QUALITY OF WORK AND WORK LIFE: UNDERSTANDING THE WORK ETHIC OF MEDICAL PROFESSIONALS IN SELECTED HOSPITALS IN THE EASTERN CAPE REGION OF SOUTH AFRICA

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ABSTRACT

This thesis reports a study of work ethic values, beliefs and attitudes held by medical professionals in selected hospitals in the Eastern Cape, South Africa. The study was in response to the public outcry about the declining work ethic and poor service delivery in South Africa's healthcare sector.

Scholarly interest in the work ethic and its role in economic development dates back to Max Weber's classical work, which was the starting point for my study. The German economic sociologist published his seminal essay on *The Protestant Ethic and the Spirit of Capitalism* in 1904/1905. Since that time, Weber's ideas on the Protestant work ethic continue to inform and influence studies of the contemporary work ethic, which is thought to have become secularised.

My study was informed by data collected in 2009 through a questionnaire survey and personal interviews. A total of 174 doctors and nurses, working in four urban, peri-urban and rural hospitals near East London, completed a self-administered questionnaire. The questionnaire replicated the Multi-Dimensional Work Ethic Profile (MWEP) developed by Miller, Woehr and Hudspeth in 2001/2002. The instrument examines seven critical dimensions of the work ethic, namely self-reliance, morality, (foregoing) leisure, hard work, centrality of work in life, not wasting time, and delay of gratification. In addition, I conducted personal interviews in the same four hospitals with 41 hospital managers, doctors, nurses, and patients to discuss their understanding of the work ethic and its practical application.

The study found that both doctors' and nurses' overall work ethic scores on the MWEP scale were above average. Although there was no significant difference between the overall work ethic scores of the two professions, doctors scored significantly higher than nurses on the 'hard work' and 'self reliance' dimensions of the work ethic scale. In the qualitative study, the doctors' work ethic was rated much more highly than the nurses' by their superiors and patients; and the work ethic of nurses in the urban hospitals was rated much lower than that of their rural colleagues.

In contradiction to the idea of the secularization of the contemporary work ethic, religiosity and religious beliefs were influential in the endorsement of work ethic principles. In line with the notion that 'happy' workers are more productive, job and life satisfaction were found to be strong correlates of the work ethic of medical professionals.

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For we know, it is *"not by might, nor by power, but by my spirit, saith the lord of hosts" (*Zechariah 4:6).....

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CHAPTER ONE

INTRODUCTION

STUDY RATIONALE

Work ethic is considered to be a major force that drives economic activity at all levels of society. Indeed the literature has identified low work ethic as a factor that inhibits economic growth and development and contributes to the persistence of poverty (Applebaum, 1992; Bernstein, 1988). In their working paper, "Why doesn't development always succeed; the role of a work ethic", Zabojnik and Patrick (2000) state that various economies can be categorized into two: those with a generally high work ethic in a 'steady' state, and those with welfare-dominated characteristics where the work ethic is generally low. The authors further argue that development efforts are more efficient in the high-work-ethic 'steady' state. Stucky (1998) reports a direct relationship between the work ethic and the socio-economic development of a country. McCleland (1961; 1965; 1971 in Munroe and Munroe, 2001) argues that the Protestant work ethic values are associated with an individual's concern with achievement. Luna-Arocas and Tang (2004) found that achieving individuals with high scores in success factors tend to have a high work ethic.

The concept of the work ethic was first coined by the German sociologist, Max Weber (1904/1905). Weber himself argued that the Protestant work ethic was responsible for the development of capitalism in Western Europe and North America. According to some

development theorists, capitalism is the economic system in which economic development occurs most rapidly. One of such theorists, Rostow (1971, 1978) argued that an aggressive work ethic among employees was one of the factors that made it possible for countries in East Asia, for example, to move from low- to middle-income status.

It is because of its strong association with economic development that the decline of the work ethic is of major global concern. Work ethic is an attribute that employers want their employees to possess, but as Stevenson and Bowers (1986) and Hill and Petty (1995) point out, this attribute is frequently hard to find. According to Miller, Woehr and Hudspeth (2001/2002), one viewpoint is that the work ethic is declining in industrialized countries. Others argue that the decline in the work ethic is more prevalent in the younger generation (Miller et al., 2001/2002). Hamilton-Attwell (2010) observes that older workers believe that members of the 'new' generation do not want to work hard and are not sufficiently committed to their work or organization.

Most researchers note that — for the vast majority of employed people in both middle- and working-class groups — work is regarded as just a means to an end, serving as nothing other than an economic function (Furnham, 1990:148). More and more members of the business community express concerns about the work ethic that, according to Miller et al. (2002), is ingrained in popular culture and acknowledged as an important determinant of work-related behaviour. The prevailing view is that hard-working employees are a thing of the past; and that employees in the past worked harder than

the employees of today (Hamilton-Attwell, 2010). The above authors also observe that societal values have changed due to education systems, the emancipation of the workforce, affluence, and the psychology of entitlement amongst people. Albee (in Tang and Tzeng, 1991:164), observes that "….Americans now live in a society where only the experience of the moment is important and pleasure is the overriding goal."

The concern for the declining work ethic, according to Miller et al. (2001/2002:452), is that poor work ethic corresponds to "lower levels of job performance, higher levels of absenteeism, and increases in counter-productive behaviour, ranging from unauthorized breaks to employee theft." Although schools, vocational education and career development programmes are expected to address these requirements, such efforts often fall short of expectations (Hill and Petty, 1995). Bhagat (1979) maintains that career education cannot prepare students adequately for developing a desirable work ethic. According to the author, firms often create programmes to assist workers in job skills development but seldom offer programmes that foster the development of positive work attitudes. The focus, he argues, tends to be directed at critical thinking and basic skills, while personal qualities such as positive work values, beliefs, and attitudes, which are a tangible expression of the underlying work ethic, are ignored (see also Hill and Petty, 1995; and Kirkcaldy, Furnham and Martin, 1998, in this connection).

Similar evidence on low work ethic in South Africa is abundant, as expressed in the media and in the form of protests across the country

against poor service delivery. The problem is also frequently aired by government leaders. Echoing the work ethic problem cited in the literature above are the following examples of statements reportedly made by South African politicians in the recent past:

> "*We must be impatient with those in the public service who see themselves as pen-pushers and guardians of rubber stamps, thieves intent on self-enrichment, bureaucrats who think they have a right to ignore the vision of Batho Pele* [tending to people's needs], *who come to work as late as possible, work as little as possible and knock off as early as possible*." (Mbeki, 2004).
>
> "*A slack attitude among government officials ... with the general work ethic remaining at 'worryingly low levels*' and '*laziness and administrative apathy in my government'..."* (Balindlela in *Daily Dispatch,* 16 July, 2004).
>
> "*Villagers continue to be treated with disrespect when seeking government services ... victims of neglect..."* (Holomisa, 2003:12).

Most recently, South Africa's president Zuma, when addressing the country's first nursing summit, advocated a revival of the work ethic in the profession in the following terms:

> *"At times public servants think that they are doing members of the public a favour, when in fact they are providing services that citizens are entitled to. ...The era of the rude, uncaring and impatient civil servant or nurse must be a thing of the past as we build a caring government and a caring society. ...Citizens should not be treated as if they are a*

> *burden or a nuisance by staff who are employed to serve them. The constitution of the republic states that everyone has the right to have access to healthcare services. It is their right and not a privilege that can be taken away.…Nurses historically were important people in South Africa, they were exemplary …they were respected. …This is a profession we believe needs to be brought back to that status."* (Marrian, 2011:21)

President Zuma's complaints about poor service delivery in the health sector is shared by the media and the general public. There has been such strong public criticism of medical professionals in South Africa's Eastern Cape provincial hospitals, that hospital administrators, doctors and nurses have, so to speak, become the subject of ridicule as illustrated in the following cartoons in the *Daily Dispatch* in 2010 and 2011.

BROKE E.C. HEALTH DEPT SEEKS CASH INJECTION
AN INJECTION WON'T HELP WHAT WE NEED IS RADICAL SURGERY !
PROVINCIAL HEALTHCARE
CORRUPTION
DON'T CARE ATTITUDE

I CAN ASSURE YOU THAT WE ARE TAKING EVERY PRECAUTION !
2007
Daily Dispatch
BABIES DIE DUE TO POOR INFECTION CONTROL
CEO
EAST LONDON HOSPITAL COMPLEX

Hypocrisy Oath
I swear to take care of my patients - unless it's my tea break !
I will offer help and respect for my patients - unless I send them home to die.
I promise to take care of the gravely ill only if they are lucky !
WE BELIEVE IN CARING

The above scenarios are but a few examples of the extent to which the health sector of South Africa has been inundated with extensive negative coverage by the media on poor service and other related issues concerning its public service. It was for this and other reasons as explained below, that I chose this sector as the focus of my study.

OTHER CONTEXTUAL BACKGROUND MOTIVATING THE STUDY

According to Haagensen (2010:12), "South Africa's public health system in its present state is dysfunctional, inefficient, and in desperate need of improvement". This is contrary to the dictates of the South African constitution, which prescribes the right of every South African citizen to healthcare. Moreover, considerable public funding, as compared to other countries, is allocated to the health sector by South Africa, as Table 1.1 below shows.

Table 1.1

Health expenditure from selected countries in 2006

Country	**Total health expenditure as a proportion of GDP (%)**	**Per capita health expenditure (ppp $)***
China	4.6	1124
Ghana	5.1	214
UK	8.2	4259
India	3.6	426
Brazil	7.5	1460
Mexico	6.6	1208
South Africa	**8.0**	**1100**
Sweden	9.2	4588

Source: World Health Organisation Statistical Information System (WHOSIS), 2006 Indicators, in Haagensen, 2010:2). * purchasing power parity.

According to the table, South Africa's expenditure on healthcare, as a percentage of GDP, is comparable to that of the United Kingdom and much higher than those of the other countries listed, except Sweden. Despite such high expenditure, however, Haagensen (2010) reports that the World Health Report (2000) ranked the South African healthcare system's performance at number 182 out of 191 member states evaluated.

A number of media reports provide further evidence, including comprehensive documentation, in support of the above observations. In its investigations of Frere Hospital in the country's Eastern Cape Province, *The Daily Dispatch* in July 2007, reported on the following five areas:

Hospital Maintenance and Equipment

A dire need for more labour-ward beds.

General renovation of the entire maternity building.
Shortages of equipment in the labour wards and nurseries, including CTGs (foetal heart monitors), incubators, CPAP machines, oxygen points, and suction catheters.

Infection Control

Unhygienic conditions, such as overflowing medical waste receptacles and laundry bins.

An incident in which a general assistant wearing a blood-stained uniform, was observed serving food to patients.

Grimy corridors with spots of dry blood.

Used latex gloves in a maternity lift.
Mothers giving birth and recuperating in soiled clothes.

Staff Issues

Dozens of mothers claimed that negligence, on the part of medical staff, was a direct cause of the deaths of their babies.

Critical shortages of clinical and support staff throughout the maternity section.

Overworked staff suffering from burnout.

Inexperienced staff attending to labour patients.

Consultants not doing night rounds and only being available telephonically.

Unsupervised interns manning maternity wards at night.

Controversial staff rotation systems, implemented by the former director of nursing services, whose management style contributed towards general staff unhappiness.

Cleaners delivering babies.

Record Keeping

Abortions and Stillbirth Book erratically maintained.
Overall record-keeping problematic.

Hospital Management

Management failed to act on baby deaths, despite admissions by staff and doctors that most were avoidable and due to lack of care. (*Daily Dispatch*, July 23, 2007).

The investigation by the *Daily Dispatch* was prompted by an unusually high number of sudden deaths of babies at the hospital. Armed with hidden cameras, the *Daily Dispatch* team attended mass burials of dead babies and interviewed hospital staff and grieving mothers. The deaths were generally blamed on "outright negligence; exhausted staff; and lack of equipment" (*Daily Dispatch*, July 13, 2007). During the investigations, a former hospital gynaecologist admitted that "mothers and babies die at an alarmingly high rate." The figures for 2006 were officially the highest on record. At least 199 babies were stillborn that year (*Daily Dispatch*, July 12, 2007).

Internal documents showed that senior management had known that the situation was out of control for years, but they did little to address

the crisis. Minutes from weekly management meetings reveal damning admissions by doctors that patients were dying because of outright negligence (*Daily Dispatch*, July 12, 2007).

Grieving mothers told stories of their experiences with "negligent" hospital staff. Some mothers "complained of sitting on wooden benches in prolonged labour, wearing blood-soaked clothes and being left unattended during and after birth." Others blamed insufficient equipment for the deaths of their babies: "You feel so helpless as the deaths could have been avoided if there was enough equipment," said a maternity nurse (*Daily Dispatch*, July 12, 2007).

The problems reported above are not isolated incidents occurring in the Eastern Cape only or at only one hospital; rather, they seem to be widespread throughout the country. Reports on poor hospital conditions include the following aspects: deteriorating buildings, neglect, overcrowding, inadequate sanitation, poor disease and infection control, and failing infrastructure. In her overview of South Africa's public healthcare system, Haagensen (2010) cites incidents occurring at a number of South African hospitals in other provinces: the deaths of five babies in the Mahatma Gandhi Hospital in KwaZulu-Natal in 2005; the infestation of mice at the Chris Hani Baragwanath Hospital in Johannesburg in 2007; a back-up power supply failure at the Ngwelezane Hospital in KwaZulu-Natal during surgery; the suspension of a Chief Executive Officer at Helen Joseph Hospital in Johannesburg, Gauteng Province, due to the death of a patient waiting in a long queue, and the death of a boy who was denied entry into three clinics.

At a glance the hospital-related problems reported in the *Daily Dispatch* in 2007 and 2009 seem to tally with the complaints aired by former president Mbeki and others quoted earlier about the generally poor work ethic among workers.

Miller et al. (2001/2002) observed that such complaints, although in popular culture, have not yet been subjected to empirical analysis. As a result, there is no precise indication of what is encompassed in the concept of 'work ethic', which has been used almost as a 'catch phrase' in many reports. What are the underlying factors that drive employees toward a commitment or non-commitment to values associated with the concept of a 'work ethic'? The media investigations, described above, demonstrate that situations arising from what seems like an obvious lack of work ethic may encompass a complex of contextual and/or structural dilemmas associated with work behaviour. As Karl Marx observed, "work is the most important, the primary human activity. As such it can provide the means either to fulfill people's potential or to distort and pervert their nature and relationships with others" (in Haralambos and Holborn, 2004:620).

The media investigation into the hospital-related problems is examined in detail in Chapter 2, which reveals that problems were not entirely due to the actions of employees (in this context, nurses and doctors) *per se*, but also with administration problems at both provincial and national levels, including the ministry of health itself, which is responsible for providing resources to enable employees to perform their duties. As a researcher, I found that this situation created a gap in the empirical knowledge with respect to the

assessment of the work ethic, which is understood to be lacking, but which is also in the popular understanding and perception of the concept. On the other hand, a superficial observation of the scenario indicates that unconditional commitment to work (work for its own sake) might indeed be lost. This is in agreement with Tang and Tzeng's (1991) observation that the Protestant work ethic in America cannot be defined today as it was in the past. The same observation can be made in the South African context. Weber himself did admit that, in a capitalist society, what was previously described, in a pre-capitalist society, as the 'Protestant work ethic' has now become a secular work ethic. His understanding of 'work' was that which was done for its own value. It was a self-imposed willingness of individual workers to identify with, and conform to, the goals of society and to volunteer their service to the abstract ethic of industrial acquisition, effort, enterprise and growth (Furnham, 1990:142).

Although it was mentioned earlier that the problem of service delivery is widespread across the country, it is noteworthy that the majority of complaints have related to hospitals in urban areas. I was unable to obtain any reports of similar stories, as narrated above, in respect of the Victoria and Nompumelelo hospitals, which represent the rural context in my study.

AIM OF THE STUDY

With this background, the purpose of this doctoral thesis is to attempt to gain a scholarly understanding of the main features which characterize the work ethic values, beliefs and attitudes (VBAs) of

the public service medical profession in South Africa, through a study of these professionals in the Eastern Cape Province of the country.

To provide a more detailed explanation, this empirical study has a two-fold purpose. Firstly, the theoretical aim is to explore and describe the work ethic of workers in the Eastern Cape region of South Africa, the poorest province in South Africa (SAIRR, 2004; 2010), with specific reference to medical professionals. Secondly, the study aims to understand better and where possible explain the nature of the work ethic among medical professionals. Such an understanding would serve the practical purpose of informing the South African government and general public about possible work ethic interventions that might improve service delivery and the quality of life of the citizens.

Improvement of service delivery would in turn contribute towards reduction of poverty and underdevelopment to which low work ethic is linked (e.g. Hill, 1997; Zabojnik and Patrick, 2000; Miller et al., 2001). Improved service delivery in one sector of society, in this case the health sector, would spill over into other sectors, including the economy, given that health is associated with higher productivity. According to the structural functionalist sociologists, e.g. Talcott Parsons (1951), sickness is a violation of role expectations. It is dysfunctional not only for the sick individual or their family but for the entire society. "The equilibrium that society maintains can be disrupted when individual members, due to sickness, fail to fulfill routine responsibilities" (Weiss and Lonnquist, 2012:147). Moreover,

members of the medical profession, like any other participating organs of society, have a role to play in the development of the country. They are not only involved in the treatment of disease but some of them also occupy positions of power in the administration of hospitals. For example, the management and use of funds is entrusted to some medical professionals, yet mismanagement of hospital funds is one of the reasons cited for poor service delivery in the health sector. Table 1.1. shows that the government of South Africa allocates an amount of money to the health sector that is comparable to that of the developed countries. However, it is not clear how this money is spent, to the extent that the whole sector is considered "in its present state to be dysfunctional, inefficient and in desperate need of improvement" (Haagensen, 2010:12). The unaccounted for funds therefore, as far as the literature is concerned, has negative economic implications for government, which is responsible for the economic development of the country and the poorest provinces such as the Eastern Cape.

Furthermore, lessons learnt on work behaviour patterns and work performance from one sector may inform the work behaviour patterns of those in other sectors and successful interventions in the studied sector might be applied in the other sectors. The work ethic measure designed by Miller et al. (2001/2002) is applicable across a broad spectrum of work organizations whether in the private or public sectors.

South Africa provides a unique social context in which to study work values, beliefs and attitudes (VBAs) as indicators of work ethic,

given its apartheid history. Eighteen years into democracy, South Africa is still a society in transition. Classical sociologists such as Emile Durkheim, argued that rapid social change ushers in social upheavals, one of them being Anomie (Durkheim, 1947). Indeed the political transition from the apartheid system to multi-party democracy has seen what sociologists would describe as normlessness. Indicators of such normlessness in South Africa are not very different from those identified by Durkheim during the transition from pre- to industrial societies in late 19th century. The best example characterizing both periods is industrial conflict. The health sector of the country has not escaped this despite the profession's Hippocratic Oath which bars medical professionals from going on strike. As far as Durkheim was concerned such behaviour indicates a breakdown of normative control. In Durkheim's words, "The scale is upset; but a new scale cannot be immediately improvised. Time is required for the public conscience to reclassify men and things" (Durkheim, 1947, in Haralambos and Holborn, 2004:624). Further, Durkheim argued that in times of rapid social change the customary limits to people's wants and expectations from life are disrupted. The traditional ceiling on their desires is disintegrated. More importantly, increasing prosperity aggravates the situation. So in times of what seems an 'environment of plenty', selfish drives rather than collective goals, may thrive. Moving from the many years of deprivation during the apartheid era to prospects of greater affluence and 'a land of milk and honey' under democracy, many black South Africans may be inclined to pursue individual interests instead of collective goals. This pattern of behaviour fits with Durkheim's idea of the transition from 'mechanical' to 'organic solidarity'. Durkheim posits a new type of

society where rural dwellers have moved from closely knit communities – in the case of South Africa, the former 'homelands' – held together by social solidarity and consensus (in the South African context having a common enemy in white oppressors) to the impersonal cities characterized by organic solidarity (looser ties with other members of society whose values may differ from one's own), especially considering that South Africa is also a multicultural society which encompasses diverse cultures.

A change in work attitudes may have accompanied the transition to democracy. The emancipation of the workforce, affluence, and the psychology of entitlement, referred to earlier by Hamilton-Attwell (2010), may usher in new dimensions in work relations between the employers and their employees. Given South Africa's history, there are many extraneous factors that may influence work VBAs.

Further, as a legacy of the apartheid era, South Africa remains a country of two worlds, the developed and the underdeveloped. The gap between the rich and the poor has widened since democracy (Leibbrandt, Woolard, Finn and Argent, 2010). There is a two-tier system of healthcare. While the rich have access to medical insurance and enjoy the luxury of world-class private hospitals, the poor have to contend with run-down state health facilities – again a legacy from the past – which do not have enough healthcare professionals, especially doctors. Formally, medicine was one of the professions reserved for whites. Only a limited number of blacks could join the profession, and the training they received at the medical schools for black students was of inferior quality than was offered to white

students. In contrast, nursing was one of the few avenues for social advancement for black women. As a result, nursing may not have been a 'calling' for black women in the sense of the concept coined by Max Weber (1904/1905). It may not be surprising, therefore, that nurses, as will be shown later, fall short of the 'caring spirit' embedded in their code of ethics.

Given the above scenario, South Africa may be a particularly suitable context in which to study work VBAs.

In addition to the background already given, motivation for the study also derives from the fact that although the prevalence of the 'Protestant work ethic' as described by Weber (1904/1905;1958) has been examined in many cultures and societies, including Taiwan, the Republic of China, Hong Kong, Malaysia, East and South Africa, the Americas, and Great Britain (Tang and Tzeng, 1991), very limited attention however, appears to have been focused on this concept in recent times (Halman and Muller, 2006:140). For example, while these authors observe that work orientations have been widely investigated, they also point out that studies and publications on this topic have been confined to countries and populations in the Western world. They further note that — in view of their findings relating to differences in work orientation among Africans, Western and Eastern Europeans — "there is a need to dig much deeper into the interpretation and understanding of the concepts and the comparability of the indicators used." Most previous studies, however, used a variety of instruments to focus only on selected components of the work ethic concept. Such work has yielded

equivocal results (Miller et al., 2002). In this connection, the study in this doctoral thesis, which has measured work ethic using a multi-dimensional measurement approach, is perhaps the first of its kind in South Africa and possibly even in Africa.

This study applies the secular Multi-dimensional Work Ethic Profile (MWEP) developed by Miller et al. (2001), the most comprehensive instrument to explore VBAs to date. The MWEP is ideally suited to explore work VBAs as it was specifically designed to be a current, practical and psychometrically sound measure of work ethic, even across samples in different professions with or without work experience. It was also designed to be conceptually grounded in Weber's original ideas yet current and applicable across religious orientations. It is a sound measurement of the multi-dimensions shown to comprise work ethic. In particular, the approach of this profile is well suited for the measurement of primary work ethic indicators among contemporary workers in a range of rural and urban social contexts as well as assessing differences among them on demographic and quality-of-life characteristics that correlate with the work ethic. (These aspects of the study are presented in greater detail in Chapters 2 and 3).

The use of the MWEP, which relies heavily on self-evaluation, is complemented by personal interviews (in a mixed method approach) to counteract the effects of social desirability in responses characteristic of positivistic approaches to social inquiry. The personal interviews, which involve both self-evaluation and evaluation by a person other than oneself, in a more interpretive

grounding, provides a richer and more in-depth understanding of the nature of work behaviour patterns.

CHOICE OF STUDY AREA

The above scenario was what prompted me to embark on this research topic as my PhD study. The Eastern Cape region was chosen for the study for three reasons:

The first one was that the most negatively-publicized hospitals in the media – the Frere Hospital and the Cecilia Makiwane Hospital — are in the Eastern Cape.

The second one was that the Eastern Cape was more accessible to me as I work and reside in this province.

Moreover, the province is rated the poorest in South Africa (SAIRR, 2004; 2010:277) and work ethic is associated with economic growth and development.

My research will be used not only to demonstrate gaps in the knowledge of the understanding of the concept of 'work ethic' in a South African setting but also suggestions will be made regarding suitable interventions to improve the quality of healthcare and other services in the country.

DEFINITION OF CONCEPTS

Max Weber (1904/1905), the German economic sociologist, defined the Protestant ethic as "an orientation towards work which emphasizes dedication to hard work, deferment of immediate rewards, conservation of resources, the saving of surplus wealth, and the avoidance of idleness and waste in any form" (Beit-Hallahmi, 1979:263). Current conceptualisations that originate in Weber's work tend to view the work ethic as "an attitudinal construct pertaining to work-oriented values. Thus, an individual espousing a high work ethic would place great value on hard work, autonomy, fairness, wise and efficient use of time, delay of gratification, and the intrinsic value of work" (Miller et al., 2001:4).

The other concepts used in this study namely: job satisfaction, life satisfaction, work orientations (intrinsic and extrinsic/individualism, collectivism, humanism and materialism) and work ethic profiles are defined by the indicators measuring them as set out in Chapters 2 and 3 of the thesis.

MAIN RESEARCH QUESTIONS

This study sought to provide answers to the following questions:

a. What is the nature of work ethic values, beliefs and attitudes (VBAs) among medical professionals in a sample of hospitals in the Eastern Cape region of South Africa?

b. How strong is the work ethic among medical professionals in the studied hospitals measured by the concept of MWEP of Miller et al. (2001/2002) and how does its strength vary (as mean scores), across profession, gender, religiosity/religious beliefs, urbanization (i.e. in rural, and urban contexts), work experience, age, educational level, income, job level and marital status?

c. Which work orientations (collectivism versus individualism; materialism versus humanism, considered together with corresponding intrinsic and extrinsic work qualities) are dominant among the professionals in this study?

d. Are the work ethic levels among these professionals in any way related to their levels of job and life satisfaction?

STUDY OBJECTIVES

In summary, the present study sought to achieve the following objectives:

a. To compile work ethic profiles in terms of different socio-demographic categories of medical professionals in selected hospitals in the Eastern Cape region of South Africa in order to identify peculiarities and similarities among the categories.

b. To evaluate the work ethic levels of the sample, based on Miller et al.'s Multi-dimensional Work Ethic Profile (MWEP), in terms of the mean score for each dimension of the scale and the mean score for all dimensions combined.
c. To determine work orientation patterns for the sample.
d. To determine the levels of job satisfaction and life satisfaction of the sample and the relationship between these variables and the work ethic.

SUMMARY

This chapter has identified the work ethic concept as coined and defined by Weber (1904/1905) in his classic work on *The Protestant work ethic and the spirit of capitalism.* Many scholars following in the footsteps of Weber have equated endorsement of the work ethic with economic activity and development. Therefore, the apparent decline in endorsement of work ethic values is regarded as a matter of global public concern. Schools and other institutions responsible for transmitting work ethic values, beliefs and attitudes are viewed as incapable of achieving this goal. It is not clear where and among whom the work ethic is declining and why. However, education, affluence and a culture of entitlement are cited as some of the proposed possible influences in the literature.

Social demographic characteristics such as age, gender, marital status, geographic locations, income, educational level, religiosity/being religious, work experience and job level, together with job satisfaction and life satisfaction, have been identified as correlates of the work ethic although results are not conclusive. The declining work ethic in South Africa is presented as needing urgent attention, particularly in the health sector which is described as dysfunctional and inefficient. However, despite all the negative publicity surrounding the health sector regarding poor service delivery, no empirical study has been done to evaluate the extent of the problem and possible influences. The current study takes this as a point of departure to assess the work ethic of medical professionals in the province of the Eastern Cape where many lives, especially those of babies, have been affected. Irregularities in the delivery of healthcare services have been reported extensively in the media, particularly for the two urban hospitals included in the study, the Cecelia Makiwane and Frere hospitals in East London. Two other hospitals in the nearby rural areas are included in the study for comparative analysis purposes.

The history of apartheid and the transition to democracy are important factors that may have affected work VBAs in South Africa. The study applied the Multidimensional Work Ethic Profile (MWEP) developed by Miller et al. (2001/2002), which is considered the most comprehensive instrument for measuring work VBAs in contemporary society where work ethic is viewed as being more secular than the original Weberian Protestant work ethic. The measure has been shown to be superior to previous ones which

yielded only equivocal results (Miller et al., 2001/2002). Personal interviews with health professionals, hospital managers and patients were conducted to complement the more quantitative survey approach using the MWEP. The chapter closes with a formulation of research questions and objectives. The following chapter will review the literature which informs the hypotheses of the study and provides the background to the concept of the work ethic. The next chapter also introduces the context of study in South Africa.

CHAPTER TWO

THE WORK ETHIC IN THE LITERATURE

This chapter reviews the literature on the work ethic, the primary objective being to identify gaps in existing knowledge on the topic, if any, and to formulate research questions and hypotheses, as well as other foundations of this thesis.

BRIEF HISTORY OF THE WORK ETHIC

Past researchers have alluded to the development of the work ethic through the ages within particular ideological contexts. Various economists, poets and philosophers, have tried to explain the nature of work. According to Furnham (1990) the Hebrews thought work was necessary because it was punishment imposed upon men due to the sins of their fathers. Others, like the Greeks and Romans, viewed work as punishment, a curse suitable for slaves (Furnham, 1990; Maywood, 1982).

Historically, the cultural practice of attaching a moral value to the act of doing a good job is a new belief system (Hill, 1997). According to this author, working hard was not the norm for Hebrew classical or medieval cultures and that it was only after the Protestant Reformation that physical labour became culturally acceptable.
The Reformation period during the 16th Century, brought about many new principles including new ideas about labour, which came to be regarded as one of the important attributes of an individual's

personality (Tilgher, 1930). According to Tilgher (1930) many early 'heretics' as well as some later leaders in the Reformation, such as Martin Luther, placed an emphasis on work as a form of serving God. These leaders did not however approve of commerce, trade and finance, which they claimed required no real work. According to the German sociologist Max Weber (1904/1905), the real architect of this major change in attitude towards work, was Protestantism. Weber linked such shifts in attitude to the doctrine of 'Predestination' whose exponents were leaders within Protestant sects.

In his best-known book, *The Protestant Ethic and the Spirit of Capitalism* (1904/1905), Max Weber examined the historical relationship between the emergence, and rapid expansion, of capitalism as a result of industrialization in Western Europe and North America, and the Protestant Reformation that had occurred in earlier centuries. He focused on the asceticism that had developed within Protestant sub-denominations such as Baptism, Pietism, Calvinism, and Methodism and identified a new perception whereby work was revered as a calling by God. Weber concluded that the Puritan value of asceticism and the belief in a 'calling from God' were partly responsible for the rapid expansion of capitalism and industrialization in Western Europe and North America (Lehmann, 1993; Furnham, 1990; Byrne, 1990). Weber proposed that it was the application of such values that led to the development of the new work ethic (Woehr, Arciniega and Lim, 2007). The teaching by Protestant reformists such as John Calvin (1509–1564) — that financial success through hard and persistent worldly activity was a sign of being chosen by God as one of the 'saved' — placed great

emphasis on the doctrine of predestination. The same economic system grew to be regarded by the proponents of modernization theorists as being responsible for economic growth and development (Kendall, 1999). The doctrine of predestination was a belief that all people were divided into those who were saved and those that were damned. Only God knew who belonged to the saved group (*The Elect),* that were predestined to go to heaven after death, and those who were to be damned and predestined for hell. In order to create assurance of salvation, which is itself a sure sign or proof of election, diligence in one's calling (hard work, systematic use of time, and a strict asceticism with respect to worldly pleasures and goods) was highly recommended. The most important contribution of Protestantism to capitalism was the spirit of rationalization that it encouraged. To Weber, therefore, wealth is an unintended consequence of religious piety and hard work. For him, the spread of such a belief system, together with the social behaviour that accompanied it, fitted very well with the activities of capitalists, and contributed to the spread of such behaviour throughout society, including those societies in which Calvinism was not dominant.

MODERN PERCEPTIONS OF THE WORK ETHIC

Weber noted that more mature capitalist-value practices, although religious in origin, have become rationalized and secular (Weber, 1904/1905). He observed that, with the secularizing influence of wealth, people often think of wealth and material possessions as the major (or only) reason to work. However, according to Kendall

(1999), although no longer referred to as the 'Protestant Work Ethic' (PWE), many people still refer to the 'work ethic' in somewhat similar terms as Weber did. Over the years the PWE has been transformed into a concept that relates to character ethics, business ethics, work values, work beliefs, and belief systems (Smola and Sutton, 2002).

For example, political and business leaders in the USA often claim (as mentioned earlier) that 'the work ethic is dead' referring to the seeming decline of the same principles of the PWE. It is felt not only by politicians and businessmen, but also by some social scientists (Highhouse, Zicklar and Yankelevich, 2010). These authors conducted a study, following reports which suggest that Americans have lost their belief in working for work's sake. The study sought responses to the following question: "Would you continue to work if you inherited enough money to live comfortably without working?" They found that Americans are currently less likely to say that they would continue working if it were not a financial necessity. They concluded that, indeed, the shift in emphasis from industry and achievement to personal growth and even self-indulgence was said to begin with post-war societal changes and the growth of human relations in industry. The general trend suggested a decline in the type of employment commitment that goes beyond direct financial rewards. The same result was found across different sectors of the USA's working population. They report, however, that this decline has recently stabilized (Highhouse et al., 2010).

Yankelovich (1978) previously observed that loyalty to the organization had been replaced by loyalty to the self and that concern for leisure had taken over from concern for work.

Morse and Weiss (1955 in Highhouse, 2010) had posed the same question (as that of Highhouse et al., 2010, mentioned above) to a sample of working men in various parts of the USA. They found that 80% of respondents would indeed continue to work. Vecchio (1980 in Highhouse, 2010) examined the responses to a similar question posed by the United States National Opinion Research Center in 1974, 1976 and 1977 to see whether Morse and Weiss's findings still held true. He reported that 72% of the respondents across the three data sets had indicated that they would continue to work. Vecchio concluded that the results supported the view that there had been a steady decline in the value attached to work since the middle of the 20th century. According to Vecchio, a leisure ethic might be replacing the traditional work ethic in the USA.

In its operational sense, the work ethic can be described as a set of characteristics and attitudes in which an individual worker assigns importance and merit to his or her work. Those with a high work ethic place a positive value on doing a good job and describe work as having an intrinsic value of its own (Hill and Fouts, 2005). Employees with a high work ethic are generally dependable, have good interpersonal skills, and demonstrate initiative. Other desirable qualities relating to the work ethic include hard work, community involvement, avoidance of idleness, and a tendency to evaluate work as being the most worthwhile way to spend one's time (Tang and Tzeng, 1991). Because of the obvious associated economic benefits,

employers try to encourage a high work ethic. Employees who have a low work ethic are said to cause companies a loss in productivity and profits (Hill and Fouts, 2005).

Research has however shown that such an idealized work ethic, as described above, is hard to find among employees. Tang and Tzeng (1991) emphasized this finding, noting that “the PWE today cannot be defined as it was in early America because Americans.....now live in a society where only the experience of the moment is important and pleasure is the overriding goal” (Tang and Tzeng, 1991:164, citing Albee, 1977). They support the impression that people with high levels of education are less likely to support the PWE and also note that modern Americans are less likely to accept traditional values. The authors also observe that well educated persons may be able to find better jobs and do not, therefore, have to strive as hard as would be the case for less educated persons.

Halman and Muller (2006) support the above Tang and Tzeng findings, although with fewer generalizations. They confirmed that, in Western Europe and Africa, education and income are important predictors of whether people endorse Weber’s work principles relating to the intrinsic value in work or not. Their finding on the correlation between education and work ethic is, however, a negative one as far as education and income are concerned. They report that in both Africa and Western Europe, intrinsic work qualities (inner satisfaction) are stressed more by the highly educated and people from higher income groups. Gabannesch (1972) offers a further explanation for this and states that educated people’s abilities and

cognitive skills make them critical of authority; they enjoy a higher level of personal autonomy and the freedom to make individual judgements. Zanders (1994) agrees with Gabannesch and observes that educated people are more likely to pursue personal development goals in work, in comparison to less-educated, or uneducated, people.

Other demographic differences have been reported in the literature, including age, urban versus rural contexts (level of development), work experience, marital status, religiosity, and gender.

RELIGIOUS WORK VALUES AND ECONOMIC OUTCOMES IN CONTEMPORARY SOCIETIES

Following Weber's (1904/1905) publication, a great deal of work on religious values has been reported. Over the years, this work has especially received impetus from the publication of large-scale, cross-cultural values surveys (Inglehart, 1990, 1997; Hofstede, 1980, 2001). The surveys made it possible to empirically examine value differences between countries and relationships between values and social economic outcomes at individual- and group-level in a variety of nations and cultures.

While some researchers have continued to investigate this aspect using the approach by Weber, others have examined ethical values of a variety of religious beliefs and how these relate to economic performance. For example, Harrison and Huntington (2000), Kahn (1979) and others have studied Confucianism; Tawney (1926) studied

Catholicism; and Granato, Inglehart and Leblang (1996) studied non-religious-specific values. Further studies by Barro and McCleary (2003) and Guiso, Sapienza and Zingales (2006) have correlated religious values with economic behaviour. In the majority of these studies, the context is the link between religion and work ethic and how this relationship influences economic outcomes.

The Islamic work ethic (IWE) is known to have originated from the Quran in the sayings and practices of Prophet Mohammed (Yousef, 2000). The IWE states that dedication to work is a virtue and that people should put sufficient effort into their work. The IWE emphasizes cooperation in work and consultation is seen as a way of overcoming obstacles and avoiding mistakes. Healthy social relationships at work are encouraged in order to meet one's needs and to establish equilibrium in one's individual and social life. In addition, work is considered to be a source of independence and a means of fostering personal growth, self-respect, satisfaction and self-fulfilment. In summary, IWE is based on the notion that for peoples' lives to have meaning, they should work hard. Yousef (2000) found that people who support IWE principles, particularly people belonging to the Islamic religion, were committed to their organizations, placed an emphasis on hard work and meeting deadlines on time, and were likely to positively embrace change in their work environments

Allport's (1950) Religious Orientation Scale, with its conceptualisation of intrinsic and extrinsic religiousness, is regarded as one of the most widely used religious scales. Individuals with an intrinsic orientation towards religion view their practice of religion as

a goal in and of itself and believe in religious practices for their own sake. Those with an extrinsic orientation perceive the practice of religion as a means to a personal or social end, such as acceptance in a group or the attainment of personal comfort (King and Crowther, 2004).

It is expected that devout people will be inclined to strive for virtue, morality and justice in line with the teachings of their religion. All major religions contain certain moral codes and teachings and truly religious people (that is, those with an intrinsic orientation to religion) should be less willing to engage in unethical behaviour because they believe that God knows all things and will be displeased by such behaviour (Conroy and Emerson, 2004). Hence, religious people would be expected to consider certain anti-social practices — such as cheating, lying, stealing — as unethical, since their religious beliefs consider that such behaviour is wrong (Lowery and Beadles, 2009).

A number of research studies have investigated relationships between religious constructs and ethics among students. Angelis and Ibrahim (2004) surveyed business students and found a significant relationship between the degree of religiousness and attitudes towards the ethical aspects of corporate social responsibility. Using a measure of religiosity based on church attendance, Conroy and Emerson (2004) observed that religiosity influenced students' ethical attitudes. Vitell and Singh (2005; 2006) observed a significant relationship between intrinsic religious behaviour and consumers' ethical beliefs. Lowery and Beadles (2009) found that people tend to perceive ethical

behaviour differently if the behaviour takes place while the person is at work, as opposed to when the person is outside work. Unethical behaviour at work appears to be relatively more acceptable than if one actively benefits (for example, adjusts scales used to measure food items) or passively benefits (for example, fails to report the receipt of excess payments) at the expense of others. Unethical behaviour that might cast an individual's employer in a negative light is not considered to be as bad as those behaviours where one benefits, either through an active or passive role, at the expense of others in transactions that do not involve the individual's place of employment.

Deceptive behaviour (such as accidentally bursting a sachet of milk in a supermarket and doing nothing about it), although viewed as wrong, was more tolerated than unethical behaviour in the work environment (Lowery and Beadles, 2009). According to Vitell and Muncy (1992), the difference between deceptive behaviour and actively-benefitting behaviour is that although the individual plays an active role in both, deceptive behaviour is less likely to be considered illegal.

Assessed from a Christian perspective, intrinsic practice of religion was a significant predictor of work-related ethics. People who are 'true believers' (with an intrinsic orientation to religion) view unethical activity in a very serious light – both at work as well as outside the work environment – as opposed to those with an extrinsic orientation to religion. People who are more religious appear to be relatively less likely to hide mistakes at work, to falsify reports, to inflate figures, to use company resources for personal purposes, and

to engage in other unethical activities – perhaps because they want to please God and/or avoid punishment for sin. In contrast, the practice of religion for the purpose of attaining social or personal advantages has little or no influence on ethical beliefs (Lowery and Beadles, 2009).

WORK ETHIC VALUES AND CULTURE

Apart from studies among different religions, the Protestant work ethic has also been studied in different cultures, for example in the Republic of China and Taiwan (Tang, 1990; Tang and Baumeister, 1984), Malaysia (Furnham and Muhiudeen, 1984), Hong Kong (Ma, 1987), among Afro-Americans and Afro-Carribeans (Gonsalves and Bernard, 1983), New Zealand (Poulton and Ng, 1988), East African Quaker (Munro, 1986), among white males in South Africa (Bluen and Barling, 1983), Great Britain (Furnham, 1984; 1989), and the United States of America (Greenberg, 1977; Tang, 1989). Such studies have focused on the relationship between work ethical values and culture, emphasizing the cultural basis of work ethics.

It is through such cultural studies that differences in work values have been discovered. For example, Asian employees are reported to differ from employees from other continents, being regarded as harder workers than their counterparts in other countries. The Japanese work ethic, in particular, is reported to be different from the PWE in some respects. The Asian view of work is based on the Confucian model of human nature, affirming mankind's innate goodness, which is the opposite of Western views that are based on man's fall from grace

and the resultant punishment of having to earn their bread by 'the sweat of their brow' (i.e. to have to work in order to survive). Asians who get exposed to Western organizations experience changes in their view of work (Hamilton-Attwell, 2010).

Over the past few decades, African values have been forced to adapt to Western values, particularly in environments of colonial occupation with advanced systems of communication and infrastructure (Soonteins and de Jager, 2010). According to Soontiens and de Jager (2010) cultural evolution has an impact on social outcomes, which in turn determines value systems, including the work values. An unprecedented exposure to Westernized culture and value systems has resulted in a gradual acceptance of Western values or, in some cases, replacement of African traditional culture and values with Western ones.

A blend of Western and African values is however possible, particularly in South Africa, as has been observed among the Japanese who have embraced core Western values but still retain a strong communal society (Soonteins and de Jager, 2010). According to Tasie, the Japanese have excelled in borrowing the best practices from the West without themselves becoming too Westernized or Europeanized (Tasie, 2009). At the same time, they have created their own skills and management styles, fostered by their own cultural values and social beliefs (Tasie, 2009).

CULTURE AND WORK VALUE ORIENTATIONS: INDIVIDUALISM VERSUS COLLECTIVISM

Obotetukudo (2001) argues that Africans as individuals do not know how to maximize opportunities to benefit oneself, but rather, take actions that benefit the community as a whole. The author asserts further that, in Western Europe and America the concept of the self resides in the individual, whereas in Africa the self is inseparable from the community and evolves in the company of others. In the USA the ideology of individualism is more important than society; African cultures do not, however, share this concept of individualism. Health decisions, for example, are made by a society, family, or a group and not by individuals (Ludwick and Silva, 2000).

The most commonly used dimension in discussing cultural differences is the individualism-collectivism contrast (Suh, 1999). In collectivist cultures people are "interdependent within their in-groups (family, tribe, nation, etc.), prioritize the goals of their in-groups, shape their behaviour primarily on the basis of in-group norms, and behave in a communal way" (Mills and Clark, 1982, quoted in Triandis, 2001:909). In collectivist cultures, the concern is particularly placed on relationships (Triandis, 2001).

In individualist societies individuals function largely independently from their in-groups. They prioritize their personal goals over the goals of their in-groups and they behave primarily on the basis of their attitudes rather than the norms of their in-groups (Triandis, 2001:909). Triandis (1989) found that in surveys aimed at examining

the attitudes of people in individualist cultures, such as those of North and Western Europe and North America, there was a high probability of people emphasizing elements of the personal self (for example, 'I am kind'). People from collectivist cultures, such as those of Asia, Africa and South America, tend to emphasize elements of the collective self (for example, 'my family thinks I am kind').

Halman and Muller (2006) introduced into the formula the relationship between individualism and materialism and they concluded that, contrary to their expectation, people in more individualistic societies tended to stress extrinsic work orientations. This implies a correlation between individualism and materialism.

In a South African study, Mann (1962) compared the values of a group of black, coloured, and Indian students at the University of Natal (Durban) with those of white participants. He found that the group of black students, when compared to the whites, preferred community-related values to private ones and favoured public well-being and democratic values.

Watkins and Mauer (1994), using a British measure of achievement motivation, found that the typical structure of work values found in a sample of white managers was absent among black managers from South Africa. The findings showed that, with the exception of values relating to mastery skills, black managers did not possess typical Western performance values. This was explained by the historical exclusion of South African black people from human resource practices; for example, performance appraisal for incentives and

promotions. Watkins and Mauer (1994:82) concluded that this lack of intrinsic and extrinsic rewards hampered the development of performance values among blacks. They refer to Moerdyk (1986), who reported that most whites were also educated in values related to the PWE in which the accumulation of wealth is justified as opposed to blacks, who were raised to believe in the concept of sharing or 'Ubuntu'. Orpen (1978) reported that black South African employees who had lived in a city for a long time and had been influenced by Western attitudes and lifestyles scored higher on a measure of the PWE than those from rural areas who had more traditional attitudes.

Theron and Strydom (1966) found that Zulu-speaking South Africans had a greater preference for conformity than whites, who preferred independence. They attribute this tendency to conform on the part of Zulus to Ubuntu, whose major principle is an orientation towards others. Independence on the part of the white South Africans, and perhaps whites in general, can be linked to individualism.

Although collectivism is the opposite of individualism, a degree of both is also common where elements of both cultures are borrowed and applied according to different situations. Triandis (2001) warns that not everybody in an individualistic culture will have all the characteristics of that culture. He also states that there are as many varieties of collectivism and individualism as there are collectivist and individualist cultures. Moreover, there are many other dimensions defining varieties of individualism and collectivism. Most importantly, he notes that, as cultures interact, the possibility of acculturation increases, resulting in changes in some domains, which

include job behaviour, while other domains may remain unchanged, including religious or family life.

Such variations cannot be ignored. For example, Harvey, Carter and Mudimu (2000) — in a study that compared work values and motives among Zimbabwean and British managers — report that, while traditional values are important in managerial motivation in Africa, there is also need for autonomy and self-fulfilment, values that are characteristic of Western societies. They also report high levels of bureaucracy in organizations in Sub-Saharan Africa but these same highly structured organizations are characterized by some mutually-understood ground rules about "when, how and by whom the regulations may be bypassed" (Harvey et al., 2000:725, citing Lamb, 1990). Yet, for Western managers, such ground rules may be hard to understand as they reflect different sets of values. They quote Munro (1986) and state, "an interaction of value systems is occurring in Africa …(and) ...indigenous theories (of work motivation and values) have not emerged and research methods that embody African values remain to be invented" (Harvey et al., 2000:726). This observation is supported by Harries (1997), who in his review of Atkins's (1993) book, "*The moon is dead! Give us our money!*", explains that the author related the phenomenon of migrant workers, who left their rural homes and entered the labour market, with a strict work ethic that their "culturally arrogant employers" were frequently unable to grasp. Atkins referred to this as a misunderstanding that underlies the struggle over labour. Harries points out that "Africans who refused to subject themselves to a work regime that ignored the parameters of their culture were simply regarded as lazy by their racist employers"

(Harries, 1997:668). To Atkins, he states, failure to relativise the virtues of indigenous culture resulted in conflicts between white employers and their African employees. More recently, Sartorius, de la Nuez and Carmichael (2011), confirm the importance of traditional humanist values in the workplace in Mozambique.

A further concern, voiced by Ludwick and Silva (2000), on the possibility of a coexistence of a diversity of values is that, although diversity is accepted as positive in today's workplace, individual workers can experience conflict and confusion where too many value systems are at play. It remains perplexing as to what the best scenario should be!

CULTURE, WORK AND AGE

It is argued that all values co-vary with age. Thus for example, the current young generation is more conscious and accepting of change in values and behaviours than was the case in the older generation (Soontiens and de Jager, 2010).

Sudheimer (2009) states that each generation of nurses shares similar values, motivations and historical experiences, which bond them together. The veteran generation is described as having been born between 1922–1943, baby boomers were born between 1943 and 1960, generation Xs were born between 1960 to 1980 and generation Y (or 'Millennials') were born after 1980. Generation X is able to relate to generation Y because they have similar characteristics, such as the advancement of technology and work ethics (Sudheimer,

2009). Veterans, on the other hand, do not understand the younger generations, and baby boomers have difficulties understanding generation X, while at the same time, generation Xs empathize with baby boomers (Sudheimer, 2009). The new generation, which is generation Y, is presently coming of age and shares commonalities with the younger members of generation X but does not understand the oldest generation Xs, the baby boomers, or the veterans (Sudheimer, 2009).

According to Hamilton-Attwell, there is a significant difference between the workforce of today and that of the older generation. The latter group believes that the 'new' generations do not want to work hard and are less committed to their work or organization (Hamilton-Attwell, 2010). Supporters for the 'older' generation believe that the 'new' generation can be taught how to work according to their standards, through the elite group of diligent workers. They feel the good old PWE should be re-established through the education system, by producing literate, numerate people who are taught how to be responsible, hardworking and committed employees (van Aswegen and Engelbrecht, 2009).

Generation X and Y do it their own way; the new generation differs from their parents and grandparents with regard to their attitudes towards work. They believe in behaving according to one's values and being allowed the opportunity to develop to one's full potential (self-actualization). They enjoy life and the benefits of work, unlike the deferred gratification that their parents subscribed to (Hamilton-Attwell, 2010). They are unpunctual, because they need more time to

deal with personal issues, and will not work overtime if it will take them away from their families or recreational activities. Thus a job is a means to an end and once they earn enough money they resign. They also feel entitled to certain benefits, ranging from change in dress code to the type of food served in canteens, to the right to have access to sensitive organizational information and to participate in strategic decisions. Moreover, the new generation regards it as their right to question anybody in a leadership position (Hamilton-Attwell, 2010). Smola and Sutton agree with Hamilton-Attwell, in that they expect that today's employees want to be treated as valued members of the organization and their employers should take into consideration their work-life balances (Smola and Sutton, 2002).

According to Steyn and Kotzé (2004), the process of globalization, modernization and industrialization have improved economic conditions for the younger generation. This has led to flexible and temporary work hours, with a new breed of employees that hold their organizations liable for providing them with the resources needed to facilitate individual development and growth. This attitude has typically replaced that of the traditional organizational employee. Today's workers are less motivated by material rewards (extrinsic work qualities), status, advancement or even job security; instead they want opportunities for personal growth, change and stimulation (Steyn and Kotzé, 2004).

In a study reported on earlier by Highhouse et al. (2010), younger respondents were found to be more likely to report a desire to continue working after a financial windfall, compared to older

respondents. They argue, however, that such a difference may point to differences in interpretation between age groups. Younger workers simply face more years of idleness if they retire. In addition, younger people do not have the retirement assets of older workers and, as such, may not view a sudden financial windfall in the same way. Highhouse et al. (2010) concluded that the desire to continue work for work's sake may be predicted by motives of achievement, affiliation and dignity.

Tang and Tzeng (1991) found that young people were more orientated toward the PWE than was the case for older people. This was in agreement with the findings of Bucholz (1978a:226), who argued that "young people enter the workforce with individualistic notions and a belief in the value of work in and of itself, but after some years of being in the workforce and facing the realities of the workplace day in and day out, these beliefs may weaken". These reports support the conclusions of Furnham (1987) who had found earlier that age was a significant predictor of both instrumental and human values.

Halman and Muller (2006), in a study that compared work orientations (intrinsic = pursuit of inner growth; and extrinsic = pursuit of goals external to work) in Africa and Europe, hypothesized in accordance with the common argument that — at least in Europe — young people would display an intrinsic work orientation. This was because young people were raised and socialized in a wealthier society than that of their older predecessors. As such, young people were not expected to work in order to satisfy survival needs, as had

been the case for the older generations. Accordingly, young people could be expected to display higher levels of intrinsic work values while older people would stress extrinsic values. The opposite scenario was, however, expected in African populations since the youth in these contexts had become worse off economically. Contrary to their expectations, Halman and Muller found that older age groups in all regions tended to be less extrinsic in their work orientations than was the case for younger groups. The only regional differences were that in Europe the decline in orientation toward extrinsic work qualities by age was more linear than in Africa and Eastern Europe. In Eastern Europe the 55–64 age group tended to favour extrinsic qualities more than was the case for the 45–54 age group. Those in the 65 and 75 age group were less in favour of extrinsic qualities. In Africa, although the adherence to extrinsic work qualities was lower among older age groups, there was no steady decline from the youngest to the oldest.

WORK ETHIC VALUES AND EXPERIENCE

The observation by Tang and Tzeng (1991) described above, on the weakening of work values of young people first entering places of work, implies a relationship between work ethical values and work experience. These researchers argued that people who work hard in their daily lives are also those who support a work-related value system. An individual’s support of the PWE may also change as he or she progresses in his or her career or life. Endorsement of the PWE may serve as a good predictor of an individual's work-related activities and behavioural tendencies. This is in support of Furnham’s

(1985) finding that PWE beliefs were very powerful predictors of work values and social beliefs and suggested a possible developmental pattern, where a particular type of socialization leads people to hold conservative and puritan work ethic beliefs that determine employment choice, behaviour and success.

According to Samuel and Lewin-Epstein (1979), attitudes and beliefs associated with the work ethic may change or develop with actual work experience, so that the longer the individual stays in one particular job the more he/she will learn to adhere to the principles of the work ethic. Although this finding confirms that endorsement to work ethic values can be a useful predictor of work behaviour, it reverses the relationship between the two variables when compared to the findings of Buchholz (1978a:226) cited earlier who observed that individualistic work values weakened with work experience.

CULTURE, WORK ETHIC VALUES AND GENDER

Notions of culture, among other things, also encroach on the domain of gender. Many studies have reported gender differences in work ethics. There is scientific evidence to suggest that women tend to score higher than men with respect to work ethic values across occupations (Meriac, Poling and Woehr, 2009). However these authors note that, in spite of all the research that has been done, the findings fail to demonstrate the multifaceted nature of the work ethic and lack information on measurement equivalence/ invariance of the instruments used to draw conclusions regarding gender differences. They point to the likelihood that gender stereotypes may lead to

different work ethic endorsements for both women and men, and the work ethic construct might have different socially-constructed meanings for women and men.

Earlier studies, for example one by Tang and Tzeng (1991), had found no correlation between work ethics and gender. Goldthorpe, Lockwood, Bechhofer and Platt (1969), on the subject of what motivates people to work, suggested that men were either expressively or instrumentally motivated towards their work. If they were instrumentally motivated, they worked 'just for the money' and if they were expressively motivated, they saw work as a sphere for 'self-actualization'.

Hakim (2003) in Nolan (2008) suggests that, while most women prefer some sort of 'work–family' balance, men fall into two main groups: adaptive and work-centred, with a negligible group being home-centred. Work-centred women and men are described as those who are driven by competition, the need for achievement, and individualism, rather than collectivism. Home-centred women and men, on the other hand, prefer the sharing, caring, and non-competitive atmosphere of private family life. Adaptive people are those who are caught in the middle, who divide their time and effort between the public world of work and the private world of the family. As such, 'adaptives' have to simultaneously deal with two different value systems.

A study by Nolan (2008) found that men in the 'adaptive' category viewed the family, rather than work, as their central life value

(although they were not necessarily committed to becoming involved in the day-to-day organization of housework and childcare). Adaptive people, men and women, were hesitant to embrace the competitive, achievement-orientated values of the work-centred people. The work-centred group, however, placed a higher priority on their career than on family life.

In his study of cultural differences and how they play themselves out to bring about differences in work orientations among individuals, groups and whole societies, Hofstede (2001) categorized cultures in terms of masculine and feminine. Societies can therefore be characterized as either 'masculine' or 'feminine' depending on certain features corresponding to masculine or feminine dispositions. The defining features for a masculine society include emphasis on material success, money and possessions, being ambitious, living in order to work, stress, competition, and performance. Feminine societies on the other hand are identified by the extent to which they emphasize the following type of qualities: a belief in work as a means to live, cooperation, solidarity and quality of life. This applies to the work qualities that males and females endorse.

Using the above theory, Halman and Muller (2006) hypothesized that the more emphasis a nation's culture places on masculine work qualities, the more that nation would prefer extrinsic work values and the less it would stress intrinsic work qualities. The reverse was expected for feminine cultures. Their findings, however, did not support these hypotheses in Western European countries where it was found that emphasis was laid on expressive/intrinsic work qualities.

On the other hand, the hypothesis was confirmed in terms of workers' attitudes in Eastern and African countries.

In the above study, housewives in Europe were found to be least in favour of intrinsic work qualities compared with men and working females, with the biggest differences being in Eastern European countries. African housewives on the other hand, were similar to men while working African women emphasized intrinsic qualities much less than men and housewives.

The healthcare profession is dominated by female health-care workers. Relationships in this profession are however strongly male-dominated, with a prevalence of male dominance and female subordination (Enberg, Stenlund, Sundelin and Öhman, 2007). The system is considered gender coded, with specific jobs coded for either females or males. This code also implies less status and less payment for tasks considered to be ‘female’ (Enberg et al., 2007).

WORK ETHIC AND INCOME

A number of research studies have examined the influence of income on the work ethic values. Furnham (1987) found income, among other social demographic factors, to be a significant predictor of both instrumental (extrinsic) and human (intrinsic) values. Furnham (1984) observed that high-income individuals tended to have stronger leisure-ethic beliefs than their lower-income counterparts. This was confirmed by Tang and Tzeng (1991) who observed that low-income workers tended to have stronger PWE values than was the case for

high-income groups. Halman and Muller (2006), in their comparative analysis of European and African work value orientations, found that Western Europeans in higher income groups stressed extrinsic qualities to a lesser degree than was the case for lower income groups who preferred such work qualities. In Africa, on the other hand, extrinsic work qualities were valued more by middle- and high-income groups.

WORK ETHIC VALUES AND MARITAL STATUS

It appears that very little work has been done to assess the influence of marital status on work ethics. According to Tang and Tzeng (1991), however, single people were found to have a tendency towards a stronger commitment to the PWE than was the case for other groups. He attributed this to the fact that married people tended to get involved in more activities than unmarried workers.

WORK ETHIC VALUES VERSUS RURAL/URBAN DIVIDE

Orpen (1978) reported that black South African employees who had lived in a city for a long period of time and who had adopted Western attitudes and lifestyles scored higher in assessment that measured PWE than those from rural areas and a more traditional background.

Research has also focused on the transformation in work orientation as societies have changed from agrarian societies to modern industrial and highly-developed welfare states. According to Yankelovich, Zetterberg, Strumpel, Shanks et al. (1985), in traditional agrarian

societies, people’s reasons for working were predominated by the need for sustenance. Work was ‘a necessary evil’ for survival. In industrialized societies, the predominant concern involves the accumulation of money and possessions and the emphasis shifts towards attaining material success (representing an extrinsic work orientation). In contemporary societies, work is no longer necessary to provide security and satisfaction of ‘lower needs’; instead quality of life, individual autonomy, and general wellbeing (intrinsic-value work orientations) are emphasized. This means that, as societies move from traditional agrarian societies to contemporary modern societies, people’s work values change from ‘working to gain external rewards’, such as money, to ‘working because work in itself brings satisfaction’. This implies that people in contemporary, more highly developed, economies have a greater commitment to PWE principles than is the case for people in more traditional agrarian (rural) economies.

A similar argument, grounded in modernization theories, was applied in a study by Halman and Muller (2006). After finding contradictory results when comparing European and African work orientations, these researchers confessed, that “modernization is apparently a Western concept and thus does not provoke similar outcomes in non-Western contexts” (Halman and Muller, 2006:138). They found, however, that characteristics such as individualism, development, masculinity, working in agriculture, and living in equal societies, did indeed matter in a Western context. Their finding confirmed that “societies develop at their own speed, following their own path.... at a very abstract level, in the same direction. Many people in Africa,

perhaps also in some Eastern European countries, are still more concerned with pure survival, not only in the context of work but also more generally" (Halman and Muller, 2006:138). Some characteristics of development were however found to have the same expected effect in all contexts. The more developed a society was in terms of life expectancy, adult literacy, welfare etc., the less extrinsic work qualities were emphasized.

PROTESTANT WORK ETHIC, JOB SATISFACTION AND LIFE SATISFACTION

Job satisfaction is defined by Biton and Tabak (2003) as the emotional attitudes towards one's work and the emotional evaluation of one's experiences during work. Saari and Judge (2004) describe job satisfaction as "an attitude of the employee" and state that the work situation impacts on job satisfaction.

Research by Zelenski, Murphy and Jenkins (2008) found happy workers to be more productive than those with lower levels of happiness. However, other scholars state uncertainty regarding the validity of the 'the happy productive worker thesis' (Wright and Cropanzano, 2004). Blood (1969) reported that individuals with positive work-ethic beliefs experienced greater satisfaction with their jobs as well as with their lives in general. He also found that, in general, work ethic dimensions related significantly to job involvement, organizational commitment, and job satisfaction. This means that, taken together, the Multidimensional Work Ethic profile

(MWEP) dimension scores are significant predictors of each of the three attitude variables (Miller et al., 2002).

The International Council of Nurses (ICN) recognizes that most health workers in Sub-Saharan Africa are over-worked, stressed, and under-valued (ICN, 2006a).

In South Africa, Pillay's (2009a) research identified job dissatisfaction as the main reason for the high turnover and absenteeism of nurses in hospitals, which in turn affects work efficiency and effectiveness, leading to poor health service delivery. Dissatisfied employees provided poor service and paid less attention to their patients (Pillay, 2009b). The results of Pillay's research also highlight the dissatisfaction of nurses in the public sector in terms of their remuneration, work load, and resources available to them. In contrast, he found that private sector nurses were only moderately dissatisfied with their remuneration and work load and only marginally dissatisfied with their career opportunities (Pillay, 2009a). Differences in satisfaction levels were related to work contexts such as remuneration, work load, schedules, management, and autonomy. Job satisfaction in the nursing practice can also depend on the age of the nurse. Pillay's study found that nurses older than 20 years were generally more satisfied with their work than was the case for younger nurses with less experience (Pillay, 2009a).

ETHICS AND THE PRACTICE OF MEDICINE

The original motive for the development of the medical profession was to seek solutions to the suffering of mankind, using the best methods possible, especially through technological advances (Hewa and Hetherington, 1990). These authors also report that the fundamental purpose of nursing was to ensure the wellbeing of patients, from a humanitarian view, and that the nursing profession began from a religious background, having been influenced by Judeo-Christian values. On the other hand, the medical profession was influenced by science and technology (Hewa and Hetherington, 1990). This implies a difference, to a certain extent, between the ethics of nurses and doctors.

Ethical practice requires that organizations align themselves with strategies that have ethical standards and good codes of practice; thus corporate governance good practice requires that health organizations implement ethics management programmes (Landman, 2008). Ethics do not prescribe to a specific set of rules or polices; instead, it provides a framework for assessing problems and choosing the best course of action to solve such problems (WHO, 2009).

The concepts of ‘morality’ and ‘common morality’ relate to norms associated with the question of what constitutes moral and immoral human conduct. Such norms are normally widely shared within a particular society (Beauchamp and Childress, 2001). We learn moral standards and responsibilities as we grow and they are transmitted from generation to generation (Beauchamp and Childress, 2001).

Common morality is accepted by all morally serious people; thus each profession contains a professional morality with standards that are acknowledged by those in the profession. In medicine, the morality of professional staff coincides with the general moral norm for the institutions, practices, and traditions associated with professional medicine (Beauchamp and Childress, 2001). Professional morality has been emphasized over the years, through codes of medical and nursing ethics and codes of research ethics (Beauchamp and Childress, 2001).

In medicine, two sets of ethics are used: firstly, ethics that have been around since the beginning of time, and bioethics that developed in the age of modern medicine (Sanderson, 1999). Bioethics is an interdisciplinary field within the healthcare profession, which only developed over the last three decades (Sanderson, 1999). According to Snyder and Leffler (2005), medical and professional ethics often have a greater impact on moral behaviour at work than does the law.

Medical ethics are based on principles that encourage ethical codes of practice. These are encompassed in the principles of beneficence and non-maleficence: beneficence encompasses the duty to promote good practices and to act in the best interest of the patient and the health of society; non-maleficence encompasses the duty to do no harm to patients, respect for patient autonomy (truth-telling), and the duty to protect and foster a patient's free uncoerced choices (Snyder and Leffler, 2005).

Ethical legislation associated with medicine encompasses a set of five major aspects of ethical medicine law that play a role in the doctor-patient relationship. These encompass the way in which medical practice and services are rendered, the privacy of patients, the confidentiality of patient information, the patient's right of self-determination, and informed consent by the patient (Oosthuizen and Vershoor, 2008).

South Africa is currently not keeping up with standards and academic rigour required for bioethics, as practised by other countries in the world (Oosthuizen and Vershoor, 2008). For instance, ethical issues and human rights have not been included in the practice of medicine. There is no uniform curriculum for medical students on human rights, ethics and medical law in medical schools in South Africa (Oosthuizen and Vershoor, 2008).

The practice of medicine is controlled by legislative and judicial powers (Oosthuizen and Verschoor, 2008). Doctors have to consider legal and ethical debates around issues relating to patient-doctor relationships and the role that doctors play in the broader debate on bioethics (Oosthuizen and Verschoor, 2008).

In today's medicine, the question of ethics is so intertwined with law and human rights that it forms an important component of the practice of medicine. Previous practitioners were only required to consider ethical values when practising medicine. Today's practitioners, however, also have to include legislative requirements (Oosthuizen and Verschoor, 2008). If doctors follow ethical rules

they will be able to protect themselves from disciplinary actions and legal aspects of medical malpractice (McQuoid-Mason, 2008).

NURSING ETHICS

According to Sanderson (1999), nursing ethics is the system of principles concerning the actions of the nurse with regard to his/her relationship with patients, family, or other health professionals, and society as a whole. Codes of ethics provide a set of standards and values for the profession.

According to the International Council of Nurses (ICN), nurses have four fundamental responsibilities: to promote health, prevent illness, restore health, and alleviate suffering (ICN, 2006b). Furthermore, the ICN code of ethics for nurses has four principal elements that outline the standards of ethical conduct.
Firstly, when dealing with patients, nurses have to provide an environment in which human rights, values, customs, and spiritual beliefs, of the patient, family and community is respected. Secondly, they have to ensure that individuals receive adequate information on which to base consent for care and treatment. Nurses have to take personal responsibility for upholding principles associated with nursing practice and to maintain competence by continual learning. Thirdly, nurses should also maintain a high standard of personal health so that they can provide quality care and a standard of conduct that will reflect on the profession and increase public confidence. Lastly, nurses should maintain a sustainable relationship with co-workers in nursing and other fields. Nurses have the right to

safeguard individuals, families, or the community from any health threats from co-workers or any other person.

A competent nurse must be able to deal with the human dimension of caring and, if the care is to be competent, the balance between science and morality must be understood (Sanderson, 1999). A morally professional nurse's most useful tool is a set of principles, or standards. Ethical principles create a common ground between nurses, patients, their family and other healthcare physicians, which can be reached through an understanding and a collective agreement (Sanderson, 1999).

Nurses must be prepared to deal with ethical conflicts in the day-to-day practice of their profession. They also have to recognize unique features of each situation and to handle each one according to its uniqueness in order to satisfy individual patients' needs (Sanderson, 1999).

Fitzgerald and Hooft (2000) posed a Socratic question to a focus group of nurses in Australia. The question was, "What is love in nursing?" The conclusion they made was that nurses who love the practice of caring go beyond the role definition of the duty of care. These nurses are said to be prepared to think differently about the practice of nursing in their profession. They are characterized as competent risk takers who are committed to the betterment of others. "These qualities are given expression through an act of nursing in which the intention is to nurture a relationship of understanding of people that accepts or tolerates the will of the other where that

'other's' choice is based on a well-informed health belief. It is bringing the nurse's own self to a relationship of understanding and feeling with the patient in order to nurture a state of health, well-being and comfort. It is an intention that expresses the nurse's own health beliefs in the light of the desires of 'the other'" (Fitzgerald and Hooft, 2000:491). The suggestion is that love in nursing is something qualitatively different from caring. Love takes nurses beyond the duty of caring to a level of deep commitment and dedication.

Applying the above scenario to the South African context, the idea of going beyond the call of duty could be demonstrated through the concept of Ubuntu. Haegert (2000) discusses this African concept and how it applies to the nursing profession. Ubuntu has been described as a practical humanist disposition towards the world. Included in this are the ethical concepts of compassion (or mercy), tolerance and fairness. Ubuntu is an ethic that ideally leads people to embrace other people trustingly and completely; it enfolds a person with significance and meaning in life.

Haegert (2000) illustrates the practice of Ubuntu using two true contrasting stories. The first one was published in the media, while the second was told by a participant in Haegert's research study.

Haegert reports:

> "Cape Town was greeted one day with the headline, 'Cape Town's shame'. 'Beneath these words was a picture showing a group of people looking at a wheelbarrow. The legs of a person were seen to be hanging from the barrow. A tragedy was being witnessed. The 'Death in a wheelbarrow' was described by the husband who had pushed his chronically ill

> wife between two health centres, in his only form of transport – a wheelbarrow – trying to save her life. She died without treatment and without a bed, without the dignity and peace that should be the fundamentals of our nursing philosophy.
>
> This story, which continued to be discussed in the media for a week, is not one to be proud of, yet it illustrates beliefs about what is valuable or what matters to a particular group: a community. The community listened to the narration by the husband and wept over this tragic death. Yet, the lives of this couple seemed not to be important to the healthcare professionals. We need to realize that our perceptions, ideas and beliefs determine the way we act towards others. Our attitudes and behaviour can form a particular ethic that can be either positive or negative. Commentating (sic) on this incident, the health minister acknowledged that the top priority for the health service was 'to make it more caring'. Later, he 'slammed the "unprofessional attitude" of staff'. The media perceived it as 'the callous enforcement of petty bureaucracy, placing rules above the compassionate treatment of people in urgent need of help.'" (Haegert, 2000:493–4).

The second story was that of a black nursing sister in a rural South African hospital. This nurse volunteered to bath a cancer patient in bed when her fellow colleagues refused to do so because of the smell surrounding the patient. The nurse in the second story reportedly helped the patient because she wanted the patient to have "peace of mind". She said she was a nurse because of patients.

Haegert (2000) argues that in the first story, the humaneness of the person was either denied or forgotten. The nurse in the second story displayed a combination of Ubuntu – treating the patient humanely, with dignity and respect as a fellow human being – and the African proverb (in Xhosa): *Umntu ngumntu ngabantu*, which in English means "A person is a person through persons". The nurse exercised

her unique 'personness' to be free to be her professional and private 'self'. The story, Haegert explains, expands upon the above proverb of Ubuntu, whose alternative translation —"I am, because we are and we are because I am" — incorporates the South African constitutional idea of Ubuntu (compassion and justice or humanness).

Haegert (2000) argues that freedom is necessary in the practical expression of any ethical behaviour or ethical decision making. He reminds the reader that care and compassion form the foundation of morality. He further notes that nursing ethics has followed particular Western moral philosophers who have taught it along the lines of Kohlberg's (1981) theory of morality, with its emphasis on rules, rights, duties and general obligations. In Haegert's view, these principles are universalistic, masculine and non-contextual.

The stories related above by Haegert (2000) are but a few of what could be told about the health service in South Africa. A number have already been enumerated in the first chapter of this thesis. Work ethics and service delivery in South Africa's public service have been marred by a lack of responsiveness to the needs of clients, tardiness in the discharge of duties, inefficiency, and corruption (Dorasamy, 2010). Unethical behaviour normally starts at the top of public service leadership, because public service values are not personified or promoted by management (Dorasamy, 2010). The new white paper on "Transforming Public Service Delivery" introduced the '*Batho Pele'* principles, again along the lines of Ubuntu, to transform public service, which means 'People first'. This is the motto that public service workers are supposed to adhere to (Dorasamy, 2010). The

Batho Pele principle states that all citizens should receive equal service, citizens should be consulted about the services available to them, and the service providers should ensure considerate and courteous treatment to the public. Moreover, clear transparency on the management of government departments, accountability for quality service, and responsibility to provide efficient and effective service, are required (Dorasamy, 2010).

The reality of conditions relating to service delivery in South Africa indicates an opposite picture from what is proposed in the *Batho Pele* principles. The World Health Organization's mortality target is ten deaths per 1000 people; in South Africa the number is 36 per 1000. The Eastern Cape Department of Health concedes that the death rate at some hospitals in various regions of the country is quite high (Department of Health, Eastern Cape Provincial Government, 2010).

WORK ETHIC AND STRIKES IN THE SOUTH AFRICAN MEDICAL PROFESSION

Although strikes are a rare occurrence in the medical profession worldwide, in recent years there have been numerous strikes by doctors and nurses in South Africa. According to Snyder and Leffler (2005), physicians in the medical profession should not participate in any demonstration that affects access to healthcare by the public, or that results in anti-competitive behaviour. Medical professionals should not be involved in strikes, boycotts, work stoppages, or slow downs, that are designed to limit or deny services that would have otherwise been available to patients. The majority of the South

African strikes were initiated by junior doctors and arose from delays in salary increases and disputes associated with the new policy of Occupation Specific Dispensation (OSD). The purpose of this policy was to introduce revised salary structures — which would encourage career-path planning and encompass pay progression and grade progression — as a means of keeping professionals and other specialists in the public sector (Ogunbanjo and Knapp van Bogaert, 2009). An agreement was signed between the government and doctors in 2007. By 2008, nurses had received only 20% of their promised salary increase and the doctors' salary increases were postponed (Ogunbanjo and Knapp van Bogaert, 2009).

During the strikes, the Health Professionals Council of South Africa (HPCSA) issued stern warnings to the doctors about striking, emphasizing that their actions were going against the Hippocratic Oath and South African legislation that prohibits doctors from striking (Ogunbanjo and Knapp van Bogaert, 2009). Furthermore, the HPCSA stated that the doctors were acting in an unethical and inappropriate manner and were going against their core ethic of serving people (Makhubo, 2009a). During strikes, patients may have been harmed in numerous ways, including loss of work, money wasted on transportation, treatment delays, prolonged suffering, irreversible damage to health, and incorrect doses of drugs being administered. Some of these harmful effects could have led to the death of patients (Ogunbanjo and Knapp van Bogaert, 2009) and there is at least one recorded incident when this happened. In 2009, during the strikes in the Eastern Cape, a pregnant woman died at Frere Hospital in East London. Nurses struggled to save her life as

there were no doctors to attend to her. In such circumstances normal procedure dictates an emergency delivery of the baby. However, the nurses couldn't perform the delivery due to a lack of required expertise (Makhubo, 2009b).

The benefit of the strikes for doctors would be increased salaries and improved working conditions, which in turn would lead to reduced emotional stress, ultimately resulting in a greater number of doctors remaining in the country. However, as a result of their strike action, the public lost confidence in doctors (Ogunbanjo and Knapp van Bogaert, 2009).

Negative accounts of poor service and negligence by doctors continue to be reported in the media (Naidoo, 2010). The Medical Protection Society reveals that more than 800 claims of negligence have been assessed and more than 1000 claims still need to be assessed. The claims include incidents of children born with brain damage and other birth defects not noticed at birth, and the failure to perform caesarean sections when needed (Naidoo, 2010). Some 80% of the claims come from the public sector. The HPCSA reported that, since 2000, about 44 doctors have been recalled from the profession due to unethical and unprofessional conduct (Naidoo, 2010).

APARTHEID AND THE WORK ETHIC IN THE SOUTH AFRICAN MEDICAL PROFESSION

During the apartheid era the medical profession in South Africa was under the scrutiny of international medical ethics, producing highly

unequal healthcare systems over which the majority of South Africans had no control or influence (Bell, 2006). The segregation of hospitals and general practitioners clearly contravened the Hippocratic Oath in that the healthcare sector followed the example set by the state to discriminate against the black population. In about 1990, only 5.5% of South African doctors practised in rural areas, even though over half of the black population lived in these areas (Bell, 2006). Poor living standards and poor healthcare in rural areas made it difficult to combat illnesses and communicable diseases such as tuberculosis. The elite white community was less vulnerable to contagious diseases and focused on so-called ‘diseases of affluence’, such as cancer (Bell, 2006).

During the apartheid era black nurses were deprived of voting rights in the medical profession and of equal opportunities within the nursing profession. The black nurses were often exploited by health services facilities. They worked under poorly-equipped conditions and segregated health and education facilities (van der Merwe, 1999). They received low salaries and often lived far from their place of work (van der Merwe, 1999).

Discrimination on the basis of colour also meant that, for many black women, nursing may not have been a vocational choice, as few professional career options were open to them outside of nursing, teaching and social work. This may explain the present flaws in their work behaviour.

Although the South African workforce has been restructured in a number of ways — laws put in place against any form of discrimination, progression towards employment equity, and a service delivery system that benefits all — progress has remained slow (Grobler, Warnich, Carrell, Elbert and Hatfield, 2002; 2006). Conflicts still occur due to political and personal values that cause resistance to change and transformation (Baldwin-Ragaven, London and de Gruchy, 2000).

Although employment levels among black women are higher than ever before, due to political initiatives against gender discrimination, changes in family structures have not kept pace with those in the workplace. Single parenting and dual-career couples face an often-daunting task of balancing demands of work and family (Grobler, 2005). There may also be some resentment among childless employees, many of whom feel exploited because they perceive themselves as 'losers' in comparison with workers who receive benefit packages that favour families with children. According to Grobler (2005) it is not unusual for childless employees to be given time-consuming assignments, or to be targeted for out-of-town travel or weekend work.

Racial and ethnic minorities tend to receive lower quality healthcare, even when their health insurance status and financial capacity are controlled (Rothberg, 2008).

In the medical profession, it is still not easy to change or integrate the workforce because, even though the number of graduates has

increased over the years, Africans continue to be under-represented in medical schools (Erasmus and Breier, 2009). Although the number of matriculants has increased, the percentage of black students graduating in higher grade mathematics and science subjects — necessary entry requirements for medical school — is still low (Erasmus and Breier, 2009).

WORK ETHIC AND ECONOMIC DEVELOPMENT

From a development point of view, work ethic values have been associated with economic growth. In their research on national differences in personality, socio-economic aspects, and work-related attitudinal variables, Kirkcaldy et al. (1998) support the view formulated by Weber (1904/1905) that the concept of the PWE was the driving force behind national economic development. They conclude that work ethic, competitiveness, and concern about money are useful drivers of economic activity, but note, however, that these qualities decline once economic growth has been achieved (Kirkcaldy et al., 1998).

Miller et al. (2001:2) draw attention to evidence on a decline in the work ethic, as alluded to in Chapter 1, which is associated with, "lower levels of job performance, higher levels of absenteeism, and increases in counter-productive behaviour, ranging from unauthorised breaks to employee theft". This state of affairs is contrary to work ethic values and can negatively impact on the economic growth and development of whole countries. Indeed, social development theorists have used Weber's PWE as the basis to construct theories of

development and to explain underdevelopment in Third World countries, global inequality, and persistent poverty. Such development theorists include some modernization theorists.

The most widely known development theory is the modernization theory, which approximates a functionalist sociological perspective. It suggests that low-income economies can move to middle- and high-income economies by achieving self-sustained economic growth. Work ethic is a core value widely believed to be of great significance in the modernization process (Kendall, 1999).

Kendall (1999) further observes that the modernization theory suggests less developed nations can improve their standard of living through undergoing a period of intensive economic growth accompanied by changes in people's work values, beliefs and attitudes (VBAs) in work. As a result of modernization, the VBAs of people in developing countries supposedly become more similar to those of people in high-income nations. For example, the number of hours that people work at their jobs each week is one measure of the extent to which individuals subscribe to the work ethic. Likewise, as societies industrialize, they also urbanize. The outcome of workers relocating their residences to areas near factories, offices and other places of work, is that urban VBAs overshadow the folkways of the rural areas. For this reason, the participants in this study were chosen from rural, urban, and peri-urban contexts. One of the most widely known theories of modernization is that of Walt W. Rostow (1971/1978) who proposed that one of the largest barriers to development in low-income nations is the traditional cultural value

system held by people, particularly fatalistic beliefs such as viewing extreme hardship and economic deprivation as inevitable and unavoidable facts of life. In cases of fatalism, people do not see any need to work in order to improve their lot in life: since it is predestined, then why bother? Based on modernization theory, poverty can be attributed to people's cultural failings, among other things.

Rostow suggested that all countries go through four stages of economic development.

(1) In the 'traditional' stage very little social change takes place: people are passive about their situation, hold a fatalistic value system, do not subscribe to the work ethic, and save very little money.
(2) The 'take off' stage is characterized by substantial economic growth, and beliefs in individualism, competition and achievement. People in this stage look forward to the future, save and invest money, and discard traditional values. According to Rostow's modernization theory, the development of capitalism is essential for the transformation from a traditional, simple society to a modern, complex one.
3) The technologically mature stage is characterized by improved technology: people reinvest in new industries and embrace the beliefs, values and social institutions of high-income developed nations.
(4) The high-mass-consumption stage has a corresponding high standard of living.

The above theory can be said to be the basis of Zabojnik and Patrick's (2000) statement that an economy can be in either a high-work-ethic 'steady' state or a welfare-dominated low-work-ethic state and that development efforts in the former state are more efficient. The same viewpoint — concerning the VBAs of South African workers — is echoed by some South African leaders, as illustrated in former President Mbeki's comments on bureaucrats, "*who come to work as late as possible, work as little as possible and knock off as early as possible*" (Mbeki, 2004)

DEVELOPMENT MODELS AND THE THIRD WORLD

In terms of historical perspectives, as societies have evolved, socio-political changes have taken place. According to contemporary theorists this has resulted in tremendous impacts during the process of modernization. As a result, the pattern of development, as envisaged by modernization theorists, has been altered. The period of apartheid in South Africa, for example, may have ushered in new dimensions in the development path of the country. This, and many other similar arguments, has formed the basis of the criticism leveled against modernization theorists and similar schools of thought. However, such conflicts in ideas relating to development theory may indeed explain conflicts in the work values of the participants in this study. As such it is important to pay attention to other schools of thought in order to widen our understanding of the concept of the work ethic and its functionality in society. In the earlier section of this chapter, the findings of various empirical studies demonstrated a number of variations in the practical application of work ethic values.

One example of such variation was in the work value orientations according to regions, namely European, Asian and African regions (Halman and Muller, 2006).

From the perspective of contemporary schools of thought on development, a critical examination of earlier development theory reveals a number of flaws when applied to the African context. These conflicting viewpoints cannot be ignored.

New development theories criticize older theories, including modernization theories, as being biased towards the West, and therefore inapplicable to the experience of many developing countries (Lemco, 1988). The Western models arose from a Judeo-Christian ethic that is largely inapplicable to the Third World experience. The timing and sequencing of development stages in the West are not necessarily replicable in the developing world. Contrary to Western beliefs, traditional institutions, such as clans or tribes, can act as agents of modernization and development. When implemented in developing countries, Western development models might impair the modernization process (Lemco, 1988). According to Lemco, an indigenous development plan can only exist for a certain period of time and no nation can develop in complete isolation, as external factors will influence various economic activities, such as trade patterns, oil requirements, and financial planning (Lemco, 1988).

Obotetukudo (2001) argues that, as individuals, Africans do not know how to maximize opportunities to benefit the self rather than the community as a whole. In Western Europe and America 'the self'

resides inside the individual, whereas in Africa 'the self' is inseparable from the community and evolves in the company of others (Obutetukudo, 2001). In other words, while Western work value orientation may be individualist, the African one may be collectivist.

African development has been riddled with philosophical questions relating to whether the reason for the lag (in development) is due to colonialism, neocolonialism, or Africans' own inadequacies (Kebede, 1999). The same author claimed that colonialism kept Africa away from modernity, meaning that colonialism has negatively affected and disturbed what Africans think of themselves. This is referred to as a dehumanizing practice of colonialism, which left Africans in a deep and long-lasting identity crisis (Kebede, 1999).

Indications of failed development plans can be seen in African countries that have implemented strategies and policies informed by particular Western schools of thought and paradigms (Chambua, 1994). Development approaches vary between theory and practice. African countries that followed the development fads of the day failed to achieve development and had to restructure their economies (Chambua, 1994). Some modernization paradigms were developed at a time when African societies were still under colonial rule, while others were developed at a time when most African countries were just emerging from colonialism (Chambua, 1994).

In contrast, other contemporary scholars blame the underdevelopment of African countries on poor internal politics and propose that

historical explanations and underdevelopment are nothing but excuses for present-day shortcomings (Himmelstrand, 1994). It is, however, important to consider the impacts of the slave trade, the long-term effects of which were brutalized and demoralized human societies, a breakdown of fair transaction rules, and social disintegration (Himmelstrand, 1994).

In South Africa, development was marred by the apartheid system, which ensured that the whites in the country had access to the best of the education system, and resources were divided unevenly according to racial and class background (Khalema, 2004), the impact of which was to slow down the rate of development of black South Africans (Khalema, 2004).

Perhaps the 'missing link' between Weber's Protestant ethic theory of economic development and the development paradigms of the schools of thought discussed above, is the religious ingredient in the development process.

WEBER'S PROTESTANT WORK ETHIC THEORY

The PWE ideas developed by Weber suggest that we fulfill our duty to God by being diligent and hardworking because hard work contributes to the morals of the individual and to the health of society. The PWE further emphasizes that individuals need to put work before their families and view wealth as a major goal in life that will lead to leisure ('work now and enjoy later'). People that

subscribe to the PWE apply these values throughout their work experience (Arslan, 2001).

The strong link between Weber's Protestant ethic theory and the modernization theory cannot, therefore, be ignored. In "*The Protestant Ethic and the Spirit of Capitalism*" (1904/1905), Max Weber considered the impacts of the PWE in terms of economic development and theorized that economic development was driven by religious teachings. He argued that the religious teachings of John Calvin concerning work were directly related to the rise of capitalism. This was made possible through the concept of 'predestination' as described earlier in the chapter. According to the Protestant Ethic, those who had faith, performed good works and achieved economic success, were more likely to be among the elect. This motivated people to work hard, to save money, and reinvest it rather than spend it on worldly goods. Investments were made in land, equipment and labour (Chalfant, Beckley and Palmer, 1994). It is against such a backdrop that the spirit of capitalism grew and capitalism, according to the proponents of the modernization theory, is the economic system in which economic development occurs most rapidly. It is emphasized that, in fact, the countries that have been most successful at moving from low- to middle-income status typically have been those most centrally involved in the global capitalist economy. A good example provided is East Asian countries, which have successfully made the transition from low- to higher-income economies through factors such as high rates of savings, an aggressive work ethic among employees, and the fostering of a market economy (Rostow, 1971; 1978).

Weber notes, however, that with the secularizing influence of wealth, people often think of wealth and material possessions as the major (or only) reason to work. It is this idea of materialism motivating people to work instead of religious ideology, in modern society, that led to the examination of my respondents' degree of religiosity in this study. The religious professionals were assumed to hold different patterns of work VBAs from the less religious, or from 'non-believers' in the influence of religion in work. In the present study, therefore, differences according to religiosity were examined rather than differences based on religious denominations (since, according to Weber, the work ethic in modern societies is no longer Protestant).

The theory guiding the categorization of value orientations used in this study follows the sociological point of view, i.e. that differences in the meaning of work are most likely related to the social conditions under which individuals are employed. Therefore, not only occupational (medical ethics) but also socio-political ideologies, are considered as important components in understanding the social environment in which work is undertaken (Drucker, 1975). Accordingly, the following value systems are identified: individualism, collectivism, materialism, and humanism (Samuel and Lewin-Epstein, 1979). The Protestant work ethic emphasized individualism. The secular work ethic may be less oriented to individualism. In South Africa a collectivistic approach may prevail among certain groups of workers. Given the diversity of cultural values in the country, others might tend towards different

orientations. This study explores the orientations that are dominant in the sample, and the implications thereof.

According to Arslan (2001), Weber's thesis concerning religious individualism provides one of the important aspects of the PWE and 'the spirit of capitalism'. He observed that religious individualism was one of the important origins of secular individualism and that, according to Weber's thesis, Protestants tend to give more importance to economic rationality, regardless of their situation in society.

Contemporary developments show that Japan is an example of a non-Western country and culture that has succeeded in ridding itself of the traditional agrarian and aristocratic restrictive attitudes towards work and mobility. Applying the Weberian model to the Tokugawa religion, Bellah (1957) found, among the Japanese, aspects of a religious tradition with inherent elements comparable to those of the Protestant ethic. Looking at the special qualities of Japanese religion and culture, scholars have been able to specify functionally-relevant aspects of Confucianism and concluded that, when values are removed from imperial pretensions, these values have contributed towards the growth of a disciplined and practical attitude towards work. During the last two decades developments in other Asian nations, such as South Korea, Taiwan, Singapore, and Hong Kong, have led to them also being regarded as newly industrializing countries. These are successes, which according to Lipset (1990), have proved that fears about Chinese culture being antithetical to work and economic development were unfounded.

KEY WORKING HYPOTHESES

In accordance with the reviewed literature and the theories guiding the study, a number of assumptions were made at the outset of the study. These are outlined below, by way of summary of the reviewed literature that informed the study.

As discussed earlier in this chapter, work ethic values are culture-based. South Africa is a multicultural society; therefore it can be expected that workers from different social and cultural backgrounds will attach different meanings to their work and have a variety of work VBAs, resulting in different work value profiles. Given South Africa's history, it can be expected that Western and African meanings and values of work coexist (Atkins, 1993). Depending on which work VBAs workers subscribe to, they may identify with any of the following work orientations: materialist (preference for extrinsic rewards), humanist (preference for intrinsic rewards), collectivist (orientation toward others), or individualist work qualities (orientation toward self) (Samuel and Lewin-Epstein, 1979; Halman and Muller, 2006).

The second assumption made in this study, is that orientations to work would be expected to be influenced by factors beyond culture. A main focus in the literature has been on variations in the work ethic according to personality (Mirels and Garrett, 1971) and demographics (including age, gender, education, ethnicity) (Furnham and Muhiudeen, 1984; Hakim, 2003; Halman and Muller, 2006; Nolan, 2008; Meriac et al., 2009; Highhouse et al., 2010, among others). This study sought to establish whether social demographic

characteristics could explain variance in work-ethic profiles and orientations.

Research has shown that attitudes and beliefs associated with the work ethic may change or develop with actual experience of the workplace so that the longer one stays in the job the more one learns to adhere to the principles of the work ethic (Samuel and Lewin-Epstein, 1979). On the contrary, Buchholz's (1978a; 1978b) research found that young people entered the workforce with the individualistic notions that are commonly associated with the conventional Protestant work ethical principles. He observed that young people's individualistic orientations weakened with work experience.

Research has also shown that the more workers agree with the ideals of the PWE, the more they are satisfied with their job and life in general and the better they perform on the job (Blood, 1969; Miller et al., 2001). Blood also states that, in general, work ethic dimensions related significantly to job involvement, organizational commitment, and job satisfaction. While some quality-of-life scholars have found an association between happy workers and productivity (Zelenski, Murphy and Jenkins, 2008), others have reported uncertainty about the relationship (Wright and Cropanzano, 2004).

In South Africa, Pillay (2009a) identified job dissatisfaction as being responsible for high turnover and absenteeism of nurses in hospitals, which affected work efficiency and effectiveness, leading to poor health service delivery. Dissatisfied employees provided poor service

and paid less attention to their patients (Pillay, 2009b). Pillay's findings also highlight the dissatisfaction of nurses in the public sector in terms of their remuneration, work load, and the resources available to them compared to their private sector counterparts who were only moderately dissatisfied in these areas. Job satisfaction was also found to be dependent on the age of the nurse. Nurses older than 20 years were generally more satisfied with their work than was the case for younger nurses with less experience (Pillay, 2009a).

The modernization theorists argue that urbanization plays a role in shaping work VBAs. This is supported by Durkheim (1947), as earlier stated, who saw the creation of a new type of society when rural dwellers moved from closely knit communities held together by social solidarity and consensus (collective conscience) to the impersonal cities characterized by organic solidarity (looser ties with other members of society based on difference rather than similarity of work activities). According to Yankelovich et al. (1985), in traditional agrarian societies, people's reasons for working were predominated by the need for sustenance. Work was 'a necessary evil' for survival.

Orpen (1978) reported that black South African employees who had lived in a city for a long period of time and who had adopted Western attitudes and lifestyles scored higher on measures of the Protestant work ethic than those from rural areas and with a more traditional background. It is possible that medical professionals in the urbanized, more developed East London city setting might hold different work VBAs from those in the less developed rural towns of Alice and

Peddie in the Eastern Cape Province. Similarly, medical professionals who have a rural upbringing might differ — in the nature of their work values, attitudes and beliefs — from their colleagues who have experienced an urban upbringing.

Five hypotheses are therefore tested by the study in this thesis, namely:

1. Different demographic categories characterizing the sample — namely age, gender, educational level, religiosity, rural/urban environments, job level, work and job experience, income, marital status, and profession — would display differences in work ethic value profiles as described in the MWEP scale of Miller et al. (2002).

2. The overall mean score for the sample, in both the personal interviews and on the MWEP, would lie between the midpoint of the scale and the scale maximum.

3. The mean score of the sample on each of the seven MWEP dimensions would lie between the midpoint of the scale and the scale maximum. The mean scores on the seven dimensions of the MWEP would vary, depending on the level to which individual items that make up the dimensions are endorsed by respondents.

4. The dominant work orientation for the sample would be collectivist rather than individualist, and humanist as against materialist.

5. The work ethic scores for the sample would be strongly and positively correlated to job satisfaction and life satisfaction scores.

SUMMARY

This chapter has presented a review of the literature in respect of the main themes covered by the research questions. A detailed discussion of the origins of the concept of work ethic provides the background to the relationship between endorsement of the Protestant work ethic principles and the development of a capitalist economic system. Since its inception the concept of the work ethic has undergone some changes in its nature. Modern conceptualizations view the work ethic as more secular than in its original character but it is still very much ingrained in popular culture and its presence or absence among employees is a subject of major concern. A number of empirical studies based on the work of Max Weber on the relationship between religious work values and economic outcomes were reviewed. The Islamic work ethic was identified as having the same effect on behaviour patterns as the Protestant work ethic. The literature identifies a distinction between intrinsic and extrinsic orientations to religion. While individuals subscribing to the latter perceive religion as a means to a social or personal end, the former practise religion for

its own sake. It is therefore not uncommon to show commitment to religious practice but not apply it to work contexts. Intrinsic practice of religion was found to be a significant predictor of work-related ethics.

Culture was found to be an important determinant of work ethic orientation, with some cultures subscribing to individualism, others to collectivism, others to humanism, yet others to materialism. Levels of development are reported by some scholars as influencing work orientation while others dismiss this finding. Work orientations correspond to what Halman and Muller (2006) termed extrinsic and intrinsic work qualities. Individualistic societies tend to stress extrinsic work qualities, implying that there is a correlation between individualism and materialism. Humanism on the other hand, corresponds with intrinsic work qualities, therefore correlating to collectivism. These ideal types, however, may not exist in their pure form; a mixture is not uncommon.

Other correlates of the work ethic reported on in the literature which are still contested include age, work experience, gender, income, marital status, rural/urban contexts, job satisfaction and life satisfaction.

The medical ethics literature was reviewed to provide the historical background of what the medical profession stands for and its relevance for the work ethic. Violation of medical ethics incorporated in the Hippocratic oath may be related to non-endorsement of work ethic principles.

The discussion of the apartheid history in South Africa was provided as contextual background that might explain work behaviour patterns of local workers and to highlight some of the structural dilemmas of a society that has recently gained independence from political oppression.

Literature on development theory was reviewed to highlight the relationship between the work ethic and economic development as first proposed in Max Weber's essay on the Protestant ethic and the spirit of capitalism.

Finally the reviewed literature informs the formulation of some working hypotheses of the study.

The next chapter will explain the choice of research design and the methodological approaches followed to execute the design. The methodological weaknesses are identified in the last section of the chapter.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

INTRODUCTION

This chapter of the thesis introduces the research design and methodological paradigm to be followed in executing the design. It provides a detailed description of the study areas, defines the population of the study, the unit of analysis, data collection methods, and describes the sample – its size, the sampling tools and procedures, the time frame, the ethical standards that were observed, and identifies the data collection limitations that could affect the findings.

RESEARCH DESIGN

This is an empirical research study that utilised primary data, gathered by the author with the help of a research assistant. Its design combines elements from survey and qualitative designs in order to build on their complementary strengths. The two designs yield both numeric and textual data that render themselves to both positivist and interpretive understanding. This is because the variables measured were work values, beliefs and attitudes (VBAs) which are to a large extent personal and private attributes that are not easily accessible in a pure objective reality. Therefore the design strategy was a triangulation of paradigms and methods as explained in the methodology.

METHODOLOGY

The study is grounded in both qualitative and quantitative methodological paradigms in which a mixed methods approach to sampling, data collection, analysis and interpretation were utilised. The qualitative paradigm has a direct link with the interpretive epistemology which can be traced, again to Max Weber, among others. Weber argued that social science should study and learn the personal reasons or motives which shape a person's internal feelings and guide decisions to act in certain ways (Neuman, 2011). According to the interpretive science, most behaviour or statements can have several meanings and can be interpreted in various ways (Neuman, 2011).

Taking this as a point of departure this study triangulated the measurement of the work ethic from the perspective of the medical professionals themselves, their colleagues, their managers and their patients. The self-evaluation was done through two techniques: the self administered survey questionnaire (linked to the positivist epistemology) and less structured personal interviews. The personal interview technique was also used to gather information from colleagues, managers and patients of the nurses and doctors under study. The survey questionnaire method is typically informed by the positivist assumptions with great emphasis on quantitative data, rigour, exact measures, objectivity and statistics. While positivists focus on explanation of phenomena, interpretivist scientists focus on exploring, describing and understanding the object of study, thus a

combination of both is ideal for the purposes of the present study. Measuring phenomena from different viewpoints and angles emanates from the principle that "we learn more by observing from multiple perspectives than by looking from only a single perspective" (Neuman, 2011:164). Details of how the different approaches were combined to gain a deeper and more detailed understanding of the work ethic VBAs of medical professionals will become clearer in the sub-sections that follow, and in Chapters 4 and 5 where data from different sources are presented and interpreted.

STUDY POPULATION

The target population of the study was comprised of professional doctors and nurses with varying job and professional experience, working in selected urban and rural public hospitals in the Eastern Cape Province. Personal interviews were also conducted with hospital managers, the majority of whom were also medical nurses or doctors, and patients at the selected hospitals. The selected hospitals serve East London city and surrounding areas (Frere and Cecilia Makiwane hospitals), Peddie town and surrounding areas (Nompumelelo Hospital) and Alice town and surrounding areas (Victoria Hospital). The Eastern Cape Province was chosen for reasons given earlier in Chapter 1. The towns of Peddie and Alice, being more rural and less developed were chosen to provide a comparison to East London city, which is more urbanized (modernized) and relatively developed. The specific hospitals were chosen because they were the main public hospitals serving their areas.

It is also important to note that the two rural hospitals do not appear to have been subjected to the negative publicity suffered by both the urban hospitals. In fact, almost all hospitals, even the ones in other provinces of South Africa, that have acquired reputations for poor service delivery, have been located in urban areas. This is part of the reason a rural context was included, for comparative analysis. The second reason for studying the medical professionals in both the rural and urban contexts relates to the supposition that the level of development co-varies with trends associated with work ethics.

Units of analysis were individual professional nurses and doctors. Respondents with variable work experience (in terms of number of years worked) within the medical profession were included in the sample so as to test a hypothesis that work ethic VBAs vary according to work experience. A number of geographical locations (social contexts) were chosen, based on the assumption — put forward by the modernization theorists and other scholars — that urbanization plays a role in shaping work VBAs. Other demographic variables — including gender, age, marital status, income level, and educational level — were also introduced into the study because of disagreements in the literature: some researchers found differences in work ethic according to selected demographic categories, while others did not. The aim of this study was to find out about the situation in a South African context, since almost all the research reported in the literature has been conducted in the developed world.

SAMPLE SIZE AND SAMPLING METHOD

The urban hospital complex that includes the Cecilia Makiwane and Frere hospitals employs 302 doctors and 1500 nurses. The rural hospitals under study employ a total of 14 doctors and 191 nurses: 6 doctors and 72 nurses in Victoria Hospital and 8 doctors and 119 nurses in Nompumelelo Hospital.

Subjects for the survey questionnaire were selected using purposive sampling, whereupon any professional nurse or doctor, who met the criterion for the study, could form part of the sample. Due to the unwillingness of some medical professionals to participate in the study, the respondents could not be proportionately selected according to geographical location. A deliberate attempt was made to include a broad cross section of respondents in terms of age and gender, religiosity and work experience. The sample was comprised of two sub-samples since two methods of data collection were employed: one for the survey questionnaire and the other for the personal interviews: The sample for the survey questionnaire comprised of only professional nurses and doctors. This sub-sample consisted of a total of 174 professionals of which 108 were nurses and 66 were doctors.

The sample for the personal interviews was originally intended to comprise three administrators, three nurses, three doctors and three patients from each hospital. However, due to the sensitivity of the topic of study and given the negative publicity that hospitals — especially the ones in East London — had received in the past few

years concerning poor service delivery, it was difficult to achieve this goal. The media referred to “witch hunts” launched by the East London Hospital Complex to find ‘whistle blowers’ willing to leak reports to the media (*Daily Dispatch*, 7 March 2011).

Participants for personal interviews, 41 in all, were chosen using purposive sampling, as in the survey questionnaire. This added up to a total sample of 215 respondents for the entire study.

DATA COLLECTION METHODS

Questionnaires were handed out for respondents to complete on their own, while the personal interviews were carried out by the writer of this thesis and an assistant.

Although it was intended that focus group discussions would follow this first phase of data collection, in order to validate the findings from the questionnaires, all respondents — without exception — turned down the request to participate, due to fear of victimization if they were found out or reported. This difficulty was a result of the negative publicity that the hospitals were experiencing at the time.

The self-administered questionnaire method of data collection was advantageous in that it enabled respondents to remain anonymous.

The personal interview and the self-administered questionnaire method complement each other in the following ways: responses obtained can be confirmed and checked, possible gaps in the data can

be filled and uncovered ground can be identified more easily. The questionnaire items that were used required both qualitative and quantitative interpretation. Self-administered questionnaires were also structured to include checks for reliability of responses. However, it was deemed unnecessary to translate the questionnaire into isiXhosa since all of the respondents had a reasonably high educational level.

The questionnaire and the interview items included both open- and closed-ended questions covering demographics, work-related factors, job performance, and job and life satisfaction. Work ethic was measured using the Multidimensional Work Ethic Inventory (Miller et al., 2001; 2002) which measures work ethic on seven dimensions: morality, hard work, centrality of work, wasted time, delay of gratification, self reliance, and leisure.

Table 3.1 below lists the seven work ethic dimensions together with their definitions as given by Miller et al. (2001; 2002).

Table 3.1
The Multidimensional Work Ethic Profile by Miller et al. (2001/2002): dimensions and their definitions

Dimension	Definition
Self-reliance	Striving for independence in one's daily work
Morality/ethics	Believing in a just and moral existence
Leisure	Pro-leisure attitudes and beliefs in the importance of non-work activities
Hard work	Belief in the virtues of hard work
Centrality of work	Belief in work for work's sake and the importance of work
Wasted time	Attitudes and beliefs reflecting active and productive use of time
Delay of gratification	Orientation toward the future; the postponement of rewards

Table 3.2, below, presents the seven dimensions together with the items by which they were measured. These items are numbered as they appear in the questionnaire. The first five dimensions in the table have ten items each and the last two dimensions (wasted time and delay of gratification) each have eight and seven items, respectively.

Table 3.2
The Multidimensional Work Ethic Profile by Miller et al. (2001/2002): Dimensions and their items

Item No.	Dimensions and their items
	Self-Reliance
68	To be truly successful, a person should be self-reliant
83	Self-reliance is the key to being successful
88	People would be better off if they depended on themselves
90	As much as possible, one should live one's own life, independent of others
94	One must avoid dependence on other persons whenever possible
96	I do not like having to depend on other people
106	I strive to be self-reliant
112	Having a great deal of independence from other people is very important to me
117	Only those who depend on themselves get ahead in life
121	It is important to control one's destiny by not being dependent on others
	Morality
69	One should always take responsibility for one's actions
77	One should always do what is right and just
78	I would take items from work if I felt I was not getting paid enough
87	One should not pass judgment until one has heard all of the facts
99	You should never tell lies about other people
110	Stealing is alright as long as you don't get caught
113	It is important to treat others as you would like to be treated
116	It is never appropriate to take something that does not belong to you
119	There are times when stealing is justified
123	People should be fair and just
Leisure	
67	Life would be more meaningful if we had more leisure time
70	I would prefer a job that would allow me to have more leisure time
76	The more time I can spend in leisure activity, the better I feel
80	The less time one spends working and the more leisure time one has, the better
89	Work takes up too much of our time, leaving little time to relax
93	More leisure time is better for people
105	The world would be a better place if people spent more time relaxing

111	The job that provides the most leisure time is the job for me
120	People should have more leisure time to spend in relaxation
125	Leisure time activities are more interesting than work
Hard Work	
79	Nothing is impossible if you work hard enough
82	Working hard is the key to being successful
84	If one works hard enough, one is likely to make a good life for oneself
86	Hard work makes one a better person
97	By working hard, one can overcome every obstacle that life presents
100	Any problem can be overcome with hard work
107	If you work hard you will succeed
109	Anyone who is able and willing to work hard has a good chance of succeeding
115	A person should always do the best job possible
122	By simply working hard enough, one can achieve one's goals
Centrality of Work	
64	I feel uneasy when there is a little work for me to do
66	I feel content when I have spent the day working
72	Even if I were financially able, I would never stop working
75	A hard day's work is very fulfilling
92	It is very important to always be able to work
95	Even if I inherited a great deal of money, I would continue to work somewhere
102	Even if it were possible for me to retire, I would still work
103	Life without work would be very boring
114	I experience a sense of fulfilment from working
126	A hard day's work provides a sense of accomplishment
Wasted Time	
63	It is important to stay busy at work and not waste time
71	Time should not be wasted, it should be used efficiently
74	I schedule my day in advance to avoid wasting time
85	I constantly look for ways to productively use my time
98	I try to plan out my workday so as not to waste time
101	How a person spends their time is as important as how they spend their money
118	Wasting time is as bad as wasting money
127	Distaste for hard work usually reflects a weakness of character
Delay of Gratification	
65	If I want to buy something, I always wait until I can afford it

73	I get more fulfilment from items I had to wait for
81	Things that you have to wait for are the most worthwhile
91	A distant reward is usually more satisfying than an immediate one
104	I prefer to save until I can buy something instead of buying it on credit
108	The best things in life are those you have to wait for
124	The only way to get anything worthwhile is to save for it

TIME FRAME

The personal interviews and the questionnaire survey were carried out in January 2009.

DATA ANALYSIS

Mean scores for the sample were calculated on the different dimensions of the work ethic. The mean score on all dimensions combined provided the 'overall work ethic mean score'. Mean scores on each dimension and all dimensions combined were also calculated for each demographic category. Differences on overall work ethic and dimension mean scores among demographic categories were calculated using one way Analysis of Variance (ANOVA). Pearson correlation analysis was used to determine the relationships between work ethic, job satisfaction, and life satisfaction.

Work ethic profiles were compiled on the basis of the rank-ordered dimension mean scores for each demographic category in order to explore dominant work VBAs and their implications for service delivery in the workplace.

Data from the personal interviews were analysed qualitatively and manually. The small sample size made manual analysis possible. Quantitative analysis of some of the data was also done in cases where it was important to determine who held what perceptions regarding work ethic values, beliefs and attitudes. In such instances, frequency distributions were utilized. Such data were also analyzed for content and responses compared to establish patterns, similarities and differences among the various interviewee categories.

LOCATION OF STUDY AREAS

The Eastern Cape Province, with its capital being located at Bhisho, incorporates the former so-called homelands, known as the Transkei and Ciskei. The province is home for the Xhosa and for many prominent South Africans, including former presidents Nelson Mandela and Thabo Mbeki. It is the second largest province in the country, with a population of 6 527 747, making it the third most densely populated (2007 Census Statistics).

At least 80% of the residents of this province speak isiXhosa, while the remainder is made up of predominantly Afrikaans, English, isiZulu and SeSotho speakers.

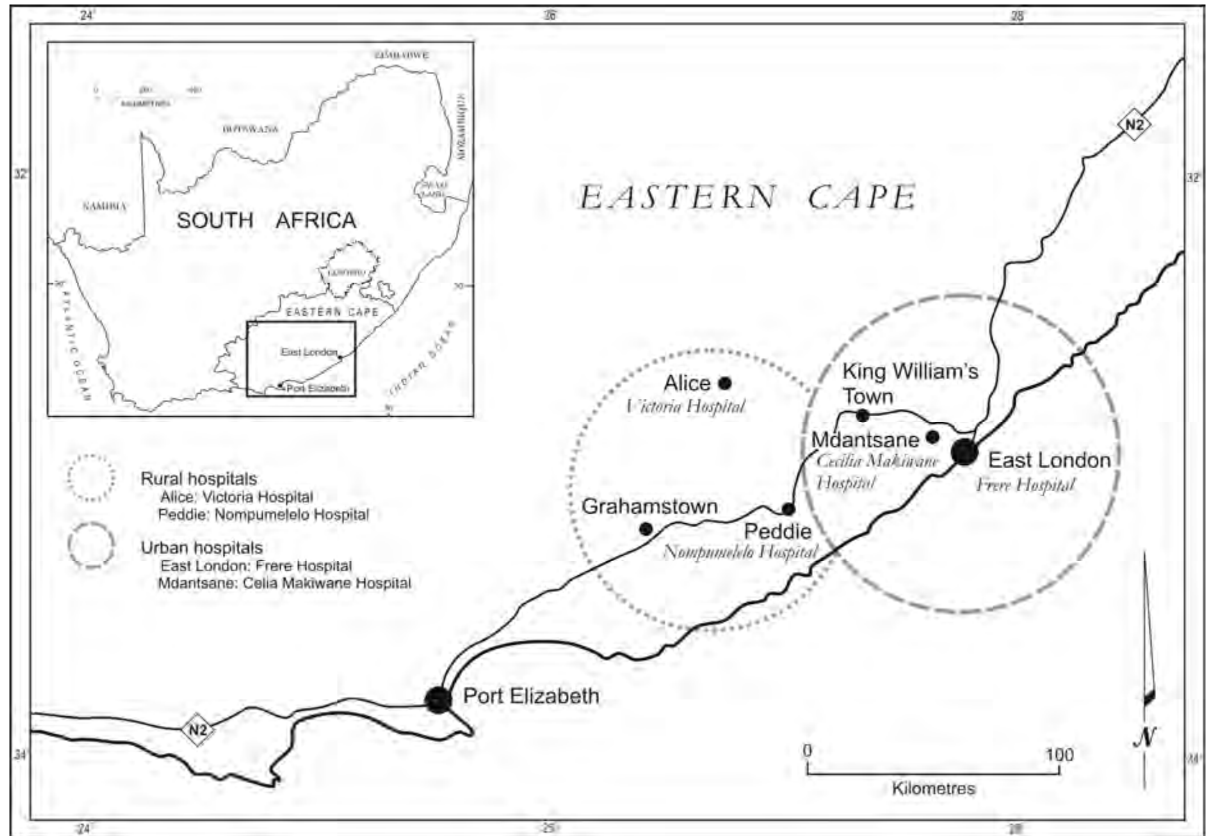
The province remains one of the poorest in South Africa with poverty levels, inherited from former homelands, sometimes being extreme. Subsistence agriculture is the main economic activity.

The province, however, has two major industrial centres —namely, Port Elizabeth and East London — both with well-developed economies, based on the automotive industry. General Motors and Volkswagen are the pride of Port Elizabeth while East London is the home of Daimler Chrysler.

THE STUDY HOSPITALS

The four hospitals in the study are categorized as urban (Frere and Cecilia Makiwane) and rural (Victoria and Nompumelelo). The hospitals within each category are located within a 50 kilometre radius from each other.

The locations of the four hospitals are shown in the map below.



Frere Hospital

Situated in East London, Frere Hospital was opened on the 7th September 1881 and was named after the Right Honourable Sir Henry Bartle Edward Frere, who was governor of the Cape Colony from 1877 to 1880. At the time, East London had only a handful of doctors. Today, however, the number of doctors and nurses is much higher although still too few to meet the required standard of

doctor/patient and nurse/patient ratios. This is a major problem in South Africa in general. The doctor/patient ratio is 7.7 doctors per 10 000 people. In the Eastern Cape Province the ratio is even lower, at 2.7 doctors per 10 000 people.

At present, the Frere Hospital has more than 910 beds, with a personnel staff of 2 643. The average length of stay of patients is 10 days.

The mission of the hospital places emphasis on providing a clear sense of purpose regarding the hospital's need to achieve a high performance hospital complex, focusing on equity, efficiency, quality and sustainability. The hospital further strives to provide a leadership and guidance framework that can address some key challenges it is facing.

The stated vision of the hospital is to provide excellent healthcare services to all and become the healthcare provider of choice.
Its list of core values are comprised of: Honesty, Empathy, Accessibility, Loyalty, Trustworthiness, Humility, Evolving, Liaison, Horizon and Commitment (Lazarus, 1987).

Frere Hospital, together with Cecilia Makiwane Hospital and the East London mental health unit, form what is now known as the East London Hospital Complex, established in 2002. This is a massive complex serving a population of nearly three million people. Specialists rotate through the hospitals as there are not enough skilled staff to keep services going both for Cecilia Makiwane and Frere

Hospitals simultaneously. It is therefore difficult to know the exact number of doctors serving the hospital since they work across the three hospitals. For the whole complex there are 302 doctors, and 1500 nurses. An estimate would be approximately 100 doctors and 500 nurses per hospital.

Cecilia Makiwane Hospital

Cecilia Makiwane Hospital is a provincial referral hospital that forms part of the East London Hospital Complex. It is located in Mdantsane Township, the second largest township in South Africa after Soweto. The hospital is situated approximately 23 km from the business centre of the city of East London and was named after one of the nurses who had served the hospital with such dedication that she won the respect of the community. One of her contributions was that of being a forerunner in the training of nurses among black women in South Africa. Moreover she was registered as the first black professional nurse. Black women had very few career opportunities during the apartheid era in South Africa. The few opportunities available to them were in the areas of nursing, teaching or social work. Apart from naming the present Cecilia Makiwane hospital after Cecilia, a statue was also erected by the nurses of South Africa at the Lovedale hospital (Steensma, Shampo and Kyle, 2005).

The mission of Cecilia Makiwane Hospital is to empower the health service providers for proper utilisation of available resources in providing excellent services to patients in line with the *Batho Pele* principle.

The vision of the hospital can be summarised as follows: integrated service delivery, accessibility, equity, sustainability and sensitivity to the needs, expectations and belief systems of patients.

The core values of the hospital include: Honesty, empathy, accessibility, loyalty, trustworthiness, humility, evolving, liaison, horizon, and commitment.

Victoria Hospital

Situated about 3 kilometres from Alice on the Ntselamanzi Road, Victoria Hospital serves a population of about 83 000. It owes its origin to the founding of the Lovedale Missionary Institution and was the first hospital to be established for black people in South Africa under the auspices of missionaries. The hospital owes its name to the fact that the first building grant given by the then apartheid government was taken from a fund derived from Native taxation and set apart to be used for some purpose in honour of the Diamond Jubilee of Queen Victoria. It was opened in 1898, with 20 beds, under the direction of Dr McCash and Miss Wallace, the first matron. The hospital closed in 1899 due to the outbreak of war, but re-opened in 1903, with Dr Neil Vicar as the medical superintendent and Miss Mary Balmer as matron.

The aims of the hospital were declared as follows in a 1952 document:

> To provide for medical treatment of natives and Europeans in the wards or at the dispensary.

To provide for the training of blacks as hospital assistants and nurses.

To provide a short course in elementary medicine and nursing for intending missionaries and others likely to benefit by it.

To diffuse among all classes a better knowledge of personal and domestic hygiene and the care of the sick.

To attend to the spiritual welfare of patients.

In the late 1890s and early 1900s, African people reportedly had no confidence in the hospital, seeing it as a place of death. It was not until a few Africans suffered injuries as a result of a train disaster that they recognized the importance of making use of hospital services. After they had seen the casualties recovering quickly and going back home, they started visiting the hospital on their own initiative for treatment. The wards of Europeans were closed in 1904 as a result of the negative behaviour of the Europeans who showed no respect for the black nurse probationers (Shepherd, 1971).

The mission of the hospital is to "provide a 24 hour quality care service by adequately skilled and committed health practitioners that are accountable for efficient service delivery". Its vision is "a hospital service promoting a better quality of life for all our clients."

The stated core values are apparently also linked to the name of the hospital as follows:

V: Venerable

I: Integrity

C: Caring

T: Trustworthy

O: Openness

R: Responsibility

I: Initiative

A: Accountability

Nonpumelelo Hospital

Nompumelelo Hospital is situated approximately 3 km from the N2 national road, about halfway between King Williams Town and Grahamstown in a small town called Peddie, in the Eastern Cape Province. It serves the population of Ngqushwa Municipality, which is part of the greater Amathole District Municipality. Nompumelelo serves 23 clinics that are spread out within a radius of about 50 km. It serves 9 397 people from all population groups.

The hospital's mission is "to promote inter-sectoral collaboration within the institution capable of delivering good quality healthcare services to all people and to monitor such services so that health for all is achieved." The hospital purports to uphold the following core values: Commitment, accountability, culture of team work, attitude, caring and quality.

MEDIA REPORTS ON THE HOSPITALS UNDER STUDY

The hospitals under study were subjected to heavy media publicity prior to the commencement of the fieldwork. Frere Hospital in East London was singled out when a high number of babies died mysteriously at the same time. In the course of an investigation by

the *Daily Dispatch* in 2007, prompted by these sudden deaths, reporters attended mass burials of the dead babies. In their interviews with hospital staff and grieving mothers they found that the deaths were generally blamed on "outright negligence, exhausted staff, and lack of equipment" (*Daily Dispatch*, July 13, 2007). A former hospital gynaecologist admitted to the *Daily Dispatch* that, "Mothers and babies die at an alarmingly high rate". He reported that the figures for 2006 were officially the highest on record and that at least 199 stillborn babies had been recorded that year (*Daily Dispatch*, July 12, 2007).

According to the *Daily Dispatch,* internal documents showed that senior management had known for years that the situation was out of control but they did little to address the crisis. Minutes taken at weekly management meetings revealed damning admissions by doctors that patients were dying because of outright negligence. (*Daily Dispatch*, July 12, 2007).

During the interviews with grieving mothers, reporters for the *Daily Dispatch* were told of stories of these mothers' experiences with "negligent" hospital staff. Some mothers "complained of sitting on wooden benches in prolonged labour, wearing blood-soaked clothes and being left unattended during and after birth". Others blamed insufficient equipment for the deaths of their babies. "You feel so helpless, as the deaths could have been avoided if there was enough equipment," said one maternity nurse (*Daily Dispatch*, July 12, 2007).

The above events took place in 2007, following which the then minister of health promised a set of corrective measures including:

1. A budget increase for the East London Hospital Complex, which includes Frere and Cecilia Makiwane, from R3.5m to R35m
2. Urgent recruitment of clinical and support staff
3. An additional labour ward
4. Six additional foetal heart monitors and an ultrasound scanner
5. New incubators and neonatal ventilators to replace the old ones
6. Hiring porters, messengers, general assistants and clerical staff to relieve staff of these extra duties outside their job description
7. A new maternity ward for Frere hospital, etc (*Daily Dispatch*, March 3, 2011)

However, four years on very little is reported to have been done about the above promises. Despite promises of action, nothing has changed in the hospitals in the past four years. The *Daily Dispatch*'s 7 March front-page headline again read: "Baby deaths hit Frere". The article states that during January and February 2011, 37 babies died in 48 days at Frere Hospital. This infant mortality rate is reportedly the highest ever recorded. The cause of death for five of the children was recorded by the hospital as "unknown" (*Daily Dispatch*, 7 March, 2011.

A few days earlier, the same reporters (*Daily Dispatch,* March 3, 2011), also through a front-page headline, "How superbugs killed EC babies", revealed that 13 newborns had died in the same hospital

complex, but this time, at Cecilia Makiwane in January 2011. The cause of death was reported to be a deadly bacteria known as Klepsiella, a gram negative bacteria, which infects the blood stream. The same infection had been reported at Mahatma Ghandi Hospital in Durban in 2005 which killed 26 people. By the end of the month a further 29 babies had died at Cecilia Makiwane. According to the reporters, the 37 babies at Frere hospital had also died of the same infection – Klepsiella

As the editor of the *Daily Dispatch,* Mkhabela (2011) laments: "Dying babies, unfortunately, have become synonymous with East London." The history of the East London hospital complex in 2007 is repeating itself in 2011 (*Daily Dispatch*, March 9, 2011).

Other isolated incidents of suffering patients at the same hospital complex continue to be reported. The *Daily Dispatch* tells the story of 29-year-old Thembelani Tola, who was sent home to 'rot' by Frere hospital nursing staff, "for Christmas", despite the fact that he was chronically ill and suffering maggot-infested bed-sores. Nurses told Tola's mother "to wash her son herself, because they could not touch him". Following the publication of this incident by the *Daily Dispatch*, the boy was taken in by a hospice whose manager had read the story in the paper. Tola was subsequently able to talk to the reporters while at the hospice and reported to be recovering well (*Daily Dispatch*, January 13, 2011)

ETHICAL CONSIDERATIONS

This study and the methods used in it, were given clearance by the Rhodes University Ethics Committee. Respect for non-participation on the part of potential respondents was endorsed, as were anonymity, confidentiality and informed consent. The former two aspects were particularly important when conducting face-to-face interviews. For example, in most cases, the names of interviewees were not revealed to the interviewer. All known names have been removed from reports on the research findings. Results from the interviews are presented unaltered no matter how sensitive and contradictory they appear to be. The interpretive paradigm avoids stereotypical value judgements when analysing and interpreting, in order to access the reality of subjects from their own perspectives. As part of the dissemination of information process, I intend to give participating hospitals feedback on the findings of the study, together with relevant recommendations, to share with their staff. I hope that the hospitals will allow me to have a meeting with their professionals to discuss the findings and recommendations with them. The latter scenario would perhaps be the most effective, if permission is granted.

DATA COLLECTION LIMITATIONS

The following limitations at the data collection phase are acknowledged:

a. Out of a sample of 300 respondents anticipated in the initial proposal, only 222 participated in the final study. Reasons for this have been explained above.

b. The number of doctors and nurses and other demographic categories could not be matched.

c. The majority of the personal interviews could not be conducted by the present writer, apparently because the writer is a foreign national. It was found that prospective interviewees did not believe that the researcher would conceal their identity, so they were concerned about how and where the findings would be published. To overcome this problem, the services of a male research assistant were obtained. He spoke the same language as the majority of the respondents and had relatives who worked in the same profession as the respondents. As a result, some information that could have been obtained through deeper probing was lost. Given the trust situation, recording devices, such as tape recorders, could not be used.

d. The study was conducted during the height of negative publicity on the urban hospitals under study. This could have affected the responses as respondents may have answered in a 'socially desirable' manner.

Despite the above limitations, the results presented in this thesis are based on authentic responses that have not been altered or manipulated in any way.

SUMMARY

This chapter has explained the design of the study and the methodology used to achieve the desired design. A mixed methods approach was preferred due to the nature of data required. The two methods complemented each other in uncovering what the one method might have concealed. The study population, and sample were described in detail. The sample sizes for the various sub-samples and categories within sub-samples were explained. The questionnaire survey only required a sample of medical professionals who evaluated their own work ethic. The personal interviews were conducted with a sample of medical professionals, managers and patients. The medical professionals evaluated themselves and their colleagues; while the managers and patients assessed the work ethic of the medical professionals. To date, evaluations of work ethic in the literature have only been done through self-evaluation. This study included both self and other evaluation to close the gap. The Miller et al. MWEP was used as the sole instrument for the survey questionnaire along with additional variables to measure job and life satisfaction and work orientations. The instrument for personal interviews was constructed by the author.

Details relating to the choice of study area and hospitals were provided and the study hospitals were described. The research ethics that guided the research were explained and the limitations of the data collection methods which could have introduced biases in the study were enumerated.

The next chapter reports and interprets the results from the personal interviews which will later be compared to the results from the survey questionnaire.

CHAPTER FOUR

RESULTS FROM THE PERSONAL INTERVIEWS

INTRODUCTION

This chapter reports on the data collected through personal interviews with managers, medical professionals, and patients in four hospitals. Frere Hospital in the city of East London and Cecilia Makiwane Hospital (also referred to as CM in this chapter) represented the urban setting; Nompumelelo Hospital in Peddie and Victoria Hospital in Alice represented the rural setting.

The results are presented and interpreted according to themes addressed in the interview guide (see appendix). Results are also reported as per hospital and according to interviewee category, namely: management, doctors, nurses and patients. For the purpose of further summarizing and condensing data, the categories of doctors and nurses are, in some instances, combined and discussed as one category of professionals.

The different interviewee categories had different interview guides. Some themes appeared only in some schedules and not in others, depending on their relevance to the specific interviewee category. The main themes included the following:

Demographic characteristics of the sample;
The relationship between religion and work;

The work ethic: its meaning, and how it is indicated and evaluated;

The patient's attitude towards the health services received at the hospitals where they were treated;

Job satisfaction of managers, doctors and nurses;

The 2006 strike by medical professionals.

SAMPLE CHARACTERISTICS

Table 4.1 shows the distribution of the sample according to hospital sites and respective geographical (rural /urban) setting.

Table 4.1
Distribution of respondents according to hospital

	Nompumelelo (Rural)	Victoria (Rural)	CM (Urban)	Frere (Urban)	Total
Managers	3	3	3	3	12
Doctors	1	1	2	4	8
Nurses	2	2	3	2	9
Patients	3	3	3	3	12
Total	9	9	11	12	41

As indicated in Table 4.1, the sample composition of interviewees was as follows: 12 management level personnel, eight doctors, nine nurses and 12 patients. The total number of interviewees per hospital was as follows: nine interviewees from Nompumelelo, nine from Victoria, 11 from Cecilia Makiwane and 12 from Frere.

The total number of interviewees from the rural hospitals was 18 while that from urban hospitals was 23. The reason for interviewing more respondents in the urban hospitals was because there were more

ofcomplaints raised, by management and patients, in these hospitals than was the case in the rural hospitals. In order to probe these problems further, extra interviews had to be conducted with a further four doctors and one nurse. As a result, six doctors were interviewed at the urban hospitals compared to two at the rural hospitals. As Frere Hospital seemed to have more problems than Cecilia Makiwane, twice as many doctors were interviewed there. Four were interviewed at Frere and two at Cecilia Makiwane. The total sample was therefore 41 interviewees.

The distribution of the sub-samples from the rural hospitals, according to job levels, is summarized in Table 4.2 and that from the urban hospitals in Table 4.3.

Table 4.2
Rural sub-sample distribution according to job level

Rural Sub-sample	**Number of interviewees**
1. **Management**	
Hospital manager	2
Departmental director	2
Nursing director	1
Assistant director	1
2. **Doctors and nurses**	
Doctor	2
Professional nurse	1
Enrolled nurse	3
3. **Patients** (employment)	
Unemployed	4
Domestic worker	1
Teacher	1
Total	18

Table 4.3
Urban sub-sample distribution according to job level

Urban Sub-sample	**Number of interviewees**
1. **Management**	
Hospital manager	1
Superintendent	1
Operational manager	1
Senior administrator	1
Director	1
Assistant Director	1
2. **Doctors and nurses**	
Doctors	6
Professional nurse	2
Enrolled nurse	3
3 **Patients** (employment)	
Unemployed	4
Domestic worker	1
Teacher	1
Total	23

Tables 4.4a–4.4c show the demographic make-up of the sample categories: management (Table 4.4a), doctors and nurses (Table 4.4b), and patients (Table 4.4c).

Table 4.4
Sample distribution according to demographic characteristics

4.4a: Demographics: Managers

	Rank[1]	Age	Gen-der	Nationality	Popu-lation group	Job level[1]	Ex-perience	Religion
Victoria								
1		51	F	SA	Xhosa		7 years	Anglican
2		60	M	SA	Xhosa		10 years	Methodist
3		49	F	SA	Xhosa		11 years	Anglican
Mpumelelo								
1		38	M	SA	Xhosa		8 years	7th Day Adventist
2		43	F	SA	Xhosa		7 years	Anglican
3		44	M	SA	Xhosa		6 years	Methodist
CM								
1		37	M	SA	Coloured		4 years	Muslim
2		47	M	SA	Black		6 years	Islam
3		36	F	SA	Xhosa		5 years	Methodist
Frere								
1		41	M	SA	Xhosa		10 years	None
2		39	F	SA	Black		5 years	Anglican
3		40	M	SA	Black		6years	None

[1] Information relating to rank and job level, which was reported in the original, has been removed to protect identities

4.4b: Demographics: Doctors and nurses

	Rank	Age	Gender	Nationality	Population group	Job level	Experience	Religion
Victoria								
1	Doctor	40	M	SA	Indian	Doctor	15 years	Islam
2	Nurse	33	F	SA	Xhosa	Professional nurse	10 years	Anglican
3	Nurse	35	F	SA	Xhosa	Enrolled nurse	8 years	Anglican
Mpumelelo								
1	Nurse	26	F	SA	Xhosa	Enrolled nurse	6 years	Anglican
2	Nurse	42	F	SA	Xhosa	Enrolled nurse	7 years	Methodist
3	Doctor	53	M	SA	Indian	Doctor	20 years	Islam
CM								
1	Nurse	27	F	SA	Xhosa	Enrolled nurse	7 years	Presbyterian
2	Nurse	57	F	SA	Xhosa	Senior enrolled nurse	26 years	Faith mission
3	Nurse	23	F	SA	Xhosa	Assistant nurse	4 years	AME
4	Doctor	51	M	SA	Xhosa	Doctor	30 years	Atheist
5	Doctor	59	M	SA	Xhosa	Doctor	35 years	PCA
Frere								
1	Nurse	56	M	SA	Coloured	Professional nurse	15 years	Methodist
2	Doctor	40	M	SA	Black	Doctor	27 years	Methodist
3	Sister	35	F	SA	Black	Nursing sister	5 years	Methodist
4	Doctor	55	M	SA	Pakistani	Doctor	35 years	Islam

4.4c: Demographics: Patients

	Occupation	Age	Gender	Nationality	Population group	Period in hospital	Religion
Victoria							
1	Domestic worker	35	F	SA	Xhosa	2 months	Methodist
2	Teacher	25	F	SA	Xhosa	3 weeks	Anglican
3	None	18	M	SA	Xhosa	1 month	Methodist
Mpumelelo							
1	Unemployed	50	F	SA	Xhosa	6 months	Anglican
2	None	23	F	SA	Xhosa	2 months	AME
3	Unemployed	25	F	SA	Xhosa	2 months	7th Day Adventist
CM							
1	None	25	F	SA	Xhosa	2 months	Methodist
2	Teacher	31	F	SA	Black	2 months	Methodist
3	Unemployed	20	M	SA	Xhosa	2 weeks	ZCC
Frere							
1	None	55	F	SA	Xhosa	6 months	African
2	Retired teacher	60	F	SA	Black	6 months	Protestant
3	Unemployed	59	M	SA	Xhosa	4 months	African

The demographic information in the above tables has not been discussed in detail as it does not seem to play a role in shaping the opinions of interviewees regarding the work ethic of nurses and doctors. It can be observed from the tables that there were a number of non-mother-tongue isiXhosa speakers in the sample, although they

were all South African. These included two Indian doctors, one Pakistani doctor and one black doctor as well as one black nurse, three black managers and two patients. The latter interviewees preferred to identify themselves as simply 'black' instead of specifying their ethnic group. That was respected.

The ages of the interviewees varied greatly: the majority of managers were in the 30–49 year group; the doctors were dominated by those in the 50–59 year group; the nurses were relatively young with the majority in the 23–35 year group, and the patients were predominantly in their early 20s with only three in the 50 years and above group.

In terms of gender, the managers comprised seven males and five females; the doctors were all male except one. Similarly, the nurses were all female except one and the patients comprised nine females and three males. The gender composition of the doctor and nurse category is not surprising as these are highly gendered professions. In South Africa nursing is typically a 'female career' and being a doctor an almost exclusively 'male career'.

With respect to professional experience, the doctors had much more experience in comparison with the nurses. All the doctors had more than 14 years experience and three had been in the profession for 30 years or more. The nurses tended to be more inexperienced. All of them, except two, had been in the profession for less than 10 years. Of the latter, one had 10 years experience and the other 26 years experience. This limited job experience is not surprising though since

these nurses were quite young. Only two nurses were more than 50 years old, one being 56 and the other 57. The managers were not asked the question on experience, since their work ethic levels were not assessed in the personal interviews as that would have necessitated revealing their names. Moreover, the patients would not be in a position to evaluate them as they only interacted with those managers who were also practising professionals.

It is important to note that the period of time that the patients spent in hospital ranged from two weeks to six months, with half of that number (six out of 12) having been hospitalized for two months and three of them having been in hospital for six months. This length of time spent interacting with the doctors and nurses is of great significance in that the patients' assessment of the work ethic of their doctors and nurses is based on fairly long experience. As such it can be considered more reliable than responses from patients who have been outpatients or have had only a few days' contact with their doctors and nurses.

FINDINGS

THE ROLE OF RELIGION IN WORK AND OUTLOOK ON LIFE

A number of studies, following on Weber's work, have reported a relationship between religion and principles relating to work ethics. This relationship is re-investigated in the present study. One of the themes discussed with the interviewees concerned the influence of

religion in their work and outlook on life. The following question was asked: “*Does religion play any role in your work and in your outlook on life?”*

A substantial proportion of interviewees, particularly doctors and managers, indicated that religion played a role in their work and outlook on life, as described in the next section.

Managers’ views on religion and work

Among the managers in rural hospitals, all except one said religion played a role in their work and outlook on life. The two sets of roles identified were the motivational and encouraging roles. They specifically reported that religion encourages them to ‘do good’. In other words it is a religious virtue to do good to others. Applied to their profession it could be expected that such religious beliefs would motivate these health workers to commit to their work and do a good job when they treat their patients, which would in turn give them intrinsic satisfaction. This applies to everything they do in life in keeping with their stated focus of ‘doing good’.

Managers in urban hospitals on the other hand, were divided in their responses: two reported that religion did play a role in their work and outlook on life. One of these, a Muslim, said religion played a constructive role; the other, who was not attached to any particular religious denomination, said he was not sure of the role that religion played, although he felt that it definitely played a role. A third manager would not respond to the question at all claiming that, “it was personal”. The other three managers said religion did not play a

role in their work. One of the latter was a Muslim and the remaining two were not associated with any religious denomination.

Doctors' views on religion and work

The two doctors from the rural hospitals both felt that religion played a role in their work and outlook. One said this was a "spiritual role", while the other said religion played a "constructive role". The spirituality in work expressed by the one doctor had the same implied meaning as doing good. By constructive role is meant religion had a positive influence which may be similar in meaning to the motivational role of commitment to work and doing a good job.

Of the doctors in urban hospitals, one said religion played no role in his work, and the one atheist among them did not completely dismiss the role of religion, but cautiously stated that, "it did not *per se* play a role". The rest believed that religion played a role. The justification by one of them for his belief was that he was subjected to religion at a very early age, so it should play a role. In other words, religion was so ingrained in him that it unconsciously influenced his job performance and his understanding of life. One doctor said that his religious belief encouraged him to be hardworking. Another, a specialist, echoed the statement of the first one, saying that religion "is a socializing agent so it acts as a guiding spirit". The last doctor claimed that, "As a result of religion, I am hardworking, respectful and effective". He added that, because of religion, he is "more focused".

The religious values which underlie the responses by the doctors in urban hospitals cannot be ignored. Those doctors who said religion played a role in their work and outlook on life, expressed the following thoughts and principles that relate to religious values:

1 “To do good to others.”

2. “To do good to others as God instructs; enjoy work and life in general” (i.e. balance work and leisure).

3 “I do everything … even work for Allah.”

4 “Hard work, responsibility, effectiveness, being highly productive and doing good to others as taught by elders.”

5 “I believe God guides us in everything we do and must be honoured and worshipped at all times. As a result, I value respect and hard work.”

It should be noted that the doctor referred to in response Number 5 above was a ‘born-again Christian’, unlike the rest, who were simply religious. A ‘born again Christian’ is one who has publicly declared to have accepted Jesus Christ as Lord and Saviour, an expression of commitment to the belief in God, to strictly obey his commandments, do God’s will, and live one’s life according to godly principles. This would include espousing work ethical principles as taught in the Bible. The Bible emphasizes hard work and discourages laziness as expressed in the following quote from the book of Proverbs (10:4), “Being lazy will make you poor, but hard work will make you rich.”

The above value systems, expressed by the doctors from urban hospitals, have been highlighted because they are striking compared to those reported by the rural doctors, which were to “do good” or, those relating more to management, for example: “Do well”, “Jesus

rules", and "God is alive". The enthusiasm with which the urban doctors expressed their religious work beliefs, attitudes and values compared to that of the rural doctors seems to suggest that they feel more strongly about such principles than their counterparts in rural hospitals. Alternatively, it could be the case that the urban group was more outspoken than their more humble colleagues in 'humble' rural contexts.

As an overall trend, it was, however, noted that the doctors' work VBAs tended to tally with the way their work was evaluated by their patients, management and themselves, as described later in this chapter.

Nurses' views on religion and work

The nurses' response to the same questions regarding the role of religion in their work and outlook are outlined below.

Of those from the rural hospitals, two said religion played a role, but only one of these could describe the exact role that it played, which related to motivation. The other thought that religion played a role but could not define the nature of this role. Of the remaining two nurses, one was unsure whether religion played any role at all and the other was certain that it did not play any role in her attitude towards her work.

The urban hospital nurses had a variety of beliefs. Two of them said religion plays a role (in their work) and identified these roles as "doing good" and "being honest". The other three were more cautious: two nurses preferred to say that religion played a role "to

some extent" and one nurse vaguely indicated that it played "somewhat" of a role. It can be concluded that the nurses, in general, believed that religion has some role to play in their work, but had some difficulty in defining and quantifying this role.

The religious values that they identified, which underlie their responses as discussed above, are listed below. Nurses in the urban hospitals expressed the following religious values:

1. "Honesty and fairness";
2. "Hurt none";
3. "Golden rule: do good to others";
4. "Do good to others".

The religious principles guiding rural hospital nurses were all reported as either "doing good," or "doing good to others." As was the case for the rural doctors, their expressions of these principles appeared more reserved than those of the more self-assured nurses from urban hospitals.

Such differences notwithstanding, all the nurses, without exception, from both rural and urban hospitals, belonged to a religious denomination. However, none of the nurses in the rural hospitals was a 'born-again Christian', while two nurses in the urban hospitals were 'born-again Christians'. The conflict in such variations is that, despite the apparent adherence of urban hospital nurses to religious work values, their patients and managers evaluated them less highly in terms of their work ethic than they did for their rural hospital

colleagues. The doctors' scores, on the other hand, were consistent with their religious work values.

Discussion

Although not conclusive, due to the small sample, it would appear that — according to the evaluation of the nurses' work behaviour and ethics by patients' and management' (outlined below) — the religious beliefs and values held by some of the nurses, particularly in urban hospitals, did not influence their work ethic. The findings seem to suggest that if such principles were fully applied the many complaints about the nurses in urban hospitals would not arise. On the other hand, it could be argued that if these beliefs and values did not exist at all, there may have been many more complaints than reported. These complaints are listed below.

UNDERSTANDING OF THE WORK ETHIC

Under the work ethic theme were items that explored interviewees' understanding of the work ethic, the characteristics of good and bad work ethic, and evaluation of nurses' and doctors' work ethic.

Interviewees were asked the following question: "*What do you understand by 'work ethic'?"*

All together, the following descriptors of work ethic were identified: being good, caring and hardworking, efficiency, thorough work, effective [work], dedication, patient recovery, good results/improved health, work timeously, work conscientiously, productive, do per

requirement, result driven, being responsible, ‘nursing and nursing’ (working persistently), being kind, ability to work acceptably, and *Batho Pele.*

Comparison of interviewees’ definition of the work ethic with the scholarly definition

According to the secular multi-dimensional work ethic profile (MWEP) by Miller et al. (2001; 2002), the dimensions that determine the work ethic of a group comprise the following: centrality of work, delay of gratification, hard work, leisure, morality/ethics, self-reliance, wasted time.

Miller et al. (2001:4), in addition to hard work and delay of gratification, also define the work ethic in terms of autonomy, fairness, wise and efficient use of time, and intrinsic value of work.

A list was compiled of the descriptors used by the interviewees to define the work ethic to compare them with the Miller et al.’s definitions. If the descriptors — put forward by the interviewees — are categorized according to a list of work ethic dimensions that combine both the scale of MWEP, as proposed by Miller et al (2001; 2002), and combined with the respondent’s own descriptors, then the emerging dimensions — in order from the most to the least popular — would be as follows:

Morality/Ethics dimension (mentioned by 12 interviewees):

Being good
Caring / best care
Batho Pele (putting people first)
Being responsible
Do per requirement

Work acceptably

Hard work (mentioned by five interviewees):

Use of time (mentioned by two interviewees):

Nursing and nursing [working persistently]
Work timeously

Intrinsic work qualities (mentioned by eight interviewees):

Dedication
Work conscientiously
Thorough work
Effective
Efficient

Outcomes-based descriptors (mentioned by nine interviewees)

Good results/improved healthcare
Being productive
Result driven
Patient recovery

From the above descriptors, only three of the dimensions of work ethic measurement put forward by Miller et al. (2001:2002), morality, hard work and use of time, could be discerned from the interviewees' understanding of the concept. The rest represent the interviewees' own creation. This therefore is likely to impact on their evaluations of themselves and each other (in the case of doctors and nurses) on the work ethic in terms of rating the item reported later in the chapter.

The dimensions of 'intrinsic work qualities' and 'outcomes of work' are considered unique to interviewees and have been named for purposes of study. Although the category of intrinsic work qualities might refer to some of the dimensions in Miller et al.'s MWEP, the category is not identified as such in the labels of the scale dimensions.

A list of descriptors was also compiled for the various interviewee categories. The work ethic defined by managers, doctors, and nurses are as follows:

1. Rural Hospital Managers
    - Being good and caring
    - Good work
    - Efficiency
    - Thorough work
    - Hard work
    - Being effective

2. Urban Hospital Managers
    - Staying and working on the job (work persistently)
    - Productivity/being productive
    - Do per requirement
    - Perfection and being result driven

3. Rural Hospital Doctors
    - Deliver health services
    - Best services

4. Urban Hospital Doctors
    - Responsibility and positive results
    - Dedication, curing patients and patience
    - Work efficiently and *Batho Pele*
    - Being productive and effective
    - Hard work
    - Effective and hardworking

5. Rural Hospital Nurses
    - Dedication
    - Hard work
    - Hard work, care and patient recovery
    - Good results and improved healthcare

6. Urban Hospital Nurses
    - Producing results and patients being cured
    - Nursing and nursing (dedication)
    - *Batho Pele*
    - Work acceptably

- Work effectively
- Producing results

In summary, the rural hospital managers, in their definitions of work ethics, focus on the manner in which work is done, namely: good (well), caringly, efficiently, thoroughly, industriously, and effectively.

The urban hospital managers on the other hand stress outcomes (productivity/results) with one of them even mentioning "perfection".

The rural doctors tend to define work ethic in the same way as the urban managers with an emphasis on outcomes (results).

The urban doctors deviate somewhat from the rural doctors, in that their emphasis, just like that of the rural managers, is based on intrinsic work qualities (dedication, patience, efficiency and effectiveness). Outcomes take second place followed by moral/ethical descriptors (responsibility and *Batho Pele*) and lastly hard work. For their rural colleagues, outcomes take first place followed by intrinsic work quality.

The nurses from rural hospitals understand the work ethic concept firstly in terms of outcomes (patient recovery and improved healthcare) and hard work. Secondly, they describe the work ethic in terms of intrinsic work quality (dedication) and moral/ethical principles (care). Their understanding of the work ethic sets them apart from the doctors who place hard work first, followed by

‘outcomes’. Nurses have similar priorities as those of urban managers, who also place an emphasis on outcomes.

Urban hospital nurses have similar priorities — in terms of work ethics — as those of rural nurses, urban-based managers and rural-based doctors. They differ, however, from the urban doctors in that, while the latter place intrinsic work qualities first and outcomes second, the nurses place the two at the same level, i.e., they are equally emphasized. The moral/ethical dimension follows in third place. They also differ from their rural counterparts, who place hard work at the same level as outcomes, while their colleagues in urban hospitals don’t even mention hard work; instead they place moral/ethical values in third place. This finding cannot, however, be generalized to the whole profession because of the sampling method used and the small sample size.

Interviewees’ understanding of good versus bad work ethics

The next question put to the interviewees was: “*What do you consider a bad/good work ethic? (List the characteristics of a good and bad work ethic).”*

The characteristics of a good work ethic were exactly the same as the ones discussed above, while those for bad work ethics were listed as the exact opposite of those associated with good work ethics, meaning that either one has a good work ethic or one does not. This consistency demonstrates conviction relating to the way in which interviewees define the work ethic. More evidence of this is observed in responses to the question after the one discussed immediately

below. The question required interviewees to explain why they thought the work ethic of nurses and doctors was good or bad. Since the majority of interviewees perceived the work ethic of doctors and nurses as good, the explanations given reflected the descriptors they had used to define a good work ethic. These descriptors were said to manifest themselves in the work of doctors and nurses: for example, managers in urban hospitals gave the following explanations:

Hospital manager:	"They practise work ethic as defined earlier"
Superintendent:	"They are more or less productive"
Operational manager:	"Work requirements are fulfilled"
Senior administrator:	"They try their best"
Director:	"The general level of client satisfaction is evidence"
Assistant Director:	"Those with a good work ethic work productively and those without don't".

EVALUATION OF NURSES' AND DOCTORS' WORK ETHIC

Having established their understanding of the work ethic, the interviewees were asked a follow-up question:

"Based on [your understanding of the work ethic], on the whole, do you consider your /'employees'/doctors'/nurses'/ work ethic good or bad?"

Rural hospital interviewees' assessment

Although the majority of managers, doctors and nurses evaluated the work ethic of doctors and nurses as being good, all the interviewees

from rural hospitals, without exception, rated their nurses and doctors as having a good work ethic.

Urban hospital interviewees' assessment

The rating pattern for urban nurses and doctors was similar to that of their rural counterparts. All managers rated them as having a good work ethic, except two who expressed skepticism. The superintendent at Cecilia Makiwane Hospital rated his doctors and nurses as having a "more or less" good work ethic, while one nursing sister from Frere Hospital rated them as being "50/50." This simply means that they are 'in between' a good and a bad work ethic. They may be good in some respects and bad in others. This will become clearer in the next chapter where the survey findings show that the respondents endorsed some dimensions of the work ethic and not others.

In the original sample, of one doctor per hospital, the doctors' and nurses' evaluation of each others' work ethic was that it was good, with the exception of one doctor, who conceded that, "almost all have a good work ethic, although there are some 'bad apples' as is the case everywhere". One nurse expressed the same feeling by refusing to evaluate all nurses and doctors together saying, "I don't believe in generalizations".

To probe this problem further, an additional set of five doctors was interviewed: two from Cecilia Makiwane Hospital (CM) and three from Frere Hospital. One doctor from CM agreed with a previous doctor, also from CM, saying, "almost all have a good work ethic but everywhere you get 'bad apples'". The second doctor from CM said,

"most doctors have a good work ethic but for the nurses, only some [can be said to have a good work ethic]".

The first doctor of the extra three from Frere Hospital rated his colleagues (nurses and doctors) as having an "almost good" work ethic, while the second doctor said, "Generally good but there are always 'maggots in a few peaches'". The third doctor at Frere Hospital rated his colleagues as having "mostly a good work ethic".

In summary, the majority of interviewees from the urban hospitals indicated that there are problems concerning the work ethic at the Cecilia Makiwane and Frere hospitals. These problems are echoed by a senior nursing sister from Frere Hospital and the superintendent from the Cecilia Makiwane Hospital.

MEDICAL PROFESSIONALS' WORK ETHIC RATING ON A SCALE OF 1 – 10

To further probe the work ethic of nurses and doctors, interviewees were asked to evaluate the work ethic of both at the relevant hospitals on a scale from 1–10, with 10 indicating the highest work ethic. The doctors participating in the interviews had to evaluate their fellow doctors, the nurses and themselves, as individuals. The nurses had to do the same. The ratings are presented in Table 4.5 below.

Table 4.5

Ratings of work ethic of doctors and nurses on a scale of 1–10

Profession	**Rural**				**Urban**			
	Victoria	**Mean**	**Nom-pumelelo**	**Mean**	**Cecilia Makiwane**	**Mean**	**Frere**	**Mean**
	Other Evaluations							
Management*								
Doctor	9 9 9	**9**	9 9 9	**9**	9 8 7	**8**	9 8 5	**7.3**
Nurse	9 8 9	**8.6**	8 9 8	**8.3**	8 5 7	**6.6**	7 6 5	**6**
Doctors*								
Doctor	9	**9**	10	**10**	8 9	**8.5**	8 8 7 9	**8**
Nurse	9	**9**	10	**10**	8 7	**7.5**	7 8 7 9	**7.7**
Nurses*								
Doctor	9 9 9	**9**	9 9	**9**	8 9	**8.5**	8 8	**8**
Nurse	9 9 9	**9**	9 9	**9**	8 9	**8.5**	8 7	**7.5**
Patients*								
Doctor	9 9 9	**9**	9 9 10	**9.3**	8 4 7	**6.3**	8 8 8	**8**
Nurse	7 9 9	**8.3**	9 7 9	**8.3**	6 4 7	**5.6**	8 5 4	**5.6**
Overall Means		**8.9**		**9.1**		**7.4**		**7.3**
Self-Evaluation								
Doctors*	9	**9**	10	**10**	8 9	**8.5**	9 8 9 9	**8.8**
Nurses*	8 9	**8.5**	9 9	**9**	8 9	**8.5**	8 8	**8**

The profession column indicates both the rater and the rated: the bolded professional is the rater in the 'other' evaluations

In summary, the nurses and doctors from rural hospitals are rated highly in terms of work ethic. The scores assigned to the rural nurses ranged from 7–10 and were lower than the scores assigned to rural doctors, which ranged from 9–10. The urban scores, on the other hand, ranged from 4–9 for both nurses and the doctors. This indicates

a large difference between the work ethic attributed to rural and urban nurses and doctors. The lowest score, of 4, for both nurses and doctors was given by patients at Cecilia Makiwane Hospital, while at Frere Hospital the same score was given again by the patients but for the nurses only. The managers shared almost the same attitude as the patients towards the work ethic of nurses at urban hospitals. The lowest score, of 5, given by managers to nurses was very close to the score of 4 by the patients. These two categories of evaluators, managers and patients, were responsible for the low overall work ethic scores, particularly the scores given to the nurses at the urban hospitals. Managers and patients were also more critical of the nurses at rural hospitals than their fellow evaluators. The lowest score they gave to the nurses in each rural hospital was 7, from the patients, and 8 from the managers.

In terms of mean scores, the trends were the same as those displayed by the raw scores. Mean scores for rural nurses' work ethic ranged from 8.3–10, which was again lower than the mean score for doctors, which ranged from 9–10. In contrast, the mean scores for the urban nurses' work ethic ranged from 5.6–8.5, while the doctors' scores ranged from 6.3–8.5.

The scores from the self-evaluations tended to be very high. This is of course expected (Table 4.5). Doctors were much more self-confident in the way they evaluated themselves than was the case for nurses. The doctors' raw scores ranged from 9–10, while that of the nurses ranged from 8–9. The most self assured were nurses and doctors at Nompumelelo Hospital in Peddie while the most modest were the

nurses in urban hospitals. Generally, both the nurses and the doctors in rural hospitals rated themselves more highly than was the case for their colleagues in urban hospitals. This trend is similar to the one noted from other evaluators, discussed earlier.

Since urban nurses' scores were substantially lower than those of urban doctors, it is worth examining them more closely, as individual groups presented separately in tabular form.

Table 4.6 shows the mean scores for doctors as evaluated by managers, doctors, nurses and patients.

Table 4.6
Doctors in urban hospitals: Evaluation of work ethic by different interviewee categories: mean scores (10 = highest)

Hospital	Management	Patients	Doctors	Nurses	Themselves	Mean of means
CM	8	6.3	8.5	8.5	8.5	**7.96**
Frere	7.3	8	8	8	8.8	**8.02**

Although general differences are marginal, doctors at Frere Hospital are rated more highly than those at Cecilia Makiwane Hospital (CM), particularly by patients (8.0 compared to 6.3). There is no obvious explanation except to highlight the fact that CM, although considered an urban hospital, is situated in a peri-urban environment of Mdantsane township, the second largest township in South Africa after Soweto. The interviewees from CM might not enjoy the same resources as those at Frere Hospital, which is situated in the city

centre. The two hospitals, however, belong to the same hospital complex, namely the East London Hospital Complex.

While doctors at CM are rated more highly by managers (8 compared to 7.3 for Frere), when they are rated by fellow doctors there is only a negligible difference in scores. The same is observed when doctors evaluate themselves as individuals. This is perhaps expected as no one would want to put themselves down, either as individuals or as a part of a group.

The pattern for nurses' work ethic evaluation is shown in Table 4.7 below.

Table 4.7.
Nurses in urban hospitals: Evaluation of work ethic by different interviewee categories: mean scores (10 = highest)

Hospital	Management	Patients	Doctors	Nurses	Themselves	Mean of means
CM	6.6	5.6	7.5	8.5	8.5	**7.34**
Frere	6.0	5.6	7.7	7.5	8	**6.96**

Interestingly, again it is mainly the patients who give lower ratings. Possibly they are the 'proof of the pudding'. As indicated in both Tables 4.6 and 4.7, above, compared to the doctors, the nurses at Frere Hospital score substantially lower on the work ethic scale than the doctors do at the same hospital (6.96 and 8.02, respectively). The difference in scores between the doctors and nurses at CM is negligible (7.96 and 7.34, respectively).

There is a visible difference between the two urban hospitals in terms of nurses' scores. As shown in Table 4.7, nurses at CM score a mean of 7.34 while those at Frere have a mean of 6.96, a difference of 0.38. This trend reflects the way in which they tend to rate themselves more highly compared to the way in which they are rated by others. For example, they rate both themselves and their colleagues at 8.5 at CM and 8 and 7.5, respectively, at Frere. Doctors award the nurses at CM and Frere scores of 7.5 and 7.7, respectively. The patients' rating scores for nurses at both hospitals was 5.6, and managers score them at 6.6 and 6.0, respectively. The most critical evaluators are patients and managers. This evaluation might be a truer reflection of the real situation than that of the ratings given by their colleagues, the doctors, and by themselves in self-evaluations.

Compared to the scores of rural hospital nurses and doctors, whose mean scores were between 8 and 9, the scores of the urban hospital nurses and doctors were clearly much lower. Although the difference between the mean scores of rural and urban doctors was not as great as that of the nurses, it was still substantially higher (at 9 to 10, respectively for nurses and doctors) for those at rural hospitals, compared to scores of 6 to 7.4 (respectively) for those at urban hospitals.

In order to understand the low scores given by patients when assessing nurses and doctors, particularly in urban hospitals, a further question on their attitude toward the services they had received at their relevant hospitals was asked of them. This is discussed in the following section.

PATIENTS' ATTITUDE TOWARD THE SERVICES RECEIVED AT THEIR HOSPITALS

Perhaps the best place to look for reasons for patients' low evaluation of the work carried out by nurses at the urban CM and Frere hospitals, lies in their replies to certain questions, as outlined below.

Patients were asked whether they were happy with the services they received at their relevant hospitals and requested to explain their response. The responses were revealing.

Almost all patients responded with a "yes, but……."

Table 4.8, below, summarizes the patients' responses to the question as to whether they were happy with the services they had received at their relevant hospitals.

Table 4.8
Patients' satisfaction with services received at their hospitals

Hospital	Patient	Response
Rural:		
Victoria	1	Yes, but some nurses are rude
	2	Yes, I am healing
	3	Yes, but food is not okay
Nompumelelo	1	Yes, good medication
	2	Yes, good care, although sometimes medicines run out
	3	Yes, provision of medicine and care
Urban:		
CM	1	Yes, good medicine and care
	2	No, medicine not available sometimes, only get it later, and nurses treat you like dirt
	3	Yes, except food- food is not good!
Frere	1	Yes, but food is little
	2	Yes, but only the doctors treat us well
	3	Yes, but sometimes nurses are rude and food is bad

The responses shown in Table 4.8 convey the message that the patients were generally satisfied with the service they had received. What seems to be the explanation to their happiness with the services is that, in the first place, the services are provided by different medical personnel (doctors and nurses). The question did not require them to specify whose services to evaluate. Secondly, what they really seem to be happy about is that they received good medicine when it was available (which is prescribed by the doctors). As a result of good medicine they were healing (getting well). If they focused their attention/priority on the fact that they came to hospital to get

well and they did in fact get well, then everything else becomes secondary. Moreover, not all nurses ill-treat their patients.

Because of the general nature of the question on satisfaction with services, the responses (summarized in Table 4.8) concentrated on highlights: obtaining medicine and getting well, being the first priority. Only after that need had been met did the other sets of needs become important, i.e. food and the need to be treated well (feeling of being loved). That is why those who answered "yes", without adding "but", were happy with the medicines and care they received and did not look further. The shortage of medicines ("running out of medicines") cannot be blamed on the doctors and the nurses, as it is a factor that is (most likely) beyond their control, as is also the case concerning the quality and quantity of food ("bad" or "too little"). This is a very common and well-known complaint in institutional settings like hospitals, and comes as no surprise.

In urban hospitals, however, the complaints tend to outweigh the praises, in as much as some have to do with food and unavailability of medicine. The complaints about nurses from a patient at Victoria Hospital in Alice is also picked up by another patient at Cecilia Makiwane Hospital, who complains that, "nurses treat you like Dirt!" The problem grows bigger when two out of the three patients at Frere Hospital echo the same complaint saying that, "some nurses are rude" and "only doctors treat us well". This brings the number of patients complaining about nurses to 50% of the patients in urban hospitals. Out of the total sample of patients (12), eight had some complaint (either about unavailability of medicine, poor food, ill treatment from

nurses, or a combination of poor food and ill-treatment from nurses), which represents 67% of the total sample of patients. Put in order of the number of complaints, ill-treatment from nurses comes first, followed by poor/little food, followed by lack of medicine. It can be claimed that nurses can be held responsible for the bad/little food, in that — although they don't cook the food — it is common practice that they serve it, so they can have some control over the amount and quality of food served, besides which, a concern about food should be part of patient care. This might sound judgmental, but a patient's diet goes hand in hand with recovery, and although nurses may not cook the food, they can influence change.

PATIENTS' SATISFACTION WITH TREATMENT RECEIVED AT THEIR HOSPITALS

In another follow-up question, patients were asked whether they were happy with the treatment they had received at their hospital and to explain their answer.

The responses were not very different from the ones for the previous question, except that, in some cases, details were added. Also, one respondent from Nompumelelo Hospital in rural Peddie, who had not complained about nurses previously, now added her voice to the complaints, saying that, "some nurses were rude". This brought the number of complainants about nurses in the rural hospitals to two out of six (33.3%).

In the urban hospitals, on the other hand, the second patient from Cecilia Makiwane who had in the previous question complained about nurses treating patients “like dirt”, repeated that same complaint and stated categorically as she had said earlier that she was “not happy”. She added that a patient might receive medicine only two days after it had been prescribed. She was the most critical of all the patients. Perhaps her profession, as teacher, and her higher educational level explained her assertiveness, in contrast to the other patients who were more humble and perhaps more accepting of the conditions they found themselves in. This, however, does not explain away the equally low work ethic score given to nurses by the managers.

At Frere Hospital, another dimension was added when the first patient, who in the earlier question had complained only about insufficient food, now added that, “nurses are rude”, and that “doctors are very few”. The second patient maintained the stance that he was happy with the treatment received, but only from the doctors, not from nurses who, he reported, “sleep at night, they don’t care”! The third patient responded, “Yes and no“. Asked to explain her answer, she said, “Some nurses swear at you!” The number of patients complaining about nurses in this hospital increased from two, in the previous related question, to three. If responses to the question on satisfaction with treatment and services are taken together, all three patients interviewed at Frere Hospital voiced complaints about nurses.

The next follow-up question also related to patients' attitudes toward doctors and nurses at their respective hospitals. Patients were asked to state what they liked and disliked about doctors and nurses in their hospitals.

Table 4.9 shows the patients' responses to the above-mentioned question.

Table 4.9
Patients' likes and dislikes about doctors and nurses

Hospital	**Patient**	**Response**	
		Likes	**Dislikes**
Rural:			
Alice	1	Good doctors	Some nurses not good
	2	Care and politeness	None
	3	Good cure and care	None
Mpumelelo	1	Patience and care	None
	2	None	Rude remarks from nurses
	3	Everything good	None
Urban:			
CM	1	Good doctors	Bad apples among nurses
	2	Nil	Bad nurses and no medicine
	3	Kindness and good treatment from doctors	No response
Frere	1	Medicine, treatment and care from doctors	No response
	2	Good doctors	Bad nurses
	3	Doctors spend time asking patients questions	Nurses are cheeky

Among the responses received (Table 4.9), there were two complaints about nurses from the rural hospitals and four from the urban hospitals. It should be noted that the silence of the two patients in the urban hospitals who preferred not to speak their mind regarding their dislikes about anybody, should be understood as being an indication of dissatisfaction with nurses. This conclusion is based on their responses to questions on what they liked. They clearly pointed out the positive qualities about doctors and none about nurses. The conclusion is they preferred to point out the good about doctors and remain silent about the nurses. Among those who pointed out their dislikes, such dislikes were all directed at nurses as being, "bad", "bad apples", and "cheeky". Five out of nine patients in urban hospitals had nothing good to say about nurses. The exact opposite was, however, the case with doctors. No dislikes were aired about doctors and this was the trend throughout the interviews.

It cannot be overemphasized that there is 'bad blood' between the nurses and their patients, specifically at urban hospitals, and to some extent in rural hospitals.

An important question at this stage then becomes: "*Are nurses aware of the complaints from their patients?*" A question was put to both nurses and doctors as to whether patients and the general public were happy with their hospital work. Table 4.10 summarizes the nurses' responses to the question.

Tables 4.10
Nurses' evaluation of their patients and the general public's happiness with their hospital work

Hospital	Nurse	Response
Rural		
Victoria	1	Yes, from feedback
	2	Yes, from own observation
Nompumelelo	1	Yes, they say so(feedback)
	2	Yes, the patients say so
Urban		
CM	1	Yes, I treat them well
	2	Yes, they say so (feedback)
Frere	1	Yes, I always do my best
	2	Yes, they give compliments

Again, there seems to be a clear contradiction between how the nurses perceive their services and how they are evaluated by their clients. Perhaps in the rural hospitals this is not entirely the case, considering that most patients said they were satisfied with the nurses' services and the scores awarded to the nurses were high (7–9). The situation at urban hospitals, on the other hand, still leaves one with doubts as to whether what is claimed as positive feedback can be depended upon. It could be similar to the former question, where patients preferred not to mention their dislikes about the nurses or to give only positive comments to protect themselves from any backlash from their caregivers. Secondly, responses such as, "I always do my best" and "I treat them well" might be seen as defensive on the part of nurses. It is also worth speculating that the nurses' definition of good service, might exclude 'rudeness' or rudeness is not an issue as long as, at the end of the day, the patients receive treatment, which is the reason why they are in hospital. It could also mean that nurses

perceive the patients as being difficult or too demanding, in which case the nurses might think patients deserve the treatment they receive.

Changes suggested by patients to improve service delivery in their hospital

Asked what they would like to see changed in their relevant hospitals, the patients gave the following responses (see 4.11 below).

Table 4.11
What patients would like changed in their hospitals

Hospital	Patient	Suggested changes
Rural		
Victoria	1	Some manners in nurses
	2	Nothing
	3	Food quality
Nompumelelo	1	Nothing
	2	Provision of medicine and elimination of rude nurses
	3	Nothing
Urban		
CM	1	Get enough medicine
	2	Medicines and good doctors
	3	Food and rude nurses
Frere	1	Nothing
	2	Bad treatment by some nurses
	3	Nurses must be given more training in Ubuntu

In Table 4.11, over a third of patients singled out nurses' bad manners or their rudeness as priorities for change. It is important to

note that the attitude of patients regarding this matter has remained the same up to this stage, which suggests consistency in their evaluation. Urban hospitals consistently continue to attract negative comments. As observed earlier, the patients whose complaints focused on food, medicine or no complaint at all may have decided to focus on more urgent needs — such as stocking enough medicines and improving the amount and quality of food — which are more vital for their recovery than the rudeness of nurses.

JOB SATISFACTION

It was anticipated when the interview guideline was developed that some other factors outside medical personnel could be at play with regard to problems of service delivery in healthcare. Accordingly, questions to probe such factors were included in the interview schedule. The questions concerned, among others, nurses' and doctors' satisfaction with their work and what they would want improved at their hospitals, so that their work would be easier and more satisfactory. The following question was put to the managers and the medical professionals: *"How satisfied are you with your work?"*

Rural managers' job satisfaction

With one exception, all managers in the rural hospitals were not just satisfied but very satisfied. The manager with a slightly different opinion stated that he was "well satisfied" which may not imply the same high level of satisfaction. The reasons for their satisfaction are listed in Table 4.12 below.

Urban managers' job satisfaction

The managers from urban hospitals were not very different in their responses from the rural ones. All three managers from Cecilia Makiwane Hospital said they were very satisfied. However, those from Frere Hospital, although generally satisfied with their jobs, expressed concern about staff shortages, general staff apathy, and lack of resources, including staff shortages. The only manager who said he was very satisfied based his level of satisfaction on the "good salary". In other words, he derived satisfaction from an extrinsic work quality, unlike the others whose satisfaction stemmed from intrinsic factors relating to the efficient delivery of the services they rendered, for example, 'good results' and 'client satisfaction'. The same factors also formed the basis for the satisfaction of all interviewees from the other hospitals.

Table 4.12
Managers' explanations of their satisfaction/ dissatisfaction with their work

Hospital	Manager	Response
Rural		
Victoria	1	Efficient, speedy and caring delivery of health
	2	Patients are healed
	3	Efficient work
Nompumelelo	1	Delivery of services
	2	I deliver
	3	The services I supply
Urban		
CM	1	Good results
	2	Client satisfaction
	3	Good results
Frere	1	Good salary
	2	(Satisfied to some extent) – due to staff shortages and general staff apathy
	3	That I do my best although lack of resources like staff is disturbing!

Rural doctors' job satisfaction

In general, the doctors' satisfaction levels were not very different from those of managers. Those from rural hospitals both reported to be very satisfied with their jobs.

Urban doctors' job satisfaction

The doctors from urban hospitals were mostly satisfied.

Nurses' job satisfaction

Nurses from all the hospitals were, on the whole, not just satisfied but very satisfied. Only one nurse from Cecilia Makiwane Hospital, said she was satisfied "to some extent".

The satisfaction levels of nurses and doctors, as reported above, did not provide an explanation as to why their work is perceived with mixed feelings by their managers and patients. As a researcher, I hoped to gain more insight into job satisfaction from responses to a further question. Interviewees were asked what they would like to see improved at the hospitals where they work. It was hoped that this question might indicate some dissatisfaction that influenced their job performance.

What nurses and doctors would like to see changed in their work to improve working conditions

Asked what they would want to see improved in their work, nurses and doctors gave a number of responses, as summarized in Table 4.13.

Table 4.13
What doctors would want changed in their hospitals

Hospital	Doctor	Suggested changes
Rural		
Victoria	1	Increased medical staff
Nompumelelo	1	Everyone should be committed to work
Urban		
CM	1	More appointment of staff (both nurses and doctors) in maternity and HIV wards
	2	More staff in certain sections especially casualty
Frere	1	More staff allocation
	2	More medicine allocations as they run out
	3	Better infrastructure in neighbouring hospitals and clinics so that there is no overload on one hospital.
	4	More staff
	5	More medicine
	6	Overtime payment be effected as staff had downed tools on the basis of this
	7	The CEO appointment should be a medical appointment and there should be a balance between core and non-core personnel.
	8	Fill all vacancies especially in critical sections

The problems reported above are major administrative issues that raise concerns and greatly affect service delivery. Understaffing could affect the nurses' attitude toward their patients as it is a general tendency that quality of work life conflicts can spill over onto job performance. Understaffing means that the few who are on the job are overworked and over-stretched. Shortages of medicine reported by patients, were confirmed by doctors. The complaint of overloading a single hospital with patients is evidence of pressure on a few staff members who have to cope with large numbers of patients. The part-

time staff that was put in place was not being paid promptly and had in fact refused to work. Considering that Frere is the main hospital in the centre of East London, it is not surprising that there is a complaint of overloading. This has led to a request that the infrastructure be improved so that patients can be referred to neighbouring hospitals and clinics instead of putting pressure on a single hospital that is already understaffed.

It was observed in the doctors' recommendations that doctors from Frere Hospital had been the most enthusiastic when expressing the changes that they required and also had a greater sense of urgency about such changes, than was the case for doctors from other hospitals. The Frere doctors also produced a more thorough and elaborate list of what could be referred to as 'demands' rather than 'needs'. The reader is reminded that a deliberate effort was made to interview more doctors at Frere Hospital than at the other hospitals because the work ethic scores for nurses and doctors were comparatively low at this hospital. The larger sub-sample may have been responsible for the larger body of information. Besides, the hospital has been the most affected in the region by negative media reporting. This interview might have provided a platform for the doctors to point out the root causes of the problems at the hospital, in an attempt to rectify them.

The nurses' recommendations for change in their work is shown in Table 4.14.

Table 4.14

What nurses would want changed in their hospitals

Hospital	Nurse	Suggested changes
Rural		
Victoria	1	More medical staff
	2	More medical staff
Mpumelelo	1	More staff and equipment
	2	Increase staff complement
Urban		
CM	1	More medicines
	2	More medicines and improve staff shortage
Frere	1	More staff and resources e.g. medicine
	2	All posts be filled

The nurses emphasized the need for more staff and medicine. That both nurses and doctors made the same demands can be taken as confirmation of the seriousness of these difficulties. One might defend the urban nurses in claiming that the pressure of work might affect the way in which they treat patients. One is, however, also confronted with the question as to why there have been fewer complaints from patients about the behaviour of nurses at rural hospitals, even though they have the same problems (as nurses from urban hospitals) relating to staff shortages and lack of medicine. Their staff problems should even be worse because resources are scarcer in rural areas and not many nurses and doctors want to work there. The same question can be asked about the rural doctors, who also experience staff shortages, in fact much more so than the nurses, but no such complaints have been made about them. This calls for

further research into the work behaviour patterns of nurses in South African hospitals.

THE STRIKE

The following topics were examined with respect to certain aspects relating to a countrywide strike by medical staff that took place in 2007: its history, the participants, its events, and the outcomes.

In order to probe further into problems at the four hospitals investigated in this study, interviewees were asked to respond to a set of questions regarding the 2007 strike. This was a general strike called by all medical staff at all hospitals in South Africa. Analysis of data on this theme reveals complaints that were highlighted in the media reports, but not particularly to the themes already discussed. One important factor, that has not so far been highlighted in my discussion, is the issue of low wages. Only one doctor from Frere Hospital raised this issue as one of the things he wanted changed (see Table 4.13). Yet interviewees, without exception, pointed out that the main causes of the strike were low salaries and poor conditions of work. Important aspects relating to poor working conditions were reported to be: overwork, unrewarded qualifications, unpaid leave days, and non-payment of overtime. Perhaps at the time of the interviews the issue of wages had been resolved. The complaints from interviewees in my study, so far, have not been related to low wages but rather to the lack of medicine and staff shortages, which surprisingly, were not listed as causes of the strike. It is possible that staff shortages may have been covered under 'overwork', but the two

are not necessarily synonymous. One explanation could be that the problem of under-payment or non-payment of wages may have been resolved at the time of the interview, but more strikes on the same issue followed later. A more plausible explanation could be that, in order for the government to end the strike, salaries were increased but not implemented soon enough. Indeed, interviewees reported that the strike was settled in favour of the workers; in other words, government acceded to medical professionals' demands. It seems, however, that the problem of overwork had not been dealt with at the time of the study. One can still argue that, similarly, if there were subsequent strikes about low wages — which indeed there were — then this suggests there was still dissatisfaction regarding that issue at the time of the interview and that complaints should have been made in that respect. Surprisingly, there were no such complaints. The levels of satisfaction expressed by nurses and doctors in the previous question cannot be explained considering their reports of being overworked and underpaid. We can only speculate that the nurses and doctors did not want to discuss how important pay is in motivating them to perform optimally. Instead, they seem to have preferred to respond in a socially desirable manner.

Asked how the strike affected the work ethic of staff, most interviewees said no change had been observed. However, a doctor at Cecilia Makiwane Hospital reported that some staff members (nurses specifically) experienced a sense of triumph, which had led to an 'I-don't-care attitude' to authority. Another doctor, this time from Frere, reported that the strike created an air of victory, which manifested itself in nurses being casual about work. These observations were

also made in rural hospitals where a doctor at Nompumelelo in Peddie, noted that "nurses have developed an 'I-don't-care attitude.'" Only one nurse, from Victoria in Alice, said there was a sense of victory among the nurses, but offered no further explanation. In the urban hospitals, one nurse at Cecilia Makiwane also commented that nurses had developed an "I-don't-care attitude". The rest were either not sure how the strike had affected the work ethic of staff or had observed no changes.

A manager at Victoria Hospital reported that some staff "don't care for authority", while another from Cecilia Makiwane Hospital said, there was "laxity for instructions".

It is difficult to determine the real impact of the strike. One would have expected a change of heart on the part of nurses once they had won the battle over wages and conditions of service. It is not unusual to see insubordination, lack of commitment, disloyalty, and disrespect for authority on the part of nurses if they have to fight for their own justice in respect of wages. The question is, who is the victim in the crossfire? The patient! Should patients also go on strike? These and many other questions need further research if the problems associated with hospitals and healthcare in South Africa are to be successfully addressed — especially given the country's high expenditure on healthcare relative to other developed and developing countries.

SUMMARY

This chapter has presented the main findings from personal interviews conducted with selected hospital staff and patients. Although some items in the interview guide yielded numerical data, the main purpose of the methodological approach employed in this section of the study was to gain a deeper and more detailed understanding of the subject of study in order to explore and describe work behaviour patterns from the perspective of the staff, as well as from the perspective of others in the work setting. Other evaluations were solicited from fellow nurses and doctors, managers and patients. Indeed the information obtained from these interviews provides a bigger picture than is painted by the survey data as we shall see in the next chapter. Survey studies of the work ethic have tended to produce equivocal outcomes. It was hoped that a comparison of own and other evaluations would produce greater clarity of outcome. The findings of this study indicate that self-evaluation, as is the approach used in the MWEP instrument, results in an over-rating of one's own work behaviour patterns compared to a more objective appreciation by others, be it as a consumer of the provided service, a peer, or a supervisor.

The work ethic VBAs of medical professionals are higher for the rural than the urban hospitals. In contrast to the popular belief that religion no longer influences the work ethic in modern capitalist society, religious beliefs play an important role in the endorsement of work ethic principles in both rural and urban hospitals. Although nurses gave themselves a positive evaluation, their work behaviour

patterns and ethics are found to fall short of the ideal by all other evaluators. Shortage of medical supplies, medical staff and poor quality diet at the hospitals are some of the factors contributing to poor service delivery in the studied hospitals.

In the next chapter, data from the questionnaire survey that involved a larger sample and employed a more quantitative method of data collection and analysis is presented and interpreted. Reference is made to the findings reported in this chapter for purposes of an initial comparison. A more detailed comparison of findings from the qualitative and quantitative results is given later in Chapter 6.

CHAPTER FIVE

RESULTS FROM THE QUESTIONNAIRE SURVEY

INTRODUCTION

This chapter presents an analysis of data collected through a self-administered questionnaire that was completed by 66 doctors and 108 nurses. Some of these doctors and nurses held administrative positions. Medical professionals, the target population of the study, were drawn from two rural hospitals (Nompumelelo in Peddie and Victoria in Alice) and two urban hospitals (Frere and Cecilia Makiwane in the city of East London). All four hospitals are situated in the Eastern Cape region of South Africa. The sample was selected using a purposive/judgmental sampling method, i.e. any medical professional from any of the hospitals mentioned above, who was willing to participate in the study, qualified for inclusion in the sample. Although it was the initial intention to match the sample to relevant demographic variables, this goal could not be achieved because of the sensitivity of the topic and the negative publicity, received by the hospitals, at the time when this study took place. Respondents were afraid to speak to researchers for fear of victimization, which some of their colleagues had already experienced. Accordingly, the numbers of respondents from the four hospitals were not matched in terms of gender, age, or educational level.

Survey participants completed the Miller et al.'s (2001/2002) inventory, the Multidimensional Work Ethic Profile (MWEP). The inventory comprises seven dimensions which measure the different aspects of the work ethic. The dimensions and their abbreviations are: **Self-reliance (S-R); morality (M); wasted time (W-T); delayed gratification (D-G); centrality of work (C-W); leisure (L); and hard work (H-W).** The order of the dimensions is of no particular significance here, as all dimensions are considered to be of equal importance. The definition of each dimension was provided in Chapter 3. Each of the dimensions was defined and measured according to at least seven items.

The chapter is organised as follows: First, I present the sample's mean score for each item in the MWEP inventory; then I report the overall sample mean scores on the work ethic scale and on each of the seven dimensions. Lastly I analyze the variations in mean scores on all seven work ethic dimensions according to demographic categories.

SAMPLE MEAN SCORES PER DIMENSION ITEM

In Table 5.1, the items in the MWEP are grouped according to the dimension they measure and identified by the number assigned to them in the questionnaire. The sample was evaluated in terms of each item on each dimension of the work ethic scale and the mean scores for the sample for each item were computed. The mean scores were computed from responses recorded on a 5-point Likert- scale, from 1 (strongly disagree) to 5 (strongly agree). In this case, 1 is the lowest score on the scale, indicating the weakest agreement to the work ethic

principle, while 5 represents the highest score. Three items on the morality dimension — namely items, No. 78, No. 110 and No. 119, together with all items measuring leisure — were reverse scored in order to combine the dimensions they measure with other dimensions in the scale, since they are negatively correlated with the other dimensions (Miller et al., 2001/2).

Table 5.1
Mean scores on items in the MWEP for the total sample

Item No.	Dimensions and their indicators	*Mean score*
	Self-reliance:	***3.37585***
68	To be truly successful, a person should be self-reliant	*4.0636*
83	Self-reliance is the key to being successful	*4.2370*
88	People would be better off if they depended on themselves	*3.8421*
90	One should live one's own life independent of others as much as possible	*2.9249*
94	One must avoid dependence on other persons whenever possible	*3.8023*
96	I do not like having to depend on other people	*4.0983*
106	I strive to be self-reliant	*4.1156*
112	Having a great deal of independence from other people is very important to me	*2.5838*
117	Only those who depend on themselves get ahead in life	*4.0058*
121	It is important to control one's destiny by not being dependent on others	*3.9017*
	Morality	***4.1764***
69	One should always take responsibility for ones actions	*3.8439*
77	One should always do what is right and just	*3.8902*
78	I would take items from work if I felt I was not getting paid enough	*4.2543*
87	One should not pass judgment until one has heard all of the facts	*4.2948*
99	You should never tell lies about other people	*4.3353*
110	Stealing is alright as long as you don't get caught	*4.1618*
113	It is important to treat others as you would like to be treated	*4.3006*
116	It is never appropriate to take something that does not belong to you	*4.3121*
119	There are times when stealing is justified	*4.0756*
123	People should be fair and just	*4.2849*
	Leisure	***3.5484***
67	Life would be more meaningful if we had more leisure time	*3.0173*

70	I would prefer a job that would allow me to have more leisure time	*3.5491*
76	The more time I can spend in leisure activity, the better I feel	*3.5291*
80	The less time one spends working and the more leisure time one has, the better	*3.6069*
89	Work takes up too much of our time, leaving little time to relax	*3.4509*
93	More leisure time is better for people	*3.2312*
105	The world would be a better place if people spent more time relaxing	*3.6047*
111	The job that provides the most leisure time is the job for me	*3.9302*
120	People should have more leisure time to spend in relaxation	*3.7791*
125	Leisure time activities are more interesting than work	*3.7616*
Hard Work		***4.1304***
79	Nothing is impossible if you work hard enough	*3.9249*
82	Working hard is the key to being successful	*4.0819*
84	If one works hard enough, one is likely to make a good life for oneself	*4.1618*
86	Hard work makes one a better person	*4.2573*
97	By working hard, one can overcome every obstacle that life presents	*4.0058*
100	Any problem can be overcome with hard work	*4.1503*
107	If you work hard you will succeed	*4.1860*
109	Anyone who is able and willing to work hard has a good chance of succeeding	*4.2367*
115	A person should always do the best job possible	*4.2254*
122	By simply working hard enough, one can achieve one's goals	*4.0988*
Centrality of Work		***3.9973***
64	I feel uneasy when there is a little work for me to do	*4.1734*
66	I feel content when I have spent the day working	*3.9186*
72	Even if I were financially able, I would never stop working	*3.7919*
75	A hard day's work is very fulfilling	*4.0235*
92	It is very important to be to always be able to work	*3.7427*
95	Even if I inherited a great deal of money, I would continue to work somewhere	*3.9827*
102	Even if it were possible for me to retire, I would still work	*3.9827*
103	Life without work would be very boring	*4.1445*
114	I experience a sense of fulfillment from working	*4.1637*
126	A hard day's work provides a sense of accomplishment	*4.0233*
Wasted Time		***4.1060***
63	It is important to stay busy at work and not waste time	*3.9532*
71	Time should not be wasted, it should be used efficiently	*4.1329*
74	I schedule my day in advance to avoid wasting time	*4.1680*

85	I constantly look for ways to productively use my time	*4.2339*
98	I try to plan out my workday so as not to waste time	*4.1792*
01	How a person spends their time is as important as how they spend their money	*4.1561*
118	Wasting time is as bad as wasting money	*4.0465*
127	Distaste for hard work usually reflects a weakness of character	*3.9535*
	Delay of Gratification	***4.0696***
65	If I want to buy something, I always wait until I can afford it	*4.0058*
73	I get more fulfillment from items I had to wait for	*3.9480*
81	Things that you have to wait for are the most worthwhile	*4.0347*
91	A distant reward is usually more satisfying than an immediate one	*3.9360*
104	I prefer to save until I can buy something instead of buying it on credit	*4.2907*
108	The best things in life are those you have to wait for	*4.1272*
124	The only way to get anything worthwhile is to save for it	*4.1453*

Item mean scores on every dimension, as displayed in Table 5.1, are discussed below to highlight the items on which the sample performed better or worse than on others. The item scores are discussed under the dimension they measure. The order in which dimensions are listed does not reflect any ranking in terms of mean scores. (The rank-ordered dimensions are presented later in Table 5.2b).

Self-reliance

In terms of the self-reliance dimension, the sample scored most highly (above 4) in five out of the ten items, followed by three items, each with mean scores of between 3 and slightly less than 4, followed in the last position by two items, each with a mean score between 2 and under 3. The latter two items were "One should live one's own life independent of others as much as possible" and "Having a great deal of independence from others is very important". These two items suggest the value of living an independent life away from others and

it appears that this idea is what the respondents seem to object to. The five items that the respondents most agree with relate to achieving, being successful, and getting ahead in life. One can do all that and still live in communion with other people. At surface value, this finding, as commented on earlier, could indicate that this sample, consisting mainly of mother-tongue isiXhosa speakers, endorses an African belief system that values collectivism. This topic is discussed in greater detail later.

Morality

In terms of the morality dimension, the sample mean score was above 4 for eight of the ten items. Only two items had a mean score lower than 4. One of these, stating that "I would take items from work if I felt I was not getting paid enough", was reverse-scored and should have been equal to the others but, surprisingly, it was not. The score of 3.8439 is unexpectedly low from a moral perspective. This seems to suggest that a substantial proportion of the sample would prefer to assert themselves and claim justice by compensating themselves as a sense of entitlement. It could also indicate the tendency towards materialism and an individualistic ideology, as we shall see later. The other item with a mean score lower than 4 stated that, "One should always take responsibility for one's actions". This is perhaps in line with the former item as they both suggest safe-guarding their own welfare as individuals rather than taking responsibility for the sake of the collective.

Leisure

All the items measuring the leisure dimension were reverse-coded as the dimension is negatively correlated to the other dimensions in the scale. This argument is based on Weber's theory of work ethic in

which hard work and leisure are portrayed in direct opposition. This was pointed out at the beginning of the chapter. In terms of this dimension all items, without exception, had a mean score of less than 4. Given that the items were reverse-coded, high scores on this dimension would mean disagreement with the statement, which would indicate endorsement of work ethic principles. This was not the case in this instance. The sample took a middle stance, indicating a tendency to prefer a relative balance between work and leisure. This is contrary to Weber's understanding of the work ethic, which positions leisure and work as two absolute opposites. On Weber's work ethic scale they stand at the extreme poles against each other. The sample, on the other hand, seems to endorse a relatively high degree of leisure.

Hard work

On the hard work dimension the majority of items (nine out of ten) each had a score above 4. The remaining item, which received a score of slightly less than 4, related to the statement that "Nothing is impossible if you work hard enough" (3.9249). The skepticism expressed here might refer to the feeling that respondents work very hard but have not necessarily attained the expected level of success, at least in the eyes of the public they serve.

Centrality of work

This dimension surprisingly took fifth position (i.e. third last) when all dimension mean scores were rank-ordered from the highest to the lowest. The scores on this dimension were split into two sets. Five items had a mean score above 4, while the remaining set of another five each had a score below 4. The former set relates to the

qualitative benefits of hard work; the latter set relates to persistent work, despite absence of need. The emphasis here most likely relates to material satisfaction, especially considering that respondents were least likely to agree with Item 72 ("Even if I were financially able, I would not stop working)" (3.7919) and Item 92 ("It is very important for me to always be able to work") (3.7427). It may seem likely that once their material needs are satisfied, these respondents might consider giving up work. This includes a possibility of early retirement if there is no material need.

Wasted time

Six of the items relating to the wasted time dimension scored above 4 and only two items scored slightly below 4 (but still above 3.9). These items read: "Distaste for hard work usually reflects a weakness of character" and "It is important to stay busy at work and not waste time".

Delay of gratification

The majority of items (five out of seven) associated with the delay of gratification dimension had scores above 4, leaving only two items scoring below 2. The second last item states that "I get more fulfillment from items I had to wait for" (3.9480), meaning that respondents did not place a higher value on items that they had to wait for than those that they did not have to wait for. The lowest score was for the item stating that "A distant reward is usually more satisfying than an immediate one" (3.9360), which represents an almost similar idea to that of the previous item.

SAMPLE DIFFERENCES IN MEAN SCORES PER DIMENSION

To summarize the results further, the overall mean scores on each dimension for the sample were computed. Table 5.2a shows the scores according to the dimension order followed throughout the text, while Table 5.2b displays the scores in rank order from the highest to the lowest. The last row of Table 5.2a shows the overall work ethic mean score for the sample, calculated as $\Sigma x / 7$ (i.e. sum of all dimension means divided by number of dimensions).

Table 5.2a
Sample mean scores as per dimension

Dimension	N	Mean Score	Excluded/ Missing
Self-reliance	173	3.7585	1
Morality	173	4.1764	1
Leisure	172	3.5484	2
Hard work	172	4.1304	2
Centrality of work	172	3.9973	2
Wasted time	172	4.1060	2
Delay of gratification	172	4.0696	2
Mean for the sample		**3.9695**	

Table 5.2b
Sample mean scores as per dimension in rank order

1	Morality	4.1764
2	Hard work	4.1304
3	Wasted time	4.1060
4	Delay of gratification	4.0696
5	Centrality of work	3.9973
6	Self-reliance	3.7585
7	Leisure	3.5484

In the final analysis, what can be observed about the work ethic of the nurses and doctors at the studied hospitals in the Eastern Cape province of South Africa? On a five point scale — ranging from 1 (lowest) to 5 (highest) — a work ethic mean of 3.9695 was obtained for the total sample on the Miller et al. multidimensional work ethic inventory. This score is approximately 4/5ths on a five point scale, which is indicative of a high work ethic.

WORK ETHIC VALUE PROFILES

The sample endorsed some work ethic values more than others, based on the MWEP developed by Miller et al., which led to some dimensions having a much higher score than others. Accordingly — on the basis of dimension mean scores rank ordered from the highest to the lowest and using a work ethic value framework as described earlier — the work value profile was formulated. For the total sample, in accordance with Table 5.2b, the work value profile was identified as follows: Morality, hard work, wasted time, delay of gratification, centrality of work, self-reliance and leisure. The same principle is applied to formulate similar profiles for each of the demographic categories. The work value profiles indicate the extent to which a group endorses/values a certain work ethic dimension in relation to other dimensions.

According to the sample work value profile, which is based on the mean scores per dimension, the sample's performance was poorest on the leisure and self-reliance dimensions, both of which had mean

scores below the sample mean. This is due to a number of specific items on each of these dimensions, which had mean scores as low as 2.5. Two items on the self-reliance dimension had sample mean scores, as indicated in Table 5.1, of 2.9249 and 2.5838, which will have pulled the total score down. Indeed, the overall mean on the self-reliance dimension was affected, as it turned out to be only 3.7585, placing the dimension in position 6, ahead of leisure, which scored 3.5484. The leisure dimension had the greatest effect on the overall sample mean.

It is important to emphasize that the work ethic profile for the sample that relates to **morality, hard work, wasted time, delay of gratification, centrality of work, self-reliance and leisure** is also the profile for the majority of the demographic groups, as shown in the profile tables below. Following the 'majority rule' principle, it is therefore clear that this is the main profile for the sample.

DEMOGRAPHIC CATEGORIES AND THEIR WORK ETHIC MEAN SCORES

Table 5.3a shows the mean score for each demographic category on the work ethic scale. Table 5.3b gives the mean scores on the work ethic scale for each demographic category in rank order.

Table 5.3a
Work ethic mean scores by demographic category

DEMOGRAPHIC CATEGORY	WORK ETHIC MEAN SCORE
Profession	
Doctors	4.0125
Nurses	3.9427
Gender	
Males	3.9253
Females	3.9910
Age	
Below 40	3.9435
40 and above	4.0047
Education	
Undergraduates	3.9542
Graduates	3.8420
Postgraduates	4.0363
Current job experience	
Below 5 yrs	3.8814
5 to below 10 yrs	4.0282
10 and above	3.9887
Work experience	
Below 5 yrs	3.9092
5 to below 10 yrs	4.0254
10 yrs and above	3.9683
Job level	
Management	3.9633
Professional	3.9735
Home language	
IsiXhosa	3.9515
Others	4.0047
Monthly income	
R4500 and below	3.9705
R4500 and above	3.9696
Religion and work	
‘Believers’	4.1143
‘Non-believers’	3.9365
Religiosity	
Religious	4.0214
Not religious	3.9441

Satisfaction with marital/intimate relationship	
Dissatisfied	4.0591
Neither Nor	3.9580
Satisfied	3.9697
Marital status	
Single	3.9486
Married	3.9629
Separated/divorced/widowed	4.0780
Environment of upbringing	
Rural	3.9789
Urban	3.9626

Table 5.3b

Work ethic mean scores by demographic category in rank order

RANK	DEMOGRAPHIC	MEAN SCORE
1.	‘Believers’ in role of religion in work	4.1143
2.	Separated/divorced/widowed	4.0780
3.	Dissatisfied with marital/intimate relationship	4.0591
4.	Postgraduates	4.0363
5.	5 – under 10 years job experience	4.0282
6.	5 – under 10 years work experience	4.0254
7.	The ‘religious’	4.0214
8.	Doctors	4.0125
9.	40 years of age & above	4.0047
9.	Other language speakers	4.0047
11.	Females	3.9910
12.	10 years job experience	3.9887
13.	Rural upbringing	3.9789
14.	Professional job level	3.9735
15.	R4500 monthly income & below	3.9705
16.	Satisfied with marital/intimate relationship	3.9697
17.	R4501 – R11000 monthly income	3.9696
18.	10 years + work experience	3.9683
19.	Management job level	3.9633
20.	Neither/nor satisfied with marital/intimate relationship	3.9580
21.	Married	3.9629
22.	Urban upbringing	3.9626
23.	Undergraduates	3.9542
24.	IsiXhosa speakers	3.9515
25.	Single	3.9486
26.	‘Non-religious’	3.9441
27.	Below 40 years of age	3.9435
28.	Nurses	3.9427
29.	‘Non-believers’ in role of religion in work	3.9365
30.	Males	3.9253
31.	Below 5 years work experience	3.9092
32.	Below 5 years job experience	3.8814
33.	Graduates	3.8420

The pattern of mean scores on the work ethic for the different demographic categories in Table 5.3b identifies religious influence in the work sphere, religiosity, a postgraduate degree, doctor profession, longer job and work experience, older age, and non-isiXhosa home language as among the strongest factors influencing high endorsement of work ethic principles. The weakest factors were limited job experience and a graduate degree (graduates scored lower than post- and undergraduates).

Importantly, the rank-ordered work ethic mean scores highlight the differences within demographic categories: In the top ten ranks were the 'religious' and the 'believers', postgraduates and doctors, and professionals with longer job and work experience. The opposite categories: the 'non-religious' and 'non-believers', graduates and nurses, and professionals with less job and work experience were placed in the ten bottom ranks in Table 5.3b.

In Table 5.3b, work ethic mean scores range from 4.1143 for 'believers' to 3.8420 for graduates. This difference of only 0.2723 constitutes the single largest difference in mean work ethic scores both between and within demographic categories in Tables 5.3a and 5.3b, and is not statistically significant. Therefore, the next step in the analysis was to examine whether the demographic categories scored differently on any of the seven dimensions that make up the MWEP.

DEMOGRAPHIC CATEGORIES AND DIMENSION MEAN SCORES

Table 5.4 displays mean scores for the sample and sub-samples on each dimension. The dimensions in Table 5.4 are abbreviated as follows: S-R = self-reliance; M = morality; W-T = wasted time; D-G = delay of gratification; C-W = centrality of work; l = Leisure and H-W = hard work. The demographic groups and sub-groups are compared in order to highlight any differences within and across groups. Profiles are then identified for each demographic category.

Table 5.4
Differences in dimension mean scores per demographic category

			DIMENSIONS						
		N	**S-R**	**M**	**W-T**	**D-G**	**C-W**	**L**	**H-W**
Means for total sample:		*174*	3.7585	4.1764	4.1060	4.0696	3.9973	3.5484	4.1304
Sub-groups:									
Profession:	*Doctors*	*66*	3.8610	4.0849	4.1584	4.0844	4.0455	3.5924	4.2611
	Nurses	*106*	3.6936	4.2342	4.0733	4.0604	3.9673	3.5211	4.0491
Gender:	*Male*	*66*	3.7413	4.1175	4.0597	3.9805	4,0163	3.4732	4.0884
	Female	*106*	3.7691	4.2127	4.1347	4.1251	3.9854	3.5953	4.1566
Age:	*Below 40*	*99*	3.7163	4.1730	4.0870	4.0690	3.9843	3.4697	4.1051
	40 & above	*73*	3.8149	4.1809	4.1316	4.0705	4.0149	3.6553	4.1648
Education:	*Undergraduates*	*59*	3.6949	4.2475	4.0938	4.0912	3.9653	3.5068	4.0797
	Graduates	*33*	3.6432	4.1684	3.9697	3.9661	3.8650	3.3272	3.9545
	Postgraduates	*80*	3.8561	4.1282	4.1711	4.0946	4.0792	3.6842	4.2404
Current job experience:	*Below 5 yrs*	*46*	3.6636	4.0935	3.9682	3.9260	3.9053	3.5543	4.0587
	5 – 10 yrs	*31*	3.7690	4.3071	4.1905	4.2166	4.0357	3.5738	4.1048
	10 yrs or more	*115*	3.8034	4.1604	4.1391	4.0748	4.0284	3.5325	4.1825

Work experience:	*Below 5 yrs*	*26*	3.6769	4.0692	3.9911	3.9615	3.8923	3.6308	4.1423
	5 – 10 yrs	*31*	3.8169	4.2968	4.2233	4.2151	4.0484	3.4613	4.1161
	10 yrs or more	*115*	3.7599	4.1711	4.1003	4.0549	4.0072	3.5533	4.1316
Job level:	*Management*	*41*	3.6982	4.1892	4.0619	4.0354	4.0220	3.6634	4.0732
	Professional	*129*	3.7790	4.1754	4.1216	4.0805	3.9917	3.5134	4.1530
Home language:	*isiXhosa*	*113*	3.7506	4.1967	4.0622	4.0076	3.9909	3.5145	4.1377
	Others	*59*	3.7712	4.1433	4.1898	4.1885	4.0096	3.6136	4.1166
Monthly income:	*R4500 & below*	*16*	3.6563	4.2813	4.0481	4.0268	3.9565	3.7875	4.0375
	R4501 – R11000	*156*	3.7680	4.1678	4.1119	4.0740	4.0015	3.5239	4.1400
Religion & work:	*'Believers'*	*32*	3.7570	4.4663	4.2788	4.3616	4.0556	3.6250	4.2556
	'Non-believers'	*141*	3.7588	4.1106	4.0664	4.0029	3.9840	3.5310	4.1018
Religiosity:	*Not religious*	*114*	3.7789	4.0886	4.0836	4.0061	4.0031	3.5231	4.1250
	Religious	*57*	3.7178	4.3610	4.1525	4.1980	3.9856	3.5912	4.1435
Marital/ relationship satisfaction:	*Dissatisfied*	*7*	4.0036	4.1000	4.1978	4.1837	4.1000	3.5000	4.3286
	Neither nor	*33*	3.7209	4.1192	4.0577	4.0223	3.9830	3.7781	4.0250
	Satisfied	*132*	3.7545	4.1938	4.1182	4.0821	3.9953	3.4919	4.1518
Marital status:	*Single*	*66*	3.7640	4.1747	4.0690	3.9978	3.9590	3.5313	4.1446
	Married	*89*	3.7326	4.1908	4.1172	4.1105	4.0034	3.4921	4.0936
	Separated/divorced/ widow(er)	*17*	3.8817	4.0706	4.1946	4.1345	4.1118	3.8765	4.2765
Environment of upbringing:	*Rural*	*73*	3.7920	4.1562	4.0969	4.0003	4.0198	3.6689	4.1183
	Urban	*100*	3.7340	4.1911	4.1126	4.1207	3.9807	3.4596	4.1394

Work ethic mean scores, shown in Table 5.4, were computed for the sample on each dimension according to selected demographic variables. This was done to establish differences in endorsement of work ethic principles, if any, among the different demographic categories of the sample. One way analyses of variance (ANOVA) were performed to identify significant differences within groups. Results of this analysis are discussed below in such a way that only the demographic variables that registered significant differences between groups are highlighted and possible explanations are provided for the existence of such differences. Comparisons are then made between the work value profiles of demographic groups that show significant differences. All significant differences were calculated at the 0.05 confidence level.

DIFFERENCES ACCORDING TO PROFESSION

Results in Table 5.4 indicate significant differences between nurses and doctors. These differences exist on two dimensions, namely: self-reliance and hard work. The significance levels were $p < 0.001$ for self-reliance and $p < 0.006$ for hard work. The doctors' scores were higher than the nurses' scores on both self-reliance and hard work dimensions. This finding supports the qualitative data findings, described in the previous chapter, in which evaluations of work — by management, patients, nurses, fellow doctors and themselves — were much higher for doctors than for nurses. It should be emphasized, however, that both groups scored more highly on the hard work dimension than on the self-reliance dimension, the former being the

second lowest scored dimension (the lowest being leisure) for both groups. This observation will be discussed in detail later.

When the mean scores are rank ordered, the doctors' profile is as follows: hard work (4.2611), wasted time (4.1584), morality (4.0849), delay of gratification (4.0844), centrality of work (4.0455), self-reliance (3.8610), and leisure (3.5924). The nurses' profile is as follows: morality (4.2342), wasted time (4.0733), delay of gratification (4.0604), hard work (4.0491), centrality of work (3.9673), self-reliance (3.6936), and leisure (3.5211). The greatest difference in emphasis for these professionals lies in the hard work dimension (ranked number 1 for doctors and number 4 for nurses) and the morality dimension (ranked number 1 for nurses and number 3 for doctors).

DIFFERENCES ACCORDING TO RELIGIOUS BELIEFS

Significant differences were observed between nurses and doctors who believe that religion plays a role in their work and those who do not. For convenience, these two groups are referred to as 'believers' and 'non-believers'. These differences were noted on three dimensions: morality ($p< 0.003$); delay of gratification ($p< 0.012$); and wasted time ($p< 0.041$). It is perhaps not surprising that these differences exist on these specific dimensions as they are typically religious values. 'Believers' scored significantly higher on the morality dimension (4.4663) compared to the 'non-believers' (4.1106). The same pattern was also noted in terms of the 'delay of gratification' dimension (4.3616 and 4.0029, respectively) and the 'wasted time' dimension (4.2788 and 4.0664, respectively). Neither

'believers' nor 'non-believers' put much emphasis on self-reliance (2nd lowest scored) and leisure (lowest scored).

The scores for both believers and non-believers on each dimension in rank order provide the following profiles: Believers' scores were as follows: morality (4.4663); delay of gratification (4.3616); wasted time (4.2788); hard work (4.2556); centrality of work (4.0556); self-reliance (3.7570); and leisure (3.6250) and non–believers had the following scores: morality (4.1106); hard work (4.1018); wasted time (4.0664); delay of gratification (4.0029); centrality of work (3.9840); self-reliance (3.7588), and leisure (3.5310).

Compared to the doctors and nurses, the believers (as was also the case for the nurses) placed morality in the first place and hard work in the fourth place. The non-believers, on the other hand, were more similar to the doctors, with their emphasis being on hard work (ranked number 2 for them and number 1 for the doctors). On the morality dimension both believers and non-believers matched the nurses in that all three groups rated morality as the highest of all dimensions.

It becomes more interesting to observe the positions of the above groups of respondents with regard to the centrality of work, self-reliance and leisure (5th, 6th and 7th positions respectively). One would have thought that work would be considered extremely central, not only in the believers' lives, but even in the lives of non-believers. For this group of medical professionals, however, other values are given preference. Looking at the measures of the work centrality

dimension, it becomes clear, according to the scores, that work may be central in people's lives to the extent that it is a source of livelihood, but it is not necessarily a pleasurable activity. Item number 66 ("I feel content when I have spent the day working") is designed to measure this dimension. The mean score for the sample (believers and non-believers put together) is only 3.9186, being placed in the 7th position out of the 10 items on the centrality-of-work dimension (Table 5.1). Worse still, item number 92 ("it is very important for me to always be able to work") was placed in position 9 in terms of mean scores.

Differences according to religiosity

The morality dimension is consistently a strong quality for the religious believers in the sample. The next demographic variable — religiosity — also identifies significant differences between those respondents termed here as 'religious' (in so far as they are 'born again', believe in God, consider religion central in their lives, go to church very often, and believe in life after death) and those who do not hold such beliefs. The 'religious' group scored higher on the morality dimension (4.3610) than the 'non-religious' group (4.0886) ($p < 0.006$), which is not surprising, since — as indicated earlier — morality and religion go together.

The rank ordering of dimensions, based on mean scores per dimension, is as follows for the 'religious' group: morality (4.3610); delay of gratification (4.1980); wasted time (4.1525); hard work (4.1435); centrality of work (3.9856); self-reliance (3.7178), and leisure (3.5912). For the 'non-religious' group the values were as follows: hard work (4.1250); morality (4.0886); wasted time

(4.0836); delay of gratification (4.0061); centrality of work (4.0031; self-reliance (3.7789); and leisure (3.5231). These two groups differ in emphasis on everything except the last three dimensions — i.e. those from the 5th , 6th and 7th positions, (which were centrality of work, self-reliance, and leisure, respectively) — for which the two groups, discussed above, as well as all the previous groups, were in agreement.

DIFFERENCES ON THE BASIS OF EDUCATIONAL LEVEL

In terms of educational level, respondents displayed significant differences ($p < 0.002$) on the self-reliance dimension. Those respondents with a postgraduate level of education scored higher (3.8561) than the graduates (3.6432) and the non-graduates (3.6949). A further significant difference was observed in terms of the hard work dimension ($p < 0.012$), with the postgraduates scoring 4.2404, followed by the undergraduates, with 4.0797, and lastly the graduates with 3.9545. It is worth pointing out that on the leisure dimension the significant difference was very low (at the level of $p < 0.057$). The postgraduates again scored higher (3.6842) than the other groups on leisure.

The remaining demographic characteristics of the sample did not show any significant differences. It is, however, important to highlight the pattern of mean scores for all sub-groups on each dimension. Seven patterns (profiles) emerged, two of which consist of stand alone demographic categories.

WORK ETHIC PROFILES DISPLAYED BY DIFFERENT DEMOGRAPHIC CATEGORIES

As explained earlier, work ethic profiles indicate the extent to which members of a demographic category endorse/value a certain work ethic dimension in relation to other dimensions. Each demographic category in the survey was assigned a work ethic profile based on the rank order of its dimension mean scores in Table 5.4. Ten distinct work ethic profiles were identified.

Tables 5.5 to 5.14 display the different profiles and the demographic groups associated with these profiles (referred to as 'Demographic Profile 1', 'Demographic Profile 2' etc). The Demographic Profile Numbers 1 to 7 (Tables 5.5 – 5.11, respectively) related to two or more demographic categories, whereas the Demographic Profile Numbers 8, 9 and 10 were each characterized by a single (stand alone) demographic category (see Tables 5.12, 5.13 and 5.14 for details). It should be noted that the order in which the demographic categories are listed in the tables is of no significance.

Table 5.5
Demographic Profile 1

PROFILE	Morality, Hard Work, Wasted time, Delay of gratification, Work centrality, Self-reliance and Leisure.
DEMOGRAPHICS	
	1. Non-believers in religion's role in work
	2. Females
	3. All age groups
	4. Less than 5 yrs experience in present job
	5. 10 or more yrs experience in the profession
	6. All job levels (managers and professionals alike)
	7. Xhosa mother tongue speakers
	8. Satisfied with marital/intimate relationship
	9. R4501 – 11000 income level
	10. Single

Table 5.6
Demographic Profile 2

PROFILE	Morality, Delay of gratification, Wasted time, Hard work, Centrality of work, Self-reliance and Leisure.
DEMOGRAPHICS	
	1. Believers in the influence of religion in work
	2. The 'religious'
	3. Below 10 years experience in current job

Table 5.7
Demographic Profile 3

PROFILE	Hard work, Morality, Wasted time, Delay of Gratification, Centrality of work, Self-reliance and Leisure.
DEMOGRAPHICS	
	1. The 'non-religious'
	2. 10 years and above experience in current job
	3. Less than 5 years experience in profession

Table 5.8
Demographic Profile 4

PROFILES	Hard work, Wasted time, Morality, Delay of gratification, Centrality of work, Self-Reliance and Leisure.
DEMOGRAPHICS	
	1. Doctors
	2. Postgraduate level of education

Table 5.9
Demographic Profile 5

PROFILES	Morality, Wasted Time, Delay of Gratification, Hard Work, Centrality of Work, Self-reliance and Leisure.
DEMOGRAPHICS	
	1. Nurses
	2. 5 to below 10 years professional experience
	3. Graduates
	4. Non-graduates
	5. Married

Table 5.10
Demographic Profile 6

PROFILE	Morality, Wasted Time, Hard Work, Delay of Gratification, Centrality of work, Leisure and Self-reliance.
DEMOGRAPHICS	1. R4500 income and less
	2. Neither satisfied nor dissatisfied with their marital/intimate relationship

Table 5.11
Demographic Profile 7

PROFILE	Morality, Hard Work, Wasted Time, Centrality of Work, Delay of Gratification, Self-reliance and Leisure.
DEMOGRAPHICS	
	1. Male gender
	2. Rural Environment of upbringing

Table 5.12
Demographic Profile 8

PROFILE	Wasted Time, Morality, Hard Work, Centrality of Work, Self-reliance and Leisure.
DEMOGRAPHIC	
	1. Non-mother tongue isiXhosa speakers

Table 5.13
Demographic Profile 9

PROFILE	Morality, Hard Work, Delay of Gratification, Wasted Time, Centrality of Work, Self-reliance and Leisure
DEMOGRAPHIC	
	1. Urban environment of upbringing

Table 5.14
Demographic Profile 10

PROFILE	Hard Work, Wasted Time, Delay of Gratification, Morality, Centrality of Work, Self-reliance, and Leisure
DEMOGRAPHIC	
	1. Separated/divorced/widowed

Discussion of profiles

It is of great interest that, for the majority of groups, the trend is that work centrality, self-reliance and leisure are relegated to the fifth, sixth and seventh positions, respectively. The positioning of work centrality and leisure are somewhat surprising. Work is expected to be the source of livelihood for many people and the Protestant work ethic, by definition, demands a restraint on leisure. Of even greater interest is the positioning of self-reliance in the second last position, just before leisure. This reveals the value placed on group/team work as against individualism, a typical African approach, not only towards work but also towards communal living and sharing in general. It could also be argued that the medical profession, by nature, requires working together, in that a doctor may not only require the second opinion of his colleagues, but also relies heavily on the nurse who carries the most responsibility for care of the patients. Likewise, it can be assumed that the nurses rely on the doctors and each other to adequately care for their patients. The items in this dimension are not, however, purely related to work but also to a general approach to life and living. This finding is, however, in direct conflict with the results on work orientation.

WORK ORIENTATION

Work orientation was measured with a set of questions developed by Samuel and Lewin-Epstein (1979). Respondents were asked to tick the statement in each set with which they most agreed. The two sets of questions were as follows:

A)

1. "*It is very important that work would give one the opportunity to do something useful for others*" (collectivism).

2. "*It is very important that work would enable one to learn new things and develop one's own talents*" (individualism).

B)

1. "*It is very important to be employed in a job which allows considerable discretion*" (freedom of choice, using good judgment) (humanism).

2. "*It is very important to be employed in a job which provides considerable income*" (materialism)

The sample distribution according to work orientation is presented in Tables 5.15a and 5.15b.

Table 5.15a
Work orientation: Collectivism versus Individualism

Variable	Frequency	Percentage
Collectivism	28	16.7
Individualism	140	83.3
Total	168	
Missing	6	
N	174	100

Table 5.15b
Work orientation: Materialism versus Humanism

Variable	Frequency	Percentage
Humanism	4	2.4
Materialism	163	97.6
Total	167	
Missing	7	
N	174	100

Respondents generally tended to identify more with individualistic and materialistic values than with humanistic and collectivist beliefs and values. The vast majority of respondents, over four-fifths, endorsed the items that represented materialistic and individualistic tendencies. Only 28 respondents or 17% endorsed a collectivist orientation, while even fewer (4 or 2.4%) placed a higher value on humanistic values.

WORK ETHIC AND JOB SATISFACTION

Due to media reports about the general lack of facilities in hospitals in South Africa and the accompanying dissatisfaction that medical professionals were experiencing in their work, it was the intention of the study to try and establish the levels of satisfaction/ dissatisfaction of these workers, which could possibly explain the apparent low work ethic of which they were accused by the public. Results in this regard show the contrary, as shown in Table 5.16. The statement that the respondents were required to respond to was: *"Overall I am*

satisfied with my job". Responses were recorded on a 5-point Likert scale ranging from 'strongly disagree' to 'strongly agree'.

Table 5.16
Job satisfaction

Satisfied with Job	**Frequency**	**Percent**
Disagree	3	1.7
Neutral	5	2.9
Agree	133	76.4
Strongly Agree	32	18.4
Total	173	99.4
Missing	1	0.6
TOTAL	174	100

Table 5.16 shows that only three respondents (1.7%) disagreed with the statement indicating they were dissatisfied with their job, while the greatest proportion, 94.8%, agreed or strongly agreed indicating satisfaction with their job.

On a scale from 1 to 5, with 5 indicating strong job satisfaction (as opposed to dissatisfaction), the mean score was 3.07. This was correlated with the overall work ethic mean for the sample, to establish the relationship between the two variables. The Pearson correlation, which tests the association between the two variables, was 0.269, which is highly significant ($p<0.000$).

WORK ETHIC AND LIFE SATISFACTION

Another variable that relates to work ethic is life satisfaction, as explained in Chapter 2. The life satisfaction variable was measured by a single item in the questionnaire: *"Taking all things together, how satisfied are you with your life as a whole these days? Generally speaking would you say you are very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied or very dissatisfied?"*

Results on life satisfaction are shown in Table 5.17 below.

Table 5.17
Life satisfaction

Life Satisfaction	Frequency	Percent
Very satisfied	1	0.6
Satisfied	151	86.8
Neither/ nor	11	6.3
Dissatisfied	1	0.6
Missing	10	5.7
Total	174	100

The majority of respondents (87.4%) were satisfied or very satisfied with their lives; only one was dissatisfied.

Life satisfaction was significantly positively correlated with the work ethic (the sample overall mean score) (Pearson's correlation 0.225, $p<0.004$). This means that as work ethic levels increase, life satisfaction levels also increase, or vice-versa. Life satisfaction was also correlated with job satisfaction, with the result again showing a

positive correlation (Pearson's correlation 0.020 at the 0.05 significance level).

SUMMARY

This chapter has presented and interpreted the quantitative results from the survey questionnaire. The results show an above average level of work ethic for the medical professionals with no significant differences between the two professionals and the various other social demographic characteristics including age, gender, marital status, educational level, job level, and work experience. No differences were observed in terms of overall work ethic scores. However, there were significant differences on specific dimensions of the work ethic according to profession, belief in religious influence on work, religiosity, and education level. Doctors scored more highly on self-reliance and hard work than nurses. Medical professionals who believed in the influence of religion on work scored higher on morality, delay of gratification and wasted time. The religious scored higher on morality than the non-religious. Postgraduates scored higher on self reliance, hard work and leisure than both the undergraduates and the graduates.

All medical professionals in the study, without exception, tend to undervalue centrality of work, being self-reliant in work and in life in general and value leisure over work. These dimensions attracted the lowest scores.

The demographic categories in the top scoring ranks of the work ethic scale are: the believers in the role of religion on work, the religious, the postgraduates, the doctors, those with longer job and work experience, older individuals and the non-isiXhosa speakers. Those in the lowest ranks, on the other hand, were medical professionals with limited job experience and the graduates. Demographic categories were not matched for sample size due to the reluctance of many medical professionals to participate in the study. This could have biased survey results in the present study. Further research is needed to investigate the influence of demographic variables on the work ethic.

The respondents tended to favour individualistic and materialistic work orientations rather than collectivistic and humanistic orientations. This contradicts their non-endorsement of the self-reliance dimension.

Work ethic scores of the sample are found to be strongly correlated with job and life satisfaction. Indeed the sample's job and life satisfaction scores are as high if not higher than their work ethic scores. This is surprising for professionals who work under such difficult work conditions.

The next chapter seeks to compare and integrate the findings from the quantitative and qualitative strands of the study. The findings are also discussed in relation to the literature and the working hypotheses.

CHAPTER SIX

DISCUSSION OF FINDINGS

INTRODUCTION

This chapter highlights the major findings of the study and attempts to integrate results from the survey and the personal interviews. The intention is to identify the major shortcomings related to the work ethic in the delivery of health services in the studied hospitals. It is hoped that recommendations based on the findings will serve as a guideline towards policy development aimed at addressing the problems of service delivery and productivity in South Africa.

The chapter will also assess whether the objectives of the study have been achieved and whether the hypotheses stated at the outset are confirmed. Where gaps still exist in the knowledge relating to the work ethic of medical professionals, and other employees if applicable, suggestions are made for further research in this field.

INTEGRATION OF MAIN FINDINGS FROM THE PERSONAL INTERVIEWS AND SURVEY RESULTS

The main purpose of the personal interviews was to assess the work ethic of nurses and doctors by an unbiased evaluator instead of relying on self-evaluation. This was in accordance with recommendations in the literature, in response to the scholars that have criticized the exclusive use of quantitative self-evaluation of the

work ethic through survey methodology. The disadvantage of the survey method is that respondents' replies might be influenced by a wish to respond in a social desirability manner instead of providing honest responses that reflect actual practices, whether they be contrary to acceptable standards of behaviour or not. The other weakness is that there is a greater chance for a response set effect, due to the nature of instrument. In this study the respondents were evaluated by their managers, patients and colleagues and also by themselves. In other words, they had a chance to evaluate themselves twice: in the personal interviews and in the survey. Certain conflicts in the two methods of evaluation soon became evident, as outlined below.

Some of the above-mentioned criticism concerning work ethic measurements that have yielded mixed findings include Clarke, Kornberg, McIntyre, Bauer-Kaase and Kaase (1999) and Davis, Dowley and Silver (1999). These scholars have pointed out that negative findings in research on the work ethic can be attributed to methodological shortcomings inherent in the use of values surveys in which there is lack of fit between what respondents say in surveys and their deep-rooted values. House, Jovian, Dorman and Gupta (2004), and Javidan, House, Dorfman, Hanges and Sully de Luque (2006) claim that values surveys are misguided. Furnham (1990) points out that one of the primary factors limiting research in this area has been lack of common conceptualization and measurement systems for the work ethic construct.

It was on the basis of the above observations that I decided to apply two approaches to the study of the work ethic. The survey instrument

was an already existing measure that has been validated in several developed and developing countries, but only in Europe and Asia and not in Africa. The second approach used was the personal interview technique. The guideline used for the personal interviews varied according to different interviewee categories. I developed the interview guidelines for these personal interviews based on some of the ideas in Miller et al.'s survey instrument.

COMPARISON OF WORK ETHIC SCORES

Interviewees' definition of work ethic

To understand the disparity between the qualitative and quantitative findings regarding work ethic levels of respondents, it is useful to consider the definitions of the concept from the point of view of the evaluators. In this regard a summary of the definitions of work ethic by different interviewee categories in the personal interviews is provided below.

Managers understood the concept of work ethic in terms of the manner in which work is done: good (well), caringly, efficiently, thoroughly, effectively, and in terms of hard work and productivity (i.e., positive outcomes).

Doctors tended to define work ethic in similar terms as the *managers*, referring to outcomes, dedication, patience efficiency, effectiveness, responsibility, respect for *Batho Pele* principles, and hard work.

Nurses understood the work ethic concept to mean positive outcomes, such as patient recovery and improved healthcare, hard work, dedication, care, and *Batho Pele* principles.

Patients were not asked the question relating to the definition of work ethic. Their evaluation was based on the service they had received.

Importantly, some dimensions of the work ethic in Miller et al.'s (2001/2002) measurement of the concept, were not considered by interviewees when they defined the work ethic. These missing dimensions include: centrality of work, delay of gratification, wasted time, self-reliance and leisure. The narrow definition of work ethic in the interviews could therefore inflate the scores for the evaluation of work ethic, while the extra dimensions in the survey aspect of the study might pull down the scores, as was the case with the scores on leisure. There was no easy solution to such a problem as the instrument used in the survey was tailored towards self-evaluation.

Overall mean work ethic scores

According to the survey, the overall mean score for the sample, on the work ethic scale from 1 (lowest) to 5 (highest) was 3.9695 or 79.4% (Table 5.2a: Chapter 5), indicating a work ethic level above the 2.5 mid-point of the scale. In the personal interviews, based on a scale from 1-10 (lowest to highest), the overall mean score awarded to the nurses and doctors by their managers, patients, and fellow nurses and doctors was 8.2. For the purpose of comparison, these scores translate into 79% and 82% for nurses and doctors, respectively. In personal interviews, the nurses evaluated themselves

as 8.5 (85%) while doctors rated themselves as 9.1 (91%) resulting in a total mean score of 88% for doctors and nurses combined. This results in a clear difference between the ways the doctors and the nurses rate themselves, the way they are rated by others, and the way they score on the work ethic scale in the survey. The evaluation scores of both doctors and nurses appeared to be very high, but they reflected certain weaknesses, as pointed out earlier, and also have inherent average effects when scores are disaggregated according to the different professions (nurse/doctor), and interviewee categories (managers, doctors, nurses and patients), as outlined below.

In the survey, participants responded to every single item on each dimension of the work ethic scale. The mean scores for the dimensions presented in Table 5.2a in Chapter 5 can be summarized as follows: morality 4.1764; hard work 4.1304; wasted time 4.1060; delay of gratification 4.0696; centrality of work 3.9973; self-reliance 3.7585; and leisure 3.5484.

The mean score for the *centrality of work dimension* and its positioning in 5th place in the sample's profile is surprising. In the literature two specific indicators, namely, job involvement and work centrality, have been emphasized as measures of the extent to which work is a central focus and all-encompassing part of one's life (Highhouse et al., 2010). The sample's endorsement of this dimension as only the 3rd last out of seven dimensions is a contradiction to what Morse and Weiss (1955:198) had to say about the meaning of work in man's life. They state, "…most men find the producing role important for maintaining their sense of well being."

The sample's performance was poorest on the leisure dimension; self-reliance was second poorest. Self-reliance and leisure had scores below the mean score for the total sample. A technical artifact may have contributed to the low score on the leisure dimension; all leisure items were reverse coded to indicate that a high work ethic calls for sacrifice of leisure.

The positioning of *self-reliance* in 6th position, as explained in Chapter 5, is not surprising. It was shown in the literature that in African culture the group takes precedence over the individual. It was also reported in the literature that in collectivist cultures people are interdependent within their in-groups (family, tribe, nation, etc.), prioritize the goals of their in-groups, shape their behaviour primarily on the basis of in-group norms, and behave in a communal way (Mills and Clark, 1982, in Triandis 2001:909). Therefore, it is not at all surprising that the sample scored lowest on two items: "One should live one's own life independent of others as much as possible" and "Having a great deal of independence from other people is very important to me."

The contradiction however, is that the sample at the same time, tended to endorse individualist and materialist orientations both of which are direct opposites of collectivist and humanist value orientations (Samuel and Lewin-Epstein, 1979) It was shown in Chapter 5 that the sample generally tended to identify more with individualistic and materialistic values than humanistic and collectivistic beliefs and values (Tables 5.15a and 5.15b).

The contradiction in the value orientations of the sample is also not unusual according to the literature. Acculturation of values in an environment such as South Africa where a variety of cultures co-exist is expected. Therefore, although collectivism is the opposite of individualism, a degree of both is also common where elements of both cultures are borrowed and applied according to different situations. It was reported in the literature that according to Triandis (2001) not everybody in an individualistic culture has all the characteristics of that culture. There are many other dimensions defining varieties of individualism and collectivism. Most importantly Triandis notes that changes in some domains might occur while others remain unchanged including religious or family life. The work environment of these respondents – the hospital exposes them to a host of cultures. Thus, it should be understandable if they 'switch codes' to suit individual situations. However, their orientation toward individualism and materialism might also explain the strike action for higher salaries (see Chapter 2), even though it goes against their professional code of ethics. Halman and Muller (2006) equate individualism and materialism with extrinsic work orientation, the opposite of the work ethic principle of valuing work for work's own sake (intrinsic value). The tendency toward extrinsic values also goes against the respondent's strong endorsement of the morality dimension which was number one in the sample profile. It is also against the *Batho Pele* principles the respondents reported to hold in the personal interviews.

Again, given the conditions the medical professionals are forced to work under, as discussed in the literature, it becomes extremely difficult to determine the extent to which the respondents can be held responsible for not valuing work as a calling rather than an activity engaged in for material gain as advocated by Weber's Protestant ethic.

The discussion of the sample's low mean score on the leisure dimension follows later when I discuss significant differences in the work ethic according to educational level.

Just as there were variations in the scores per dimension, there were also variations on item mean scores under each dimension as explained in Chapter 5. The variations above as stated earlier had averaging effects on the overall sample mean score and that for each dimension. We can for example, specifically single out two items on the self-reliance dimension where the sample mean scores were lowest. The first item ("one should live one's own life independent of others as much as possible") had a mean score of 2.9249 and the second item ("Having a great deal of independence from other people is very important to me") a mean score of 2.5838. These two items depressed the mean on the self-reliance dimension, placing it in sixth position, and it also depressed the total work ethic score. However, in comparison to the self-reliance dimension, leisure has the strongest effect on the overall sample mean on the work ethic.

Differences in the work ethic scores according to profession

Of great interest is the finding that, according to survey results, the work ethic scores for nurses are comparable to those from the self-evaluations in the personal interviews, both being quite high. Based on the self-evaluation scale of the personal interviews, the nurses gave themselves a rating of 8.5 (on a scale of 1–10: Table 4.5, Chapter 4). In the survey they scored 3.9427 on a scale of 1–5. For purposes of comparison these scores translate into 85% and 79%, respectively. Although there is clearly a significant difference between the two scores, with the self-evaluation score in the personal interviews being significantly higher than the survey score, the difference is not as great as when the same respondents are evaluated by their superiors, i.e. the managers, and by their own patients.

Results from personal interviews (as summarized in Table 4.5, Chapter 4) indicate that, on a scale of 1–10, mean work ethic scores awarded to nurses by various groups were as follows: managers: 7.38 (74%); doctors and fellow nurses: 8.55 (86%), and patients who rated them at only 6.95 (70%). These scores clearly indicate that the evaluation of nurses by their superiors and patients was significantly lower than their evaluations of themselves, in both the survey and the personal interviews. It must however be pointed out that the managers' and patients' scores are both depressed by very low scores they awarded to the nurses, specifically in urban hospitals. The rural hospital nurses were rated significantly higher than the urban ones. The distinction was not made in the survey results where a mean score was derived for all respondents and for all health professionals,

i.e. nurses and doctors together. The rural/urban contrast is discussed later.

Scores awarded to doctors were very consistent, both in the personal interviews and in the survey, although their evaluation of themselves (9.08) was higher than that awarded by the others. In the personal interviews the doctors were awarded 8.33 by the managers, 8.88 by their fellow doctors, 8.63 by the nurses, and 8.15 (lower than others) by their patients. Again, the managers and patients appeared to be more critical, awarding lower scores. The overall mean score from personal interviews was 8.5, which is not only consistent with the survey score, but also much higher than the nurses' score of 7.86. In the survey, the doctors' overall mean work ethic score was 4.0125 (out of 5), an equivalent of 80%, compared to the nurses' score of 3.9427 (79%) (Table 5.3a in Chapter 5). Although the difference in the above figures for doctors and nurses was not significant, there were significant differences in specific dimensions of the work ethic measure.

It was reported in Chapter 5 that there were significant differences between nurses and doctors (profession variable), on two dimensions, namely: self-reliance with doctors scoring higher (3.8610) than nurses (3.6936) ($p<0.001$) and hard work with doctors again scoring higher (4.2611) than the nurses (4.0491) ($p<0.006$). It was revealed that differences relate to specific dimensions of the work ethic, rather than to the overall work ethic in the survey results. In the personal interviews there were clear differences between the two groups, although not statistically tested due to small sub-sample sizes.

The two professions also showed differences in their profiles as a result of differences in mean scores per dimension, the doctors' profile being hard work, wasted time, morality, delay of gratification, centrality of work, self-reliance and, lastly, leisure. On the other hand, the nurses' profile was: morality, wasted time, delay of gratification, hard work, centrality of work, self-reliance, and leisure. According to these profiles it appears that nurses placed great value on morality. In the personal interviews, however, their patients accused them of having a non-caring attitude, as indicated by rudeness and other inhumane behaviour patterns. It is also unusual that hard work only comes fourth in their list of values. The value placed on morality, however, is in agreement with the religious values nurses reported in the personal interviews in which they stated that, because of their belief in the role of religion in their work, they hold moral values such as: honesty, fairness, and doing good to others. Correspondingly, the morality dimension was in first position in their work ethic profile in the survey.

In the personal interviews, the doctors' religious and moral values for work were reported to be: doing good to others, hard work, and a balance between work and leisure. Reference was also made to guidance by God/Allah to take work as a calling. Hard work appears to be a priority for doctors in the personal interviews. A sense of morality is also evident in their values. However, the morality dimension is relegated to fourth place in their work ethic profile in the survey.

Work ethics governing the medical profession were enumerated in the literature review section of this thesis (Chapter 2) in which a link was observed between the values listed in the code of ethics for medical professionals and some of the values reported by the nurses and doctors in the interviews. The following extracts from the literature demonstrate this point.

"The fundamental point of nursing was to ensure the wellbeing of patients, from a humanitarian view. The nursing profession began from a religious background, and was influenced by Judeo-Christian values which shaped the nursing profession. On the other hand the medical profession was influenced by science and technology" (Hewa and Hetherington, 1990:181).

"Each profession contains a professional morality with standards which are acknowledged by those in the profession. In medicine professional morality is the general moral norms for the institutions, practices, and traditions of medicine" (Beauchamp and Childress, 2001:5).

"Medical ethics are based on principles from which positive duties occur, these principles are beneficence: duty to promote good, and act on the best interest of the patient and health of society, nonmaleficence: the duty to do no harm to patients. Respect for patient autonomy (truth-telling), the duty to protect and foster a patient's free uncoerced choices" (Snyder and Leffler, 2005:560).

With reference to the literature above, there is a strong relationship between the nurses' reports on their moral values and the values stated in their code of ethics. Therefore, the misfit between what they have internalized theoretically, regarding their professional ethics, and their practice of the same is easily discerned. The question of possible biases in terms of 'politically correct' responses (social desirability) is therefore once again brought to the fore.

It is also of interest to note that while doctors share a work ethic profile with postgraduates (only) (Table 5.8, Chapter 5); the work ethic of nurses is similar to that of professionals with between five to ten years work experience and with graduates and non-graduates (Table 5.9, Chapter 5). This should not be that much of a surprise since the majority of non-graduates and graduates are nurses while the majority of postgraduates are doctors.

Differences in work ethic scores according to educational level

Survey results showed that respondents from different educational levels displayed significant differences in terms of the self-reliance ($p<.002$) and hard work ($p<.012$) dimensions. Those respondents with a postgraduate level of education had a higher score on the self-reliance dimension (3.8561) than the graduates (3.6432) and undergraduates (3.6949). In terms of the hard work dimension, the postgraduates again scored higher (4.2404) than both the undergraduates (4.0797) and the graduates (3.9545).

The literature is ambiguous on the relationship between educational level and work ethic. Buchholz (1978a), Furnham (1982), and Tang and Tzeng (1991) found no relationship between work values and education, whereas my findings are supportive of studies by Wollack, Goodale, Witjing and Smith (1971) and Goodale (1973) that found a positive relationship.

Variations in leisure scores

According to information obtained during personal interviews, one of the doctors maintained that it was important to enjoy both work and

leisure. This could explain the near significant difference between postgraduates and others on the leisure dimension ($p< 0.057$). Postgraduates scored higher (3.6842) than the graduates (3.3272) and the non-graduates (3.5068) on leisure.

The leisure dimension attracted the lowest sample mean score. This suggests that respondents may value a leisure ethic to a greater extent than the work ethic. Work ethic scholars have observed that the value traditionally attached to work has gradually been replaced by an appreciation of leisure and a good balance between work and leisure (Yankelovich, 1978; Vecchio, 1980). Highhouse et al. (2010:354) report a leisure ethic during an economic downturn. They observed that "although one might expect less focus on leisure when the economy is relatively weak, we found the opposite."

The rural/urban contrast

In the personal interviews, the doctors and nurses from rural hospitals were rated much more highly on the work ethic than their counterparts in the urban hospitals. Tables 6.1 and 6.2 give an overview.

Table 6.1

Distribution of work ethic scores according to rural/urban hospital setting

	SETTING				
Interviewee Category	First Rural Hospital Mean	Second Rural Hospital Mean	First Urban Hospital Mean	Second Urban Hospital Mean	Overall Mean Per Interview Category
Managers*					
Doctor	9	9	8	7.3	**8.33**
Nurse	8.6	8.3	6.6	6	**7.38**
Doctors*					
Doctor	9	10	8.5	8	**8.88**
Nurse	9	10	7.5	7.7	**8.55**
Nurses*					
Doctor	9	9	8.5	8	**8.63**
Nurse	9	9	8.5	7.5	**8.5**
Patients*					
Doctor	9	9.3	6.3	8	**8.15**
Nurse	9	9.3	5.6	5.6	**7.38**
Overall Mean	**8.95**	**9.24**	**7.44**	**7.26**	**8.23**

* Underlined interview categories are evaluators

Table 6.2
Summary of work ethic mean scores according to rural/urban professional

Profession under Evaluation	Manager Evaluation (Mean)	Doctor Evaluation (Mean)	Nurse Evaluation (Mean)	Patient Evaluation (Mean)	**Overall Mean**
Doctor					
Rural	9	9.5	9	9.15	**9.16**
Urban	7.65	8.25	8.25	7.15	**7.83**
Nurse					
Rural	8.45	9.5	9	9.15	**9.03**
Urban	6.3	7.6	8	7.15	**7.26**

** All scores are means*

The most critical evaluators were the patients, who awarded both the doctors and nurses in urban hospitals a mean score of 7.15 (Table 6.2). The managers were the next most critical, awarding the urban doctors and nurses a score of 7.65 and 6.3, respectively. Although the doctors were lenient toward both their rural colleagues and nurses whom they gave 9.5 each, they too were critical of their colleagues and nurses in the urban setting to whom they awarded scores of 8.25 and 7.6 respectively. The nurse evaluators, on the other hand, do not make substantial differences between the scores awarded to the rural and urban doctors and colleagues.

To sum up, the professionals in urban hospitals therefore, consistently perform more poorly than those in the rural setting.

Table 6.3
Self-evaluation on work ethic

Profession	First Rural Hospital	Second Rural hospital	**Rural Mean**	First Urban Hospital	Second Urban Hospital	**Urban Mean**
Doctors	9	10	**9.5**	8.5	8.8	**8.65**
Nurses	8.5	9	**8.75**	8.5	8	**8.25**

According to self-evaluations shown in Table 6.3, the rural doctors showed the most confidence in themselves (score 9.5). Generally, doctors evaluated themselves more favourably than the nurses in both the rural and urban settings. Again rural doctors' and nurses' self-evaluations were more positive than the urban ones.

Table 6.4 compares the rural/urban self-evaluation scores with the scores awarded by other interviewee categories. Results indicate that the self-evaluation of rural doctors is higher (9.5) than their evaluation by others (9.16). The same applies to the doctors in urban hospitals, whose self-evaluation score is 8.65 compared to that of others (7.83).

Table 6.4
Comparison of professionals' work ethic scores by self- and other evaluation

Profession Under Evaluation	Rural Mean	Urban Mean
Evaluation by Colleagues		
Doctors	9.16	7.83
Nurses	9.03	7.26
Self-Evaluation		
Doctors	9.5	8.65
Nurses	8.75	8.25

The rural nurses surprisingly rate themselves much lower at 8.75 than they are evaluated by others who place them at 9.03. The most likely explanation might be that they feel they could do better were it not for factors beyond their control. Those in urban hospitals however, showed the opposite trend. While urban nurses rate themselves at 8.25, others award them a much lower score of 7.26.

The trend therefore is for urban doctors and nurses to evaluate themselves more highly than the evaluations that they receive from others — including their managers, patients and their colleagues —

with their most critical evaluators being their patients followed by managers. The urban hospital nurses tend to be more at the receiving end of negative judgments than is the case for the urban doctors.

Apart from the differences in scores between the rural and urban hospitals, there were also differences in scores within the two urban hospitals themselves as Table 6.1 illustrates. The second urban hospital (Frere) persistently performs much more poorly than the first (Cecilia Makiwane) for both professionals. Only the patients rate the doctors at Frere hospital higher than those at Cecilia Makiwane. The other exception is the patients who rate the nurses at both hospitals exactly the same.

In the survey data the variable on the rural/urban contrast related to the environment of upbringing rather than to the geographical location of the hospital. No significant differences were observed in the overall work ethic score for the “environment of upbringing” demographic category. Those professionals with a rural upbringing scored 3.9793 while those with urban upbringing scored 3.9626 (Table 5.3a, Chapter 5).

The minimal difference in the above scores might suggest that those with a rural upbringing, having worked and lived in the city for a long time, may have adopted the work VBAs predominant in the city. Alternatively, workers with a rural upbringing might come into the city with a high work ethic which may weaken in time. Evidence from a longitudinal study would be required to determine which interpretation holds.

According to the literature, cities are associated with Western work values and assumed to subscribe more to the work ethic principles than rural environments that adhere to more traditional attitudes. This thinking is founded on the ideas of modernization theorists – the more urbanized the more modern. In support of this school of thought, Orpen (1978) reported that black South African employees who had lived in the city for a long time and had adopted Western attitudes and lifestyles scored higher on a measure of Protestant work ethic than those from the rural area with more traditional beliefs. If the finding of higher work ethic scores in rural hospitals in the personal interviews is overlooked, then it can be tentatively concluded that the respondents with a rural upbringing have indeed adopted the city work values.

Differences on the work ethic scores in other demographic categories

As discussed in Chapter 5, the remaining demographic characteristics of the sample, considered in the survey to explain variance in work ethic scores, did not show any statistically significant differences on the dimensions of the work ethic. Such demographics include gender, age, current work experience, years employed in the profession, home language, monthly income, marital status, and job level.

However, we can distinguish between clusters of demographic categories that score highest and lowest. The pattern of mean scores identifies religious influence on work and religiosity, longer job and work experience, and the doctor profession as among the strongest

factors influencing high endorsement of work ethic principles. The weakest factors included limited job experience and a graduate degree.

The greatest differences in mean scores on the work ethic within demographic categories referred to education (postgraduates versus graduates), religious factors (the ‘believers’ and the religious versus the ‘non-believers’ and the ‘non-religious’), job-related factors (longer versus limited job and work experience), and professions (doctors versus nurses).

In terms of family life, the findings show the divorced/ separated/widowed and the dissatisfied with their marital/intimate relationships endorsed work ethic principles more highly than others. An explanation may be that it is not unusual for people to find compensation in work for the dissatisfaction they experience in other domains of life, including in marriage or intimate relationships. In other words the compensatory rather than the spillover hypothesis seems to be supported in this study. However, the numbers in these demographic categories were very small, 17 divorced/separated/ widowed and 7 dissatisfied with their relationships. There has been very little support for marital status as a predictor of work ethic. However, Tang and Tzeng (1991) found single people had stronger commitment to the Protestant work ethic than other marital statuses.

The findings on the influence of religious beliefs on the work ethic are in line with Weber’s theory of the Protestant work ethic.

Age and gender also tended to be relatively strongly associated with the work ethic in this survey. In contradiction to the difference found between the work ethic scores of doctors (rank 8) and nurses (rank 28), female respondents (rank 11) scored higher than males (rank 30), which might be explained by the larger number of females in the sample. The over forties (rank 9) scored higher on the work ethic than the under forties (rank 27).

A number of scholars have found age to be a strong predictor of work ethic values (Bucholz, 1978a; Furnham, 1987; Vecchio, 1980; Tang and Tzeng, 1991). However, the direction of age influence is contested. Highhouse and colleagues (2010), conducted a study that produced results similar to Vecchio's research, namely that younger respondents were more likely to continue working in the absence of financial necessity. In other words they showed commitment to work for work's own sake (intrinsic value of work versus extrinsic). Highhouse and colleagues offer a number of explanations. Young people may face years of idleness if they retire early. They may need more years of work in order to accumulate possessions. In contrast, Halman and Muller (2006) found in their study, that the older age groups in Western and Eastern Europe and Africa were less extrinsic in their work orientations than expected.

Vecchio (1980) and Highhouse et al. (2010) found no association between ethnicity/race and endorsement of work ethic principles. In the present study, home language, used as a proxy measure of ethnicity, was not found to be a strong predictor of the work ethic

although non-isiXhosa speakers ranked among the top ten scorers on the work ethic.

In my study, income level was a poor predictor of work ethic, although one might expect income to increase with work experience and seniority. On the other hand, the lack of an association between income and work ethic might explain why there have been a number of strikes over pay in hospitals in South Africa including the hospitals in my study. Relevant here is Furnham's (1984) finding, quoted earlier in my literature review, that high-income individuals tend to have stronger leisure ethic beliefs than individuals who earn less. Other empirical studies have drawn similar conclusions (e.g., Tang and Tzeng, 1991; and Halman and Muller, 2006).

WORK ETHIC PROFILES

The profiles identified for the different demographic categories show how each group prioritized work ethic values in comparison to others. The most popular profile, Profile 1, was: **morality, hard work, wasted time, delay of gratification, work centrality, self-reliance and leisure.** The greatest proportion of the sample falls under this profile.

The remaining nine profiles highlight the major deviations from the dominant pattern in Profile 1. Profile 2, which is unique to nurses, contrasts with the profile for doctors (No. 5). The position of morality and hard work are transposed in the two profiles. Nurses value morality (1st position) more than hard work (4th position), while

doctors prioritize hard work (1st position) before morality (3rd position). The order of the remaining dimensions conforms to the general pattern in Profile 1, the most popular one.

The Profile (No. 3) for ‘believers’ in the influence of religion on work and the ‘religious’ is only marginally different from the one that characterizes nurses. The religious/believers and nurses prioritize morality. However, delay of gratification and wasted time are transposed in their profiles. Delay of gratification is in 2nd position, wasted time in 3rd position in the believer/religious profile. In the nurses’ profile, wasted time (2nd) is positioned ahead of delay of gratification (3rd).

The profile (No. 4) for the non-religious comes close to the doctors’ profile in that hard work is first priority, whereas the ‘believers’ and the ‘religious’ prioritize morality and delay of gratification in 1st and 2nd position.

Of importance, in 6 of the 10 profiles, morality is prioritized as number one, on the basis of which we can claim that medical professionals value morality very highly. This links with accounts in the literature that indicate that nursing has historical moral origins and that morality is a strong point in the professional ethics of nurses.

In all ten profiles, work centrality, self-reliance, and leisure are placed in the last three, the 5th, 6th and 7th positions. The profile for males is the only exception which places work centrality in 4th position before delay of gratification, self-reliance and leisure.

Sample profile according to mean scores per dimension

It was noted that Profile No. 1 is the dominant one for the whole sample. Table 6.5 gives the mean scores for this profile.

Table 6.5
Sample profile with work ethic mean scores per dimension in rank order

1	**Morality**	4.1764
2	**Hard work**	4.1304
3	**Wasted time**	4.1060
4	**Delay of gratification**	4.0696
5	**Centrality of work**	3.9973
6	**Self-reliance**	3.7585
7	**Leisure**	3.5484

In conclusion, the general understanding of the work ethic of respondents in this study, on the basis of the above results, is that it is relatively high, with average scores ranging from 3.5484 – 4.1764 on a scale from 1(lowest) to 5 (highest). Whether or not this is a good enough level of work ethic for professionals needs to be determined. Acceptable standards need to be established as benchmarks against which to measure the professional work ethic. Comparisons with fellow medical professionals in other provinces, countrywide and internationally, will also need to be done.

The general overview, established through the sample mean scores on the work ethic, obscures a great deal of information. The work ethic concept is measured by considering a number of dimensions, as demonstrated earlier, which are individually measured by means of a number of different values, attitudes and beliefs. A work ethic score

for a group is therefore a result of a long sequence of averaging, starting with the averaging of item scores for each dimension, to the averaging of averages per dimension, and lastly to the averaging of all the dimension averages. It is possible that by the time the final score is arrived at, a great deal of information is lost. However laborious the process may be, it uncovers the contribution of each aspect of the work ethic measure and, as has been shown above, the respondents in this study did not perform equally well or equally poorly on all aspects. They were good at some aspects and poor at others. It is important to isolate the areas where they score poorly and structure intervention around such areas. Areas of weakness include whole dimensions as well as specific aspects on each dimension. Two such dimensions were highlighted earlier, namely self-reliance and centrality of work. Although leisure had a low score, the extent to which this dimension should be emphasized is not certain. A good balance of work time and leisure can be recommended but this depends on different individuals.

It is also questionable whether self-reliance is absolutely desirable in all work situations. If workers have been socialized to place emphasis on the good of the group, it would be difficult for them to focus on their individual performance and achievement. This would indicate a tendency toward collectivism in this particular aspect of their work ethic despite their general tendency to endorse individualism, as was demonstrated in Chapter 5. This group of professionals has persistently shown that self-reliance is not their priority. Perhaps that is why they were protective of each other when they evaluated their

colleagues' work ethic. Indeed, in their understanding of the work ethic, self-reliance and centrality of work were never mentioned.

Even in terms of dimensions in which the respondents scored highly, there were specific items on particular dimensions where their performance fell short. These are the aspects of their work ethic that should be given attention. Table 6.6 shows the range of mean scores according to dimension, which are rank ordered from the highest to the lowest.

Table 6.6

Range of mean scores per item on each dimension

	Range of mean scores	**Difference in mean scores**
Self-reliance	2.58 – 4.11	1.53
Leisure	3.23 – 3.77	0.54
Morality	3.84 – 4.31	0.47
Work centrality	3.74 – 4.16	0.42
Delay of gratification	3.93 – 4.29	0.36
Hard work	3.92 – 4.25	0.33
Wasted time	3.95 – 4.23	0.28

In Table 6.6, 'self-reliance' had the highest range, while 'wasted time' registers the lowest. This means that respondents tended to disagree most with the items relating to self-reliance, leisure, morality and work centrality while there was more consensus among them on items such as delay of gratification, hard work and wasted time. It is also noted that, although morality as a principle of work ethic was strongly endorsed by a great majority of respondents, it was also a subject of disagreement in terms of the individual items used to measure morality.

Soonteins and de Jager (2010) observed that, in many societies, an unprecedented exposure to Western culture and values resulted in a gradual acceptance, or complete replacement, of their own traditional culture and values with Western values. In some cases, acculturation resulted in a blend of Western and indigenous influences. The Japanese who embrace core Western values together with a strong communal society, are a case in point (Soonteins and de Jager, 2010). Tasie (2009:233) adds that the Japanese have excelled in borrowing the best practices from the West without themselves becoming too Westernized or Europeanized. Many cultures, particularly in Africa, do not relate to the concept of individualism (Ludwick and Silva, 2000). In this study, the lack of identification with self-reliance by the respondents may well be a reflection of this. Noteworthy is that doctors tended to be more self-reliant than nurses. In a similar observation, Yang (1998) states that, through modernization, the characteristics and values of the modern person, irrespective of culture, have become more intertwined and an increase in wealth leads to value-similarity.

In the next sections I discuss further variables that were assumed at the outset to explain variance in the work ethic: religiosity, job satisfaction and life satisfaction.

RELIGION AND WORK

The idea of religion having been instrumental in the development of capitalism through the Protestant work ethic was introduced by Max

Weber (1904/1905). Since this study is grounded in Weber's theory concerning the Protestant work ethic, it is important to examine the role of religious beliefs and religiosity in terms of influencing the work values of the respondents of the study. It is also important to examine the extent to which the respondents display a more secular work ethic, in accordance with Weber's observation that, in modern capitalist societies, the work ethic is no longer religious-based but is rather based on ascetics.

In Chapters 4 and 5, in which the results of the data from personal interviews and from the survey are presented, respondents were asked whether religion played any role in their work and outlook on life. Results from the personal interviews are summarized in Table 6.7; results from the survey in Table 6.8.

Table 6.7 below indicates that 7 out of 12 (58%) hospital managers, 6 of 8 (75%) doctors, and 7 of 9 (78%) nurses believed that religion plays an important role in their work. This adds up to a total of 20 respondents (68.97%) who stated that religion played a role in their work. Although the nurses had the highest percentage of those who believed in the importance of religion in their work, two were cautious about this belief, for example one said it "somewhat played a role".

To summarize, results from personal interviews indicated that the majority (69%) of respondents stated that religion played a role in their work. In contrast, only a minority (21%) stated that religion played no role in their work.

Table 6.7
Endorsement of the importance of religion in work: personal interviews
Respondents were asked whether religion was important in their work. The response categories were: Yes, no, and no answer.

INTERVIEWEE CATEGORY	RURAL SETTING	URBAN SETTING	TOTAL	SUB-SAMPLE TOTAL
Managers				
Yes	5	2	7	
No	1	3	4	
No answer		1	1	
Sub-Sample Total				**12**
Doctors				
Yes	2	4	6	
No		1	1	
Atheist		1	1	
Sub-Sample Total				**8**
Nurses				
1. Yes	2	5	7	
2. No	1		1	
3. Not sure	1		1	
Sub-Sample Total				**9**
SAMPLE TOTAL				**29**

To summarize, in the personal interviews, some 69% of interviewees, the 'believers', stated that religion played a role in their work. In the survey, only 32 of 173 respondents or 18% reported that religion played any role in their work (Table 6.8). For the religiosity variable, survey respondents were categorized as either 'religious' or 'non-religious' in so far as they are: 'born again', believe in God, consider religion central in their lives, go to church very often, and believe in life after death. In the survey, 57 of 171 respondents or 33% were classified as 'religious' (Table 6.8).

Table 6.8

Endorsement of the importance of religion in work: survey data

						Dimensions			
		N	**S-R**	**M**	**W-T**	**D-G**	**C-W**	**L**	**H-W**
Averages for total sample:		174	3.7585	4.1764	4.1060	4.0696	3.9973	3.5481	4.1304
Sub-groups:									
Religion & work:	*Yes,'believer'*	32	3.7570	4.4663	4.2788	4.3616	4.0556	3.6250	4.2556
	No, 'non-believer'	141	3.7588	4.1106	4.0664	4.0029	3.9840	3.5310	4.1018
Religiosity:	*Not religious*	114	3.7789	4.0886	4.0836	4.0061	4.0031	3.5231	4.1250
	Religious	57	3.7178	4.3610	4.1525	4.1980	3.9856	3.5912	4.1435

The dimension names in above table are abbreviated as to mean the following; S-R = Self-Reliance; M = Morality; W-T = Wasted Time; C-W = Centrality of Work; L = Leisure and H-W = Hard Work.

Although differences in the belief systems of respondents regarding the role of religion in work did not significantly influence overall work ethic scores of 'believers' and 'non-believers' (4.1143 and 3.9365, respectively, Table 5.3a), it was shown in Chapter 5 that significant differences, on three dimensions, were observed between those nurses and doctors who believe that religion plays a role in their work and those who do not. Such dimensions included morality ($p<0.003$), delay of gratification ($p<0.012$) and wasted time ($p<0.041$), in that order (Table 6.8). Those who hold such beliefs scored significantly higher on the morality dimension (4.4663) compared to those who did not (4.1106). Such believers also scored higher than their non-believer counterparts on delay of gratification, scoring 4.3616 and 4.0029, respectively. The scores associated with the wasted time dimension were also higher for believers (4.2788) than non-believers (4.0664). This demonstrates that the believers placed an emphasis on certain aspects of the work ethic measures,

depending on their religious beliefs, but such differences did not have an overall effect on their work ethic levels.

The believers and non-believers also differed in terms of their work ethic profiles on the basis of their mean scores per dimension (Table 6.8). The main difference between their profiles lies with the value they put on hard work (for the non-believers) and delay of gratification (for the believers). Not surprisingly, the believers share the same profile with the ‘religious’. The only other category of respondents that they also share their profile with is for those with a job experience of below 10 years. The non-believers, on the other hand, share this aspect of their profile with several other groups from all job levels, managers and professionals alike. This represents a contradiction that was pointed out earlier in this thesis: in personal interviews, respondents from all job levels believed in the role of religion in work; yet, in the survey, respondents from all job levels hold the same beliefs as those of the non-believers.

The religious scored significantly higher on the morality dimension (4.3610) than the non-religious (4.0886) ($p<0.006$) (Table 6.8).

In the profiles for the believers and the religious, morality is put in position No 1. This highlights how important the value of morality is for those respondents who have strong religious beliefs and for whom religion plays a positive role in their work.

The assumption made at the beginning of the study — that religious work beliefs and religiosity in general would influence work ethic

scores — is confirmed at the individual dimension level but not at the overall scores level. The assumption is also supported by the personal-interview findings.

JOB SATISFACTION

The study, on the basis of the reviewed literature, assumed that there would be a relationship between job satisfaction and work ethic. In particular, it was thought that the low work ethic levels, of which these professionals were accused in the media, might be explained by job dissatisfaction.

Respondents in the personal interviews were asked whether they were satisfied with their work and the greatest proportion of them said they were either satisfied or very satisfied. The most satisfied were those from rural hospitals. Respondents in the urban hospitals tended to be more reserved in expressing job satisfaction.

In the survey, respondents were asked if they agreed or disagreed with the statement, "overall I am satisfied with my job". Survey results correspond with the results from personal interviews where interviewees were overwhelmingly satisfied. The majority of the survey respondents (165 or 95%) agreed that they were satisfied with their jobs (Table 5.16, Chapter 5).

Job satisfaction was significantly positively correlated with the work ethic. Respondents scoring higher on the work ethic scale were more satisfied with their job, in support of my original assumption.

Despite the above satisfaction claim, however, when the medical professionals were asked in the personal interviews whether they would like to see some things changed in their work situation, they listed many such changes (Tables 4.13 and 4.14 in Chapter 4). It is unavoidable to reach the conclusion that, if the areas of shortcomings pointed out were a cause of concern, then more of the respondents would have expressed a greater level of dissatisfaction. There is, thus, a clear conflict between the media reports, discussed in earlier chapters of the thesis, and what the doctors and nurses themselves feel about the conditions of their work environments. One would want to look at whether it could be a matter of freedom of expression. The respondents, given the intimidation they were experiencing at the time of the study concerning talking to the media and the public about their work problems, were not free to speak out. This is the same reason I gave earlier for not achieving my sample size goals. A further possibility is that there had been a strike a couple of months before the interviews were conducted. Perhaps some of the respondents were content that their demands had been met at the time of interviews, although strikes continued long after the interviews had taken place.

It is likely that a combination of factors was at work in relation to the problems of poor service delivery experienced at these institutions. As concluded from comments of the patients (Table 4.11, Chapter 4),

some of the problems were administrative but a number of problems also related to the work ethic of individual doctors and nurses.

In his study of job satisfaction of nurses in South Africa, Pillay (2009a; 2009b), identified job dissatisfaction as the main reason for poor service delivery, high turnover and absenteeism among nurses. Pillay reports that dissatisfied employees provided poor service and paid less attention to their patients (Pillay, 2009b). Nurses in the public sector were found to be dissatisfied with remuneration, work load and resources available to them, while their counterparts in the private sector were only moderately and marginally dissatisfied with the same factors (Pillay, 2009b). He also found that the age of the nurse was an important factor. Nurses older than 20 years were generally more satisfied with their work than their younger counterparts with less experience. In the study reported here, longer work experience was among the predictors of the endorsement of work ethic principles when scores were rank ordered according to demographic categories. Age was also among the top ten predictors. Miller et al. (2001/2002) also reported a cohort effect; his organizational samples scored higher on the work ethic than the student and air force trainee samples.

Pillay (2009b) specifically points to work context as an influential factor in the dissatisfaction of nurses in the public sector. Indicators of work context were: management, autonomy, schedules, work load and remuneration in no order. These influential factors are not different from the ones reported on in the media as contributing to poor service delivery in South African hospitals, as was pointed out

earlier. Remuneration, work load and management, were particularly identified, together with lack of facilities and medicine. In the study reported here, respondents identified similar factors that needed to be changed in the studied hospitals to improve efficiency.

The patients wanted a behaviour change in nurses, an adequate supply of medicine and sufficient and better quality food. The doctors and nurses mostly wanted more staff to lessen the work load and a better supply of medicine. Management complained of "bad apples among staff", staffing and lack of resources. Surprisingly only one doctor mentioned remuneration but only in respect of overtime. There had been an agreement with government in 2007 on salary increases. However, by 2008 reportedly only 20% of the nurses' salary increases had been paid, while the doctors' increases had been postponed (Ogunbanjo and Knapp van Bogaert, 2009). It is possible that the salary issue had indeed been resolved by the time this study was conducted in 2009. However, strikes involving salaries and other complaints continued long after the study was completed. After the 2007 strike which the nurses were reported to have won, at least one manager, one doctor and one nurse indicated that "the nurses felt a sense of victory". In the same vein, it is reported that the nurses had developed an "I don't care attitude". These mixed reactions following the strikes point to factors underlying the work ethic that still need to be uncovered through further empirical research.

Indeed, a host of factors seem to be at play that result in the poor delivery of healthcare including non adherence to work ethic principles. According to the medical protection society, more than

800 claims of negligence had been reported and assessed in 2008, and a further 1000 claims were still to be assessed. Eighty per cent of all these claims came from the public sector. Some 44 doctors had been recalled from the profession due to unethical and unprofessional conduct (Naidoo, 2010). It is doubtful that the work ethic flaws among the professionals in this study are entirely due to human resource and management problems. If they were, this would have been reflected in their job satisfaction levels and their reports of what they would want changed in their work environment.

LIFE SATISFACTION

The other variable that was assumed to vary with work ethic was life satisfaction. The assumption was that subjective well-being would have positive effects on one's work performance. The assumptions that work ethic would be positively correlated with job and life satisfaction were borne out, as reported in Chapter 5. Respondents who were satisfied with their jobs and their lives had relatively higher overall scores relating to their work ethic, while dissatisfied workers scored lower.

Both job and life satisfaction are considered important indicators of well-being (Zelenski et al., 2008). Zelenski and colleagues found happy workers to be more productive than those with lower levels of well-being. This finding has implications for the respondents in this study. The respondents reported high levels of satisfaction both with their jobs and lives. Under these circumstances it could be assumed they would be highly productive workers. However, the appraisals by

the patients and managers in my study, and the ones by prominent public figures, including presidents of the country, do not tally with the level of productivity expected of such happy workers. This state of affairs indicates a weakness in the work ethic principles of medical professionals in the studied hospitals, particularly the urban hospitals.

The most plausible explanation we can make regarding the work behaviour patterns of the professionals under study, may refer to what Durkheim (1947) called 'anomie' (normlessness) as societies have industrialized and capitalism has matured. The old order (apartheid) is gone, and the new order (post-apartheid) is still to establish itself and gain complete control. The norms that held society together (collective conscience) have been replaced by individual drives and interests and until these are harnessed and translated into collective goals, normlessness persists (Durkheim, 1947).

SUMMARY

This chapter provided a detailed discussion of the findings of the study that investigated the work ethic VBAs of medical professionals from selected hospitals in the Eastern Cape province of South Africa. The study measured the sample's work ethic from different angles and points of view and this multi-method approach was of great advantage in uncovering what one method, which has predominantly been the positivistic orientation with its accompanying survey method, would not have revealed. The findings of the study have been discussed in relation to the working hypotheses enumerated in

chapter 2, and to the literature that informed the formulation of the hypotheses.

The overall work ethic mean score for the sample was 3.9695 on a scale from 1 (lowest) to 5 (highest) in the survey and 8.2 in the personal interviews on a scale from 1 (lowest) to 10 (highest), both of which are greater than the midpoints of 2.5 and 5 respectively. This finding supports hypotheses 2 and 3 regarding the expected level of work ethic scores in the sample.

The findings did not support hypothesis 1 which assumed there would be significant differences in work ethic mean scores on selected demographic categories. However, such differences were observed on individual dimensions for profession, religiosity, educational level, and belief in the influence of religion on work categories.

Hypothesis 4 was also not supported by the findings which found the dominant work orientations to be individualist and materialist instead of collectivist and humanist as was hypothesized.

The fifth hypothesis stating that the work ethic scores for the sample would be strongly and positively correlated to job and life satisfaction was borne out by the findings. This finding identifies the sample as happy and satisfied workers with a high work ethic, a picture that contrasts strongly with the negative publicity in the media regarding poor service delivery and problems related to lack of resources and equipment in the studied hospitals. The nurses' work, however, was

evaluated much lower than doctors' by all participants in the interviews except themselves. A similar contradiction between own and other evaluation was observed for the self-reliance and hard work dimensions in the survey. Both doctors and nurses in the rural hospitals were evaluated much more highly than their counterparts in the urban hospitals. Of the two urban hospitals Frere was evaluated much lower than Cecilia Makiwane.

The strongest factors influencing high endorsement of work ethic principles were: religious influence in the work sphere, religiosity, a postgraduate degree, the doctor profession, longer job and work experience, older age and non-isiXhosa home language. The weakest factors were limited job and work experience and a graduate degree. Future research is recommended to explore this further, since the unmatched sub-sample sizes in this study may have biased the findings.

The problems reported by the respondents which might influence poor service delivery in the health sector matched those identified in the literature. These included nurses' negative behaviour patterns towards their patients with rudeness and an 'I don't care attitude' predominating; insufficient supplies of medicine; understaffing; and to a lesser extent lack of equipment; infrastructure; overtime remuneration; and poor management.

The next chapter will summarize the findings further in the form of a conclusion and make possible recommendations on what suitable interventions could be introduced to overcome poor service delivery

and improve work ethic levels in the health and other sectors in South Africa. Recommendations are made for further research in the field of work ethic.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

This chapter provides some concluding comments on the work ethic of medical professionals at selected rural and urban hospitals in the Eastern Cape region of South Africa. The study reported here sought to understand the work ethic values, beliefs and attitudes of these health professionals. The findings that lead to these conclusions were compiled from personal interviews and questionnaire survey data.

Comparisons were made between the findings of work ethic scores from the questionnaire survey and from personal interviews. Work ethic profiles, which were the main tool of analysis, were compiled from the survey data for the sample as a whole and for each demographic category. The work ethic scores for the sample were correlated with job and life satisfaction. Significantly positive associations were established.

On the basis of the findings discussed in Chapter 6, the following is a summary of the main conclusions of the study.

1. The scientific measurement of the work ethic construct is still highly problematic. The multidimensional approach has been recommended as the most appropriate means for assessing this type of construct. My findings suggest that, although this method is superior to previous measures that were used, it

may be too general in terms of cultural values. This means that some of the dimensions constituting this work ethic measure may not necessarily apply to certain groups of workers. This is disadvantageous in that low scores on such dimensions negatively affect overall scores for the group. A case in point is self-reliance. It is not clear whether there is provision for flexibility in terms of the extent to which workers depend on themselves or on others. In the case of the medical profession, it may be desirable to place more emphasis on team work. A doctor relies heavily on consulting: this applies to consultations with more senior colleagues as well as with specialist and general consultants. Doctors also consult with nurses who, in turn, consult with other nurses. Medical ethics may dictate this kind of team work and it thus becomes confusing when a respondent, who is a medical professional, has to endorse a statement such as, "I do not like having to depend on other people". Similarly, in societies where value is placed on the community (group) rather than the individual, the statement, "Having a great deal of independence from others is very important to me" is likely to yield a negative response.

It is recommended that further studies be conducted, especially in Africa, to determine the relevance of the Multidimensional Work Ethic Profile developed by Miller et al. (2001/2002).

2 It is likely that the social desirability effect played a role in the responses to the questionnaire in this study. The work ethic scores from the survey were comparable to those from self-evaluations. This was especially the case for the nurses — particularly those in urban hospitals — whose evaluation by their managers and patients was much poorer than their self-evaluations, in the survey and in the personal interviews.

The assessments of managers and patients suggest that work ethical standards of nurses and doctors in urban hospitals are weaker than those of their rural counterparts. In this respect, these assessments also suggest that the performance of nurses is worse than that of doctors. The performance of doctors in terms of self-reliance and hard work was also found to be higher than that of nurses. The reasons for differences, in terms of work ethics, between the rural and urban medical professionals could not be ascertained, particularly as such urban professionals were found to enjoy high levels of job satisfaction. We can only speculate that fear of victimization might have hindered respondents from expressing their dissatisfaction with their work situation.

It is therefore recommended that a variety of methodologies be used to assess work ethical standards for any group of workers. Personal interviews with consumers of the service are an important way in which to assess the social desirability effect of the survey instrument as well as the problems relating to the subjectivity of self-evaluations.

3 On the basis of the last finding, a complex deconstruction of the work ethic construct enables us to identify underlying weaknesses in worker attitudes, values, and beliefs that would otherwise be overshadowed by a superficial assessment of these constructs. In this regard, the multidimensional instrument used in this study is a commendable approach.

Given that, in the era of globalization, job performance and job advancement must be measured according to certain international standards, the dimensions of work ethic identified by Miller et al. (2001/2002) should be upheld and employees be trained in these areas. Employees that exhibit poor performances in terms of specific dimensions of the scale, and on specific items within these dimensions, should receive education and training in these areas. The respondents in this study, for example, would benefit from an education exercise that draws their attention to all the dimensions of the work ethic, with particular emphasis on work centrality, self-reliance and, to a certain extent, leisure. Regarding leisure, it will be important to emphasize the advantages of maintaining a healthy balance between work and leisure, so as to avoid burn-out and boredom (in the case of those whose work is repetitive). Although these dimensions in their entirety form part of professional training, a greater emphasis needs to be placed on specific areas of each dimension. Knowledge of the different dimensions of work ethic is imperative for workers, since this study revealed that respondents, especially the

underperformers, tended to understand and define the concept of work ethic in narrow terms. A greater part of the knowledge of the work ethic by medical professionals in this study seemed to originate from their professional ethics and from *Batho Pele* principles, which some may have internalized (possibly for the sake of political correctness). Yet, according to their patients, these principles are not acted out in practice.

There also appears to be a disparity between how nurses think their patients view their service and the evaluations of the same nurses by their patients and managers. In this respect authentic feedback from data obtained through scientific methods should be provided to the nurses so that they can attempt to improve their ethical standards in terms of those areas for which they have been criticized.

4 Recommendations tabled in Chapter 4 encapsulate the ideas of various interviewees — including managers, doctors, nurses and patients — concerning the changes that they would like to see in the delivery of medical services. These need to be brought to the attention of higher authorities in the health sector and acted upon. The patients were more concerned about the nurses' negative approach in dealing with patients, quality and quantity of food; the managers expressed concern about "general apathy among staff", the negative attitudes of some nurses; and shortages of staff and medicine. The doctors complained about understaffing, shortage of medicine,

remuneration in respect of overtime, infrastructure improvement so that the surrounding clinics and hospitals carry some of the patient load instead of overburdening the main hospitals, lack of commitment on the part of staff, and changes of appointment strategy so that managers have a medical background. The nurses mostly recommended an increase in staffing and medical supplies.

These factors can be categorized broadly as: work ethical issues, staffing shortages, medical supplies shortages, food quality, non-payment of overtime, infrastructural problems and appointment of senior officials at provincial and national levels. These may combine in complex ways to produce the anomie observed in the healthcare system in South Africa. However, this study produced no evidence to suggest that work ethic flaws stem directly from any of the above problems beyond VBAs. Extraneous factors need to be studied in further empirical research in hospitals in other provinces using larger sample sizes and multiple approaches. A comparison of medical professionals in the public and private health sectors is also recommended for future studies. This study found differences in the work ethic in rural and urban hospitals. This finding needs to be investigated further.

5 In terms of prioritization of work ethic values, the sample can be divided into two main demographic groups. On the one hand, there was a group consisting of only two demographic

characteristics: age and job level. The profiles from all the age groups were similar, as was also the case for the various profiles associated with job levels. A second demographic group comprised all the other demographic categories: gender, profession, current job experience, professional experience, satisfaction with marital/intimate relationships, income, religiosity, belief in a relationship between work and religion, rural or urban upbringing, home language (isiXhosa mother tongue speakers versus non-isiXhosa speakers) and marital status. A number of different profiles were identified, most of which incorporated more than two of the above-mentioned categories. There were, however, two demographic categories — the non-isiXhosa speaking and the separated/divorced/widowed categories — that produced stand-alone work ethic profiles. These two demographic categories comprised much smaller numbers than others. Out of the total sample of 174, there were 59 non-isiXhosa speakers and only 19 persons in the divorced/separated /widowed category.

The educational level demographic could not be placed in either the first or the second group. It was unique, in that two of its categories — the graduates and non-graduates — had a similar profile, while the postgraduates had their own profile.

The profile assigned to the vast majority of demographic categories defined the profile for the whole sample, namely: **Morality, Hard work, Wasted time, Delay of gratification,**

Centrality of work, Self-reliance and Leisure. The value placed on morality, as indicated in Chapter 6, seems more likely to be linked to the internalized medical professional ethics and the *Batho Pele* principles than to the respondents' own convictions. This is particularly so with respect to the nurses, considering that reports from patients on the attitudes with which some of the nurses render their services were largely negative. This is in line with the literature, as quoted earlier. For example, according to Hewa and Hetherington (1990), the nursing profession was founded on religious ethics influenced by Judeo-Christian values, which have shaped the nursing profession. These incorporated the idea that the most important attribute of a professional nurse was a set of principles or standards that created a common ground between nurses, patients, their families and other healthcare physicians. Such principles facilitated understanding and collective agreement (Sanderson, 1999).

6 This study made use of the Multidimensional Work Ethic Profile by Miller et al. (2001/2002), which is understood to be a secular measure. Nevertheless, religion emerged as an important factor influencing the work ethic and outlook on life of respondents in the study. Although a few respondents could not clearly identify the role that religion played, reports from the largest proportion of the sample indicated that, not only did religion motivate them to do their work well, it also promoted positive values in their work. In the case of nurses, positive values included honesty, fairness, the intent to hurt

no one, and to do good to others. The doctors stated that they were motivated to do good to others, enjoy work and life in general, to work for God/Allah, to work hard, be responsible, effective, highly productive, and to value respect and hard work. The latter introduced the value of respect in work, which was not part of the work ethic measure of Miller et al. (2001/2002).

The performance of those who believed that religion played a role in their work was significantly higher than those of non-believers in terms of morality, delay of gratification, and wasted time dimensions. The two groups did not however differ in terms of their overall work ethic scores.

The role attributed to religion in work also produced different work ethic profiles. These differed in terms of the placement of hard work and delay of gratification, two key characteristics of the Weberian work ethic. Delay of gratification is the second most important work value after morality for believers, while hard work is relegated to fourth place in the profile. In the non-believer profile, hard work is the second most important category after morality, with delay of gratification in fourth place.

The respondents who believe that religion plays an important role in work and the 'religious' had similarly high scores on the work ethic scale and had identical work ethic profiles.

Both groups performed significantly higher than their counterparts in terms of the morality dimension.

It is, however, important to note that the medical profession might not be a suitable sector for establishing a relationship between religion and work, as the profession has a strong historical religious and moral foundation. Future research should aim at testing the relationship between religious beliefs/religious practices and work ethics, on a category of workers that do not have such historical links to religion and morality.

It is also important to note that only 57 respondents in the sample could be categorized as religious, based on an index made up of five indicators. The other 114 respondents were considered to be not religious. The majority of respondents did, however, report that religion played a role in their work. It could therefore be argued that these professionals fitted with the distinction, described by Allport (1950), between having an intrinsic or extrinsic orientation to religion. According to King and Crowther (2004), individuals with an intrinsic orientation to religion view their practice of religion as a goal in and of itself and believe in religious practice for its own sake. Individuals with an extrinsic orientation, on the other hand, perceive the practice of religion as a means to personal and/or social ends: for example, acceptance or comfort. Angelis and Ibraham (2004), in their survey of business students, confirmed what other research studies had

already shown: a link between religious constructs and ethics. They found a significant relationship between the degree of religiousness and attitudes towards the ethical components of corporate social responsibility. The majority of respondents in the present study did not have a strong orientation towards religiosity, but a substantial majority believed that religion played an important role in their work. This could be viewed as an extrinsic orientation to religiosity and may explain the weaknesses in their work ethic, as reported by patients and the media, as well as the low work ethic scores awarded to urban nurses and, to some extent, to doctors. In other words, although these medical professionals hold moral/religious work values, in practice they may not be committed to the application of these principles. Alternatively, some other factor(s), including poor working conditions, may interfere with the application of these values.

7 In this study the work ethic was found to be correlated with job satisfaction. Indeed, the high scores in the work ethics of respondents were matched to high job satisfaction levels.

8 Work ethic was also found to be positively correlated with life satisfaction. The results in this study indicated that the higher the work ethic levels among workers, the higher their levels of life satisfaction, and vice versa. The direction of the relationship was not tested, but it can be assumed that if individuals are dissatisfied with their lives they may indeed have a low work ethic as life dissatisfaction may spill over

into their work behaviour. However, the professionals in my study who were dissatisfied with their marital/intimate relationships scored somewhat higher on the work ethic than their satisfied counterparts which suggests a compensatory rather than a spillover effect. It is recommended that future research should be undertaken to establish the direction of this relationship.

9 The medical professionals under study tended more toward individualism and materialism than towards humanism and collectivism. It is seemingly contradictory that a group of professionals who placed so much value on morality and religion, and did not value self-reliance as being important in their lives, could at the same time be individualistic and materialistic oriented! This suggests that lip service is paid to professional values which have not been internalized. This propensity towards extrinsic work values ties in with extrinsic religious orientation and might explain why nurses went on strike although their professional ethics prohibits such action.

A more detailed study on work orientations using more than one measure is required to validate or invalidate the above finding. A study comparing medical and other professions that do not subscribe to the Hippocratic Oath would enhance the robustness of the findings.

10 It is seemingly contradictory that a group of professionals who placed so much value on morality and religion did not value self-reliance as being important in their lives.

   A more detailed study on work orientation is required to validate or invalidate the above finding.

11 On the basis of the findings of this study, a medical professional who espouses a high work ethic can be said to be one with the following qualities: subscribes to the belief in the role of religion in work, is religious, moral, hardworking, effectively uses time, postpones gratification, enjoys high levels of life and job satisfaction, values individualism and materialism, has a postgraduate degree and longer job and work experience. Working in a rural environment has an added value. Again confirmation of these findings is required to counter the possible effects of unequal sub-sample sizes pointed out in the limitations of the study.

   Nevertheless, if these professionals were also to be evaluated on the other three dimensions of the scale to establish their true reflection of work ethic, they would need training in work centrality (to be sensitized to consider work as central in their lives), self-reliance, and leisure.

As part of my commitment to my respondents, some of the recommendations arising from the findings of the study will be shared with the participating hospitals. A better understanding of the

many dimensions of the work ethic may serve as guideline for the training of medical professionals in the *work ethic* skills which should result in improved delivery of health services in the Eastern Cape.

SUMMARY

The study reported in this PhD thesis was an attempt to probe the extent to which medical professionals in selected hospitals in the Eastern Cape province of South Africa endorse or do not endorse work ethic principles as conceptualized in both the modern and Weberian understandings. The study was motivated by an outcry not only in South Africa but globally about the declining work ethic among workers in every sector of society. The study responded to the call from empirical researchers for current innovative empirical studies to measure the construct of the work ethic in its multidimensional entirety rather than in select aspects. Although some multidimensional studies of the work ethic have been carried out, they have been limited in number, and with few exceptions have been confined to developed countries. This present study is ground breaking in an African and South African context. The South African context is a unique one in respect of its apartheid history. The transition to democracy has not been without anomalies. The targeted population of study – the medical care sector has been the subject of negative criticism in its delivery of healthcare services. It is hoped that the findings of this study have opened doors for discussion, debate and further research on the work ethic, all of which are vital for positive change in the delivery, not only of healthcare but of other

public services, in the Eastern Cape and the rest of South Africa, that will improve the quality of life of the country's citizenry. Such positive change will, as is expected, have a spillover effect into the development of the country given that a strong work ethic is associated with economic growth.

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APPENDICES

Work ethic indicators survey 2009

Letter of introduction

Personal interview guideline:
Personal interviews with hospital managers,
doctors and nurses, and patients

WORK ETHIC INDICATORS SURVEY – EASTERN CAPE 2009

Write an X next to the applicable answer:

1 Age:

1. Under 20	___	6. 40 – 44	___
2. 2. 20 – 24	___	7. 45 – 49	___
3. 3. 25 – 29	___	8. 50 – 54	___
4. 4. 30 – 34	___	9. 55 – 59	___
5. 5. 35 – 39	___	10. 60+	___

2 Gender:

1. Male	___	2. Female	___

3 Marital status:

1. Single/Never Married ___
2. Living together with partner ___
3. Married – Civil ___
4. Married - Traditional/Customary ___
5. Separated/Divorced ___
6. Widowed ___

4 Please rate your satisfaction with your current relationship/married/single status:

1. Very dissatisfied ___
2. Dissatisfied ___
3. Neither satisfied nor dissatisfied ___
4. Satisfied ___
5. Very satisfied ___

5. Educational level:

1. None	___	5. Undergraduate diploma	___
2. Below Std 5	___	6. First degree	___
3. Std 5 – 7	___	7. Postgraduate diploma	___
4. Std 8 – 10	___	8. Postgraduate degree	___

6. Religion:

1.	___	5.	___
2.	___	6.	___
3.	___	7.	___
4.	___	8.	___
5.	___	9.	___

7. Whether born again:

1. Yes	___	2. No	___

8. Do you believe in God?

1. Yes	___	2. No	___

9. Is religion central in your life?
   1. Yes ___ 2. No ___

10. How often do you go to church?
   1. 1 – 2 times a week 3. Never ___
   2. 3 – 4 times a week ___

11. Do you believe in life after death?
   1. Yes ___ 2. No ___

12. Does religion play a role in your work?
   1. Yes ___ 2. No ___

13. If your response to number 11 above was "yes", what role does it play

   ____
   ____

14. Monthly income:
   1. Below R200 ___ 7. R3501 – 4500 ___
   2. R201 – 500 ___ 8. R4501- 6000 ___
   3. R501 – 1000 ___ 9. R6001 – 8000 ___
   4. R1001 – 1500 ___ 10. R8001 – 11000 ___
   5. R1501 – 2500 ___ 11. R11001 – 16000 ___
   6. R2501 – 3500 ___ 12. R16000 – 30000 ___

15. Nationality:
   1. South African ___ 3. Eastern country (specify) ___
   2. Other African ___ 4. Western country (specify) ___

16. Population Group:
   1. African / Black ___ 3. Indian/Asian ___
   2. Coloured ___ 4. White ___

17. Home language/Ethnicity:
   1. English ___ 8. Ndebele ___
   2. Afrikaans ___ 9. Swati ___
   3. Xhosa ___ 10. Tsonga ___
   4. Zulu ___ 11. Venda ___
   5. Sesotho ___ 12. Other SA language ___
   6. Pedi ___ 13. Non-SA language ___
   7. Tswana ___

18. Province(s) of upbringing:
   1. Eastern Cape ___ 6. Gauteng ___
   2. Western Cape ___ 7. Limpopo ___
   3. Free State ___ 8. Mpumalanga ___

4. Northern Cape ___ 9. KwaZulu-Natal ___
5. North West ___

19. Environment of upbringing:
1. Rural ___ 2. Urban ___

20. Work Location:
1. Mthatha
2. Rural hospital ___ 3. East London ___

21. Job level:
1. Top Management ___ 4. Middle Management ___
2. Supervisory ___ 5. Professional ___
3. Skilled labour ___ 6. Unskilled labour ___

22. Total number of years employed:
1. Under 2 years ___ 9. 9 – under 10 years ___
2. 2 – under 3years ___ 10. 10 – under 11 years ___
3. 3 – under 4years ___ 11. 11 – under 12 years ___
4. 4 – under 5 years ___ 12. 12 – under 13 years ___
5. 5 – under 6 years ___ 13. 13 – under 14 years ___
6. 6 – under 7 years ___ 14. 14 – under 15 years ___
7. 7 – under 8years ___ 15. 15 years + ___
8. 8 – under 9 years ___

23. Number of years in current job:
1. Under 2 years ___ 9. 9 – under 10 years ___
2. 2 – under 3 years ___ 10. 10 – under 11 years ___
3. 3 – under 4 years ___ 11. 11 – under 12 years ___
4. 4 – under 5 years ___ 12. 12 – under 13 years ___
5. 5 – under 6 years ___ 13. 13 – under 14 years ___
6. 6 – under 7 years ___ 14. 14 – under 15 years ___
7. 7 – under 8 years ___ 15. 15 years + ___
8. 8 – under 9 years ___

24. Terms of employment:
1. Permanent ___ 4. Temporary ___
2. Fixed period contract ___ 5. Hourly paid ___
3. Casual ___ 6. Seasonal ___

25 Working hours:
1. Full time ___ 2. Part time ___

26 Total number of working hours per day:
1. 5 hours and less ___ 4. 12 – 14 hours ___
2. 6 – 8 hours ___ 5. 15+ hours ___
3. 9 – 11 hours ___

For the following set of statements:
Circle SA if you strongly agree with the statement.
Circle A if you agree with the statement.
Circle N if you neither agree nor disagree with the statement.
Circle D if you disagree with the statement.
Circle SD if you strongly disagree with the statement.

27	I take a great deal of pride in the work that I do.	SD	D	N	A	SA
28	Overall, I am satisfied with my job.	SD	D	N	A	SA
29	My boss behaves in an intimidating and bullying way towards me.	SD	D	N	A	SA
30	I am not adequately trained to do many aspects of my job.	SD	D	N	A	SA
31	I do not enjoy my job.	SD	D	N	A	SA
32	I enjoy working for this organization to the extent that I am not actively seeking a job elsewhere.	SD	D	N	A	SA
33	Overall I am happy with my organization.	SD	D	N	A	SA
34	I am committed to this organization.	SD	D	N	A	SA
35	I do not have proper resources or equipment to do my job.	SD	D	N	A	SA
36	My boss is always finding fault with what I do.	SD	D	N	A	SA

Use the following categories to evaluate your work – circle the applicable number:
1 = Never 2 = Sometimes 3 = Often 4 = Always

37	Do you have too much work to do?	1	2	3	4
38	Does your work make sufficient demands on all your skills and capabilities?	1	2	3	4
39	Does your job offer you opportunities for personal growth and development?	1	2	3	4
40	Do you feel appreciated by your supervisor (person you report to)?	1	2	3	4
41	Do you get on well with your colleagues?	1	2	3	4
42	Do you get on well with your supervisor?	1	2	3	4
43	Do you know exactly what your direct supervisor thinks of your performance?	1	2	3	4
44	Do you receive sufficient information on the results of your work?	1	2	3	4
45	Does your direct supervisor inform you about how well you are doing your work?	1	2	3	4
46	Can you participate in the decisions about the nature of your work?	1	2	3	4
47	Do you need to be more secure that you will still be working in one year's time?	1	2	3	4
48	Do you need to be more secure that you will keep your current job in the next year?	1	2	3	4
49	Do you think you are paid a good salary?	1	2	3	4

50	Can you live comfortably on your pay?	1	2	3	4
51	Do you think you are paid enough for the work that you do?	1	2	3	4
52	Does your work offer you the possibility to progress financially?	1	2	3	4
53	Does your work offer you opportunities to follow training courses?	1	2	3	4
54	Does your job offer you the opportunity to be promoted?	1	2	3	4
55	Do you rate yourself as a high performer in your job?	1	2	3	4
56	Do you think you are good at your job?	1	2	3	4

For the following set of statements:
Circle SA if you strongly agree with the statement.
Circle A if you agree with the statement.
Circle N if you neither agree nor disagree with the statement.
Circle D if you disagree with the statement.
Circle SD if you strongly disagree with the statement.

57	My life is not close to my ideal.	SD	D	N	A	SA
58	The conditions of my life are excellent.	SD	D	N	A	SA
59	I am not satisfied with my life.	SD	D	N	A	SA
60	So far I have got the important things I want in life.	SD	D	N	A	SA
61	I am not satisfied with the state of my health.	SD	D	N	A	SA
62	If I could live my life over, I would change almost nothing.	SD	D	N	A	SA
63	It is important to stay busy at work and not waste time.	SD	D	N	A	SA
64	I feel uneasy when there is little work for me to do.	SD	D	N	A	SA
65	If I want to buy something, I always wait until I can afford it.	SD	D	N	A	SA
66	I feel content when I have spent the day working.	SD	D	N	A	SA
67	Life would be more meaningful if we had more leisure time.	SD	D	N	A	SA
68	To be truly successful, a person should be self-reliant.	SD	D	N	A	SA
69	One should always take responsibility for one's actions.	SD	D	N	A	SA
70	I would prefer a job that allowed me to have more leisure time.	SD	D	N	A	SA
71	Time should not be wasted, it should be used efficiently.	SD	D	N	A	SA
72	Even if I were financially able, I would not stop working.	SD	D	N	A	SA
73	I get more fulfillment from items I had	SD	D	N	A	SA

	to wait for.					
74	I schedule my day in advance to avoid wasting time.	SD	D	N	A	SA
75	A hard day's work is very fulfilling.	SD	D	N	A	SA
76	The more time I can spend in a leisure activity, the better I feel.	SD	D	N	A	SA
77	One should always do what is right and just.	SD	D	N	A	SA
78	I would take items from work if I felt I was not getting paid enough.	SD	D	N	A	SA
79	Nothing is impossible if you work hard enough.	SD	D	N	A	SA
80	The less time one spends working and the more leisure time one has, the better.	SD	D	N	A	SA
81	Things that you have to wait for are the most worthwhile.	SD	D	N	A	SA
82	Working hard is the key to being successful.	SD	D	N	A	SA
83	Self-reliance is the key to being successful.	SD	D	N	A	SA
84	If one works hard enough one is likely to make a good life for oneself.	SD	D	N	A	SA
85	I constantly look for ways to productively use my time.	SD	D	N	A	SA
86	Hard work makes one a better person.	SD	D	N	A	SA
87	One should not pass judgment until one has heard all of the facts.	SD	D	N	A	SA
88	People would be better off if they depended on themselves.	SD	D	N	A	SA
89	Work takes too much of our time, leaving little time to relax.	SD	D	N	A	SA
90	One should live one's own life independent of others as much as possible.	SD	D	N	A	SA
91	A distant reward is usually more satisfying than an immediate one.	SD	D	N	A	SA
92	It is very important for me to always be able to work.	SD	D	N	A	SA
93	More leisure time is good for people.	SD	D	N	A	SA
94	One must avoid dependence on other persons whenever possible.	SD	D	N	A	SA
95	Even if I inherited a great deal of money, I would continue to work somewhere.	SD	D	N	A	SA
96	I do not like having to depend on other people.	SD	D	N	A	SA
97	By working hard a person can overcome every obstacle that life presents.	SD	D	N	A	SA
98	I try to plan out my workday so as not to waste time.	SD	D	N	A	SA
99	You should never tell lies about other people.	SD	D	N	A	SA
100	Any problem can be overcome with hard work.	SD	D	N	A	SA

101	How a person spends their time is as important as how they spend their money.	SD	D	N	A	SA
102	Even if it were possible for me to retire, I would still continue to work.	SD	D	N	A	SA
103	Life without work would be very boring.	SD	D	N	A	SA
104	I prefer to save until I can afford something and not buy it on credit.	SD	D	N	A	SA
105	The world would be a better place if people spent more time relaxing.	SD	D	N	A	SA
106	I strive to be self-reliant.	SD	D	N	A	SA
107	If you work hard you will succeed.	SD	D	N	A	SA
108	The best things in life are those you have to wait for.	SD	D	N	A	SA
109	Anyone who is able and willing to work hard has a good chance of succeeding.	SD	D	N	A	SA
110	Stealing is all right as long as you don't get caught.	SD	D	N	A	SA
111	The job that provides the most leisure time is the job for me.	SD	D	N	A	SA
112	Having a great deal of independence from others is very important to me.	SD	D	N	A	SA
113	It is important to treat others as you would like to be treated.	SD	D	N	A	SA
114	I experience a sense of fulfillment from working.	SD	D	N	A	SA
115	A person should always do the best job possible.	SD	D	N	A	SA
116	It is never appropriate to take something that does not belong to you.	SD	D	N	A	SA
116	Only those who depend on themselves get ahead in life.	SD	D	N	A	SA
117	Wasting time is as bad as wasting money.	SD	D	N	A	SA
118	There are times when stealing is justified.	SD	D	N	A	SA
119	People should have more leisure time to spend in relaxation.	SD	D	N	A	SA
120	It is important to control one's destiny by not being dependent on others.	SD	D	N	A	SA
121	By simply working hard enough, one can achieve one's goals.	SD	D	N	A	SA
122	People should be fair in their dealings with others.	SD	D	N	A	SA
123	The only way to get anything worthwhile is to save for it.	SD	D	N	A	SA
124	Leisure time activities are more interesting than work.	SD	D	N	A	SA
125	A hard day's work provides a sense of accomplishment.	SD	D	N	A	SA
126	A distaste for hard work usually reflects a weakness of character.	SD	D	N	A	SA

127 Why are there people in this country who live in poverty? Here are four reasons. Which one reason do you consider to be most important, and which one do you consider to be second most important?

	Most important	Second most important
1. Because they are unlucky.	1	2
2. Because they are lazy and lack will-power.	1	2
3. Because there is injustice in society.	1	2
4. It is an inevitable part of modern progress.	1	2
5. None of these.	1	2
6. Do not know.	1	2

128 Do you have any comments about workers in the Eastern Cape in relation to their job performance?

………………………………………………………………………………...
………………………………………………………………………………...
………………………………………………………………………………...

129 For each of the following pairs of opinions circle the one you most agree with:

1. It is very important that work would give one the opportunity to do something useful for others.
2. It is very important that work would enable one to learn new things and develop one's own talents.

130

1. It is very important to be employed in a job which allows considerable discretion (freedom of choice, using good judgement).
2. It is very important to be employed in a job which provides considerable income.

131 Which of the following do you think have most influenced your opinion about work. Rank order them from 1 up to 5 where 1 means the most influential, 2 means the second most influential etc.

1. Family	1	2	3	4	5
2. School	1	2	3	4	5
3. Friends	1	2	3	4	5
4. Church	1	2	3	4	5
5. Media	1	2	3	4	5

132 Taking all things together, how satisfied are you with your life as a whole these days? Generally speaking, would you say you are…

1 Very satisfied
2 Satisfied
3 Neither satisfied nor dissatisfied
4 Dissatisfied
5 Very dissatisfied

THANK YOU FOR YOUR CO-OPERATION!

10/11/2008

TO WHOM IT MY CONCERN

RE: Request to participate in a Research Study on: Work Ethic Indicators Among Employees and prospective Employees in the Eastern Cape Region of South Africa.

I write to request your participation in the above mentioned research study to be conducted during the period Jan – Feb 2009. The study is being conducted as part of a PhD degree study pursued at Rhodes University – Grahamstown. I appeal for your support towards the success of this worthwhile study, which aims at understanding and explaining problems of work ethic and quality of work life in the work place with a purpose to improve service delivery and job success as a strategy for poverty reduction and development in the region. Such support may include: responding to a questionnaire accompanied by this letter; being part of a focus group discussion or personal interview; granting permission for the study to be conducted in an area under your leadership or management, identifying potential interviewees etc.

In line with the ethical standards of social research, the information you provide in the questionnaire and interviews will only be used for purposes of this study and will be treated anonymously and strictly confidential.

Your co-operation in this regard is highly appreciated.

Yours sincerely

S A Kwizera.
Department of Sociology
Walter Sisulu University
Tel: 0475022638
Cell: 0822007578

Qualitative Research Instrument

(1st Visit – Interview with Superintendent/Equivalent)

1. Age

2. Gender

3. Religion
   - How religious are you (e.g are you born again?)
   - Tell me about your religious values, attitudes and beliefs.
   - Does religion play a role in your work? What role
   - Does it play a role in your outlook on work?

4. Nationality

5. Population group

6. City of work

7. Institution

8. Job Level

9. Number of years in current job

10. Sometime back, you experienced a strike at this hospital, can you tell me your experience of it?
    - Is there a history to the strike?
    - Who participated? Why?
    - What exactly happened?
    - What was the outcome? How have things changed?
    - How has the strike shaped the institution and mind set of employees here?

11. What is your understanding of Work Ethic? (WE)
    - What do you consider a bad/good work ethic? (list characteristics for each)

12. Based on the above definitions, on the whole do you consider your Employees', WE good or bad?
    - In what way is it good? In what way is it bad?
    - If it is good, why is it so (what are the contributing factors)?
    - If it is bad, why is it so (what are the contributing factors)?
    - How does their WE compare to that of other workers in the country?

- On a scale from 1 – 10, how would you rate your employees' WE (give a separate rating for doctors and nurses)

13. What is the meaning of work to you?
    - What is the meaning of work to your employees?

14. Does your institution have an Ethic relating to work (Values, beliefs, and attitudes should be upheld)?
    - What WE values, beliefs and attitudes do you expect of your employees to uphold; do they uphold them? If not, why?
    - Why do you think your employees work? How central is work to their lives? How central is it to yours?

15. What do you think of your work as a medical professional? What do you think of the hospital as an institution (e.g its role for individuals, community, society and the country as a whole)?

16. How satisfied are you with your work? Please explain your answer.

17. Are you happy to work here? Why?

18. Are placement trainees salaried employees just like other doctors?

19. How many doctors, nurses do you have?

20. How many male doctors, female doctors?

21. How many male nurses, female nurses?

22. Would you mind participating in a focus group discussion (please provide contact)

THANK YOU FOR YOUR TIME!

Qualitative Research Instrument

(Interview with Doctors/Nurses)

1. Age

2. Gender

3. Nationality

4. Religion:

   - How religious are you (e.g. are you born again)?
   - What are your religious values, beliefs and attitudes?
   - Does religion play a role in your work, what role?
   - Does it play a role on your outlook on work?

5. Population group

6. City of work

7. Institution

8. Job level

9. Number of years in current job

10. What does work mean to you? Does it mean the same to fellow doctors and nurses?

11. How central is work to your life, doctors' and nurses' lives?

12. What do you understand by Work Ethic (WE)? (Give a list of characteristics)

13. What is a good/bad work ethic (list characteristics for each)

14. According to the above definitions, do doctors here have a good or bad WE, Why? What about nurses, and why?

15. Do you consider yourself as having a good or bad work ethic? What factors play a role here?

16. On a scale of 1 – 10 please rate your WE

17. On a scale of 1 – 10 how would you rate the work ethic of doctors and nurses here? (Give each category a score)

18. Did you participate in the strike?

- What caused it?
- Who participated?
- What were the outcomes
- How has it shaped the Doctors' and nurses' attitudes to work, WE and the hospital at large?

19. What are your expectations (i.e. what makes a good doctor, what makes a good nurse) of a doctor? What are your expectations of a nurse?

20. Are these expectations met? Why do you say so?

21. What has shaped these expectations? Have they changed since 1994?

21. What are your professional ethics relating to work?

22. Are these ethics met? Do these, tally with those values, attitudes and beliefs displayed by doctors and nurses in this work place? Give details.

22. Do you think your patients and general public are happy with your work in this hospital? Why do you say?

23. What would you want changed?

24. If there were rewards for good WE would the WE of doctors and nurses be better.

25. How satisfied are you with your work as a doctor/nurse in this hospital, and with the institution as a whole?

26. How happy are you with the work of this hospital in this community?

27. Would you participate in a focus group discussion later on? (Please provide contact)

THANK YOU FOR YOUR TIME!

Qualitative Research Instrument

(Interview with Patients)

1. Age
2. Gender
3. Nationality
4. Population group
5. Religion
6. Occupation
7. Period in hospital
8. What is your opinion of the work of the medical personnel in this hospital?
9. Are you happy with the services you have received in this hospital? Explain your answer.
10. How happy are you with the way you get treated here by: doctors and nurses? Why do you say so?
11. What do you think of the work of doctors and nurses?
12. On a scale of 1 – 10, rate the work of doctors and nurses
13. Why do you think the work of doctors and nurses in this hospital is good/bad (give a list of the things you like about their work, and a list of those things you don't like).
14. What are your expectations of doctors? What are your expectations of nurses?
15. Are these expectations met? Why do you say so?
16. What do you think, should be improved?
17. How do you like/dislike the hospital as an institution? (give a list of the likes and dislikes).

THANK YOU FOR YOUR TIME!