ORIGINAL ARTICLE

Demotivating Factors Among Government Doctors in Negeri Sembilan

S Sararaks, M. Comm. Health*, R Jamaluddin RAM, MSc.**, *Public Health Institute, Jalan Bangsar, 50590 Kuala Lumpur, **Department of Community Health, Medical Faculty, Universiti Kebangsaan Malaysia, Jalan Raja Muda Abdul Aziz, 50300 Kuala Lumpur

Summary

Motivation, especially on the relationship of remuneration of government doctors to it, has long been an issue of concern. This study sought to elucidate the demotivating factors in service and the perceived discrepancy in income. It was conducted amongst doctors serving in the Ministry of Health, Negeri Sembilan, using self-administered questionnaires.

Factors considered demotivating were remuneration, workload and recognition given. Career development, promotion prospects, issues with superiors, resources and patient attitudes were other factors identified.

On average, respondents expect an income of 1.63 times more than their current drawn salary and 87.2% cited rewards as a recommendation to improve their satisfaction in service. In-service training was desired by almost all. Though the medical profession has traditionally been viewed as altruistic in nature, doctors in service are voicing out their views and perception, and they should be heard.

Key Words: Motivation, Doctors, Income, Rewards

Introduction

Motivation refers to the harnessing and concentration of efforts towards achieving a particular condition or result[1]. The choice to work hard or not depends on the individual's evaluation of his/her work situation[2], needs and expectations[3], fairness in treatment[4,5,6], environment at work[7,8], and especially for doctors, intellectual interest/stimulation[9,10,11], together with challenges of the profession[9,12].

The organisation can influence the work situation[4] or change the characteristics of work, and hence, the worker's motivation and satisfaction[6]. Tied closely to motivation and satisfaction are the needs and expectations of the worker. Material needs such as pay, benefits and physical work needs vie with less concrete needs such as relationships at the workplace and opportunities for growth and self-actualisation. Of these, pay had always played an important role[3,5], and sometimes even considered as one of the basic needs of an individual[13]. More than just the salary itself, however, is the discrepancy in what the individual expects and what he/she actually receives[14,15], whereby the larger the gap, the larger the felt unfairness in treatment[2].

Even as far back as two decades ago, the Malaysian Medical Association (MMA)[16] had identified remuneration as the most important reason influencing job satisfaction and intention to resign of government doctors, and sadly, it is still an important issue even now[17]. In addition, a myriad of other issues, which contribute to discontentment and disenchantment among doctors in Malaysia, had been identified. These

include workload, training and recognition, to opportunities for transfers and promotion. Knowledge of demotivating factors in-service, as perceived by doctors, and what they would recommend to improve their situation, would be helpful in alleviating matters.

Materials and Methods

Using a cross sectional design, all doctors who were serving in the Ministry of Health (MOH), Negeri Sembilan in 1994/95 were studied using a self-administered postal questionnaire. This study, besides looking into demotivating factors in service, also covered the issue of job satisfaction and intention to resign, which had been reported[17].

Open ended questions, which would allow for multiple responses, were used to encourage respondents to respond unlimitedly in terms of what factors they find demotivating in service and what they would recommend to improve the situation.

Besides their current income, respondents were also inquired with regards to what they perceive would be reasonable pay, which the MOH is able to pay them for the same work they were doing. This then, was considered the expected income. The percentage of discrepancy in income follows the discrepancy theory by Locke[14], which was operationalised among doctors by Lichtenstein[15]. It is a function of the expected and current income, and computed using the following formula: ((Expected income-current income)/current income) x 100)[15].

Efforts were made to increase the response rate through ensuring confidentiality and anonymity, repeated mailings of new questionnaires to respondents and telephone calls to those who had yet to respond[17]. Out of 252 doctors registered by the State Health Office of Negeri Sembilan, 219 were sent questionnaires, while the remainder were excluded as they were on long leave or further studies.

Results

A response rate of 69.4% was achieved, with 152 returned questionnaires. Medical officers made up 70.4%, specialists 24.3%, with the remainder house officers. Most (75.7%) were serving in hospitals, and more than half (57.2%) were lady doctors. There were 39.5% Malays, 29.6% Indians and 23.7% Chinese, with a small percentage of other ethnicity. Majority was married (74.3%), and 59.2% obtained their first degree locally. Their mean age was 34.6±7.4# years, median of 32.0 and ranges from 25.8 to almost 55 years old. Reported income ranges from RM1,600.00 to RM10,922.00, with an average of RM2,898.14±1,627.24#. Half reported to earn RM2,073.00 or less, with only one tenth drawing RM5,600.00 or more. On the average, duration of service in the Ministry was 7 years, and 23 months for service in current unit[17]. (*#Standard deviation)*

Though house officers were under-represented in this study, the proportion of respondents with regards to gender, sector of service (hospital or health), ethnicity, job designation (house officers, medical officers or specialists) and place of graduation were comparable to the study population[17].

Almost all (96.1%) responded to the section on demotivating factors faced/experienced in service. Rewards were the commonest factor mentioned, followed by issues with superior, workload/time, relationship with staff and promotion. Other factors included postings, training, resources and patient's attitude (Table I).

In rewards, income made up 86% of the issues mentioned, others being compensation for work done after office hours and other incentives. For superiors, the lack of appreciation/encouragement from superiors formed half of the issue, with a third citing poor relationship with the superior. Others mentioned were, lack of support, and to quote, *"pressure"* from superior and *"slow-moving superiors"*.

Respondents also mentioned workload, especially with regards to calls, having insufficient time for patient and/or family and time off after calls as demotivating to them. Staff issues cover mainly the lack of staff, specifically doctors and paramedics. Furthermore, respondents voiced unhappiness with administration staff and felt demotivated when confronted with lazy/laid back staff or those resistant to change.

Promotion also featured prominently, especially the lack of opportunity for it, "double standards" of selection, of it being tied to transfers and being "overlooked" for promotion. In training, opportunities for in-service

Table I
Perceived Demotivating Factors Experienced in Service
(n=146)

Demotivating Factor	Count	Percentage of cases (%)
Rewards	73	50.0
Relationship with superiors	70	47.9
Workload/time	55	37.7
Staff issues	43	29.5
Promotion	31	21.2
Training	22	15.1
Posting/transfers	22	15.1
Resources	18	12.3
Patient attitude	18	12.3
Others	47	32.2
Total responses	399	

training, teaching from superior, opportunity for scholarships and lack of continuing medical education (CME) were mentioned, while postings/transfers were mainly with regards to its frequency, inconsiderateness and separation from family, and getting their posting of choice. The "others" group consists of a mixture of diverse comments covering relationship with peers, communication, "biases", red tape and turnover of staff, to doing things outside of his/her specialty.

Hospital sector doctors more often mentioned rewards and workload, while the health side mentioned promotion and training more frequently. Lady doctors mentioned workload more often, while the men were more concerned with promotion. A higher percentage of specialists find the opportunity for promotion a demotivating factor compared with medical officers.

Income was a predominant demotivating factor mentioned. In terms of the discrepancy between expected income and drawn income, on the average, a doctor expects his/her income to be 1.63 times higher than what it is, i.e. a discrepancy of 63%. Hence, if a person's current income was RM2,000.00, on an average, he expects his income to be RM3,260. Figure 1 shows the discrepancy between expected income and current income, as perceived by the respondents. Expected income fluctuates with the current income.

There is not much difference in discrepancy across gender, marital status, ethnicity, place of first degree and job designation. However, hospital doctors seem to have higher expectations on income compared with health-based doctors, with the former perceiving an average income of 1.69 times higher (discrepancy of 69.2%) than what they were getting, while the latter expects 1.46 times only (discrepancy of 45.6%).

Across different current income quartiles, higher bracket earners recorded a lower level in perceived discrepancy, with the highest quartile reporting the least discrepancy. (Figure 2). Medical officers and specialists also had varying perception towards income discrepancy, with those in the lower quartiles expecting an income that is much higher (Table II & III).

Current income, besides being positively correlated with expected income, also had a positive significant correlation with age and duration in service.

In what the respondents would recommend for improvement in service, an overwhelming majority mentioned the issue of rewards. Coming a dismal second is issues pertaining to superiors. Other factors were promotion, posting/transfer, training, manpower, workload, facilities/equipment and quality of care. (Table IV).

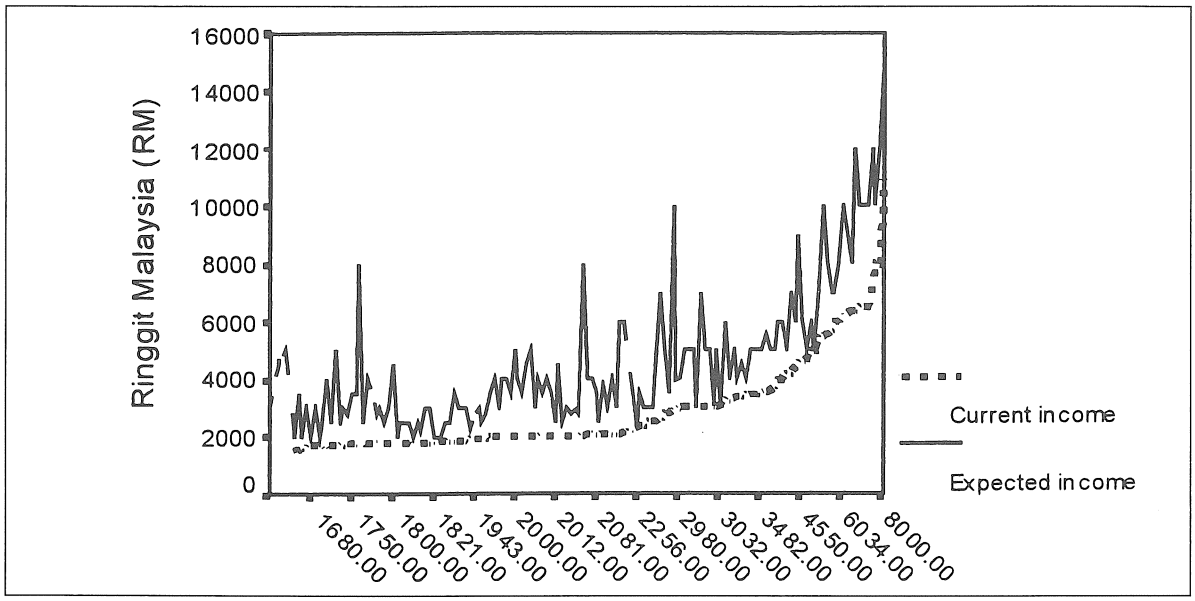

Fig. 1 Reported Expected and Current Income of Respondents (n=141).

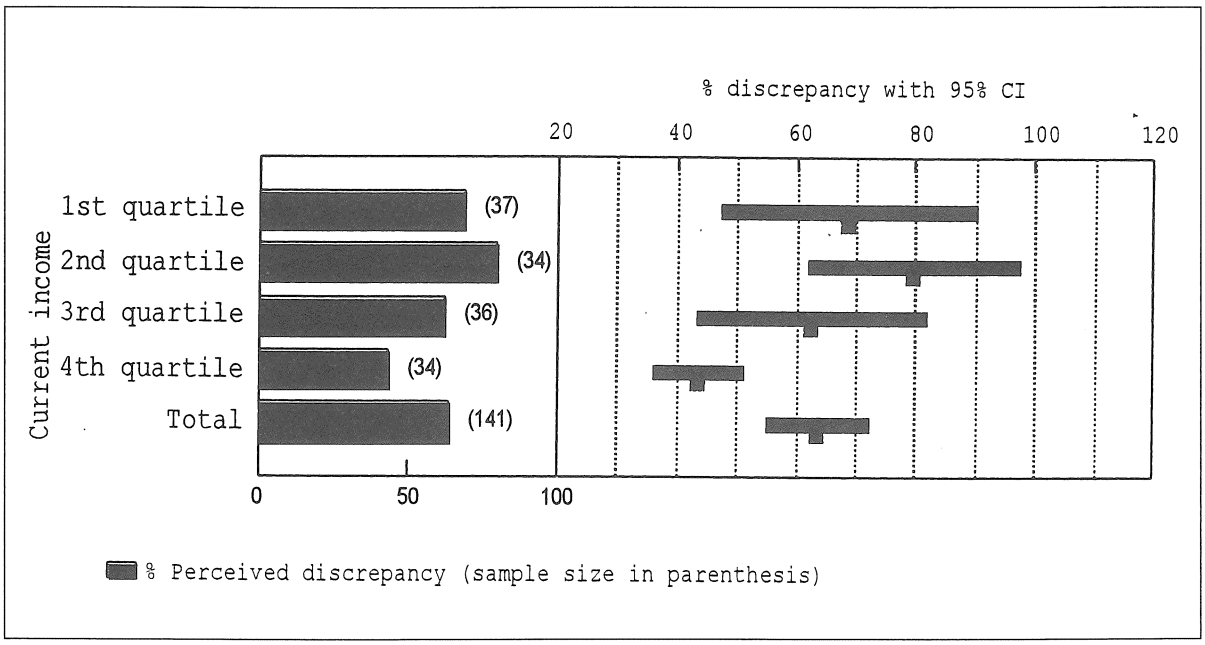

Fig. 2 Perceived discrepancy between current and expected income by current income quartiles.

Table II
Income Expectations of Doctors

Category	Average current income per month* (in RM)	Perceived discrepancy in income (per month) in %	(in RM)	Desired income in RM Per Month	Per year
Current income					
1st quartile	1761.00	68.5	1206.29	2967.29	35,607.42
2nd quartile	1991.00	79.6	1584.84	3575.84	42,910.03
3rd quartile	2722.00	62.2	1693.08	4415.08	52,981.01
4th quartile	5859.00	43.3	2536.95	8395.95	100,751.40
Job designation					
House officer	1838.00	34.6	635.95	2473.95	29,687.38
Medical Officer	2265.00	64.1	1451.87	3716.87	44,602.38
Specialist	4929.00	67.4	3322.15	8251.15	99,013.75
Overall	2898.00	63.5	1840.23	4738.23	56,858.76

**rounded to the nearest Ringgit*

Table III
Income Expectations of Doctors

Job Designation Category		Average current income per month**	Perceived discrepancy in income (per month)		Desired income (in RM)	
Current income quartile*	Sample size (n)	(in RM)	in %	in RM	Per month	Per year
Medical Officers						
1st	30	1750.00	67.9	1188.05	2938.05	35,256.57
2nd	31	1991.00	77.8	1549.19	3540.19	42,482.31
3rd	30	2698.00	53.6	1445.92	4143.92	49,726.99
4th	7	3954.00	32.3	1275.73	5229.73	62,756.71
Specialists						
3rd & below	9	2546.00	131.1	3337.28	5883.28	70,599.31
4th	27	5723.00	46.2	2644.04	8367.04	100,404.5

**Current income quartiles based on overall sample quartile values.*
***Rounded to the nearest Ringgit*

Table IV
Factors Recommended by Doctors to Improve Condition in Service (n=141)

Factors	Frequency	Percentage of cases
Rewards	123	87.2
Issues pertaining to superior	35	24.8
Promotion	31	22.0
Posting/transfers	30	21.3
Training	25	17.7
Manpower/staff issues	22	15.6
Workload/Calls	15	10.6
Facilities/equipment	14	9.9
Quality of care	11	7.8
Others	26	18.4
Total responses	332	

Specifically, in rewards, 62.6% out of 123 mentioned pay as a factor for improvement, while other issues mentioned were allowances, incentives, payment for overtime, loans from government and recognition for work done. Issues with superiors include relationship with the superior, discussions, better leaders and working relationship between central (MOH) and district level.

In promotion, the lack of it, opportunity for career advancement, being tied to transfers and the loss of automatic promotion were mentioned. Also voiced were requests for postings of choice, transfers with consideration for their families, and in training, to be given a chance for training and to attend short courses.

Calls were the main reason mentioned in alleviating workload, specifically the number of calls, time off and having the choice of doing calls or not. Besides this, increasing number of doctors and requests to post house officers and registrars to district hospitals, shift work and omitting unnecessary ward rounds were other recommendations made.

Table V
Areas of Interest for In-Service Training (n=113)

Area	Frequency	Percentage of cases
Internal Medicine	25	22.1
Management	16	14.2
Public Health	15	13.3
O & G	14	12.4
Pediatrics	7	6.2
Family Medicine	6	5.3
Any field/specialty	17	15.0
Others	38	33.6
Total responses	138	

The "others" category consists of diverse comments on reducing "red tape", relationships within department, annual leave privileges, public education, privatisation and partial private practice.

A vast majority of doctors (98.0%) further responded that they would like to attend in-service training if given the chance. Commonly mentioned were courses in internal medicine, management and public health (Table V).

Discussion

Rewards have always been an important factor influencing the motivation to work and job satisfaction, and doctors are not exempted. Salary has been viewed as a basic, or lowest level need in the worker[13] and pay had been identified as an important predictor of likelihood of turnover[16,17,18,19]. No matter how one views it, salary does matter.

Government doctors in Negeri Sembilan expects 1.63 times more in income than what they are getting, which boils down to an average of RM1,890 to top up the average doctor's salary of approximately RM3,000. Is this reasonable, an average annual income of RM58,680? Medical officers requested for RM44,602, specialists, RM99,014 per annum. (Table II). In 1995 to 1996, United States primary care practitioners were earning between US$97,000 to US$135,000, while specialists earned a median of US$221,544[20,21,22]. Malaysian senior executives were reported to earn, in 1998, an average of RM3,107 (RM37,284 annually), managers RM5,700 (RM68,400 per annum)[23]. As a guesstimate, a medical officer employed by a private clinic or hospital is probably earning between RM4,000 to RM6,000 per month.

Here, doctors wanted a 63% increase in salary. Sadly, there currently is no available comparison of similar nature for doctors in Malaysia. However, graduates in Malaysia in 1998[23] desired an increase of 30% (ages 26 - 30 years) to 94% (ages 41 - 60 years). Graduates aged 36 - 40 had similar expectations to the doctors in this study, at 66%, while senior executives (both graduates and non-graduates) expected 64%.

As for income expectations between groups of doctors, Table II indicates that doctors in the highest income bracket group has the highest discrepancy in income (in absolute terms). However, a closer examination at the percentage of perceived discrepancy in income across current income and job designation groups, the highest percentage seem to be the junior medical officers and junior specialists groups. (Table III). This might well indicate that comparatively, junior medical officers and junior specialists have higher income expectations than house officers and senior specialists.

Hence, if the salary expectation of all doctors were to be fulfilled, this will result in a narrowing of income differences between the different categories of doctors. If a review of salaries of government doctors were carried out, a suggestion from the authors is to consider a higher quantum of increase for junior medical officers and junior specialists.

In Malaysia, the New Remuneration System (NRS) or "SSB" had been noted to be not beneficial to medical officers[24] and the general perception is that the private sector pays better. Furthermore, the pay of a young doctor has been noted to be 'miserable'[25]. The abolishment of automatic promotion to senior time-scale after five years of service had also created widespread discontentment when it was introduced. Whether expectations and comparisons with the private sector's presumably more lucrative earnings are eroding into the practice of medicine as a healing profession in Malaysia, as appears to be the case in America[26], is a disturbing issue that can but remain a question now.

The discontentment is not solely related to the paycheck, though it may be the predominant factor. Intricately tied with it are other factors closely related to personnel management such as recognition for work done, relationship with superiors and promotion, some of which are highly open to intervention by local managers. Recognition given by superiors for a good job done, discussions with superiors, which could not only foster a good working relationship but also promote high morale and provide a learning exercise for the officer, and perhaps even the superior, are relatively amenable measures asked for by the respondents for improvement of their circumstances.

This was similarly so with the request for in-service training and short courses. To this end, though the mainstay of organized continuing medical education (CME) is the formal conference or short course, there exists a range of educational approaches from skills training to self-instructional programmes and small group learning[27]. These may be employed to not only motivate doctors but also evaluate doctors' performance, and when systematically planned on the basis of needs assessment and prioritization, could prepare the doctor to meet the changing needs of society and medicine[28].

Doctors in management and supervisory positions should be further trained to enhance their management skills. This need was itself expressed by 27.5% of respondents when they requested for in-service training in management or public health. Such managers and supervisors can be more innovative in instituting management changes especially in areas that could result directly or indirectly in motivating and enhancing professional satisfaction of doctors under their charges.

More that one fifth of the doctors had recommended that promotion prospects be made brighter. It is acknowledged that the need to be promoted is influenced by the individual's desire for psychological development and progress, and is closely tied to the hope for better pay and social status[5,14]. An employee with unmet needs will seek elsewhere if he perceives that those requirements could not be fulfilled by his present organisation[2]. Furthermore, promotion and turnover are closely linked, in that opportunity for promotion can occur with staff turnover, especially in an organisation with a policy for internal promotions[29]. Though the MOH is one such organisation, the issue is not to increase turnover to open up opportunities for promotion, but rather to have more openings within the organization so as to even the odds of retaining experienced staff.

Workload, insufficient time and staffing issues are other concerns voiced. Increasing workload with shrinking compensation leads to fed up, angry doctors[30], and unreasonable workload, depression[31]. Payment for additional work done is only fair[25]. The government has recognised this and taken measures to recruit medical staff, including doctors, from outside Malaysia. Within Malaysia, private sector doctors had been found to be willing to help out in areas that are needed[32]. This may effectively handle the symptom, but Olden[31] advocates organisational support for the physician, and fostering job satisfaction is the key.

Overburdened doctors who do not feel adequately rewarded are likely to be less responsive to patients[33]. Furthermore, job satisfaction of doctors is also linked to patient satisfaction[34,35] and in this climate of promoting quality care and putting the clients (patients) first in Malaysia[36], the internal client, the doctor, needs to be taken care of.

A limitation of this study is the issue of excluding those on long leave/further studies. They might be more satisfied with their situation at work, and hence these findings might be biased towards the unhappy doctor. Furthermore, though certain characteristics of the respondents were similar to the population, non-response may possibly bias the results. Similarly, item non-response is also present and may contribute some degree of bias.

In conclusion, two major demotivating factors found in this study were remuneration and other management related "problems" such as recognition, relationships, training, workload and staffing issues. Possible solutions would involve increasing remuneration especially for medical officers and junior specialists, better training in management for supervisors especially in manpower/personnel management and instituting innovative management changes itself. With the expected corporatisation of government hospitals during the 7th Malaysia Plan[37], it is timely that the government re-look at the above issues and take positive steps in resolving them. However, even though the plan calls for corporatisation of government hospitals, all government doctors serving in the health sector should be included in the review process.

Acknowledgement

The authors wish to thank the Director General of Health for permission to publish this paper. The authors also wish to thank the Ministry of Health and the Negeri Sembilan State Director of Health for their permission to conduct this study, and all the doctors in Negeri Sembilan for their participation. The authors wish to express their gratitude to Universiti Kebangsaan Malaysia for giving a research grant under Project No:F/5/95.

References

1. Schneider B. Organisational Behaviour. Ann. Rev. Psychol. 1985; 36: 573-611.
2. Vroom VH. Work and motivation. New York: John Wiley & Sons Inc., 1964.
3. Herzberg F., Mausner, B. & Snyderman, BB. The motivation to work (2nd ed). New York: John Wiley & Sons Inc., 1956.
4. Milton CR. Human Behaviour in organisations. N.J. Prentice-Hall Inc., 1981.
5. Arnold HJ. & Feldman DC. Organisational Behaviour. New York: McGraw-Hill Book Company, 1986.
6. Hellreigel D. & Slocum JW. Jr. Management. Reading: Addison-Wesley Publishing Company, 1992.
7. Likert R. New Patterns of Management. New York: McGraw-Hill Book Company, 1961.
8. Blum ML. & Naylor JC. Industrial Psychology. Its theoretical and social foundations. New York: Harper & Row Publishers, 1968.
9. Charles SC., Warnecke RB., Wilbert JR *et al.* Sued and nonsued physicians. Psychosomatics 1987; 28(9): 462-66.
10. Petrozzi MC, Rosman HS, Nerenz DR *et al.* Clinical activities and satisfaction of general internists, cardiologists and ophthalmologists. Journal of General Internal Medicine 1992; 7: 363-65.
11. Skolnik NS, Smith DR & Diamond J. Professional satisfaction and dissatisfaction of family physicians. The Journal of Family Practice 1993; 37(3): 257-63.
12. Reames HR Jr & Dunstone DC. Professional satisfaction of physicians. Archives of Internal Medicine 1989; 149: 1951-56.
13. Aldefer CP. An empirical test of a new theory of human needs. Organisational Behaviour and Human Performance 1969; 4: 142-75.
14. Locke EA. The nature and causes of job satisfaction. In Dunnette MD (ed). Handbook of industrial and organisational psychology. Chicago Rand McNally, 1976; 1297-1349.
15. Lichtenstein R. Measuring job satisfaction of physicians in organised settings. Medical Care 1984; 22(1): 56-68.
16. A report of the Council of the Malaysian Medical Association. The future of health services in Malaysia. Malaysian Medical Association, 1980.
17. Sararaks S & Jamaluddin RAM. Job satisfaction of doctors in Negeri Sembilan. Med J Malaysia 1997; 52(3): 257-63.
18. Buchbinder SB & Melick CF. Physician job satisfaction and likelihood of practice change. AHSR Annual Meeting Abstracts 1993, June 27-29. (http://www.ahsr.org/ANSR2/1993/buchbind.html).
19. Williams ES & Konrad TR. Turnover of primary care physicians in large group practices. AHSR Annual Meeting Abstracts 1995, June 5-6. (http://www.ahsr.org/ANSR2/1995/williama.html).
20. Tamkins T. Physician earnings dip in managed care. Medical Tribune 1995, Dec 7. (http://www.medscape.com/jobson/MedTrib/).
21. Charnow, JA. FPs see higher starting salaries, survey finds. Medical Tribune: Family Physician edition 1997; 38(11) (http://www.medscape.com/jobson/MedTrib/).
22. Kostreski F. Primary Care pay raises lag behind specialists. Skin and Allergy News 1998; 29(1): 38.
23. Latest Salary Statistics. Job Street 1998. (http://www3.jaring.my/mol/recruit/statistic/salary_stats. html.)
24. Chandrasekaran L. Remuneration in government medical service. Berita MMA Ogos 1994; 25(13): 14,16,19.

25. Sng KH. Expectations from government doctors. Berita MMA Sept. 1996; 26(9): 2,18.

26. Lown B. Physicians need to fight the business model of medicine. Hippocrates 1998; 12(5): 25-28.

27. Davis D. Global health, global learning. BMJ 1998; 14(3): 279-83.

28. Towle A. Changes in health care and continuing medical education for the 21st century. BMJ 1998; 14(3): 275-8.

29. Mowday RT, Porter LW & Steers RM. Employee-organisational linkages. The psychology of commitment, absenteeism and turnover. New York: Academic Press, 1982.

30. Dahl D. Rediscovering the joy of medicine. Hippocrates 1997;11(11): 42-46, 49.

31. Olden M. Physician burnout: Stemming the epidemic among us. California Physician 1997;14(7). (http://www.cmanet.org/Public_Interest/)

32. Memorandum on privatisation and Malaysia Incorporated in relation to the Public Health Services. Malaysian Medical Association, 1984.

33. Mechanic D. The organisation of medical practice and practice orientations among physicians in prepaid and non paid primary care settings. Medical Care 1975; 13(3): 527-30.

34. Weisman CS & Nathanson CA. Professional satisfaction and client outcomes. A comparative organisational analysis. Medical Care 1985; 23(10): 1179-92.

35. Linn LS, Brook RH, Clark VA et al. Physician and patient satisfaction as factors related to the organisation of internal medicine group practices. Medical Care 1985; 23(10): 1171-78.

36. Ministry of Health Malaysia. Malaysia's Health 1996. Technical report of the Director-General of Health, Malaysia. Ministry of Health Malaysia, 1996.

37. Rancangan Malaysia Ketujuh 1996-2000. Unit Perancang Ekonomi, Jabatan Perdana Menteri, Malaysia 1996.