 from Fiji and 55 from other Pacific Island nations had been trained to a one-year Diploma level or above. Data on these enrollees are analysed by gender, race, highest qualification awarded, and current working location.

Results. 64.6% and 65.5% of Fiji and regional enrollees respectively had left training with a Diploma, while the remainder were studying for or had been awarded a specialist Masters (MMed) degree. Of the 58 Fiji and 45 regional graduates no longer in training, 39.7% and 82.2% respectively were employed in the public sectors, and 37.9% and 9.4% respectively were believed to have

migrated permanently to a developed country, particularly Australia and New Zealand. By January 2005, more Fiji graduates lived in developed countries (25) than were working in the public sectors in Fiji (23).

Discussion. Australian aid has historically made an important contribution to medical education in Fiji and the Pacific. However, this study suggests that in spite of good intentions, donor nations such as Australia can inadvertently become major beneficiaries of their own aid, to the detriment of the countries they are trying to assist. Therefore attention should be given to try to prevent this from occurring. Australia needs to address its own doctor shortages and adhere to ethical recruitment standards. Fiji needs to determine and address the reasons for dissatisfaction of doctors working in the public sectors.

Introduction

It is increasingly being recognised that shortages of health care workers, exacerbated by migration, is one of the major threats to improving health status in developing countries and to achieving the millennium development goals¹⁻¹⁰. Human Resources for Health has been identified as a critical issue internationally, and has been selected as the focus for the World Health Report for 2006¹¹. A recent editorial in the Medical Journal of Australia has emphasised the role of Australia in helping developing countries, especially its near neighbours, to reach the Millennium Development Goals, including a commitment to strengthening the health care workforce in these countries¹⁰.

The lack of availability of specialist training in developing countries has been cited as a contributing factor to migration, and doctors who pursue specialist training in industrialized countries often do not return to their home countries. In-country or regional specialist medical training has been proposed as a means to address this problem¹².

Australia has played an important role in supporting both undergraduate and postgraduate medical education in the Pacific over a number of decades, both at the University of Papua New Guinea (UPNG) School of Medicine and the Fiji School of Medicine (FSM). These activities have been described in detail^{9, 13-16}. In 1998, postgraduate training was established at FSM in order to address the shortages of specialists in the Pacific^{9, 13}. The postgraduate training programs at FSM deliver Diploma and Masters in Medicine (MMed) training in Obstetrics and Gynaecology, Internal

Medicine, Child Health, Anaesthesiology and Surgery, and were established through funding from the Australian Agency for International Development (AusAID), supported by specialist advisors from Australia and New Zealand. After a few years, it became apparent that many graduates of these programs were migrating, mostly to Australia and New Zealand. Concern has previously been raised about the migration of doctors from Fiji, including postgraduate trainees⁹. This study was designed to document the overall outcomes of the first 7 years of the specialist training programs in Fiji, with a particular focus on public sector retention and migration.

Methods

FSM records were used to compile a list of enrollees in the postgraduate specialty training programs between 1997 and 2004. 120 students who had enrolled and had obtained at least a diploma from FSM (107) or elsewhere (13) were included. The specialist coordinators reviewed and verified the completeness of the lists and, for each enrollee, provided information on the home country (defined as country of permanent residence at time of enrolment), gender, years of Masters training, and where and in what capacity the candidates were working as of 1 February 2005. Coordinators were able to name a current working location for all enrollees with reasonable certainty. For enrollees who were identified as having migrated to Australia or New Zealand, state or national medical registration details were checked, with details confirmed in 19 of 21 cases. The locations of doctors working in Fiji were confirmed through external sources in 38 of 39 cases. The coordinators' impressions of working location agreed

with external sources in all cases. Developed country migration was classified as temporary or permanent based on the judgement of the specialist coordinator.

Data were entered in EXCEL and analysed using Epi-info¹⁷. As all data are categorical, statistical comparisons were made using 2-tailed uncorrected chi-square calculations or 2-tailed Fisher-exact calculations where the expected value of a cell was less than 5.

These data were collected as part of a larger, qualitative study on migration in order to locate and select individuals for in-depth interviews. The study was approved by the Fiji National Ethics Review Board and the James Cook University Ethics Committee (Townsville, Australia).

Results

The specialist training programs at the Fiji School of Medicine (FSM) award a Diploma after successful completion of the first training year, and trainees who perform well are eligible to enrol in the next 3 years of the Masters in Medicine (MMed). Of the 120 enrolees who had undertaken training by early 2005, 65 (41.5% female) were from Fiji ("Fiji enrolees") and 55 (30.9% female) were from ten other Pacific Island nations or American Samoa ("Regional enrolees") (see Table 1).

Fiji enrolees

Of the 65 Fiji enrolees, 7 were current MMed students and 58 were "graduates", sixteen with an MMed and 42 with a Diploma only. Of the 58 graduates, 23 were employed in the "public sectors" (this includes government hospitals, the Fiji School of

Medicine and UN agencies). Seven were in private practice in Fiji, and 3 were working in American Samoa. Three were believed to be temporarily in Australia or New Zealand undertaking further medical training, while twenty two were believed to have migrated permanently, including 14 to Australia, 5 to New Zealand, and one each to Canada, the USA and the UK. The combined permanent loss to Australia and New Zealand, the major supporters of the establishment of the postgraduate training program, represented 32.8% (19 of 58) of the Fiji output of the postgraduate programs. As of early 2005, more graduates were permanently or temporarily in developed countries (25) than were working in the public sectors in Fiji (23) (see Table 2).

The main racial groups in Fiji are indigenous Fijians ("Fijians") and "Indofijians" (Fiji citizens of Indian ancestry), comprising 51% and 44% of the population respectively. Indofijians were especially affected by the Fiji coups of 1987 and 2000, and historically have had higher migration rates than Fijians. Only one of 20 Indofijians had completed an MMed degree compared to 14 of 41 Fijians ($p=0.013$). Indofijian graduates were significantly more likely to have migrated permanently (64.7%) compared to Fijians (27.0%) ($p=0.008$), and they were significantly less likely to be working in the public sectors (17.6%) as compared to Fijians (48.6%) ($p=0.03$).

Regional enrolees

American Samoa and ten English-speaking Pacific Island nations have sent specialist trainees to Fiji (see Table 3). Of the 55 regional enrolees, 36 (65.5%) had left training with a Diploma, nine were MMed graduates, and 10 were

current MMed students (see Tables 1 and 2). The regional countries have sponsored between one and eight enrolees each (see Table 3), with five nations only sponsoring candidates to the Diploma level.

Of the 45 regional graduates, 37 were either in the public sectors in their home countries (36) or employed at the Fiji School of Medicine (one). Three had migrated permanently to a developed country. One was temporarily training in Australia, two were in Fiji and two were in private practice in their home countries. These results compared favourably to the experience in Fiji, where only 39.7% were working in the public sectors (OR 7.04 for regional public sector "retention", $p < 0.0001$) and 37.9% had migrated permanently to a developed country (OR 8.56 for Fiji migration, $p = 0.0002$) (see Table 2).

Discussion

The postgraduate programs at the Fiji School of Medicine have had mixed results. While good retention rates to date for regional graduates have already led to positive impacts on specialist numbers, movement of individuals between the Pacific Islands is well-established,⁷ and in the future, regional enrolees may move to other Pacific Island nations, especially to former and current US jurisdictions where salaries are higher.

In Fiji itself, it is promising that as of early 2005, 43 of 65 enrolees were still either in the Pacific or temporarily overseas, including 23 graduates and 7 current students in the public sector. These doctors in most cases have been trained to a higher standard than would have been possible without the programs. Ten of 16 MMed graduates

were currently working in the public sectors in Fiji, compared to only five of the many Fiji citizens who have successfully completed specialist training abroad. This has tripled the number of specialists with formal full postgraduate qualifications. Despite this, migration to developed countries has continued at substantial levels and remains a major threat to success of the programs.

There are a number of reasons why retention may be better for regional graduates than for those from Fiji. In Fiji, postgraduate trainees continue working in established public service posts, allowing them to undertake training as a part of a decision-making process about their careers, with minimal disruptions to their lives. Participation in a training program developed through support from Australia and New Zealand, especially if overseas attachments are included, may make graduates feel more confident to migrate, and the Australasian orientation to their training may make them more attractive to employers in these countries. The coup of 2000 is also likely to have influenced some decisions to migrate.

For regional enrolees, on the other hand, an international move for further training is a major commitment sponsored at considerable cost by one's home nation, and most doctors would be expected to feel a moral if not practical obligation to return home following training. Also, if a doctor decides to leave his or her home nation to pursue postgraduate training, it would make more sense to try to undertake their training in the intended country if they intend to migrate, but to go to FSM if they don't intend to migrate.

This study has some important limitations. Permanence of migration could not be established with certainty, and was based on the judgement of the specialist coordinators. Another major limitation is the short time (7 years) that the programs have been in existence, although early review allowed the whereabouts of almost all enrollees to be established with certainty. Clearly, the true impact of the postgraduate programs will not be apparent until many more years have passed.

Data on the outcomes of specialist training programs in other developing countries are limited^{15, 18-21}. Compared to studies in other countries, our study covers a shorter period of time, but coincides with a recent period of increased global migration with nearly complete follow-up and a focus on retention and migration. Of particular relevance is the experience at the University of Papua New Guinea, where a 2004 article reported that out of 132 local clinical specialists trained since 1975, 71% had been retained in the public sector¹⁵, which is higher than in Fiji. Of concern, 5 of 9 migrants had left between 2000 and 2004. Of greater concern, by 2006 "brain drain" was being reported in the medical literature as a major issue for all PNG doctors, with at least 65 PNG doctors working overseas, 50 in Australia and 15 in other Pacific countries²² (there were reported to be 275 doctors in PNG in 2000⁶).

Australia, along with New Zealand has played a vital role over several decades in supporting both undergraduate and graduate medical education in the Pacific, and it is hoped that they will continue to do so. Therefore it is of particular concern that to date, the medical workforces in Australia and New Zealand have been major

beneficiaries of the Fiji postgraduate specialist programs that they helped to set up. It could even be argued that these programs have served as specialist training sites for these two countries. This was never the intent of those who conceptualised and established the programs, and future development aid to the Pacific should be planned to avoid donor countries becoming major beneficiaries of their own overseas aid at the expense of the countries they are trying to assist. Australia and New Zealand clearly need to address their own shortages of doctors as well as adhering to ethical recruitment standards^{23, 24}.

An important consideration is whether our experience in the Pacific has applicability to other developing countries. Pacific salaries, while low, are generally felt to be "liveable", unlike in much of the developing world. The living environment in the Pacific is, for the most part, safe, though with some recent political upheaval. Postgraduate training programs in more impoverished and/or less stable countries may experience higher losses to migration. Despite these observations, our study suggests that in-country or regional specialist training probably offers retention advantages compared with developed-country training.

Specialist workforce shortages in many developing countries are acute, and training "pipelines" last many years. Therefore, the short and medium-term outcomes described in this study may be of interest to countries with urgent needs. Our experience in the Pacific should serve as a cautionary note to developing countries that are considering establishing postgraduate training programs, as well as to the donor nations considering funding these programs.

In summary, postgraduate training at the Fiji School of Medicine has produced real benefit tempered by substantial losses of graduates to migration. Clearly, the reasons for dissatisfaction with working in the public sector in Fiji^{7, 8} need to be addressed. Qualitative studies may have a role in further defining the factors underlying migration and retention.

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Table one: Qualifications awarded by the Fiji School of Medicine 1998 – 2004 (including Anaesthesia 1997^a)

	Fiji		Other Pacific Islands		Total	
	Diploma	MMed ^b	Diploma	MMed ^b	Diploma	MMed ^b
Anaesthesia	10	2	17	0	27	2
Internal Medicine	12	5	8	2	20	7
Obstetrics and gynaecology	4 (+10) ^c	3	10	4	14 (+10) ^c	7
Paediatrics	15 (+3) ^c	3	8	0	23 (+3) ^c	3
Surgery	11	3	12	3	23	6
TOTAL	52 (+13) ^c	16	55	9	107 (+13) ^c	25

^aOnly Anaesthesia Diplomas were awarded in 1997

^bAll enrollees with an MMed (Masters) qualification have also been awarded a Diploma at the Fiji School of Medicine or elsewhere

^cTen OBGYN and three paediatrics enrollees who entered MMed (Masters) training had been awarded diplomas elsewhere

Table two: Enrolees in postgraduate specialist training at the Fiji School of Medicine, 1997 - 2004: characteristics and outcomes

	Regional (n=55)	Fiji (n=65)
Females	17 (30.9%)	27 (41.5%)
MMed (Masters) graduates	9 (16.4%)	16 (24.6%)
Diploma graduates ^a	36 (65.5%)	42 (64.6%)
Current MMed student	10 (18.2%)	7 (10.8%)
Graduates Only (excluding current students)		
	Regional (n=45)	Fiji (n=58)
Public sectors ^b	37 (82.2%)	23 (39.7%)
Private practice - home country	2 (4.4%)	7 (12.1%)
Pacific Is outside home country	2 (4.4%) (both Fiji)	3 (5.2%) (all American Samoa)
Temporarily in developed country	1 (2.2%)	3 (5.2%)
Permanent developed country migrant	3 (6.7%)	22 (37.9%)

^a Includes ten OBGYN and three paediatrics enrollees who entered MMed (Masters) training after being awarded diplomas elsewhere

^b Includes the Fiji School of Medicine, UN agencies, and government employees at public hospitals

Table three: Total postgraduate enrolment at the Fiji School of Medicine by country, plus demographic country data

Study data		UNICEF data ²⁵			Joint Learning Initiative data ⁶	
Country	Total Enrollees / MMeds)	Population (x1000) ¹	Per capita GNI \$US ^{1,2}	Under mortality /1000 ¹	# of doctors (doctor density per 1000 population)	Per capita health spending \$US
American Samoa	4 / (1)	70 ³	-	-	-	-
Cook Islands	3	18	-	21	-	-
Federated States of Micronesia (FSM)	8 / (1)	109	2090	23	64 (0.60) ^d	172
Kiribati	8	88	880	49	24 (0.30) ^b	40
Marshall Islands	1	53	2710	66	24 (0.47) ^d	190
Palau	4 / (1)	20	7500	28	20 (1.09) ^b	426
Samoa	7	178	1600	24	120 (0.70) ^c	74
Solomon Islands	8 / (3)	477	600	22	54 (0.13) ^c	40
Tonga	6 / (2)	104	1490	19	35 (0.34) ^e	73
Tuvalu	2	11	-	51	-	-
Vanuatu	4 / (1)	212	1180	38	20 (0.11) ^a	42
TOTAL REGIONAL	55 / (9)					
Fiji	65 / (16)	839	2360	20	271 (0.34) ^c	79
TOTAL	120 / (25)					

¹based on 2003 data from UNICEF

²GNI = gross national income \$US in 2003

³ <http://education.yahoo.com/reference/factbook/aq/popula.html> (July 2003 estimate for American Samoa: 70,260)

^a 1997; ^b 1998; ^c 1999; ^d 2000; ^e 2001