ORIGINAL STUDY

Factors Influencing Job Satisfaction Among Primary Health Care Physicians in Qatar

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Abstract:

Occupational stressors associated with compromised job satisfaction amongst general practitioners (e.g. time constraints, burdensome patient loads and interruptions in personal life) have been found to adversely affect the quality of primary health care services.

A cross-sectional survey of 128 physicians in 22 primary health care centers in Qatar used a self-administered questionnaire on factors associated with job satisfaction. Most physicians reported time pressures attributable to large patient loads that appeared to affect the quality of work and personal life. Younger and female physicians reported frustration at not having time to read about new research and advances.

Methods of addressing these problems, such as an appointment system, were favorably received by most physicians. Strategies to reduce occupational stress on most of the physicians may involve allowing them greater control over their work environment and providing time for Continuing Medical Education and postgraduate studies. This, in turn, should lead to improved primary health care.

Keywords: Job satisfaction, time constraints, and Primary Health Care, Qatar

Introduction:

It has long been recognized that occupational stress amongst physicians can adversely affect the quality of primary health care (PHC)[1-4] although the factors that affect the quality of the work environment of physicians are not clearly understood [5-6]. Previous studies on physicians practising in PHC settings have identified two common work-related stressors; the degree to which the work interferes with personal life[7-8] and heavy patient loads under intense time constraints[9]. In Shattner and Coman's survey of 296 family physicians in Australia nearly 50% claimed to have considered leaving PHC because they felt overburdened by large volumes of patients[9]. Another key factor is a lack of control PHC physicians have over their working times[4,10].

A disturbing trend in PHC centers throughout North America and the UK is an overall increase in stress levels and burnout amongst the physicians. This has led to medical students devaluing PHC as a specialty, decrease in job satisfaction and a high turnover of physicians[11-12].

Given that a relationship exists between occupational stress amongst physicians and the quality of PHC services, it is important to investigate the sources of that stress in order to optimize care for patients. The present study surveyed occupational stressors and overall job satisfaction in PHC physicians in Qatar.

Material and Methods:

In the State of Qatar all one hundred and thirty-eight primary care physicians (PHC) in the twenty-two primary health centers were asked to complete a survey on job satisfaction. These were collected on site by a researcher assistant during a period of four weeks in January 2000.

The questionnaire, written in English, was in two parts. The first part contained seven questions on the socio-demographic and professional characteristics of the sample in the PHC setting. The second part asked 16 questions on satisfaction with current work shifts and with the time available for reading journals, pursuing preventive medicine with patients, and personal social commitments. Physicians were also asked about financial incentives, administrative support, facilities, public perceptions of their role and their overall job satisfaction.

Responses used a 4-point Likert-type scale (1 = Strongly disagree, 2 = Disagree, 3 = Agree, 4 = Strongly agree). Confidentiality of data was assured. The completed forms were analyzed using the SPSS statistical package.

Results:

One hundred and twenty-eight of one hundred and thirty-eight questionnaires were returned, a response rate of 92.8%.

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The socio-demographic characteristics of the sample are shown in Table 1. Respondents were 64.1% male. Sixty-eight (53.1%) physicians did not have postgraduate training although 63 of these indicated they would take advantage of postgraduate studies if the opportunity arose.

Nearly all (95.31%) were happy working with the team of their primary care center. Most (71.1%) were satisfied with their current working hours; 64 (50.0%) agreed and 27 (21.1%) strongly agreed with the statement, "Current hours are ideal for PHC services". The majority (62.5%) disagreed with the statement "The two shifts bother me" and when asked whether work shifts should be changed back to the old system, the response was split (53.1% agreed; 46.9% disagreed). Most (87.5%) were not in favor of a 9 a.m.-6 p.m. shift.

Approximately one half of the sample (53.13%) said they were too busy to update themselves by reading journals and books. This problem was more prevalent amongst younger physicians: 66.7% of physicians under the age of 35, 60.7% of physicians aged 36-45, and 39.1% of physicians over the age of 45, chi-square (df = 2) = 6.20, $p = .044$. Similarly this problem was expressed by 62.5% physicians who had been practising 10 years or less, and 38.8% of physicians who had been practising for more than 10 years, chi-square (df = 1) = 6.59, $p = .010$.

There was also a sex difference: female physicians were more likely than men to say that this was a problem (71.1% versus 43.9%), chi-square (df = 1) = 8.65, $p = .003$.

Approximately two-thirds of the sample (66.4%) indicated that, due to the number of patients that they see, there is too little time for preventive medicine during consultations. The same number of respondents (66.4%) felt they did not have time to satisfy their social commitments.

A perceived lack of incentives to motivate physicians in the PHC system was reported by many (85.2%) respondents. Most (90.6%) felt that incentives would be helpful in their career; although this was indicated by more men than women (97.5% versus 88.4%), chi-square (df = 1) = 4.34, $p = .037$. All but eight of the 128 respondents (93.8%) considered that administrative support was of great importance.

Responses pertaining to the adequacy of medical facilities for patient care were varied; 57% said facilities were inadequate and 39.8% disagreed. The few Qatari physicians in the sample (7.8%) all agreed that facilities were inadequate (versus 56.4% of non-Qatari), chi-square (df = 1) = 7.24, $p = .007$.

To rectify the problem of heavy patient loads, the suggested use of an appointment system was favorably received by 88.3% of the sample. Approximately one-third (34.3%) of the physicians in the sample felt that the PHC specialty was regarded as "below" other specialties. Many more (88.3%) felt that it was the general public who underestimated the importance of PHC physicians.

Discussion:

Most of the physicians in the present study were not Qatari, possibly due to the demands of the PHC service requiring recruitment from other countries. The small group of Qataris (7.8%) in the family physician specialty represented approximately half of the 14.1% physicians aged 35 years or younger.

Only MBBS with two years experience is required for recruitment to the PHC service in Qatar and so most of the PHC physicians do not have a postgraduate qualification; a few have a Master's degree or a post-graduate diploma. Most of the

Table 1: Socio-demographic and professional characteristics of sample (N = 128)

Characteristics	N (%)
Age [a]	
< 35	18 (14.1)
36 - 45	57 (44.5)
> 45	46 (35.9)
Unknown	7 (5.4)
Sex	
Male	82 (64.1)
Female	46 (35.9)
Nationality	
Qatari	10 (7.8)
Non-Qatari	118 (92.2)
Religion	
Muslim	121 (94.5)
Non-Muslim	7 (5.5)
Language [b]	
Arabic	125 (97.5)
Non-Arabic	6 (4.6)
Postgraduate Qualification	
Masters degree	51 (39.8)
Postgraduate diploma	9 (7.0)
None	68 (53.1)
Experience in PHC [c]	
< 10 years	73 (57.0)
> 10 years	49 (38.3)
Not specified	6 (4.7)

[a] *M = 42.95, SD = 6.78, Range: 28-59*
[b] *Three participants were bilingual*
[c] *M = 9.09, SD = 6.55, Range: 0-25*

*Table 2: Agreement to items pertaining to time constrains by family physician in Qatar.**

Item	Age (Years)	Strongly Disagree	Disagree	Agree	Strongly Agree
1. Current hours are ideal for PHC services.					
	< 36	1 (5.9)	2 (11.8)	10 (58.8)	4 (23.5)
	36 – 45	6 (10.5)	11 (19.3)	26 (45.6)	14 (24.6)
	> 46	1 (2.2)	13 (28.3)	24 (52.2)	8 (17.4)
2. The two shifts bother me.					
	< 36	2 (11.1)	10 (55.6)	5 (27.8)	1 (5.6)
	36 – 45	8 (14.3)	25 (44.6)	18 (32.1)	5 (8.5)
	> 45	4 (8.7)	26 (56.5)	13 (28.3)	3 (6.5)
3. There is not enough time for preventative medicine during consultations.					
	< 36	0 (0)	5 (27.8)	8 (44.4)	5 (27.8)
	36 – 45	3 (5.3)	19 (33.3)	18 (31.6)	17 (29.8)
	> 45	2 (4.3)	11 (23.9)	19 (41.3)	14 (30.4)
4. I can hardly find time satisfy my social commitment.					
	< 36	0 (0)	5 (29.4)	8 (47.1)	4 (23.5)
	36 – 45	5 (8.8)	16 (28.1)	24 (42.1)	12 (21.1)
	> 45	1 (2.2)	13 (28.3)	25 (54.3)	7 (15.2)

* *N (%)*

participants indicated that they were willing to join a postgraduate study if given the chance.

Most physicians were satisfied working with the team of their PHC and with the present working hours. The various sources of stress identified in the study were largely organizational and administrative. The majority of physicians admitted that the workload was an obstacle in participating in Continuing Medical Education and, because of the number of patients to be seen per shift, they were too busy to update themselves by reading books and journals. This was particularly the case among younger and female physicians. It is possible that younger physicians are more inclined to read up on new medical research and procedures and feel more frustration when reading time is unavailable.

The workload was also found to be a barrier to promotional and preventive activities during a consultation, resulting in patients receiving inadequate advice. Its interference with social life was an important source of stress and dissatisfaction for both male and female physicians.

This study revealed some important aspects recognized by the majority of physicians as directly or indirectly affecting job satisfaction. These were lack of incentives, especially financial, and lack of essential medical facilities and administrative support.

At present, apart from some specialized services provided on a weekly basis, the PHC services do not have an appointment system; most clinics operate on a "walk-in" basis. However, the idea of an appointment system was favorably received by 88.3% of the PHC physicians, highlighting the importance of this strategy for improving the quality of patient care by managing patient loads and regulating working conditions.

Approximately one-third of physicians felt that the PHC specialty was held in less regard than other specialties. This could be explained by the lack of essential facilities, incentives and administrative support resulting in more stress and low self-esteem but, on the other hand, this feeling of inferiority may be due to the misunderstanding of the concept of the primary care system or the fact that they were not vocationally trained in PHC services. Furthermore, the majority felt that it was the general public who underestimated the importance of the PHC physicians. This overall perception of inferiority was strongly related to the feeling that they had insufficient time to pursue preventive medicine during a consultation thus indicating that they did value preventive medical practice but rarely had the opportunity to explore such issues with their patients.

The study showed that the major factors of job dissatisfaction among PHC physicians include the workload, lack of incentives and administrative support, and the lack of an appointment system. These results have implications for health administrators whom, through procedural and remuneration polices, are in a position to optimize the work environment for physicians and

*Table 3: Agreement to items pertaining to job satisfaction by family physician in Qatar.**

Item	Age (Years)	Strongly Disagree	Disagree	Agree	Strongly Agree
1. There are few incentives to motivate PHC physicians.					
	< 36	1 (5.9)	1 (5.9)	11 (64.7)	4 (23.5)
	36 – 45	0 (0.0)	5 (9.1)	28 (50.9)	22 (40.0)
	> 45	0 (0.0)	7 (15.6)	17 (37.8)	21 (46.7)
2. Financial incentives will help my career.					
	< 36	0 (0.0)	1 (5.6)	10 (55.6)	7 (38.9)
	36 – 45	0 (0.0)	4 (7.1)	33 (58.9)	19 (33.9)
	> 45	0 (0.0)	2 (4.7)	16 (37.2)	25 (58.1)
3. Administrative is important to my career.					
	< 36	0 (0.0)	1 (5.9)	6 (35.3)	10 (58.8)
	36 – 45	0 (0.0)	4 (7.3)	19 (34.5)	32 (58.2)
	> 45	0 (0.0)	0 (0.0)	15 (32.6)	31 (67.4)
4. Medical facilities are insufficient.					
	< 36	0 (0.0)	5 (27.8)	11 (61.1)	2 (11.1)
	36 – 45	4 (7.0)	21 (36.8)	19 (33.3)	13 (22.8)
	> 45	3 (6.5)	15 (32.6)	21 (45.7)	7 (15.2)
5. The PHC specialty is below other specialties.					
	< 36	3 (16.7)	13 (72.2)	2 (11.1)	0 (0.0)
	36 – 45	10 (17.5)	23 (40.4)	10 (17.5)	14 (24.6)
	> 45	9 (19.6)	21 (45.7)	12 (26.1)	4 (8.7)
6. The public underestimates the role of PHC physicians.					
	< 36	0 (0.0)	3 (16.7)	7 (38.9)	8 (44.4)
	36 – 45	1 (1.8)	4 (7.1)	30 (53.6)	21 (37.5)
	> 45	1 (2.2)	5 (10.9)	23 (50.0)	17 (37.0)
7. The appointment system in PHC settings may address the problem of patient load.					
	< 36	2 (11.1)	4 (22.2)	9 (50.0)	3 (16.7)
	36 – 45	3 (5.3)	16 (17.5)	26 (45.6)	18 (31.6)
	> 45	1 (2.2)	7 (15.2)	19 (41.3)	19 (41.3)

* *N (%)*

thus improve care for patients visiting PHC centers. Surprisingly, the working hours or shifts were not the big issue, as more than 50% of PHC physician were happy with the new system. It also showed that the PHC is being served by some physicians who may be without adequate training.

The following suggestions are made for improving the job satisfaction of PHC physicians and for improving the quality of PHC services:

1) Workload should be reduced through establishing an appointment system, with the availability of one walk-in clinic on each shift.

2) Adequate incentives, both material and financial, as well as administrative support should be provided for physicians on different occasions.

3) For physicians without adequate training, in-service vocational training should be provided.

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