JOB SATISFACTION OF OCCUPATIONAL THERAPISTS IN THE PUBLIC HEALTH SECTOR, FREE STATE PROVINCE

by

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Dissertation submitted in full requirement for the

MAGISTER DEGREE IN OCCUPATIONAL THERAPY

Faculty of Health Sciences
University of the Free State

Bloemfontein

(240 Credits)

NOVEMBER 2010

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DECLARATION

"I certify that the dissertation hereby submitted by me for the Masters degree at the University of the Free State is my independent effort and had not previously been submitted for a degree at another university/faculty. I furthermore waive copyright of the dissertation in favour of the University of the Free State."

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Juanita Millicent Swanepoel

This work is dedicate to all Occupational Therapists,
those who bring Hope to the lives of others who might otherwise have merely existed.
I honour your joy at "making a difference".

ACKNOWLEDGEMENTS

I would like to extend my heartfelt appreciation and gratitude to the following persons and institutions:

My *husband, children and parents* for their unwavering faith and support throughout my life. I deeply appreciate the sacrifices you made to help me realise this dream. I love you all.

My study-leader, mentor and motivator, *Dr. Rita van Heerden*. I thank you for always believing in me and being such a rich treasure of knowledge, guidance, support and dedication without which this study would never have succeeded.

My co-study leader and friend, *Mrs. Tania van der Merwe*. You are an inspiration and I extend my heartfelt thanks for the diligence and grace with which you guided me through this study.

Professor Brigitte Smith for providing much valued insight at a critical moment in this study.

My friends, *Elize Janse van Rensburg and Veda Alexander* for all the technological, logistical, semantical and emotional support and advice you provided. This journey is better travelled due to your companionship.

The *Occupational Therapists of the Free State Department of Health* for your willingness, bravery and honesty while taking part in this study.

The *Free State Department of Health and the CEO of National District Hospital* for granting permission for this study to be conducted.

Me. Corné Vrey, Assistant Director Disabilities and Rehabilitation, for the valuable insights provided into the Free State Department of Health throughout this study.

Lollie Prinsloo and Simoné Williams for the impeccable job you did editing this work.

All *my colleagues*, especially *Mrs. Annemarie van Jaersveld*; Head of the Occupational Therapy Department at the University of the Free State. Your support and encouragement throughout the last two years has been exceptional and I am honoured to count you all friends.

This work is a testament to the grace and love of Our Creator.

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LIST OF ACRONYMS

CI	–	Confidence Interval
Dissat.	–	Dissatisfied
DOH	–	Department of Health
FS	–	Free State
HSRC	–	Health Science Research Council
MPT	–	Multi-professional team
OT	–	Occupational Therapist
PDMS	–	Performance Development and Management System
PERSAL	–	Personnel Database of Government Employees
PHS	–	Public Health Sector
Sat.	–	Satisfied

CONCEPT CLARIFICATION

In the proposed study references will be made to various concepts. In order to gain clarity and consistency regarding the meaning of these concepts as it pertains to the purpose of this study, the following operational definitions are provided:

Overall job satisfaction

Job satisfaction refers to a person's perception of the fulfilment and gratification they experience doing their job in a current setting. In describing their job satisfaction a person would essentially, taking into account all internal and external factors, answer the questions: Do I like what I am doing at work? Do I like the circumstances I am working under? Does doing what I do and working where I work bring meaning to my life? (Evans, 1998:12; King, 1995:103).

Facet job satisfaction

Facet job satisfaction refers to the person's perception of satisfaction experienced when addressing one aspect of the job.

Job dissatisfaction

Job dissatisfaction refers to the state of being where employees are more dissatisfied than satisfied with their jobs.

Sources of job satisfaction or dissatisfaction

Sources of job satisfaction are facets of the job that hold the potential to increase job satisfaction while sources of job dissatisfaction are facets that hold to potential to increase job dissatisfaction.

Perceptions

Perceptions refer to the individuals' thoughts, feelings, opinions and beliefs regarding their personal experiences as it relates to the phenomenon being studied, in this case, job satisfaction. It is a subjective report of their conceptions of the reality they perceive on a daily basis and is based on the

experiences they live in/through while doing their jobs every day (Robbins, 1998:90,120).

Public Health Sector

The public health sector forms part of the public service package provided and governed by structures of the government of South Africa. It is concerned with all issues relating to healthcare services in South Africa (Orientation Manual for new officials in the Free State Department of Health, 2005:9).

Occupational therapist

An occupational therapist is seen as a clinical practitioner, who has obtained at least a four-year degree in occupational therapy, and holds a current registration as occupational therapist with the Health Professions Council of South Africa (HPCSA). For the purpose of this study, the term will include only occupational therapists working in the public health sector. The term, “therapist”, may at times be used to refer to occupational therapist.

Community service occupational therapist

Community service occupational therapists are employees of the Department of Health for one year after completion of their degree at a tertiary institution. They are registered with the Health Professionals Council of South Africa as Community Service Health Therapists. These therapists are concerned with clinical functions within an institution and/or the community.

Senior occupational therapist

Senior occupational therapists are employees of the Department of Health and at the time of the study received remuneration packages on level 7, notch 1 -16 (entry level). These therapists may be concerned with clinical and/or managerial functions within a department.

Chief Occupational Therapist

Chief occupational therapists are employees of the Department of Health and at the time of the study received remuneration packages on level 8, notch 1-16.

These therapists may be concerned with clinical and/or managerial functions within a department and have a higher rank than senior occupational therapists.

Assistant Manager in occupational therapy

Assistant managers in occupational therapy are employees of the Department of Health and at the time of the study received remuneration packages level 9 or 10, notches 1 -16. These therapists are mainly concerned with the management of clinical services and are more senior than chief occupational therapists.

Clinical Occupational Therapy Services

Clinical occupational therapy services refer to occupational therapy services at primary, secondary and tertiary level of the government health structure and are emphatically concerned with direct patient care. These services may be set in rural/urban communities, clinics, community health centres and hospitals. The services comprise of two functions, namely clinical practice and direct, day-to-day management of the clinical service.

SUMMARY

The aim of this study was to investigate the job satisfaction status of occupational therapists in the Public Health Sector (PHS) of the Free State (FS). For the purpose of this study, job satisfaction referred to the occupational therapist's perception of the fulfillment and gratification experienced while doing their work within the context of the PHS.

A scientific inquiry was instigated to assess and address the job satisfaction of occupational therapists in the PHS of which the researcher, at the time of the study, was part. Employees of the PHS at that time seemed to suffer from low morale and the frequency with which occupational therapists became disillusioned with either the profession or the PHS was worrisome.

The investigation was conducted by making use of multiple research methods namely questionnaires for the quantitative typical descriptive study design and semi-structured interviews for the qualitative phenomenological study design. Electronic self-administrative questionnaires were distributed to all the occupational therapists in the service of the Free State Department of Health in November 2008. Thirty-five (n=35) questionnaires were used for the analysis of quantitative data. In augmentation to this base-line data gathered, semi-structured interviews with an opening question and an interview schedule were conducted among fifteen occupational therapists practicing in the PHS of the FS between November and December 2008.

The thirty-five respondents in the quantitative investigation, as well as the sixteen participants in the semi-structured interviews, represented a largely homogenous group of white, Afrikaans-speaking females on senior, chief and assistant manager level. Community service occupational therapists who had already completed at least six months' tenure were also included. Only occupational therapists directly involved in clinical services were eligible to participate in the study.

The results of the study showed that the occupational therapists in the PHS of the FS experienced low levels of job satisfaction. This was found to be in contrast with most other studies conducted on the job satisfaction of occupational therapists in other parts of the world.

This disparity was clarified when the contextual factors of the PHS such as; inadequate resources, excessive red-tape, poor management and an undesirable working environment were configured. The results and findings showed that the afore-mentioned facets were sources of dissatisfaction for the participants and consequently increased their job dissatisfaction. More so however, the *main* causes of the occupational therapists dissatisfaction were; the low status of occupational therapy as a profession and poor salary. Inadequate career-paths and disillusionment with the current performance appraisal system of the PHS added to further dissatisfaction for the participants in this study.

The main source of the occupational therapists' satisfaction with the job was that of "working with people, making a difference and experiencing success with clients". Secondary facets of satisfaction were the relationships colleagues had with each other, inherent characteristics of the profession such as autonomy, creativity, diversity and to a lesser degree some advantages to working in the PHS such as fringe benefits and job/income security.

In conclusion it was found that the job satisfaction status of the occupational therapists in the PHS of the FS was low. This was mainly due to the influence of contextual factors and not with regards to profession itself. As was the last objective of the study, extensive recommendations were made to redress the balance between job satisfaction and dissatisfaction for this population.

OPSOMMING

Die doel van die studie was om die werksbevredingstatus van arbeidsterapeute in the Openbare Gesondheidsektor (OG) van die Vrystaat (VS) te ondersoek. Vir die doel van hierdie studie het werksbevrediging verwys na die arbeidsterapeut se persepsie van die vervulling en bevrediging wat ervaar word tydens die verrigting van sy/haar werk binne die konteks van die OG.

‘n Wetenskaplike ondersoek is geloots om die werksbevrediging van arbeidsterapeute in die OG, van wie die navorsing ten tyde van die studie, deel gevorm het, te bepaal en aan te spreek. Dit het voorgekom dat werknemers van die OG ten tyde van die studie lae moraal getoon het en die veskynsel dat al hoe meer arbeidsterapeute met of die beroep, óf die OG, ontnugter word, was kommerwekkend.

Die ondersoek is gedoen deur gebruik te maak van veelvuldige navorsingsmetodes byname vraelyste vir die kwatitatiewe tipiese beskrywende studie ontwerp en semi-gestruktureerde onderhoude vir die kwalitatiewe fenomenologiese studie ontwerp. Elektroniese self-administrerende vraelyste is gedurende November 2008 na alle arbeidsterapeute in die OG van die VS gestuur. Data van vyf-en-dertig (n=35) vraelyste is aangewend vir kwantitatiewe analise. Bykomend tot hierdie basis-lyn data is vyftien onderhoude met arbeidsterapeute wat in die OG van die VS praktiseer, tussen November en Desember 2008 gedoen.

Die vyf-en-dertig respondente van die kwantitatiewe ondersoek sowel as die vyftien deelnemers van die semi-gestruktureerde onderhoude het ‘n hoofsaaklike homogene groep wit, Afrikaanssprekende vroue wat as senior, hoof en assistant bestuurder arbeidsterapeute in die staatsdiens werk, verteenwoordig. Gemeenskapsdiens arbeidsterapeute is ook by die studie ingesluit indien hulle reeds ses maande in diens van die OG was. Slegs arbeidsterapeute wat direk betrokke was by kliniese dienste is ingesluit.

Die resultate van die studie het getoon dat die arbeidsterapeute van die OG in die VS lae vlakke van werksbevrediging ervaar. Hierdie bevinding was teenstrydig met die meeste ander studies rakende arbeidsterapeute se werksbevrediging regoor die wêreld.

Die diskrepansie is geklarifieër toe kontekstuele faktore inherent aan die OG soos; onvoldoende hulpbronne, oormatige beurokrasie, swak bestuur en 'n ontoereikende werksomgewing in ag geneem was. Die resultate en bevindinge het aangedui dat die vooraf gestipte fasette bronne van ontevredenheid was en het gevolglik die deelnemers se werkontevredenheid laat toeneem het. Meer as dit egter, was die hoof oorsake van die arbeidsterapeute se werksontevredenheid, swak status van die beroep en swak salarisse. Onvoeldoende bevorderingsgeleenthede en ontnugtering met die huidige prestasie bestuurstelsel van die OG, het tot verdere ontevredenheid vir die deelnemers van hierdie studie bygedra.

Die hoofbron van tevredenheid met die werk was die geleentheid "om met mense te werk, 'n verskil te maak en sukses met kliënte te ervaar". Sekondêre fasette van bevrediging was die verhoudings tussen kollega's, inherente eienskappe van die beroep soos outonomie, kreatiwiteit, diversiteit en tot 'n mindere mate, sommige voordele van die OG soos byvoordele en werk-/inkomste sekuriteit.

Ter afsluiting het die studie aangedui dat die werksbevredingstatus van arbeidsterapeute in die OG van die VS laag was. Hierdie resultaat kan hoofsaaklik toegeskryf word aan kontekstuele faktore en nie as gevolg van die beroep opsigself nie. Soos aangdui deur die laaste doelwit van die studie is uitgebreide aanbevelings gemaak ten opsigte van die herstel van die balans tussen werkstevredenheid en ontevredenheid vir hierdie populasie

.

CHAPTER 1

INTRODUCTION AND ORIENTATION

1.1 INTRODUCTION

In this era of frequent organisational restructuring, rapid technological advancement and political and economic uncertainty it has become crucial that successful organisations have employees who are open to innovation, changing roles and productivity – in other words – employees who, research shows, experience high levels of job satisfaction (Cranny, Smith & Stone 1992:iv).

The aforementioned authors continue to state that an employee's level of job satisfaction is the single most important piece of data a manager can have to predict the rate of absenteeism, personnel turn-over or level of psychological withdrawal at work. The question now arises as to how problematic environmental and managerial structures within an organisation influence the job satisfaction its employees? In the case of this study, these employees are the occupational therapists of the Public Health Sector (PHS) of the Free State (FS).

Upon their first day of entering an occupational therapy degree program at university, students are habitually asked: Why did you decide to become an occupational therapist? Predictably, most of the students would answer: "Because I would like to work with people", most in fact, referring to a desire to work with children. Some even allude to a flexible work routine, the chance to take advantage of their inherent creativity, a desire to balance practice and theory and a desire for variety or challenge. Already the preconceived notions of what it is like to be an occupational therapist have taken shape. Exciting and inspiring as these conceptions are, they are also based on desires and are not necessarily representative of what can in reality be found in practice (Evans 1998:24).

Taking into account variables such as personality, intellectual abilities, interests and values it has become a human practice to musingly make a decision on a certain career that will, for most workers, have a lasting and catalytic effect on the rest of their lives (Jooste 2003:61; Robbins 1998:66; Gruneberg 1976:90). Considering the significance of this decision, is it not then worrisome how little time is spent on actually investigating the realities of the field of practice? Nevertheless, as part of the human condition, certain preconceived conceptions are formed of practicing the chosen career (King 1995:26).

Already in 1999 Ntulini postulated that logistical challenges, availability of resources, social and economic factors, politics and future needs were only considered by a rare few, leaving others vulnerable and uninformed about the reality of practice. Tragically, these relatively uninformed conceptions play an irrevocable role in setting the criteria by which all future experiences as practicing occupational therapists will be judged (King 1995:27).

The question now arises as to the influence of preconceived ideas on the job satisfaction of occupational therapists. Is the working environment conducive to realising these initial ideals or have occupational therapists in the PHS of the FS become disillusioned with their choice of career?

These are some of the questions that led the researcher to investigate the opinions and lived experiences of occupational therapists working within the field of clinical practice– specifically those working within the PHS of the FS.

The PHS is described as that portion of government concerned with providing and governing health services to the public of South Africa (Orientation Manual for new officials in the Free State Department of Health 2005:9; Ntulini 1999:6). Since the start of its alliance with health, as early as in days of Hippocrates, Galen and Asclepiads, occupational therapy has formed an integral part of health services.

Today, occupational therapists are nationally appointed in various areas of health service delivery within the PHS. These areas include management and

administration as well as the clinical field of practice (PERSAL: Staff establishment of occupational therapy in the Free State province. dated November 2007:2-12).

Considering the prevalence of reform in world organizational behaviour, post-democracy changes in South African organizational practices can be expected and is most evident within South African government structures including the PHS (Jousted 2003:7-8; Past-Hunt 2002:63; Tulane 1999:67-73). Challenges such as pressure to achieve greater proficiency in service delivery, moral imperatives, public pressure and opinion, equity and accessibility, improved management and availability of resources, decentralization of responsibility and authority and reduction of bureaucratic practices have become salient issues in South Africa (Jousted 2003:8). These are all potential factors endangering the job satisfaction of PHS workers leaving them vulnerable to decreased work performance, indifferent attitudes, low motivation and excessive rates of personnel turn-over (Sulsky & Smith 2005:88,152,171; Prabst-Hunt 2002:64; Robbins 1998:23-27; King 1995:76).

By studying the theories of Maslow, Locke and Herzberg the determinants of job satisfaction were identified and investigated within the experiences of the occupational therapist thus enabling the researcher to make a comprehensive description of the job satisfaction of occupational therapists in the PHS and equally recommend strategies as to how job satisfaction may be enhanced (Jooste 2003:57; Robbins 1998:169; Visser 1990:105).

Although the journey to the discovery of this phenomenon began with the personal experience of the researcher just over three years ago, the problem that serves as the background for this study has been around far longer and will be presented in the following section of this chapter.

1.2 STATEMENT OF PROBLEM

Lately, issues of personnel turn-over, staff retention, absenteeism and motivation of public servants received great interest and critique within and outside the Department of Health (Ntulini 1999:73-80).

According to the co-editor of the South African Health Review (SAHR), Antoinette Ntuli, health managers (of which occupational therapy managers form part) in 2001 reported a low sense of personal accomplishment (Thom 2007:1). This same report also expressed concern regarding the growing decline in the number of key personnel available to care for patients in the public sector - despite the introduction of community service (Thom 2007:1).

Martinez and Martineau (2002:6) report that low staff motivation, poor commitment, low sense of achievement and inequity in available resources between the public and private sector result in trained health professionals preferring other sectors of employment to the PHS – or other countries to work in all together.

While engaged in the PHS as an occupational therapist, the researcher often observed experienced occupational therapists leaving the relative security of the PHS to pursue their work elsewhere. In some cases, even the profession itself was discarded in favour of child-rearing or other income-generating pursuits. At the same time, during informal conversations with other occupational therapists in the PHS, the question of low morale and perceived disillusionment with the initial wonder of the profession was often raised.

In both aforementioned cases, the incidence and cause of personnel turnover, low morale and disillusionment amongst occupational therapists in the PHS could only be speculated upon as no studies relating to these topics have been conducted within the South African health services context. It was however clear that before assumptions regarding the experiences of occupational therapists could be made, that a scientific inquiry was needed.

Therefore, this study poses the question: Are the occupational therapists in the PHS of the FS experiencing job satisfaction? In an effort to understand the everyday experiences of occupational therapists working in the PHS and its effect on personnel turnover, low morale and disillusionment, an investigation into the factors causing job satisfaction and dissatisfaction for occupational therapists working in the PHS, was conducted.

1.3 RESEARCH AIM

The aim of this study was to investigate the job satisfaction of the occupational therapists in the Public Health Service of the Free State.

1.3.1 Research Objectives

1.3.1.1 To describe the current job satisfaction status of occupational therapists in the PHS of the FS (Questionnaire and semi-structured interview).

1.3.1.2 To identify and describe common factors influencing the job satisfaction and dissatisfaction of occupational therapists in the PHS of the FS (Questionnaire)

1.3.1.3 To explore the perceptions of occupational therapists with regards to their experience of job satisfaction in the PHS of the FS and the meanings they attach to this phenomenon (Semi-structure interviews).

1.3.1.4 To recommend possible guidelines that would address the job satisfaction of occupational therapists in the PHS of the FS (Questionnaire and semi-structured interviews).

1.4 METHODOLOGY

In order to achieve the objectives stated above the researcher made use of multiple methods in the form of both a quantitative and a qualitative approach (Leedy & Ormrod 2006:133-179; Burns & Grové 2005:232).

To establish whether therapists were experiencing job satisfaction and which factors contributed to satisfaction or dissatisfaction, a quantitative approach in the form of a typical descriptive study design was proposed. Although this type of study design allowed for the gathering of baseline data in order to get an overall picture of the phenomenon, the examination of the types and degrees of relationships could not be sufficiently established (Burns & Grové 2005:232). For this reason, in addition to a quantitative typical descriptive study design, the researcher also used a qualitative phenomenological study design. Burns and Grove (2005:55) state that the philosophical positions taken by phenomenological researchers have not always been common within the nursing (health professions) culture and have in the past differed from traditional research practices. This indeed gives rise to the impression that the more subjective phenomenological approach may be viewed with a jaundiced eye by traditionally inclined researchers. The authors however continue by stating that the use of a phenomenological study design is now appearing more frequently within nursing literature (Burns & Grove 2005:255). To confirm the increased awareness and application of the phenomenological approach Burns and Grove (2005:255) list the names of fifteen respected authors in nursing literature currently describing the phenomenological study design as an accepted method of conducting qualitative research. Leedy and Ormrod (2005:133) state that qualitative approaches to research have now "gained wide acceptance as legitimate research" despite the inherent subjective nature thereof.

For the purpose of collecting mainly quantitative data a coded self-administrative questionnaire was developed and distributed to the participants via an internal e-mailing system. The questionnaire was used to collect information from a relatively large number of Occupational Therapists (60) and also assisted the researcher in clarifying concepts without subjecting the data to

researcher bias (De Vos, Strydom, Fouché & Delport 2006:295). The data gathered allowed the researcher to quantify and describe what therapists experience with regards to job satisfaction on a daily basis.

Considering the depth of meaning required to bring forth the value of this study the researcher felt encouraged and required to conduct semi-structured interviews. It was assumed that the true meaning and importance of job satisfaction for occupational therapists in the PHS could be found in these conversations as it gave the participants the opportunity to express and explain their views, feelings and perceptions of their jobs. Interviews were conducted by the researcher at the convenience of the participant and lasted between 20 minutes and one and a half hours. All interviews were conducted at the participants' place of work, during working hours as permission for this was gained from the head of allied health services in the Free State. Interviews were audio-recorded, transcribed and then member-checked (Rubin & Rubin 1995:126-127).

Prior to the commencement of the study a pilot study was conducted in order to ensure the validity (specifically the face validity and internal validity) and reliability in the content of the questionnaires as well as refining and auditing the procedures to be followed. The questionnaire was also piloted specifically to address the lay-out and clarity of the instrument (Leedy & Ormrod 2005:193; De Vos *et al.* 2005:170,172). Three semi-structured interviews were conducted as part of the pilot study and served the researcher well in order to assess and improve her skill in the interview process.

The analysis of the data on the questionnaires was done by the Department Biostatistics, University of the Free State. Qualitative data was analysed by the researcher, a co-coder who was an expert on qualitative research and another who was an expert in the field of the PHS. Data analysis was done according to the methods proposed by Creswell (1998:147-150) and Tesch (1990:134-135).

Both the qualitative and quantitative data collected enabled the researcher to make a comprehensive description of the current job satisfaction status of

occupational therapists in the PHS of the FS. The data also allowed the researcher to identify common factors promoting and reducing occupational therapists' job satisfaction. Six categories of findings relating to job satisfaction were identified.

Measurement errors such as the risk of a low response rate, misinterpretations of questions, incomplete answers, data contamination due to participant influence or researcher bias, the long length of the questionnaire as well the skill of the researcher in conducting interviews were all identified in advance and where possible, relevant measure were put into place to reduce or circumvent the effect of the error. However, limitations of the study were identified through the course of the study and are discussed in detail in Chapter 5 (cf. 5.4).

1.5 ETHICAL CONSIDERATIONS

The research proposal was be presented to the Ethics Committee of the Faculty of Health Sciences of the University of the Free State and approved (Ethics number: ETOVS 154/08). Consent for conducting the study was gained from the Manager: Disabilities and Rehabilitation, Free State Department of Health. All information in the study was treated as confidential and where possible, questionnaires were administered anonymously. Any participant was free to withdraw from the study at any time without prejudice or penalty to them. All participants were informed of the researcher's intention to make public the results of the study. The detailed discussion of the ethical considerations of this study is done in Chapter 3 (cf. 3.7).

1.6 VALUE OF THE STUDY

The main value of this study was that it provided quantitative and qualitative data on the job satisfaction of specifically occupational therapists within a South African context. Prior to this study this form of data was absent.

Secondly, the results and findings of this study provided scientifically founded principles by which those who are concerned about the job satisfaction of occupational therapists can reason on the phenomenon. It provides a strong point of departure for future research where occupational therapists are concerned.

The results of this study will enable occupational therapy managers to identify areas of successful practice as well as areas of growth in order to improve on strategies aimed at enhancing the job satisfaction of their staff. The results and findings of this study also yielded a relatively comprehensive assimilation of recommendations to address the job satisfaction of occupational therapists in the PHS. For the most part, these recommendations are realistic and practice-based and can be implemented directly and without delay.

In addition, the study voiced the concerns and opinions of occupational therapists working in the field and provided them with the opportunity to play an active role in enhancing their own job satisfaction. Lastly, this study formed a basis on which further research can be conducted.

1.7 CHAPTER LAY-OUT

As each chapter in this dissertation revolves around a specific phase in the research process of this study a short summary of each chapter is now presented.

The current chapter**, Chapter 1**, *Introduction and Orientation,* serves as the general background to the study and aims at orientating the reader to a) the study and b) the course of the dissertation. Chapter 1 provides a short onset to the problem and stipulates the consequent aim and objectives of the study. A broad summary of the research methodology is presented. An overview of the ethical implications of the study is presented. The chapter concludes with a synopsis of all chapters contained in this dissertation.

Chapter 2 comprises the *Literature review*, which is discussed in two sections. Section A gives an account of history and philosophy of occupational therapy and its relation to the PHS. The changes resulting from political reform in South African health services are discussed and linked to possible threats to the job satisfaction of occupational therapists working in the PHS. In Section B, comprehensive argumentation of the different job satisfaction theories is done. Job Satisfaction is defined and furthermore described with regards to the determinants thereof. In conclusion, the chapter offers some findings obtained by researchers who have studied the job satisfaction of occupational therapists in countries such as Australia and Sweden. No South African studies relating the to job satisfaction of occupational therapists could be discussed as none were available at the time of this study.

In **Chapter 3**, *Research Methodology,* the scientific procedures followed during this study, are detailed. The chapter introduces the multiple methods of the study design as quantitative and qualitative approach and provides a description of the study population. The chapter continues by discussing the research designs, sampling procedures, measurement instruments, pilot studies, data collection procedures, data analyses and data quality controls for both the quantitative and qualitative approaches separately. Measurement errors are stipulated along with the measures employed to reduce their impact on the procedures and outcomes of the study. Lastly, the chapter provides the detail on the ethical considerations implicit to conducting this research study.

Chapter 4 is a presentation of, as well as a *discussion and interpretation of the results* gained from the research conducted during this study. The chapter is divided into two sections, where section A focuses on the presentation and discussion of quantitative findings. Section B entails the presentation and interpretation of qualitative findings.

The *Conclusions, Recommendations, Limitations and Value of the study,* are discussed in **Chapter 5** when a critical examination of the study's finding is made. Results are coalesced and their implications for occupational therapy, occupational therapists, occupational therapy managers and educators in the field of occupational therapy are identified while relevant recommendations are made. In the second part of the chapter, the limitations of the study are discussed after which the chapter concludes with the closure of the study.

1.8 SUMMARY

This chapter served as a general orientation to the study. During the introduction the importance of job satisfaction was established while questions were asked as to how occupational therapists react in terms of their job satisfaction when faced with depreciating factors such as insufficient resources, inept management and undesirable working conditions.

The problems of personnel turnover, low morale and disillusionment within the PHS and presumably under occupational therapists working in the PHS are discussed and the conclusion is drawn that the lived experiences of occupational therapists working in the PHS should be investigated in systematic and scientific manner.

Consequently, four objectives relating to the comprehensive description of the job satisfaction of occupational therapists in the PHS were identified. An overview of the research methodology employed in this study was presented and lastly, the ethical considerations were attended to.

As the background of the study has now been established, it follows that certain concepts such as occupational therapy, the PHS and job satisfaction should come under greater scrutiny. Such is the purpose of the literature study done in Chapter 2, *Occupational Therapy in the Public Health Sector and Job Satisfaction*.

CHAPTER 2

LITERATURE STUDY

INTRODUCTION

In the previous chapter the researcher introduced the concept of job satisfaction and its relevance to occupational therapists. The aim of the study, namely to investigate the job satisfaction of occupational therapists in the PHS of the FS was put forward and an overview of the methodology and ethical considerations were discussed.

In order to succeed in the aim of the study, it was imperative that a comprehensive literature study be done to orientate the researcher toward the phenomenon under study. Figure 2.1 illustrates the lay-out of the literature discussed in this chapter:

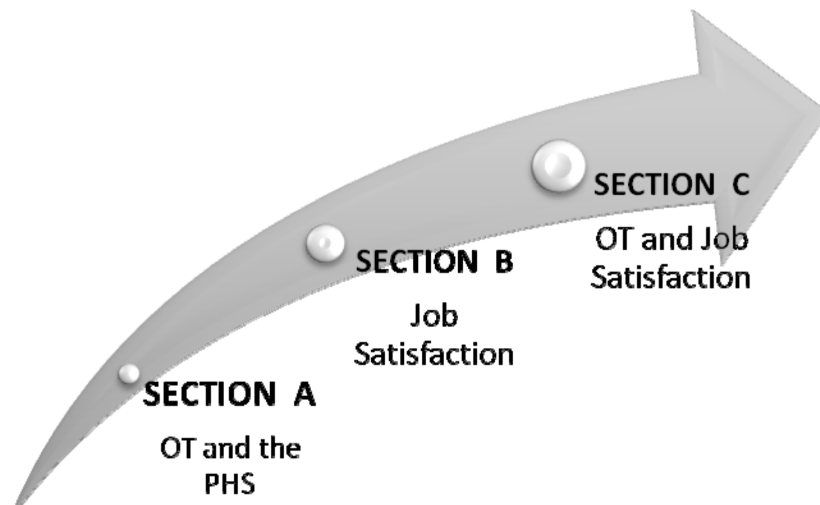

Figure 2.1 Lay-out of Literature Review

In section A, occupational therapy, its history and philosophical base are discussed. The link between occupational therapy and health, more specifically the PHS, is made and consequently a description of the PHS and the advantages of, or the challenges in the PHS which might influence the job satisfaction of occupational therapists working in this environment, is provided.

In section B, the complex phenomenon known as job satisfaction is discussed. Theories and determinants of job satisfaction are explained at length. Measurement and consequences of job satisfaction are conferred.

Lastly, section C provides insight into the findings of other studies on the subject of the job satisfaction of occupational therapists conducted around the world.

2.2 SECTION A: OCCUPATIONAL THERAPY AND THE PUBLIC HEALTH SECTOR

The following section of this literature review provides an overview of the profession occupational therapy and its relationship with the PHS.

2.2.1 Occupational Therapy

Occupational Therapy is based on the belief that purposeful and meaningful activity (occupation) prevents or mediates dysfunction of physical or psychological origin (Trombley and Radomski 2002:19). It is concerned with the person as a whole and aims to promote good physical and psychological health through balancing the activities a person performs in their daily lives.

The earliest writings regarding “activity treatment” can be found in the works of Hippocrates, Galen and Asclepiads (Trombley and Radomski 2002:19). With the advent of World War I and II the need for the expansion of hospitals to introduce post acute medical care services became imminent (Trombley 1997:6-11). It is due to this need that occupational therapy and health services

of the world became inseparable partners and still continue their somewhat symbiotic relationship up to this day.

When viewed in comparison to other health professions such as medicine and nursing, occupational therapy could be said to be a relatively young profession. This in itself suggests that the development of the profession into its fullness is still taking place. Therefore, it is argued that due to the emerging nature of the profession, research findings in occupational therapy are somewhat limited to only that which could have been accomplished in the last century or so, leaving many a question relating to occupational therapy and occupational therapists without definite answers.

Although no positivist answers exist for the reason why people – mostly females – choose to become occupational therapists, it would seem reasonable to suggest that a need to serve and “make a difference” in the lives of others is a common thread that links most occupational therapists to their jobs. This suggestion is supported by studies relating to the job satisfaction of occupational therapists around the world and speaks a fundamental truth about the motivation of occupational therapists to bring about hope, ability and wellness where it might otherwise be lost (Moore, Cruickshank & Haas 2005:19).

This central theme in the motivation of occupational therapists may well become very important to the study of their job satisfaction. The opportunities to serve and make a difference often are contextually bound and may be adversely influenced by challenges faced when performing duties within a certain organisation or even by generic issues (such as perceived status of the profession) experienced by the global occupational therapy community (Moore *et al.* 2006a:20; Smith-Randolph, Doisy & Doisy 2005:50-51).

Although occupational therapists can be found in various settings of society, schools, old age homes and private practice, the organisational structure most relevant to this study is that of the PHS. Within the PHS, occupational therapy forms an integral part of the health service package provided by the government

of South Africa and as such, occupational therapists are nationally appointed in all areas of health service delivery including management and administration and the clinical field of practice (*PERSAL*: November 2007).

As mentioned previously, challenges within the context of the PHS (Ntulini 1999:67-73) may well be deciding factors in the experience of job satisfaction/dissatisfaction by occupational therapists. These challenges are better understood when seen against the background of the changing nature of the health system of South Africa today.

2.2.2 Definition, History and Organisational Structure of the Public Health Sector of South Africa

The Public Sector (PS) can be defined as that portion of the economy whose activities (production, delivery and allocation of goods and services) are under control and direction of the state (Wikipedia – Public Sector 2010:1 of 2). The state owns all the resources in this sector and uses them to achieve whatever goals it may have to promote the economic welfare of the ruling elite or to maximize the well-being of society as a whole (Ntulini 1999:6).

Taken from this, the PHS is described as that portion of government concerned with governing and providing health services to the public of South Africa (RSA 1997:9). Today, the PHS is more commonly known as the Department of Health (DOH).

Early health services in South Africa were distinctly known by its bureaucratic structure and characterised by highly routinised tasks performed through specialisation, strict formal and abstract rules and regulations, a strong hierarchy governed by centralised authority, strict channels of command and impersonal contact between managers and subordinates (Louw 1997:85; Heinzen 1994:13). Taking into account the political history determining early health services in South Africa it is understood that the prevailing system at the time was not accessible to all South Africans and restructuring the system was

a forgone conclusion when democracy at last reached this country in 1994 (Ntulini 1999:1; King 1995:46).

In 1994, the new democratic government of South Africa inherited a highly fragmented, inequitable health system with health departments for four different racial groups as well as each of the 10 homelands having its own department of health. Health services were essentially doctor-dependent medical services biased towards curing existing diseases rather than preventing disease (Cullinan 2006:5). That same year, the African National Congress adopted a primary health care (PHC) philosophy. This was founded on community development and community participation in the planning, provision, control and monitoring of services (Cullinan 2006:6).

It would however seem that the changes needed for the restructuring of the health system presented many challenges. It was only ten years later, in 2004 that the National Health Act, giving effect to the White Paper on Health Services, was signed into law (RSA 1997:1). This paper provided guidance on how a national health system should be managed and implemented. The idea of a decentralised, nurse-driven system, based on the district health system where people can access health services near to where they live, was implemented (Cullinan 2006:6). The country was finally divided in 53 health districts with management delegated from national level to district level, representing South Africa's first baby step in moving away from the traditional bureaucratic system.

Jooste (2003:7) states that the environment of health care organisations is changing rapidly and is the cause of fundamental transformations that have a direct impact on these organisations. It is clear now, that looking forward from 1994, reform and transformation have been and will continue to be operative functions in South Africa - a process evidently related to the political changes in our country and no stranger to diverse and often demoralising challenges.

2.2.3 World Reform and Challenges in the Public Health Sector

Challenges in the PHS described in literature (Jooste 2003:7-8; Ntulini 1999:67-73; Heinzen 1994:11-26) seem to be directly related to issues of reform in world view as adopted by our new democratic government.

Industrial and behavioural psychologists have long now been concerned with the global reform of organisational behaviour and holds up the following as examples of such transformation: the creation of a global village, from homogeny to workforce diversity, improving quality and productivity, improving people skills, from management control to empowerment, from stability to flexibility and the focus on improving ethical behaviour (Jooste 2003:25-28; Ntulini 1999:67-73; Robbins 1998:12-18). Reforms in management strategies, greater quality and productivity and workforce diversity have all become salient concerns in public health management and administration (Prabst-Hunt 2002:63).

Jooste (2003:7-8) describes challenges such as pressure to achieve greater proficiency in service delivery, moral imperatives, public pressure and opinion, equity and accessibility and changing demographic patterns as prominent influences in the reform-process in public health. The improved management and availability of resources, decentralisation of responsibility, power and authority to lower levels and reduction of bureaucratic practices are all concerns that have come under scrutiny since democracy in South Africa (Jooste 2003:8).

In addition, Ntulini (1999:67-73) adds the following as burning challenges in the Public Service and by implication the PHS: resistance to change, breakdown in communication, poorly designed training programs, personal and domestic problems of employees, disproportionate working hours, overtime and shift-work, poor remuneration, poor organisation and leadership, inadequacy of resources and equipment, poor physical working conditions, incorrect placement of persons and lack of opportunities for promotion.

Literature (Robbins 2001:545-550; Maslow 1968:44-59) also consistently observes the inherent nature of man to resist change. The notion of reform is often viewed as a threat by personnel in an organisation and is therefore met with reservation and opposition (Sulsky & Smith 2005:31; Ntulini 1999:73; Robbins 1998:632-634). Sulsky and Smith (2005:135,152-154) reflect that any event eliciting feelings of insecurity, prejudice and unfairness in employees is perceived as a threat and will have a negative impact on the employee's job satisfaction and work performance.

Taking into account all these challenges and viewed within the organisational structure of the PHS, the variables of ineffective organisational behaviour such as absenteeism, decreased work performance, indifferent attitudes, low motivation and excessive rates of personnel turn-over can almost be anticipated and predicted (Robbins 1998:23-27).

If it is accepted that the above-mentioned variables of ineffective organisational behaviour stem from job attitudes and behaviours employed by humans and as health services are managed and provided by health care practitioners, the issue of the human's lived experience of these organisational changes becomes most relevant (Gilmer & Deci 1977:228-229; Siegel & Lane 1982:284; Saal & Knight 1988:314-325),.

As discussed in the beginning of this chapter (cf. 2.2.2), occupational therapy forms an integral part of health services and consequently is irrevocably part of the changing phenomenon that is our PHS. How are occupational therapists dealing with all of the above-mentioned challenges?

Perhaps even more pertinent would be the question of how these seemingly insurmountable challenges affect experiences on the job and how do we responds to these experiences in attitude and emotion? This is the concern of section B of this chapter that focussed on the theory and determinants of job satisfaction

2.3 SECTION B: JOB SATISFACTION

The following section focuses on the phenomenon of job satisfaction.

2.3.1 Theory of Job Satisfaction

The study of the nature of job satisfaction has, since its conception in the 1930's, been a point of great debate between researchers such as Hawthorn, Herzberg, Maslow and Locke – all considered seminal sources in the field of job satisfaction (Evans 1998:32).

Even though Edwin Locke, already in 1969, estimated the number of studies in this field to already exceed 4000, opinions still differ on the width of the application of these research findings (Evans 1998:3-5; King 1995: 22-26; Gruneberg 1976:5-8). Contention as to the true nature of job satisfaction exists to this day and a myriad of theories exist to explain this complex phenomenon.

Whilst venturing into the field of job satisfaction - a field not theoretically familiar to most occupational therapists – it was observed that even in the mere discussion of these theories some division exists. Evans (1998:6) also encountered this perceived ambiguity and advised that researchers should make a full study of the prevailing theories on job satisfaction before attempting to operationalise a definition. It would however seem that most sources agree that theories around job satisfaction can be grouped into two categories namely, content theories and process theories, as was suggested by Campbell in 1970 (Coetzee 1999:41; Louw 1997:21; Gruneberg 1979:9)

The following theories are discussed based on their relevance and potential to enrich this study.

2.3.1.1 Content Theories

Content theories draw attention to the somewhat accepted assumption that humans have certain needs and that attempts at work to fulfil these needs are

directly related to the experience of job satisfaction or dissatisfaction (Robbins 2001: 156-157; Spector 2000:177; Coetzee 1999:37; Mouton 1998:61; Vorster 1992:48; Muchinsky 1983:319; Siegel & Lane 1982: 274; Gruneberg 1979:9; Landy & Trumbo 1976:337).

Academia holds up the enlightenments of Maslow (1954) and Herzberg (1966) as eminent content theories and their postulations have found great intuitive appeal (Gruneberg, 1979:9-18) - although these are often heavily criticised as methodologically unsound (Cranny, Smith & Stone 1992:28-23). Nevertheless, *Maslow's Needs Hierarchy Theory* and *Herzberg's Motivation-Hygiene Theory* were found to be valuable to this study. This notion was supported by other occupational therapists such as Moore, Cruickshank and Haas (2005:19) who stated that the Herzberg theory served as a "useful guide on which to based their enquiry" on studies relating to job satisfaction among occupational therapists.

2.3.1.1.1 Maslow's Needs Hierarchy Theory

Maslow's needs hierarchy theory has its value in introducing the concept of needs satisfaction. Maslow hypothesized that in every human being there is a hierarchy of five needs (Jooste 2003:57; Robbins 1998:169; Visser 1990:105). Figure 2.2 illustrates these needs:

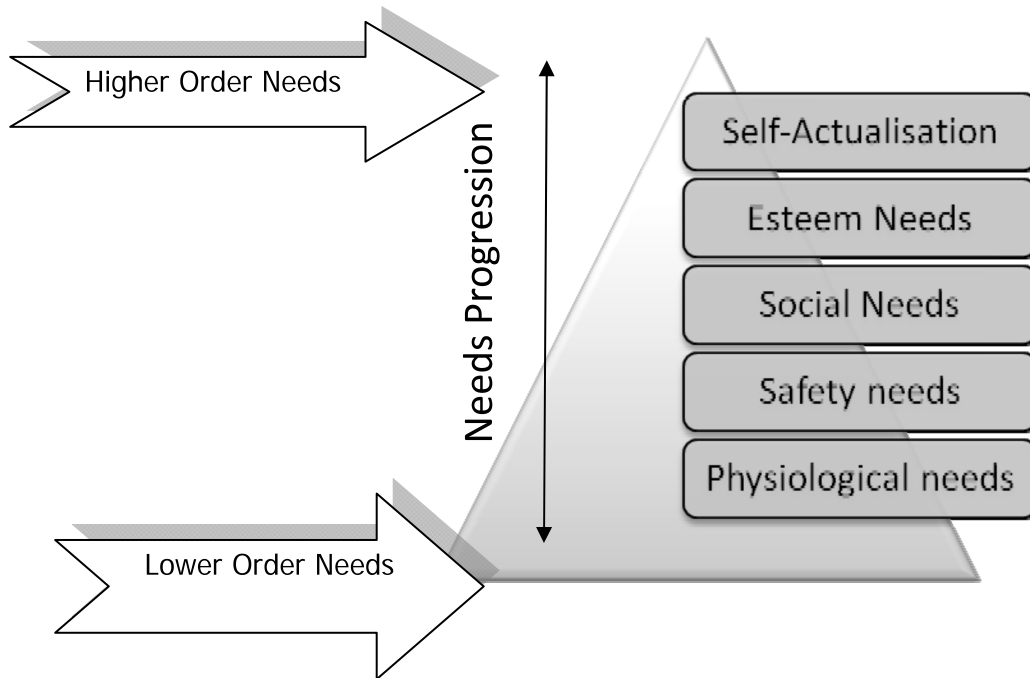

Fig. 2.2 Maslow's Needs Hierarchy (Siegel & Lane 1982:246)

Maslow stated that needs are satisfied incrementally and that lower-order needs (physiological, security and social needs) usually have to be satisfied before the human can expend energy on higher-order needs of self-esteem and self actualisation (Evans 1998:35). According to Robbins (1998:169) this theory suggests that needs are never fully satisfied and that advancement and regression in the hierarchy is a common and continuous process.

Although Maslow's need theory has received wide recognition in practice, it is not generally validated by research findings and has little empirical support (Robbins 1998:170). Visser (1990:106) also states that Locke opposes this theory on the basis that a needs hierarchy does not necessarily exist and that measurement in this regard is near impossible. Consequently the theory cannot be validated.

Visser (1990:106) however, was of the opinion that the theory forms a good basis on which to gain an understanding with regards to human nature and motivation and Robbins (1998:170) supports this view.

Muchinsky (1983:362) and Jooste (2003:59) emphasize three principles from Maslow's work that are of value for researchers studying motivation and job satisfaction. These are:

- Needs satisfaction is a continuous process and should be viewed as such.
- Humans are more enthusiastically motivated by what they do not have than by what they already have.
- If lower-order needs are not met, humans will first seek to expend energy on meeting their basic needs.

Furthermore, Maslow (1963:21-22) and Evans (1998:42) also alluded that ineptitude in efforts to satisfy higher-order needs of self- esteem and self-actualisation often lead to regression to the lower-order needs. This, can perhaps serve an a possible explanation as to why employees often feel needful of better salaries once they become discontent in their jobs (Muchinsky 1983:362), when in fact most literature purports that pay is not an efficient motivator of personnel and may rather serve as a de-motivator (Evans 1998:42-43; Robbins 1998:196). In this instance, discontented employees seek to satisfy physical and security needs in an attempt to assuage their feelings of inadequacy in meeting self-esteem and self-actualisation needs e.g. the need for self-confidence and the experience of occupational flow.

Another observation drawn by Gruneberg (1979:10) in relation to Maslow's theory is that those people in lower order occupations are likely to be motivated by lower order needs (pay and security) and those in higher level occupations who have had their basic needs met will be more motivated by opportunities to fulfil their higher order needs such as self-esteem and self-actualisation. This observation proposes a potential prediction of the results of this study as occupational therapy is regarded a professional occupation (high level), as stated by Louw (1997:72) in his study with psychologists as study population. More to the point, the assumption could be made that occupational therapists will attach more value to those determinants of job satisfaction that have an influence on their self-esteem (e.g. perceived status) and opportunities to self-

actualise (e.g. making a difference in the lives of others) rather than lower order needs of physiological comfort and security (e.g. favourable working conditions).

Mouton (1998:61) concludes that unfulfilled needs in the job lead to feelings of discontent which is as synonymous to job dissatisfaction, while met needs can be direct instigators of feelings of satisfaction with and gained from the job.

Vroom (1976:344-345) discusses the work of Schaffer, done in 1953, who to some extent agreed with the aforementioned statement but added that needs vary in strength and therefore vary in terms of the influence it has on job satisfaction. In Vroom (1976: 344), Schaffer explained this by saying: "…*overall job satisfaction will vary directly with the extent to which those needs of an individual, which can be met on the job, are actually satisfied; the stronger the need, the more closely job satisfaction will depend on its fulfilment*." Schaffer in Vorster (1992:41) continued to build from Maslow's theory and in his job satisfaction theory specified the needs individuals experience with relation to their jobs. These are:

- The need of recognition
- The need for affection and interpersonal relations
- The needs for skill
- The need to dominate
- The need to help others
- The needs express the self
- The need for socio-economic stature
- The need to be independent
- The need for creativity and competition
- The need to correlate behaviour with a certain ethical code
- The need for economic security

It is perhaps prudent to note that no mention is made by Schaffer regarding a hierarchy existing between these needs but rather, judging from his statement

quoted above, importance of the need is based on the individual's strength of the need (Vroom 1976:345).

Another theorist departing from Maslow's idea of a *hierarchy* of needs is Herzberg. Frederick Herzberg claimed that needs reside on a continuum - more importantly on separate continuums for those factors which cause job satisfaction and job dissatisfaction (Coetzee 1999:53; Mouton 1998:62; Louw 1997:36; Gruneberg 1979:11-13). This theory will now be discussed.

2.3.1.1.2 Herzberg's Motivation-Hygiene Theory

The work of Herzberg, Mausner, Petersen and Capwell (Herzberg, Mausner & Snyderman (1959:3) was conducted in the 1960's and has since then been considered as one of the most influential sources in understanding job satisfaction (Evans 1998:32; Vorster 1992:43).

This theory purports the belief that factors leading to job satisfaction and factors leading to job dissatisfaction are separate and distinct and that job satisfaction and dissatisfaction should not be considered as opposite ends of a continuum but rather as two entirely different concepts (Jooste 2003:61; Coetzee 1999:53; Louw 1997:36; King 1995:23).

Herzberg identified two completely different dimensions which contribute to an employee's behaviour at work: *motivation-factors* and *hygiene-factors* (Robbins 1998:172; Gruneberg 1967:22). This theory argues that contrary to motivation-factors, hygiene-factors stem from pain- avoidant behaviour and is externally controlled while motivation-factors stem from a higher-order need to achieve and grow and is an internally controlled process (Robbins 1998:172; Gruneberg 1967:22).

According to Herzberg (Herzberg, Mausner & Snyderman 1959:36), the presence of motivation-factors in the work situation will lead to high satisfaction as individuals are essentially motivated by these factors. Motivation-factors are the following (Coetzee 1999:54; Mouton 1998:62; Gruneberg 1979:13):

- Achievement
- Recognition
- The work itself
- Responsibility
- Advancement and growth

The theory further postulates that hygiene-factors cannot be used to serve as effective motivators and must rather be viewed as de-motivators, if they are perceived as unsatisfactory by employees (Robbins 1998:172; Gruneberg 1967:22). Mouton (1998:62) clarifies this by stating that low incidence of hygiene-factors in a job situation result in de-motivated employees and consequently in the experience of job dissatisfaction. The hygiene factors are (Coetzee 1999:54, Mouton 1998:63; Gruneberg 1979:13):

- Salary
- Status
- Work conditions
- Supervision
- Security
- Company policy and administration
- Interpersonal relationships at work (supervisor, peers and subordinates)

Saal & Knight (1988:302-303) describe critique against the Herzberg theory as widely spread and investigated by many researchers such as King (1970), Gardner (1977) and Lock (1976-1995). Gruneberg (1979:12-18), possibly provides the most comprehensive argumentation on the evidence for and against the Herzberg theory and upholds the following points of debate:

- The claim was made that the population used by Herzberg in his investigations was too narrow a sample of the working population and findings can therefore not be applied to all involved in the work force. Gruneberg (1979:12) however continues by stating that a large number

of studies using Herzberg's technique of data collection have confirmed results found by him and that therefore, Herzberg findings are relevant to the general work force because of the variety of samples used by other investigators.

- One of the most serious charges against Herzberg's theory is that it is method-bound. Investigators have attempted to use alternative methods to that of the critical-incident method employed by Herzberg, but have consistently failed to confirm Herzberg's theory (Gruneberg 1979:15). This leaves the field open for critics of Herzberg's work to surmise that he did not take into account the fact that people can often misinterpret their feelings – especially during critical incidents -, leading to inconsistencies in the findings (Robbins 1998:173; Visser 1990:107).

- Lastly, most of the controversy surrounding Herzberg's theory arises because of his own ambiguity in interpreting the results (Munchinsky 1983:362; cf. Figure 2.3).

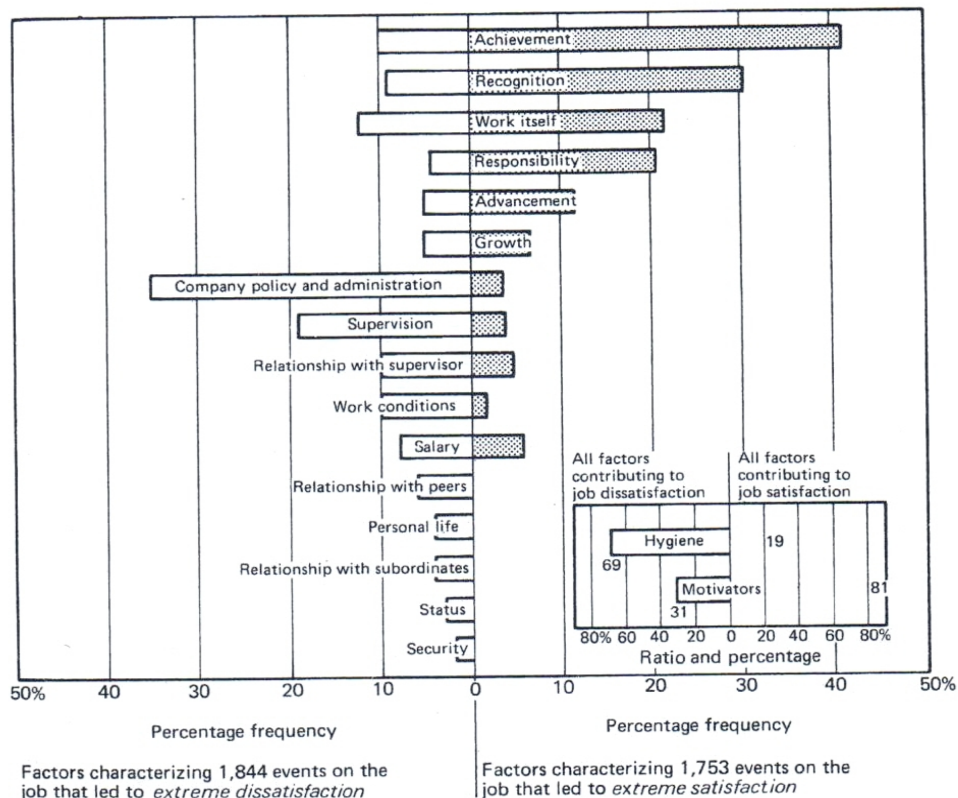

Exhibit 1 Factors affecting job attitudes, as reported in twelve investigations

administration, supervision, interpersonal relationships, working conditions. salary. status. and security.

Figure 2.3: Factors reported to influence job satisfaction by Herzberg (Gruneberg, 1976:23)

The diagram clearly shows that hypothesised motivators appear more frequently when participants talked about satisfying incidents. Similarly, hypothesized hygiene factors appeared more frequently when discussing feeling of dissatisfaction. A fact that was seemingly ignored by Herzberg was that motivators and hygiene factors did not appear exclusively to separate sides of the continuum as is illustrated by the considerable extension of salary into the continuum of “satisfiers” while the work itself, recognition and achievement extend considerably into the continuum of “dissatisfiers” (Gruneberg 1979:13-14). This raises questions as to the true nature of some of the factors identified by Herzberg and serves as a warning to researchers not to accept perceived “satisfiers” and “dissatisfiers” at face value.

One possible explanation of the ambiguousness of the hygiene-factor “salary” it that perhaps the value humans derive from salary is often judged by society in terms of status and importance (cf. 2.3.5). Thus, whilst salary certainly represents security and physiological comfort – placing it in the hygiene category – it also is a factor strongly linked to self-esteem, recognition and achievement in the human condition (Gruneberg 1979:56-59). Coetzee (1999:55) and Louw (1997:38) both describe salary as a determinant of self-importance in the human mind and must therefore at times be considered a “satisfier”.

Coetzee (1999:55) and Louw (1997:55) also describe the work of Biesheuvel in 1984 who added to the Herzberg theory by classifying motivation-factors as intrinsic work factors and hygiene-factors as extrinsic work factors. This implied that motivation-factors are internally determined by the individual and is independent of outside influences, whilst the opposite is true for hygiene-factors (Coetzee 1999:55; Louw 1997:55).

Although marked by many methodological and conceptual problems Herzberg’s theory provided new perspectives in the understanding of the nature of job satisfaction. Whilst previous theories seemingly ignored the influence of the complexities surrounding the actual work, Herzberg’s emphasis on this fact proved to be a healthy reaction toward adding dimension to the phenomenon of people’s reactions to their jobs (Gruneberg 1979:18).

Considering the theories of Maslow and Herzberg the summation can be made that motivation stems from certain needs and when needs are satisfied, workers experience satisfaction. The question can now be asked: “What determines needs?”

This is the one concern of process theorists who postulate that needs are derived from values, expectations and peer comparisons (Gruneberg 1979:19). Three classes of process theories will now be discussed.

2.3.2 Process Theories

Whilst content theories all have it in mind to identify the variables leading to job satisfaction or dissatisfaction, in contrast, process theories aim to describe the origins of and the interactions between these variables (Gruneberg 1979:19). Three classes of process theories can be described (Coetzee 1999:55; Mouton 1998:66; Gruneberg 1979:19):

- Expectations and Equity theories
- Reference Group theories
- Value Fulfilment theories

2.3.2.1 Expectations and Equity Theories

The central notion of equity theories are that humans have certain expectations about their environment which causes certain behaviours. It argues that workers have some notion of what justly become them and based on how well they receive these rewards; workers are either satisfied or dissatisfied (Gruneberg 1979:20). Just *how* workers arrive at this notion of fair reward can be explained by either the valence theory of Vroom (Vroom 1964:15) or the Discrepancy theory as described by Locke(1976:91-93).

2.3.2.1.1 The Valence Theory

The valence theory rests on the assumption that workers have certain expectations toward the rewards they will receive based on the job they do (Mouton 1998:64; Vroom 1964:16). Vroom (1964:15-16) was of the opinion that workers will be motivated to produce well if it could be predicted that their achievements would be successful and consequently justly rewarded.

According to this theory three basic variables can be identified (Mouton 1998:65; Cranny *et al.* 1992:131; Gruneberg 1979:20; Vroom 1964:17)

- Expectations: The expectations that certain behaviours will lead to certain outcomes.
- Instrumentality: The degree to which certain behaviour will lead to certain reward.
- Valence: The strength of the individual's preference for a specific reward (can be positive or negative).

The valence theory predicts that occupational therapists expect that their efforts in practice will lead to certain outcomes if successful. These efforts are of intrinsic nature and are employed by occupational therapists specifically to attain an outcome, whether it is improvement in the patient's condition or recognition of their success by a supervisor. The intensity of their efforts will depend on their judgement of how much of the reward they will receive as well as the strength by which they feel the need for that specific reward.

2.3.2.1.2 Locke's Discrepancy Theory

The theory of discrepancy by Locke (1976:91-93) postulates that satisfaction or dissatisfaction with as aspect of the job reflects a dual judgement based on the values of the worker. The first judgement is based on the perceived discrepancy between what the individual wants and what is received (Siegel & Lane 1982:274). It asserts that the greater the discrepancy between a worker's expected reward and the actual reward received, the greater the dissatisfaction experienced by the worker (Mouton 1998:99; Visser 1990:107-108). The second judgement is based in the individual's propensity to attach certain importance to that which is wanted (Siegel & Lane 1982:275).

According to Gilmer and Deci (1977:233) the perceived discrepancy also gives rise to a shift in attitude and when perceived as negative, will result in negative behaviours. Gruneberg (1979:20) predicts that workers may choose to put in less work, take extended breaks, deliver work of poorer quality or any other number of passive-aggressive or hostile behaviours (Gilmer and Deci 1977:233).

This theory is especially valuable to the study when considering the perceived expectations occupational therapists had of the career and the reward they actually receive in practice. If the discrepancy between their expectations and the reality they work in daily is great, according to this theory, dissatisfaction will increase and may even lead to passive-aggressive or hostile behaviour – ultimately damaging the profession as well as the employer.

By implication, this theory also draws attention to individual preferences of the nature and strength of expectations. Two workers receiving the same reward might not experience the same level of satisfaction based on their own evaluation of the importance they place on their needs and the given reward (Mouton 1998:66).

The issue of "importance" leads us to the last of the classes of process theories. Taken from the previous two theories it is now understood that expectations and the measure to which they are met has some influence on a worker's satisfaction or dissatisfaction with their jobs. What is not clear is how workers arrive at these expectations. Two possible explanations can be found in literature, one, in the theory of values described by Locke in 1976 (Mouton 1998:66) and the other, in the reference group theory (Gruneberg 1979:21). The latter will now be discussed.

2.3.2.1.3 The Reference Group Theory

Advocators of the reference group theory have argued that an understanding of the groups to whom individuals relate (their reference group) is of utmost importance in understanding job satisfaction (Gruneberg 1979:21).

This theory suggests that individuals base their expectations of the reward they ought to receive by comparing their own situation to those of a preferred reference group and consequently feels either satisfied or dissatisfied with the reward they receive (Coetzee 1999:55; Mouton 1998:68; Gruneberg 1979:21-22).

Needless to say, reference group theories are often critiqued as gross generalisations which fail to take into account that not all humans live by comparison and that a significant number of people choose dance to the beat of their own drum (Gruneberg 1979:23). Gruneberg (1979:24), however continues by mentioning that reference group theories have some intuitive appeal as it would seem part of human condition to compare oneself to others and derive some feelings of favour or disfavour there from.

One critic of reference group theorists is Locke, who altogether questions the validity of theories based on expectations but rather assert that satisfaction or dissatisfaction will depend on the value a worker places on the reward (Gruneberg 1979:22). Born from this train of though, was Locke's Value theory (Coetzee 1999:49; Mouton 1998:66; Gruneberg 1979:24).

2.3.2.1.4 Locke's Value Theory

Locke (1976:94) states that job satisfaction is a complex emotional reaction to work and determined by the effect a worker's value system has on his perception of job satisfaction or dissatisfaction rather than needs.

Locke (1976:95) distinguishes between needs and values by stating that are objective requirements of the individual to ensure his existence while values are learned, subjective desires that determine the actions humans take to satisfy their needs. In support of this statement, Mouton (1998:67) and Gruneberg (1979:22) argues that humans do not always value the things they need and therefore, the value a worker places on a certain factor of their job is a stronger indicator of satisfaction or dissatisfaction than a need.

This theory once again emphasises the importance workers attach to the determinants of their job satisfaction. As such, it called the researcher's attention to allowing participants' of this study to qualify their answers during a qualitative investigation as well as to give respondents the opportunity to present a hierarchy of the factors determining their job satisfaction in order to

describe the importance they attach to the different variables influencing their job satisfaction.

2.3.3 The Contribution of Modern Day Theories on Job Satisfaction

As acknowledged by Muchinsky, modern day theories of job satisfaction are relatively new and as yet not enough time has elapsed to effectively judge them in terms of suitability to the application of the phenomenon job satisfaction (Louw 1997:58). They are however shortly included in this literature study as they present new dimensions to the concept of job satisfaction and are perhaps, when judged at face value, more in keeping with the changes governing human behavioural paradigms today.

2.3.3.1 The Opponent-Process Theory

The opponent-process theory as postulated by Landy (1976:339-340) originates from the viewpoint that job satisfaction is the result of emotional equilibrium experienced by the worker. Coetzee (1999:57) interprets that for each emotional reaction experienced in the work situation, humans possess an internal mechanism designed to generate an equal apposing emotional reaction.

Furthermore, Landy (1976:339) continues to state that with each exposure to a reaction, the opposing reaction becomes stronger – the reason for this being the psyche's effort to protect the body from extreme emotional states which are assumed to be harmful to the individual.

Mouton (1998:57) hold that the most value contribution of this theory is the implication that the accuracy of research findings on job satisfaction would increase if studies are conducted during different time-intervals In addition, this theory provides a possible explanation for why workers, over a period of time report feelings of boredom with their jobs (Louw 1997:42) since opposing reactions to initial excitement with the job, increase in frequency and strength and therefore neutralises the initial positive response over a period of time. It

also cautions researchers to remember that satisfaction with a factor at one time-interval may well change to dissatisfaction with the same factor at a later stage (Mouton 1998:57). As with all theories on job satisfaction, findings should be interpreted within it's the boundaries of its temporal context and not be generalised to all time (Gruneberg 1976:27).

2.3.4 Defining Job Satisfaction

In its most rudimentary sense, job satisfaction can be defined as the extent to which one is generally fulfilled in their current job (Mackenzie 2008:15).

The conceptualisation of the definition of job satisfaction is as diverse as the theories existing around it. Gruneberg (1979:3) observes that the major difference between definitions can be found in terms of the different ways in which the diverse aspects of job satisfaction are combined, while Louw (1997:10) explains that the definition of job satisfaction is often linked to a certain theoretical perspective and that due to the complexity thereof, cannot be fenced into a generalised statement.

However, as described by Louw (1997:10), in spite of extensive research done on the phenomenon, no one conclusive definition exists and therefore researchers would do well to understand the components which make up the various definitions and forthwith decide on an operational definition most suitable to the purpose of their given investigation (Luddy 2005: 20; Gruneberg 1979:3). Accordingly, the researcher sums up the components that make up different definitions of job satisfaction as follows:

2.3.4.1 First component: Affect, Cognition and Behaviour

One aspect of job satisfaction that is fairly well acknowledged among scholars is the notion that job satisfaction is in fact an attitude engaged in by workers with relation to their jobs (Josias 2005:52; Coetzee 1999:35; Vroom 1964:99). The last aforementioned author quotes that: "An attitude is a relatively stable

and learned inclination to react toward people, objects, institutions or issues in a certain way" (Coetzee 1999:35).

In addition, Coetzee (1999:36) also remarks that these attitudes can either be positive or negative resulting in job satisfaction or dissatisfaction respectively.

Louw (1997:12) concludes that an attitude is produced from three components namely cognition, affect and behaviour and holds up the following example as explanation:

> *"'n Werker handhaaf die* oortuiging *dat sy werk geen bevorderinggeleentheid bied nie (kognitiewe component). Hy maak die uitspraak dat om in 'n doodloopstraat te wees,* glad nie aangenaam is nie *(affektiewe component). Die gevolg is dat hy vir hom 'n nuwe werk* begin soek (*gedragskomponent)"*

Although ignoring the importance of cognition and behaviour, Spector (1997:1) captures the component of affect well by defining job satisfaction simply as "the degree to which people like their jobs." This definition is expanded on by Luddy (2005:52) who describes job satisfaction as an individual's cognitive, affective and evaluative reactions toward their jobs.

2.3.4.2 Second component: Determinants of job satisfaction

Job satisfaction will vary from one determinant to another (Visser 1990:87). Schermerhorn (1993) in Luddy (2005:53) defines job satisfaction as an affective or emotional response towards various aspects of an employee's work. The author emphasizes that likely causes of job satisfaction include status, supervision, co-worker relationships, job content, remuneration and extrinsic rewards, promotion and physical conditions of the work environment, as well as organisational structure (Luddy 2005:53).

Luddy (2005:21), based on the work of Cherrington in 1994, also advises that a distinction be made between overall job satisfaction and facet satisfaction -

where overall satisfaction focuses on the general internal state of satisfaction or dissatisfaction within the individual and facet satisfaction refers to the tendency for an employee to be more or less satisfied with various facets or aspects of the job.

2.3.4.3 Third component: The concept of equity

Job satisfaction is also defined in terms of equity (Josias 2005:52). Robbins, Odendaal and Roodt (2003:16) define job satisfaction as “the difference between the rewards employees receive and the reward they believe they should receive.” As a result, the higher this discrepancy, the lower job satisfaction will be.

Perhaps then, considering the aforementioned components that can be gleaned from most residing definitions on job satisfaction, the most comprehensive would be that of Locke in 1976 which stated:

“Job satisfaction is a pleasurable or positive emotional state resulting from the appraisal of one’s job or job experiences” (Josias 2005:52; Sulsky & Smith 2005:87; Coetzee 1999:36, Mouton 1998:56; Vorster 1992: 37; King 1995:22; Gruneberg 1979: 3).

The definition of Locke, quoted directly before, will serve as the operational definition for this study.

2.3.5 Determinants of Job Satisfaction

A review of the literature shows that numerous variables have been investigated in their relation to job satisfaction. These variables include demographic data, e.g. age, gender, and race, intrinsic features of the job, e.g. recognition, advancement, and responsibility, and extrinsic variables, e.g. salary, supervision, and working conditions (Worrell 2004:18). Extrinsic sources of job satisfaction are determined by conditions that are beyond the control of the employee while intrinsic sources of job satisfaction primarily come from within

the individual and are essentially longer lasting than the extrinsic sources (Josias 2005: 53-67; Coetzee 1999:60-76; Vorster 1992:57).

Mouton (1998:72) and Louw (1997:45) cite that the categorisation of the different determinants of job satisfaction is arguably most comprehensively described by Locke(1976:103). Landy (1976:337) states that Locke's categorisation is the "result of a wide review of all job satisfaction literature" and therefore, a sagacious basis on which to present the determinants of job satisfaction.

Locke (1976:103) postulated that the determinants of job satisfaction can be placed into two categories namely.

a) Incidents or circumstances – occurrences responsible for a worker's feelings of satisfaction or dissatisfaction.

b) Agents – people, organisational and non-organisational structures and ideologies responsible for the incidents and circumstances.

The original categorisation of Locke is illustrated in Table 1.

Table 1: Locke's dimensions of job satisfaction (Louw 1997:46)

INCIDENTS OR CIRCUMSTANCES	AGENTS
The work itself • Work content • Work challenge • Work transparency	**The employee** • Functional differences • Demographic dimensions
Rewards • Salary • Reasonable reward • Promotion	**Role player inside the organisation** • Supervision • Colleagues
Work context • Circumstances • Advantages (Special Privileges)	**Role players outside the organisation**

After a comprehensive review of available literature, the determinants of job satisfaction can be illustrated by adapting and expanding the original categorisation of Locke. It is the opinion of the researcher that presenting information in this summarised fashion allows for an effort. Furthermore, for the purpose of this study, in-depth discussion of each factor is better suited to Chapter 5; Discussion of Results, as relevance and the prevention of unnecessary duplication of information can be assured this way. Accordingly, the researcher now presents the determinants of job satisfaction in figures 2.4 - 2.6: Incidents or Circumstances as Determinants of Job Satisfaction and figures 2.7 - 2.9: Agents as Determinants of Job Satisfaction.

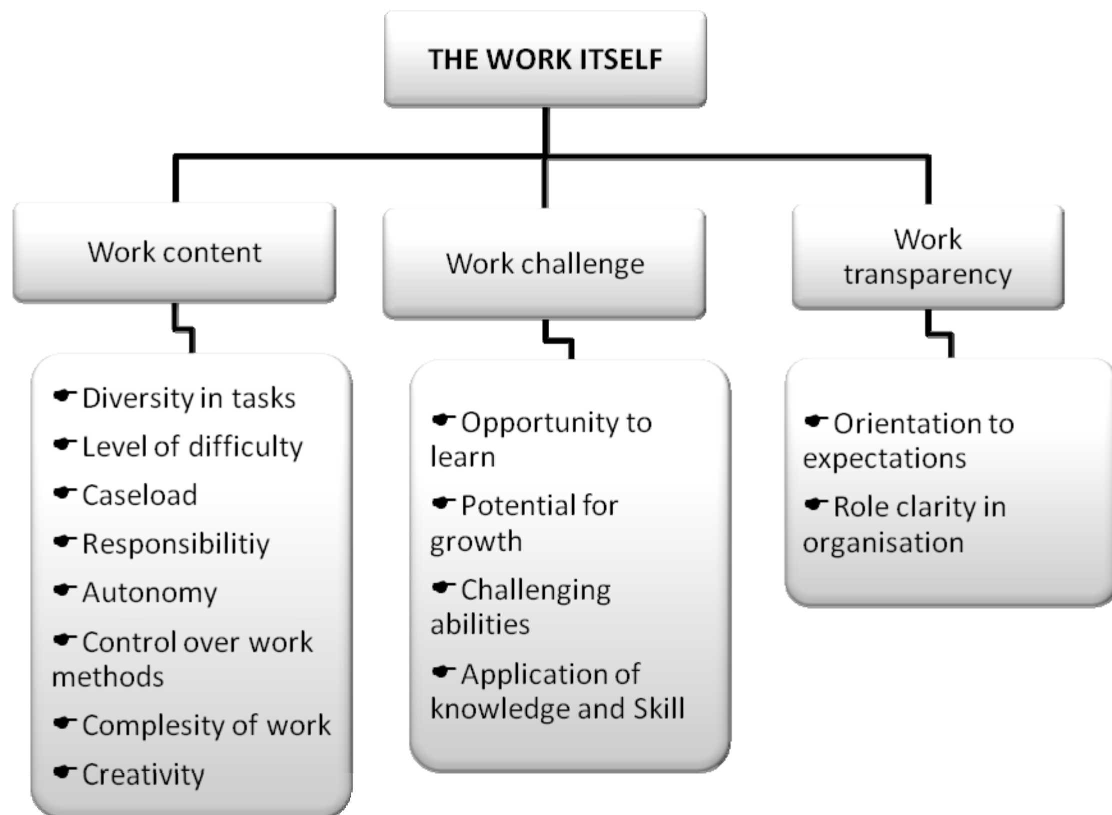

Figure 2.4: Incidents or Circumstances as Determinants of Job Satisfaction – The Work Itself (Adapted by J. Swanepoel 2010)

Figure 2.4 illustrates the facets of the work itself that influence job satisfaction. Humans tend to choose a certain career based on their perception of the work content (Mouton 1998:74). Aspects (cf. fig 2.4) such as diversity, difficulty, responsibility, autonomy and creativity are, according to Locke, key considerations when workers evaluate their job satisfaction (Louw 1997:47).

Work challenge is another dimension of job satisfaction and is in part a result of the work content (Louw 1997:49). The intellectual stimulation obtained from performing a job seems central to the level of attention and involvement a worker have with their job (Mouton 1998:75).

It can be argued that if intellectual stimulation is inadequate, the worker will experience low work challenge and therefore may experiences high levels of boredom. According to literature, boredom with the job will result in increased

job dissatisfaction and consequent higher incidences of absenteeism, personnel turnover, poor achievement, poor discipline, unresolved conflict and low creativity (Coetzee 1999:62).

Work transparency has its function in decreasing levels of anxiety in workers as well as preventing unrealistic expectations from forming in both the employer and the worker (Mouton 1998:64; Gruneberg 1979:35).

Robbins (1998:447) asserts that organisational structure has a major influence on the attitude of workers and continues by saying: "The degree to which organisations reduce ambiguity for employees and clarifies concerns…shapes their attitudes (satisfaction) and motivates them to higher levels of performance."

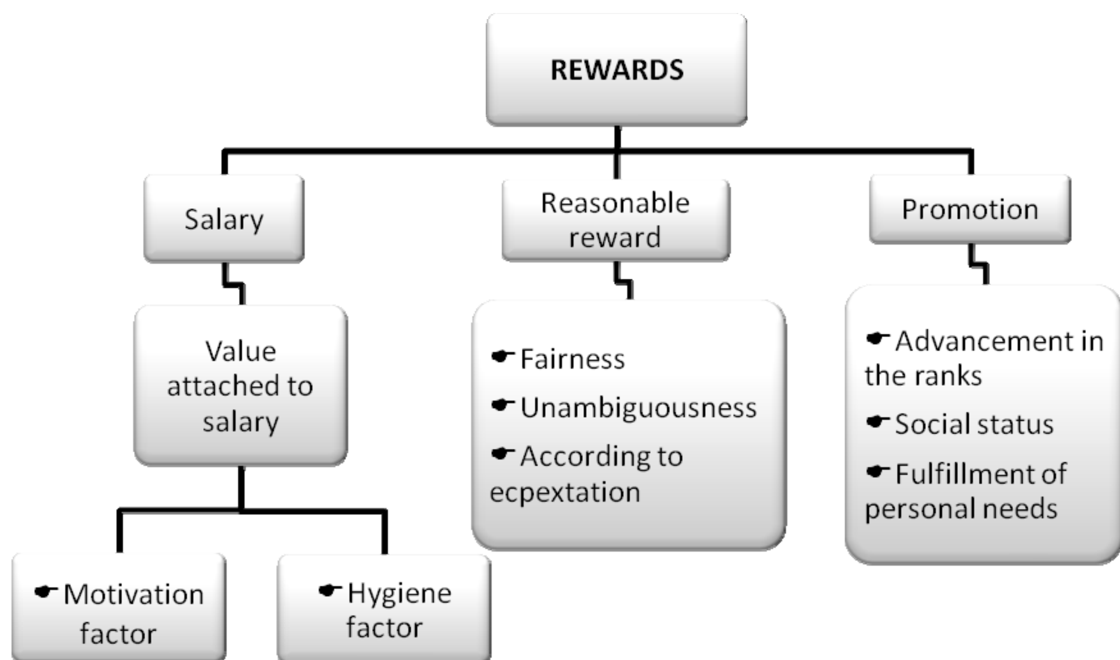

Figure 2.5: Incidents or Circumstances as Determinants of Job Satisfaction – Rewards **(**Adapted by J. Swanepoel 2010)

Figure 2.5 illustrates the facets of reward that influenced job satisfaction. Josias (2005:53) state that wages and salaries are recognised to be a significant, but complex, multidimensional predictor of job satisfaction. Most studies suggest

that the actual monetary value of the salary shows only low correlation with the worker's job satisfaction (Josias 2005:53; Worrell 2004:67; Louw 1997:51).

Mackenzie (2008:11) however argues that salary is the main driving force behind job satisfaction and supports this by adding that it is not just the financial reward but the implied significance of the work, the value the worker feels the organisation places in him/her and the accompanying social status that is of actual importance. Some may view salary as a hygiene factor (e.g. a source of physical comfort), while others may well view their salary as a manifestation of their self worth (Coetzee 1999:65; Gruneberg 1979:56-59).

A factor which is seemingly more significant as a determinant of job satisfaction is that of the fairness or reasonability of the reward. The concept originates from the expectations and equity theories that argues that workers have some notion of what justly becomes them, and based on how well we receive these rewards, we are either satisfied or dissatisfied (Gruneberg 1979:20).

Promotion is also viewed as part of the reward system in an organization. Josias (2005:55) postulates that promotion provides employees with opportunities for personal growth, more responsibilities and also increased social status. Robbins (1998:103) maintains that employees seek promotion policies and practices that they perceive to be fair and unambiguous and in line with their expectations. Research (Josias 2005:55) indicates that employees who perceive that promotion decisions are made in a fair and just manner are most likely to experience job satisfaction.

Once again, dissatisfaction with one's salary may lead to poor performance, job strikes, absenteeism and high personnel turn-over (Coetzee 1999:65).

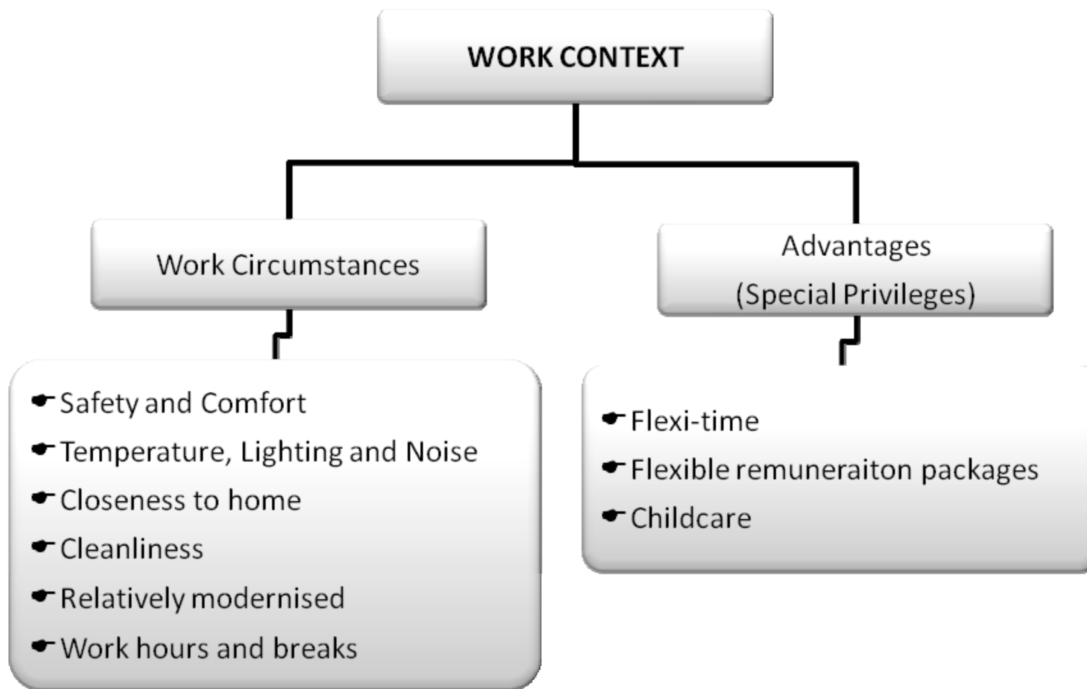

Figure 2.6: Incidents or Circumstances as Determinants of Job Satisfaction – Work Context (Adapted by J. Swanepoel 2010)

Figure2.6 illustrates the influence of work context factors on job satisfaction. Working conditions is an extrinsic factor that has a moderate impact on an employee's job satisfaction (Josias 2005:57).

Locke (1976) however observed that workers in general tend to accept their work environment as it is except in cases where it is either extremely bad or extremely good – as is the case when workers receive special privileges such as flexi-time and child-care (Louw 1997:55).

Based on studies conducted by Barber in 1986 and Fieldman in 1983, Coetzee (1999:63) agrees that work conditions is only a moderate indicator of job satisfaction but states that dissatisfaction with the work environment is often a symbolic manifestation of other deep-seated issues such as personnel problems or mistrust. Coetzee (1999:63), however, reminds researchers that for some individuals the work environment is also a reflection of their social status and as such, it plays a more important role in the worker's job satisfaction than when viewed simply as a hygiene factor.

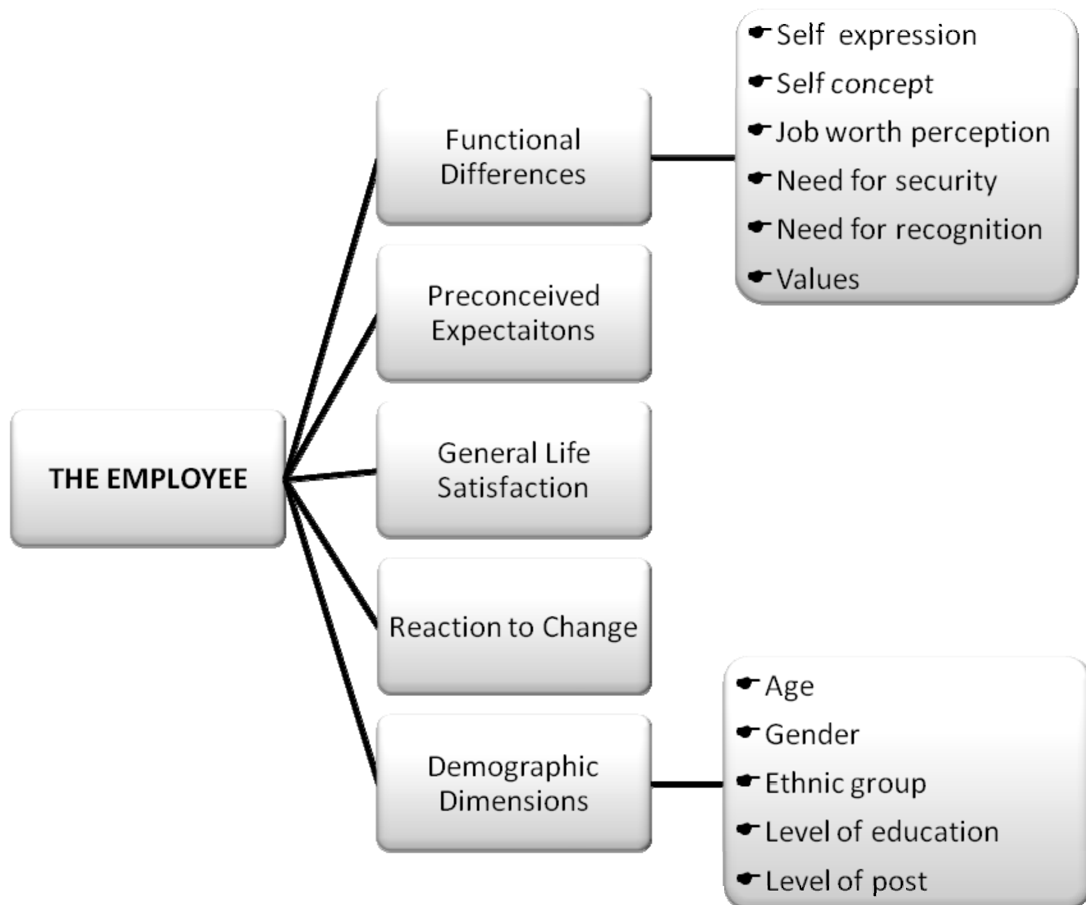

Figure 2.7: Agents as Determinants of Job Satisfaction – The Employee (Adapted by J. Swanepoel 2010)

As is shown in Figure 2.7, the unique and individual composition of the employee is also a determinant of job satisfaction.

Functional differences result from workers' differences in personality, values, talents and needs (Louw 1997:59). According to Sulsky and Smith (2005:33-35) employees whose personality type, values and talents correlate well with their job have better chance at achievement and success in the job and therefore growth needs are more satisfied than when a low correlation exists.

Preconceived expectations often form the basis on which employees choose their jobs (King 1995:26). The aforementioned author continues by stating that the greater the discrepancy between the expectation and the reality of the

experience the greater the dissatisfaction would be. This is in keeping with Locke's discrepancy theory described earlier in this chapter (Mouton 1998:99, Visser 1990:107-108).

Another individual factor described as having a significant influence on job satisfaction is the employee's experience of general life satisfaction. Gruneberg (1979:125) describes the relationship between job satisfaction and general life satisfaction as two-way street where the casual aspect of the relationship is unclear.

It is however generally accepted that an employee's life background predisposes the individual to either be more happy or more unhappy and that, as a result, the individual will either be more prone to satisfaction or dissatisfaction on the job (Gruneberg 1979:125).

Mouton (1998:94) supports this view and adds that satisfied workers are generally more flexible, better adapted, more suited to overcoming unfavourable circumstances and more realistic with regard to their work expectations than workers who report low life satisfaction. This statement of Mouton also explains the individual's reaction to change and implies that unsatisfied workers will experience higher levels of resistance to change than satisfied workers (Ntulini 1999:73).

Demographic dimensions such as age, gender, and ethnic group, level of education and level of post are also considered to be indicators of the employee's job satisfaction. Vorster (1992:67) reports that a wide range of authors concur that job satisfaction increases with age as the worker's expectations lower and they become better adapted to the job because of their experience.

Gruneberg (1979:91) however caution researchers not to generalise this concurrence as many studies have either failed to find a significant correlation between age and job satisfaction or have found other factors such as gender, political environment or social expectations to be the causal determinant.

Visser (1990:90) purports that individuals in high level jobs have more psychological needs that have to be met on the job than workers occupying lower order jobs. This points to a positive relation between job satisfaction and the level of the job – the higher the job level, the greater the potential is to derive satisfaction from the job. The same relationship exists between the level of education and job satisfaction (Louw 1997:63).

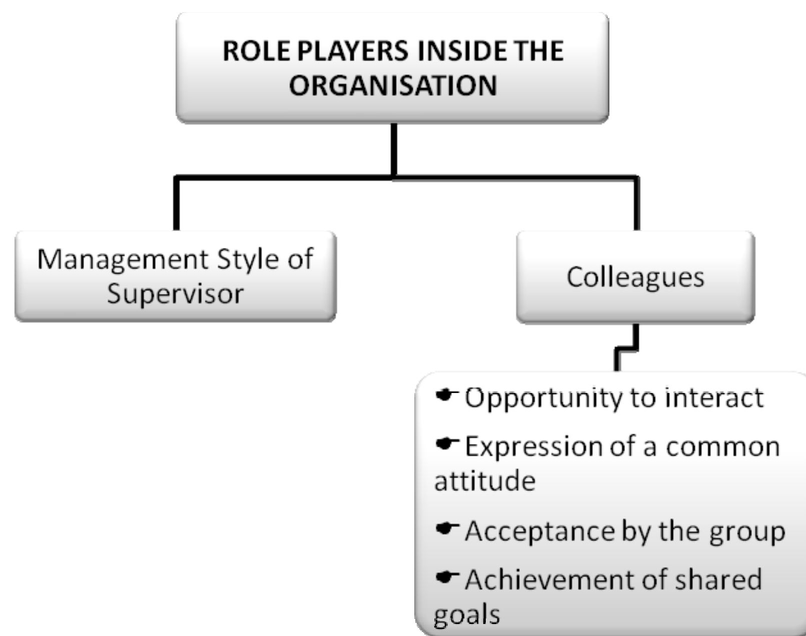

Figure 2.8: Agents as Determinants of Job Satisfaction – Role Players inside the Organisation (Adapted by J. Swanepoel 2010)

Figure 2.2 present two factors of agents inside the organisation as role players in determining an employee's job satisfaction. These are: The management style of the supervisor and work colleagues.

Research indicates that people who enjoy working with their supervisors will be more satisfied with their jobs. Worrell (2004:27) states that adequate supervision is correlated with higher levels of job satisfaction. Josias (2005:56) continues that satisfaction with supervisors was highly related to organisational and team commitment, which in turn resulted in higher productivity, lower turnover and a greater willingness to help.

Coetzee 1999:62 describes a good supervisor as someone who is friendly, acknowledges and rewards performance, listens to subordinates' opinions and gives personal attention. Siegel and Lane (1982:279) claim that workers prefer to work with supervisors who are warm, approachable and employee-orientated.

The extent to which supervisors concern themselves with the welfare of their employees, the extent to which people participate in decisions that affect their jobs and the employee's perception of whether they matter to their supervisor all show a positive relation to job satisfaction (Josias 2005:56).

Vorster (1992:62) reports that co-worker interaction has a significant influence on job satisfaction. According to the aforementioned author (1992:62), co-workers represent the potential fulfillment of individuals needs to interact, express a common attitude, gain peer acceptance and achieve shared goals (Vorster 1992:62).

Mouton (1998:98) accentuates the importance of co-worker relations with regards to job satisfaction by quoting the words of Elton Mayo as follows: "a man's desire to be continuously associated in work with his fellows is strong; if not the strongest human characteristic". The train of this thought would indeed find resonance with the earliest schools of research on job satisfaction (e.g. the classis Hawthorn-studies) that professed human associations at work to the most important job satisfaction determinant (Gruneberg 1979:6).

Although research on job satisfaction has expanded greatly to include many other factors such salary and the work environment, the importance of co-worker relations should still be considered of highest priority – especially when working with professionals such as occupational therapists who seem to draw high volumes of energy from interaction with others.

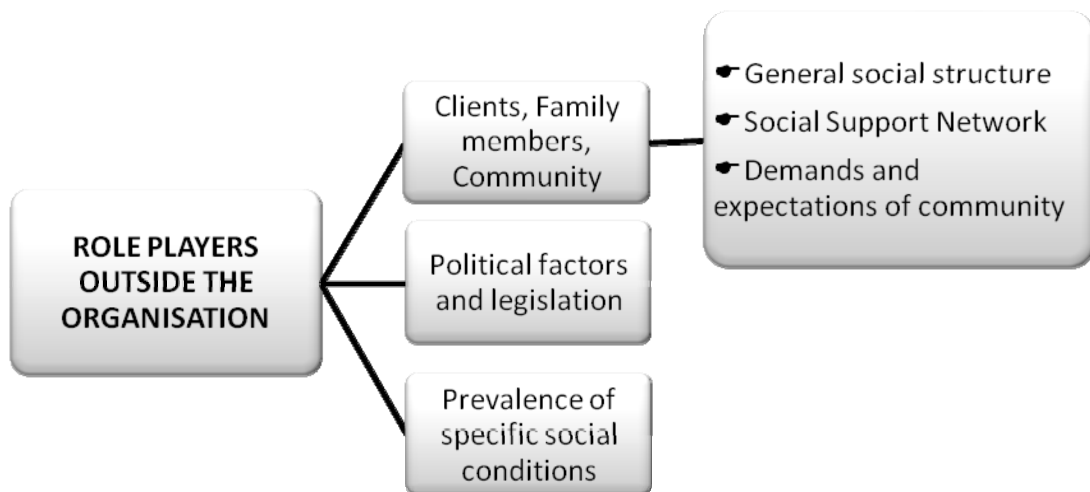

Figure 2.9: Agents as Determinants of Job Satisfaction – Role Players outside the Organisation (Adapted by J. Swanepoel 2010)

Role players outside the organisation, as illustrated in figure 2.3, often influences an employee's perception regarding their job satisfaction (Louw 1997:68). Literature as described by Gruneberg (1979:125) and Louw (1997:69) explains the role of outside influence based on two theories namely:

- The *compensation theory* which argues that non-work related factors can compensate for inadequacies in a worker's personal life and *vice versa*
- The *spillover theory,* which in contrast to the compensation theory, purports that happiness or unhappiness with non-work related factors will spill over into work.

Of the two theories, Gruneberg (1979:125) reports that the *spillover theory* is "almost universally accepted".

Saal and Knight (1988:318) caution researchers to remember that the relations between non-work related factors and job satisfaction is context bound and interpretations of these external factors should only be made within the frame of reference of the population under study.

It is clear that a myriad of factors, intrinsic and extrinsic, has significant influence on the employee's experience of job satisfaction. Understanding these factors is however not enough. It is only once the exact impact of the different factors on job satisfaction is determined that researcher will be able to make recommendations to assuage the predicted negative effects of job dissatisfaction. Determining the exact impact of each job satisfaction determinant is done by measurement and consequently the measurement of job satisfaction will now be discussed.

Measuring job satisfaction is difficult, for it is an abstract personal cognition that exists only in an individual's mind (Worrell 2004:16) Since there is no single agreed upon definition of job satisfaction, and no widely accepted theory to explain it, it is no surprise that there is also no general consensus on the best way to measure job satisfaction.

Spector (1997:43) proposed that the most basic forms of measuring job satisfaction might include an interview, a single-item measure, or a workplace observation. According to Worrel (2004:16) questionnaires are easily distributed, have less room for bias, have increased likelihood of confidentiality, and require much less time and money than one-on-one interviews. Job satisfaction questionnaires also can examine any number of facets that have hypothesized impact on job satisfaction, although the lack of common agreement with definition and theory can present challenges when weighting each facet and interpreting the results (Evans, 1998:84).

However, most researchers opt for a more objective and in-depth survey instrument (Worrel 2004:16). Munchinsky (1983: 239-328) continues by citing the following survey instruments as most widely acclaimed in literature: a) The Job Satisfaction Survey (JSS), b) the Job Descriptive Index (JDI) and c) the Minnesota Satisfaction Questionnaire (MSQ).

2.3.5.1 The Job Satisfaction Survey

The Job Satisfaction Survey was developed by Paul E. Spector to assess employee attitudes about the job and aspects of the job. It measures different facets of job satisfaction including pay, promotion, benefits, supervision, contingent rewards, operating procedures, coworkers, nature of work, and communication. Each of these facets is assessed with four items, and a total score is computed from all 36 items. Responses to each question range from "strongly disagree" to "strongly agree" (Worrel 2004: 17).

2.3.5.2 Job Descriptive Index

The Job Descriptive Index (JDI) was first discussed in Smith, Kendall, and Hulin's publication of the Measurement of Satisfaction in Work and Retirement in 1969. This 90-item scale is designed to measure employees' satisfaction with their jobs by looking at five important aspects of job satisfaction which are present job, present pay, opportunities for promotion, supervision, and coworkers. It has been widely used and researched for over 40 years (Worrel 2004:17).

2.3.5.3 Minnesota Satisfaction Questionnaire

Perhaps the most likely instrument to use for the purpose of this study is , the *Minnesota Satisfaction Questionnaire* (MSQ) that was first developed by Weiss, Dawis, England and Lofquist in 1967 (Weiss, Dawis, England & Lofquist, 1967: v). Worrel (2004:17) states that the MSQ has become a widely used instrument to evaluate job satisfaction.

Three forms of the MSQ have been developed, two 100-item long forms (1977 version and 1967 version) and a 20-item short form (Weiss *et al.* 1967:vii). The MSQ is designed to measure specific aspects of an employee's satisfaction with his or her job, and it provides more information on the rewarding aspects of a job than more general measures of job satisfaction(Worrel 2004:17).

The MSQ is a gender-neutral, self-administered paper-and-pencil inventory. The short form can be completed in approximately five minutes while the long form can be completed in 15 to 20 minutes. Although both the short and long forms provide job satisfaction estimates, the long form provides much more information when compared with the short additional administration time required. The MSQ can be used in an individual or group setting, and standardised instructions for administration are provided (Worrell 2004:17-18; Weiss *et al.* 1967:2-5).

Although of formative value in giving a comprehensive description of the employee's job satisfaction status, the MSQ has some contextual limitations which restrict its use with regards to the population of this study. These limitations are:

- The MSQ was standardized on a western population in a first-world country in direct contrast to circumstances in South Africa.
- The norms for the MSQ are occupation specific and as yet, no norms exist for the profession occupational therapy.
- The test manual suggests that the researchers select a similar norm group if no norms for the specific occupation can be found. The authors however, strongly caution researchers to take great care to ensure that a large number of similar characteristics between the two vocations exist (Weiss *et al.* 1967:4). No significantly similar norm group could be identified for the population of this study.

The value of the MSQ was however to such an extent that it was used as a guideline to assist the researcher in developing the self-administrative questionnaire used in this study. The specified dimensions, phrasing of questions, response options and number of items were adapted to the purpose of this study and incorporated in the questionnaire (Weiss *et al.* 1967:14-15).

2.3.6 Consequences of Job Satisfaction/Dissatisfaction

The consequences of job satisfaction or dissatisfaction are complex and often ambiguous in nature (Gruneberg 1979:105). Job satisfaction is often assumed to be as determinant of the following consequences (Louw 1997:70-72; Gruneberg 1979:105-128)

- Low productivity
- Withdrawal from the work environment
- Increased absenteeism
- High personnel turnover rates
- Counterproductive behaviour (e.g. theft, vandalism, private use of organisational resources)
- Poor physical and mental health
- Poor life satisfaction

2.4 SECTION C: JOB SATISFACTION AND OCCUPATIONAL THERAPY

The job satisfaction of occupational therapists have intermittently been the topic of research studies since the 1970's with most of the research taking place from the 1990's onward. Earlier studies tended to focus on providing a description of the occupational therapist's job satisfaction whilst later studies sought to investigate job satisfaction/dissatisfaction as a means to identify retention and recruitment strategies aimed at addressing the shortage of health care professionals worldwide (Baily 1989:23; Greensmith & Blumfield 1989:389; Baily 1991:449).

Research on the job satisfaction of occupational therapists has been conducted in Europe, America, Israel, Australia, Sweden and Great Britain. To date, no studies on this phenomenon could be found in South Africa, although some occupational therapy clinicians have indeed studied job satisfaction with regards to their clients.

Borrowing from the way research in this phenomenon has developed, the discussion of literature pertaining to the job satisfaction of occupational therapists will proceed as follows:

a) General results of job satisfaction studies in occupational therapy
b) Occupational therapy, job satisfaction and specific phenomenon
c) Retention and recruitment strategies in occupational therapy

2.4.1 General Results of Job Satisfaction Studies in Occupational Therapy

It is notable that throughout the years the factors contributing to job satisfaction and dissatisfaction of occupational therapists have remained relatively the same.

Generally, the most distinct factors of satisfaction relate to the work itself whilst dissatisfaction with working conditions and perceived poor professional status is frequently reported (Moore *et al*. 2006:19-21; Meade, Brown & Trevan-Hawk 2005:137; Smith-Randolph, Doisy & Doisy 2005:50; Eklund & Hallberg 1999:167).

Moore and other authors (2006a:22), using a phenomenological approach in urban Australia found that most of the occupational therapists interviewed were satisfied with being occupational therapists and "working with clients to make a difference". They also found that the diversity inherent in occupational therapy and autonomy in performing work tasks was congruent with job satisfaction. Along with limited financial resources, the undefined role and status of occupational therapists amongst other health profession as well as their clients, contributed strongly toward job dissatisfaction (Moore *et al*. 2006a:22-24).

Occupational therapists, Eklund and Hallberg (1999:167), found that general satisfaction with the work, and communication and co-operation among team members to be great contributors toward job satisfaction for Swedish occupational therapists working in psychiatric care. The influence of relatives

on patient's care was the highest source of job dissatisfaction. The researchers also found that older therapists, with more work experience, reported higher levels of job satisfaction. In contrast with other studies and literature, Eklund and Hallberg (1999:167) found no relationship between employment conditions, care system and type of position and the therapists' job satisfaction.

In a study concerned with the gender perspective of occupational therapist's job satisfaction, Meade and other authors (2005:137-147) found that male occupational therapists are more concerned with opportunities for promotion and rates of pay while female therapists view teamwork, client contact, respect and working conditions as more prominent indicators of their satisfaction/dissatisfaction with their work. In this study, bureaucracy, excessive administration, limited resources, poor pay, poor opportunity for promotion and large caseloads were found to be factors leading to dissatisfaction among the occupational therapists.

Adequate staffing, stable environment and balance between work and home have all been cited as significant factors influencing job satisfaction among rehabilitation personnel of which occupational therapy forms a part (Smith-Randolph, Doisy & Doisy 2005:50).

2.4.2 Occupational Therapy, Job satisfaction and Specific Phenomenon

Over time, research has highlighted the experiences of occupational therapists' job satisfaction in relation to several phenomenons such as self-efficacy and career expectations, perceived autonomy and management styles, attrition and reaction to changing work environment. A précis of these findings will now be discussed.

2.4.2.1 Self-Efficacy, Career Expectations and Job Satisfaction

In their study, Bush, Powell and Herzberg (1993:927) stated that a career expectation is an issue ultimately affecting occupational therapists job satisfaction and consequently also personnel retention. Greensmith and

Blumfield (1989:390) in England found that 41.7% of occupational therapists stated that their career expectations were not fully met and cited job disillusionment as their reason for leaving the profession. These results were confirmed one year later in America by Baily (1990b:33) who studied over 600 occupational therapists who had already left the profession or were planning to do so. Over one third of Baily's sample group was practicing non-occupational therapy job and reported that, once again, disillusionment with the career prompted their attrition (Baily 1990b:34). In conclusion, Bush, Powell and Herzberg (1993:929-931) stressed that the role of occupational therapy educators, fieldwork whilst training and entry-level career adjustment was of the utmost importance in preventing future loss of personnel due to poor efficacy in career expectations.

2.4.2.2 Perceived Autonomy and Managerial Styles

Davis and Bordieri (1987:591) found that the degree to which occupational therapists experience personal responsibility for work outcomes was positively related to job satisfaction. These findings are confirmed in almost all occupational therapy studies relating to job satisfaction (Moore *et al*. 2006:18; Meade, Brown & Trevan-Hawk 2005:137; Smith-Randolph, Doisy & Doisy 2005:51; Eklund & Hallberg 1999:169). Davis and Bordieri (1987:592) however continue and implicate the role of the occupational therapy manager as a major contributor/detractor of work autonomy. The afore-mentioned authors list the following desirable traits in occupational therapy managers:

a) The ability to integrate the department and its members.
b) The ability to use power for the benefit of staff development and the achievement of organisational goals.
c) The ability to guide rather than dictate.

2.4.2.3 Career Attrition

Several occupational therapy researchers have begun to investigate the reasons occupational therapists choose to leave the profession (Turgeon & Hay

1994:277; Hasselkus & Dickie 1993:145; Baily 1989:23;Greensmith & Blumfield 1989:389). In lieu of an unnecessarily lengthy discussion on the reasons why occupational leave the profession; the following assimilation of the research findings of all of the above-mentioned authors is outlined:

- Depression and disillusionment in dealing with chronically ill patients
- Role ambiguity
- The need for more control over working hours
- Disillusionment with work (feeling that occupational therapy does not really make a difference
- High cost of getting to work and arranging child-care
- The lack of part-time work
- The lack of respect for occupational therapy by other professions
- The need for more challenge and autonomy
- Poor understanding by others of what occupational therapists do
- Unmet career expectations
- Poor salary
- Unfavourable working conditions
- Excessive administration and bureaucracy
- Stress, overload and dealing with other's pain
- Entering the field by default

2.4.2.4 Occupational Therapists' Reaction to a Changing Work Environment

Occupational therapist, Evelyn Pringle (1996:401), studied the occupational therapist's reaction to a changing National Health Service (NHS) in Britain and the consequent impact on their job satisfaction. The reform of the health system in Britain started in the mid 1980's and was in many instances similar to the reform implemented in the South African health system post 1994 (cf. 2.2.3).

Conducting a qualitative study, Pringle identified several themes which impacted in the job satisfaction experiences of the occupational therapists working in the new NHS. These were (Pringle 1996:402-404):

- Changes in role
- Changes in patient expectations
- Influence of NHS on Clinical autonomy

Pringle (1996:402) found that all the therapy managers felt that the role of occupational therapist was changing an may indeed be under threat as a result of NHS reform. The element of reprofiling (similar to occupation specific dispensation in South Africa), the consequences of community care legislation (similar to the primary health care package of South Africa) and the poor appreciation of the occupational therapist's role by general practitioners and other health affiliated staff were cited as the most worrisome reasons inducing feelings of insecurity with regards to the future of occupational therapy as a profession (Pringle 1996:402).

Respondents in Pringle's study also reported that patient's expectations have risen and that although additional demands were made, no supporting resources were made available (Pringle 1996:403). Pringle found this to be congruent with feelings of job dissatisfaction and work stress.

Lastly, Pringle (1996:404) found that overall, occupational therapists felt that their clinical autonomy remained unchanged but that rapid patient turn-over, lack of resources and down-referral were impacting their clinical autonomy – and consequently their job satisfaction, negatively.

2.4.3 Retention and Recruitment Strategies in Occupational Therapy

Although strategies for recruitment and retention of occupational therapists is not the primary concern of this study, it was found that understanding the incentives and experiences provided to occupational therapists as a means to

either recruit or retain, was indeed indicative of occupational therapy managers' focus on increasing their staff's job satisfaction.

Several researchers have focussed their attention to this phenomenon and include the works of Jenkins (1991:449-452), Freda (1991:240-245), Smith, Schiller, Kay and Sachs (1994:412-419) and Okerlund, Jackson, Parsons and Comsa (1994:263-265).

Flexible working hours, paid sign-on bonuses, on-site childcare and paid membership fees were cited by Smith and other authors (1994:413) as the most frequent reasons occupational therapists decided to take up new employment or remain in their current positions.

Freda (1991:243) found similar result in her study but added that the lack of promotional opportunities and the lure of higher salaries often prompted occupational therapists to resign from their current jobs. Jenkins (1991:450) highlighted that high case load and inadequate staffing were often the instigators of occupational therapists seeking alternative employment.

Okerlund and other authors (1994:264) found that salary and fringe benefits, access to continuing education, flexible working schedules, positive co-worker relationships, opportunity to participate in decisions and the amount of freedom on the job as the factors most mentioned by occupational therapists when considering new employment. These factors, as written above, were ranked in order of importance.

2.5 CONCLUSION

After reviewing this chapter, it is apparent that no singular explanation can be given for the nature or the occurrence of job satisfaction. Job satisfaction is a multi-faceted, subjective experience which is often context bound and largely dependent on interpretation within the setting of a specific study.

Although many empirically evidenced intrinsic and extrinsic determinants of job satisfaction have been identified, their exact influence can only be fully understood by in-depth study of the given population and its specific working environment.

Job satisfaction among occupational therapists has intermittently been the concern of researchers. Over time, most studies have reported similar results and several specific phenomena have also been identified. Later studies focussed on ways to retain and recruit occupational therapists.

It would be fair to argue that given the complexity of the phenomenon, research methodology on which job satisfaction studies are based should be clear, sound and supportive of in-depth study.

In the following chapter, the qualitative and quantitative nature of this study is discussed; the chapter details the study design, sampling procedures and measurement strategies whilst providing the theoretical and statistical imperatives for data analysis. *Chapter 4, Research Methodology.* is now presented.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In the previous chapter, the relevant theory of job satisfaction and its relation to changes in world view, occupational therapy and the public health system of the Free State was discussed. Although of great importance as context to the study, the previous chapter provides little explanation of the sound systematic and scientific process, responsible researchers are compelled to investigate and implement in a research study (Fouchè & Delport 2005:71).

The purpose of this chapter is firstly to define the study design and secondly to describe the research methodology as a means to illuminate the scientific process followed in this study. In order to provide a systematic and logical presentation of the research methodology, the quantitative and qualitative sections of this study will be discussed separately. However, preceding the separate discussions of the two distinct yet augmentative research approaches employed in this study, an overall description of the study's population is provided.

Figure 3.1 illustrates a schematic lay-out of how the discussion in this chapter will proceed.

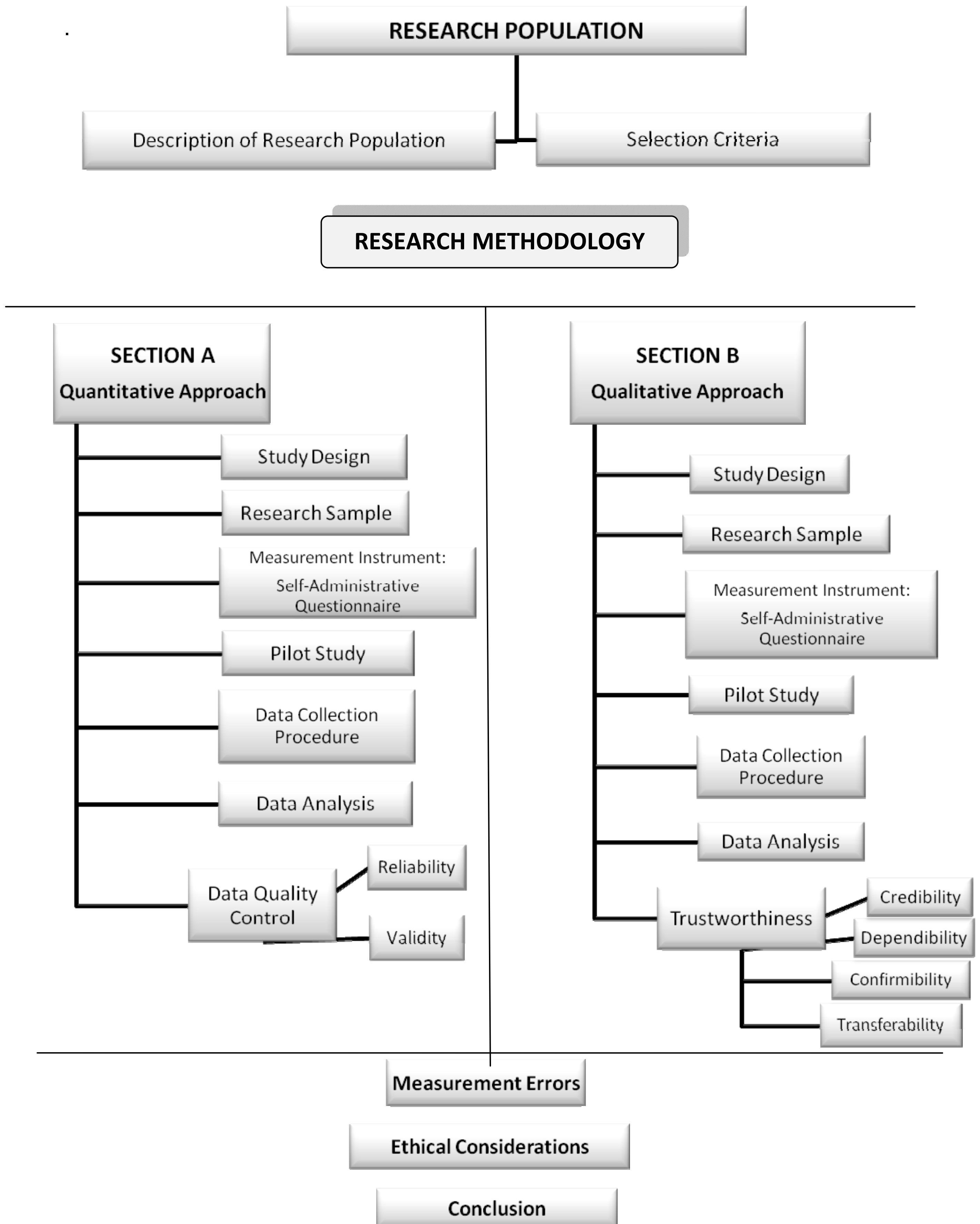

Figure 3.1: Schematic Presentation of Chapter 3

3.2 RESEARCH POPULATION

The study was conducted among registered occupational therapists working in the PHS of the FS.

The selection of this specific group of occupational therapists as subjects was initially based on the researcher's personal observation of their dilemma regarding job satisfaction in a work environment where innumerable challenges existed. The selection also proved to be apt as the majority of occupational therapists working in the FS was indeed employed by the PHS, whilst all newly qualified occupational therapists are guaranteed to work at least once within this environment as community therapists. These facts lent some merit to the study as the results would prove to be relevant to a large portion of occupational therapists in the FS.

At the time of the execution of the study the total population of occupational therapists in the PHS of the FS numbered 63. The distribution of the occupational therapists into their different designations is shown in table 3.1.

Table 3.1: Designations of Occupational Therapists in the PHS, FS

DESIGNATION	TOTAL NUMBER OF THERAPIST
Community Occupational Therapists	23
Senior Occupational Therapist (Level 7)	28
Chief Occupational Therapists (Level 8)	8
Assistant Managers (Level 9 & 10)	4
	63

All occupational therapists meeting the selection criteria were eligible to participate in this study.

3.2.1 Selection Criteria

Selection criteria were set both for inclusion and exclusion from the study.

3.2.1.1 Inclusion Criteria

The following portion of the population was eligible to participate in both the quantitative (questionnaires) and qualitative investigations (interviews):

- All qualified occupational therapists and community service occupational therapists working in the public health sector on primary, secondary and tertiary levels in the Free State, South Africa.
- All occupational therapists with applicable current registration with the Health Professions Council of South Africa.
- All occupational therapists working as clinicians or direct managers of clinical services in an occupational therapy department.
- Occupational therapists who were fluent in either English or Afrikaans.
- Community service occupational therapists who had completed at least six months of service by the time the study was executed.
- Due to financial implications and logistical challenges, only therapists residing within a 100 km radius of Bloemfontein were selected for the interviews.

3.2.1.2 Exclusion Criteria

- To limit bias, all occupational therapists working at the same institution as the researcher, and therefore under her supervision at the time of the study's execution, were excluded from the qualitative investigation of the study (interview) but were still eligible to participate in the quantitative investigation (questionnaires) as anonymity could be assured.
- Occupational therapists working as managers not acting in direct supervision of *clinical* services were excluded.

3.3 RESEARCH METHODOLOGY

In order to achieve the objectives of this study, an explanatory study with both a quantitative and qualitative study design was selected (Ivancova, Cresswell &

Plano Clark 2010:266; Leedy & Ormrod 2006:133-179; Burns & Grove 2005:232).

For the quantitative approach, a typical descriptive study design was chosen while a qualitative phenomenological approach was also followed (Leedy & Ormrod 2005:135-146, 179-183). The rationale of using both the afore-mentioned study designs in augmentation of one another was that the quantitative results provided baseline data of the job satisfaction status of the study population whilst the qualitative results refined, explained and provided depth to the phenomenon as a whole, as well as its multiple facets (Ivancova, Cresswell & Plano Clark In Maree 2010:266).

3.3.1 SECTION A: QUANTITATIVE APPROACH

Section A of this discussion on research methodology deals with the quantitative approach to the study.

3.3.1.1 Study Design

A *typical descriptive study design* was selected as the means to collect quantitative data in this study (Leedy & Ormrod 2005: 135-146). The purpose of descriptive studies, according to Polit and Beck (2006:189) is to observe, describe and document the aspects of a situation.

In this study the typical descriptive study design facilitated the assimilation of previously absent data regarding the job satisfaction of the occupational therapists in a South African context. It also served a valuable purpose in obtaining the indicators of job satisfaction or dissatisfaction which served as the baseline for the qualitative inquiry. Additionally it allowed the collection of large amounts of data in a time-saving and cost-effective manner. However, the most valuable contribution of this quantitative approach was that it provided exact data by which the overall job satisfaction of the study population could be described.

3.3.1.2 Research Sample

The research sample for the quantitative typical descriptive investigation comprised of all occupational therapists and occupational therapy managers adhering to the selection criteria (cf.3.2.1).

All the occupational therapists were listed on the *PERSAL database* of government employees. The database was accessed with the assistance of the manager of occupational therapy in the Free State. The list was scrutinised by the researcher and updated to include all current employees.

A total of 63 occupational therapists listed as current government employees in the Department of Health of the FS, were requested to respond to a self-administrative questionnaire.

3.3.1.3 Measurement Instrument: Self-Administrated Questionnaire

For the purpose of collecting mainly quantitative data, a coded self-administrated questionnaire was designed (cf. Annexure A).

The value of a questionnaire as a research instrument is widely discussed in literature (Burns & Grove 2005: 398; Leedy & Ormrod; 2005:185; Polit & Beck 2006:296). The advantages and disadvantages of using a self-administrated questionnaire in this study were numerous and consistent with literature. The most relevant advantage was that the questionnaire allowed the researcher to access a large portion of the population whilst protecting the anonymity of the respondents.

Considering the size of the population, their geographical distribution, logistical factors and the researcher's relationship to most of the respondents, the advantages of using a self-administrated questionnaire out-weighed the disadvantages, especially since measures could be implemented to limit the negative aspects of this measurement instrument such as lower response rates (cf. 3.6). Thus, after thorough consideration, a questionnaire was developed.

a) Development of the questionnaire

The questionnaire was developed by following the twelve guidelines to the development of a valid and reliable questionnaire proposed by Leedy & Ormrod (2005:190). The structure of the questionnaire was separated into two sections namely that of Section A, the demographic and work-related information and Section B, specifically assessing job satisfaction (Annexure A).

Dichotomous (e.g. q3 - 10), cafeteria (e.g. q2.11), rank-order (e.g. q12), rating (q11, 15, 16) and open-ended questions (q13, 14, 17) were all used in the questionnaire (cf. Annexure A; Polit and Beck 2006:295; Burns & Grovè 2005:399-402). The content of the questionnaire was derived from mainly three sources: Information from previous studies conducted in the health sector in South Africa and globally, past experiences of the researcher and the theory of job satisfaction (cf. 2.3.5).

Additionally the Minnesota Satisfaction Questionnaire (MSQ) was also appraised. Although widely prescribed by industrial psychologists, the researcher found the use of the MSQ as a measurement instrument to not aptly suit the purposes of this study since no normative data existed for occupational therapy (cf. 2.3.6.2). Nevertheless, in order to further enhance the validity of the measurement instrument, the long form of the MSQ was used as a guideline to assist with the development and assessment of the questionnaire (Weiss, Dawis, England & Lofquist 1967: v). The specified dimensions, phrasing of questions, response options and number of items were adapted to the purpose of this study and incorporated in the questionnaire. After development, the questionnaire was piloted.

3.3.1.4 Pilot Study

A pilot study is defined as a smaller version of the proposed study in order to refine the research methodology (Burns & Grove 2005:42) and was conducted in order to promote the face validity, internal validity and reliability of the content

of the questionnaire. It also served to refine and audit the procedures followed in the study and specifically to addressed the lay-out and clarity of the instrument (Delport 2005:170-172; Leedy & Ormrod 2005:193).

Three therapists were included in the pilot study. Their designations were representative of the population. To ease the logistical arrangements one senior and one chief therapist as well as an occupational therapy manager within the greater Bloemfontein area was selected for the pilot study. Written consent was gained from the participants of the pilot study and permission was obtained from the manager of occupational therapy in the FS.

All three participants were asked to complete and return the questionnaire electronically. They were also provided with an audit tool compiled by the researcher (Annexure B). The audit tool was designed from literature on research methodology and aimed at evaluating the relevance, consistency and phrasing of questions asked. It also provided participants with the opportunity to identify disparities and give suitable suggestions to improve the questionnaire.

The responses and suggestions from the participants determined that the following changes were made to the questionnaire:

- Question 2.10 – the language was corrected
- Question 5b) – the sentence changed to include other options than just private practice
- Question 8e) – the question relating to language and culture was added
- Question 8p) – the question was extended to include flexi-time
- Question 12 – the rating scale was adapted
- Question 16 – the question was added

Due to the changes made to the questionnaire after the pilot study the data of the questionnaires used in the pilot study, was not incorporated in the results of this study.

3.3.1.5 Data Collection Procedure

Data collection is the process of selecting subjects and gathering data from these subjects (Burns & Grovè 2005:430). Data collection comprised of two aspects namely, the distribution and the return of the questionnaires.

a) Distribution of questionnaires

Authors such as Burns and Grovè (2005:402) place great emphasis on the consistency in the way a questionnaire is administered toward maintaining the validity of the instrument.

In this study the data was collected electronically via the common e-mail system of the PHS, *GroupWise.* Two occupational therapists did not have access to *GroupWise and* received the questionnaire via their personal electronic mail account.

GroupWise, as a resource, was employed as it was readily available to most occupational therapists in the PHS. Electronic distribution was also a time-saving and convenient method of distributing information. It incurred no cost on the part of the researcher or the respondents. All the respondents were familiar with the system. It was supposed that all occupational therapists had the necessary competencies to download, complete and return the questionnaire via e-mail as this task formed a basic part of their every-day work. As an added reassurance, the researcher included a step-by-step instruction guide with the information document.

The questionnaire was distributed for a second round under the same conditions as the first to allow eligible participants who missed the first return date with a second opportunity and thereby increase the number of respondents in order to gain more accurate and representative data.

b) Return of Questionnaires

An initial response time of 10 days was allowed in the first round and prevailed during the second. An e-mail reminding respondents of the return date was sent out after one week passed.

Questionnaires were retuned via *GroupWise* to the researcher's work, and in some instances, the researcher's private e-mail address. The participants were asked to ensure that the subject line was marked "JOB SATISFACTION STUDY" to assist the researcher in identifying the document. After the expiration date marking the conclusion of the first round, a second round of distribution occurred under the same circumstances of the first.

Altogether 60 participants were eligible to complete and return the questionnaire. Forty one questionnaires were returned translating into an initial response rate of 68%. However, one questionnaire was discarded due to it being too incomplete and five returned questionnaires were marked "Declined", which brought the number of questionnaires returned for data analysis purposes to 35, i.e. a final response rate of 58%.

To reduce the risk of a low response rate with regard to the questionnaire the following measures were taken:

- An information letter accompanied the questionnaire describing the potential value of the study for the respondents – this may have served as motivation for the respondents to cooperate (Leedy & Ormrod 2005:193; Delport 2005:167).
- The return date was marked on the e-mail in bold red letters to draw the respondent's attention to the fact (Delport 2005:170).
- An electronic introductory leaflet was sent to all potential participants one week before the distribution of the questionnaires to raise awareness regarding the study (Annexure C).
- The questionnaire was distributed during the third week of the month as this is commonly accepted as the least busy time for therapists and

followed shortly after the distribution of the introductory leaflet (Leedy & Ormrod 2005:193).

- The respondents were reminded of the return date via e-mail two days before questionnaires were to be returned.
- The considerable length of the questionnaire may have resulted in a poorer response rate or incomplete questionnaires. The researcher attempted to control this by informing participants of the value of this study to them as well as emphasizing the importance of completing the questionnaire in full. Administration of the questionnaire was done fairly easily as it was electronic and may have, as such, served as a positive factor for respondents when completing it.

3.3.1.6 Data Analysis

Descriptive statistics namely frequencies and percentages for categorical data and medians and percentiles for continuous data were calculated. Scale values were compared to each participant's own perception and described y means of 95% confidence intervals for the paired medians difference. The participant's own perception of job satisfaction was compared and described by means of 95% confidence intervals for the median difference in terms of the following variables: years experience, dependants, level of service, field, area, job level and type of tasks. The total scale was compared and described by means of 95% confidence intervals for the median difference in terms of the following variables: per year and post level. The data analysis for this study was generated using SAS software. Copyright, SAS Institute Inc. SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAL Institute Inc., Cary, NC, USA. The analysis was done by Department Biostatistics, UFS. To determine the current job satisfaction status of occupational therapists in the PHS of the FS (objective 1) and to identify and describe common factors influencing the job satisfaction and dissatisfaction of occupational therapists in the PHS of the FS (objective 2), a cut-off value of 60% satisfaction or dissatisfaction for each determinant was designated. The following groups of determinants were identified.

Table 3.2 Groups of Determinants and Corresponding Questions in the Questionnaire

GROUP	QUESTIONS IN THE QUESTIONNAIRE	TOTAL NUMBER OF QUESTIONS
1. OT as a Career	3a, 3b, 3c, 3d, 3e, 3f, 3g, 4d, 4k	9
2. Work Content	4a, 4c, 4e, 4f, 4g, 4i, 4j, 4b, 4h, 6j, 6p, 6q, 8j, 8k, 8l, 8e	13
3. Work Challenge	4b, 4k, 6b, 6a, 8h, 8i	6
4. The PHS as Employer	5a, 5b, 5c, 5d, 5e, 5f, 5g, 5i, 10f	9
5. Management	6a – 6q	17
6. Remuneration	7a-7i, 5a, 8q, 8r	12
7. Colleague Relationships	9a-9f	5
8. Myself	10a-10e, 10g, 10i-10l, 8e	11
9. Work Environment	118a-8d, 8f-8p, 5h	16

For objective one, the collective value of all ten determinants as measured in the questionnaire was calculated to indicate overall job satisfaction or dissatisfaction. For objective two, each determinant was calculated separately to identify satisfaction or dissatisfaction with the specific determinant independently.

Along with the cut-off values, the open-ended questions and questions number 15 and 16 were used to determine the current job satisfaction status of the occupational therapists.

As for objective four, namely exploring recommendations regarding possible guidelines that could optimize the job satisfaction of occupational therapists in the PHS of the FS, the focus of the analysis was on questions 11, 12, 13, 14 and 17.

Seven control questions were incorporated into the questionnaire and compared to determine the consistency with which respondents marked responses of satisfied or dissatisfied. The questions were:

- Number 4f and 4j (creativity)
- Number 4g and 6p (autonomy)
- Number 6g and 6i (recognition)

- Number 4e and 6q (decision-making)
- Number 7b and 7f (salary)
- Number 5g and 8g (physical working conditions)

3.3.1.7 Data Quality Control

The following measures were taken to promote and assure reliability and validity in the study.

a) Reliability

As described in literature, reliability is considered a major criterion for establishing the quality of quantitative data. “Reliability is the consistency with which an instrument measures the attribute” (Polit & Beck 2006:324). Neuman (2000:164) explains that reliability in a measurement instrument signifies that the numerical results produced by an indicator do not vary because of characteristics of the measurement process or the instrument itself. In this study, considerable effort was made to enhance and ensure the reliability of the questionnaire.

i) Measures for ensuring reliability

- A pilot study was conducted in order to ensure that all questions were clearly conceptualised and to assess if any ambiguity could be detected in the respondents’ interpretations of the questions (Delport 2005:172; Neuman 2000:166).
- Respondents in the pilot study made use of an audit tool derived from literature to assess the construct content and levels of measurement of the questionnaire.
- The researcher strived to use the highest possible and most reasonable level of measure (multiple refined categories/options) as indicators in the questionnaire. “Indicators at higher or more precise levels of measurement are more likely to be reliable” (Neuman 2000:166).

- The questionnaire was presented in both English (official correspondence language for government employees) and Afrikaans (mother language for most participants).
- The researcher paid special attention to the lay-out, clarity and user-friendliness of the questionnaire as respondents were more likely to complete and return questionnaires that made a good first impression. The questionnaire was piloted specifically to address the lay-out and clarity of the instrument (Leedy & Ormrod 2005:193; Delport 2005:170-172).
- A documented audit trail was kept (Polit & Beck 2006:336). The audit trail detailed the number of questionnaires distributed the e-mail addresses of participants, the number of users on a specific address, the times and dates of distribution and return as well as similar documentation of the second round
- Therapists were strongly encouraged to refrain from engaging in discussions of their responses until such time as the study results were made public. This was done as contamination of the data may have occurred if respondents consulted each other regarding their responses (Delport 2005:168). The researcher requested respondents to return the questionnaire directly after completing it.

b) Validity

Validity is the degree to which an instrument measures what it is supposed to be measuring (Polit & Beck 2006:328). Delport (2005:160) describes the essence of validity in two aspects. One, the instrument actually measures the concept in question and two, that this is measured accurately. The following measures for enhancing the validity of the questionnaire were taken:

i) Measures for enhancing validity

- The content of the questionnaire was based on indicators derived from literature on job satisfaction (face validity). Additionally, the researcher's

experience in the field as well as the long form of the Minnesota Satisfaction Questionnaire was taken into consideration to ensure internal content validity.

- The questionnaire was piloted. The reviewers were representative of the population. The reviewers were asked to critique the questionnaire on its content as well as the construction and phrasing of questions (internal content validity).
- The pilot study was also conducted in order to determine if any facets of the phenomenon was previously overlooked by the researcher (internal content validity).
- When completing the questionnaire the respondent is unable to elaborate on responses or ask clarifying questions. This may have led to misinterpretation of questions. The occurrence of this human threat in collecting reliable data was minimized by conducting a pilot study to eradicate any ambiguity and inconsistency in the content of the questionnaire. In addition the researcher aimed to provide the highest possible level of measurement in order to give the respondent an opportunity to answer according to what most represented their views.
- Respondents may have left out some of the questions threatening the validity of the data. In order to circumvent this, the researcher provided clear instruction as to the administration of the question. In the information letter accompanying the questionnaire, the importance of completing all the questions was stressed. However, participants were not forced to answer questions against their will.

3.3.2 SECTION B: QUALITATIVE APPROACH

The following section deals with the qualitative research methodology employed in this study. While the methodology of qualitative research is based in sound theory, readers are implored to remain attentive of the fact that the researcher is intrinsically part of the qualitative research process and her being should therefore not stand separate from the processes engaged in during this study.

3.3.2.1 Study Design

Phenomenology, with its roots in philosophy, was developed by Husserl and Heidegger in 1962 and has its purpose in describing and/or understanding experiences as they are "lived" by the people within the field of the phenomenon (Burns & Grove 2005:55; Polit & Beck 2006:219). Phenomenology investigates "subjective phenomenon in the belief that critical truths about reality are grounded in people's lived experiences" (Polit & Beck 2006: 219). It aims to understand the *meaning* people bestow on experiences of their daily life within the specific phenomenon being studied (Fouché 2005:270).

All phenomenologists agree that each individual has their own reality which is considered subjective and unique. But, it is only in allowing these subjective realities to be described and interpreted that the nature of a phenomenon can be fully investigated. Instead of a single truth being discovered there may be multiple perspectives held by the people experiencing the phenomenon - all equally valid and true (Polit & Beck 2006:221).

This form of a qualitative approach allowed the researcher to further explore the baseline provided by quantitative data and to discover the depths thereof by providing a scope wherein the emergent meanings and perceptions of the participants could be interpreted and illustrated (Polit & Beck 2006:210). Specifically pertaining to the context of this study it was felt that a qualitative approach would provide some explanations as to why the participants indicated certain opinions in the quantitative questionnaire. It facilitated further investigation of the intensity of the experiences leading to job satisfaction or dissatisfaction amongst occupational therapists in the PHS in an interpretive rather than positivist-fashion only.

Simply put, it was in understanding why respondents answered the questions as they did, why they felt the emotions they did and why they focused on the topics they did, that the depth of this study became evident. Non-verbal clues, choice of words, vehemence and passion observed, resulted in a description of the essence of the experience being studied (Fouchè 2005:270) and served as

an expansion and explanation of the data gathered from the quantitative investigation.

3.3.2.2 Research Sample

Only a sample of the occupational therapists working in the PHS of the FS was selected to participate in the qualitative inquiry (in-depth semi-structured interviews). Potential participants were grouped into the following categories according to the selection criteria of this study (cf. 3.2.1):

Table 3.3 Participants for the qualitative component of the study

GROUP	DESCRIPTION OF PARTICIPANTS	POPULATIO N	NUMBER ADHERING TO SELECTION CRITERIA	MINIMUM TOTAL IN FINAL SAMPLE (25% OF POPULATION)
Group A	Community Service occupational therapists	23	5 (3)*	**5 (3)***
Group B	Senior occupational therapists	28	15 (-1 decline = 14)*	**7**
Group C	Chief occupational therapists	8	4	**2**
Group D	Assistant managers	4	1	**1**
TOTAL		**63**	**25 (22)***	**15 (13-1decline=12)***

*Indicates final numbers after adjustments to selection process were made.

Community service occupational therapists were grouped separately to assist with the analysis of data. Senior and chief occupational therapists were separated to account for the typical difference in years of experience. Occupational therapists functioning as managers made up the last group as their daily tasks and consequently their experiences of the phenomenon differ to those of clinicians yet are directly related to the clinical setting.

It is purported that the number of participants selected for in-depth semi-structured interviews is determined by the level of saturation reached during the study (Leedy & Ormrod 2005:139). Saturation is the point where the researcher begins to hear the same information repeatedly and where no new themes seem to emerge (Greeff 2005:294). Literature suggests that data saturation

could readily be reached in 5-25 interviews (Leedy & Ormrod 2005:139). While some qualitative researchers argue in favour of fewer interviews, others reason that the number of participants depend on the data gathered and the context of the study. Polit and Beck (2006:219) however narrow the margin for saturation down to approximately 10-12 interviews. In a similar study conducted by Moore and other authors in urban Australia, data saturation was reached after 14 interviews (Moore *et al*. 2005:21).

From the number of occupational therapists adhering to the selection criteria (25), an initial sample of 15 participants was proportionally identified with the assistance of the biostatistician. Group D was used as the baseline since only one of the four participants was found eligible according to the selection criteria. This number constituted a quarter (25%) of the total population for group D and consequently 25% of the three remaining groups were identified to ensure proportionate representation of the population.

The names of the 25 occupational therapists in their respective groups were organised alphabetically and numbered. With the assistance of a randomisation program the biostatistician selected the required number of participants from each group. These numbers were cross-referenced with the alphabetical list and the participants were identified. The initial selection was as follows:

- Group A: Community service occupational therapist – 1, 2, 3, 5, 7
- Group B: Senior occupational therapists – 2, 6, 7, 8, 10, 11, 15
- Group C: Chief occupational therapists - 2, 4
- Group D: Assistant manager – No sample, included one that adhered to selection criteria

Greeff (2005:294) points out that the process of selection can be repeated and a representative ratio proportionally calculated to select additional participants if saturation had not been reached after the pre-selected number of interviews. In the case of this study re-selection was not necessary as saturation was reached well within the initial selection.

It was however, in the pursuit of collecting inclusive and trustworthy data and taking into account unforeseen and unpredictable logistical and human factors, that the following substitutions to the initial selection of participants were made.

- Selected participants in Group B, numbers 2,7,10, and 15 all worked at the same institution and therefore at the same level of health care. This number made up half of the sample for this group. This institution is also a tertiary institution in the Free State and therefore not representative of the typical work environment of the larger population. It was decided to substitute two of these participants with the person either preceding or following them on the list. The selection then, was numbers 3, 6, 8, 9, 11 and 15.
- Of the five community service occupational therapists adhering to the selection criteria, two had to be withdrawn from the study as one transferred to a different province and the other was later found not to have already completed the prerequisite six months of work.
- After these adjustments, the total of selected participants was 13. One participant in group B declined to participate and could not be replaced due to logistical hindrances. Consequently, the final number of participants selected was 12. This was however later viewed to be insignificant since it was considered that data saturation within this particular group was reached after only 6 interviews.

The sample for the qualitative section of this study consisted of 12 participants plus the three interviews done during the pilot study, bringing the total number of participants to 15.

3.3.2.3 Measurement Instrument: Semi-structured interview

For the purpose of collecting mainly qualitative data, semi-structured interviews were selected as the preferred method for data collection. A semi-structured interview is “an interview in which the researcher has listed topics to cover rather than specific questions to ask” (Polit & Beck 2006:510).

The purpose of a semi-structured interview was to give the participants the opportunity to freely express their views feelings and perceptions of the phenomenon of job satisfaction. It also assisted the researcher in clarifying concepts without subjecting the data to researcher bias (Greeff. 2006:295).

According to Polit & Beck (2006:296) the strengths of interviews far outweigh those of questionnaires. This was evident in this study as the response rate was high, questions and answers were clarified and participants were able to engage in lengthy, in-depth discussions of their experiences. Burns & Grovè (2005:397), while in agreement with Polit & Beck, do however warn researchers of the disadvantages and possible bias inherent in interviewing. The main disadvantage of this form of data collection in this study was of a financial nature as costs due to travelling and transcription of interviews were considerable.

3.3.2.4 Pilot Study

Three semi-structured interviews were conducted as part of the pilot study. The same sample was used as is discussed in the quantitative section of this chapter (cf. 3.4.4).

Interviews were conducted during working hours at the participant's place of work. Again, written consent was gained in this regard. As in the actual study, the semi-structured interviews with participants in the pilot study were conducted by the researcher.

The application and comprehensiveness of the topic guide was assessed. The interviews were audio-recorded and scrutinised in order to ascertain and improve the competence of the researcher as an interviewer. Transcriptions of the interviews were subjected to member checking by the participants and no changes to interview content or procedures were suggested. No changes were made to the opening question or the topic list and consequently the data gained from the pilot study was deemed valuable to the study and was included in the final results.

3.3.2.5 Data Collection Procedure

Bearing in mind the complexity of the dynamics inherent to interviewing (Greeff 2005:287) the researcher considered three aspects with regards to planning the data collection procedures: the interviewer, logistical arrangements and the interview process.

a) The Interviewer

Literature emphasizes the importance of a skilled interviewer in ensuring the trustworthiness of the data (Greeff 2005:287; Leedy & Ormrod 2005:146).

Interviews were conducted by the researcher. The researcher's ability to conduct an interview was rehearsed during the pilot study and carefully scrutinized to improve her skill. The desired level of competence was attained (cf. 3.5.7.1).

b) Logistical arrangements for conducting the interviews

Initial interviews were scheduled over a period of two weeks according to the availability of the researcher, logistical resources and the convenience of the respondents.

All the respondents opted to have the interviews conducted at their place of work during working hours. Clinical services were not adversely influenced by the interviews and permission in this regard was gained from the Manager of Occupational Therapy in the FS. When traveling was necessary, the researcher travelled to the interviewee's place of work to conduct the interview.

Interviews were arranged telephonically and confirmed one to two days ahead of the scheduled date - depending on the distance to be travelled.

Participants were also orientated toward what to expect in terms of the topics, time implications and the respective roles of the interviewer and interviewee (Leedy & Ormrod 2005:147).

An electronic information letter was sent to each participant in order to allow them the opportunity to make an informed decision regarding participation (Van Heerden 2007: 22).

The interviewee arranged an appropriate place where the interview could be conducted without any disturbances (Creswell 1998:124; Leedy & Ormrod 2005:147). Interviews were conducted in a private, well-lit and aired room. No interruptions occurred during the duration of the interviews. Water was available and participants were requested to switch off their cell phones and landlines. Interviews lasted between approximately 20 and 90 minutes (Creswell 1998:122; Leedy & Ormrod: 2005:146).

c) The interview process

"The process of an interview is an….elusive though powerful component of the interview. It involves reading between the lines…. The process may confirm, enrich or sometimes even contradict the content "(Greeff 2005:291).

As, according to the first of the ten commandments for conducting an interview, the researcher started the interview by "spending several minutes chatting and making small talk" in order to establish a rapport with the interviewees (Burns & Grove: 2005:541). After the participant seemed relaxed, the researcher gently led the conversation into a discussion of the purpose of the day. The aspect of confidentiality of the interview was discussed and written consent was obtained (Greeff 2006:295). At this point, the researcher introduced the opening question. For this study, the following opening question was asked:

> *You have been working as an occupational therapist in the government service for …… years/months. Can you tell me more about your job satisfaction as an OT in the public health service?*

or in Afrikaans:

Jy werk alreeds…..jaar/maande in die staatsdiens as ‘n arbeidsterapeut. Kan jy my meer vertel van jou werksbevrediging as ‘n arbeidsterapeut in die staatsdiens?

The researcher made use of an interview schedule to guide her during the interview (Polit & Beck 2006:291, Greeff 2006: 296). The topics of the interview schedule were gleaned from theory relating to job satisfaction and the findings of previous studies in this field. The following topics were used as broad stroke reminders of aspects relevant to job satisfaction or dissatisfaction during the interviews (Weiss *et al*. 1967:1-2):

- The respondent’s impression of what it is like to work in the PHS
- Advantages and disadvantages of working in the PHS
- Policies and practices in the PHS, moral values
- Remuneration and benefits, recognition
- Professional status
- Personal and professional growth, achievement and advancement
- Management and supervision
- Human relations at work
- Physical work environment (work place, availability of resources travelling and personal safety)
- The content of the work (performing tasks, utilizing abilities, keeping busy)
- Autonomy, independence, creativity, variety and responsibility at work
- Service to others

The researcher was however continually reminded of the importance to take into account the emergent nature of the study of a qualitative study and therefore had to remain flexible and accommodative to the changes and different nuances which occurred during the course of each interview (Polit &

Beck 2006:210). The topics were not necessarily covered in the same order during different interviews and not all topics received the same amount of attention. This allowed the unique influence of each participant to be distinguished and emphasized.

As suggested by Greeff (2005:298) audio recordings were made of the interviews in order to minimise the loss of data and confirm the auditability of the study. Written permission from each participant was obtained in this regard (Creswell 1998:124). The tape recorder was placed inconspicuously as to not unnerve the participant (Greeff 2005:298). A second tape recorder was available for quality control measures but was not used as no unforeseen incidents occurred. Participants were entitled to request the tape recordings after the interview but none did.

During the interview the researcher took on the part of an active listener, calmly steering the conversation to cover the predetermined topics. It was the responsibility of the interviewer to constantly identify areas which needed further probing and enlightenment. Leedy and Ormrod (2005:147) stress the fact that the interviewer should encourage trust and general feelings of closeness by showing compassion and genuine interest in what the participant is saying. Based on previous relationships with the participants and through active listening skills, the researcher aimed at creating a comfortable atmosphere so the interviewee could at all times feel free to disclose their beliefs, thoughts and feelings.

The interviews were concluded gradually. Main points of the discussion were summarized and the participant was given the opportunity to clarify or add any further comments. The participant was thanked for their participation and given a small token of appreciation.

Directly after the interview the researcher made field notes to document the researcher's impressions of the interview, emotions experienced and possible prejudices and expectations identified (Greeff 2006:298-9).

Tape recordings were transcribed as soon as possible after the interview. Due to extensive time required for transcribing interviews, an independent scribe was used in this regard. The transcribed conversation was e-mailed to each participant for member checking, giving the participant the opportunity to confirm the authenticity of the transcribed interview (Rubin & Rubin 1995:126-127). This concluded the process of the interview and the conversations recorded were viewed as confirmed data, ready for analysis.

3.3.2.6 Data Analysis

In accordance with the suggestions of literature, the six steps identified by Creswell (1998:147-150) and Leedy & Ormrod (2005:140) in the analysis of the phenomenological data was scrutinized. These steps were found to be a valuable broad-base frame of reference in which the researcher could orientate herself toward the processes involved in qualitative data analysis.

More specifically, the researcher used the data analysis method as proposed by Creswell (1998:140-149) and Tesch (1990:134-145). In their works, the authors describe the following steps in practical, executable language:

- The transcriptions were read through multiple times to gain an overview of the data. Memo's and field notes were transferred onto the transcription.
- Divergent perspectives and perceptions were identified and marked. At the same time the researcher assimilated common meanings and opinions as experienced by the participants.
- Initial themes and associated themes were identified and linked to statements made by the participants. Relevant and irrelevant data was separated.
- A diagram was drawn up to illustrate themes and associated themes. This was scrutinised in order to identify and eradicate any duplication of themes or contradictions.
- Themes were now grouped into categories.

- This process was also followed by the co-coders. Investigator triangulation was used to verify the categories, themes and associated themes from the statements made by the participants. Frequencies in prevalence of themes were also determined and verified.
- Categories were stratified in order of high to low prevalence by identifying the frequency of each theme and/or associated theme inherent in the category.
- The categories with the highest frequency and subsequent highest prevalence was then believed to be the most commonly-held experiences of job satisfaction or dissatisfaction of the occupational therapists in the PHS of the FS and discussed as such in Chapter 4.

As a final comment of the analysis of the qualitative data, the researcher would once again emphasize her own intrinsic involvement in all processes of the qualitative research but even more so during data analysis. Therefore, it is for this reason that the researcher often chose to present herself in the first person during the discussion of qualitative findings in Chapter 4.

3.3.2.7 Trustworthiness

According to Lincoln and Guba (1985) in Creswell (1998:197) and Polit and Beck (2006:332), four criteria is suggested for establishing trustworthiness in qualitative data: credibility, dependability, conformability and transformability. Creswell (1998:203) recommends that researchers engage in at least two of the eight procedures for establishing trustworthiness in a qualitative study. To adhere to these measures the researcher proposed and implemented the following quality control measures:

a) Credibility

Credibility refers to confidence in the truth of the data and interpretations of them (Polit & Beck 2006:335).

i) Researcher credibility

According to Patton (2001) in Polit and Beck (2006:334) researcher credibility refers to the faith that can be put in the researcher's training qualifications and experience.

The researcher has been part of various short cases (mini research) and research projects involving students at the University of the Free State. She has completed a module on research methodology at the University of the Free State (UFS). As part of the occupational therapy curriculum at the UFS the researcher was trained in conducting an interview and developed further skill in practice. The researcher was subject to the guidance and supervision of study leaders – both qualified in post-graduate degrees in occupational therapy and actively involved in research projects on a daily basis. However, it was anticipated that the skill of the researcher in conducting interviews may have resulted in errors in measurement. This was controlled through the pilot study and peer review sessions aimed at auditing the researcher's skill. Additionally the presence of the researcher during the interview may have result in bias on the part of some of the therapists as she is known to them (Creswell 1998:163). In some cases this may have served as an advantage as trust had already been established. The opposite may have been true in other cases depending on the preconceived ideas these participant may have had about the researcher. At no time during the study could any bias in this regard be confirmed nevertheless, the researcher aspired to maintain a friendly and professional attitude in general.

ii) Investigator triangulation:

Polit and Beck (2006:333) described investigator triangulation as using more than one person to collect analyse or interpret a set of data.

As suggested by Creswell (1998:202) the researcher was subjected to peer review sessions. "Peer debriefing is a session held with objective peers to review and explore various aspects of the inquiry" (Polit & Beck 2006:333). The

role of the peer reviewers was to keep the researcher honest, critiquing the methods followed by the researcher, confirming or rejecting meanings and interpretations made by the researcher and generally challenging the researcher to critically assess the research process as it unfolded (Creswell 1998:202).

The researcher also made use of two co-coders to assist with the analysis of themes in the data. Both were experts is their own right, one on qualitative data analysis and the other on the PHS. The analysis of the co-coders was compared to that of the researcher consequently verification of the analysis by more than one person was achieved.

b) Dependability

According to Polit and Beck (2006:335), "The dependability of qualitative data refers to data stability over time and over conditions". The authors propose two measures which can be implemented to enhance the dependability of the study.

i) Prolonged engagement

Prolonged engagement refers to the investment of sufficient time in data collection activities (Polit & Beck 2006:332). Interviews of 1-2 hours with each participant were planned. Literature suggested this to be sufficient time to exhaust themes (Creswell 1998:122; Leedy & Ormrod: 2005:146). In the case of this study, the participants completed their discussions in approximately twenty minutes to one and a half hours. After concluding, participants were encouraged to talk about any other aspect relating to their job satisfaction. This was done as a constructive attempt to prolong the engagement and to provide the participant with ample opportunity to express themselves. In some interviews, this measure added to the depth of the data.

ii) Persistent observation

Persistent observation refers to the researcher's focus on the aspects of a situation that are relevant to the phenomenon being studies (Polit & Beck 2006:333). Persistent observation in a study provides depth. The researcher endeavoured to achieve this through extensively clarifying emerging themes and ensuring that all aspects relevant to the themes were discussed during the interviews. This was supported further by making use of a interview schedule (Greeff 2006:296-7)

c) Confirmability

Confirmability is "the potential for congruence between two or more independent people about the data's accuracy relevance or meaning" (Polit & Beck 2006:336).

i) Triangulation

Triangulation refers to the use of multiple referents to draw conclusions about what constitutes truth (Polit & Beck 2006:333). Three types of triangulation were used in this study:

- Data Source triangulation: Polit & Beck (2006:333) state that using multiple data sources in a study leads to higher comfirmability. The researcher interviewed diverse key informants such as senior and chief therapists, assistant managers, managers and clinical therapists on the same topic. Their settings ranged from urban to rural and participants had varied ranges of experience and fields of practice. Topics were derived from literature, the Minnesota Satisfaction Questionnaire and the respondents' answers to the questionnaire.
- Method triangulation: Polit and Beck (2006:333) suggest using multiple methods to address a research problem. In this study a questionnaire as well as in-depth semi-structures interview was used to collect data. All

interviews were recorded and transcribed. Field notes were kept by the researcher.

ii) Member checking

Member checks allowed the researcher to solicit the participants' view of the credibility of the findings (Creswell 1998:202; Polit & Beck 2006:334). The transcribed interviews were e-mailed to the participants for verification of the authenticity thereof. Participants were asked to provide an electronic signature to confirm their agreement on the accuracy of the transcription (Creswell 1998:202).

d) Transferability

Transferability refers to "the extent to which the findings from the data can be transferred to other setting or groups…" (Polit & Beck 2006:336).

i) Rich thick description

By compiling what is called a "thick description" (Creswell 1998:203; Polit & Beck 2006:334) the researcher enabled the readers to transfer information to similar settings because of shared characteristics. The researcher provided a detailed description of the population and the setting under which the interviews took place (cf. 4.3.1).

3.4 ETHICAL CONSIDERATIONS

The research proposal was presented to the Ethics Committee of the Faculty of Health Sciences of the University of the Free State and was approved (ETOVS 154/08).

Consent for conducting the study was gained from The Manager: Occupational Therapy, Disabilities and Rehabilitation Directorate, Free State Department of Health.

An information letter explaining the purpose of the study, as well as what was required was sent to each participant. Participants automatically gave consent to participate when they completed and returned the questionnaire. Participants were notified of this in the instruction section of the questionnaire. Interviewees gave consent by signing a consent form prior to the commencement of the interview (cf. Annexure F; Polit & Beck 2006:94; Strydom 2005:59-67).

It is the researcher's opinion that the study held great value for the participants as the results of this study led to various suggestions to improve and enhance their current level of job satisfaction. It also provided the participants with a relatively safe opportunity to air their views on aspects they might not always have the confidence or platform to use. These benefits were made known to participants in the information letter accompanying the questionnaire.

The study was conducted in either English or Afrikaans as was the participant's language of preference. English is the official language of the Department of Health and most participants were Afrikaans speaking.

All information in the study was treated as confidential and questionnaires were administered anonymously. Incoming e-mails were de-identified by the Information Technology Department of the Department of Health in the Free State. (Polit & Beck 2006:95; Strydom 2005:61). Confidentiality was observed throughout the interview process as well as during the analysis of qualitative data. Participants' names as well as any identifying information e.g. hospital names were deleted from the transcripts before co-coders were given access to the transcripts.

All participants were free to withdraw from the study due to personal preference at any time without any prejudice or penalty (Polit & Beck 2006:88; Strydom 2005:59).

All audio-recordings of interviews were kept in an undisclosed safe location for the duration of the study and will be destroyed after completion thereof. Participants were and are entitled to request copies of both the audio-tapes and

the results of the study if they so wish (Strydom 2005:61-63). To date, none have however done so.

All participants were informed of the researcher's intention to make public the results of the study.

3.5 CONCLUSION

This chapter focused on the research methodology employed in this study. The reader was introduced to the multiple methods employed in this study. The chapter also presented a detailed description of the study design and argumented the suitability of the chosen paradigm and processes implicit therein. Furthermore, the population and selection criteria were discussed and particular attention was given to the sampling procedures. The discussion of the development of a reliable measurement instrument – the self-administrative questionnaire – served as an appropriate introduction to the quantitative data collection procedures employed during the study.

For the collection of mainly qualitative data by means of semi-structured interviews, three aspects were examined: the interviewer, logistical arrangements and the interview process. The execution of the pilot study was reported. Data quality control was emphasized, with reliability and validity discussed in relation to quantitative data and trustworthiness with regards to qualitative data. Finally, the researcher focused on ethical aspects taken into consideration during the planning and execution of the study.

In synchronization with the current chapter, Chapter 4, firstly presents the quantitative results followed by a full description and interpretation of the qualitative findings of this study.

CHAPTER 4
PRESENTATION AND INTERPRETATION OF THE RESULTS AND FINDINGS

4.1 INTRODUCTION

In the previous chapter, the research methodology of this study was discussed. The dual nature of the study design was introduced as both a quantitative and qualitative approach. The typical descriptive study design, with its measurement instrument, the self-administrated questionnaire was discussed, followed by the discussion of the semi-structured interviews for the phenomenological approach also followed in this study.

In this chapter, the results gained from the self-administrated questionnaires and the semi-structured interviews are presented and interpreted.

Although, at times, data for overall job satisfaction as well as facet job satisfaction were reciprocated in both the quantitative and qualitative inquiries, it was felt that, in its first form, the quantitative data was most aptly suited to describe *overall* job satisfaction whilst qualitative data presented clearer understandings of the different *facets* involved in the occupational therapists' work experiences. Thus, in order to present these two different yet related sets of results, this chapter will be discussed in two sections.

The first section of this chapter focuses on the presentation of quantitative data and includes demography as well as data regarding overall job satisfaction. Satisfaction with different topics relating to groups is also discussed. Section A concludes with the presentation of the job satisfaction indicators the occupational therapists in this study identified as important.

Section B of this chapter is concerned with the presentation of qualitative findings in the form of six categories, their various themes and in most instances, related themes. These findings emerged from the semi-structured

interviews and had, as mentioned earlier, its main focus on facet job satisfaction. In this section, detailed descriptions of the different facets of the occupational therapists' working experiences are described. The interpretations, associations and meanings the participants attached to these facets are explored and explained. Furthermore, literature is envoked on a consistent basis as befits a qualitative research study.

Chapter 4 concludes with a summary of the results of this study.

4.2 SECTION A: QUANTITATIVE DATA

Section A predominantly deals with the presentation and discussion of quantitative results as were gained from the self-administrated questionnaire.

4.2.1 Demographic data of the study population

Demographic data was collected from the first section of the self-administrated questionnaire (Annexure A). The information collected pertained to descriptive factors such as gender and age as well as the participants' educational and relevant work history.

In all, sixty occupational therapists were eligible to participate in this study. Three of these participated in the pilot study of which the results (from their self-administrated questionnaires) were not included in the final results of this study. The total number of returned questionnaires was 35 (cf 3.4.5.2).

4.2.1.1 Sample

Thirty five (n=35) occupational therapists working in the Public Health Sector (PHS) in the Free State comprised the sample of this study. All participants, with the exception of one, were female. Ages ranged between 23 years and 50 years, with a median age of 25 years. Fifteen of the participants (42.86%) had dependents (children). Twenty seven (77.14%) participants were Afrikaans

speaking while seven (20%) listed English as their home language and one (2.86%) indicated Sesotho as his/her preferred language.

4.2.1.2 Highest level of qualification

Thirty three (94.29%) of the participants' highest qualification was a B. Occupational Therapy or B.Sc. Occupational Therapy degree while two (5.71%) of participants had a Master's degree in Occupational Therapy. No higher and/or other qualifications were reported.

4.2.1.3 Tenure in PHS

Years of service in the PHS ranged between one and twenty-seven years (median three years), with 82.86% of respondents having less than ten years of service. This was concurrent with data from the *PERSAL* data base that showed most occupational therapists in the employ of the PHS in the FS to have less than ten years tenure (PERSAL November 2007)

4.2.1.4 Level of employment

The level of employment refers to the rank of the occupational therapist within the structure of the PHS. Table 4.1 shows the distribution of the rank of the participants in this study.

Table 4.1: Level of Employment (n=35)

POSITION HELD	FREQUENCY	PERCENTAGE
Community Service (Junior) Occupational Therapist	7	20.00
Senior Occupational Therapist	21	60.00
Chief Occupational Therapist	6	17.14
Assistant Manager	1	2.86

The majority of the respondents (60%) held positions as senior occupational therapists. One (2.86%) respondent was an Assistant Manager which was, at the time of this study, the highest rank attainable to occupational therapists

directly involved with clinical services. The distribution of rank from these respondents were considered relatively representative of the overall population as most occupational therapists employed in the PHS of the FS are indeed senior occupational therapists with chief and community therapists being the second and third highest.

4.2.1.5 Level of Service

The type of service delivered by the participants of this study is divided in two sections. The first refers to the level of health care provided and the second to the classification of the work area in terms of rural and/or urban settings.

The level of the service refers to the level of health care provided by the facility at which the respondent was employed. Table 4.2 shows the distribution of the levels of health care at which the participants of this study were employed.

Table 4.2: Level of Health Care (n=35)

FACILITY LEVEL OF HEALTH CARE	FREQUENCY	PERCENTAGE
Primary Health Care Facility	15	42.86
Secondary Health Care Facility	4	11.43
Tertiary Health Care Facility	16	45.72

Sixteen (45.72%) of the respondents worked in tertiary health care facilities while fifteen (42. 86%) worked in primary health care. This fairly equal distribution of the levels of service was advantageous to this study as data would be representative of the different challenges/advantages of various levels.

The second component of the level of service refers to the setting of the work environment. Table 4.3 shows the distribution of participants working in rural, urban or combined work settings.

Table 4.3: Work Setting (n=35)

WORK SETTING	FREQUENCY	PERCENTAGE
Urban	18	51.43
Rural	15	42.86
Combination urban and rural	2	5.71

Of the 35 respondents, fifteen (42.86%) classified their work environments as rural areas while eighteen (51.43%) work in an urban setting. The remaining respondents worked in areas considered to be a combination between rural and urban settings. The relatively even distribution of respondents between rural and urban settings was beneficial to the results of this study since data gathered would be representative of both areas with good infra-structure as well as areas where infra-structure, equipment and other physical resources were limited.

4.2.1.6 Focus area of work

The focus area of the work was considered based on two aspects, namely the field of practice as presented in table 4.4 and the primary responsibilities as presented in table 4.5.

Table 4.4: Fields of Practice (n=35)

FOCUS AREA	FREQUENCY	PERCENTAGE
Community-based occupational therapy	13	37.14
Physical rehabilitation	8	22.86
Mental Health	3	8.57
Combination of physical and psychiatric OT	6	17.14
Vocational evaluation and rehabilitation	2	5.71
Other	3	8.57

The results showed that thirteen participants (37.14%) worked in community-based practice while the least number (n=2) worked in vocational evaluation and rehabilitation. Eight (22.86%) practiced physical occupational therapy while

three (8.57%) worked exclusively in psychiatry. Other areas specified were neuro-rehabilitation (n=1) and paediatrics (n=2).

The second consideration in the focus area of work was differentiating between participants who performed managerial and clinical duties as their primary responsibility. Table 4.5 shows the distribution of the primary responsibilities of the participants in this study.

Table 4.5: Primary Responsibilities (n=35)

PRIMARY RESPONSIBILITY	FREQUENCY	PERCENTAGE
Clinical occupational therapy	24	68.57
Managerial and administrative	5	14.29
Combination of clinical and managerial responsibilities	6	17.14

Twenty-four (68.57%) respondents reported that they were clinicians only and not responsible for managerial tasks. Five (14.29%) respondents performed mainly managerial duties while the remaining six (17.14%) were responsible for both managerial and clinical tasks.

4.2.1.7 Management

In this study, some respondents were managed by occupational therapists while others had managers who were from other professions. Table 4.6 shows the percentages of the respondents who had occupational therapy managers and those who were managed by supervisors from other health affiliated professions.

Table 4.6: Profession of the Direct Manager (n=34)

PROFESSION OF DIRECT MANAGER	FREQUENCY	PERCENTAGE
Occupational Therapist	19	55.88%
Non-Occupational Therapy Managers	15	44.12%

Of the respondents who answered this section of the questionnaire (n=34), nineteen (55.88%) reported that their direct managers were occupational therapists by profession. The fifteen (44.12%) respondents who reported not having occupational therapists for managers worked under the supervision of various other health professionals.

Table 4.7 shows the professions of the non-occupational therapy managers.

Table 4.7 Professions of Non-Occupational Therapy Managers (n=15)

PROFESSION	FREQUENCY	PERCENTAGE
Physiotherapists	5	33.33%
Chief Professional Nurse	3	20.00%
Medical Officer	2	13.33%
Radiographer	2	13.33%
Social Worker	2	13.33%
Pharmacists	1	6.67%

The majority of respondents who were not managed by occupational therapists worked under the supervision of Physiotherapists (33.33%). The professions of the other ten managers were chief professional nurses, medical officers, radiographers, social workers and pharmacists.

4.2.1.8 Job turn-over

Job turn-over refers to the number of times the respondents had changed jobs since graduating. Table 4.8 shows the job turn-over for the respondents in this study.

Table 4.8 Job Turn-Over since Graduating (n=35)

NUMBER OF JOB CHANGES	FREQUENCY	PERCENTAGE
None	15	42.86
One (1)	11	31.43
Two (2)	6	17.14
Three (3)	2	5.71
Four (4)	1	2.86

The number of job changes ranged from none to four times since starting their careers. The median number of changes was one. Fifteen (42.86%) participants were still in their first job (i.e. have not changed their job since they qualified). Twenty (57.14%) respondents reported that they have changed jobs between one and four times in their careers. Completion of the community service year contract and spousal relocation were the most frequent reasons given for job turnover.

4.2.1.9 Absenteeism

The respondents' orientation toward absenteeism was assessed in the questionnaire. Table 4.9 shows the respondents' views regarding absenteeism in their departments.

Table 4.9 Absenteeism (n=35)

STATEMENTS	% AGREE	% DISAGREE
I am never absent from work without a valid reason	100	0
I believe unnecessary absenteeism is a problem in our department	40	60
I tend to look for reason to be absent from work when I have difficulty in my personal or working life	20	80

All of the participants agreed with the statement that they were never absent from work without a valid and reasonable reason. Conversely, 40.00% (n=14) believed that unnecessary absenteeism was a problem in their department. Three (8.5%) of the respondents also agreed that they tended to look for excuses to be absent from work when they were not satisfied with some aspect of their working and/or personal lives.

In concluding this section of the demographic profile of the respondents in this study it can be said that the sample was indeed representative of the population with regard to tenure, level of employment, work setting, diversity in practice areas and management. Consequently, the views of this sample concerning their overall job satisfaction could well be considered representative of those of the population as a whole.

4.2.2 Overall job satisfaction

The study of job satisfaction allows for the exploration of the different facets of job satisfaction individually but also as associative entities that, in combination, determine the overall level of job satisfaction. Overall job satisfaction refers to the worker's general feelings of satisfaction with regard to their job - all aspects considered.

Results for the overall job satisfaction of the occupational therapists working in the PHS of the FS were based on quantitative data. The self-administrated questionnaire assessed the overall level of job satisfaction by means of a dichotomous question and two separate rating scales.

In the first instance (the dichotomous question), respondents were asked to indicate whether they were satisfied or dissatisfied with their current jobs, all things considered (cf. question 10h in questionnaire). The results showed that 55.88% - the majority of the respondents - were dissatisfied.

Secondly, a rating scale was employed by which respondents rated their current level of job satisfaction on a scale from one to ten. A score of one indicated the lowest level of job satisfaction and a score of ten the highest. Table 4.10 shows the percentage of respondents who rated their current job satisfaction on the corresponding level.

Table 4.10 Rating of Current Job Satisfaction Level (n=35)

	RANGE 1-10	FREQUENCY	PERCENTAGE	CUMULATIVE PERCENTAGE
satisfaction	3	3	8.57	8.57
	4	8	22.86	31.43
	5	6	17.14	48.57
	6	6	17.14	65.71
Satisfaction	7	7	20	85.71
	8	3	8.57	94.29
	9	2	5.71	100

The range of ratings was from $^{3}/_{10}$ to $^{9}/_{10}$. The median score for this question was $^{6}/_{10}$ which was exactly the cut-off value[1] decided upon for this study. Interpreting from the median score, it can be surmised that the majority of the participants experienced low levels of job satisfaction. This is confirmed by the data that shows 65.71% of the respondents reported job satisfaction levels lower than the 60% cut-off value for this study. The largest percentage (22.86%) of respondents indicated a job satisfaction level of $^{4}/_{10}$.

None of the participants indicated a ten as their current level of job satisfaction, while only two (5.71%) and three (8.57%) indicated a score of $^{9}/_{10}$ and $^{8}/_{10}$ respectively.

Considering the decision of a 60% cut-off value, some might well be justified in arguing that a score of $^{6}/_{10}$ does not necessarily signify that the respondent was dissatisfied in their current job. This is true, as the subjective nature of one's evaluation of job satisfaction is widely published (cf. 2.3) and attempts to ascribe generalised values to such a subjective experience are often biased. However, in this study, respondents were asked to respond to a third question regarding their *preferred* level of job satisfaction. By using the same rating scale and comparing the score respondents ascribed to their current level of job satisfaction to the respondents' preferred level of job satisfaction, the issue of bias and subjectivity was eliminated.

Results showed that ratings for the preferred level of job satisfaction ranged between $^{8}/_{10}$ and $^{10}/_{10}$. The majority of the population (60%) rated their preferred level of job satisfaction at $^{10}/_{10}$ and the remaining 40% at $^{8}/_{10}$ (14.29%) and $^{9}/_{10}$ (25.71%).

By comparing the ratings of the current level of satisfaction and the preferred level of satisfaction, statistical analysis in the form of the 95% confidence interval (CI) for the paired median difference was 1:2 [-5;-3]. This established

[1] For the purpose of this study a 60% cut-off value was used which implied that levels of $^{6}/_{10}$ and lower were interpreted as dissatisfaction while levels of $^{7}/_{10}$ and higher were interpreted as satisfaction with the current job

that the actual job satisfaction experienced by the respondents was significantly lower than their preferred level of job satisfaction.

It was interesting to note that if the respondents preferred level of job satisfaction was used as the cut-off value to determine general satisfaction or dissatisfaction with their current jobs, results would have dramatically increased to further dissatisfaction. For instance, if the lowest level of preferred job satisfaction was used ($^{8}/_{10}$), the cut-off value would have been 80% and consequently 94.29% of the respondents would have reported general job *dissatisfaction* (cf. table 4.5). If the median of $^{10}/_{10}$ for the preferred level of job satisfaction was used, *all* respondents would have reported job dissatisfaction.
All three investigative questions support the conclusion that the current level of job satisfaction of the population under study is low. Taken from this and in answer to the first aim of this study (cf. 1.3.1), it was shown that occupational therapists working in the PHS of the FS, experienced moderately high to very high levels of overall *dissatisfaction* with their current jobs.

4.2.3 General Satisfaction with Grouped Topics

Following the format of the MSQ (cf. 2.3.5.2) and using the indicators of job satisfaction (cf. 2.3.5) described in literature, the questions in the self-administrated questionnaire were assimilated into specific groups all dealing with a related topic. In all, nine groups were identified and investigated by prompting respondents to answer the question: *In my current job, this is how I feel about ….* In each group between 5 and 18 questions were asked, depending on the complexity of the topic. Tables 4.11 to 4.19 show the different groups as well as the aspects investigated in each group (Note: the terms “satisfied” and “dissatisfied” were shortened to SAT and DISSAT when used as headings in all the following tables).

4.2.3.1 Group 1: Occupational Therapy as a Profession

Group one dealt with occupational therapy as a profession and the satisfaction or dissatisfaction respondents experienced based on practicing this profession.

Aspects such as the value of the profession, the choice to be an occupational therapist and recommending occupational therapy as a prospective career were important indicators investigated in this group.

Table 4.11 Group 1: Occupational Therapy as a Career (n=35)

GROUP 1	FACETS	% SAT	% DISSAT
Occupational Therapy as a Career	• Occupational therapy as career choice	77.14	22.86
	• Value of occupational therapy	71.43	28.57
	• Prospect of remaining an occupational therapist	48.57	51.43
	• Security of occupational therapy as profession	34.29	65.71
	• The chance to make a meaningful impact	85.71	14.29
	• Recommending occupational therapy to prospective students	65.71	34.29
	• Sense of fulfillment received from being an occupational therapist	65.71	34.29
	• Opportunity to work with people	91.43	8.57
	• Chance to be of service to others	80.00	20.00
	• Feeling valuable practicing occupational therapy	52.94	47.06

The results of this study show that 91.43% of the respondents were satisfied with the opportunity their jobs provided them to work with people. Over 80% of the respondents also reported feeling satisfied with the chance to have a meaningful impact and be of service to others. Although the respondents showed overall satisfaction with occupational therapy as a profession, the majority felt dissatisfied with the future security of the profession (65.71) and the prospect of remaining occupational therapists for the remainder of their careers. This phenomenon was explained by reviewing qualitative data as presented later in this chapter (cf. 4.3.3.1b). Other factors in this group which were met with high levels of satisfaction were the choice to be occupational therapists and the value of practicing occupational therapy.

4.2.3.2 Group 2: Work Content

The second group of topics focussed on the actual content of the respondents' work. Diversity in tasks, decision-making, challenging and stimulating work and autonomy were some of the topics investigated in this group.

Table 4.12 Group 2: Work Content (n=35)

GROUP 2	FACETS	% SAT	% DISSAT
Work Content	• Diversity in work tasks	68.57	31.43
	• Stimulating and challenging work	57.14	42.86
	• Chance to make decisions	68.57	31.43
	• Opportunity to be creative	71.43	28.57
	• Opportunity to work independently	77.14	22.86
	• Chance to exercise authority over others	60	40
	• Amount of administration	51.43	48.57

Table 4.12 shows that overall, the respondents felt satisfied with the content of their work as occupational therapists. The opportunity to work independently (cf. 4.3.3.2b), creativity and diversity (cf. 4.3.3.2c) and the chance to make decisions were perceived as the most satisfying indicators in this group. The amount of administration done on a daily basis received almost equal responses of satisfaction and dissatisfaction – an occurrence that is later clarified by means of qualitative data (cf. 4.3.3.2e)

4.2.3.3 Group 3: Work Challenge

Work challenge, with regards to making use of abilities and knowledge, personal and professions goals and continued professional education, comprised group three.

Table 4.13 Group 3: Work Challenge (n=35)

GROUP 3	FACETS	% SAT	% DISSAT
Work Challenge	• The way managers facilitate subordinates' professional goals	58.82	41.18
	• The way managers facilitate subordinates' personal goals	50.00	50.00
	• Opportunity to attend workshops, courses or post-graduate studies	34.29	65.71
	• The availability of funds in the PHS for professional development	17.14	82.86

The results show that 82.86% of the respondents reported dissatisfaction with the availability of funds in the PHS to attend courses or workshops. In addition to the financial constraints, 65.71% of the respondents also felt that opportunities to attend professional development sessions were limited. The reasons provided for this perception were found in the qualitative inquiry (cf. 4.3.3.3b). In general, results were equally distributed between feeling satisfied and dissatisfied regarding the role the manager plays in facilitating professional development and personal growth at work.

4.2.3.4 Group 4: PHS as Employer

Group four focussed on the PHS as the employer. Aspects directly linked to the organisation were investigated and included a variety of factors ranging from institutional values to administration and also external factors such as the influence of the press.

Table 4.14 Group 4: PHS as the Employer (n=35)

GROUP 4	FACETS	% SAT	% DISSAT
PHS as the Employer	• The values and practices of the PHS	25.71	74.29
	• Discrimination	12.12	87.88
	• The amount of red-tape involved in daily activities	40.00	60.00
	• The prospect of staying in the PHS as apposed to working in a different setting	37.14	62.86
	• The prospect of working in the PHS for a long time	25.71	74.29
	• My choice to be an OT in the PHS	62.86	37.14
	• Current changes in the PHS	5.88	94.12
	• The morale of OTs in the PHS	11.43	88.57

Although the majority of the respondents in this study felt satisfied with their choice to be occupational therapists in the PHS (62.86%), all other aspects relating to the PHS as employer in this group were met with distinct dissatisfaction (cf. 4.3.6). The current changes in the PHS – referring to political and managerial changes as well as the restructuring of the health system in general – elicited the highest percentage of dissatisfaction (94.12%). Respondents (87.88%) also reported dissatisfaction with the chance that they could be discriminated against within the PHS. Other aspects of dissatisfaction included the prospect of staying in the PHS for a long time (74.29%) and the morale of occupational therapists working in the PHS (88.57%).

4.2.3.5 Group 5: Management

The topic of management was dealt with in group five. The main focus of this group was with regards to the direct supervisor as many lower level clinicians do not have regular contact with higher managerial structures. Some questions did however pertain to top management and several comments were made with regards to top management in the open questions.

Table 4.15 Group 5: Management (n=34)

GROUP 5	FACETS	% SAT	% DISSAT
Management	• Direct manager's competence	76.19	23.81
	• Direct manager's acknowledgement of my strong points	74.29	25.71
	• Conflict management	38.24	61.76
	• Trust in manager's decision making skills	76.65	32.35
	• Support from manager	61.76	38.24
	• Keeping me informed	64.71	35.29
	• Respect for manager	82.35	17.65
	• Manager's ability to perform tasks	71.43	28.57
	• Manager's qualifications	85.71	14.29
	• Recognition from manager	73.53	26.47
	• Understanding personal issues	73.53	26.47
	• Manager's ability to make me feel valued and appreciated	61.76	38.24
	• Opportunity manager allows for self-leadership	73.53	26.47
	• Manager's ability to help me see the bigger picture	73.53	26.47
	• Opportunity managers allows to make independent decisions	76.47	23.53

Table 4.15 shows that the respondents in general were satisfied with aspects relating to their direct manager. Of the respondents, 85.75% felt comfortable with their direct manager's qualifications while 82.35% also reported that they respected their direct managers. The only aspect respondents were more dissatisfied with was that of the manager's ability and skill in managing conflict (61.76%). The distinction between the respondents' views of their direct managers and top management is further explored when discussing qualitative data (cf. 4.3.7.1)

4.2.3.6 Group 6: Recognition and Rewards

Group six comprised all aspects regarding rewards and recognition. The largest topics investigated here were salary, leave benefits, promotion, performance appraisal and status.

Table 4.16 Group 6: Recognition and Rewards (n=35)

GROUP 6	FACETS	% SAT	% DISSAT
Recognition and Rewards	• The way my salary reflects the importance of the work I do	22.86	77.14
	• The salary I am paid monthly	25.71	74.29
	• The idea that salaries should be based on individual qualifications and work responsibilities rather than generic for all	60.00	40.00
	• The idea that therapists working in remote areas should receive a special allowance therefore	58.82	41.18
	• The impact of my salary on my job satisfaction	34.29	65.71
	• The way my salary correlates with other health professions	14.29	85.71
	• The way my salary reflects my tertiary education level	14.29	85.17
	• The fringe benefits such as medical aid, leave and pension	88.57	11.43
	• The chance that I may be promoted at work	11.43	88.57
	• The prospect of advancement in my job	17.14	82.86
	• The option of working flexible working hours	60.00	40.00
	• Current working hours	79.41	20.59
	• The status of OT in the PHS compared to that of other settings e.g. private practice	11.43	88.57

With the exception of aspects such as working hours and fringe benefits, all other factors involved in reward and recognition (cf. 4.3.5) were received with singular dissatisfaction. The three aspects that elicited the highest percentage of dissatisfied responses were those of the status (cf. 4.3.6.2) of the PHS occupational therapist (88.57%), promotion opportunities (88.57%) and salary (85.71%). Sixty percent of the respondents were satisfied with the idea that salaries should be based on individual qualifications rather than generic salary

scales while only 58.82% were satisfied that rural-based therapists receive special compensation because of their work setting. The option to work flexi-hours (4.3.4.2.1) was received positively by 60% of the respondents.

4.2.3.7 Group 7: Relationships at Work

Relations with colleagues were investigated in group seven. Relations with other occupational therapists, the direct manager and the multi-professional team (MPT) were addressed.

Table 4.17 Group 7: Relationships at Work (n=35)

GROUP 7	FACETS	% SAT	% DISSAT
Relationships at Work	• The relationship I have with colleagues in my department	88.57	11.43
	• The impact of work relations on my job satisfaction (n=32)	78.13	21.88
	• Communication	68.57	31.43
	• Support	84.85	15.15
	• Relationship with manager	77.14	22.86

The results of this showed that in general the respondents were well satisfied with the state of their working relations (cf. 4.3.7.2). Almost 90% of the respondents were satisfied with their relationships with colleagues in the department (88.57%) and felt that they received adequate support here (84.85%). Most of the respondents also reported to have positive relations with their direct manager (77.14%). The resounding majority felt that their relationships at work had a positive impact on their job satisfaction (78.13%).

4.2.3.8 Group 8: Myself at Work

The respondents' feelings toward their working self as well as personal support networks were investigated in group eight.

Table 4.18 Group 8: Myself at Work (n=35)

GROUP 8	FACETS	% SAT	% DISSAT
Myself at Work	• The influence of my job on my personal life	65.71	34.29
	• The way my job meets the expectations I had of the profession	28.57	71.43
	• My confidence in my knowledge and abilities at work	74.29	25.71
	• My self-esteem when at work	77.14	22.86
	• The support I receive from family and friends regarding my work	82.86	17.14
	• My reaction to changes in the work place (n=34)	67.65	32.35
	• My ability to communicate effectively in other languages	20	80
	• My confidence that I am a good OT	82.86	17.14

The results showed that 82.86% felt confident that they were indeed good occupational therapists even though 80% felt that they were not satisfied with their ability to communicate effectively in the home language of all of their patients (cf. 4.3.8.2). It was interesting to note that 71.43% reported that the job did not actually meet the expectations they had of the profession (cf. 4.3.3.1b). Lastly, the majority of respondents in this study did, however, feel that their reaction to changes in the workplace was satisfactory (67.65%).

4.2.3.9 Group 9: Working Environment

The final group, Group 9 focussed on the physical working environment and also investigated aspects such as resources and staffing. Issues of health and safety were also addressed.

Table 4.19 Group 9: Working Environment (n=35)

GROUP 9	FACETS	% SAT	% DISSAT
Working Environment	• The space and furniture available	37.14	62.86
	• Access to technology	48.57	51.43
	• Access to sufficient equipment and materials	25.71	74.29
	• Access to official transport	37.50	62.50
	• Time spent travelling	41.18	58.82
	• The physical environment at work	42.86	57.14
	• Risk of contracting infectious diseases at work	22.86	77.14
	• Personal safety when travelling for official purposes	42.86	57.14
	• Health and safety regulations at work	57.14	42.86
	• Impact of physical working environment on job satisfaction	37.14	62.86

The results of this study show that with the exception of health and safety regulations at work, the respondents were generally dissatisfied with all other aspects of their physical working environment. The highest percentage of dissatisfaction stemmed from the risk of contracting infectious diseases at work (77.14%), insufficient equipment and materials (74.29%) and inadequate working space and furniture (62.86%). In general, 62.86% of the respondent felt dissatisfied with the impact their physical working environment had on their job satisfaction (cf. 4.3.4.1a).

4.2.3.10 Combined results for nine groups

The respondents' satisfaction or dissatisfaction with each group was once again measured against a 60% cut-off value. This implied that if a respondent answered "satisfied" to more than 60% of the questions in a group, it was interpreted that the respondent was satisfied with the specific group as it related to his/her job. Subsequently, if respondents indicated "dissatisfied" with 60% or more of the questions, the respondent felt dissatisfied with the group. Figure 4.1 shows the percentages of respondents who experienced satisfaction with the various groups.

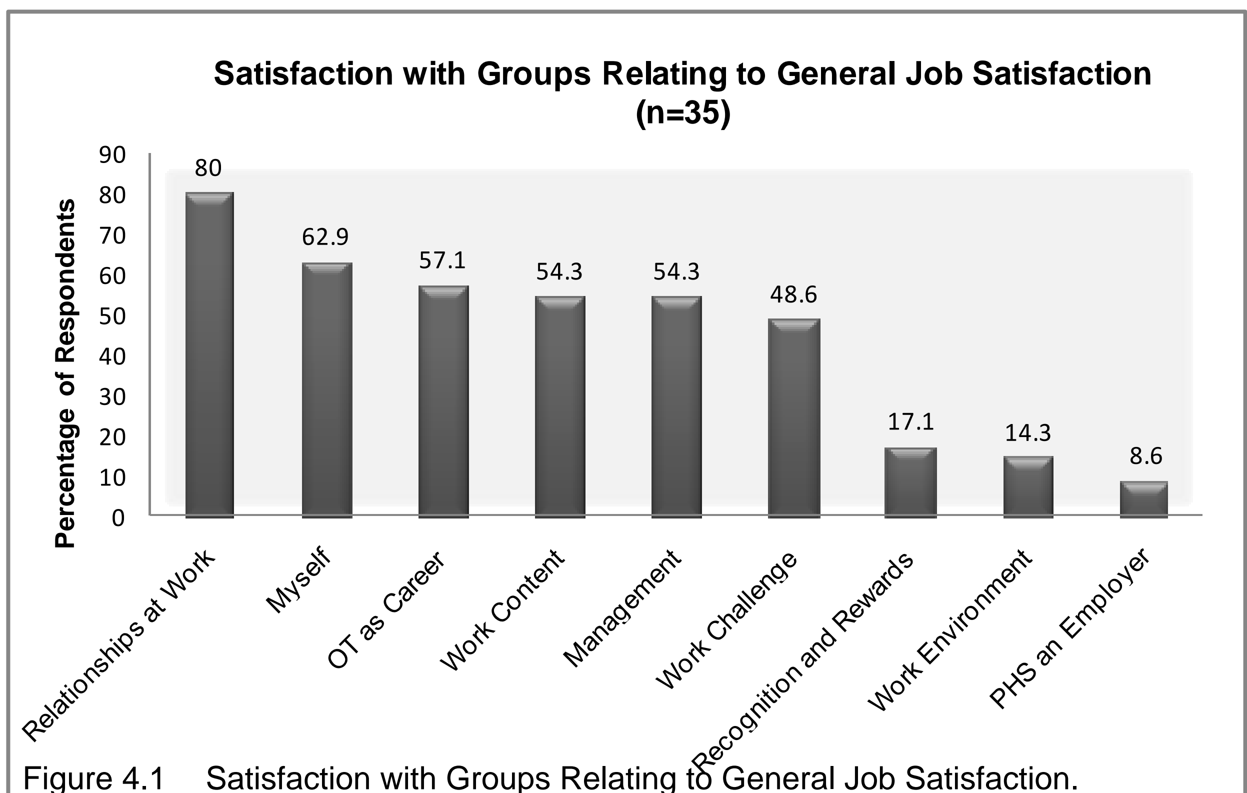

Figure 4.1 Satisfaction with Groups Relating to General Job Satisfaction.

In figure 4.1, the percentage of the respondents who answered “satisfied” to at least 60% of the questions asked in the specific category, is illustrated. From the figure it was established that slightly more than half of the respondents are satisfied with occupational therapy as a career (57.1%), their work content (54.3%) and the manner in which they are managed (54.3%).

Furthermore, it is clear that the majority of the respondents (80%) were satisfied with the relationships they had with colleagues and their managers. Over sixty-two present indicated that they were satisfied with how they felt about themselves as pertaining to aspects such as being a good clinician or manager, their self-esteem, their reaction to change and the influence their work has on their personal life.

From these results it can be established that occupational therapists working in the PHS of the FS are very satisfied with the relationships they have with colleagues and in general report that the quality of these relationships is a source of job satisfaction for them. Four respondents also remarked in the open questions that the supportive nature of their relationships with their occupational therapy colleagues was the aspect of their job they were most

satisfied with. One respondent even qualified this statement by saying if it was not for her supportive colleagues she would have left the employment of the PHS long ago and possibly even the profession altogether. It would seem that the importance of positive relations in the work place should not be underestimated. This aspect will indeed be further elaborated upon during the discussion of facet job satisfaction (cf. 4.3.7.2).

The three aspects which received very low responses of satisfaction were the PHS as employer (8.6%), recognition and rewards (17.1%) and the work environment (14.3%).

The facets respondents reported to be very dissatisfied with all seem related to the organization (the PHS) and its consequent systems that do not address their needs for recognition and a well-equipped, pleasing work environment. At this stage in the discussion of the results it can only be hypothesized that the impact of these organisation-bound facets plays a principal role in the respondents' negative assessment of their overall job satisfaction. These aspects seem to influence the respondents' wariness in ascribing "satisfaction" to other aspects of their work such as work content and work challenge, presumably because these categories are indirectly also bound to the environment (the PHS) they are working in. In the extreme, these doubts may even lead them to question their choice of career and the value of their input. This hypothesis may account for the somewhat lukewarm results in the groups regarding the topics of *occupational therapy as a career* and *my working self*. It is for this reason that the insights gained in the qualitative inquiry are of such importance to this study, as will be evident in the discussion of facet job satisfaction later in this chapter (cf. 4.3.4.1a).

4.2.4 General Job Satisfaction and Demographic Differences

Several demographic aspects of the respondents in this study were investigated to determine whether differences with regard to general job satisfaction could be identified. These demographic aspects included: tenure in the PHS, family,

level of service, field of practice, geographical area and the focus and type of work.

4.2.4.1 Tenure

To determine possible differences in overall job satisfaction of respondents based on their years of service in the PHS, the data was analysed in three groups. Group one (n=16) included respondents with 0-2 years of service, group two (n=13) included respondents with 3-10 years of service and the final group (n=6) was set for respondents with more than 11 years of service.

Calculating the 95% Confidence Interval for the groups showed that no significant difference existed in the overall job satisfaction of the respondents in each of the three groups. The median job satisfaction rating of the respective groups was 6 (group 1), 5 (group 2) and 5.5 (group 3) out of a possible 10.

4.2.4.2 Family

Respondents were divided into two groups. The first group included respondents who indicated that they have dependants (children) and the second group for those who do not.

The 95% Confidence Interval was 1-2: [-52.2%:2.2%] which established that the respondents in group 2 (without dependants) experienced significantly higher levels of job satisfaction than the respondents in group 1 (with dependants). In this case, 90% of respondents without dependants indicated that they were satisfied with their jobs while only 64.26% of the respondents with dependants indicated the same.

When given the option of spending more time with family as an indicator to enhance their job satisfaction, 73.3% of the respondents with dependants indicated that this option would increase their job satisfaction a lot. Conversely though, it was the respondents without dependents who strongly supported the idea of working more flexible hours with 70% (as opposed to the 46.67% of

those with dependants) indicating positive responses to this idea. It can be inferred that in the case of group two, flexible working hours would be spent on pursuits other than "family time", e.g. private work, shopping, secular appointments or even just sleeping late some times. Most respondents with children however, indicated that flexi-time would allow them to play a more "present" role in the lives of their children and that flexi-time would indeed for the most part be used for this purpose.

It must however be remembered that control over working hours has a strong link to other aspects of job satisfaction, such as feeling valued as a professional, perceived autonomy and balancing work and home life (cf. 2.3.5). These aspects are more fully discussed later in this chapter (cf.4.3).

4.2.4.3 Level of Service

Respondents were grouped into three groups namely group 1 – those working in primary health care, group 2 – those working in secondary health care and groups 3 – those working in tertiary health care.

Each group was compared to the other individually and the following results were evident.

When comparing group 1 and 2 as well as group 2 and 3, the Kruskal Wallis test was applied and yielded p-values of 0.39 and 0.36 respectively. These p-values indicated that no significant difference existed between the overall job satisfaction of respondents working in primary and secondary health care as well as in secondary and tertiary health care.

A comparison between group 1 and 3 however, showed a tendency of tertiary level workers experiencing higher levels of job satisfaction than their colleagues in primary health care. The 95% Confidence Interval for the paired data in this case was 1:3 [-3:0].

4.2.4.4 Field of Practice

The field of practice generally refers to working in the community, physical occupational therapy or psychiatric occupational therapy or a combination of the above. Once again these groups were all compared to the others and in all cases no significant difference could be calculated using the 95% Confidence Interval for each set of paired data.

From these results – when viewed collectively – it would seem that overall job satisfaction for this population was not significantly different based on their field of practice. One would however make a mistake in assuming that the field of practice has no bearing on the respondent's job satisfaction. Qualitative data revealed that the preferred field of practice does indeed have a distinct role to play in the individual's facet satisfaction (cf.4.3.3.2a). The significant role of the preferred field of practice will be fully elaborated upon later in this chapter.

4.2.4.5 Geographical Area

The geographical areas the respondents worked in were either urban or rural. The overall job satisfaction of these two groups was compared using the 95% CI for the paired groups. The result was [-2; 0] which indicated a tendency of the urban-based respondents to experience higher levels of job satisfaction than the respondents working in rural areas. Although no specific reasons were given for this occurrence, probable explanations may include the extensive travelling involved when working in rural areas, as well as a lack of satisfactory infra-structure in remote communities. It must be noted that a multitude of reasons may exist for this occurrence and as such it requires in-depth research to further explore all the possibilities.

4.2.4.6 Focus and Type of Work

The focus of the respondents' work refers mainly to being in a managerial or clinical post. Using the 95% CI for the paired data a result of 1-2: [-2; 1] was

obtained. This result indicated a tendency of clinicians to experience higher levels of job satisfaction than the managers.

This was further confirmed by the result that indicated that respondents who performed mainly clinical duties once again showed a tendency to experience higher levels of job satisfaction than the respondents who performed mainly administrative duties in their work. The 95% Confidence Interval for the paired data in this case was 1-2: [-1; 3].

Based on these results it would appear as if occupational therapists performing clinical duties had a better chance at experience job satisfaction than the occupational therapists in managerial positions, who, for the most part, perform administrative duties during the day. This occurrence is closely linked to the occupational therapist's need for client contact (cf.4.3.3.1a) which is explained at length later in this chapter.

In conclusion of this section, it can be surmised that differences in the levels of overall job satisfaction does exist based on certain demographics (e.g. dependants, geographical area and focus and type of work). However, aspects such as tenure and field of practice yielded no statistically significant differences. In the case of the level of the service no difference occurred between the three groups except for a tendency difference between primary and tertiary health care workers.

4.2.5 Job satisfaction indicators

In order to gain data reflecting the importance occupational therapists attached to different aspects of job satisfaction (cf. 1.4.2), the respondents were asked to rank ten possible indicators of job satisfaction in order of importance (cf. Annexure A, q11).

The ten possible indicators were: success with patients, salary, stimulating work, relationships with colleagues, promotion, autonomy, resources,

management and supervision, professional development and work environment.

Respondents were asked to rate these aspects in order of 1 to 10 with 1 being the aspect they considered most important to their job satisfaction and 10 the aspect they considered least important to their job satisfaction. The results were analysed by including only the indicators rated under the top five most important aspects. These results are presented in figure 4.2.

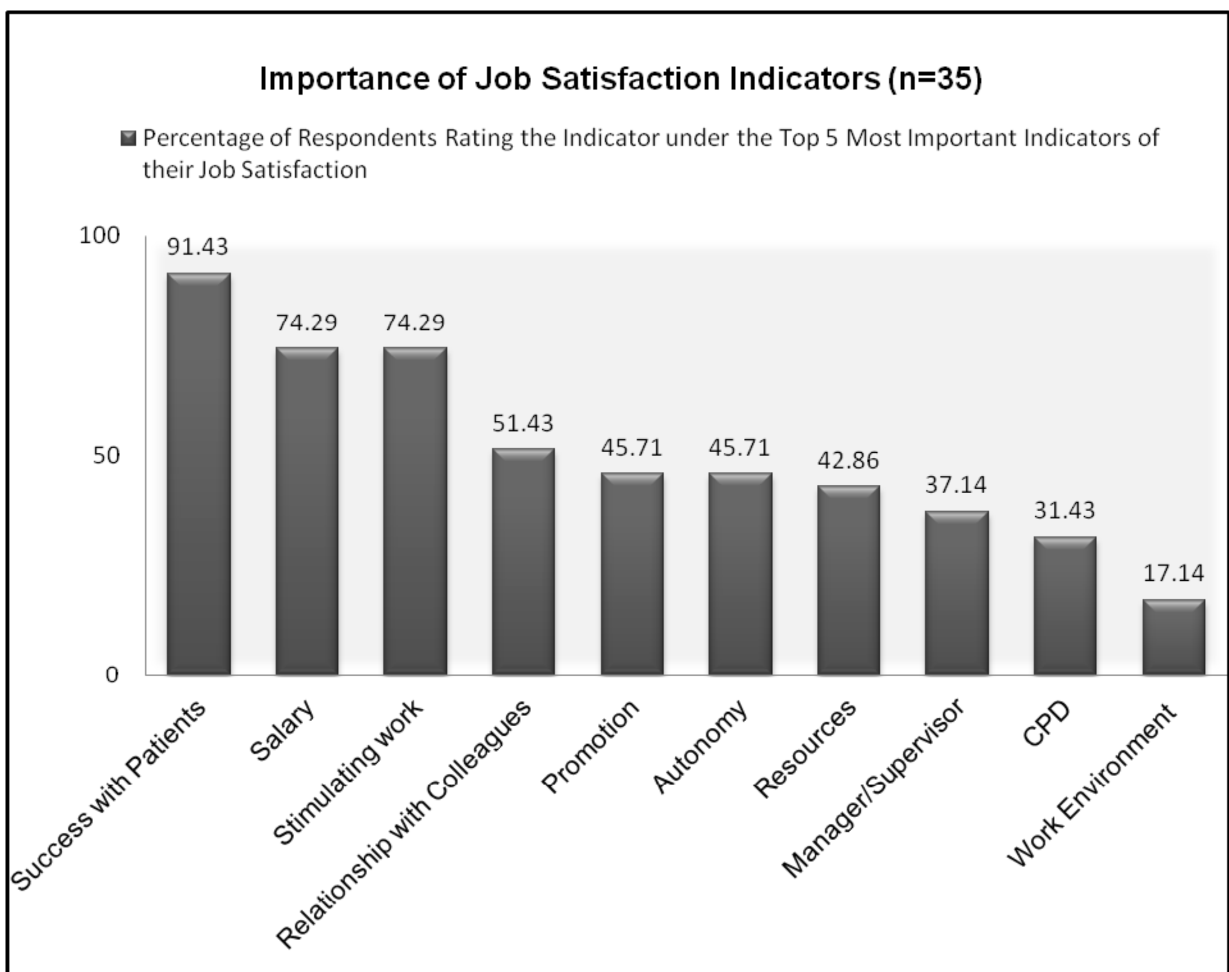

Figure 4.2 Ranking of Job Satisfaction Indicators

The most important indicator of the respondents' overall job satisfaction was achieving success with their patients, as was reported by 91.43%.

The second position of the most important job satisfaction indicators was shared between earning a good salary (74.29%) and doing stimulating and challenging (74.29%). Over fifty percent (51.43%) also reported that the quality of their relationships with colleagues were also indicative of their job satisfaction.

Only 17.14% of respondents rated a comfortable physical working environment as one of the top five indicators of their job satisfaction. This comparatively low score seemed to suggest that, of the ten options presented, respondents viewed their physical working environment as least important. At first glance this result may seem incongruent with the results of the qualitative study, where discussion on the physical working conditions of the participants was extensive and often laden with heavy feelings of dissatisfaction (cf.4.3.4.1a). It is in instances such as these where possible misinterpretation of data becomes evident, were it not for the abundance of theories available on job satisfaction. By way of explaining the afore-mentioned statement, attention is drawn to back to the Herzberg's Motivation-Hygiene Theory (cf. 2.3.1.1.2) which postulates that factors leading to satisfaction and dissatisfaction are separate and distinct. In the questionnaire, respondents were asked to rate a comfortable physical working environment in terms of its importance to job *satisfaction* and the result showed this aspect to be of little importance but, while discussing this same topic in the qualitative interviews, participants were referring to job *dissatisfaction* where it was indeed of great importance. This interpretation is congruent with Herzberg's theory (cf. 2.3.1.1.2) and shows that factors leading to job satisfaction and job dissatisfaction are indeed separate and distinct and results should be viewed against the background of satisfaction and dissatisfaction as befits the context of the inquiry.

In conclusion, the results of this study show that occupational therapists working in the PHS of the FS view success with patients as their most important indicator of job satisfaction, while a comfortable working environment was the least important to their job satisfaction.

4.2.6 Factors to Enhance Overall Job Satisfaction

The fourth aim of this study (cf. 1.4.4) was to investigate possible recommendations as to measures which could be taken to increase the job satisfaction of the respondents. As a first layer in answering this aim, a baseline of possible improvements was investigated. It was to this end that respondents were asked to respond to questions regarding sixteen options that, if increased, may or may not influence their job satisfaction (cf. Annexure A, q.12).

Options were rated from 2-5 where 2 indicated that an increase in the specified aspect would have no influence on their job satisfaction and 5 indicated that an increase in this aspect would increase their job satisfaction very much. Rating an aspect 1 indicated that the specified aspect was not applicable to the respondent.

Data was analyzed for the top ten factors that would enhance the job satisfaction by calculating only the scores of 4 or 5 for each factor. These scores indicated that an increase in the specific factor would increase job satisfaction moderately to a lot. Figure 4.3 illustrates the results of this rating scale.

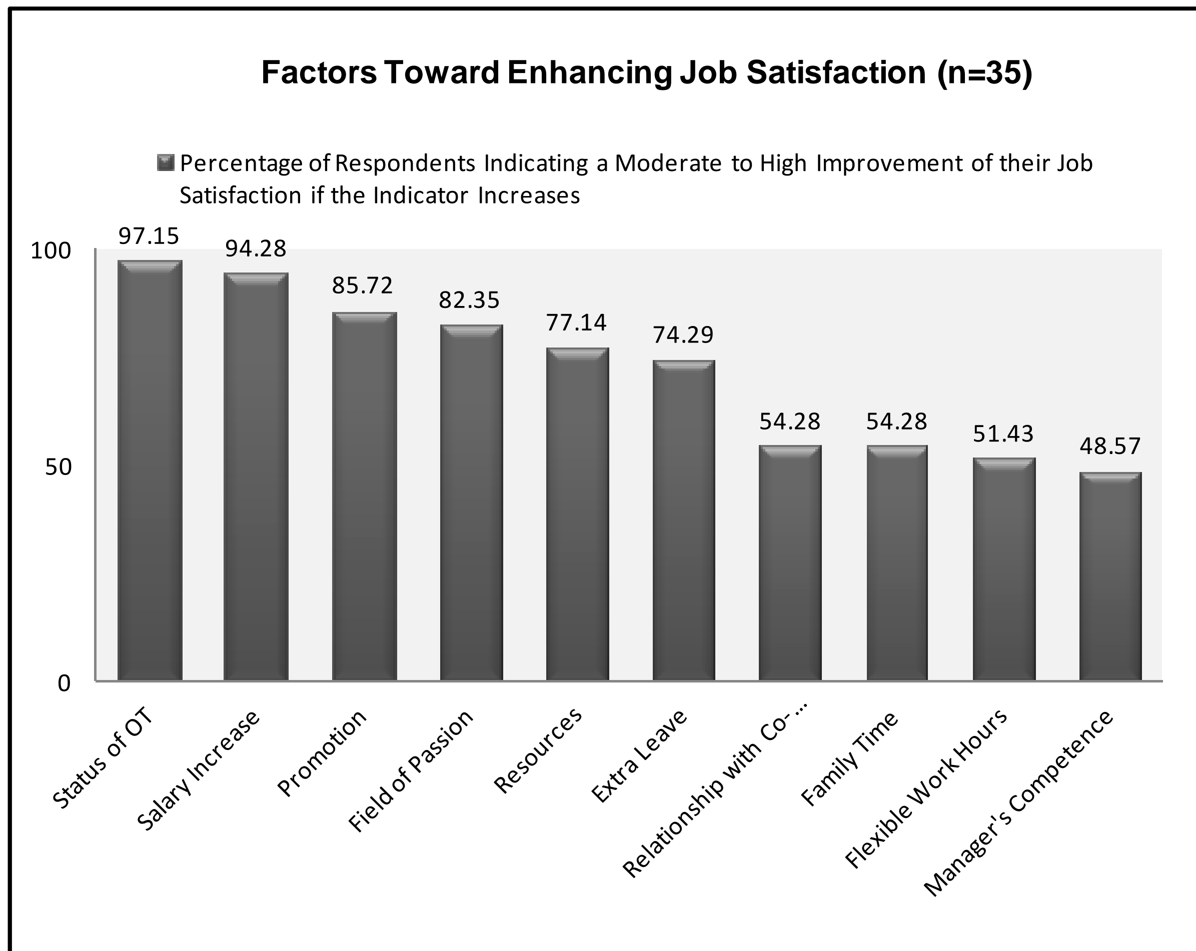

Figure 4.3 Factors to Enhance Job Satisfaction

Thirty-four (97.15%) of the respondents rated an increase in the status of occupational therapists on a 4 or 5 which showed that this factor would enhance their job satisfaction moderately to a lot.

An increase in salary (94.28%) and a promotion (85.72%) were rated as second and third most likely factors to enhance the job satisfaction of the respondents. Increased opportunity to work in the preferred field of passion (82.35%), better and more equipment, resources and space (77.14%) and increased leave benefits (74.29%) all received high scores.

Improvement in the direct manager's competency was scored 4 or 5 by 48.57% of the respondents indicating that nearly half of the respondents felt this aspect would enhance their job satisfaction significantly.

Improved relationships with colleagues, more time to spend with family and the opportunity to work flexi-time was also cited as having potential to increase the job satisfaction of more than 50% of the respondents.

Factors not included in figure 4.3 were less travelling, access to clinical supervision, increased personal safety at work, access to professional assistance for personal problems, more contact with the multi-professional team (MPT) and increased participation of the community. These factors were all scored on 3 and lower and thus deemed not to have strong propensity to increase the job satisfaction of the respondents.

As mentioned in the beginning of this discussion (cf. 4.3.5) the quantitative data presented here provided a baseline toward understanding possible factors that if addressed may enhance the job satisfaction of the occupational therapists in this study. Full interpretation of these findings can only be done once a clear understanding of the qualitative findings has been gained in section B of this chapter.

4.3.6 Control Questions

Six control questions were incorporated into the questionnaire. This was done by asking the same question with slightly different phrasing in two separate parts of the questionnaire.

Although these control questions by no means established either reliability or validity in the questionnaire it was felt that by including them the researcher would gain an idea of whether questions were answered with constancy, as well as surety that the respondents were clear on their views regarding their job satisfaction.

The 95% CI for the percentage difference for paired data was calculated. Table 4.20 presents these results.

Table 4.20 Control Questions (n=35)

FACETS	95% CI
• Creativity	[-14.2%;8.4%]
• Autonomy	[-9.6%;21.4%]
• Recognition	[-25.9;3.0%]
• Decision making	[-7.2;24.5%]
• Salary	[-4.9%;21.8%]
• Physical working environment	[-32.1%;12.2%]

The results showed no statistically significant variance between the answers provided in the first and second questions for the group as a whole. This showed that respondents did indeed answer questions with fair constancy and also provided surety that the respondents were clear in their assessment of their current job satisfaction.

From the quantitative data presented in this section of the chapter, the first layer of the phenomenon of the job satisfaction of the occupational therapist in the PHS of the FS has been unveiled. It was established that the current job satisfaction status of the respondents was low (cf. 1.4.1, 4.3.1) and common factors influencing job satisfaction (cf. 1.4.2, 4.3). Continuing the discovery of this phenomenon, a qualitative view will now be added in Section B.

4.3 SECTION B: QUALITATIVE FINDINGS

Qualitative findings were gained from conducting semi-structured interview (open-ended questions guided by an interview schedule). The qualitative inquiry yielded findings that explored, explained and illuminated the perceptions of the participants regarding their experiences of the different facets contributing to their job satisfaction or dissatisfaction. For this reason, section B of this chapter has its focus on *facet job satisfaction,* i.e. the different individual yet inter-related facets of the job which when assimilated provide the conclusion for determining overall job satisfaction.

These facets of job satisfaction emerged from the interviews and were analysed as proposed by Creswell (1998:140-149) and Tesch (1990:134-145) and grouped into categories, themes and related themes. Each category will be discussed in detail during this section.

At this stage however, it must also be mentioned that, as described in Chapter 3 (cf. 3.5.6), the researcher formed an intrinsic part of the qualitative research process. Considering this, it was believed that some of the findings of this study should be engaged with in the first person in order to maintain an authentic reflection of the participants' lived experiences.

Firstly though, in keeping with the descriptive nature of qualitative research, a narrative of the interviewees is presented.

4.3.1 Description of the Participants of the Semi-structured Interviews

Fifteen participants were selected randomly based on the selection criteria (cf. 3.2.1). The participants' post levels, years of experience and duties were diverse and corresponded to the overall population in this study (cf. 3.5.2). This increased the transferability (cf. 3.5.7.4) of the results.

With the exception of one participant, all were female. Thirteen participants preferred their interviews to be conducted in Afrikaans while two favoured English. Participants' field of work varied from psycho-social occupational therapy to physical rehabilitation and vocational rehabilitation. Participants worked with patients from diverse ages, cultures and educational levels. All the participants were hospital-based, in either an urban or rural setting, with some moving out into the communities they served by delivering services at clinics, schools, homes for the elderly and other community-based facilities.

Interviews lasted for between twenty minutes up to ninety minutes. I perceived that participants were comfortable during the interviews and in general presented their views spontaneously and comprehensively. They seemed appreciative of the opportunity to vocalise their experiences as occupational

therapists working in the PHS. Older, more experienced participants expressed themselves more effortlessly, with a lot of discussion on a particular theme. I observed that younger participants, especially the community service therapists, felt at times that they had had not been exposed to the system for a long enough period of time to be able to provide such rich and descriptive information, but nonetheless their comments brought enlightenment to many topics.

Initially, some participants seemed wary of the audio-recorder, but soon forgot about the device as they started talking about their experiences. The interviews seemed to come to end gradually and of their own accord. All participants verified the transcriptions as true and accurate reflections of their feelings and thoughts regarding their experience of job satisfaction or dissatisfaction. No participants changed or added to the content when transcriptions were sent for member checking.

4.3.2 Presentation of Qualitative Findings

Six categories emerged from this study. Each category was divided into several themes and in most cases, related themes. The categories were based on literature with specific reference to the adapted classification of Locke's model of the determinants of job satisfaction (cf. 2.3.5). Table 4.21 presents the six categories, themes and related themes[2].

[2]Note: Although every effort has been made to keep readers contextualised, the richness of the findings in this study is such that losing perspective as to how related themes relate to categories may at times be unavoidable. Please refer back to table 4.21 when engaging with the qualitative data discussed further along in this chapter, as it may serve as a valuable visual aid to regain context.

Table 4.21 Qualitative Data: Categories, Themes and Related Themes

CATEGORY	THEME	RELATED THEMES
1 **THE WORK ITSELF**	**OT as a Career**	• Client Contact/Making a difference • Relevance of OT as a Profession
	Work Content	• Field of Passion • Autonomy • Creativity/Diversity • Student Supervision • Administration/Procedural Red-tape
	Work Challenge	• Challenging Abilities • Opportunity to Learn and Grow
2 **THE WORK CONTEXT**	**Work Circumstances**	• Work Environment • Staffing • Health and Wellness at Work
	Special Privileges: Flexi-time	
3 **REWARDS**	**Remuneration**	• Reasonable Salary • Fringe Benefits
	Promotion	
	Security	• Financial Security • Job Security
	Performance Recognition	
4 **THE EMPLOYER / EMPLOYEE**	**Organisational Structure and Climate**	• Policies • Public Image • Stringency Measures
	Status	
5 **ROLE PLAYERS WITHINTHE PHS**	**Management**	• The Direct Manager • Top Management
	Colleague Relations	
	MPT	• Contact with the MPT • Knowledge of OT
6 **ROLE PLAYERS OUTSIDE OF THE PHS**	**Clients and Community**	
	Language and Culture	

Categories 1, 2 and 3 are derived from incidences or circumstances influencing the job satisfaction of the participants, while categories 4, 5 and 6 reflect the influence of agents. Each category and its themes and related themes will now be discussed in detail.

4.3.3 Category 1: The Work Itself

Category one comprises of incidents or circumstances which influence the job satisfaction occupational therapists experience with regards to the work itself (cf. 2.3.5, table 4:11-13). Three themes have been identified in this category:

- Theme 1: Occupational Therapy as a Career
- Theme 2: The Work Content
- Theme 3: The Work Challenge

4.3.3.1 Theme 1: Occupational Therapy as Career

Satisfaction or dissatisfaction with occupational therapy as a career was identified as the first theme in category one. Some of the findings in this qualitative analysis brought to light facets such as the occupational therapists' satisfaction with their choice to be an occupational therapist, the value of the profession, the chance to have a meaningful impact on the lives of others and the chance to work with people. These facets were grouped into to related themes namely:

- Related theme 1: Client Contact and "Making a Difference"
- Related theme 2: Relevance of Occupational Therapy as a Profession

a) Client Contact and " Making a Difference"

Category 1:	The Work Itself
Theme 1:	Occupational Therapy as a Career
Related Theme 1:	**CLIENT CONTACT AND "MAKING A DIFFERENCE"**

During the qualitative investigation, working with people and making a difference emerged as the primary concepts when discussing contact with clients. Comments on the opportunity to work with people and "make a difference" were persistent in all the semi- structured interviews conducted with clinicians. Some examples were:

> *"Dit is nogsteeds my passie om met mense te werk …Dit gee my baie bevrediging as ek sien dat ek vir iemand iets beteken en ek sien dat daardie persoon kan aangaan met sy lewe."*

> *"Ek dink die grootste deel van my werksbegrediging bly maar die pasiënte en die geleentheid wat jy kry om mense te help. So dit is nogal die een ding wat dit vir my, as ek 'n ruk lank nie by die werk was nie, maak dat ek wil terugkom werk toe, om regtig mense te help, om te sien dat jy 'n verskil maak."*

From the excerpts above it was clear that working with people and "making a difference" was an important theme to the participants in this study. Participants explained that helping clients was often their strongest motivator and indeed their greatest source of job satisfaction.

These findings are also supported in the emperical evidence of the quantitative investigation of this study (cf. table 4.11). Theoretical evidence in support of these findings is universal among all studies conducted in the field of the occupational therapists' job satisfaction. Moore, Cuirckshank and Haas (2006:22) reported that patient contact and the sense of achievement occupational therapists experience when clients achieved therapeutic goals were commonly described experiences of job satisfaction among occupational therapists working in Urban Australia. Meade, Brown and Trevan-Hawk (2005:137) reported the same results in their study concerning the job satisfaction of occupational therapists from a gender perspective (comparison between male and female occupational therapists). Jacobs (1994:992), who studied "flow" and the occupational therapy practitioner, found that when

therapists engaged in patient intervention they experienced the highest levels of flow. In the aforementioned study "flow" was described as experiencing joy, feeling intensely involved with deep concentration, enjoying clarity of goals and lacking self-consciousness (Jacobs, 1994:989) – all feelings associated with job satisfaction.

However, the qualitative findings of this study allowed for further exploration and revealed many facets which impacted the participants' opportunity to have client contact and to experience feelings of "making a difference". Many of these facets will come to light later on in this chapter, but some aspects, due to the directness of their influence, demand immediate attention.

The first direct influence was that of the success occupational therapists experience in the treatment of their patients. The exact nature of the influence could only be described as ambiguous, as in some instances it yielded positive experiences and in other negative. A comment explaining the "see-saw effect" of patient success was as follows.

> Researcher*: " Hoe laat dit jou voel as jy sukses bereik met pasiënte?"*
>
> Participant*: "Ek voel gelukkig en ek voel entoesiaties oor die hele beroep, dat dit regtig 'n verskil maak - maar dan kry jy ook die negatiewe – as hulle terugkom. Dan voel jy dit help ook nie eintlik nie. Maar as jy dit regkry en net daai klein reaksie uit hom kry … dan voel jy baie gelukkig en betekenisvol en jy het weer hoop vir die lewe!"*

Once again empirical evidence to support the importance of achieving success with clients could be found in the quantitative results of this study (cf. figure 4.2). Furthermore, research found that success with patients was listed as one of the top two sources of job satisfaction for both male and female occupational therapists (Meade, Brown & Trevan-Hawk 2005:142). Hasselkus and Dickie (1993:147) illlucidated the importance of success with patients by explaining

that the accompanying feelings of dissatisfaction when successful change in patients could not be attained, was manifested in dramatic ways such as quitting a job or leaving the profession altogether. It can be inferred that experiencing success or failure with patients, becomes a strong determinant of the occupational therapist's feelings of being valuable and consequently also determines their general satisfaction with the profession (cf. 4.3.3.1b; 4.3.8.1).

While one negative influence on success with patients was the occurrence of patient relapse (cf. 4.3.8.1) several participants also remarked on short hospitalisation time as a factor which has a negative influence on their opportunity to make a successful difference.

> *"Die kort tyd wat die pasiënte in die hospitaal is, is regtig frustrerend want jy loop nie die hele pad met die pasiënt nie… jy moet maar na die* comm serv *verwys. Jy weet hy word opgevolg maar jy sien nie self die vordering nie – so dit beïnvloed jou negatief – jou werksbevrediging ook".*

> *"…hierdie vinnige ontslagting maak dit negatief, want dit voel ons mors ons tyd. En dit voel vir my ek is nie die moeite werd nie, ek beteken nie iets vir die pasiënte nie."*

Although short hospitalisation time was the frustration of secondary and tertiary level occupational therapists, for primary level workers the negative influence stemmed from a socio-economic nature where it was reported that patients often do not get time off work or have the taxi-fare to attend occupational therapy. It would seem that factors limiting the quality of care the participants were able to provide were all viewed with utter dissatisfaction.

Smith-Randolph, Doisy and Doisy (2005:58) supported the claims of this study regarding the influence of short hospitalisation time and patient relapse on the occupational therapists job satisfaction. The afore-mentioned authors reported that providing quality care to patients was considered one of the top four most important indicators of career satisfaction for occupational therapists and was

significantly influence by factors such as hospital turn-over time and patient relapse (Smith-Randolph, Doisy and Doisy 2005:58).

In summary of this related theme, it was established that occupational therapists derive high levels of satisfaction from working with people and “making a difference” in the lives of their patients. This was also viewed as the primary source of their job satisfaction and is consistent with other studies done on occupational therapists around the world.

b) The Relevance of Occupational Therapy as a Career

Category 1:	The Work Itself
Theme 1:	Occupational Therapy as a Career
Related Theme 2:	**THE RELEVANCE OF OCCUPATIOANAL THERAPY AS A CAREER**

The relevance of occupational therapy as career refers to whether the participants felt that their profession was of important value and meaningful to them. Qualitative findings revealed that the participants experienced high levels of satisfaction with the value of the work they do.

> *“Once you get into the system, you realise that there’s really a great need for the service you’re providing and you get motivated by that point, especially because you feel like you have an important role to play.”*

> *“Ek glo verseker dat arbeidsterapie ‘n positiewe impak het op die samelewing. Verseker, veral in die nuwe gesondheidstelsel….is arbeidsterapeute die enigste professionele persone wat regtig in ‘n onbekende omgewing kan inbeweeg, ‘n opsomming maak…en dan die werkilike gapings kan aanspreek.”*

Feelings of worth, satisfaction and importance were all evident in the responses of the participants to the question as to how they viewed the value of occupational therapy. The participants felt that their profession held the

potential to truly “make a difference” and viewed their role as allied health professionals as important.

These qualitative findings were also empirically confirmed in this study (cf. table 4.11). Furthermore, theoretical evidence in support of this related theme abounded. Freda (1992:244) and Pringle (1996:403), in separate studies, both found that occupational therapists' job satisfaction showed a positive correlation with their feelings of practicing a valuable profession. Reese and Smith (1991:292) found that overall, occupational therapistst experienced higher levels of satisfaction than the combined score for other health professionals and ascribed this occurence largely to the belief occupational therapists held that they were practicing a valuable profession. Even for a minority group, namely male occupational therapists, Brown (1998:561) found that the lure of practicing a valuable profession was one of the top four reasons why males chose the profession.

However, at this stage it is important to note that within the context of practicing this valuable profession certain negative influence do come into play. One of these was the lack of recognition that other health professionals and the top management ascribed to the value of occupational therapy.

> *“ Hulle (*top management and other allied health professions*) glo nie regtig dat arbeidsterapie 'n verskil maak nie. Dit maak dat mens soms twyfel… Beteken ek nou regtig iets? Ja, dit laat mens eintlik minderwaardig voel. En partykeer voel ek kwaad, want ek weet dat arbeidsterpie baie beteken vir die pasiënte.”*

In the quantitative results of this study, the participants' need to receive appropriate recognition for the value of their profession was evident in their wish for increased professional status (cf. figure 4.3). Theoretical evidence to this nature was found in the work of Moore, Cuirkshank and Haas (2006:23), Freda (1992:241), Reese and Smith (1991:293) and Baily (1990b:25) all who reported that the lack of respect and understanding of occupational therapy by other health professions was the one of the greatest sources of dissatisfaction among

occupational therapists, but more relevantly perhaps, stated that this occurrence contributed extensively to occupational therapists' decisions to leave the profession.

In the case of this study, the perceived lack of support for the profession from top management and other health professionals sparked feelings of insecurity amongst the participants regarding the future of occupational therapy. Discussions on the attitude of others toward the value of occupational therapy invariably led to the concerns regarding the future of the profession being voiced.

> *"Ons kan filosofies daaroor raak en sê die sekuriteit van die beroep is goed – dat dit altyd behoue sal bly – maar dis nie die realiteit nie. Die realiteit is ons sal baie meer moet inspring en bemark. Arbeidsterapie het al die potensiaal om 'n* "whoohaa" *beroep te raak – sodra ons 'n manier vind om die werk wat ons doen aan die publiek en die bestuur te beskryf."*

Results from the quantitative inquiry of this study showed a marked reluctance of respondents to recommend occupational therapy to prospective students and also a high incidence of dissatisfaction with the idea of practicing occupational therapy indefinitely (cf. table 4.11). These results all indicate a propensity among the participants to feel insecure about the future of their profession.

Only one other study (identified by the researcher) done across the spectrum of job satisfaction in occupational therapy reported on feelings of reservation toward the security of occupational therapy as a profession. Pringle (1996:401) conducted a study investigating the views of occupational therapists in England regarding the influence of a reformed National Health Service on their job satisfaction. Pringle (1995:402) found that the majority of therapists felt that the role of the occupational therapist was under threat as a direct result of the reforms in the health service in England. The reforms as described in Pringles' (1996:401-402) study bear a striking resemblance to changes within the health system of South Africa (cf. 2.2.3). Perhaps the state of political reform in South

Africa (cf. 2.2.2, 2.2.3) and its consequent influence on changing health policy can be ascribed as an instigator of feelings of job insecurity among the occupational therapists who participated in this study. Pringle (1996:402) explained that as a result of reforms, the impositions of cash limitations and limited resources, occupational therapy may be sidelined as a peripheral rather than an essential service – a fact that amplified the doubts of occupational therapists in England.

Additionally though, another possible contextual circumstance that may have led to the prevalence of participants of this study's insecurity about their profession was that the study was conducted within a time-period when the economic recession of the world received much public attention. Insecurity about jobs, retrenchment and job-losses were themes extensively discussed in the media and may have caused feelings of insecurity to be brought to the forefront of the participants' minds.

In conclusion of this theme, the findings of this study show that occupational therapists working in the PHS demonstrated high levels of satisfaction regarding the value of occupational therapy. Practicing a worthy profession was established is regarded as a source of job satisfaction but the satisfaction the participants were able to gain from this factor was markedly decreased by concerns regarding the worth other health professionals and top management placed on occupational therapy. Consequently, participants expressed some reservation regarding the future security of the profession – a finding that should be also observed within the current prevailing political and economic context of South Africa.

4.3.3.2 Theme 2: The Work Content

The second theme identified in the first category comprised incidents or circumstances relating toward the work content (cf. 2.3.5, table 4.21). This theme revolved around facets such as diversity, autonomy, creativity and the nature of the work tasks, which are key considerations when workers evaluate

their job satisfaction (Mouton 1998:74; Louw 1997:47). Five related themes were identified:

- Related theme 1: Working in the Preferred Field of Passion
- Related theme 2: Autonomy
- Related theme 3: Creativity and Diversity
- Related theme 4: Student Supervision
- Related theme 5: Administration / Procedural Red-tape

a) Working in the Preferred Field of Passion

Category 1:	The Work Itself
Theme 2:	Work Content
Related Theme 1:	**WORKING IN THE FIELD OF PASSION**

Working in the preferred field of passion refered to the participant's area of interest and sometimes expertise, e.g. paediatrics, hands, adult psychiatry or neurology.

From qualitative findings it would seem evident that although the participants were comfortable working in various fields the scope of occupational therapy allows, most reported that not being in a post that promoted working in their preferred field of passion increased their job dissatisfaction in varying degrees.

> *[If not working in the preferred field of passion] "Dit voel jy spandeer jou tyd heel jaar aan iets wat nie vir jou lekker is nie. Dis sieldodend!"*

> *"En wat ook vir my sleg is, ek persoonlik werk nie in die rigting waarvan ek hou nie. Dit is nie my passie waarmee ek besig is nie en dit is vir my sleg. …Dit maak vir my dat ek 'n bietjie* compassion fatigue *het partykeer…"*

"…dit maak dat jy nie alles vir jou pasiënt gee soos jy sou gee as dit jou passie was nie, of dit waarin jy natuurlik goed is nie."

For some paticipants this occurrence contributed to severe dissatisfaction, while for others it merely served as a detractor of their work motivation. The three statements above most closely reflect the continuum of complete dissatisfaction to low motivation that emerged from participants in this study who did not perceive their opportunity to work in their preferred field of passion as adequate.

The quantitative result of this study provided empirical evidence in support of the notion that opportunity to work in the preferred field of passion was indeed an influencer of the respondents' job satisfaction (cf. figure 4.3). Theoretical evidence showed that disillusionment in a specific field of work was a significant reason why some occupational therapists in the USA chose to leave the profession and others switched to a more satisfying area of work (Baily 1990b:34). Literature also cautions that occupational therapists have found limited opportunity to work in the preferred field of interest a significant reason why some occupational therapists quit their jobs or the profession altogether (Freda 1992:241).

Concluding this theme, it was established that working in the preferred field of passion had a definite influence on the participants' assessment of their job satisfaction. The nature of the influence was determined by the opportunity available to work in the preferred field of passion. When sufficient opportunity occurred, no dissatisfaction was observed whilst a range of negative impacts were evident when the opportunity was insufficient.

b) Autonomy

Category 1:	The Work Itself
Theme 2:	Work Content
Related Theme 2:	**AUTONOMY**

The second aspect regarding work content that was identified as having a significant impact on the job satisfaction of the participants in this study, was

that of clinical autonomy. The chance to work autonomously with regards to clinical practice was reported as an aspect of their job that was very highly valued by the participants in this study.

> "*Om redelik onafhanlik te kan werk is vir baie belangrik. Daar is pasiënte wat gesien moet word, maar niemand sê dit vir my nie. Dis nie asof iemand heeltyd oor my skouer loer en vir my sê wat om te doen nie. So ek kan self besluit wát ek met my pasiënte doen, hoe laat ek hulle* book *in die dag en hoe gereeld ek hulle sien, so dis nogal lekker."*

Quantitative data from this study lent empirical support to the theme of autonomy (cf. table 4.12; figure 4.2) and theoretical evidence was discovered universally among research studies that dealt with the job satisfaction of occupational therapists. Research has shown that a positive correlation exists between autonomous practice and the job satisfaction of occupational therapists (Moore, Cuirkshank & Haas 2005:21; Pringle 1996:404). Davis and Bordieri (1987:591-595), who specifically studied the effect of perceived autonomy on the job satisfaction of occupational therapists in America, defined clinical autonomy as the state in which an occupational therapist experiences personal responsibility for clinical work outcomes. These authors found clinical autonomy to be an intergral part of the allure of the profession and an aspect highly valued by occupational therapists (Davis and Bordieri 1987:594).

Although all participants remarked on their satisfaction with operating autonomously, once again the practice of autonomy was influenced by limiting contextual factors. The following two aspects were identified as limiters of the participant's opportunities to experience clinical autonomy: a) availability of equipment and materials (cf.4.3.4.1a) and b) the PHS system (cf.4.3.3.1e, 4.3.6.1). Some reflections on the influence of these limitators were:

> *"…die voorrade is nie altyd genoeg nie, so partykeer kan jy net doodeenvoudig nie doen wat jou wou nie. Dan moet jy óf aanpas, óf dit maar los. Dit perk mens bietjie in."*

"Die sisteem maak dit partykeer dat jy nie regtig beheer het nie. Daar is te veel pasiënte, te veel vergaderings, te veel addisionele goed wat niks met arbeidsterpaie te doen het nie. Jy kan nie net êrens een dag uitboek vir admin *nie. Daai deel is frustrerend, want in terme van dit het jy nie regtig beheer oor jou dag nie"*

Participants explained that lacking resources and the eccesive processes involves in aquiring resources often limited their activity choices and freedom to engage in treatment approaches they want to. These excerpts provide empirical evidence as gained from this study that draws attention to the realities in which occupational therapists practice their professions – realities that cannot always accommodate the needs of the occupational therapist in terms of job satisfaction.

Interestingly though, another divergent to the phenomenon of clinical autonomy was the incidence where especially younger, less experienced participants referred to clinical supervision concurrently with clinical autonomy. The afore-mentioned participants expressed feelings of needing to work independently but simultaneously needing to have a safety-net in the form of clinical supervision.

" [Name], ons manager, het my verskriklik baie gehelp. Sy het nie al die hand-pasiënte vir haar gehou nie. Sy het my 'n kans gegee om self aan te gaan. As ek gesukkel het, het ek haar gaan vra en sy het kom help, maar sy het dit nogsteeds vir my gelos om te doen." (one year tenure)

"Veral hierso is dit nogal baie nodig om self besluite te neem. Ek geniet dit maar dis 'n groot verantwoordelikheid . Daarom is ek so bly vir my hoof. Sy gee my 'n kans maar ek weet as ek hulp nodig het is sy altyd daar vir my" (two years tenure)

"Ek hou daarvan om onafhanlik te werk maar ek wens partykeer ons kan net 'n uur 'n week kry saam met iemand sodat ons net kan check *dat ons nog op die regte pad is. Ons probeer maar so nou-en-dan, soos op die kursusse, met ander terapeute praat, maar dis nie genoeg nie." (two years tenure)*

The nature and process of the clinical supervision was not clarified but it would seem that most of these participants reported that clinical supervision was initiated by them when they came across a problem and that this suited their needs well. Some however did express the need for a more structured process of clinical supervision and/or mentoring.

Quantitative confirmation of the idea of clinical supervision did not occur for the majority of the respondents in this study. Although provided as an option to increase job satisfaction, clinical supervision was not cited under the top ten factors to enhance job satisfaction for the participants of this study (cf. figure 4.3). Equally weak support for the idea could be found in literature. Only one research study alluded to the possibility of employing clinical supervision to increase job satisfaction (Baily, 1990b:35). In this study it was argued that encouraging new graduates to take jobs alongside experienced therapists might decrease the propensity of young therapists to feel insecure in their profession and consequently become disillusioned therewith (Baily, 1990b:35). No further support for this idea could be gained, as a matter of fact; most studies show that occupational therapists zealously guard their independence and find autonomy to be one of the most attractive aspects of their jobs.

In conclusion, clinical autonomy is established as a source of satisfaction when practicing occupational therapy. It provides occupational therapists with the right to have relative control over their day especially in terms of patient care. Constraints in resources and time at times prevent occupational therapists from acting fully autonomously but only become severe threats to their job satisfaction once it impedes their ability to have contact with clients. Younger, less experienced occupational therapists also placed high value on clinical autonomy but expressed a need for limited supervision to act as a safety-net.

c) Creativity and Diversitiy

Category 1:	The Work Itself
Theme 2:	Work Content
Related Theme 3:	**CREATIVITY AND DIVERSITY**

Although literature tends to discuss creativity and diversity separately from one another (cf. 2.3.5) the mention of one of these aspects during the semi-structured interview invariably led to the incorporation of the other topic at once. Participants tended to discuss these aspects as synonymous, inter-related aspects of their jobs. In keeping with the qualitative nature of the semi-structured interview, these separate but seemingly synonymous topics were grouped into one related theme.

> *"As arbeidsterapeut is ek nogal heel tevrede, want ons sien baie verskillende goed omdat ons in psigiatrie is. Ja, want ek sien van langtermyn tot akuut tot multi-gestremdes, so die verskeidenheid is vir my lekker. En om arbeidsterpie-areas te ontwikkel, dis die kreatiewe deel, dis ook vir my lekker. Dit is ook vir my lekker om nuwe personeel te kom oriënteer en op te lei – die studente deel is ook vir my lekker."*

What is being inferred by the statement above, and by other similar statements made by participants, is that occupational therapists attached great value to diversity in their work content.

Quantitative results substatiated the respondents' satisfaction with diversity as a facet of their jobs (cf. table 4.12). Furthermore, these results are in accordance with results gained from other researchers in the field of occupational therapy (Hasselkus & Dickie 1993:150; Jenkins 1991:450). Jenkins (1991:450) found that variety in work and creativity in practice were both features of occupational therapy most attractive to newcomers, as well as the feature most enjoyed by occupational therapists in practice. Hasselkus and Dickie (1993:147-148) explained that occupational therapists' needs for practicing in a creative way, based on the results of their study, was of such importance that the participants

in their study often regaled stories where the therapist's adaptation to limitations was quite remarkable and often beyond the call of duty.

In most cases, the participants' need for diverse work tasks was satisfactorily met. However it was noticeable that participants who worked in super-specialised fields such as vocational evaluation and rehabilitation tended to not talk about diversity as frequently as participants who worked in areas that were less specialised. This is not to say that these participants experienced less job satisfaction, but rather that they indicated that their derivation of job satisfaction was from a different source – perhaps even the very fact that they were performing tasks on a super-specialised level?

As with previous satisfiers already discussed in this chapter, the influence of work circumstances on participants' experience of creativity on the job was negative. Participants in general reported that their opportunity to be creative was somewhat restricted by the lack of resources in the PHS, especially with regard to consumable materials.

> "*Daar is nie altyd tyd en die fasiliteite van kreatiwiteit en aktiwiteit soos wat ons dit graag sal wil doen nie. Veral die fasiliteit of die voorraad, die verbruikbare goed. En dit vat mens bietjie weg van wat arbeidsterapie is. So, ja, ek dink ons kreatiwiteit is baie ingeperk*"

Nevertheless, the creativitiy and diversity inherent in the practice of occupational therapy consistently lead to experiences of job satisfaction and can therefore be seen as a source of job satisfaction for the occupational therapists.

d) Student Supervision

Category 1:	The Work Itself
Theme 2:	Work Content
Related Theme 4:	**STUDENT SUPERVISION**

On the issue of student supervision the perspectives of the clinicians and managers seemed to concur that working with students was enjoyable and that it had a definite positive impact on their job satisfaction.

> *"Studente supervisie is een van die ligpunte in my werk. …ek is baie mal oor die studente. Ek geniet die evaluasie en ek geniet dit om hulle te help, dis vir my baie,baie lekker."*

> *"Dis die lekker deel – die studente deel is my lekker. Partykeer is dit moeilik om by alles uit te kom…maar ek hou daarvan."*

Smith, Schiller, Kay Grant and Sachs (1995:418) found student supervision to be positively related to the job satisfaction of occupational therapists in Ohio, USA. Furthermore, these researchers also found student supervision to be an interpersonal and professional growth factor which had a moderately high mean effectiveness ($^{3.14}/_{5}$) as a recruitment and retention strategy used by occupational therapy directors in various care settings. These results indicated that occupational therapists enjoyed student supervision and mentoring on both an interpersonal level and as a medium to develop and maintain their professional knowledge. It also indicated that student supervision was positively associated with therapists remaining in the profession and the specific work setting.

Gleaning from the comments made by the participants, several reasons why student supervision added to their job satisfaction were identified.

> *"Ons studente-lading is hoog maar dit gee vir my ook baie bevrediging as ek weet dat ek my ervaring met hulle kan deel – dat ek vir die studente leiding kan gee met hulle opleiding. Ja, soos ek sê, die lading is partykeer hoog maar vir my is dit belangriker om ook op hoogte bly met watter opleiding en teorie in die akademie aangaan, so dis nog 'n positiewe ding."*

> *“…ek dink dit [*student supervision*] dra baie by tot my werksbevrediging. Dis nogals lekker, want dit hou my op my tone, sonder dat ek myself moet dwing. En, dit help ook met die verhoudinge in die department. Ons [*therapists in the department*] moet mekaar help en ons doen. Almal help met die studente, daar’s niemand wat vier of vyf verslae moet merk en die ander sit en niks doen nie. Dis amper ‘n tipe spanwerk. Dis nou nogals lekker.”*

Participants reported that maintaining and promoting their professional knowledge, sharing their experience and enhanced interpersonal relations and teamwork, to be some of the reasons they viewed student supervision as a positive aspect of their job. These results were consistent with the findings of Smith, Schiller, Kay Grant and Sachs (1994:418) as described above.

Although occupational therapy managers acknowledged the value of being involved in student training, most of the managers expressed concern regarding the impact student training had on the workload of their personnel, as well as the balance between student training and doing clinical work. One manager’s reflection on the issue of student supervision was as follows:

> *“Die een ding wat ek dink moet aandag geniet is net ‘n balans in studente hantering. Dat daar ‘n balans moet wees in die interaksie van akademiese personeel en die kliniese personeel, so ook die verantwoordelikhede wat die studente het en ‘n dankbaarheid vir die bydrae wat die terapeute lewer. Maar ook, in terme van lading wat studente in die department dra, daar moet nie net op hulle gesteun word nie en die terapuete moet nie so betrokke wees by studente toesig dat hulle nie by hulle kliniese verpligtinge kan uitkom nie.”*

All participants involved in student supervision also reported good and supportive relations with the academic personnel. For some, these relations

were a source of satisfaction while other participants were merely satisfied with the state of the relationship.

Research studies that included the facet of student supervision as an influence on job satisfaction made no mention of the position of managers regarding student supervision.

In conclusion, student supervision was found to be promotative of job satisfaction for the occupational therapists in this study. It was also established as a source of satisfaction with the potential to increase job satisfaction.

e) Administration

Category 1:	The Work Itself
Theme 2:	Work Content
Related Theme 5:	**ADMINISTRATION**

Administration was identified as the last related theme to work content. Taken from the findings of this study it was established that clinical occupational therapists have little argument with administrative functions that are directly linked to the care of their clients, but show scant sufferance of the administrative processes linked to general management of the facility they are working for.

> *"Die administratiewe kant van die werk is baie frustrerend – ek praat nou nie van prosesnota's of pasiënte se verslae nie, dis* okay. *Dis die ander goed. Die honderde vorms en* submissions *en die* issues *as daar nie 'n kolletjie op jou* i *is nie. Dit maak my klaar."*

> *"Dis miskien 'n* schlep *maar dis eintlik lekker vir my om gou daai nota of verslaggie te tik, dis partykeer lekker afleiding in die dag. Dis net die gesukkel met die ander goed, soos as jy iets wil aankoop of op 'n kursus wil gaan of studieverlof moet reël. Dis sielmergelend!"*

> *"Ek het partykeer gevoel ek wil huil as hulle weer vir die veertigste keer bel en sê daar is fout met my* submission*. En jy maak hom so reg as wat jy hom moontlik kan maak, maar 'n fout sal hulle êrens vind. Ons spraakterapeut sal vir jou 'n heel ander storie vertel want hulle het twee van haar* submissions *net laat wegraak. Daar is net verskriklike frustrasie met as die romp-slomp in die staat."*

Proof from the quantative results support the ambiquity of the participants' feelings toward administration (cf. 4.12). These results and findings are echoed by those gained by Moore, Cuirkshank & Haas (2005:22) which stated that the occupational therapists in their studies reported to be satisfied with administrative aspects, such as process-notes and clinical progress reports, but had very low tolerance of other forms of administrative functions. From other studies done in the field of occupational therapists' job satisfaction, it was ascertained that occupational therapists are rarely satisfied with the extent of administrative functions they have to perform (Jacobs 1994:992; Freda 1991:241; Baily 1989:26).

For occupational therapy managers the issue of administration was less dissatisfying as they accepted administrative duties as part of the responsibility allotted them from their managerial position. All the managers reported that they accepted the administrative function of their job and even to some extent enjoyed it.

> *"Ek het nie 'n probleem met die* admin *nie, dis deel van my werk. Dis partykeer nogal lekker en ek dink dit pas by geaardheid. Waarmee ek wel 'n probleem het is die* admin support services *soos* HR *en* Supply Chain Management*…. "*

These results are once again consistent with literature as Jacobs (1994:992) found documentation and administration/organisation to be the second and third highest ranking duties that elicited experiences of flow amongst managers of

occupational therapy services. These duties were only out-ranked by the level of flow experienced when doing intervention with a client or patient.

As can be seen from all three quotes in the discussion of administration, and especially the last section of the quote directly above, the role of the support services in the PHS also plays a significant part in the experiences of the participant's satisfaction/dissatisfaction with the amount of administration they have to perform. All of the participants reported that the above-mentioned influence was of a negative nature and did not in any way enhance their job satisfaction. A full discussion of support services is done later in this chapter (cf.4.3.4.1b).

The results of this showed that the occupational therapists were satisfied with patient-related administration but very dissatisfied with the procedural red-tape of daily abministrative functions

4.3.3.3 Theme 3: The work challenge

Work challenge (cf. 2.3.5, table 4.21) was identified as the fourth and final theme with regards to the category of the work itself. Mouton (1998:75) cites that work challenge is the intellectual stimulation a worker finds in performing their work tasks. Coetzee (1999:62) postulates that work challenge is central to the worker's organisational commitment and their job involvement, resulting in job satisfaction. Two related themes were identified:

- Related theme 1: Challenging Abilities
- Related theme 2: Opportunity to Learn and Grow

a) Challenging Abilities

Category 1:	The Work Itself
Theme 3:	Work Challenge
Related Theme 1:	**CHALLENGING ABILITIES**

The propensity of the work to challenge the abilities of the occupational therapists in this study was identified as the first facet regarding work challenge.

> *"Ons [*occupational therapists*] is ook intellektuele wesens, so ons wil 'n* challenge *hê. Ons wil uitgedaag word en ons wil groei."*

> *"Die werk is stimulerend en jy word heeltyd uitgedaag. Vir my is dit een van die belangrikste dinge anders raak ek bitter gou verveeld en dis nie goed nie…"*

Taken from the quote above, and many similar comments made by the participants, it was surmised that challenging and stimulating work was an essential facet to the experience of job satisfaction for most of the participants.

Quantitative data supported this statement but enlightened the fact that currently many of the participants did not experience satisfactory work challenge (cf. table 4.13; figure 4.1; figure 4.2). This interpretation is congruent with the findings of various studies done on the job satisfaction of occupational therapists that found challenging and stimulating work to be essential to the experience of job satisfaction for occupational therapists. (Moore, Cuirkshank & Haas 2005:22; Smith *et al.*1994:417; Davis & Bordieri 1987:591).

Explanations as to why work challenge was viewed as important by the participants were not clear but some may be inferred by studying the nature of the occupational therapist. Mainly two aspects are considered, namely, the volition and the intellect of the occupational therapists.

In some cases the work challenge seemed to stem from the occupational therapists' desire to do what in most cases would be considered hopeless and impossible (cf. 2.2.1).

> *"Jy moet 'n manier vind om dit (*treatment) *te laat werk. Jy kan nie net sê daar's nie hoop nie. Jy moet alles vat wat jy het en 'n plan*

maak anders ly jou pasïent daaronder. …wanneer jy dit regkry, (dan) voel jy jy het gewen!"

Literature supports this notion as Moore, Cruikshank & Haas (2005:19) as well as Hasselkus & Dickie (1993:147) report that finding a way to help a client or a community regain their independence or promoting wellness where circumstances are not optimal provides a challenge that calls to inherent volition of the occupational therapist and when success is achieved, promotes their job satisfaction.

The second consideration revolves around the intellect of the occupational therapist. In the first quote provided above. the participant described occupational therapists as "intellectual beings" with a need for their intellectual abilities to be stimulated and challenged. It is commonly accepted that occupational therapists are selected to the degree based chiefly on their intellectual abilities and furthermore, only those who present an above-average intellect are allowed into the course. Louw (1997:64) describes this kind of population as high-level workers and Visser (1990:90) reports that individuals in high level jobs have more and stronger psychological needs of which work challenge is one. It can therefore be said that based on their inherent intellectual abilities, occupational therapists experience strong needs for stimulation and challenge.

Stimulation and challenge in work serves as a source of satisfaction with the propensity to enhance job satisfaction if congruent with the need of the occupational therapist. If not of acceptable standard, this factor may detract from job satisfaction and should be addressed with haste.

b) Opportunity to Learn and Grow

Category 1:	The Work Itself
Theme 3:	Work Challenge
Related Theme 2:	**OPPORTUNITY TO LEARN AND GROW**

The opportunities provided in the PHS to learn and grow were assessed in both the quantitative and qualitative investigations of this study. Generally, this facet elicited moderate to high levels of dissatisfaction.

Participans' expressions of their frustration and disillusionment with regard to further education opportunities were varied.

> *"…so ruk terug was daar 'n kursus. Ek sou vir my self betaal en self soontoe ry, so dis glad nie 'n uitgawe vir die staat nie, maar toe mag ek nie gaan nie, want iemand moes in die department bly. Daar was nie pasiënte geboek nie. Daar was niks! …Ek het gesmeek maar dit het nie gehelp nie. .. dit ontneem mens daai vordering-geleentheid want mens moet groei en jy moet vorder. Hoe sal ons anders die beste vir ons pasiënte kan doen?"*

> *"…die belofte is daar, maar as jy die dag aansoek doen, dan is daar nie noodwendig geld nie, want die* budget *is gewoonlik uitgeput, so ek dink die struktuur is daar om aansoek te doen maar dit gebeur nie noodwendig nie."*

> *"…die kursusse hierrond gaan meestal oor kinders of volwasse neuro … ek werk nie met kinders nie so ek gaan nie. Daar is nie regtig kursusse hier in my belangstellingsveld nie. Dis meestal in Gauteng of in die Kaap."*

Regarding the time off work to attend courses or workshops (first quote above), participants indicated that in some cases, even tough they had been willing to shoulder all financial responsibilities and workschedules allowed for them to attend; the opportunity was still denied them based on seemingly unreasonable standards. Government funding for professional development (second quote above) was widely discussed during the semi-structured interviews. Discussions ranged from disillusionment with the system and the effects of stringency measures (cf.4.3.6.1c) to manager's fears concerning staff morale. Discussions also encompassed the issue of the content of courses (third quote

above). It was clear that participants mainly engaged in the field of hands, orthopaedics and adult psychiatry felt that courses in their fields of practice were not readily available. On the issue of opportunities to attend workshops, courses or post-graduate studies, qualitative findings showed that the participants experienced high levels of dissatisfaction. Some explanations where given and are reflected in the summary below:

- The topic and/or content of available workshops or courses where not in their field of interest or expertise.
- Institutional policies demand that at least 50% of staff be at work and therefore only some people may attend workshops, specialty days and courses. (Note that institutional policy rates differ.)
- Time off from work could not be gained due to inter-office politics.
- Post-graduate studies could not be accommodated due to personal commitments at home or financial constraints.
- Courses or workshops are not readily and frequently available in the area where they work. Long-distance travel was often required.
- No financial reward for further qualifications is offered by the PHS (cf.4.3.3.3b).
- Individuals are lacking financial support for course fees, travel and accommodation.

The participants' dissatisfaction regarding opportunities for professional development was also evident from the quantitative results of this study (cf. table 4.13; figure 4.2). These findings indicated that the issue of opportunities to promote professional development was indeed viewed as an indicator of job satisfaction by occupational therapists. Theoretical evidence to support this claim was found in the work of Smith and other authors (1994:414-415) who reported that professional development opportunities was one of the most effective strategies to retain occupational therapists, and the second most effective strategy used in recruiting therapy personnel. Baily (1990b:37) views this facet of the job of such importance that she decries institutions that do not attend to the matter of continued professional development with earnest as

shortsighted and actually courting the possibility of professionals leaving their service.

Opportunities to learn and grow - in the form of attending courses or workshops - leave the participants of this study feeling distinctly dissatisfied. An aspect of the work that should function as a motivator has shifted to become a great source of dissatisfaction due to institutional policy, lack of funds and lack of representative opportunities. Consequently this factor functions as a source of dissatisfaction with the potential to only increase or decrease job dissatisfaction. In the case of this study, this source of dissatisfaction tipped the scale in favour of job dissatisfaction.

4.3.4 Category 2: The Work Context

The second category (cf. table 4.21) which emerged from qualitative findings comprises incidents or circumstances that influence the job satisfaction of occupational therapists with regards to their work context (cf. 2.3.5). Facets such as the physical working environment and resources along with employment specific additional benefits are encompassed in this category. These facets have been assimilated under two themes:

- Theme 1: Work Circumstances
- Theme 2: Special Privileges

4.3.4.1 Theme 1: Work Circumstances

The first theme identified under the category of work context was the work circumstances. In literature (cf 2.3.5), work circumstances generally refer to aspects such as safety and comfort, lighting, temperature, noise, safe machinery, manpower and so forth. Within the context of this study these factors were grouped into three related themes namely:

- Related Theme 1: The Work Environment
- Related Theme 2: Staffing

- Related Theme 3: Health and Wellness at Work.

a) The Work Environment

Category 2:	The Work Context
Theme 1:	Work Circumstances
Related Theme 1:	**THE WORK ENVIRONMENT**

The work environment the participants of this study performed their daily tasks in emerged as the first related theme under work circumstances. Participants in the qualitative investigation spent a lot of time discussing their frustrations and disillusionments with their working environment. The inter-related dynamics of the work environment on other facets of the job emerged strongly from these semi-structured interviews and included aspects such as dealing with excessive red-tape, the influence of inadequate equipment and materials on patient care, travelling and making use of private resources to compensate for the lack of resources in the PHS.

In general participants' reported feeling satisfied with the physical space they had to work in.

> *"Ek kan regtig nie kla oor ons area nie. Daar's genoeg spasie om almal te kan werk. Partymaal brand ons vas maar dis niks wat goeie beplanning nie kan uit sorteer nie."*

> *"Ons het 'n uitstekende area. Hier is genoeg ruimte en die area is goed uitgelê en toegerus. Dis regtig lekker om hier in te stap en te kom werk. Dis altyd netjies en skoon. Dis perfek. Dis ingerig volgens ons behoeftes. Ons het regtig nie 'n probleem nie, ons area is* beautiful*."*

> *"Die werksarea hier is okay. Ons het behandelingsareas – twee, maar ons moet almal een spasie deel vir 'n kantoor en met die ander* rehab*-ouens ook. Ons gebruik soms van die Sprakies se*

areas maar dis nie altyd beskikbaar nie. Die behandelingsareas is ver van die kantoor af wat dinge bietjie moeilik maak as, byvoorbeeld die telefoon lui of iets en jy is alleen hier. …Dit sou lekker gewees het om net nog een area by te kry sodat ons dit kan inrig vir hande. Daar is sprake, maar vir nou doen ons met wat ons het."

However, at this stage it must be mentioned that all the participants of the qualitative study were, in accordance with the selection criteria of the study, fairly closely situated to Bloemfontein, which in turn meant that these participants were all hospital-based, even though some went into community areas as well. The fact that the participants were based at fairly large institutions meant that infra-structure was already established. If participants were selected from rural areas, the possibility may have existed that the results on their satisfaction with work space could have been less positive due to a lack of infra-structure in these rural areas. Nevertheless, the tendency of higher care level workers (secondary and tertiary) to be more satisfied with their allotted work space and general infra-structure than their colleagues in primary health care was, duly noted. Attitudes were securely satisfied in tertiary settings, while on primary level the participants accepted their general infra-structure, but made known that several improvements could be made.

The working environment in this study had significant influence on the job satisfaction of the participants, as respondents in the quantitative investigation showed marked dissatisfaction with all aspects related to the physical working environment (cf. table 4.19). However, discussed earlier in this chapter a comfortable physical working environment was only rated in the top five indicators of job satisfaction by 17.14% of the respondents (cf. figure 4.2.). This seemed to signify that a comfortable physical working environment was, in fact, not a strong indicator of the respondents' job satisfaction. The deduction is congruent with literature on the subject, which states that at best, a comfortable working environment can only serve as a moderate indicator of job satisfaction (Coetzee 1999:63; Louw 1997:55).

Occupational therapy studies on job satisfaction have mostly been conducted in first-world countries and consequently the issue of infra-structure is, at best, only mentioned but not investigated. This however is not the case in a developing country such as South Africa. Pillay (2009:6) found that poor infrastructure in the PHS was indeed one of the main reasons why PHS nurses reported higher levels of dissatisfaction than their colleagues in private hospitals. In agreement, Chipkins and other authors (2008:99) also warn that within the South African context, improvement of the infra-structure of hospitals needs urgent attention, as the current state of facilities is costing the system some of its best talented and skilled professionals as they immigrate to countries with better infra-structure in their hospitals.

A second facet linked to the physical working environment was the availability of equipment and materials. Here, the respondents' frustrations when trying to procure new materials or equipment was openly expressed and felt. A variety of negative emotions and gestures were observed in the participants as they discussed their problems with regards to acquiring materials or equipment. These emotions ranged from intense anger to complete cynicism and were evident in all the interviews conducted. Some expressions of these feelings were as follows.

> *"Ek raak briesend van woede om te dink dat my pasiënte in die saal lê en druksere kry omdat ons nie vir hulle opblaas matrasse kan koop nie, maar met elke vergadering is daar kos ge-*cater*! As ek dink aan die* schlep *waardeur ons moet gaan net om 'n* brace *te bestel of miskien 'n hulpmiddel wat 'n pasiënt nodig het, ek raak sommer dadelik negatief – dis wat my die meeste frustreer!"*

> *"Dit is vir my baie moeilik om my personeel gemotiveerd te hou as hulle nie goed het om mee te werk nie. Ons* supply chain management *is vir my 'n verskriklike groot probleem! Ek is al so onpopulêr by daai mense want ek lê dag en nag op hulle nekke om my goed te kry. Ek raak 'n aaklige mens as ek daar instap. "*

" … elke keer as die goed goedgekeur moet word, moet ek gaan verduidelik hoekom ek dit wil hê en waarvoor ek dit wil gebruik – alhoewel ek al 'n hele dokument opgestel het waar ek elke item beskryf het. So dit maak my moeg, dit maak my rêrig moeg om oor en oor dieselfde goed te verduidelik."

"…so, hulpmiddels maak ek baie keer uit my eie sak uit. Nie dat dit vir my 'n problem in nie maar, in aggeneem die salaris wat ek kry, is dit moeilik. Ek kan dit nie altyd doen nie."

Inferring from the four statements above it is clear that many facets can be associated with the lack of equipment and materials reported by the participants in this study. The first, and certainly the one most worrying to the participants, was the influence insufficient resources had on patient care and treatment. The second aspect associated with the lack of resources was the participants' frustration with the organisations' processes and the perceived incompetence or negative attitudes experienced from administrative support services. This was patently evident in the statement made by one manager in the second excerpt above. All the participants in this study complained that the number of forms they had to complete was excessive and policies regarding procedures were not applied consistently. The last aspect associated with the lack of resources in the PHS was the occurrence of the participants using their private resources to compensate for the lack of consumables, equipment and other resources (e.g. official transportation) in the PHS. Most participants reported that they use their own money to finance activities and assistive devices in order to provide their patients with what they needed based on the scope of occupational therapy treatment as they were taught. Another aspect frequently mentioned was the use of their private vehicles to travel for official purposes without satisfactory reimbursement. In terms of the relevance to this study, these behaviours of the participants can be seen as an effort to do what most provides them with job satisfaction and that is "making a difference in the lives of their clients" (cf. 4.3.3.1a). It is however worrying that this attempt on their part to satisfy a motivation-need (cf. 2.3.1.1.2) in most cases, also mobilises experiences of dissatisfaction. From the excerpts above the participants needs

to experience success with patients and “to make a difference” is inferred in the participants’ willingness to use private resources for work, but conversely, the momentary search for satisfaction turns into experiences of frustration and inadequacy – ultimately leading to disgruntlement and dissatisfaction. It must also be commented that the momentary satisfaction of providing for a patient - albeit with private resources - seems to sit well with the younger, less experienced participants who have not yet been disillusioned to the long term implications of their good-naturedness. It must be considered that their method of compensating for the lack of resources, at this time, enables them to experience more success and consequently better job satisfaction. However, the frequency with which more experienced participants reported using private resources for work was significantly less and it would seem that dissatisfaction with using private resources for work increases with tenure. Alternatively, another explanation for the reluctance of more experienced therapists to use their private resources for work can be found in the demographic orientation as these were the respondents who were most likely to already have several children and consequently increased financial responsibilities at home - making it more difficult for them to use their private resources for work purposes. Nevertheless, although less in frequency, some of the older participants still reported incidents where they do make use of their private resources for work purposes.

As mentioned before, the lack of evidence regarding the influence of equipment and material of the job satisfaction of occupational therapists from studies done in first world countries, show this aspect to be of little importance in these countries. However, once again, the uniqueness of the South African context is highlighted as all studies done on health care personnel within South African institutions report a distinct dissatisfaction with the lack of resources, equipment and consumable materials to work with (Lombaard 2010:1-6; Pillay 2009:6; Chipkin *et.al.* 2008:98; Moodley & Bachmann 2002:397; Lopopolo sa:2,19)

In summary of this related theme it was established that the majority of the respondents were satisfied with the space available to them but very dissatisfied with the availability of equipment and materials to work with.

Several associations were made with regards to their frustrations concerning equipment. These were, the influence in patient care, dealing with red-tape and support services and making use of personal resources for official purposes. The facet of work circumstances is a source of dissatisfaction which holds only the potential to decrease job dissatisfaction if experienced favourably by occupational therapists. In the case of this study, the lack of physical resources increased the participants' dissatisfaction with their jobs.

b) Staffing

Category 2:	The Work Context
Theme 1:	Work Circumstances
Related Theme 2:	**STAFFING**

The second related theme that emerged from the work circumstances the participants were exposed to was that insuffient and unskilled hospital workers.

During the qualitative inquiry participants often commented that although occupational therapy staff was sufficient, the effects of nursing staff shortages and incompetencies in administrative support services severely impacted on their ability to treat patients effectively.

> *" Ons is baie gelukkig om ons poste gevul te hê, maar in die hospitaal is die verpleegpersoneel 'n probleem…en die verpleegsorg, want hulle het 'n tekort, dis nie dat hulle swak verpleegsters is nie, daar is regtig net te min. Een voorbeeld is die druksere, die ouens wat nie gedraai word nie, dit is wat my direk beïnvloed."*

> *"…die* admin support*, soos by* HR*, is nie regtig so erg nie. Ja, dinge vat maar lank en mens sukkel om nuwe mense aangestel en betaal te kry maar hulle is oor die algemeen redelik hulpvaardig. Dis* supply chain *wat eintlik maar die grootste probleem is. Die ouens daar doen nie hulle werk nie. Ons kry self kwotasies, reël self alles omdat hulle dit so verskies maar op*

> *die ou end is hulle die ouens wat die hele proses stop oor hierdie* policy *of daardie reël. En die ergste is, een keer word die* policy *tot op die letter toegepas en die volgende keer glad nie. Dit hang net af wie jy is en hoe hulle op daardie dag voel. Hulle is nie 'n* support service *nie! En dis ook nou nie dat hulle tekort het aan personeel nie. Hulle* staff establishment *is vol! Hulle kan nie of wil net nie die werk doen nie!"*

No direct mention was made of nursing staff shortages in the quantitative investigation of this study. However, Moodley and Bachmann (2002:395) report that understaffing in the nursing profession is a major concern with South Africa's health system – an aspect which has far reaching consequences on the quality of care provided to patients. Pillay (2009:6) also noted that the increase workload due to staff shortages often added additional strain to the professional nurse in the PHS, an exacerbation of a condition that may lead to indifferent attitudes to the needs of health care users. Both Mackenzie (2008:82) and Lopopolo (nd:13) indicated that PHS-based dieticians and physiotherapists respectively also found that understaffing among hospital workers (nurses and administrative support included) led to non-compliance with their prescribed treatment and the general decline of the patients' condition. This was a sentiment echoed by occupational therapists in this study.

In conclusion, staff shortages among other health care professional is a source of dissatisfaction for occupational therapists as this has a negative impact on patient care.

c) Health and Wellness at Work

Category 2:	The Work Context
Theme 1:	Work Circumstances
Related Theme 3:	**HEALTH AND WELLNESS AT WORK**

The last related theme of work circumstances entailed issues of personal safety and psychosocial well-being at work. These were grouped under the heading, Health and Wellness at Work.

(Physical health) *"Wat ek geniet van die fisies is die vordering. Dis baie lekker vir die pasiënte maar op hierdie stadium, ek word blootgestel aan baie siektes omdat ek in neurologie is - TB, Meningitis en so. Dit is vir my sleg, veral nou [*referring to pregnancy*]. Maar dis okay, ons bly by die* infection control reëls*…"*

(Emotional well-being) *"Hier, in my eie ou wêreldjie is ek gelukkig, maar daar buite is dit 'n ander storie. Mense [*referring to other occupational therapists*] is negatief en moeg en die moraal is definitief baie laag"*

(Support structures) *"Weet jy nee, ek sal nie sê daar is genoeg strukture daarvoor [*referring to assistance with emotional problems*] nie. …Ons het wel 'n* occupational health clinic *en ek moet sê die mense is in terme van fisiese probleme baie tegemoedkomend. …maar as ek dink in terme van die emosionele, dan is daar defnitief nie genoeg ondersteuningstrukture daarvoor nie."*

Although many respondents experienced negative feelings regarding the infection risk at work, most accepted it as part of their jobs and were not overly influenced by it. As a whole it seemed that the participants in this study acknowledge the risk of contracting infectious diseases at work, but did not feel that it impacted their job satisfaction adversely. With regards to emotional well-being at work the discussions of the participants all followed the same pattern. All the participants reported feelings of satisfaction with their individual psychosocial state but said that they definitely felt that a negative morale was strongly evident within the psyche of the occupational therapists as a group. With regards to the available support structures at the participants' work, the general consensus was that by means of health and safety regulations and the occupational health clinics at the institutions, the support for physical ailments

was satisfactory. Some participants did however feel that there were not enough support systems in place to assist with emotional problems.

Concerning the emotional well-being and morale of the respondents it was interesting to note that the same contradictory view emerged in both the qualitative and quantitative investigation (cf. table 4.18). Furthermore, most participants (77.14%) were in fact disstatisfied with the potential negative impact their jobs could have on their physical health (cf. table 4.19) however qualitative results showed that mostly, the participants accepted this risk as part of their working lives.

Smith and Rees (1991:293) found occupational therapists as more pressured than the majority of other health professional groups. These authors postulated – based on the result of their study – that the increased pressure experienced by occupational therapists was largely related to interpersonal relations and constant worry of perhaps being less forceful than other health care professionals, but certainly no less ambitious. Eklund & Hallberg (1999:168) found that occupational therapists working in mental health care are at greater risk of burn-out than their colleagues in different work settings However, Smith *et.al. (*1994:417) as well as Schlenz, Guthrie and Dudgeon (1995:990,991) also found the incidence of emotional exhaustion to be relatively high among occupational therapists engaged in physical rehabilitation although the occurance of emotional depersonalisation was low. Basset and Lloyed (2001:407-408) and Baily (1990a:26), identified the nature of the “ill” client, lack of professional identity, role conflict with other health professions imbalances between home and work life, lack of supervision and training as well as the risk of personal injury to be the major sources of stress among occupational therapists.

Concluding this related theme, the study showed that with regards to physical health in the work place, the occupational therapists acknowledged their feelings of dissatisfaction with disease and physical health but also accepted it as part of the job and practiced safety measures as were appropriate. The issue of emotional well-being received more attention. The occupational therapists

judged themselves to be in good emotional health as individuals but expressed dissatisfaction with the morale of the group as a whole.

4.3.4.2 Theme 2: Special privileges: Flexi-time

Category 2:	The Work Context
Theme 2:	**SPECIAL PRIVILEDGES: FLEXI-TIME**

The second theme of category two was identified as incidences or circumstances related to special privileges received while performing a certain job for a certain organisation. In the case of this study only flexi-time was mentioned as a possible special privilege.

During the qualitative investigation most participants remarked that their current working hours were satisfactory, since they did not have to work overtime or on weekends. Neither was there the expectation for them to be "on call" outside working hours.

> *"Ek is tevrede met my werksure. Ons werk nie oortyd nie en naweke is ons af. Dis ook nie soos die dokters wat op roep is nie. Dit is eintlik heel gemaklik."*

Some participants did however express interest in the suggestion of working flexi-time[3].

> *"Dit sal vir my baie lekker wees om halfdag te werk maar dit sal nie vir my lekker wees om 'n halfdag salaris te kry nie. Flexi-ure sal* great *wees. … dit sal lekker wees om te besluit ek gaan*

[3] It should be mentioned that the concept of flexi-time and that of job-sharing (cf. 2.3.5) are not well known concepts among occupational therapists working in the PHS and therefore comments in this regard may well have been influenced by lack of knowledge.

vanoggend werk van 8:30 tot 16:30. Of ek kom al 5:30 in en ek gaan 14:30 huis toe. Dit sal lekker wees, ja!"

Quantitative data presented earlier in this chapter (cf.table 4.16) showed that over half of the occupational therapists (60%) felt that flexi-time would increase their job satisfaction moderately to a lot. These results and findings seem to concur with those of other occupational therapy studies. Hellickson, Knapp and Ritter (sa:297) found that school-based occupational therapists reported higher levels of job satisfaction than their hospital-based colleagues and postulated that this was mainly due to the flexible working schedules of school-based occupational therapists. Similarly, Caceres-Rodriguez and Ryu (2010:15) also found flexible working schedules to be the most important variable of family friendly work benefits and continued to state that flexi-time is condusive to job satisfaction in a female-dominated profession – as was indeed the case with the occupational therapists in this study.

In summary of this related theme it can be said that in general the occupational therapists working in the PHS of the FS are satisfied with their work hours. Flexi-time is classified as a source of satisfaction which in the case of this study, decreased job satisfaction as it was not currently an available option. The participants also seemed intrigued with the idea of working flexi-hours but did not consider half-day work financially viable. Flexi-time may well serve as another factor to decrease job dissatisfaction.

4.3.5 Category 3: Rewards

The third category that emerged from this study incorporated facets of job satisfaction linked to incidences or circumstances that are perceived as rewards. In this study, discussion on different facets of rewards included the salary paid, fringe benefits, the opportunity to be promoted, income and job security as well as performance appraisal systems. These facets were grouped into four themes:

- Theme 1: Remuneration
- Theme 2: Promotion
- Theme 3: Security
- Theme 4: Recognition.

4.3.5.1 Theme 1: Remuneration

Remuneration referred to the package of financial and subsidiary benefits the occupational therapists received as government employees. In this study two distinctive parts of the remuneration benefit were identified. The first was the salary the participants received and the second the fringe benefits. In their case, fringe benefits were synonymous to medical aid subsidy, pension benefit, leave benefit, housing subsidy and scarce skills allowance. Issues on remuneration were consequently divided into two related themes:

- Related theme 1: Reasonable Salary
- Related theme 2: Fringe Benefits

a) Reasonable Salary

Category 3:	Rewards
Theme 1:	Remuneration
Related Theme 1:	**REASONABLE SALARY**

The issue of a reasonable salary was identified as the first related theme concerning the remuneration the participants of this study received. Literature holds that workers evaluate their satisfaction with their salary based on whether they perceive it to be a reasonable reward for their efforts on the job (cf. 2.3.5) In the case of this study, the reasoning of this principle in literature rang true as participants evaluated their satisfaction with their current salary based on several aspects they linked to a reasonable reward. These were:

1. the salary's reflection of the importance of their jobs;

2. comparing their salary to that of other health professionals and
3. the effort, time and difficulty inherent in obtaining a degree in occupational therapy.

The following excerpts represent the criteria by which the participants of this study judged their salaries to be unreasonable:

> *(Criterion 1)* "*…ons salarisse is nie vir my gelyk aan wat ons doen nie, wat ons waarde is nie… dit skep die indruk dat wat ons doen nie regtig soveel sin het nie en dat ons maar net 'n minderwaardige diens lewer. "*

> *(Criterion 2) "…ons werk fisies, of sal ek sê meer aktief betrokke by die pasiënte. Hulle [*referring to psychologists and social workers*] sien die pasiënte dalk 'n uur in 'n dag. Hierso, sien ons hulle ses ure 'n dag. En ons sien 'n groter hoeveelheid van die pasiënte hier as die ander. Ons sien amper almal en hulle net sekeres. So dit maak my nogal ongelukkig, want ons kry soveel minder geld maar ons is baie meer betrokke by die pasiënte."*

> *(Criterion 3) "…ek weet nie of die salaris wat jy kry regtig weerspiëel dit wat jy geswot het, hoeveel jy ge*swot *het of die tyd en moeite en regtig vier jaar se harde werk nie. 'n Vriend van ons het 'n ander kursus geswot. Hy het deur sy drie-jaar kursus ge-breeze, 'n honeursgraad gekry na sy vierde jaar en vandag verdien hy dubbeld wat ek kry met my vierjaar B-graad. … Die een ding wat ek altyd vir iemand sê wat wil arbeidsterapie* swot *is: Doen dit vir die mense – nie omdat jy dink jy gaan baie geld kry nie want dit gaan nie gebeur nie"*

In the first excerpt, participants felt that their current salaries actually detracted from the importance of their services. This sentiment has strong ties to the overwhelming frustration occupational therapists experience with regard to status (cf.4.3.6.2). In this instance, the amount of money paid to the

participants strengthened their perception that their input is not valued and that occupational therapy is an “under-recognised” profession. The second comparison the participants made was with regard to comparing their salaries to other members of the MPT. Once again the comparison was unfavourable and participants expressed their severe dissatisfaction on this matter, often citing that they spend more hands-on time with a larger portion of the population than other members of the team. The last criterion was linked to the years of study and the effort, time and money participants spent on acquiring a degree in occupational therapy. Here, too, participants felt that their salaries were an unjust reward for the years of training they had put in, but especially so when the time, effort, sacrifices and stress that accompanied their training were considered. Most participants expressed that the prime motivation for students to become occupational therapists should be based on a love for people and definitely not on the monetary rewards of the job as these were quite insufficient.

Quantitative data revealed much the same results as the sentiments expressed above – salary elicited marked responses of dissatisfaction among the respondents (cf. figure 4.1, table 4.16). Almost 80% of the respondents were dissatisfied with their salary’s reflection of the importance of their work, while 85.71% indicated dissatisfaction with their salary’s reflection of their educational level as well as the way their salaries correlated with that of other members of the MPT.

Theoretical evidence to support these claims is strong in studies done on public servants. This report is echoed by the findings of Luddy (2005:177) who found that health workers in a Western Cape public health institution were most dissatisfied with their salaries as a facet of their job satisfaction. Furthermore, Pillay (2009:6) compared the dissatisfaction of nurses in public and private health institutions and found that although both parties were dissatisfied, the PHS nurses were dramatically more dissatisfied. For occupational therapists else-where (Freda 1992:243; Jenkins 1991:450; Baily 1990a:32; Greensmith & Blumfield 1989:391; Davis & Bordieri 1988:594) the results were consistent with those gained in this study, in that dissatisfaction with pay sometimes resulted in

overall job dissatisfaction. However, in these studies the salary dissatisfaction was not as an important facet of job dissatisfaction as facets such as lack of promotion, the poor status of the occupational therapist, case overload, poor balance between work and home life or total disillusionment with the profession. Once again the South African context seems to be the reason for the variance in the result of this study as The Health Science Research Council reported that earning a high income was the fourth strongest work value for South African workers but was also the area of job satisfaction with highest discrepancy in reality (HSRC 2009:2). Being of such high value, it can be argued that the heightened strength of salary as an indicator of job satisfaction for South African occupational therapists (compared to occupational therapists in first world countries) was indeed reasonable and an accurate interpretation within the context of our country.

In conclusion, the occupational Therapists in the PHS of the FS reported high levels of dissatisfaction with their salaries. Participants felt that their salaries were unreasonable based on the importance of their job as well as the difficulty level of the occupational therapy degree. Furthermore, participants found that their salaries did not compare favourably to those of other health professionals and this added to their dissatisfaction very strongly.

The classification of salary as a “dissatisfier” or “satisfier” is complex in nature due to its links to facets with the potential to increase both job satisfaction and dissatisfaction. Traditionally (cf. 2.3.1.1.2) salary is a hygiene factor which leaves it only with the potential to influence job dissatisfaction. However, in the case of this study, the dissatisfaction of participants regarding their salaries was based on value judgements such as “feeling important”, “just reward” and “being valued”. Therefore, although salary is classified as a “dissatisfier” it remains of imperative value to also see the potential increased salary can have on job *satisfaction* (cf. Chapter 5).

b) Fringe Benefits

Category 3:	Rewards
Theme 1:	Remuneration
Related Theme 2:	**FRINGE BENEFITS**

The issue of satisfaction or dissatisfaction with the fringe benefits provided by the PHS for the occupational therapist was identified as the second related theme to remuneration.

Qualitative findings yielded that when asked about the biggest advantages of working in the PHS, respondents frequently and consistently referred to fringe benefits such as leave benefits and subsidies as the biggest advantages.

> *"Kraamverlof…werksure en die medies en die pensioen, is natuurlik ook 'n voordeel. Seker een van die grootstes om in die staat te werk."*

Quantitative results showed that 88.57% of the respondents were satisfied with the fringe benefits provided by the PHS as an employer (cf. table 4.16). Pillay (2009:7) found that nurses also viewed their fringe benefits as one of the biggest advantages to working in the PHS, while Luddy (2005:118) reported that overall, health workers in a Western Cape public health institution found the fringe benefits provided by the PHS satisfying. Occupational therapy studies as a whole did not make the distinction between salary and fringe benefits, but generally reported their results wholistically under the heading "remuneration". However, Hellickson, Knapp & Ritter (sa:296) were the exceptions and reported that a higher percentage of school-based occupational therapists considered fringe benefits as a source of job satisfaction than hospital-based therapists. This result was probably due to the extensive leave benefits school-based therapists enjoyed.

In conclusion, this study's participants expressed their satisfaction with the fringe benefits provided as part of their remuneration package in the PHS. Most went as far as ranking this aspect as the top most satisfying facet of their

employment in the PHS. Fringe benefits are classified as sources of satisfaction and served the purpose of increasing the participant's job satisfaction.

4.3.5.2 Theme 2: Promotion

Category 3:	Rewards
Theme 2:	**PROMOTION**

Issues revolving around promotion were included as the second theme of category 3 - Rewards. In this study, high levels of dissatisfaction were reported regarding the prospect of being promoted.

> *"Ek is nou al vir meer as die helfde van my loopbaan op dieselfde vlak. Die enigste manier hoe ek verder kan vorder is om in* management *in te gaan. Ek het dit al probeer en ek wil dit nie doen nie…. Hulle moet 'n* career-path *skep vir ouens wat net klinici wil bly en nie* managers *wil word nie.* Management *is nie vir almal nie!"*

> *"In die verlede het ons baie meer invloed gehad. Ons was geken en ons kon ons mening lewer. Deesdae beteken ons motivering vir bevordeing niks nie. As jy gelukkig is kry jy maar die 1% verhoging (*referring to PDMS) *maar aan jou pos verander niks nie. Dit maak die personeel negatief en dit maak dat ons goeie terapeute verloor!"*

Quantitative data showed that it was the perception of the respondents that the opportunities open to them in terms of promotion were not satisfactory and also that their chances of ever being promoted were very slim (cf. figure 4.1). The quantitative investigation also highlighted that the respondents viewed promotion as a serious influencer of their job satisfaction as 85.72% reported that promotion would significantly enhance their job satisfaction (cf. figure 4.2).

It was interesting to note that the flattened career-path available to occupational therapists – and especially clinicians – was a concern for occupational therapists around the world. All studies done on the recruitment and retention of occupational named the lack of advancement as one of the prime instigators of career attrition among occupational therapists (Smith *et.al.* 1994:415; Freda 1992:243; Jenkins 1991:450; Greensmith & Blumfield 1989:391; Davis & Bordieri 1988:594). More toward the South African context, it was found that promising advancement opportunities was the most important work value of South African workers (HSRC 2009:2) and consequently of great influence on the job satisfaction of South Africans. Concurrently, MacKenzie (2008:132) found that dieticians experienced the lack of promotional opportunities available to them as the third highest reason for their job dissatisfaction locally as well as abroad. Pillay (2009:7) added to these findings by also stating that discrepancies between the career-paths available to clinical nurses and nurse managers was one of the reasons why nurses in public health institutions experienced promotion as a source of job dissatisfaction.

It would seem evident that the issue of promotion and the career-path available to the occupational therapist in the PHS is rather worrisome if occupational therapists were to be retained. The flattened career structure of occupational therapists in the PHS was at the root of the dissatisfaction with this facet. However, negotiations within the chambers of the PHS regarding occupation specific dispensation (OSD) have been completed and it is hoped that the new career-path available to occupational therapists in the PHS will alleviate some of the dissatisfaction in this regard (Vrey 2010). Here, it is hoped that along with a fair and unambiguous promotion system, an all-inclusive career-path for occupational therapy managers and clinicians alike may emerge.

In conclusion, promotion served as a source of job dissatisfaction for the occupational therapists in this study.

4.3.5.3 Theme 3: Security

The facet of security was identified as the third theme in the category of rewards. Security was discussed in terms of two facets and these were grouped as two related themes:

- Related theme 1: Secure Income
- Related theme 2: Job Security

a) Secure Income

Category 3:	Rewards
Theme 3:	Security
Related theme 1:	**SECURE INCOME**

The reality of receiving a stable and secure income was one aspect of working in the PHS the participants of this study were well satisfied with.

> *"Ek dink in die Staat wat lekker is is die stabilitiet. Dis vir my 'n voordeel. Jy weet die 15de van die maand is jou salaris inbetaal en dit gaan so wees. Dit gaan nie ophou nie. … Jy't sekuriteit, ja!"*

> *"Baie ouens hou van sekuriteit. Die wete dat jy elke maand jou geldjies sal kry. Dis nie so in privaat nie. Hulle verkies dit en dis baie keer wat hulle – en mý - hier hou."*

Quantitative results showed that in an open question (cf. annexure A:q13), four (11.4%) respondents indicated that receiving a secure monthly income was indeed one of the aspects of their jobs that they liked the most. Louw (1997:96) found the same result among psychologists working in the PHS and stated that the prospect of receiving a secure income – although potentially less in monetary value than in private practice – was one of the main reasons why some participants in his study preferred to work in the PHS. Mouton (1998:89)

concurred with the results found by Louw for psychologists but added that income security was especially attractive to young graduate psychologists who had study loans to pay off and were not yet experienced enough to to successfully practice in a private setting. These findings were also corroborated by Weeks (2007:71,76) who argued that in the PHS receiving a stable income was an advantage not found private practice and further postulated that inconsistency in income was one of the major sources of job stress for private practitioners. In occupational therapy studies the issue of receiving a secure monthly income has, to date, not been specifically addressed. Perhaps the relatively less important state of salary as a dissatisfaction source (cf.4.3.5.1a) among occupational therapists in first world countries could account for the more superficial description of the facets involved in earning a salary, which rendered a facet such as the nature of the income unnecessary to investigate.

Nevertheless, receiving a steady monthly income provided the participants in this study with a sense of security and reduced stress. This is aspect of remuneration that was a source of satisfaction and increased the job satisfaction of participants in this study.

a) Job Security

Category 3:	Rewards
Theme 3:	Security
Related Theme 2:	**JOB SECURITY**

On the issue of job security the participants felt that the chances of their losing their jobs in the PHS were relatively slim and also stated that this was one of the biggest reasons why they chose to stay in the PHS.

> *"Jy het sekuriteit in daai opsig. Jy het werk, en tensy iets drasties gebeur sal jy more nog daai werk het. Dis nie so in privaat nie, en dis waarskynlik hoekom ek nog hier [*PHS*] werk".*

> *"Ten minste weet ek dan ek het 'n werk en 'n inkomste. Dit vat bietjie van die stres weg."*

Quantitative results showed that two (5.7%) of the respondents specifically mentioned job security as an aspect of their job they liked the most (cf. annexure A:q13). Participants felt that compared to private practice, job security in the PHS, was higher and therefore a facet which lessened their work stress. Pillay (2009:7) found that although nurses in private health care settings were more satisfied than their colleagues in the PHS, there was no significant difference between the two groups of nurses' levels of anxiety with regard to job security. Similary, Hellickson, Knapp and Ritter (nd:296) also found no discrepancy between the perceived job security of school-based and hospital-based occupational therapists. However, it must be noted that in both citations above, the groups of participants were still all employed by an institution (either private hospitals or schools) and therefore not comparable to being employed in the more unpredictable working environment of private practice. The importance of job security to the participants of this study – especially at the time of the study (cf. 4.3.3.1b) – was duly noted and confirmed by the research conducted on almost 3000 South African professionals, of which 99% reported job security as their most important work value (HSRC 2009:2).

Job security was considered an advantage to working in the PHS and is classified as a source of satisfaction which in the case of this study proved to increase job satisfaction.

4.3.5.4 Theme 4: Performance recognition

Category 3:	Rewards
Theme 4:	**Performance Recognition**

Recognising and rewarding the efforts of the occupational therapists was identified as the fourth theme in category 3. In general, the participants reported moderate levels of satisfaction with recognition received from their direct managers (cf.4.3.7.1a) and high levels of satisfaction gained from the appreciation shown by clients (cf. 4.3.3.1a). However, official performance recognition, in the form of the Performance Development and Management

System (PDMS) of the PHS, was a major source of dissatisfaction for the participants in this study.

> *"My gevoel is dit bly 'n subjektiewe sisteem wat deur mense beheer word. En dan die finansiële* constraints *wat daar is maak dat jy nie werklik erkenning kan gee vir mense wat PDMS verdien, veral i.t.v bonuses, so jy moet keuses maak indien jy 'n span van drie uitstekende persone het wat vir jou werk. Maar jy moet maar jaar tot jaar keuses maak van wie die bonus gaan kry en dit is glad nie 'n refleksie op hulle werklike vermoëns en die regte resultate nie. As ek kon sou almal wat 'n verskil maak wel 'n bonus kry, so dis 'n baie subjektiewe stelsel wat aan baie beleide en riglyne en beperkinge gekoppel word. Dit dien nie die doel waarvoor dit veronderstel was nie. Dis negatief, definitef negatief!"*

> *"PDMS is 'n klug! Dis belaglik en dien glad nie doel waarvoor dit in die eerste plek ingestel is nie. Inteendeel, dit dien glad nie meer as 'n aansporing vir mense om goeie werk te doen nie. Dit veroorsaak net ongelukkigheid en konflik. Dis die heel slegste tyd van die jaar!"*

During the qualitative investigation, discussion on the Performance Development and Management System (PDMS) was engaged in with such vehemence and persistence, that it demanded being included in the study results as a related theme. This system is the official performance management system of the PHS. The system works on a rating scale where employees are allocated certain points which indicate the level of their work performance. In addition, the system is also connected to a performance bonus system that pays out percentages of bonuses to workers who performed above the norm. Qualitative data yielded that the PDMS system served as a detractor of their job satisfaction and rather than uplifting the workers, it was described as a demoralising and demotivating system. All participants expressed their dissatisfaction with the system. This was indeed the facet of the semi-

structured interviews discussed with the most expression of frustration, anger and disdain. All participants denounced the system as unjust, untrue and severely flawed.

Eight (22.9%) of respondents specifically mentioned PDMS as an aspect of their jobs they liked the least (cf. annexure A:q14). Maslin (1991:83) stated that for occupational therapists performance appraisals are exciting due to the potential to receive recognition for a job well done, however, the author warns that it is often a frustrating process that can lead to severe conflict for both clinicians and their managers. Braveman (2006:164) holds that although performance appraisal systems should indeed serve as a motivational tool for occupational therapists, it often perceived as a threat, flawed in the sense that objective feedback is difficult to attain and ineffective when financial aspects are not managed efficiently. From personal experience I can attest to the problem of being confronted with the negative impact financial constraints had on the authenticity of performance reviews i.e. being forced to change scores in order to financial directives. These financial implication of the system leads to workers not receiving an accurate and truthful performance assessment and consequently the system is decried a fallacy. It is my opinion that most occupational therapists often overachieve in the work environment due to their strong work ethic and desire to “make a difference” (cf. 4.3.3.1) in the lives of their patients. Therefore, it is reasonable to assume that a higher percentage of occupational therapists deserve a performance bonus than just the benchmark of a maximum of ten percent of personnel that is budgeted for. Often performance bonus budgets allow only for one person in a department to receive a bonus and consequently performance reviews of other staff members have to be manipulated to such an extent that it does not reflect the true performance of the employee. Both Maslin (1991:208) and Braveman (2006:164) warn that inconsistency in performance reviews leads to major dissatisfaction among occupational therapists and a system that was intended to be a motivational strategy turns into a severe source of cynicism, distrust and abhorrence .

In conclusion it was established that the participants of this study viewed the PDMS as a flawed, untruthful and unjust system. Their dissatisfaction in this regard was very high. Furthermore, the system served as a demoraliser, demotivator and an amplifier of their dissatisfaction with their work.

4.3.6 Category 4: The Employer / Employee

The employee as a facet in the calculation of job satisfaction was identified as the fourth category in this study. Two themes emerged from the qualitative interviews and comprised several incidences where attitudes, expectations and occurrences in personal lives were influenced by either promoting job satisfaction or dissatisfaction. The second aspect connected to this category was the social and professional status participants perceived that they had based on their job. These facets were grouped into two themes namely:

- Theme 1: The Organisational Structure and Climate of the PHS
- Theme 2: Status

4.3.6.1 Theme 1: The Organisational Structure and Climate of the PHS

Theme one of category five comprised of facets linked to the organisational structure and climate of the PHS. Though, by no means a comprehensive assimilation of all the characteristics of the PHS, this theme highlights some facets of the organisation that have become salient issues to the participants of this study. Three related themes were identified from the qualitative data:

- Related theme 1: Policies
- Related theme 2: The Public Image of the PHS
- Related theme 3: The Effects of Stringency Measures

a) Policies

Category 4:	The Employer / Employee
Theme 1:	Organisational Structure and Climate
Related theme 1:	**POLICIES**

The policies of the PHS and the implementation of these policies emerged as the first related theme regarding the organisational structure of the PHS.

During the qualitative inquiry participants clarified their ambiguity regarding the policies of the PHS by repeatedly stating that although they were indeed satisfied with the policies as they are written on paper, when it came to the actual implementation of these policies, dissatisfaction abounded.

> *"Die gondwet en die beleide waarop ons werk is uitstekend saamgestel. Dis regtig, as arbeidsterapeut – voldoen dit aan my beginsels en waardes van opheffing van die gemeenskap. Maar die uitvoering is glad nie daar nie … daar is 'n ongelooflike gaping tussen dit wat op skrif staan en dit wat toegepas word – en die feit dat van dit glad nie toegepas word nie. Dit dra definitief by tot werksontevredenheid. Dit is op skrif, dit word mondelings gesê, maar niks daarvan word toegepas nie. …dit maak my ontsettend gefrustreerd en woedend want op die ou end van die dag, lippetaal beteken niks nie!"*

One participant summed up the general consensus by saying:

> *"So eintlik vereenselwig ek my met dit wat op papier is, maar nie met dit wat gedoen word nie."*

From the findings of this study it was evident that policies were either not implemented at all or practices occurred that belied the policy altogether. This resulted in occupational therapists often feeling frustrated and angry – feelings that strongly contribute to their disillutionment with the PHS as an employer.

Pillay (2009:6) found that in reality the implementation of policies within the PHS do not meet the values of nurses working in these state hospitals. In a study done by the Human Science Resource Council, it was found that implementation of mandates – of which policy implementation was core – was a definite problem at local government level in the Department of Health (HSRC 2008:97). Louw (1997:85) states that bureaucratic organisations, such as the public service, are characterised by a profusion of policies implemented to strengthen the mechanistic vision under which it operates. However, Robbins (2001:423) argues that although policies serve a great value in aligning certain procedures within a bureaucracy to a common vision, these same policies often become a noose around the neck of the employees and when implemented inconsistently holds no more power while employees become disillusioned with the vision very quickly. This was indeed the case with the participants of this study.

For occupational therapists else where, inconsistent policy implementation often led to disillutionment (Pringle 1996:403; Bush, Powell & Herzberg 1993:932). Hasselkus & Dickie 1993:151). Concurringly, Maslin (1991:171-172) explains that although occupational therapists in general osbserve good standards of practice, inconsistent policy implementation gives rise to discontentment among occupational therapists, as these inconsistencies often impact on their ability to provide quality care to their clients. Moore, Cuirkshank and Haas (2006b:316) are of the opinion that good occupational therapy managers are responsible to implement policies consistently in order to maintain quality of care, general order and positive staff morale in their departments. However, Maslin (1991:172) though in agreement with the previous authors, warns that slavish and blind adherence to policies and procedures may lead to dissatisfaction and consequent inefficiency in the origanisation.

It is concluded that the policies of the PHS, fails in its original intention to operationalise a higher vision and work ethic in the particpants of this study. At best, participants acknowledge the worth of policies as they are presented on paper, but as predicted by Robbins (2001:423), they become disenchanted very quickly. The fact that policies are not practiced on ground level and up, serves

only as a detractor of the overall job satisfaction of the occupational therapists of the PHS in the FS and the facet served as a source of dissatisfaction.

b) Public Image of the PHS

Category 4:	The Employer / Employee
Theme 1:	Organisational Structure and Climate
Related Theme 2:	**PUBLIC IMAGE OF THE PHS**

Intermittently, participants remarked on the public image of the PHS. Qualitative enquiry into this phenomenon yielded that some participants felt that the public image of the PHS was unfavourable.

> *"Once upon a time, as iemand my gevra het waar werk ek, het ek gesê: Ek is 'n Arbeidsterapeut en ek werk in [name of hospital] in Bloemfontein. As iemand my nóú vra waar ek werk dan sê ek ek werk in Bloemfontein. …Dis amper 'n skaamheid…"*

> *"…dit voel vir my daar is niks om op trots te wees in die staatsdiens nie. Dis nou al op so punt dat ek half skaam voel om te sê ek werk vir die Departement van Gesondheid. Ek het gister met 'n dokter in 'n privaat praktyk gepraat toe sê hy: In my oë werk jy vir die Departement van Ongesondheid!" Dit was bitter sleg…"*

Most comments were made in relation to the negative press the government health service receives. As an example to illustrate the poor public image of the Department of Health (DOH), I hold up the posting of three newspaper articles (City Press, 14 February 2010) by the Treatment Action Campaign that, at the time, bemoaned the frenzy of negative media realeses on the DOH. In these articles the DOH is decried as an unhealthly institution, marked by incompetent management, financial ruin and a system that thwarts patients of life-saving care. In some cases during this study media reports such as decribed above reflected negatively the personal self esteem of the participants of this study but for the most part they didn't want to work at such an institution. Pillay (2009:2)

found that according to nurses working in South African hospital settings, the PHS (or DOH) is publically typified as being ineffective and insufficient and further found this aspect one of the main reasons why nurses preferred working in the private sector. In concurrence with these findings, Herma (2005:5) explains that the poor public image of the PHS is, among other factors, one of the strongest reasons why there continues to be an exodus of professional employees from its service.

In this study the majority of the respondents experienced low levels of organisational commitment and felt embarrassed to be associated with the PHS. This is worrisome as the negative public image of the PHS may well be the cause of occupational therapists seeking other employment settings or leaving the profession altogether. The issue of negative public image is regarded as a source of job dissatisfaction.

c) Stringency Measures

Category 4:	The Employer / Employee
Theme 1:	Organisational Structure and Climate
Related theme 3:	**STRINGENCY MEASURES**

At the time of this inquiry, the PHS of the FS was, for the second consecutive year, in a phase of financial difficulty. "Stringency measures" as they were coined, had already been employed for several months with distressing effects on the morale of the participants engaged in this study.

Most participants seemed angry as a result of the impact the stringency measures had on patient care.

> *"…die finansiele bestuur in die department is nie 'n probleem nie, maar die Departement van Gesondheid se finansiele bestuur het definitief 'n invloed [*referring to her job satisfaction*]. Op hierdie stadium is daar mos nou groot probleme finansiëel, so dit verhoed my om miskien aansoek te doen vir 'n ander pos, want daar is nou geen aanstellings nie. Of dit verhoed ook die aankope van*

goed vir die pasiënte, die verbruikbare goed, wat ons nou self uit ons eie sakke moet aankoop. En dan ook die kursusse. Dit is vir my absoluut swak, daar is vir my baie swak prioriteite in die bestuur van geld, dit is vir my baie swak hoe hulle in watter kanale geld instoot. Dit het ook 'n invloed op die pasiënte se well-being – *wat dit vir my baie sleg maak. …Hulle is vuil, hulle kan nie doeke kry nie,hulle het nie genoeg personeel om na hulle te kyk nie, ag nee, dis 'n groot frustrasie, dis wat my die meeste frustreer…dit maak my kwaad..en baie ontevrede."*

"…dis die mees frustrerenste en demoraliserendste tyd ooit in my lewe. Soos ek gesê het, bande met die kliënte word onmiddelik afgesny. Jy mag nie telefonies met hulle kontak hou nie, jy mag nie ry nie. Nee, onmiddelik voel jy jy het geen nut en waarde in wat jy doen nie. …Nou as bestuurder is dit vir my net so frustrerend want ek weet presies waardeur die terapuete wat onder my is gaan. Die mense kan nie aangaan nie, daar is geen nut hoekom hulle hier is nie. Hulle is veronderstel om die kliënte te dien. …Dit het defnitief 'n baie, ongelooflike negatiewe impak en frustrasie, glo ek, vir elke arbeidsterapeut."

Stringency measures play a large role in making occupational therapists in the PHS feel dissatisfied with their jobs. This dissatisfaction stemmed from not being able to apply for other posts or for funding to attend workshops. For the most part though, they experienced dissatisfaction as their contact with patients (cf. 4.3.3.1) was broken and their ability to "make a difference" (cf. 4.3.3.1) was greatly impeded.

The Human Science Research Council, in report for the Free State Provincial Government, stated that buget constraints (stringency measures) impacted negatively on the whole heahlth system, including the need to train staff (HSRC 2008:99). Lombaard (2010:1) explained this negative impact by reporting that the massive cost-cutting drive employed by the DOH resulted in suppliers not being paid, medicine shortages, staff shortages, posts being frozen and most of

all the general decline patient health status. All of these accusations were echoed by the participants in this study and caused them to feel angry, frustrated, demoralised and very dissatisfied.

Due mainly to the negative impact of stringency measure on the quality of patient care and opportunities for continued professional development, stringency measures are classified as a source of job dissatisfaction.

4.3.6.2 Theme 1: Status

Category 4:	The Employer / Employee
Theme 1:	**STATUS**

The social and professional status derived from being an occupational therapists and practicing occupational therapy was the only theme identified as important to the employee. This theme encapsulated both social and professional status as it emerged that participants observed their status based on several criteria.

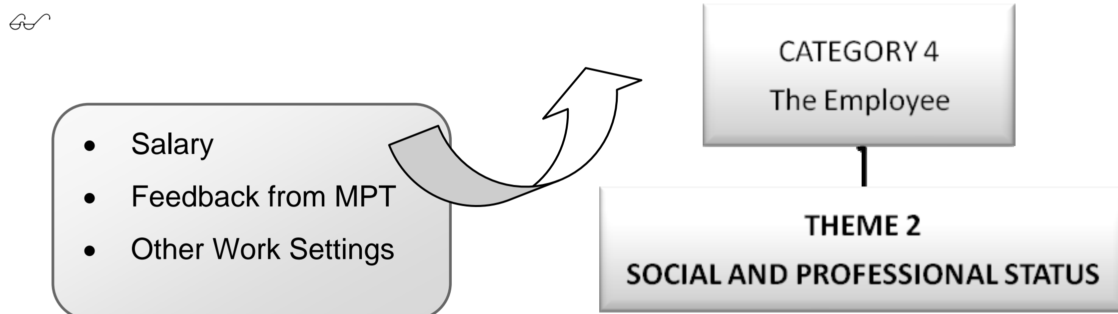

Figure 4.4 Criteria for Judging Social and Professional Status

Figure 4.4 presents a visual illustration of all the criteria (spectacles) the participants in this study used to determine the status they currently have.[4] These three criteria were:

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[4] Note that these influence are not separated into related themes as they are extensions of the same facet namely status. The participant's perceptions of their status were based on different

1. Salary and its reflection of the importance (status) of their job.
2. How occupational therapy is viewed by other team members and top management.
3. Comparing the perceived and experienced status of the occupational therapist working in the PHS to that of an occupational therapist working in another setting, in this case, private practice.

The following excepts represent the criteria by which the participants of this study judged their status to be unsatisfactory:

> (Criterion 1) *"…ek ervaar nie daardie respek wat ons moet hê nie. En mens sien dit van ons* management [referring to hospital management] *af. Dis eers die susters en dan die dokters en miskien aan die einde, arbeidsterapie. Ons goed is heel laaste op die prioriteitslys. Dit is sleg, want ons verdien dieselfde respek. …Een plek waar mens dit maklik kan sien is met ons salarisse. Die geld wat ons kry weerspiëel definitief nie die waarde van wat ons elke dag doen nie. Inteendeel, as mens dit vergelyk met ander* health services*, beklee ons maar die laagste posisie…"*

> (Criterion 2) *"…volgens hulle (other team members) is ons nie* critical care *nie en dit beteken net dit sal* okay *wees vir hulle as ons nie hier is nie. Dis duidelik dat ons volgens hulle nie noodsaaklik is nie en ook nie belangrik nie. Dis regtig sleg want wat beteken my werk nou eintlik?"*

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criteria and therefore they are included as different facets of the same theme and not as separate related themes.

(Criterion 2) "*The other day I had a meeting with the hospital CEO about creating this employee assistance program in the hospital. He was impressed but the most important thing that should happen, he thinks, is going to be putting psychologists and a social worker on board because those are the two critical points according to him. …So, I asked him what about OT and he said:* No, we will consider them later! *So that is actually how these people think about us. We have to go through thát."*

(Criterion 3) "…*daar is defnitief die persepsie wat bestaan dat terapeute in privaat meer dinamies is as terapeute in die staat…"*

(Criterion 3) "*As jy vir iemand sê jy werk in die staatsdiens dan vra hulle altyd of wil jy nie eerder in privaat werk nie – so al asof privaat die beter opsie is"*

It was established that some participants in this study measured their status as occupational therapists by means of their salary's reflection of the importance of the job they are doing. They felt that their salary was unreasonable and unfair (cf.5.3.5.1a) and also perceived it as a slight to their professional status and consequently experienced more dissatisfaction with their jobs.

A second pair of spectacles some participants used to view their status from was the opinion that doctors, physiotherapists, social workers, nurses and hospital management had of occupational therapy. Opinion on this matter varied based on the participants experience with other team members but overall participants felt that the opinion of the MPT regarding occupational therapy was limited (cf.4.3.7.3b). Many participants did, however, reported on positive experiences with regard to the opinion team members had of occupational therapy (cf.4.3.7.3b), but still maintained that the status of the occupational therapist needed to improve. Generally, the participants felt that support for occupational therapy services from top management (hospital, district and provincial management) was severely lacking and that occupational

therapy services were not given the opportunity to be utilized to their full potential.

The last pair of spectacles emerged as a result of comparing the perceived status of private sector occupational therapists to those working in the PHS. Participants bemoaned the fact that public perception viewed working in private practice more lucrative and consequently of greater status than working in the PHS. The participants did not agree with the notion, but nonetheless acknowledged that popular opinion had a negative impact on their job satisfaction, as they were constantly forced to justify their choice to be occupational therapists in the PHS.

Quantitative data (cf. figure 4.3) showed that 97.15% of the respondents indicated that an increase in the status of occupational therapy would - enhance their job satisfaction - moderately to very much. This result identified an increase in the status as the single most likely effective factor that would enhance the job satisfaction of the participants in this study.

Research has shown that allied health professionals in general feel that their various professions lack the respect and esteem they deserve and that doctors have traditionally been seen as the epitome of medical professions, while other health services were viewed as secondary professions (Jooste 2003:68). One example is found in the study of McKenzie (2008: iii) who reported that dieticians experienced low levels of job satisfaction mainly due to poor professional image. Many occupational therapy studies have also highlighted the struggle occupational therapists experience with regards to establishing a professional identity that receives its just recognition (Bassett & Lloyd 2001:408; Griffin 1997:2; Rees & Smith 1991:239). The aforementioned authors stipulate that the role of the MPT in valuing the occupational therapy is critical in establishing a secure professional identity. Occupational therapists world-wide lament their lack of status (Moore, Cruikshank, Haas 2006a:23) citing that occupational therapists believed their status to be low primarily because clients, the MPT and top management were not knowledgeable and/or appreciative of the occupational therapist's role. Concerning the comparison between the

status of PHS employees versus those of other work settings, research studies in occupational therapy is largely absent. Nevertheless, Helllickson, Knapp & Ritter (nd:295) found that school-based occupational therapists believed their status to be slightly higher than hospital-based occupational therapists due to the perception that school environments were more attractive than public health institutions. Similary, Pillay (2009:5) found that nurses in private hospital settings enjoyed greater social status than their colleagues in the PHS. In this case the reasons were: improved work safety in private institutions, reduced workload, better career-development opportunities and higher satisfaction rates with regard to hospital management.

Status is classified as a source of job dissatisfaction and was also highly dissatisfying to the participants in this study.

4.3.7 Category 5: Role Players Within the PHS

The fifth category identified from qualitative data revolved around agents or circumstances related to factors inside of the PHS (cf.2.3.5) that had an influence on the participants' overall job satisfaction. Three themes have been identified under this category:

- Theme 1: Management
- Theme 2: Colleague relationships
- Theme 3: Multi-professional team

4.3.7.1 Theme 1: Management

The firstt main theme identified as a role player inside the PHS was the role of management and the manager on the job satisfaction of the participants. The qualitative inquiry yielded considerable discussion on the topic of management. A distinction was made between the participants' feeling regarding their direct manager and those regarding top management. Therefore, the theme was divided into two related themes:

- Related theme 1: The Direct Manager
- Related theme 2: Top Management

a) The Direct Manager

Category 5:	Role Players Within the PHS
Theme 1:	Management
Related Theme 1:	**THE DIRECT MANAGER**

Most participants expressed their satisfaction with and in some cases their appreciation of their direct manager. Participants based their assessment of their manager on the quality of the relationship they had with them. The following was a typical response from participants:

> *"Ek het 'n baie goeie bestuurder. Ons het 'n baie goeie verhouding"*

These findings are supported by the empirical (quantitative) results of this study, which showed that 82.35% of the respondents respected their manager, while 77.14% reported to having a good relationship with their direct managers (cf. table 15; table 4.18). Moore, Cuirkshank and Haas (2006b:314) state that the relationship that developes between the manager and the occupational therapist is predictive of the job satisfaction occupational therapists will experience in this facet. This is congruent with literature on the role of the manager with regards to the job satisfaction of employees, which concurs that the manager-employee relationship is directly associated with employees' perception of their job satisfaction (Stephen 2001: 325, 545; Saal & Knight 1988:297; Spector 2000:199; Siegel & Lane 1982:333). As empirical results proved that the participants in this study had positive and supportive relationships with their managers, it is assumed based on literature that this facet added to the job satisfaction of participants in this study.

The findings of this study also yielded itself to the identification of some traits in managers the participants found positive and negative. Undesirable traits were

mostly related to managers taking an indifferent attitude to the participant's individual need for feedback, a lack of interest and investment in the participant as a person and poor management of conflict by the manager. These views were reflected as follows.

> *"… my hoof se terugvoer oor my* performance *frustreer my so bietjie. Ons kry nie regtig terugvoer nie. As jy iets goed of sleg gedoen het, dit sien jy maar self. Ons kry dit nie van ons bestuurder nie. So, dit frustreer my partykeer, maar ek moes ook nou al leer om* fine *te wees daarmee."*

> *"Sy [*manager] *is 'n wonderlike administratiewe hoof, jy hoef nooit te wonder waar iets is nie, maar, vir my as persoon, insette om persoonlik te groei is daar nie regtig nie. Dis nie haar ding nie. Mens leer maar om daarmee te* cope"

> *[*on discussing conflict with the manager*] "…Nee, ek is doodeenvoudig te bang! Daar was al konflik tussen ons, daar was al meningsverskille maar ons hoof ignoreer sulke goeters of sy ignoreer jou totdat dit oorwaai of totdat jy nou maar aanvaar daar gaan niks aan gedoen word nie. … Ek oorleef met dit, dis nie vir my* okay *nie, maar ek oorleef daarmee."*

In summary, the reasons supplied for dissatisfaction with a manager were:

- Restricted opportunity for clinical autonomy
- Not receiving enough feedback on performance
- No input by the manager to promote personal growth
- Not handling everybody in a consistent and fair manner
- Poor conflict managements skills

These findings are substantiated by empirical evidence gathered in this study that showed that participants were mostly dissatisfied with their managers'

conflict management skills (cf. table 4.15). Moore, Cuirkshank and Haas (2006b:315) found favouritism, letting personal feelings interfere with professional judgement and an unwillingness to perform clinical duties to be additional undesireable traits of occupational therapy managers. Robbins (2001:382) holds that managers who are not proficient in the management of conflict, those who employ nepotism and favouritism and those who lack effective communication skills are generally viewed by employees as ineffective managers and these behaviours often lead to extensive periods of conflict, frustration and low organisational commitment.

Most comments by participants who did feel satisfied with their current managers also revealed some characteristics they experienced as being positive. The following excerpts attest to this:

> *"Researcher: Jy sê van die positiewe apekte is jou bestuurder. Kan jy vir my meer vertel oor hoe sy jou bestuur en hoe dit jou laat voel?*
>
> *Participant: Ek dink sy probeer elke keer die beste uit elkeen kry en om almal te akkomodeer. En dan verder dink ek sy is baie regverdig, sy hanteer almal dieselfde en sy probeer almal, hoe kan ek sê, nie gelukkig hou nie, maar sy is nogsteeds eties, objektief en professioneel daarmee."*
>
> *" Sy [manager] is ondersteunend. Sy doen moeite om op hoogte te bly met wat in die department en die hospitaal aangaan. …Dinge word dadelik hanteer en deurgevoer na die regte kanale waar daar aandag aan gegee moet word."*
>
> *"…hulle [*managers*] moet goeie luistervaardighede hê, hulle moet goeie mense-vaardighede en kennis hê. Jy moet kan saamwerk as 'n span en jy moet almal saam bevoordeel en saamwerk."*

From these, and many similar comments made during the semi-structured interviews, it was clear that the participants had a definite view of what they felt positive traits of a manager were. These included:

- Acknowledging individual strengths and utilizing them within the department
- Accommodating individualism and incorporating it in the daily functions of the work
- Being consistent, fair and professional
- Providing support in whatever form necessary
- Keeping up to date with new developments
- Handling complaints, conflict and tension immediately and through the correct channels
- Being a good listener
- Promoting team work in the departement

The quantitative results of this study also showed that aspects such as receiving support and recognition from managers, self-management opportunities and an interst in the respondents' personal life was highly valued (cf. table 4.15). The findings of Moore, Cuirkshank and Haas (2006b:314) are concurrent with the findings of this study as they also highlighted approachability, consistency, encouragement, advocacy, good communication and dedication to policy development as desireable traits of an occupational therapy manager.

In conclusion of this related theme, it can be said that the majority of the participants of this study were satisfied with their current direct managers. The role of the direct manager in job satisfaction serves as a source of satisfaction which in the case of this study worked positively toward decreasing job dissatisfaction among the occupational therapists.

a) Top Management

Category 5:	Role Players Within the PHS
Theme 1:	Management
Related Theme 2:	**TOP MANAGEMENT**

Although the participants of this study reported satisfaction with their direct managers, this was not the case when they spoke about top management. For the purpose of this study the concept "top management" was described based on the participant's perception that it involved all managerial structures higher than their direct managers.

Qualitative data revealed that most participants felt that top management had a decidedly negative influence on their job satisfaction. This sentiment was articulated as follows:

> *"…baie keer, as ek met my mense praat, kan ek nou al vir jou sê, hulle sê, as arbeidsterapeute werk ons almal regtig lekker. Maar, sodra jy moet uitbeweeg en met die stelsel moet werk, met die* management-*sisteem, sjoe dan raak jy moeg, dan is jy op!"*

The aspect of top management was not investagted in the quantitative section of this study. It was a distinction that emerged from the qualitative discussions once again proving the advantage of using multiple methods in investigating a complex phenomenon such as job satisfaction. Nevertheless, theoretical evidence for the participants' dissatisfaction with top management is rife. Underqualified hospital managers are one of the most important challenges facing the PHS currently (Parliamentary Monitoring Group Report on 2010-2013 strategic plan for the DOH 2010:6). Cullinan (2005:11) asserted that poor management in the PHS was the sole cause of exacerbated job dissatisfaction among its employees. Pillay (2009:6) found that while private sector nurses were well satisfied with top management in their organisations, public sector nurses expressed great dissatisfaction with the top level managers in the PHS.

The issue of top management's poor knowledge and recognition of the scope and importance of occupational therapy seemed to be at the core of most participants' – especially the occupational therapy manager's – perception that their top management was unsupportive of their service (cf.4.3.7.1b). In reviewing these findings, it was found that this perception is often confirmed and compounded by having to repeatedly motivate why procurement of certain equipment and material was necessary (cf.4.3.4.1a), inconsistency with policy implementation (cf.4.3.6.1a), lack of resource support for projects (cf.4.3.4.1a), failure to appoint occupational therapy personnel (cf.4.3.7.1b) and perceived low salary (cf.4.3.5.1a).

This facet is classified as a dissatisfier and in this study, and added to the growing dissatisfaction of the occupational therapists in this study.

4.3.7.2 Theme 3: Colleague Relations

Category 5:	Role Players Within the PHS
Theme 2:	**COLLEAGUE RELATIONS**

The third theme identified as a role player inside the PHS was that of relationships with colleagues in the occupational therapy department. The nature of the relationships between colleagues was investigated with regards to quality, its impact on job satisfaction, communication, support and the importance thereof.

During the semi-structured interviews, all the participants remarked on the relationships they had with their colleagues in the occupational therapy department. Most participants reported that they were satisfied with the current state of the relationships.

> *"Ons terapeute kom goed oor die weg. Ons help mekaar, leer bymekaar en groei almal saam. Ons is eintlike meer vriendinne as kollega's."*

"…ons (occupational therapists) kan teenoor mekaar afpak en ons kan kla en kerm en as ons na ons eie area toe teruggaan, dan voel ons sterker."

For most participants, being happy at work seemed closely knit to the quality of the relationships that existed between themselves and their colleagues.

Empirical data from the quantitative study supported these findings (cf. table 4.1; table 4.17) as 80% of the respondents reported feeling satisfied with the relationship they had with their co-workers. Theoretical evidence in support of these findings is abundant in job satisfaction studies done on most health professions. Luddy (2005:116) found that employees at a public health institution in the Western Cape were the most satisfied with their relationships with co-workers while King (1995:35) found the same result among social workers. Likewise, Louw (1997:99) concluded that job satisfaction among psychologists working in the PHS was positively influenced by supportive relationships with co-workers. Occupational therapy studies have consistently reported the similar results to those found among other health professions (Smith-Randolph, Doisy & Doisy 2005:5; Pringle 1996:403; Jacobs 1994:11; Bush, Powell & Herzberg 1993:932; Hasselkus & Dickie 1993:151; Davis & Bordieri 1998:594).

Other than merely being satisfied *with* the relationships, many respondents also reported that these relationships often serve as a source to derive satisfaction from, i.e. being satisfied not only with the relationship but also *by* the relationship.

*"Die verhoudings tussen ons [*occupational therapy collegues*] is eintlik maar wat ons aan die gang hou. Dis eintlik maar die rede hoekom ek na 'n slegte dag nogsteeds tevrede kan wees met my werk…dít, en die pasiënte."*

*"Ek dink dis eintlik die groot ding waaroor die hele ding [*relationships at work*] gaan. Dit is die top een belangrikste ding*

vir my. Ondersteuning is die heel belangrikste deel. As dit nie daar is nie, verloor jy mense!"

Quantiative data from this study once again supported these findings, as relationships with colleagues was rated the fourth strongest indicator of job satisfaction among the participants in this study (cf. table 4.2). Helickson, Knapp & Ritter (2009:296) found that colleague relationships were second only to "client contact" as the top source of job satisfaction for occupational therapists in both school-based and hospital settings – yielding an even stronger potential for colleague relationships to influence the job satisfaction of occupational therapists. Once again, other health care practitioners also viewed their co-workers as a source of job satisfaction. For example, among nurses in both private and public health care settings, Pillay (2009:5) found that colleague relations were deemed a very positive influence on their job satisfaction. Many occupational therapy researchers have continued from this stance to suggest that nurturing supportive relationships among co-workers may yet serve as one of the most effective retention strategies occupational therapy managers could employ (Smith *et. al.* 1994:416; Freda 1992:243; Jenkins 1991:450; Baily 1989b:36).

In conclusion of this theme it was found that the occupational therapists in this study experienced high levels of satisfaction with their colleague relations. Many reported that the nature of relationships at work is of top priority to them and that it has a most significant influence on their job satisfaction. This aspect may serve as a satisfier and when viewed positively – as was the case in this study – holds the potential to increase job satisfaction.

4.3.7.3 Theme 4: The Multi-Professional Team

The last theme as a role player inside the PHS was that of the Multi Professional Team (MPT). Mainly two aspects emerged as relevant to this theme and were grouped into two related themes.

- Related theme 1: Contact with the MPT

- Related theme 2: MPT's Knowledge of the Science, Role and Value of Occupational Therapy.

a) Contact with the MPT

Category 5:	Role Players Within the PHS
Theme 3:	The Multi-Professional Team (MPT)
Related theme 1:	**CONTACT WITH THE MPT**

The first facet that emerged from qualitative data regarding the MPT was that of team contact.

Qualitative data showed MPT contact tot be of great importance to the participants.

> *"…wat bydrae tot my werksbevrediging sal eerstens wees, ek werk saammet 'n baie goeie multi-professionele span op hierdie stadium. Dit is vir my 'n baie bevredigende deel van my werk, want ek kry die terugvoer wat ek nodig het van die span. Hulle sien arbeidsterapie in die lig wat dit gesien moet word, en hulle verwys goed. Ek het baie goeie verhoudings met die dokters, so dis vir my op hierdie stadium baie positief. Dit was nie van die begin af so nie, maar dit as gevolg van 'n pad wat ek saam met hulle gestap het."*

Another participant who was not having sufficient contact with the MPT explained the impact of poor MPT contact as follows.

> *" Wat vir my erg is, is ons het geen saalrondtes of geen multi-dissiplinêre kontak nie. Dis vir my 'n baie slegte deel van my werk. Ek moet leer, ek is aan die begin van my professie maar ons het nie die geleentheid om by ander [*MPT*] te leer nie."*

Although the questionnaire did not specifically assess the role of MPT contact in the job satisfaction of the questionnaires, four (11.4%) participants did report that contact with the MPT was one of the most satisfying experiences of their jobs (cf. annexure A:question 13). However, eight (22.9%) participants reported insufficient contact with the MPT as one of the aspects of their jobs they liked the least. Althogether twelve (34.4%) of the respondents felt the facet of contact with the MPT of such importance that they spontaneously made mention of it. In the cases where contact with the MPT was sufficient, it added to the job satisfaction of the respondents whereas in cases where MPT contact was not sufficient it caused dissatisfaction for the respondents. These quantitative results support the findings of the qualitative inquiry of this study.

Furthermore, theoretical evidence supporting the claim that having sufficient and positive contact with other members of the health care team can be found in most studies conducted on the job satisfaction of occupational therapists. Jacobs (1994:992) found that interaction with the MPT elicited positive experiences of flow for occupational therapists. Both Baily (1990a:24) and Smith-Randolph, Doisy and Doisy (2005:3) agreed that positive interaction with team members contributed to occupational therapists' job satisfaction. However, as was seen by the results and findings of this study, Pringle (1996:404) warned that if interactions with the MPT were not successful, occupational therapists may well experience this facet as a threat to their job satisfaction. Moore, Cruikshank and Haas (2006a:23) concurred and specifically mentioned the lack of knowledge regarding occupational therapy among other team members as the prime reason why MPT contact is often dissatisfying.

It was established that contact with the MPT was of great importance to the participants. Those who received sufficient opportunity to engage with the MPT reported high levels of job satisfaction while those who had little or no opportunity contact with the MPT expressed their dissatisfaction with the matter. This facet is considerd a sourse of satisfaction that in some cases worked to promote job satisfaction and in others decreased it.

b) MPT's knowledge of the science, role and value of occupational therapy.

Category 5:	Role Players Within the PHS
Theme 3:	The Multi-Professional Team
Related theme 2:	**KNOWLEDGE OF MPT ON THE SCIENCE, ROLE AND VALUE OF OCCUPATIONAL THERAPY**

The knowledge of the MPT with regard to the science, role and value of occupational therapy was the second related theme to that of the MPT. During the qualitative inquiry, participants expressed their concern regarding the lack of knowledge the MPT had on the subject of the science, role and value of occupational therapy.

> *"…daar is van die ouens [*referring to the MPT*] wat goed ingelig is, wat besef wat die waarde van die dienste is en wat baie pro-arbeidsterpie is en die diens hoog aanskryf. Maar die meeste weet nie wat ons doen nie. Hulle sien nie die wetenskap raak nie en dink ons hou pasiënte besig. …mens kry dit baie op die verwysings…"*

> *"…it becomes so worrying at some point when you realise that other professionals don't see the need for OT or don't understand what we are doing. So you end up not getting that cooperation or support that you need because they do not see your service as important. There's that reluctance to refer…and a lot of patients get lost because we do not get a chance to make contact with them."*

> *" Die span weet nie altyd wat die arbeidsterapeut se rol is nie. Miskien is dit waar òns faal. Ons moet hulle inlig en ons beroep bemark. Dis al manier hoe hulle die waarde van arbeidsterapie gaan besef, dit en ook as al die terapeute goeie werk doen."*

Quantitative results revealed that three (8.6%) respondents noted that the negative attitude of other members of the MPT concerning occupational therapy

was one of the aspects of their jobs they liked the least. Qualitative findings clarified that this dissatisfaction stemmed from the perception that the MPT suffered from a lack of knowledge regarding the science, role and value of occupational therapy. Hasselkus, Allen and Dickie (1993:150) reported the same perception among occupational therapists in Wisconson and added the following verbatim report that explained the effect of this facet on the job satisfaction of occupational therapists: "…being in an environment where you're either hitting your head against a brick wall or trying to justify your existence is depressing." Occupational therapists in Australia also voiced their dissatisfaction with the knowledge MPT members had of occupational therapy (Moore, Cruikshank & Haas 2006a:23) and reflected that the poor attitude of MPT members could be seen in inappropriate referrals, MPT members not understanding the relevance of the name "occupational therapy" and a general lack of respect for the impact the profession makes on the lives of patients. Concurrently researchers in the field such as Baily (1990a:24), Davis and Bordieri (1987:594) and Brown (1998:566) have all found the lack of understanding for the profession of occupational therapy to be a major source of dissatisfaction and even more potently so for male occupational therapists (Rider & Brashear 1988:233).

It was established in this study that the poor knowledge of the MPT regarding occupational therapy served as a source of dissatisfaction for the the participants of this study. Furthermore the dissatisfaction is exacerbated by perceived lack of respect for the profession, inappropriate referrals and poor appreciation of the value of the occupational therapist's input. This facet is considered a source of dissatisfaction and in the case of this study, promoted job dissatisfaction.

4.3.8 Category 6: Role Players Outside of the PHS

The final category identified as having a link to the job satisfaction of the participants was that which encompassed role players outside of the organisation. Only two major themes emerged from this study and were almost in its entirety discovered through the qualitative investigation. These were:

Theme 1: Clients and Community
Theme 2: Language and Culture

4.3.8.1 Theme 1: Clients and Community

Category 6:	Role Players Outside of the PHS
Theme 1:	**CLIENTS AND COMMUNITY**

The first theme identified as a role player outside of the PHS was that of the client and the community the participants worked with. Mainly two concepts emerged from this theme namely, the awareness and knowledge of occupational therapy among the community and secondly, clients' attitude toward non-compliance with treatment.

In the first instance, participants felt that the communities they worked in did not fully understand the role of the occupational therapist and as a result could not utilize occupational therapy services optimally. One participant reported the following:

> *"…but, out there, the guys don't know what it is that we do. At the most, they confuse us with a doctor or a nurse. They don't know. How can they then come to us for help? It is only once they have experienced OT that they come to understand what we do."*

Quantitative data revealed no results specifically regarding the clients' knowledge of occupational therapy. Also, it was then interesting to note that no other studies on the job satisfaction of occupational therapists made specific mention of clients' lack of knowledge regarding the role of occupational therapists. Studies of the attrition of occupational therapists from the profession did however mention that role conflict with especially physiotherapy was one reason why some occupational therapists left the profession (Baily 1989:25). However, although clients' inability to distinguish between the two professions may well have been a source of frustration for the occupational therapists in the

afore-mentioned study, these findings were not clarified and therefore the assumption cannot be made. However, based on the overall results of this study regarding the participants' distinct and consistent perceptions that the profession of occupational therapy is misunderstood (cf. 4.3.7.3a, 4.3.7.1b, 4.3.6.2), the clients' contribution to this perception cannot be ignored.

Secondly, the participants also expressed some frustration with patient's defaulting from therapy or in some cases becoming non-compliant due to psychosocial or socio-economic reasons, such as a lack of motivation, poverty or poor education. One participant related the following case to portray her feelings with regards to patients who default from therapy.

> *"Dit gebeur baie dat pasiënte net nie terugkom nie, of as hulle terugkom vir buite-pasiënt afsprake is hulle vol druksere en begin die kontrakture klaar vorm. Dis daai dae dat ek wonder wat ek nog moet doen. Ek verstaan die mense kry swaar ek kan nie elke week inkom nie. Dit bly maar 'n moeilike saak… dan voel mens nie altyd of jy regtig iets regkry nie"*

Qualitative data yielded no result specifically pertaining to patient default. However, the importance the respondents attached to attaining success with clients was well reflected in the 91.43% who reported that successful patient treatments was their most important indicator of job satisfaction (cf. table 4.2). Once again, though, research studies on the occupational therapists' job satisfaction are vague about the role of the client with regards to patient default. However, it would seem that once again the participants' needs to "make a difference" (cf.4.3.3.1) is negatively influenced by circumstances, in this case, patients who default. As explained in the beginning of this section, all facets adversely affecting the participants' ability to have successful treatments of patients would no doubt have a negative influence on their job satisfaction.

In closure of this theme it was established, based on qualitative data that clients and communities' poor knowledge of occupational therapy impacted negatively on the job satisfaction of the participants as these people could not fully utilize

and benefit from their services. Secondly the occurrences of patients defaulting limited that participants' experiences of attaining success and making difference which consequently also impacted negatively on their overall job satisfaction. These client factors were classified as sources of dissatisfaction.

4.3.8.2 Theme 2: Language and culture

Category 6:	Role Players Outside of the PHS
Theme 2:	**LANGUAGE AND CULTURE**

The last theme in this study was one that appeared first due to the insight of a reviewer in the pilot study and secondly, mainly to intermittent comments made by some of the participants in the semi-structured interviews. This was the issue of language and cultural differences between the therapist and the client.

At this stage it must be mentioned that the absence of discussion on client context was rather striking throughout the entire study. At first even I overlooked this aspect of our work, which in recent times has become highly prevalent. To further accentuate this hole in our perceptions even further, only once, in all of the interviews, did a participant refer to the issue of cultural aspects spontaneously[5]. This was also the same participant who acted as the reviewer of the pilot study and recommended that culture be included in the study.

> *".. en wat dit partykeer moeilik maak is as ons nie met die pasiënte in hulle eie taal kan praat nie. Dit keer dat jy regtig deurdring na die pasiënt toe."*

[5] The inclusion of language and culture as a theme was not made due to its prominence in the semi-structured interviews but rather to the contrary. However, it was felt that this aspect should be included in the results of this study to highlight its absence in the interviews and therefore draw attention to an aspect the occupational therapist working in the PHS of the FS desperately needs to attend to in order to become responsible practitioners, but also to circumvent this facet from becoming a negative influence of this/her job satisfaction.

At best, the participants were prompted into commenting on the difficulty they had with giving instructions or administering a test with someone in a language other than their own.

Quantitative data showed that only 20% of the respondents were satisfied with their ability to communicate effectively in the home language of their clients. However, according to Wittman & Velde (2002:456), cultural competence moves beyond sensitive therapists to practitioners who are truly knowledgeable about their own culture and that of their clients. The question arises, however, that if the only reference to cultural aspects was made on language, have the occupational therapists in the PHs of the FS even attained the level of cultural sensitivity?

One may rightfully ask whether the issue of cultural competence is of any relation to the job satisfaction of occupational therapist. At first glance the issues do seem only distantly related. However, considering the impact cultural competence has on attaining success with clients (Awaad 2003:360), being a culturally competent occupational therapist becomes a crucial facet in securing true job satisfaction.

Even though some participants' inferred their comprehension of, for the most part, financial limitations of their clients, the relevance of cultural context in areas such as treatment compliance, attaining success with patients, making a difference, the relevance of the profession of occupational therapy and even professional status was not drawn. Being ignorant of these influences does not bode well for the occupational therapists in the FS and may well one day become a prominent cause of feeling dissatisfied with their jobs.

In summary of this theme then, it can be said that in so far as cultural competence is concerned, the only focus of the participants was dissatisfaction with being able to communicate effectively with clients who did not speak language they themselves understood. This level of cultural sensitivity is quite inadequate when dealing with such a diverse population such as South Africans

and may therefore become a definite threat to successful encounters with clients and consequently the job satisfaction of occupational therapists.

4.4 SUMMARY

This chapter presented the results of this study in two sections. The first section dealt with quantitative data while the second provided a detailed description of facet job satisfaction as gained by means of qualitative inquiry.

It was established that the overall job satisfaction status of occupational therapists working in the PHS of the FS was low. This was in answer to the first aim of the study (cf. 1.3.1.1).

It was further found that the PHS as employer, the work environment and recognition/rewards (including salary) were the top three grouped topics the occupational therapists were most dissatisfied with. Relationships with colleagues, the working self and occupational therapy as a career were the top three grouped topics the occupational therapists were most satisfied with. These results and findings were consistently confirmed between quantitative and qualitative data. Thus, the common factors influencing the job satisfaction of occupational therapists in the PHS of the FS were identified and described - as was the second aim of this study (cf. 1.3.1.2).

The third objective (cf. 1.3.1.3) of this study namely, exploring the perceptions and meanings the occupational therapists of the FS attached to different facets of their job satisfaction, was reached by means of providing in-depth and detailed descriptions of the participants' views on six categories of qualitative findings. It was found that in category one, client contact and the chance to "make a difference" were the strongest sources of job satisfaction, while aspects such as clinical autonomy and student supervision were both attractive facets of the job. Salary (category 3), poor social and professional status of the profession (category 4), poor work circumstances (category 2) and the organisational structure and climate of the PHS (category 5) were the main sources of dissatisfaction with the job.

In answering objective 4 (cf. 1.3.1.4), namely exploring possible guidelines that may serve to enhance the job satisfaction of the occupational therapists in the PHS of the FS, this chapter presented quantitative results that showed success with patients, salary and stimulating work to be the three most important indicators of the respondents' job satisfaction. More relevantly, the participants of this study designated an increase in the status of occupational therapy, an increase in salary, a promotion, increased opportunity to work in the preferred field of passion and better resources as the top five factors that would enhance their job satisfaction significantly. Further exploration of this aim is done in Chapter 5 where the recommendations of this study are made. However, preceding the recommendations of this study is Chapter 5, the conclusion of results and findings.

CHAPTER 5
CONCLUSIONS

5.1 INTRODUCTION

In the previous chapter, the results and findings of this study were presented, discussed and interpreted. It was found that the overall job satisfaction of the occupational therapists in the PHS of the FS was low. Numerous facets influencing this dissatisfaction were identified.

It is the aim of this chapter, to assimilate the conclusion of the facet influences and to summarise the significance of these facets. This is done by arguing the conclusions of the study.

This chapter also presents the recommendations made to decrease job dissatisfaction and increase the job satisfaction of occupational therapists in the PHS of the FS.

Lastly, the limitations and value of this study is discussed followed by the closure of the study.

5.2 CONCLUSIONS

The following section of this chapter encompasses the conclusions of this study. Readers are advised that these conclusions are based on the empirical evidence gathered in this study and include the individual interpretations of the researcher.

Impact Strength

SATISFACTION

Current status in this study

+ Neutral −

HIGH level impact

- Practicing a valuable profession
- Student supervision
- Job meets career expectations

WORKING WITH PEOPLE MAKING A DIFFERENCE SUCCESS WITH CLIENTS

- Clients' knowledge of OT
- Client relapse / non-compliance with treatment / default
- Cultural competence of OT
- Knowledge of MPT regarding OT resulting in ↓ referrals

- Challenging and stimulating work
- Creativity / diversity
- Clinical autonomy
- Sufficient opportunity

CHARACTERISTICS OF OT PROFESSION

- Working in the preferred field of practice
- Client related administration

- Insufficient exposure

- Contact with MPT
- Direct Manager
- Support from OT Colleagues

RELATIONSHIPS WITH COLLEAGUES

- Emotional wellness at work

- Support systems in place in the PHS

- Work hours
- Fringe benefits
- Job security
- Stable income

ADVANTAGES OF WORKING IN THE PHS

- Flexi-time
- Long leave benefit
- Funds for CPD activities

LOW level impact

DISSATISFACTION

Impact Strength

+ Neutral −

Current status in this study

HIGH level impact

STATUS

- Salary's reflection of job importance
- Top management's view of OT
- Knowledge of MPT regarding OT
- Recognition of post-graduate qualifications

SALARY

- Reflection of importance of input
- Reflection of effort / time to acquire degree in OT
- Unfair when compared to other health professionals

- Career-path for managers

PROMOTION

- Recognition of post-graduate qualifications
- Employment equity
- Career-path for clinicians

- Policy (on paper)

CHARACTERISTICS OF THE PHS

- Stringency measures
- Red-tape
- Opportunities / time off to attend CPD activities
- PDMS
- Policy implementation
- Public image

- Sufficient OT staff
- Implementation of H/S regulations

WORK ENVIRIONMENT

- Equipment and material
- Staff shortage (other health professions)

- When sufficient (secondary / tertiary institutions) ← Office space → When insufficient (primary institutions)
- Risk of contracting infectious diseases
- Younger, less experienced OT ← Making use of own resources → Older, more experienced OT

LOW level impact

Figure 5.1: Framework of Conclusions

5.2.1 Identifying main areas of satisfaction and dissatisfaction

The results and findings of this study showed four main clusters of satisfaction and five main clusters of dissatisfaction. These clusters are presented in figure 5.1.

The four clusters of satisfaction identified in this study were:

1. “Working with people, making a difference and success with clients”.
2. Characteristics of the occupational therapy profession.
3. Relationships with colleagues.
4. Advantages of working in the PHS.

These four clusters all hold the potential to influence the job satisfaction of occupational therapists. Figure 5.1 also shows the various facets that are grouped in each cluster and illustrates the current state of satisfaction, dissatisfaction or neutrality as experienced by the occupational therapists in this study. Facets listed to the left increased the job satisfaction of the participants in this study while facets indicated to the right decreased their job satisfaction. Facets depicted in the middle, were facets that did not yield significant influence but were rather accepted by the participants.

The results and findings of this study also highlighted the continuum of the impact strength of different clusters. A cluster with high impact strength will influence the occupational therapists job satisfaction to a larger degree than factors with low impact strength. As illustrated in figure 5.1 the top cluster, “working with people making a difference and success with clients”**,** had the highest impact strength (red) in this study while the bottom cluster, advantages of working in the PHS had very low impact strength (green). The middle group of clusters, characteristics of the occupational therapy profession and relationships with colleagues had moderate impact on the job satisfaction of the participants in this study.

It is therefore concluded that as a group “working with people, making a difference and success with clients” is the strongest source of job satisfaction for occupational therapists of the PHS in the FS as well the cluster with the highest impact strength.

The five clusters of dissatisfaction identified in this study were:

1. Status
2. Salary
3. Promotion
4. Characteristics of the PHS
5. The work environment

These five clusters all hold the potential to influence the job dissatisfaction of the occupational therapists in this study. Figure 5.1 shows the various facets that are grouped under each cluster and illustrates the current state of satisfaction, dissatisfaction or neutrality as experienced by the occupational therapists in this study. Facets listed to left decreased the job dissatisfaction of the participants in this study while facets indicated to the right increased their job dissatisfaction. Facets depicted in the middle, were facets that did not yield significant influence but were rather accepted by the participants.

As was the case with the satisfaction clusters, the results and findings of this study also highlighted the continuum of the impact strength of different dissatisfaction clusters. The top two clusters status and salary had the highest impact strength (red), while the remaining three clusters; promotion, characteristics of the PHS and work environment all had moderate impact on the job dissatisfaction of the occupational therapists. No very low level (green) clusters were found in this study.

It is therefore concluded that poor professional status and unreasonable salary were the two strongest source of job dissatisfaction for occupational therapists of the PHS in the FS as well the cluster with the highest impact strength. Furthermore, it was established that all five clusters of dissatisfaction have a

significant impact on the dissatisfaction experienced by the participants and should therefore all be addressed.

5.2.2 "Making a difference": A core value for occupational therapists

The appearance of the phenomenon of "working with people" – experiencing client contact was noted with pervasive consistency throughout this study. At the beginning of this study the researcher postulated that the most common reason students apply for and choose occupational therapy as their career was because they wanted to work with people and wanted to give form to their desire to have a meaningful impact on the lives of others. The population of this study consisted of practicing occupational therapists with a wide range of years experience and yet still the central theme of their experiences of satisfaction on the job was that of working with people and making a difference.

When viewed from this light, the importance of experiencing feelings of "making a difference" perpetuates, starting as the initial motivation and continuing to be the driving force behind practicing the profession throughout the career.

At this stage however, the claim that "making a difference" is a core value of occupational therapists still needs some evidence and consequently literature was systematically invoked to further validate this claim. It is advantageous to this study that many occupational therapy researchers around the world have found it meaningful to investigate the job satisfaction of occupational therapists in their countries. These published studies gift the researcher with the opportunity to assimilate international data and consequently state that in all studies – quantitative and qualitative by nature, with diverse populations, the idea of working with people and/or making a difference was consistently found to be a strong and universal indicator of job satisfaction for occupational therapists.

Thus, it was found that working with people and "making a difference were strong sources of satisfaction for the occupational therapists working in the PHS

and when interpreted against the background of global data, the concept of "making a difference" ascends to a higher level of significance as it is and established and authentic core value of the individual occupational therapist but also as a trademark of the collective profession.

Occupational therapists live out this core value by practicing what is commonly called a "serving profession". However far from being merely servants, we engage in a multitude of work roles that enable us to serve by "making a difference". We become promoters, enablers, advocates, activists, scientists, theorists, judges, actors, idea-generators, finishers, leaders, team players, educators and sometimes even patients. These are all roles we assume to bring about the personification of an existential belief – the belief that all humans deserve the opportunity to live full, happy, balanced and equal lives. We aim to be those who "make the difference" in the existence of others. It is founded in who we are and ultimately it is why we do what we do.

However, it is the nature of our world that the abstract (e.g. core values, beliefs) only finds fruition once it becomes concrete and observable in our daily lives. Living core values are always done within a certain context – a context that is more often than not bound to a broken reality where our most noble ideals sometimes turn into our most profound disillusionments. For the participant in this study, the context was the PHS.

5.2.3 Contextualising practicing occupational therapy in a work setting

The PHS is contextualised as a governmental, state-owned and managed system that provides health care services to fellow citizens who live in poverty, who for the most part carry the apartheid-burden of limited education, who face the challenges of HIV/AIDS face on, who are handicapped or marginalized and who have nowhere else to go – in short, human beings in desperate need of the occupational therapists input and the ideal "people" to work with and to "make a difference" to in their lives. Imagine the occupational therapists' anticipation and expectation…

Reality however, does not seem to come close to fulfilling its initial promise. It was found in this study that the general job satisfaction of the occupational therapist working in the PHS of the FS was low. This was in stark contrast to other studies around the world where occupational therapists reported moderate to high levels of satisfaction with the job. It was a strange occurrence as the essence of the job remains the same no matter where occupational therapists practice. However, in considering the temporal nature of job satisfaction, the clarification for the disparity between the results of this study and those of other studies was found when reviewing the context.

The system (PHS) is encumbered with threats, brokenness and challenges that are not at all easy to address.

The PHS is a bureaucratic organization characterized by highly routinised tasks, highly formalised abstract rules and regulations, a strong hierarchy, centralised power and communication, impersonal contact between top management and those working on ground level and procedural channels all orders, requests and information must follow. In addition to this, based also on the results of this study, the PHS faces innumerable challenges with regard to infrastructure, financial aid, red-tape, public image, policy implementation, political agendas and competent management.

The question now arises as to whether the occupational therapists working in the PHS of the FS have *enough* opportunities to successful experience sources of job satisfaction such as client contact. Autonomy, creativity and feeling valuable when practicing or does the bureaucratic nature of the PHS along with the challenges of political reform and the typical struggles of a third world country suppress the potential of these satisfiers. In short, the answer is yes, not only is the system of the PHS not conducive to experiencing sources of job satisfaction positively, in most cases it focused the occupational therapists attention on those aspects that can ultimately only lead to feeling dissatisfied. This influence is better understood by some examples as they emerged from this study.

The first two examples concerns the occupational therapists need be creative and to practice autonomously.

The occupational therapists of this study reported that they were satisfied with the opportunity their current jobs provided them to experience diversity in work tasks and to use their creativity when performing these tasks. These qualitative findings were asserted by quantitative results that showed over 70% of the respondents were satisfied with their jobs' propensity to allow diverse and creative practice. However, participants remarked that at times their creative potential was restricted by the lack of resources to work with within the PHS specifically with regard to consumable materials e.g. splinting material, paints, cooking ingredients. The lack of consumables restricted their freedom to use activities in the way their creative thoughts had planned and caused several adaptive responses in the behaviour of the therapists. From here on, conversations escalated to intense descriptions of the effect of lack of resources turning what was initially a discussion regarding a facet of satisfaction into an elaboration upon why they were dissatisfied.

In congruence with their need to "make a difference" the adaptation most frequently found among these participants was that of using their own resources to compensate for the lack in the PHS. This included buying equipment and consumables from private funds, bringing their own equipment/materials to work and using their private vehicles – without compensation – to attend patients located away from their institutions. Initially it would seem that the therapists were content with using their private resources for work purposes. Their need to optimalise client contact, experiment with different therapeutic activities, attain greater success with patients by using appropriate activities and experience feelings of "making a difference" outweighed the discomfort of making use of their own funds. However, later in the career two other adaptive responses could be seen. In the first instance, therapists become disillusioned with the job, lost interest in creativity and continued by practicing in a mechanical fashion, doing only what can/must be done. In the worst cases, the disillusionment with the job becomes so severe that the therapist starts to seek other forms of employment and in some cases leaves the profession altogether.

This example shows how a facet that must essentially be considered an enhancer of job satisfaction in not only restricted by inadequacies within the PHS system but descends into a spiral of negative thoughts, severe dissatisfaction, ineffective adaptive responses and ultimately disillusionment with the profession.

The second example illustrates how the characteristics of the PHS influence another essential facet to occupational therapy practice, that of autonomous practice.

Clinical autonomy is widely published as one of the most attractive aspects of practicing occupational therapy. This was indeed also case in this study where qualitative findings revealed that the occupational therapists derive much satisfaction from this aspect of their jobs and are currently also satisfied with the opportunities they are presented with in their current jobs to practice autonomously. However when linked with decision-making privileges the satisfaction rates dropped. These lower rates of satisfaction can be ascribed to mainly two negative influences. The first is that of lacking resources in the PHS where occupational therapists' decision-making privileges regarding activity choices, rehabilitation goals and continuation of therapy is often limited due to insufficient consumable materials, equipment, transport or limited resources of the patients themselves (e.g. taxi-fare to attend therapy). The second negative influence is that of the procedures and practices within the PHS that often renders the decisions of clinical practitioners – and sometimes also those of their managers – ineffectual. Consequently, the freedoms of autonomous practice are much curbed.

Due to centralised power and communication within the PHS the majority of clinicians often feel kept "out of the loop" and respond by resisting once rules, regulations, procedures, forms, red-tape and stringency measures are imposed on them. The consistency with which the participants of this study criticised all of the aforementioned facets of their jobs was striking and the vehemence with which they talked even more so.

Through these examples it is argued that based on the findings of this study that the context in which the occupational therapists performed their duties was a major role player in the overall – unfavourable - assessment of their job satisfaction. The examples given showed that even aspects the participants were reasonably satisfied with exploded into vehement discussions on dissatisfaction once linked to the PHS as employer.

It must however also be understood that the PHS as a work context did hold some favourable – although mostly unsustainable - facets. Many respondents reported the security provided in the PHS was one aspect of their job they were very satisfied with. The surety of receiving a monthly income and relative job security seemed to sit well with most of the participants. However, based on literature and the experiences witnessed by the researcher, the phenomenon of perceived security does not eliminate the threat of either job turn-over or career attrition due to disillusionment. It is postulated that once dissatisfied occupational therapists no longer have the need for a secure income or job security, perhaps due to financial support from a spouse or more pleasing prospects in another type of job, the one facet binding many occupational therapists to the PHS or the profession will be broken and may no longer been seen as a reasonable trade-off. Also, as some occupational therapists develop new life roles e.g. child rearing, increased need for freedom or emotional well-being, if at all financially feasible, they will revisit the value they placed on a secure income and perhaps find it not as important as they used to. The advantages of working in the PHS are, at best, weak extrinsic motivators and easily supplanted by changing circumstances.

The tenuous nature of the advantages of working in the PHS along with the burdens so characteristic of the PHS are the reality in which the occupational therapists of the PHS in the FS must practice, and becomes the foremost threat to the profession as disillusionment abounds.

5.2.4 Understanding how job dissatisfaction and satisfaction develop

In the previous discussion several examples were given as to how occupational therapists become disillusioned with their jobs. Disillusionment was one of the strongest reasons participants in other studies reported feeling dissatisfied and ultimately chose to leave the profession. The concept of disillusionment is rather difficult to understand, as to some, it may imply the loss of naiveté and may therefore be viewed positively. However, for others, disillusionment represents the loss of a dream, an ideal and a purpose and may lead to a wide range of negative feelings. Such feelings instigate a process of self-doubt leading to questions such as: does what I do have any value?, am I practicing a phony career?, can people really be helped or is it just useless to even try?, did I make the wrong career choice?

In the beginning of this chapter it was postulated that "making a difference" in the lives of others is a core value for occupational therapists. Realising, or perceiving that one is in fact not really "making *enough of* a difference" (due mostly to uncooperative work and socio-economic systems), becomes a disillusionment so damaging to the occupational identity of occupational therapists that prospects such a staying at home, running a guesthouse or finding a different setting wherein to practice become all the more attractive. With each layer of disillusionment uncovered, the dissatisfaction experienced escalates up to such a point where the work becomes depressing, demotivating, and soul-destroying. Some occupational therapists respond positively by inventing creative pathways of dealing with the realities of the job while others either become mechanistic in their dealings at work or choose to pursue other pastures.

In this study dissatisfaction stemmed from one singular facet only, namely contextual factors. With the exception of social and professional status all facets that were reported to be of dissatisfaction, were directly linked to the PHS as the context in which the participants practiced their profession. A broad review these factors are; salary, promotion, recognition systems, competency of

top management, inadequate resources, procedural red-tape, physical work environment, the public image of the PHS and the effects of stringency measures.

It is encouraging to note that none of these “dissatisfiers” relate directly to occupational therapy itself and even more so when it is considered that aspects reported to be satisfactory and satisfying to the participants of this study were indeed facets considered inherent in the profession. Participants felt that their jobs’ allowed them to be creative, to “make a difference” and to practice autonomously. They also felt that although members of the MPT or top management devalued their contributions, their belief in the value of their profession remained strong. The question now arises as to how the participants support this notion of their profession being valuable and meaningful? Harmoniously the answer comes in the form of the reason why they chose the profession in the first place – the differences they see their intervention make in the lives of their clients.

The strength of recognition and validation gained from success with clients, the gratitude they express, the functionality they regain, their tears of joy due to accomplishment or even the moment of flow exuded when engaging in activity is a force so strong in the convictions of the occupational therapists that doubts regarding the worth of their profession evaporate and the focus of job satisfaction assessment immediately shifts to aspects of positivity, fulfillment, joy and satisfaction. In support of this statement Locke’s expectation theory (cf. 2.3.2.1.4) is held up when it is argued that the initial expectation of the occupational therapist (or rather student) was to experience feeling of “making a difference”. As discussed previously in this chapter it is the same expectation that stays with the occupational therapist throughout his/her career and when evidence is shown to prove the difference they made (e.g. by means of patient successes), in that moment, there immediately exists congruence between the expectation and the reality of job and feelings of job satisfaction bloom.

However, in conclusion, even though extremely powerful as a motivator, momentary satisfaction gained from e.g. patient success, cannot overrule the

constant barrage of frustrations experienced due to contextual factors – especially if exposure to these negative influences have occurred over long period of time and. It becomes apparent then that dissatisfaction overshadows satisfaction due to the consistent and frequent intrusion of dissatisfiers.

5.2.5 The unrecognized profession

It was striking to note that from the baseline data gathered in the quantitative investigation, 97.15% (n=34) of the respondents rated an increase in the status of occupational therapy as the most important factor toward enhancing their job satisfaction. This in itself predicted that discussion on the issue of social and professional status during the interviews would be important and indeed it was. Participants expressed varying levels of distress when discussing the status of their profession.

This facet was linked to many other facets in their experiences such as salary, recognition systems, and status in comparison to other allied health professions, status of PHS employees in comparison to occupational therapists in other settings, regard of top management for the importance of occupational therapy and the regard of the MPT for occupational therapy as a scientific profession. In all of these categories, all of the participants held the view that their work was unappreciated, unrecognized and devalued to the point where some expressed that occupational therapy held the lowest standing of all Allied Health Profession, even though the occupational therapists themselves viewed their profession as valuable and important. These perceptions seemed to become fact in the minds of the participants once they started evaluating and comparing their salaries to other health professionals, the effort and time it took in obtaining their degrees as well as the impact they had on the lives of their patients.

The phenomenon of the dependence of occupational therapists upon the opinion of others - to the point where the value of the profession is questioned -

is quite worrisome and does indeed warrant further investigation in order to address the collective self-esteem of the profession.

Additionally, occupational therapists' apparent inability to explain to others what they do, to act as marketers of their profession and to stand their ground among other health professionals also pleads for further investigation. The results of this study, however, were not clear as to the exact dynamics behind the need for recognition of the profession. It did however establish that the issue of social and professional status was indeed relevant to occupational therapists as both great need and a strong influence on their assessment of their job satisfaction.

The devaluation of occupational therapy as a profession awakened and supported fears in the occupational therapist regarding the future security of their profession and consequently led them to doubt remaining in the profession as well as recommending the profession to prospective students. In the case of this study, the influence of the lack of professional status contributed heavily toward experiences of dissatisfaction weighing the balance of the scale between job satisfaction and job dissatisfaction decidedly negatively.

5.2.6 The balancing scale

Overall job satisfaction is the assessment of one's general feelings of happiness and fulfillment experienced when doing the job. This assessment takes place by means of a process that involves the weighing of satisfactory experiences against all dissatisfactory experiences and arriving at a feeling of either satisfaction or dissatisfaction. This process of "weighing" brings to mind the image of a balancing scale where all favourable experiences and unfavourable experiences are collectively weighed against each other and results in the scale tipping either in favour of satisfaction or dissatisfaction.

In the case of this study the scale was tipped in favour of dissatisfaction. Quantitative data support this statement and consequently it was inferred and

deduced that the job satisfaction levels of occupational therapists in the PHS of the FS was low.

Having now established the status of job satisfaction, the focus shifts to understanding *why* the scale tipped toward the direction it did. It could be argued that one side of the scale (in this study the dissatisfaction side) was laden with more facets that elicited feelings of dissatisfaction while the other contained less experiences of satisfaction. This view would however be very limited as it was already discussed earlier in this chapter that the weight/strength of some facets regarding job satisfaction was greater than others and consequently had stronger influences on the outcome of the participants' assessments.

In addition to this distinction, another is made regarding the nature of job satisfaction and dissatisfaction. It is natural to assume that job satisfaction and dissatisfaction are opposite ends of the same continuum as the [6]*net result of experiencing job satisfaction* is the same. However when choosing *strategies to address* job satisfaction the two concepts of job satisfaction and dissatisfaction need to be viewed as separate and distinct continuums altogether. The reason for this distinction is precisely because some facets bear more weight than others – a weight that is determined by the values, beliefs, paradigms, philosophies, meanings and perceptions of the participant but also by the recurrence of the phenomenon, temporal changes (e.g. economic recession) and a multitude of other contextual influences. The reasoning now stands that if job satisfaction and dissatisfaction where approached as two ends of the same continuum, one would run the risk of implementing strategies that would address the wrong side of the scale producing only momentary relief that will not be sustained and that will in the end only lead to further disillusionment. One example of this can be found by reviewing the results of this study:

[6] In order to clarify the apparent disparity between now promoting to keep satisfiers and dissatisfiers separate, when all throughout this study the inter-relatedness of facets have been emphasised, the reader's attention is drawn to the fact that up until now, the *experiences* of job satisfaction/dissatisfaction have been discussed, while the focus in this discussion has shifted toward *addressing* job satisfaction issues and thus based on reasoning provided in this passage, the separation of facets into two distinct groups is justified.

The results of the study showed that the participants of this study experienced low level of job satisfaction. Based on the balancing scale-concept one would say that the scale was tipped in favour of dissatisfaction. From the results it is known that a lack of professional status, salary and promotion opportunities were some of the heavier negative influences on the overall job satisfaction of the participants. Also, the results of the study showed supportive colleague relationships to be positively correlated to experiences of job satisfaction. A manager may now assume that creating more opportunity for positive relation between members in the department, arranging team building sessions or encouraging supportive communication in the department could serve as a positive enhancer of job satisfaction among the personnel. This reasoning however is faulted. It rests on the assumption that increasing satisfaction experiences would automatically decrease dissatisfaction experience when in fact the problem of status is not addressed at all and consequently the momentary experience of feeling good due to e.g. the teambuilding activity is unsustainable and does not weigh enough to counteract the heaviness of the "unrecognised profession". This is a direct result of assuming facets leading to job satisfaction and dissatisfaction reside on the same continuum and in the end, these mistakes serve only to further disillusion and demotivate personnel.

However, if job satisfaction (and the facet leading to job satisfaction) and job dissatisfaction (along with the facets leading to job dissatisfaction) were seen as separate continuums altogether, managers aiming to address the balance between the scale and working toward tipping the scale in favour of satisfaction, would have a clear understanding of the where to begin and what to address to gain the best results.

Following from the example used above, the manager would be aware that the balance of the scale was tipped in favour of dissatisfaction. Subsequently the manager would already know that it was important to firstly address issues of dissatisfaction in order for the weight on this side of the scale to lessen. He/she would assess only the factors related to dissatisfaction, find which solutions were most feasible and implement these, thereby addressing the real problem and all the while decreasing the heaviness of the dissatisfaction until such time

as the balance has been restored. From there on, issues related to satisfaction may be explored in order to enhance the job satisfaction of the personnel and promote it to its optimum level. Subsequently having a clear view of the continuums of satisfaction and dissatisfaction also provides the manager with information regarding potential threats that could be addressed before they acquired too much weight.

The continuums of job satisfaction and job dissatisfaction as they are presented in this study can be viewed in figure 5.1. It is concluded that that factors leading to job satisfaction and dissatisfaction for occupational therapists are separate and distinct and that certain facets posses higher level impact than others. The full application of the balancing scale is discussed under the recommendations made regarding reasoning about job satisfaction for occupational therapists (cf. 5.3.1).

5.3 RECOMMENDATIONS

The following section of this chapter deals with the recommendations with regard to decreasing the current state of job dissatisfaction among the occupational therapists in the PHS of the FS as well as enhancing the factors that would increase their job satisfaction. At the outset, general recommendations are made after which specific phenomena identified from this study are addressed. Recommendations are made regarding the role of the manager, clinicians and educators in addressing job satisfaction[7].

[7] For orientation purposes, the "educator" is defined as someone involved in teaching on either pre-or post-graduate level, research or other educational activities. Furthermore, educators can be occupational therapists external to the PHS, occupational therapy managers or clinicians in the PHS or a consultant from another profession altogether.

5.3.1 Job satisfaction: Reasoning principles for occupational therapists

The following recommendations are made regarding how occupational therapists, occupational therapy managers and educators should position their reasoning regarding job satisfaction:

a) The importance of experiencing job satisfaction as a strategy toward reducing absenteeism, increasing retention of staff, recruiting skilled and enthusiastic personnel, limiting career attrition and ultimately increasing quality care to patients should be acknowledged by all occupational therapists.

b) It should also be acknowledged that factors leading to job satisfaction and dissatisfaction for occupational therapists are separate and distinct and that merely addressing "dissatisfiers" will not increase job satisfaction. Likewise, increasing "satisfiers" will not lead to decreased dissatisfaction. Each category of factors should be addressed to attain sustainable and long term results.

c) It is recommended that "dissatisfiers" be addressed first when the overall job satisfaction is tipped in favour of dissatisfaction (as was the case in this study). It is postulated that this approach will yield more efficient results than trying to increase satisfiers. After the balance of the scale has been equalized, "satisfiers" can be increased in order to enhance job satisfaction.

d) Where possible, in cases where the job dissatisfaction is severe, it should be endeavored to make a strict priority of addressing high level impact facets of dissatisfaction (cf. figure 5.1) as this will yield the quickest result.

e) However, high level impact factors are often difficult and time-consuming to address. It is therefore recommended that when addressing job satisfaction, strategies should be categorized into long term and short

term goals. While strategic plans can be implemented to address long term goals, short term goals can be employed to provide faster and much needed relieve in an acute situation.

f) When addressing job satisfaction, enhancing feelings of satisfaction can either be done by concentrating on high level impact facets (cf. figure 5.1) or by promoting various low level impact facets. The advantage of using high level impact factors in the case of satisfaction is that these factors are easier to increase since they relate more to the client, the relationships within the department and the work content of the occupational therapists. Clinicians, managers and educators have better access to these facets and can influence them in more timely and efficient manner. High level impact factors also have greater weight to influence the job satisfaction of occupational therapists and therefore have a stronger impact. Low level impact factors have less weight and are often related to the context which makes these facets difficult to access and influence effectively. However, occupational therapists would do well to engage with these facets as long term strategies in order to prevent them from becoming " dissatisfiers" at a later stage.

g) Lastly, it is recommended that managers acknowledge the individuality imbedded in experiencing job satisfaction. Although some common denominators can be identified and addressed, individual focus is imperative. It is fortunate that in most cases, occupational therapy personnel in one department is of such a number that occupational therapy managers could comfortably engage on an individual level and therefore address job satisfaction more specifically and accurately.

5.3.2 Addressing dissatisfaction with the job

In the case of this study, results have shown that it is imperative to address the various facets of dissatisfaction with urgency. The following five key performance areas (KPA) have been identified[8]:

- KPA 1: Improving the status of occupational therapy as a profession
- KPA 2: Addressing salary
- KPA 3: Addressing recognition
- KPA 4: Limiting the effects of organization-bound "dissatisfiers"
- KPA 5: Addressing the physical work environment

In addressing these five KPA the job dissatisfaction of the occupational therapists in the PHS will decrease and consequently redress the balance of the scale between satisfaction and dissatisfaction. In order to provide a comprehensive yet concise view of recommendations made for each KPA an adapted form of an initiative charter is used.

[8] Recommendations are based on the current status of each facet as illustrated in figure 5.1 as well as the impact strength of the category. Furthermore, recommendations are made toward measures that are practical, implementable and supportable within the context of the PHS. Existential reflections have not been included.

Table 5.1 Initiative Charter 1: Addressing Job Dissatisfaction for Occupational Therapists in the PHS of the FS

OVERALL INTENT: DECREASING THE JOB DISSATISFACTION OF OCCUPATIONAL THERAPISTS IN THE PHS OF THE FS					
	KPA 1 Improving the status of occupational therapy as a profession	**KPA 2** Addressing salary	**KPA 3** Addressing recognition	**KPA 4** Limiting the effects of organization-bound "dissatisfiers"	**KPA 5** Addressing the physical work environment
STRATEGIES	Developing a national strategy	Redressing misconceptions about the importance of salary for occupational therapists' job satisfaction	Development of a career-path for occupational therapists	Preparing to minimise the effects of stringency measures	Limit negative impact of poor resources and equipment
	Promote and develop evidence-based practice through practice protocols, outcomes measure and research	Increasing the salary of occupational therapists to reflect the importance of their work	Develop inclusive promotion criteria for occupational therapists	Maximise CPD opportunities	Limiting the negative impact of staff shortages
	Maximize visibility in wards, managerial meetings and institutional events	Salary adjustments for extensive experience in specialised fields	Restructure PDMS for professionals	Limiting red-tape	
	Actively marketing the profession	Salary adjustments for post-graduate qualifications	Develop informal recognition procedures on departmental and provincial level		
	Actively promote integrated multi-professional teamwork				

5.3.2.1 KPA 1: Improving the status of occupational therapy as a profession

Addressing the issue of status should be viewed as a long term goal as sustainable results will only be observable over an extended period of time. Nevertheless, each strategy employed will provide a modicum of acute relief as some suggestions will have an immediate impact. As illustrated in table 5.1, the recommendations to increase the status of occupational therapists are made by observing five strategies:

- Strategy 1: Developing a national strategy.
- Strategy 2: Promote and develop evidence-based practice through practice protocols, outcomes measure and research.
- Strategy 3: Maximise visibility in wards, managerial meetings and institutional events.
- Strategy 4: Actively marketing the profession.
- Strategy 5: Actively promote integrated multi-professional teamwork.

Specific suggestions for each strategy will now be discussed.

5.3.2.1.1 Developing a national strategy

It is recommended that the issue of increasing the status of occupational therapists be addressed as a national initiative to increase the impact strength of the measures employed. The following suggestions are made:

- Occupational therapy managers in the FS should prioritise the issue as imperative on the provincial occupational therapy forum and consequently refer the matter as an item for discussion on the national occupational therapy forum held annually. From this platform, it is recommended that a task team be instigated to develop strategies that could be implemented nationally to increase the status of occupational

therapist. The Occupational Therapy Association of South Africa (OTASA) may serve as a valuable resource in this regard.

- The role of the task team should incorporate the following functions:

  a) Conducting research into further exploring the issue of poor professional status in South Africa but also worldwide.
  b) Developing a strategic plan with both long term and short term goals to improve the awareness and credibility of the profession.
  c) Coordinating marketing strategies and events.
  d) Gaining funding and sponsorships for implementation of marketing strategies.
  e) Developing a corporate branding strategy for the profession

- The task team should comprise of managers, clinicians and educators who are suited to marketing and its various functions.

5.3.2.1.2 Promote and develop evidence-based practice through practice protocols, outcomes measure and research

It is recommended that evidence-based practice be followed and promoted in order to empirically support the science and value of occupational therapy. This could be achieved by following the suggestions.

- Occupational therapy managers should incorporate treatment outcome measures as part of their quality assurance projects.
- Statistics should be kept on personnel adhering to outcome measures and should be visibly displayed in the department.
- Monthly reports should be structured to include data gained from outcome measures.
- Problem areas where outcomes are not reached should be investigated and redressed with urgency.
- Managers should motivate personnel to attain outcomes and reward efforts made consistently.

- Collaboration with occupational therapists from other departments, academic institutions and other experts should be encouraged.
- Clinicians should be allotted the time and knowledge to develop practice protocols for specific conditions.
- These protocols should be linked to outcomes that are measureable as well as time frames wherein these outcomes should be reached.
- Clinicians should be specific and clear when discussing patients on ward rounds.
- Patient reports should include outcome measures that are linked to patient outcomes. These should be presented in a visually easy-to-read and attractive manner e.g. by using graphs.
- Students should be educated on the importance of evidence-based practice and should be competent in developing outcomes measures when graduating.
- Educators should, in collaboration with clinicians conduct research to support the practice protocols and outcome measure developed in practice.
- Research should be disseminated to specific target markets in order to raise awareness regarding the scientific approach occupational therapists follow when treating patients.

5.3.2.1.2 Maximise visibility in wards, managerial meetings and institutional events

- Occupational therapy managers should be consistent in their approach to and attendance of managerial meetings as well as representation of their department at institutional events.
- Occupational therapy managers should endeavour to attain managerial positions in the higher ranks of the PHS as the number of occupational therapists in high ranking managerial positions is currently very limited and consequently the voice of the profession often goes unheard in the upper echelons.

- Visibility in the wards is imperative. Occupational therapists should endeavor to be consistent in their approach and engagement in the ward.
- Occupational therapists should be prepared for ward round and master the art of communicating effectively in a short amount of time.
- Occupational Therapists should remember that clinical notes in patient files, communication after referrals were received, progress reports and telephonic discussions of patients with other team member all affect the image of the profession and therefore these tasks should be attended to in a consistent, diligent and professional manner.
- Occupational therapists should actively make use of opportunities to treat patients where other team member are present, e.g. in the wards. This provides team members to see the practice of occupational therapy and often opens up discussions where occupational therapists are able to explain the science of their treatment.
- Occupational therapists should be diligent in their endeavour to understand and explain the science of their intervention strategies to members of the team as well as in an appropriate manner, to patients and clients.
- Educators should emphasize the importance of scientific practice to students and train them in such a manner that they will always be able to explain the science of their interventions.

5.3.2.1.4 Actively marketing the profession

The following recommendations are made regarding actively marketing the profession:

- Managers should identify occupational therapists that are interested and suited to marketing and add this task to their duties as part of a portfolio the person can fill. On departmental level, this person would be responsible for coordinating all marketing events and strategies. All staff should be incorporated as fits their capacity.

- Marketing aids should be developed. This includes pamphlets, DVD's and posters that can be used in presentations as well as exhibitions. In the PHS this can be a coordinated effort between all departments in order to maximize resources and limit unnecessary duplication.
- Marketing events should include: Open-days where hospital staff and other stakeholders are invited to visit the occupational therapy department. Secondly, occupational therapy week should be fully utilized e.g. exhibitions in public areas, school talks, radio talks and newspaper articles. Managers should plan for this week well in advance and it should be made a priority event in the year calendar.
- Offering employee wellness programs e.g. a stress support group, to hospital employees offers them the opportunity experience occupational therapy first hand and raises awareness of as well as respect for the profession.
- Researchers should investigate the traits of effective marketers or marketing strategies and continue to offer courses and workshops on this matter.
- Lastly, it is also recommended that the resources of the corporate communication team employed at the provincial Department of Health be identified and that departments coordinate their marketing efforts with those of corporate communication in order to increase their impact.

5.3.2.2 KPA 2: Addressing salary

It is recommended that addressing and improving the salary of occupational therapists in the PHS be made the first priority toward increasing their job satisfaction by implementing the following strategies:

Strategy 1: Redressing misconceptions about the importance of salary for occupational therapists' job satisfaction

Strategy 2: Increasing the salary of occupational therapists to reflect the importance of their work

Strategy 3: Salary adjustments for extensive experience in specialised fields

Strategy 4: Salary adjustments for post-graduate qualifications

5.3.2.2.1 Redressing misconceptions about the importance of salary for occupational therapists' job satisfaction

It is recommended that occupational therapy clinicians and managers be educated regarding the nature of the influence salary can have on job satisfaction. This is imperative to prevent the expectation that increased salary would have a sustainable positive influence on job satisfaction for occupational therapists. It must be understood that increased salaries would only decrease the dissatisfaction of occupational therapists therefore redressing the balance between satisfaction and dissatisfaction. Long term satisfaction cannot be attained by earning a higher salary however; severe dissatisfaction can occur if salary is viewed as unreasonable.

5.3.2.2.2 Increasing the salary of occupational therapists to reflect the importance of their work

The following recommendations are made toward increasing the salary of occupational therapists based on the importance of their work:

- Occupational therapy managers should assimilated statistics regarding headcounts of clients, time spent on patients treatment and scope of problems covered in occupational therapy. These statistics should be compared to those of other health care workers and appropriate recommendations should be made on institutional and provincial level.
- Evidence-based practice should be followed in order to prove the importance of occupational therapy intervention and consequently motivate for better salaries.
- Occupational therapists should endeavour to attain high visibility in the upper echelons of their institutions as well as on provincial level in order to have access to policy makers and influence decisions regarding salary adjustments.

5.3.2.2.3 Salary adjustments for extensive experience in specialised fields

The following recommendations are made toward increasing the salary of occupational therapists with extensive experience in specialised fields:

- Occupational therapist should endeavour to establish speciality areas that are recognised by the Health Professionals Council of South Africa.
- Clinicians who have proof of extensive experience within a specific field should receive additional remuneration in recognition of their expertise. This would also serve to enhance the status of occupational therapists but more pertinently perhaps, the PHS would become an institution where expert knowledge is rewarded and consequently retained.
- Policy makers should also investigate the options for rewarding long years service. Possibilities include a once-off cash bonus, significant additional leave benefits or increased subsidy percentages.

5.3.2.2.4 Salary adjustments for post-graduate qualifications

The following recommendations are made toward increasing the salary of occupational therapists with post-graduate qualifications:

- Occupational therapists' salaries should make allowance for and reward post-graduate qualifications.
- In additional to post-graduate degrees, training and qualifications in specialised fields such as sensory integration therapy, neuro-developmental therapy and hand therapy should also receive due recognition.
- A system should be developed to classify post-graduate qualifications in different levels and remuneration should be proportionate to these levels. The system should among other criteria take into account the NQF level as well as the field in which the qualification was obtained. Specialised

fields, scarce fields and fields in-line with the priorities if the National Department of Health should receive additional recognition.

5.3.2.3. KPA 3: Addressing recognition

It is recommended that recognition at work be addressed with regard to the following strategies:

Strategy 1: Development of a career-path for occupational therapy clinicians that is equal to those of managers.
Strategy 2: Develop inclusive promotion criteria for occupational therapists.
Strategy 3: Restructure PDMS for professionals.
Strategy 4: Develop informal recognition procedures on departmental and provincial level.

5.3.2.3.1 Development of a career-path for occupational therapy

The following recommendations are made toward the development of equal career advancement opportunities for all occupational therapists.

- The overall flattened career structure of occupational therapists (and allied health professions) should be addressed nationally.
- The need occupational therapists – as professionals – have toward continuous career advancement should be duly recognised and provision made for those who choose to remain in the PHS for the duration of their careers up to retirement.
- All efforts should be made to recruit and retain occupational therapists with expert knowledge and skill through providing consultation posts in the PHS.
- A career-path equal to that of managers should be developed for clinicians.

5.3.2.3.2 Develop inclusive promotion criteria for occupational therapists

The following recommendations are made toward the development of inclusive criteria for the promotion of occupational therapists:

- It is recommended that career progression be based on merit with regards to qualification, years experience and specialised services.
- Clear progression policies should be developed and implemented consistently.
- The negative effects of employment equity should be limited as far as possible while at the same time all endeavours should be made to provide equal opportunities for all occupational therapists.

5.3.2.3.4 Restructure PDMS for Professionals

The following recommendations are made toward restructuring performance appraisal systems for professional in the PHS of which occupational therapists from part:

- Performance appraisal systems for professionals should be separated from performance bonuses as the PHS does not have the funds to equitably reward the performance of the professional in its employ.
- Alternatively to current practice, an annual performance bonus can be awarded to one professional per department who have exceeded the average performance of other staff members. This recommendation is made since the PHS does have the financial capacity to implement this policy consistently.
- Performance criteria should be made specific to each individual employee while at the same time aligning these criteria with the strategic plan of the department.
- All aspects of the work should come under consideration and not only those that are specified as key performance tasks on the job description.

- The scale of the PDMS system should be converted to levels of performance indicated by grades rather than percentages. This recommendation is made since the current system ascribes a score of $^{3}/_{5}$ as fully efficient and consequently even though a score of only 60% is attained the employee was in fact 100% efficient. Grades would also limit the negative effects of performance/achievement ideology such as emphasising feelings of being sub-standard and objectification.
- After adjustments to the current system had been made, clinicians and managers alike would have to undergo a restructuring of their thought patterns regarding performance appraisal. The process should be seen as an opportunity to gain recognition (although not financial) for their efforts but also a constructive learning opportunity and a positive quality assurance tool.

5.3.2.3.4 Develop informal recognition procedures on departmental and provincial level

It is recommended that occupational therapy managers employ a variety of efforts to recognise their staff for work well-done. Some suggestions to this end are:

- Recognise the effort of staff members on a daily basis by giving specific positive feedback.
- Develop a “therapist of the month” system where a photograph of the person could be displayed in a prominent location.
- Make an effort to recognise the individual inputs of staff member during meetings. Often verbal recognition will mean more to occupational therapists than financial reward.
- Provide a compliments and complaints register that can be completed by patients and use the information to acknowledge staff members’ work.
- Employ an informal reward system for exceptional service delivered over a specific time frame e.g. one afternoon off.

- Discuss informal recognition systems with other managers to gain new ideas and compare the effectiveness of strategies.

5.3.2.4 KPA 4: Limiting the effects of organisation-bound sources of dissatisfaction

Effective addressing the effect of the limitations that characteristic of the PHS (cf. figure 5.1) is somewhat restricted due to nature of the organisation itself, financial implications and the limited influence ground-level workers can have on the policies of the PHS. Nevertheless the following strategies are suggested to at least curb the influence of these factors on the job satisfaction of occupational therapists:

Strategy 1: Preparing to minimise the effects of stringency measures.
Strategy 2: Maximise CPD opportunities.
Strategy 3: Knowledge of and adherence to policies.
Strategy 4: Capitalise on positive publicity.
Strategy 5: Limiting red-tape.

5.3.2.4.1 Preparing to minimise the effects of stringency measures

The following suggestions are made with regard to minimising the negative effects of stringency measures on occupational therapists job satisfaction:

- Occupational therapy managers should be aware of the demotivating effect of stringency measure and should mentally prepare the staff for these implications.
- Where managers have the authority to manage their own departmental budgets, every effort should be made to adhere to budget and to not overextend the resources of the department. This can be done by monitoring expenses such as telephone costs, photocopies, stationary and reckless use of consumable materials. Managers should also employ strict asset management protocols.

- Occupational therapy clinicians should implore greater creativity when selecting activities for their patients when the required resources cannot be procured due to financial limitations.
- Patients and clients should at the outset be made aware that off-base services depend on the availability of official transport and contingency plans should be explored beforehand.
- Occupational therapists should concentrate their efforts toward promoting community engagement and partnership and these systems within these communities should be established to such a degree that services (e.g. support groups) could continue when only intermittent contact with the occupational therapist is possible.

5.3.2.4.2 Maximise CPD Opportunities

The following recommendations are made toward maximising CPD opportunities for occupational therapists:

- Although procuring funding for CPD activities is not always plausible, occupational therapy manager should endeavour to make every reasonable effort to allow staff time-off for professional development sessions such as workshop and courses.
- Managers should also advocate for occupational therapists studying a formal degree to be allotted the necessary time -off without influencing the annual leave benefit.
- Where possible, departmental training budgets should provide funding for courses and workshops.
- Occupational therapy managers are encouraged to annually conduct a skills audit among their personnel as well as an analysis of patient needs in order to identify priority training areas. These areas of training should be funded by the institution.
- Educators and training institutions should provide a variety of training opportunities to occupational therapists. Accredited short courses,

clinical skills training, refresher courses, journal discussions, interests groups and formal qualifications should all be considered.

- Occupational therapists should also acknowledge their responsibility to remain current in the profession and should consequently accept some financial responsibility for furthering their education.

5.3.2.4.3 Limiting red-tape

The following recommendations are made toward limiting red-tape for occupational therapists:

- Occupational therapists should at all times be informed and aware of expected
protocols and should endeavour to follow these explicitly.
- Templates should be drawn up for monthly reports, submission and other official documents to limit time expenditure.
- Departmental red-tape should be kept to a minimum.
- Administration time should be scheduled daily to restrict backlogs.
- User-friendly assessment forms and process note charts that are easy and economic to complete should be developed.
- Where possible, technology such as electronic patient records, MEDI-TECH and databases should be used to assist occupational therapists with administration.
- Department heads should motivate to employ the services of an administrative officer to assist with appointment scheduling, procurement of equipment, data capturing and other daily administrative tasks.
- Managers should be knowledgeable of time frames attached to procedures and insist that these be adhered to.
- It should be endeavoured to develop positive relationships with administrative support staff in order ease the execution of requests.

5.3.2.5 KPA 5: Addressing the physical work environment

Correcting the physical work environment is ultimately dependant on the priorities of the institution as well as the availability of funds. These two variables make the issue somewhat tenuous to address with full effectiveness. Nevertheless, some recommendation are made that could limit the negative influences of an undesirable physical working environment. This can be done by following two main strategies:

Strategy 1: Limiting negative impact of poor resources and equipment.
Strategy 2: Limiting the negative impact of staff shortages.

5.3.2.5.1 Limiting negative impact of poor resources and equipment

- Occupational therapy managers should lobby to receive blanket approval regarding the motivations that repeatedly have to accompany the acquisition of consumable materials used in therapy. The motivation should receive attention on provincial level from where general sanction can be gained. Although institutions may still lack the funding for these acquisitions, the matter would at least receive due consideration.
- Occupational therapists should become aware that excessive use of private resources for official purposes ultimately leads to disgruntlement. Occupational therapy managers should actively discourage this behaviour.
- Room schedules for areas where space is limited could limit conflict and disappointment among staff members.
- Consumable materials should be used discriminately and where possible waste materials should be collected to supplement shortages.
- Sharing of generic equipment between occupational therapists and other allied health professionals, inter-institutional lending policies, partnerships between private institution and practices and I should be explored.

- Occupational therapists should view lacking resources as an opportunity to find creative solutions for this challenge.
- Researchers and educators should investigate cost-effective, innovative and realistic activities and training should be given in this regard.
- While in training, occupational therapy students should be encouraged to as far as possible make use only of resources available in the clinical areas as to better prepare them for the realities of the job and also to cultivate creative and innovation skills.
- Mangers should employ comprehensive asset management strategies to maintain equipment, reduce theft, replace out-dated equipment and prioritise the acquisition of new equipment.
- Sponsorships could be gained for necessary equipment; however PHS protocol has to be followed in this regard.
- Occupational therapists should acknowledge that at times their duties may also include fundraising for events or acquisition of resources.
- Occupational therapists should be knowledgeable of all resources available to them on institutional, district and provincial level and optimally utilise these resources.

5.3.2.5.2 Limiting Negative Impact of Staff Shortages

The following recommendations are made regarding limiting the influence of staff shortages among nursing personnel on the occupational therapists' job satisfaction.

- The National Department of Health should investigate the possibility of re-introducing nursing diploma's where qualifications are practice-based and completed in a shorter amount of time.
- Nursing aids in hospitals should be trained to perform care duties in alignment with occupational therapy protocols. These duties could among others include the practicing phase of feeding/eating, transfers, bed mobility and pressure relief.

- Occupational therapists should where possible make multiple visits to wards on a daily basis in order to increase visibility.
- Where applicable, the services of volunteers can be employed.
- Occupational therapists should extend their services in physical and emotional wellness programs to include the nursing staff of the institutions.
- Positive and supportive relationships should be developed with nursing staff to promote productivity.
- Repeated disregard for occupational therapy treatment prescriptions should be reported along the correct channels in a corrective rather than punitive fashion.

5.3.3. Enhancing job satisfaction

The following principles are recommended in order to enhance the job satisfaction of occupational therapists in the PHS of the FS:

- Decrease the current state of dissatisfaction by following the previously discussed strategies.
- Occupational therapy managers and clinicians alike should endeavour to maximise opportunities to work with people.
- Feelings of “making a difference” should be promoted by recording patient feedback, evidence-based practice and publishing case studies on successful treatments.
- Departmental protocols should be developed to gain a clearer understanding of what is possible in term of defining success with clients. Occupational therapists should acknowledge that different levels of service hold different potential to achieve success with patients. Occupational therapists should be realistic in their expectations and position themselves within a system where they are comfortable.
- Managers should actively concern themselves with the interpersonal dynamics in their departments and should optimally use this as a supportive structure and a motivational tool.

- Managers should be cognisant of the fact that their staff's personal lives affect their job satisfaction. This facet should be observed with consistency, good judgement and appropriate action.
- Occupational therapists should advocate for the development of institutional support networks to assist with emotional well-being.
- Contact with the MPT as well as positive relations with these team members should be cultivated and optimalised.
- Occupational therapists should discover their field of passion and make concentrated efforts to maximally work in these fields where possible.
- Managers should promote clinical autonomy and self-leadership while at the same time providing adequate supervision for less experienced clinicians.
- Occupational therapists should take responsibility for increasing their own experiences of diverse and creative practice as a means to feel more satisfied with their work.
- Managers should constantly be aware of the level of stimulation and challenge needed by their staff and should where possible endeavour to meet these needs by providing new challenges, projects and responsibilities.
- The institution of flexi-time and long leave benefits (sabbatical leave) for specific groups of occupational therapists should be further investigated.

5.3.4. Recommendations for future research and training

The following recommendations are made regarding future research in the job satisfaction of occupational therapists within the South African context:

- The job satisfaction of occupational therapists in work setting other than the PHS should be investigated to provide compressive data on the phenomenon.
- The personality types and core values of occupational therapists should be investigated to gain better understanding of their job satisfaction.

- Practice models should be developed and researched regarding the strategies employed to enhance the job satisfaction of occupational therapists.
- Retentions and recruitment strategies should be investigated and developed for occupational therapists within a South African context

5.4 LIMITATIONS OF THE STUDY

The following aspects are considered limitations of this study:

a) The study sample included only one male participant and therefore data heavily favours the experiences and perceptions of female occupational therapists in the PHS. It must however be mentioned that only two males were employed in the PHS of the FS at the time of the study and although one male was interviewed during the qualitative investigation, the other did not adhere to the selection criteria of the study. Furthermore, the study population included mostly white female occupational therapists therefore not incorporating possible differences in experience with regard to culture and worldviews. However the findings and results remain trustworthy, relevant and applicable to the population who participated in this study.

b) Although almost equal numbers of participants from rural and urban settings participated in the quantitative investigations, this was not the case in the qualitative inquiry. Due to the selections criteria of the study, occupational therapists practicing in remote areas in the FS were not included in the study possibly limiting the transferability of the study's results to this specific group.

c) The sample size for the quantitative investigation is relatively small even though a fairly good return rate was obtained. As the data collected from the questionnaires was mainly used as baseline data and later confirmed

during the qualitative inquiry, the small number of respondents is not considered to be of grave consequence.

d) Lastly, the temporal and subjective nature of the phenomenon of job satisfaction should always be observed when making use of the results of this study. These results pertain specifically to occupational therapists in the PHS of the FS. Moreover, the study was conducted late in the year at a time when the occupational therapists had already been exposed to extensive stringency measures, a public service strike and also general fatigue characteristic of the end of the year.

CLOSURE

The overall aim was reached. Subsequently all objectives were reached as well. The current status of the job satisfaction of occupational therapists in the PHS of the FS at the time of the study was low. By implementing the recommendations of the study, it is predicted that the job satisfaction of these occupational therapists will show marked improvement directly leading to lower absenteeism rates, improved productivity, greater occupational flow, decreased personnel-turn-over and lower rates of career attrition.

By prioritising job satisfaction as one of the imperative experiences relating to the job, occupational therapists will rediscover their original enchantment with the profession and the distressing state of disillusionment will be combated. Moreover, these dedicated, motivated and passionate occupational therapists will secure the profession for future generations - ultimately affording the populations we serve the opportunity to transcend from mere existence into living life with dignity, delight and enthusiasm.

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Annexure A

Questionnaire

(English and Afrikaans)

Questionnaire

on the

Job Satisfaction of Occupational Therapists in the Public Health Sector of the Free State.

Dear Occupational Therapist

Please note that if you chose to complete and return this questionnaire you are automatically giving your consent to participate in this study.
Participation is voluntary.
Participation is anonymous.

Please delete the "x" in the block below if you are unwilling to participate and return the questionnaire to botham@fshealth.gov.za or reones@vodamail.co.za

x	**I understand the implications of this study to me both personally and professionally and I willingly agree to participate in this study.**

Instructions to complete the questionnaire:

1. Please mark all responses with an "x" unless otherwise indicated
2. The questionnaire will take approximately 20-30 minutes to complete
3. Remember that all the information you provide will be kept confidential so please give a true reflection of your feelings about your present job.
4. Please answer all questions. There are 17 pages in all.
5. In cases where you are asked to answer in a block such as this ☐ simply click inside the block and make you response.
6. Other questions may be answered by typing your response on the line provided.

Section A
Demographic Information

1. Biographic Information

1-3

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1.1 **Gender**: I am a male ☐ female ☐ — 4

1.2 **Age**: I am____________years old. — 5-6

1.3 **Marital Status**: I am________. — 7

1.4 **Dependants:**
I do have dependants ☐ I do not have any dependants ☐ — 8

1.5 **Number of service years in PHS:** _______. — 9 10

1.6 **Home Language**: ________. — 11

2. Work-related Information

2.1 Please mark the block adequately stating your highest qualification

☐
☐
☐
☐
☐

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a) B. Occ Ther. / BSc. Occ Ther. Degree

b) Master's degree in Occupational Therapy

c) Master's degree in another study field.

d) PhD in Occupational Therapy

e) PhD in another study field.

f) Other. Specify:_________

2.2 Which of the following describes your current area/s of employment within the public health sector? Tick all that apply.

13

a) Clinic or Community Health Centre/ primary health care facility

b) District Hospital

c) Regional Hospital/ other secondary health care facility

d) Tertiary hospital/ other tertiary health care facility

e) Other: Specify _______

2.3 The institution I am working at is mainly concerned with:

14

a) Community-based occupational therapy

b) Physical rehabilitation

c) Mental health

d) Combination of physical and mental health occupational therapy

e) Vocational evaluation and rehabilitation

f) Other: Specify:_________________________

2.4 I perform mainly ……………. duties during a normal day.

☐ a) Clinical occupational therapy

☐ b) Managerial and administrative

☐ c) Other: Specify: ______________________________

☐ 15

2.5 Are you the manager of the occupational therapy department at your institution or have you been acting as the manager for at least the last three months?

Yes ☐ No ☐

☐ 16

2.6 What is your current designation within the department of health?

I am appointed as a ______(senior, chief, assistant manager) occupational therapist on salary level_____.

☐ 17

☐☐ 18-19

2.7 The area I am currently working in is considered a ……….

Rural setting ☐ Urban setting ☐ Combination ☐

☐ 20

2.8 How many times have you changed jobs since you qualified?

Click here and type only the number::

☐☐ 21 22

2.9 Have you changed jobs two or more times in the last five years?

Yes ☐ No ☐

☐

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2.10 What have been your most prominent reasons for changing jobs in the past?

If you have not changed jobs and the question does not apply you, mark here ☐

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Click here and type your response:

		25-26
		27-28
		29-30
		31-32
		33-34

2.11 Please mark whether you agree or disagree with the following statements regarding absenteeism from work.

	Agree	Disagree	N/A
a) I do not stay away from work without legitimate or reasonable reason			
b) I have noticed that I tend to look for reasons to absent myself from work when I am not satisfied with something at work or my personal life.			
c) I believe needless absenteeism is a problem in our department			

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Section B
Job satisfaction of occupational therapists

While thinking about the following questions, ask yourself: **How satisfied am I with this aspect of my job?** Mark the response most accurately reflecting your feelings with “x”. Make use of the following scale to guide you in answering.

Sat.	Means you are satisfied with this aspect of your job. You get what you expected or more
Dissat.	Means you are dissatisfied with this aspect of your job. It does not meet your expectations.

3. On my present job, this is how I feel about occupational therapy……

	Sat.	Dissat.
a) The choice I made to become an occupational therapist.		
b) The value of occupational therapy as a career.		
c) The prospect of staying an occupational therapist for the rest of my career.		
d) The future security of occupational therapy as a career		
e) The chance occupational therapy gives me to have a meaningful impact on other’s lives.		
f) The way the reality of being an OT meet the expectations I had when I chose this career.		
g) The idea of recommending occupational therapy to prospective		

FOR OFFICE USE

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students		
h) The sense of fulfilment I get from being an OT.		

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4. On my present job, this is how I feel about <u>my job</u>……

	Sat.	Dissat.
a) The diversity of the tasks I do		
b) The chance I get to do something stimulating or challenging		
c) The way my job correlates with my interests		
d) The opportunities I get to work with people.		
e) The chance to make decisions.		
f) The way my job allows me to be creative		
g) The way I am able to work independently		
h) The way my job allows me to make the best of my abilities and talents		
i) The way my job allows me to exercise some authority over others		
j) The way my job allows me to be		

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creative		
k) The chance my job gives me to be of service to others		

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5. On my present job, this is how I feel about <u>working in the public health service (PHS) (government)</u>……

	Sat.	Dissat.
a) The advantages of working in the PHS.		
b) The prospect of staying in the public service rather than working at an educational institution or private practice.		
c) My choice to be an OT in the PHS		
d) The morale among OTs in the PHS		
e) The prospect of working in the PHS for many years to come.		
f) The values and practices of the PHS.		
g) The probability that I will never be discriminated against in the PHS on any basis		
h) The physical working conditions at my public health institution		
i) The status OTs in the PHS has in comparison with OTs in other settings e.g. private practice		

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6. On my present job, this is how I feel about <u>the way I am managed and supervised</u>……

a) My direct supervisor is a qualified occupational therapist.

YES ☐ NO ☐

| 66 |

If no, specify the profession of the supervisor in the text box:

| 67-68 |

	Sat.	Dissat.
a) My manager's ability to perform his/her duties.		
b) The way my manager recognizes my strengths as utilizes them in the department.		
c) The way my manager handles conflict in the department.		
d) My manager's qualifications		
e) The way I can have confidence in the decisions my manager makes.		
f) The way my manager supports and cares about me.		
g) The way my manager credits me with things I do well.		
h) The way my manager makes an effort to understand and accommodate issues I have in my personal life.		
i) My manager's ability to make me feel appreciated and recognised.		
j) The opportunity my manager gives me for self-leadership		

69 70 71 72 73 74 75 76

k) The way my manager assists me to set professional goals for myself.			77
l) The way my manager assists me to set personal goals for myself.			78
m) The way my manager can see the bigger picture and helps me to understand this.			79
n) The idea that I can/should respect my manager			80
o) The way my manager keeps me suitably informed on issues within the profession and the institution.			1
p) The opportunity my manager allows me to work independently (on my own).			2
q) The chance my manager gives me to make decisions.			3
			4
			5

7. On my present job, this is how I feel about <u>the way the remuneration and benefits of occupational therapists in the PHS.</u>

	Sat.	Dissat.	
a) The way my salary reflects the importance of the work I do.			6
b) The salary I receive			7
c) The idea that therapists' salaries should be based on their			

individual experience, qualifications and work responsibilities rather than being generic for all.			8
d) The idea that therapists in remote areas should be better paid than those in urban areas.			9
e) The benefits I get such as medical aid, leave and pension.			10
f)The impact my salary has on my job satisfaction			11
g) The impact the benefits such as medical aid, leave and pension has on my job satisfaction.			12
h) The way my salary justifies my level of tertiary education.			13
i) The way my salary correlates with the salaries of other professionals I work with			14

8. On my present job, this is how I feel about <u>the working conditions of</u> <u>occupational therapists</u> in the PHS.

	Sat.	Dissat.	
a) The space and the furnishing available in the area where I do my job.			15
b) The access I have to sufficient technology e.g. computer, fax, phone etc. to assist me in my			16

work.		
c) The impact my physical working environment has on my job satisfaction.		
d) The access I have to adequate equipment / materials to ensure the effective treatment of patients/clients.		
e) The impact the availability of equipment/materials to work with has on my job satisfaction.		
f) The amount of travelling I do (If you do not travel, please ignore this question)		
g) The availability of official transport to perform my duties.		
h) The opportunities I have to attend workshops/ courses/further studies.		
i) The availability of funds in the PHS for my continual professional development.		
j) The risk I have to take of contracting infectious diseases at work.		
k) My personal safety at work or when travelling.		
l) Health and safety regulations adhered to at my work.		
m) The amount of administration I have to do at work.		

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n) The amount of red-tape I have to deal with.			27
o) My working hours			28
p) The possibility of taking a reasonable pay-cut if it meant that I would only work half-day.			29
q) The opportunity for me to be promoted at work			30
r) The prospect of advancement in my work.			31
			32

9. On my present job, this is how I feel about <u>communication and interpersonal relationships……</u>

	Sat.	Dissat.	
a) The relationships I have with the other therapists in my department.			33
b) The impact my relationships with co-workers has on my job satisfaction			34
c) Communication within our department.			35
d) The support I receive from co-workers.			36
e) The relationship between me and my manager.			37

10. On my present job, this is how I feel about myself……

	Sat.	Dissat.		
a) The confidence I have that I am a good occupational therapist.				38
b) The confidence I have in my skills as a manager. (If you perform no managerial duties, please ignore this question)				39
c) My self-esteem.				40
d) The influence my job has on my personal life.				41
e) My reaction to changes in the workplace.				42
f) The current changes taking place in the PHS.				43
g) The support I get from my family and friends with regards to my career.				44
h) The way I feel about my job (all things taken into account)				45
i) The confidence I have in my skills as a clinician.				46
j) The way I feel valuable/useful when I work.				47
j) The way I make a difference.				48
k) The ethics I practice at work.				

	49

11. Please arrange in order of *how important you view the following factors in terms of your job satisfaction*.

Number *1* **will be the factor you consider** *most important* **Number** *10* **the factor you consider** *least important***.**

Type the number in the corresponding block.

	Number
A good salary and benefits	
Good results with my patients/clients	
Supportive relationships with my co-workers	
Challenging, stimulating and meaningful work	
Comfortable physical work environment	
A good manager/supervisor	
Good promotion opportunities	
Formal opportunities for professional development e.g. workshops, courses etc.	
Adequate equipment and resources	
Chance to work independently and autonomously	

		50-51
		52-53
		54-55
		56-57
		58-59
		60-61
		62-63
		64-65
		66-67
		68-69

12. Please rate the following statements by using the following scale:

5 - I believe this would enhance my job satisfaction a lot

4 - I believe this would enhance my job satisfaction to some degree

3 - I believe this would not have an effect on my job satisfaction either way

2 - I believe this would decrease my job satisfaction to some degree

1 - I believe this would decrease my job satisfaction a lot

0- Does not apply to me

	Rating from 0-5		
More flexible working hours e.g. half-day post			70
A post on a higher level (promotion)			71
More money			72
Longer leave benefits			73
A more competent manager			74
More and better equipment, resources and office space			75
Less travelling			76
More personal safety			77
Better access to clinical supervision			78
Better access to professional help for my work-related and personal problems			79
More contact with team members or other OTs.			80
More support from my colleagues and manager			1
More time to spend with my family			

A rise in the status of occupational therapists among other health professionals				2
Better involvement from the community I work in				3
More opportunities to work in the field of my interest				4
				5

13. What are you <u>most satisfied</u> with at work?

Click here and type your response:

		6-7
		8-9
		10-11
		12-13

14. What are the aspects you are <u>most dissatisfied</u> with at work?

Click here and type your response:

		14-15
		16-17
		18-19
		20-21
		22-23

15. Please rate your current level of job satisfaction on a scale from 1-10. One, being the lowest level job satisfaction and 10 being the highest level of job satisfaction. Only type the number in the block below.

24 25

16. Any other comments or suggestions you might have regarding the job satisfaction of occupational therapists in the PHS?

Click here and type your response:

		26-27
		28-29
		30-31
		32-33
		34-35

Thank you for completing this questionnaire and participating in the study.

Vraelys

oor die

Werksbevrediging van Arbeidsterapeute in die Openbare Gesondheidsektor van die Vrystaat.

Geagte Arbeidsterapeut

Let asseblief daarop dat indien u hierdie vraelys voltooi en dit terugstuur, u outomaties toestemming gee om aan hierdie studie deel te neem.

Deelname is vrywillig.

Deelname is anoniem.

Vee asseblief die "x" in die onderstaande blok uit indien u nie gewillig is om deel te neem nie en stuur die vraelys na botham@fshealth.gov.za of reones@vodamail.co.za

x	**Ek verstaan die implikasies van hierdie studie op my, beide persoonlik en professioneel, en ek stem vrywillig in om aan hierdie studie deel te neem.**

Instruksies om die vraelys te voltooi:

7. Merk asseblief alle antwoorde met 'n "x", tensy daar anders aangedui word
8. Die vraelys sal ongeveer 20 - 30 minute neem om te voltooi
9. Onthou dat al die inligting wat u voorsien vertroulik gehou sal word, so gee asseblief 'n egte weergawe van u gevoelens oor u huidige werk.
10. Antwoord asseblief al die vrae. Daar is in totaal 17 bladsye.
11. In gevalle waar u gevra word om 'n vraag in 'n blok soos hierdie ☐ te antwoord, klik binne die boks en tik u antwoord.
12. Ander vrae kan beantwoord word deur u antwoord of opinie op die gegewe lyn te tik.

Afdeling A
Demografiese inligting

1. Biografiese inligting

1-3

VIR KANTOORGEBRUIK

1.1 **Geslag**: Ek is 'n man ☐ vrou ☐ — 4

1.2 **Ouderdom**: Ek is ____________jaar oud. — 5-6

1.3 **Huwelikstatus**: Ek is _______. — 7

1.4 **Afhanklikes:**
Ek het afhanklikes ☐ Ek het nie afhanklikes nie ☐ — 8

1.5 **Aantal diensjare in die staatsdiens**: __________. — 9 10

1.6 **Huistaal**: ________. — 11

2. Werkverwante inligting

2.1 Merk asseblief die toepaslike boks wat u hoogste kwalifikasie aandui — 12

☐ a) B. Arbeidsterapie / BSc. Arbeidsterapie Graad
☐ b) Meestersgraad in Arbeidsterapie
☐ c) Meestersgraad in 'n ander studieveld.
☐ d) PhD in Arbeidsterapie
☐ e) PhD in 'n ander studieveld.
☐ f) Ander. Spesifiseer:_________

2.2 Watter van die volgende beskryf u huidige werkarea/s

binne die gesondheidsektor? Merk almal wat toepaslik is.

☐ a) Kliniek of Gemeenskapsgesonheidsentrum / Primêre gesondheidsorgfasiliteit

☐ b) Distrikshospitaal

☐ c) Streekshospitaal / ander Sekondêre gesondheidsorgfasiliteit

☐ d) Tersiêre hospitaal / ander Tersiêre gesondheidsorgfasiliteit

e) Ander: Spesifiseer _______

☐ 13

2.3 Die instansie waar ek werk is hoofsaaklik betrokke by:

☐ a) Gemeenskapsgebaseerde arbeidsterapie

☐ b) Fisiese rehabilitasie

☐ c) Geestesgesondheid

☐ d) Kombinasie van fisiese en psigiatriese arbeidsterapie

☐ e) Beroepsevaluering en rehabilitasie

☐ f) Ander: Spesifiseer:_______________

☐ 14

2.4 Ek voer meestal ……………. pligte gedurende ’n normale dag uit.

☐ a) Kliniese arbeidsterapie

☐ b) Bestuurs- en administratiewe

☐ c) Ander: Spesifiseer: ____________________

☐ 15

2.5 Is u die hoof van die arbeidsterapiedepartement by u instansie of het u vir die laaste drie maande as ’n bestuurder opgetree?

Ja ☐ Nee ☐

☐ 16

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2.6 Wat is u huidige aanstelling binne die Departement van Gesondheid?

Ek is aangestel as ’n ______(senior, hoof-, assistentbestuurder) arbeidsterapeut op salarisvlak_____.

☐ 17

☐☐ 18-19

2.7 Die area waarin ek huidiglik werk word gesien as ’n ……….

Landelike omgewing ☐ Stedelike omgewing ☐

Kombinasie van landelik en stedelik ☐

☐ 20

2.8 Hoeveel keer het u van werk verander sedert u gekwalifiseer het?

Klik hier en tik slegs die nommer:

☐☐ 21 22

2.9 Het u gedurende die laaste <u>vyf jaar twee of meer keer</u> van werk verander?

Ja ☐ Nee ☐

☐ 23

2.10 Wat was die mees prominente redes waarom u in die verlede van werk te verander?

Indien u nie van werk verander het nie en die vraag nie van toepassing op u is nie, merk hier ☐

☐ 24

Klik hier en tik u antwoord:

		25 - 26
		27-28
		29-30
		31-32
		33-34

2.11 Merk asseblief of u saamstem of verskil van die volgende stellings betrekkende afwesigheid van werk.

	Stem saam	Verskil van	N.v.t.
a) Ek is nie afwesig by die werk sonder 'n geldige en redelike rede nie			
b) Ek het agtergekom dat ek geneig is om redes te soek om myself van werk te verskoon wanneer ek nie tevrede is met iets by my werk of in my persoonlike lewe nie			
c) Ek glo dat onnodige/onredelike afwesigheid 'n probleem in ons departement is.			

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Afdeling B
Werksbevrediging van arbeidsterapeute

Terwyl u aan die volgende vrae dink, vra uself af: **Hoe tevrede is ek met hierdie aspek van my werk?** Merk die antwoord wat u gevoelens die beste beskryf met "x". Maak gebruik van die volgende skaal as 'n riglyn.

Tevr.	Beteken u is tevrede met hierdie aspek van u werk. U kry wat u verwag het of selfs meer.
Ontevr.	Beteken u is ontevrede met hierdie aspek van u werk. Dit voldoen nie aan u vereistes nie.

VIR KANTOOR GEBRUIK

3. In my huidige werk, voel ek so oor arbeidsterapie……

	Tevr.	Ontevr.
a) Die keuse wat ek gemaak het om 'n arbeidsterapeut te word.		
b) Die waarde van arbeidsterapie as 'n beroep.		
c) Die vooruitsig om 'n arbeidsterapeut vir die res van my loopbaan te wees.		
d) Die toekomstige sekuriteit van arbeidsterapie as 'n beroep.		
e) Die kans wat arbeidsterapie my gee om 'n betekenisvolle impak op ander se lewens te hê.		

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f) Die manier hoe die realiteit van 'n Arbeidsterapeut wees aan die verwagtinge voldoen wat ek gehad het toe ek hierdie beroep gekies het.			43
g) Die idee om arbeidsterapie aan toekomstige studente aan te beveel.			44
h) Die gevoel van verwesenliking wat ek kry deur 'n arbeidsterapeut te wees.			45

4. In my huidige werk, voel ek so oor <u>my werk</u>……

	Tevr.	Ontevr.	
a) Die diversiteit van die take wat ek daagliks verrig.			46
b) Die kans wat ek kry om iets stimulerend of uitdagend te doen.			47
c) Die manier hoe my werk met my belangstellings korreleer.			48
d) Die geleenthede wat ek kry om met mense te werk.			49
e) Die kans om besluite te neem.			50
f) Die manier hoe my werk my toelaat om kreatief te wees.			51
g) Die manier hoe ek in staat gestel word om onafhanklik te werk.			52
h) Die manier hoe my werk my toelaat om die beste van my vermoëns en talente te maak.			
i) Die manier hoe my werk my toelaat			

om gesag oor ander uit te oefen.		
j) Die manier hoe my werk my toelaat om kreatief te wees.		
k) Die kans wat my werk my gee om ander te dien.		

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5. In my huidige werk, voel ek so oor my werk in die openbare gesondheidsdiens (staatsdiens)……

	Tevr.	**Ontevr.**
a) Die voordele om in die OGD te werk.		
b) Die vooruitsig om in die openbare diens te bly eerder as om by 'n opvoedkundige instansie of privaatpraktyk te werk.		
c) My keuse om 'n arbeidsterapeut in die OGD te wees.		
d) Die moraal onder arbeidsterapeute in die OGD.		
e) Die vooruitsig om vir nog baie jare in die OGD te werk.		
f) Die waardes en praktyke binne die OGD.		
g) Die waarskynlikheid dat daar nooit teenoor my in die OGD op enige basis gediskrimineer gaan word nie.		
h) Die fisiese toestande by die		

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instansie waarvoor ek werk.		
i) Die status (aansien) wat arbeidsterapeute in die OGD geniet in vergelyking met arbeidsterapeute in ander areas, bv. privaatpraktyke.		

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6. In my huidige werk, voel ek so oor <u>die manier hoe ek bestuur word</u> ……

b) My direkte bestuurder is 'n gekwalifiseerde arbeidsterapeut.

JA ☐ NEE ☐

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Indien nee, spesifiseer die beroep van die bestuurder in die teksboks.

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	Tevr.	Ontevr.
a) My bestuurder se vermoë om sy/haar pligte uit te voer.		
b) Die manier hoe my bestuurder my sterk punte raaksien en dit in die departement gebruik.		
c) Die manier hoe my bestuurder konflik in die departement hanteer.		
d) My bestuurder se kwalifikasies.		
e) Die vertroue wat ek kan hê in die besluite wat my bestuurder neem.		
f) Die manier hoe my bestuurder my ondersteun.		
g) Die manier hoe my bestuurder my krediet gee vir dinge wat ek reg/goed		

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doen.				
h) Die manier hoe my bestuurder 'n poging aanwend om kwessies in my persoonlike lewe te verstaan en te akkomodeer.				74
i) My bestuurder se vermoë om my gewaardeer en erken te laat voel.				75
j) Die geleentheid wat my bestuurder my bied om self-leierskap toe te pas.				76
k) Die manier hoe my bestuurder my help om professionele doelwitte vir myself te stel.				77
l) Die manier hoe my bestuurder my help om persoonlike doelwitte vir myself te stel.				78
m) Die manier hoe my bestuurder die groter prentjie sien en my help om dit te verstaan.				79
n) Die idee dat ek my bestuurder kan/moet respekteer.				80
o) Die manier hoe my bestuurder my oor sake binne die beroep en die instansie ingelig hou.				1
p) Die kans wat my bestuurder my gee om selfstandig (op my eie) te werk.				2
q) Die kans wat my bestuurder my gee om besluite te maak.				3
				4

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7. In my huidige werk, voel ek so oor <u>die vergoeding en voordele van arbeidsterapeute in die OGD.</u>

	Tevr.	Ontevr.
a) Die manier hoe my salaris die belangrikheid van die werk wat ek doen, reflekteer.		
b) Die salaris wat ek ontvang.		
c) Die idee dat terapeute se salarisse op hul individuele ondervinding, kwalifikasies en werksverantwoordelikhede gebaseer moet wees, eerder as 'n generiese salaris vir almal.		
d) Die idee dat terapeute in afgeleë gebiede meer betaal moet word as dié in stedelike gebiede.		
e) Die byvoordele wat ek ontvang, soos mediese fonds bydraes, verlof en pensioen.		
f) Die impak wat my salaris op my werksbevrediging het.		
g) Die impak wat die voordele, soos medies, verlof en pensioen, op my werksbevrediging het.		
h) Die wyse waarop my salaris my tersiêre opleiding regverdig.		
i) Die wyse waarop my salaris met dié van ander professionele spanlede		

	6
	7
	8
	9
	10
	11
	12

korreleer.		

	13
	14

8. In my huidige werk, voel ek so oor die werkstoestande van arbeidsterapeute in die OGD.

	Tevr.	Ontevr.
a) Die ruimte en die meubilering beskikbaar in die area waar ek my werk doen.		
b) Die toegang wat ek het tot voldoende tegnologie, bv. rekenaar, faks, telefoon, ens. om my in my werk te help.		
c) Die impak wat my fisiese werksomgewing op my werksbevrediging het.		
d) Die toegang wat ek het tot voldoende toerusting/materiale om die doeltreffende behandeling van pasiënte/kliënte te verseker.		
e) Die impak wat die beskikbaarheid van toerusting/materiale op my werksbevrediging het.		
f) Die hoeveelheid tyd wat ek aan rondreis spandeer (As u nie reis nie, ignoreer hierdie vraag)		
g) Die beskikbaarheid van amptelike vervoer om my pligte na te kom.		

	15
	16
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h) Die geleenthede wat ek kry om werkswinkels/kursusse/verdere studies by te woon.			21
i) Die beskikbaarheid van fondse in die OGD vir my voortdurende professionele ontwikkeling.			22
j) Die risiko wat ek loop om aansteeklike siektes by die werk op te doen.			23
k) My persoonlike veiligheid by die werk of wanneer ek reis.			24
l) Gesondheids- en veiligheidsregulasies wat by my werk gevolg word.			25
m) Die hoeveelheid administrasie wat ek by die werk moet doen.			26
n) Die hoeveelheid burokrasie (red-tape) waardeur ek moet werk.			27
o) My werksure			28
p) Die kans om minder geld te verdien as dit beteken dat ek net halfdag hoef te werk.			29
q) Die kans dat ek by die werk bevorder kan word.			30
r) Die vooruitsig van vooruitgang in my werk.			31
			32

9. In my huidige werk, voel ek so oor kommunikasie en interpersoonlike verhoudings ……

	Tevr.	Ontevr.
a) Die verhouding wat ek met ander terapeute in my departement het.		
b) Die impak wat my verhoudings met medewerkers op my werksbevrediging het.		
c) Kommunikasie binne ons departement.		
d) Die ondersteuning wat ek van medewerkers ontvang.		
e) Die verhouding tussen my en my bestuurder		

33

34

35

36

37

10. In my huidige werk, voel ek so oor myself……

	Tevr.	Ontevr.
a) Die vertroue wat ek het dat ek 'n goeie arbeidsterapeut is.		
b) Die vertroue wat ek in my vaardighede as bestuurder het. (Indien u geen bestuurspligte het nie, ignoreer hierdie vraag)		
c) My selfagting (self-esteem)		
d) Die invloed wat my werk op my persoonlike lewe het.		
e) My reaksie teenoor veranderinge in die werkplek.		
f) Die huidige veranderinge wat in die		

38

39

40

41

42

OGD plaasvind.		
g) Die ondersteuning wat ek van my familie en vriende met betrekking tot my beroep ontvang.		
h) Die manier hoe ek oor my werk voel (alle dinge in ag geneem)		
i) Die vertroue wat ek in my vaardighede as 'n klinikus het.		
j) Die manier hoe ek waardevol/nuttig voel wanneer ek werk.		
k) Die verskil wat ek by die werk maak.		
l) Die etiese gedrag wat ek by die werk openbaar.		

	43
	44
	45
	46
	47
	48
	49

11. Rangskik asseblief in volgorde van *hoe belangrik ung oor die volgende faktore in terme van u werksbevrediging ag.*

Nommer *1* **is die faktor wat jy die** *belangrikste* **ag**
Nommer *10* **is die faktor wat jy die** *minste* **ag.**

Tik die nommer in die ooreenstemmende blok.

	Nommer
'n Goeie salaris en voordele	
Goeie resultate met my pasiënte/kliënte	
Ondersteunende verhoudings met my medewerkers	
Uitdagende, stimulerende en betekenisvolle werk	
Gemaklike fisiese werksomgewing	

		50-51
		52-53
		54-55
		56-57
		58-59

’n Goeie bestuurder/toesighouer				60-61
Goeie geleenthede vir bevordering				62-63
Formele geleenthede vir professionele ontwikkeling, bv. werkswinkels, kursusse, ens.				64-65
Voldoende toerusting en hulpbronne				66-67
Kans om onafhanklik en selfstandig te werk				68-69

12. Gradeer asseblief die volgende stellings deur die volgende skaal te gebruik:

5 – Ek glo dat dit my werksbevrediging baie sal verbeter
4 – Ek glo dat dit my werksbevrediging tot ’n sekere mate sal verbeter
3 – Ek glo dat dit nie ’n invloed op my werksbevrediging sal hê nie
2 – Ek glo dat dit my werksbevrediging tot ’n sekere mate sal verlaag
1 – Ek glo dat dit my werksbevrediging baie sal verlaag
0 – Is nie van toepassing op my nie

	Gradering van 0- 5		
Meer buigsame werkure, bv. halfdagpos			70
’n Pos op ’n hoër vlak (bevordering)			71
Meer geld			72
Langer verlof			73
’n Meer bevoegde bestuurder			74
Meer en beter toerusting, hulpbronne en kantoorruimte			75
Minder rondreis			76
Meer persoonlike veiligheid			77
Beter toegang tot kliniese supervisie			78
Beter toegang tot professionele hulp vir my werksverwante en persoonlike probleme			79
Meer kontak met spanlede of ander			

arbeidsterapeute			80
Meer ondersteuning van my kollegas en bestuurder			1
Meer tyd om met my familie te spandeer			2
’n Verhoging in die status van arbeidsterapeute tussen ander gesondheidsberoepspraktisyns			3
Verbeterde betrokkenheid van die gemeenskap in my werk			4
Meer geleenthede om in my belangstellingsveld te werk			5

13. Waarmee is u die meeste tevrede by die werk?

Klik hier en tik u antwoord:

		6-7
		8-9
		10-11
		12-13

14. Met watter aspekte is u die minste tevrede?

Klik hier en tik u antwoord:

		14-15
		16-17
		18-19
		20-21
		22-23

15. Plaas asseblief u huidige vlak van werksbevrediging op 'n skaal van 1 – 10. Een is die laagste vlak van werksbevrediging en 10 is die hoogste vlak van werksbevrediging. Tik slegs die nommer in die onderste blok.

24	25

16. Enige ander kommentaar of voorstelle wat u mag hê betrekkende die werkbevrediging van arbeidsterapeute in die OGD?

Klik hier en tik u antwoord:

		26-27
		28-29
		30-31
		32-33
		34-35

Dankie dat u hierdie vraelys voltooi het en in die studie deelgeneem het!

Annexure B

Pilot study audit tool

(English)

Pilot Study
Review of Questionnaire

"The Job Satisfaction of Occupational Therapists in the Public Health Sector of the Free State"

Dear Occupational Therapist

Thank you for taking part in this pilot study. Your inputs are much appreciated and are very valuable in determining the effectiveness of this questionnaire. Please follow the instructions noted below to assist you in completing this audit.

Instructions

1. Before completing the questions, please read through the "review of the questionnaire" below in order to orientate yourself on which aspects of the questionnaire to assess.

2. Complete the questionnaire provided as per the instructions noted on the first page of the questionnaire.

3. Complete the review by marking the block YES or NO with an "x" and giving your comments. Please be sure to mention anything that you think might improve the questionnaire.

4. You might find it useful to keep a pen and paper handy to make notes as you work through the questionnaire to assist you in filling out the audit.

5. Please return the completed review along with your questionnaire to botham@fshealth.gov.za . Mark the Subject: **JOB SATISFACTION RESEARCH**.

Review of Questionnaire

	YES	NO	COMMENTS
1. Was the length of the questionnaire acceptable?			
2. Was the language acceptable, precise and professional?			
3. Did you find any leading questions?			
4. Did you find any questions that relied on bias on the part of the researcher? Please explain the bias.			
5. Were the instructions given effective?			
6. Is the questionnaire too time consuming? (please type the number of minutes you spent in the comment block)			
7. Do you think the questionnaire is representative of all the issues involved? Please state any left-out issues.			
8. Did you find any unnecessary questions that you feel should be excluded?			
9. Is the presentation of the questionnaire to your liking?			
10. Did you have any difficulty downloading and completing the questionnaire electronically?			
11. Would you like to make any other comments or suggestions not yet covered?			

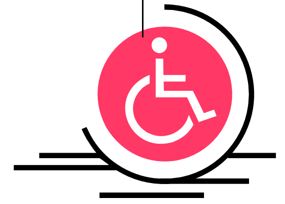
---------------------------Thank you!------------------------------

Annexure C

Introductory Leaflet

(English)

Free State OT!



This is your chance to have your say!

Soon, you will be asked to participate in a research study that will give you the opportunity to express all your thoughts and feelings on:

"The Job Satisfaction of OT's in the Public Service of the FS"

Be sure to look out for your questionnaire on your *GroupWise*!

Tell us how you feel about these topics:

- OT as a Profession
- Working for the Government
- Management and Supervision
- Salaries and Benefits
- Working Conditions
- Relationships at Work

And LOTS more!!

If you have any questions or if you do not receive your questionnaire, please contact me at:

Juanita Swanepoel

Participation is voluntary!

All info will be treated as

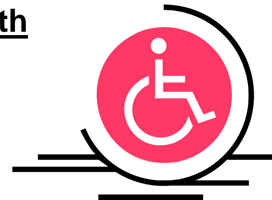
Annexure D

Information Document

(English and Afrikaans)

University of the Free State
Department of Occupational Therapy
Information Document

"The Job Satisfaction of Occupational Therapists in the Public Health Sector"



RESEARCH TEAM and CONTACT DETAILS

Lead Researcher:	J. M Swanepoel 0849411838 (cell) 051-4039678 (work)
Study leader:	Me. R van Heerden Head: Dept of Occupational Therapy, UFS 051-4012829
Co-study leader :	Me. T van der Merwe Dept of Occupational Therapy, UFS 051-4012829

Dear Occupational Therapist

You are being asked to participate in a research study investigating the job satisfaction of occupational therapists (OT) in the public health sector (PHS).

We are interested in determining what aspects of being an OT in the PHS leads to your feeling satisfied and dissatisfied in your current job. It is envisaged that by determining these aspects we will be able to make recommendations that will help to improve your job satisfaction.

By participating in this study you will have the opportunity to express your views and feelings on a variety of subjects which concern us as OT's in the PHS and in time be responsible for improving your own job satisfaction. These subjects include occupational therapy as a profession, professional status, working in the PHS, management and supervision, salary, physical working conditions and relationships at work.

We provide the following information regarding the study in order to ensure that you are fully informed before you chose to participate.

1. PURPOSE OF STUDY

The main objective of this study is to investigate the job satisfaction status of occupational therapists in the public health sector in an effort to identify and describe common factors leading to satisfaction and dissatisfaction.

The researcher also proposes to explore your perceptions of regarding job satisfaction. This will assist the researcher in gathering information regarding which aspects of job satisfaction you attach the most and least meaning to.

In addition, the information gathered during the course of this study will enable the researchers to make recommendations as to possible guidelines which can be implemented in the PHS to optimise your job satisfaction.

2. APPROVAL OF THE STUDY

The study and its procedures have been approved by the ethical committee of the University of the Free State. (Ethics number: ……….)

3. RESEARCH POCEDURES

3.1 SUBJECTS

All Occupational therapists from Level 7 upwards working in the public health sector of the FS will be included in this study. Therapists must have a current registration with the HPCSA and must be working as clinicians or direct managers of clinical services. Community service occupational therapists are also included.

3.1.1 Number of Participants and Time Commitment

This study will include approximately 130 occupational therapists and will involve approximately 20-30 minutes of your time in order to complete the questionnaire. Between 15 and 25 therapists will be randomly selected to take part in interviews conducted by the researcher. These interviews will last for 1-2 hours and will, where possible be conducted at your convenience. *If you do not wish to take part in the interviews, you may still complete only the questionnaire.*

4. PROCEDURES

You will be asked to complete an anonymous questionnaire which will be distributed to you via *GroupWise*. All questions in the questionnaire relate to your job satisfaction. There are approximately 120 questions to answer. All

questions are multiple-choice accept for three open questions. Completed questionnaires can be returned via *GroupWise*.

The participants selected for the interviews will be contacted and appointments made with them. The researcher will travel to the interviewees' private residence or place of work after obtaining your consent to participate in the interviews. The interviews are semi-structured and will be audio-recorded. A transcribed form of the interview will be sent back to each participant for verification. You may also request a copy of the audio-recording if you so wish.

5. RISKS AND DISCOMFORTS

There are no known risks and/or discomforts associated with the procedures described in this study. Participation is voluntary.

6. BENEFITS

Although many of you will not directly benefit from this study, the results of this study will enable occupational therapy managers to identify areas of successful practice as well as areas of growth in order to improve on strategies aimed at enhancing the job satisfaction of their subordinates.

In addition, the study gives voice to the concerns and opinions of therapists working in the field, giving you the opportunity to play an active role in enhancing your own job satisfaction.

The study will shed light on the issues most distressing health practitioners in the public health system, thus providing valuable information regarding practices to top managers in the Free State Department of Health.

7. ALTERNATIVES TO PARTICIPATION

If you decide not to participate, or if you withdraw from this study before it is completed, you may choose to make your own views on job satisfaction available to the management of your institutions. You can do this by:

- Selecting a representative from the union to present your views at the institution/union meeting.
- Writing a submission to the institution's management detailing your views.

8. COMPENSATION, COSTS AND REIMBURSEMENT

8.1 Compensation for Participation

Neither you nor the institutions will receive any financial remuneration for participation in this study.

8.2 Costs

There will be no costs incurred on your part for participation in this study. The researcher covers all costs.

9. WITHDRAWAL OR TERMINATION FROM THE STUDY

Participation is voluntary. You are free to withdraw from this study at any time without penalty or prejudice.

10. CONFIDENTIALITY

The information you provide will be coded. This ensures that no information can be linked to you personally. Your identity will not be revealed during the study, as no name is required on the questionnaire. Potentially identifying information such as area of work will not be revealed during the study or when the study is reported or published.

The identity of all interviewees will be treated confidentially. Every effort will be made on the part of the researcher to see to this.

10.1 Data Access

The researcher, the biostatistician and the study leaders at the University of the Free State will be the only persons to have access to the data. These persons are all subject to strict codes of confidentially and professional ethics and will as such handle all information in a highly confidential manner.

11. NEW FINDINGS

If, during the course of this study, significant new information becomes available that may relate to your willingness to continue to participate in the study, this information will be provided to you by the researcher.

12. CONTACT DETAILS OF THE RESERCHERS

If you have any questions, please feel free to contact the researchers at the above-mentioned contact numbers.

13. CONSENT

Please note that as the questionnaire will be administered electronically no written signature can be obtained from you. If you choose to complete and return the questionnaire you are automatically giving your consent to participate in the study.

You will however, be asked to delete the “x” in the consent block at the top of the questionnaire and return the questionnaire if you do not wish to participate. Alternatively, you may choose to simply return the questionnaire uncompleted.

If you agree to participate in the interview, you will be asked to sign a written consent form on the day of the interview.

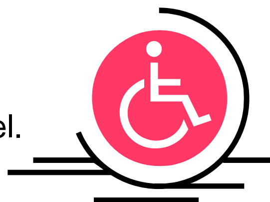
It is the intention of the researcher to make public the data collected during this study in the form of publication or an information session. Please note that confidentiality will still be assured.

Please note that a debriefing session can be arranged at your convenience for the duration of the study and thereafter should you feel needful of it.

We thank you for your consideration of our request in this matter and hope that you will see the benefit of participating in this study.

Yours sincerely,

Juanita Swanepoel.



Universiteit van die Vrystaat
Department van Arbeidsterapie
Inligtingsdokument

"Die Werksbevrediging van Arbeidsterapeute in die Openbare gesondheidsektor"

NAVORSINGSPAN en KONTAKBESONDERHEDE

Hoofnavorser: J. M Swanepoel
0849411838 (sel)
051-4039678 (werk)

Studieleier: Me. R van Heerden
Hoof: Dept Arbeidsterapie, UV
051-4012829

Medestudieleier: Me. T van der Merwe
Dept Arbeidsterapie, UV
051-4012829

Geagte Arbeidsterapeut

U word gevra om deel te neem aan 'n navorsingstudie wat die werksbevrediging van arbeidsterapeute (AT) in die openbare gesondheidssektor (OGS) ondersoek.

Graag will ons bepaal watter aspekte van AT wees in die OGS (staatsdiens) aanleiding gee tot bevrediging en ontevredenheid in u huidige werk. Daar word voorsien dat die bepaling van hierdie aspekte ons in staat sal stel om aanbevelings te maak om u werksbevrediging moontlik te verhoog.

Deur aan hierdie studie deel te neem, sal u die geleentheid kry om u mening en gevoelens oor 'n verskeidenheid van onderwerpe wat ons as AT's in die OGS raak, uit te druk. Hierdie onderwerpe sluit in: arbeidsterapie as 'n beroep, professionele status, die OGS, bestuur en toesig, salaris, fisiese werkstoestande en werksverhoudings.

Ons voorsien die volgende inligting betrekkende die studie ten einde te verseker dat u ten volle ingelig is voordat u besluit om deel te neem.

1. DOEL VAN DIE STUDIE

Die hoofdoel van hierdie studie is om die werkstevredenheidstatus van arbeidsterapeute in die openbare gesondheidsektor te ondersoek in 'n poging om die algemene faktore wat tot tevredenheid en ontevredenheid lei te identifiseer en te beskryf.

Die navorser beywer ook om u persepsies en emosies betreffende u werksbevrediging te verken. Hierdie aspek van die navorsingsproses sal die navorser help om inligting rakende watter aspekte van werksbevrediging u die minste en meeste betekenis aan heg, te identifiseer.

Verder word daar aangeneem dat die inligting wat deur die loop van hierdie studie versamel word die navorsers in staat sal stel om aanbevelings te maak rakende moontlike riglyne wat in die OGS geïmplimenteer kan word om u werksbevrediging te optimaliseer.

2. GOEDKEURING VAN DIE STUDIE

Die studie en die prosedures is deur die etiese komitee van die Universiteit van die Vrystaat goedgekeur (Etieknommer: ……….).

3. NAVORSINGSPROSEDURES

3.1 POPULASIE

Alle arbeidsterapeute vanaf Vlak 7 opwaarts wat in die openbare gesondheidsektor in die Vrystaat werk, sal in hierdie studie ingesluit word. Terapeute moet 'n huidige registrasie met die GBRSA hê en moet as klinikuste of direkte bestuurders van kliniese dienste werk. Gemeenskapsdiensarbeidsterapeute word ook in hierdie studie ingesluit.

3.1.1 Aantal deelnemers en Tydverpligting

Hierdie studie sal ongeveer 130 arbeidsterapeute insluit en sal ongeveer 15 – 20 minute van u tyd betrek ten einde hierdie vraelys te voltooi. Tussen 15 en 25 terapeute sal lukraak gekies word om deel te neem aan onderhoude wat deur die navorser gevoer word. Hierdie onderhoude sal tussen 1 en 2 uur duur en sal, waar moontlik, volgens u gemak uitgevoer word. Indien u nie aan die onderhoude wil deelneem nie, kan u steeds net die vraelys voltooi.

4. PROSEDURES

U sal gevra word om 'n anonieme vraelys te voltooi wat via *GroupWise* versprei sal word. Alle vrae op die vraelys is verwant aan u werksbevrediging. Daar is

ongeveer 120 vrae om te beantwoord. Alle vrae is veelkeusige vrae behalwe vir drie oop vrae. Voltooide vraelyste kan via *GroupWise* teruggestuur word.

Die deelnemers wat vir die onderhoude gekies is, sal gekontak word om ’n afspraak met hulle te maak. Die navorser sal na die ondervraagdes se private woning of werksplek reis nadat toestemming deur die ondervraagdes gegee is. Die onderhoude is semi-gestruktueerd en sal op oudioband opgeneem word. ’n Transkripsie van die onderhoud sal aan elke deelnemer gestuur word vir bevestiging. U kan ook vir ’n afskrif van die oudioband-opname aanvra indien dit u geval.

5. RISIKO’S EN ONGEMAKLIKHEDE

Daar is geen bekende risiko’s en/of ongemaklikhede wat met die prosedures wat in hierdie studie beskryf is, geassosieer word nie. Deelname is vrywillig.

6. VOORDELE

Alhoewel van u nie direk voordeel uit hierdie studie sal trek nie, sal die resultate van hierdie studie arbeidsterapie-bestuurders in staat stel om gebiede van suksesvolle beoefening asook gebiede van groei te identifiseer, ten einde strategieë te verbeter wat op die verhoging van werksbevrediging van hul kollega’s gemik is.

Daarby gee die studie ’n stem aan die besorgdhede en opinies van terapeute wat in die veld werk, wat u die geleentheid bied om ’n aktiewe rol in die verhoging van u eie werksbevrediging te speel.

Die studie sal lig werp op die kwessies wat die meeste bekommernis vir gesondheidspraktisyne in die openbare gesondheidsektor inhou, wat sodoende kosbare inligting betrekkende praktyke aan topbestuurders in die Vrystaatse Gesonheidsdepartement voorsien.

7. ALTERNATIEWE TOT DEELNAME

Indien u besluit om nie deel te neem nie, of as u uit die studie wil onttrek voordat dit voltooi is, kan u kies om u eie opinie oor u werksbevrediging aan die bestuur van u instansies beskikbaar te maak. U kan dit doen deur:

- ’n verteenwoordigde van die unie te nader om u opinie by die instansie/unievergadering aan te bied.
- ’n voorlegging aan die instansie se bestuur te skryf wat u sieninge opsom.

8. VERGOEDING, KOSTES EN TERUGBETALING

8.1 Vergoeding vir deelname

Nie u of die instansies waarvoor u werk sal enige finansiële vergoeding vir deelname in hierdie studie ontvang nie.

8.2 Kostes

Daar sal geen kostes wees om aan hierdie studie deel te neem nie; die navorser dek alle kostes.

9. ONTTREKKING OF AFBREKING VAN DIE STUDIE

Deelname is vrywillig. U kan te enige tyd van hierdie studie onttrek sonder enige penalisasie of vooroordeel.

10. VERTROULIKHEID

Die inligting wat u voorsien sal gekodeer word. Dit verseker dat geen inligting persoonlik aan u verbind kan word nie. U identiteit sal nie gedurende die studie bekend gemaak word nie, aangesien geen naam op die vraelys vereis word nie. Gedurende die studie of wanneer die resultate van die studie gerapporteer of uitgegee word, sal daar ook geen inligting bekend gemaak word wat u potensiëel kan identifiseer nie.

Die identiteit van alle ondervraagdes sal vertroulik hanteer word. Die navorser sal elke poging aanwend om dit te verseker.

10.1 Datatoegang

Die navorser, die biostatistikus en die studieleiers by die Universiteit van die Vrystaat is die enigste persone met toegang tot die data. Elkeen is onderhewig aan ’n streng kode van vertroulikheid en professionele etiek en sal alle inligting in ’n hoogs vertroulike wyse hanteer.

11. NUWE BEVINDINGE

Indien daar gedurende die loop van hierdie studie belangrike nuwe inligting na vore kom wat u gewilligheid om aan hierdie studie deel te neem kan beinvloed, sal hierdie inligting aan u verskaf word.

12. KONTAKBESONDERHEDE VAN DIE NAVORSERS

Indien u enige vrae het, voel vry om die navorsers by die bogenoemde nommers te kontak.

13. TOESTEMMING

Let wel, aangesien die vraelys elektronies geadministreer word, geen geskrewe handtekening van u af verkry kan word nie. Indien u die vraelys voltooi en terugbesorg, gee u outomaties u toestemming om aan die studie deel te neem.

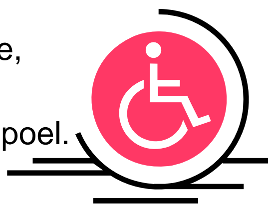
U sal egter gevra word om die “x” in die toestemmingboks heel bo aan die vraelys uit te vee en die vraelys terug te stuur indien u nie wil deelneem nie. Alternatiwelik kan u eenvoudig die vraelys onvoltooid terugstuur.

Indien u geselekteer word om aan ‘n onderhoud deel te neem, sal u gevra word om geskrewe toestemming op die dag van die onderhoud te onderteken.

Ons bedank u vir u inagneming van ons versoek in hierdie saak en hoop dat u die voordeel van u deelname in hierdie studie sal sien.

Geheel die uwe,

Juanita Swanepoel.



Annexure E

Consent for study

(English)

FREE STATE PROVINCE

To:	Me. A.S.Sesing – CEO National District Hospital
Re:	Consent for occupational therapy research study

1. PURPOSE

The purpose of this communication is to obtain your consent for conducting a research study amongst the occupational therapists of National District Hospital (NDH) and the Free Sate (FS) Department of Health between July and September 2008.

The topic of the study is "The Job Satisfaction of Occupational Therapist in the Public Health Sector, FS". The study will be conducted by Me. J. M Swanepoel (from NDH) under the supervision of her study leaders, Me. R van Heerden, Me. T van der Merwe and Me. R Nel (all from the University of the Free State (UFS)).

2. MOTIVATION

The research study will be conducted as part of the requirements for Me. Swanepoel to obtain a Master's degree in Occupational Therapy from UFS.

3. PURPOSE OF STUDY

The main objective of this study is to investigate the job satisfaction status of occupational therapists in the public health sector in an effort to identify and describe common factors leading to satisfaction and dissatisfaction among them.

The researcher also proposes to explore the perceptions of occupational therapists regarding their job satisfaction. This will assist the researcher in gathering information regarding aspect of job satisfaction the therapists attach meaning to.

In addition, it is envisaged that the information gathered during the course of this study will enable the researchers to make recommendations as to possible guidelines which can be implemented in the PHS to optimize the job satisfaction of occupational therapists.

4. APPROVAL OF THE STUDY

The study and its procedures have been approved by the ethical committee of the University of the Free State. (Ethics number: ………..)

5. RESEARCH POCEDURES

5.1 SUBJECTS

All Occupational therapists from Level 7 upwards working in the public health sector of the FS will be included in this study. Therapists must have a current registration with the HPCSA and must be working as clinicians or direct managers of clinical services. Community service occupational therapists will be included.

5.1.1 Number of Participants and Time Commitment

This study will include approximately 130 occupational therapists and will involve approximately 15 - 20 minutes of their time in order to complete the questionnaire. Between 15 and 25 therapists will be randomly selected to take part in interviews conducted by the researcher. These interviews will last for 1-2 hours and will, where possible be conducted after-hours or at such a time when normal working duties will not be adversely affected.

5.2 PROCEDURES

Participants will be asked to complete an anonymous questionnaire which will be distributed to them via *GroupWise*. All questions in the questionnaire relate to their job satisfaction. There are approximately 120 questions to answer. All questions are multiple-choice accept for three open questions. Completed questionnaires will be returned via *GroupWise*.

The participants selected for the interviews will be contacted and appointments made with them. The researcher will travel to the interviewees' private residence or place of work after obtaining their consent to participate in the interviews. The interviews are semi-structured and will be audio-recorded. A transcribed form of the interview will be sent back to each participant for verification.

6. RISKS AND DISCOMFORTS

There are no known risks and/or discomforts associated with the procedures described in this study. Participation is voluntary on the part of the therapists.

7. BENEFITS

Although participants will not directly benefit from this study, the results of this study will enable occupational therapy managers to identify areas of successful practice as well as areas of growth in order to improve on strategies aimed at enhancing the job satisfaction of their subordinates.

In addition, the study gives voice to the concerns and opinions of therapists working in the field, giving them the opportunity to play an active role in enhancing their own job satisfaction.

The study will shed light on the issues most distressing health practitioners in the public health system, thus providing valuable information regarding practices to top managers in the Free State Department of Health.

8. ALTERNATIVES TO PARTICIPATION

If subjects decide not to participate, or if they withdraw from this study before it is completed, they may choose to make their own views on job satisfaction available to the management of their institutions hospital. They can do this by:

- ❖ Selecting a representative from the union to present their views at the institution/union meeting.

- ❖ Writing a submission to the institution’s management detailing their views.

9. COMPENSATION, COSTS AND REIMBURSEMENT

9.1 Compensation for Participation

Neither the participants nor the institutions will receive any financial remuneration for participation in this study.

9.2 Costs

There is no cost to the participants for participation in this study. The researcher covers all costs. There are no direct financial implications for the institutions in this study. Indirect financial obligations may occur as a result of the recommendations following this study. Implementation of these recommendations and its consequent financial implication are however subject to the judgment and consideration of the institution’s management.

10. WITHDRAWAL OR TERMINATION FROM THE STUDY

Participants are free to withdraw from this study at any time without penalty or prejudice.

11. CONFIDENTIALITY

The information participants provide will be coded. This ensures that no information can be linked to them personally. Their identity will not be revealed during the study, as no name is required on the questionnaire. Potentially identifying information such as area of work will not be revealed during the study or when the study is reported or published.

The identity of all interviewees will be treated confidentially. Every effort will be made on the part of the researcher to see to this.

11.1 Data Access

The researcher, the bio- statistician and the study leaders at the University of the Free State will be the only persons to have access to the data. These persons are all subject to strict codes of confidentially and professional ethics and will as such handle all information in a highly confidential manner.

12. NEW FINDINGS

If, during the course of this study, significant new information becomes available that may relate to your willingness to continue to approve the study, this information will be provided to you by the researcher.

13. CONTACT DETAILS OF THE RESERCHERS

If you have any questions, please feel free to contact the researchers at the following contact numbers:

Lead Researcher : J. M Swanepoel
0849411838 (cell)
051-4039678 (work)

Study leader : Me. R van Heerden
Head : Department of Occupational Therapy, UFS
051-4012829

Co-study leader : Me. T van der Merwe
Department of Occupational Therapy, UFS
051-4012829

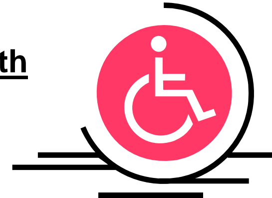
Biostatistician : Me. R Nel
Department of Biostatistics, UFS
051 – 401…..

Submitted by:
……………………………
Me. J.M.Swanepoel
Unit Manager: Occupational Therapy
National District Hospital

RECOMMENDED /NOT RECOMMENDED	RECOMMENDED/NOT RECOMMENDED
………………………………………….. Mr. M. P Kgaphola Head: Clinical Support Services National District Hospital Date: ……………………….	………………………………………….. Me. A.S. Sesing CEO: National District Hospital Date: ……………………..
RECOMMENDED /NOT RECOMMENDED	RECOMMENDED/NOT RECOMMENDED
………………………………………….. Me. N. Sookdin Assistant Manager, FS: Occupational Therapy Date: ……………………….	………………………………………….. Me. R Sibeko General Manager District Health Services Date: ……………………..
RECOMMENDED/NOT RECOMMENDED	APPROVED\NOT APPROVED
………………………………………….. Dr. S Kabane Executive Manager Clinical Health Services Date: ………………………..	………………………………………….. Prof. P.L. Ramela HOD: Health Date: ………………………..

Annexure F
Consent to participate in an interview
(English and Afrikaans)

University of the Free State
Department of Occupational Therapy
Consent to Participate in an Interview



"The Job Satisfaction of Occupational Therapists in the Public Health Sector"

RESEARCH TEAM and CONTACT DETAILS

Lead Researcher:	J. M Swanepoel 0849411838 (cell) 051-4039678 (work)
Study leader:	Me. R van Heerden Head: Dept of Occupational Therapy, UFS 051-4012829
Co-study leader :	Me. T van der Merwe Dept of Occupational Therapy, UFS 051-4012829
Biostatistician:	Me. M Nel Department of Biostatistics, UFS 051 – 4013116

Dear Occupational Therapist

You are being asked to participate in a research study investigating the job satisfaction of occupational therapists (OT) in the public health sector (PHS).

We are interested in determining what aspects of being an OT in the PHS leads to your feeling satisfied and dissatisfied in your current job. It is envisaged that by determining these aspects we will be able to make recommendations that will help to improve your job satisfaction.

By participating in this study you will have the opportunity to express your views and feelings on a variety of subjects which concern us as OT's in the PHS and in time be responsible for improving your own job satisfaction. These subjects include occupational therapy as a profession, professional status, working in the PHS, management and supervision, salary, physical working conditions and relationships at work.

We provide the following information regarding the study in order to ensure that you are fully informed before you chose to participate.

1. PURPOSE OF STUDY

The main objective of this study is to investigate the job satisfaction status of occupational therapists in the public health sector in an effort to identify and describe common factors leading to satisfaction and dissatisfaction.

The researcher also proposes to explore your perceptions of regarding job satisfaction. This will assist the researcher in gathering information regarding which aspects of job satisfaction you attach the most and least meaning to.

In addition, it is envisaged that the information gathered during the course of this study will enable the researchers to make recommendations as to possible guidelines which can be implemented in the PHS to optimize your job satisfaction.

2. APPROVAL OF THE STUDY

The study and its procedures have been approved by the ethical committee of the University of the Free State. (Ethics number: ……….)

3. RESEARCH POCEDURES

3.1 SUBJECTS

All Occupational therapists from Level 7 upwards working in the public health sector of the FS will be included in this study. Therapists must have a current registration with the HPCSA and must be working as clinicians or direct managers of clinical services. Community service occupational therapists will be included.

3.1.1 Number of Participants and Time Commitment

This study will include approximately 130 occupational therapists and will involve approximately 15 - 20 minutes of your time in order to complete the questionnaire. Between 15 and 25 therapists will be randomly selected to take part in interviews conducted by the researcher. These interviews will last for 1-2 hours and will, where possible be conducted at your convenience. *If you do not wish to take part in the interviews, you may still complete only the questionnaire.*

4. PROCEDURES

The participants selected for the interviews will be contacted and appointments made with them. The researcher will travel to the interviewees' private

residence or place of work after obtaining your consent to participate in the interviews. The interviews are semi-structured and will be audio-recorded. A transcribed form of the interview will be sent back to each participant for verification. You may also request a copy of the audio-recording if you so wish.

5. RISKS AND DISCOMFORTS

There are no known risks and/or discomforts associated with the procedures described in this study. Participation is voluntary.

6. BENEFITS

Although many of you will not directly benefit from this study, the results of this study will enable occupational therapy managers to identify areas of successful practice as well as areas of growth in order to improve on strategies aimed at enhancing the job satisfaction of their subordinates.

In addition, the study gives voice to the concerns and opinions of therapists working in the field, giving you the opportunity to play an active role in enhancing your own job satisfaction.

The study will shed light on the issues most distressing health practitioners in the public health system, thus providing valuable information regarding practices to top managers in the Free State Department of Health.

7. ALTERNATIVES TO PARTICIPATION

If you decide not to participate, or if you withdraw from this study before it is completed, you may choose to make your own views on job satisfaction available to the management of your institutions. You can do this by:

- Selecting a representative from the union to present your views at the institution/union meeting.
- Writing a submission to the institution's management detailing your views.

8. COMPENSATION, COSTS AND REIMBURSEMENT

8.1 Compensation for Participation

Neither you nor the institutions will receive any financial remuneration for participation in this study.

8.2 Costs

There will be no costs incurred on your part for participation in this study. The researcher covers all costs.

9. WITHDRAWAL OR TERMINATION FROM THE STUDY

Participation is voluntary. You are free to withdraw from this study at any time without penalty or prejudice.

10. CONFIDENTIALITY

The information you provide will be coded. This ensures that no information can be linked to you personally. Your identity will not be revealed during the study, as no name is required on the questionnaire. Potentially identifying information such as area of work will not be revealed during the study or when the study is reported or published.

The identity of all interviewees will be treated confidentially. Every effort will be made on the part of the researcher to see to this.

10.1 Data Access

Ms. Swanepoel, the biostatistician and the study leaders at the University of the Free State will be the only persons to have access to the data. These persons are all subject to strict codes of confidentially and professional ethics and will as such handle all information in a highly confidential manner.

11. NEW FINDINGS

If, during the course of this study, significant new information becomes available that may relate to your willingness to continue to participate in the study, this information will be provided to you by the researcher.

12. CONTACT DETAILS OF THE RESERCHERS

If you have any questions, please feel free to contact the researchers at the above-mentioned contact numbers.

13. CONSENT

I declare that I have read this document and understand all the risks and benefits of participating in this study.

I, …………………………………………………………, hereby give my consent to participate in an interview conducted by the researcher for the purpose of this study.

……………………………..
Signature

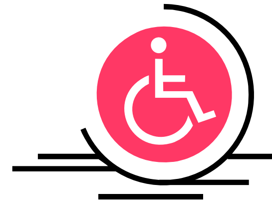
…………………………..
Date

I have explained this study to the subject above and have sought his/her understanding for informed consent.

………………………….
Researcher Signature

……………………………
Date

Universiteit van die Vrystaat
Department van Arbeidsterapie
Toestemming om aan onderhoud deel te neem



"Die Werksbevrediging van Arbeidsterapeute in die Openbare gesondheidsektor"

NAVORSINGSPAN en KONTAKBESONDERHEDE

Hoofnavorser:	J. M Swanepoel 0849411838 (sel) 051-4039678 (werk)
Studieleier:	Me. R van Heerden Hoof: Dept Arbeidsterapie, UV 051-4012829
Medestudieleier:	Me. T van der Merwe Dept Arbeidsterapie, UV 051-4012829
Biostatistikus:	Me. M Nel Dept Biostatistiek, UV 051 – 4013116

Geagte Arbeidsterapeut

U word gevra om deel te neem aan 'n navorsingstudie wat die werksbevrediging van arbeidsterapeute (AT) in die openbare gesondheidssektor (OGS) ondersoek.

Graag will ons bepaal watter aspekte van AT wees in die OGS (staatsdiens) aanleiding gee tot bevrediging en ontevredenheid in u huidige werk. Daar word voorsien dat die bepaling van hierdie aspekte ons in staat sal stel om aanbevelings te maak om u werksbevrediging moontlik te verhoog.

Deur aan hierdie studie deel te neem, sal u die geleentheid kry om u mening en gevoelens oor 'n verskeidenheid van onderwerpe wat ons as AT's in die OGS raak, uit te druk. Hierdie onderwerpe sluit in: arbeidsterapie as 'n beroep,

professionele status, die OGS, bestuur en toesig, salaris, fisiese werkstoestande en werksverhoudings.

Ons voorsien die volgende inligting betrekkende die studie ten einde te verseker dat u ten volle ingelig is voordat u besluit om deel te neem.

1. DOEL VAN DIE STUDIE

Die hoofdoel van hierdie studie is om die werkstevredenheidstatus van arbeidsterapeute in die openbare gesondheidsektor te ondersoek in 'n poging om die algemene faktore wat tot tevredenheid en ontevredenheid lei te identifiseer en te beskryf.

Die navorser beywer ook om u persepsies en emosies betreffende u werksbevrediging te verken. Hierdie aspek van die navorsingsproses sal die navorser help om inligting rakende watter aspekte van werksbevrediging u die minste en meeste betekenis aan heg, te identifiseer.

Verder word daar aangeneem dat die inligting wat deur die loop van hierdie studie versamel word die navorsers in staat sal stel om aanbevelings te maak rakende moontlike riglyne wat in die OGS geïmplimenteer kan word om u werksbevrediging te optimaliseer.

2. GOEDKEURING VAN DIE STUDIE

Die studie en die prosedures is deur die etiese komitee van die Universiteit van die Vrystaat goedgekeur (Etieknommer: ……….).

3. NAVORSINGSPROSEDURES

3.1 POPULASIE

Alle arbeidsterapeute vanaf Vlak 7 opwaarts wat in die openbare gesondheidsektor in die Vrystaat werk, sal in hierdie studie ingesluit word. Terapeute moet 'n huidige registrasie met die GBRSA hê en moet as klinikuste of direkte bestuurders van kliniese dienste werk. Gemeenskapsdiensarbeidsterapeute word ook in hierdie studie ingesluit.

3.1.1 Aantal deelnemers en Tydverpligting

Hierdie studie sal ongeveer130 arbeidsterapeute insluit en sal ongeveer 15 – 20 minute van u tyd betrek ten einde hierdie vraelys te voltooi. Tussen 15 en 25 terapeute sal lukraak gekies word om deel te neem aan onderhoude wat deur die navorser gevoer word. Hierdie onderhoude sal tussen 1 en 2 uur duur en sal, waar moontlik, volgens u gemak uitgevoer word. Indien u nie aan die onderhoude wil deelneem nie, kan u steeds net die vraelys voltooi.

4. PROSEDURES

U sal gevra word om 'n anonieme vraelys te voltooi wat via *GroupWise* versprei sal word. Alle vrae op die vraelys is verwant aan u werksbevrediging. Daar is

ongeveer 120 vrae om te beantwoord. Alle vrae is veelkeusige vrae behalwe vir drie oop vrae. Voltooide vraelyste kan via *GroupWise* teruggestuur word.

Die deelnemers wat vir die onderhoude gekies is, sal gekontak word om ’n afspraak met hulle te maak. Die navorser sal na die ondervraagdes se private woning of werksplek reis nadat toestemming deur die ondervraagdes gegee is. Die onderhoude is semi-gestruktueerd en sal op oudioband opgeneem word. ’n Transkripsie van die onderhoud sal aan elke deelnemer gestuur word vir bevestiging. U kan ook vir ’n afskrif van die oudioband-opname aanvra indien dit u geval.

5. RISIKO’S EN ONGEMAKLIKHEDE

Daar is geen bekende risiko’s en/of ongemaklikhede wat met die prosedures wat in hierdie studie beskryf is, geassosieer word nie. Deelname is vrywillig.

6. VOORDELE

Alhoewel van u nie direk voordeel uit hierdie studie sal trek nie, sal die resultate van hierdie studie arbeidsterapie-bestuurders in staat stel om gebiede van suksesvolle beoefening asook gebiede van groei te identifiseer, ten einde strategieë te verbeter wat op die verhoging van werksbevrediging van hul kollega’s gemik is.

Daarby gee die studie ’n stem aan die besorgdhede en opinies van terapeute wat in die veld werk, wat u die geleentheid bied om ’n aktiewe rol in die verhoging van u eie werksbevrediging te speel.

Die studie sal lig werp op die kwessies wat die meeste bekommernis vir gesondheidspraktisyne in die openbare gesondheidsektor inhou, wat sodoende kosbare inligting betrekkende praktyke aan topbestuurders in die Vrystaatse Gesonheidsdepartement voorsien.

7. ALTERNATIEWE TOT DEELNAME

Indien u besluit om nie deel te neem nie, of as u uit die studie wil onttrek voordat dit voltooi is, kan u kies om u eie opinie oor u werksbevrediging aan die bestuur van u instansies beskikbaar te maak. U kan dit doen deur:

- ’n verteenwoordigde van die unie te nader om u opinie by die instansie-/unievergadering aan te bied.
- ’n voorlegging aan die instansie se bestuur te skryf wat u sieninge opsom.

8. VERGOEDING, KOSTES EN TERUGBETALING

8.1 Vergoeding vir deelname

Nie u of die instansies waarvoor u werk sal enige finansiële vergoeding vir deelname in hierdie studie ontvang nie.

8.2 Kostes

Daar sal geen kostes wees om aan hierdie studie deel te neem nie; die navorser dek alle kostes.

9. ONTTREKKING OF AFBREKING VAN DIE STUDIE

Deelname is vrywillig. U kan te enige tyd van hierdie studie onttrek sonder enige penalisasie of vooroordeel.

10. VERTROULIKHEID

Die inligting wat u voorsien sal gekodeer word. Dit verseker dat geen inligting persoonlik aan u verbind kan word nie. U identiteit sal nie gedurende die studie bekend gemaak word nie, aangesien geen naam op die vraelys vereis word nie. Gedurende die studie of wanneer die resultate van die studie gerapporteer of uitgegee word, sal daar ook geen inligting bekend gemaak word wat u potensiëel kan identifiseer nie.

Die identiteit van alle ondervraagdes sal vertroulik hanteer word. Die navorser sal elke poging aanwend om dit te verseker.

10.1 Datatoegang

Die navorser, die biostatistikus en die studieleiers by die Universiteit van die Vrystaat is die enigste persone met toegang tot die data. Elkeen is onderhewig aan ’n streng kode van vertroulikheid en professionele etiek en sal alle inligting in ’n hoogs vertroulike wyse hanteer.

11. NUWE BEVINDINGE

Indien daar gedurende die loop van hierdie studie belangrike nuwe inligting na vore kom wat u gewilligheid om aan hierdie studie deel te neem kan beinvloed, sal hierdie inligting aan u verskaf word.

12. KONTAKBESONDERHEDE VAN DIE NAVORSERS

Indien u enige vrae het, voel vry om die navorsers by die bogenoemde nommers te kontak.

13. TOESTEMMING

Ek verklaar dat ek hierdie dokument gelees het en dat ek die risiko's om aan hierdie studie deel te neem verstaan.

Ek, ………………………………………………………………., gee hiermee my toestemming om aan die onderhoud wat deur die navorser vir die doel van hierdie studie gevoer gaan word, deel te neem.

……………………………..   …………………………..

Handtekening   Datum

Ek het hierdie studie aan die bostaande persoon verduidelik en het sy/haar begrip vir ingeligte toestemming verkry.

………………………….   ……………………………

Navorser handtekening   Datum