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Paediatricians and trainee paediatricians perspectives on industrial action by medical doctors in Nigeria

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Abstract*: Background:* Industrial actions have become a common means by which medical doctors attempt to communicate their grievances to the government. Paediatricians are frequently caught between a desire to support the course of their professional association and caring for their patients. The purpose of this study was to assess the opinion of paediatricians and trainee paediatricians regarding strike actions, the likely cause(s) and their reasons for and against industrial actions as a means for communicating grievances to the government.
Methods: A cross-sectional descriptive study was conducted using self-administered questionnaires randomly distributed to consenting participants at the 48th Annual Scientific Conference of the Paediatric Association of Nigeria. Data were analysed using SPSS version 20.
Results: A total of 102 respondents from the 6 geopolitical zones in Nigeria returned appropriately filled forms. Fifty-seven (55.9%) were females, 91 (81.2%) were married, 72 (70.6%) were Christians and 49 (48%) were Consultant paediatricians. Poor remuneration (36%), poor working conditions(24.3%) and failure of the government to keep promises to doctors (19.9%) were the top three reasons given for the incessant industrial actions in the recent past. Forty-nine percent of respondents did not support industrial actions, 65% responded that strikes affect the quality of training and practice and (84.3%) volunteer their services during a strike.
Conclusions: Industrial actions are not the paediatricians' preferred means of communicating grievances. Other methods should, therefore, be explored to limit the deleterious effects of industrial actions.

Keywords: Paediatrician, Nigeria, industrial action, strike, medical doctors, trainee

Introduction

Industrial actions, otherwise called 'strikes' frequently occur, the world over, and date back to the 12th Century BC.[1] It can be described as a collective action taken by employees as a protest to settle a workplace dispute about working conditions or to enforce their demands.[2] Doctors in Nigeria have often used this means to drive home their demands and grievances however the frequency and prolonged duration of industrial actions amongst doctors in Nigeria, sadly, has been on the increase.[3] The reasons given for embarking on these industrial actions are numerous and seem to be similar at every occasion of a strike.[2]Reasons given include poor staff welfare, poor remuneration, lack of basic facilities for work, poor management and funding of the healthcare system and so on.[3]While some strike actions have been judged as being productive in retrospect, many others seem to have come and gone with a majority of the demands made yet unmet.

There is also the concept of 'morality' as one may wonder, though a medical doctor is unsatisfied with the working conditions of his workplace, is he morally justified to 'down tools', knowing that many lives may be lost in the process?[4]Paediatricians are often caught in this dilemma, to either partake in an industrial action demanding better working conditions or to continue rendering uninterrupted care to their often so tender and innocent patients. Oleribe et al,[5]reported in their study that out of a total of at least 17 industrial actions involving public workers in Nigeria occurring over one year, six of them occurred in the health sector. Hence strike actions within the health sector occur commonly in Nigeria, to the detriment of the general public. Also, the Nigerian doctor is often regarded as being powerful and privileged, and these attributes are seen as capitalized on in the pursuit of their interests.[6]

Some negative effects of strike actions include, increased morbidity and mortality of sick persons, reduced

revenue generation in the health sector, poor health indices for the country and hence reduced gains from medical tourists.[3,5]It also adversely affects medical education as medical students usually undergo hospital rotations where they get hands-on clinical experience and training.[7]Strikes have also been reported in the western countries, though these strikes are often of much shorter duration and hence have minimal impact on the health indices.[7,8]Metcalfe *et al*[7] studied strikes among doctors in the USA, Israel, Spain, Croatia, South Africa, India and the UK. Most of these strikes lasted 24-48 hours. Of all the countries studied, only the strike action in South Africa lasted as long as 20 days and resulted in increased mortality rates, as patients presenting in emergency departments were 67% more likely to die than during a normal period.[7]When considering the difference, frequency and duration of strikes by health workers in low-income and high-income countries, it is clear that health systems of the two groups differ in terms of availability and management of resources, with probably better overall job-satisfaction in the high-income, compared with the middle and low-income countries.[9]

The paediatrician, a specialist in child care, is by training not only a physician for children but also an advocate for this vulnerable group of individuals. A paediatrician's utmost desire is to, at all times uphold the fundamental human rights of every child which includes a right to access basic health care, when needed. Every child should be born with equitable and optimal chance to survive, grow and develop. This study, therefore, sought to find out the paediatricians and trainee paediatricians perspectives on industrial actions by medical doctors in Nigeria, its cause(s) and their reasons for and against industrial actions as a means of communicating grievances towards the government.

Methodology

This study was a cross-sectional survey. The study included paediatricians and trainee paediatricians (junior registrars and senior registrars) who attended the 48thconference of the Paediatric Association of Nigeria (PANConf, 2017) in Kaduna, Nigeria. The PANConf is the largest gathering of paediatricians and allied healthcare workers involved or interested in child health in Nigeria. This Annual General and Scientific Conference takes place in January at different locations in the country and serves as an avenue for deliberations, promotion of knowledge and exchange of information affecting the child health specialists and on the health of the Nigerian child. It is organized by the Paediatric Association of Nigeria (PAN).

The sample size was estimated using the Cochran formula for proportions $N_0 = Z^2pq/ e^2$. We assumed p = 43.6% obtained from the prevalence of health workers consenting to industrial actions in a previous study[3] in Nigeria. N_0 = sample size, Z = 1.96 and e = 5%, hence, N_0 = 378. However, the authors also applied the finite population formula, as attendance of paediatricians at PAN Conferences vary, we estimated that about 250 paediatricians and trainees would likely be in attendance (excluding nurses and other allied healthcare workers), taking into cognizance the issue of insurgency and proximity to the conference venue in Kaduna, North West of Nigeria. Hence an estimated sample size of 150 was calculated.

We used a questionnaire which had been pretested for accuracy, analysability, and acceptability. The pretest was done among 20 paediatricians and paediatric nurses during a seminar at the Department of Paediatrics, University of Port Harcourt Teaching Hospital (these were not included in the study). Ambiguous questions identified were corrected. The questionnaire had 20 different questions that were, both close and open-ended to allow participants' adequately express their views and to prevent biased responses from single option or closed questions.

The country Nigeria has 36 states including the Federal Capital Territory and is divided into six geopolitical zones as follow; North East { Adamawa, Bauchi, Borno, Gombe, Taraba, Yobe}, North Central { Benue, Kogi, Kwara, Nasarawa, Niger, Plateau and Federal Capital Territory}, North West {Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto, Zamfara}, South East {Abia, Anambra, Ebonyi, Enugu, Imo}, South-South { Akwa Ibom, Bayelsa, Cross River, Rivers, Delta, Edo}, South West { Ekiti, Lagos, Ogun, Ondo, Osun, Oyo}. This was used to ascertain the spread of the respondents and classify them accordingly.

A systematic sampling technique was used. Questionnaires were shared to consenting participants mainly during the morning symposium sessions when all registered conference attendees were seated in the same hall for about an hour. Authors distributed 150 questionnaires to every 3rd participant sitting in a row. The pretested, self-administered, semi-structured questionnaire was used to derive information about their sociodemographics and the subject matter was then distributed to participants who gave consent. Filled out questionnaires were retrieved continuously throughout the three-day duration of the conference.

Permission to collect the data was granted by the local organizing committee of the conference. Participants were initially given background information on the aim and objectives of the study and were told participation was voluntary and refusal attracted no negative consequences.

Completed questionnaires were collected, screened for accuracy and completeness, and analysed using SPSS v 20 (SPSS Inc., Chicago, Illinois, USA). Simple frequencies and cross tables were performed, and relevant tables were developed. Chi-squared test was used to test for significant associations and p-value of 0.05 or less was considered statistically significant.

Results

A total of 150 questionnaires were distributed to the paediatricians and trainee paediatricians, and 102 returned appropriately filled questionnaires, giving a response rate of 68 %.

Demographic characteristics of respondents

Of the 102 respondents, females were 57 (55.9%), males were 45 (44.1%) and their mean age was 41±7.98 years. The respondents between 35 to 44 years of age were in the majority (table 1). Of the 102 respondents, 91 (81.2%) were married, 72 (70.6%) were Christians and 49 (48%) of the respondents were Consultant Paediatricians - fellows of the West African college of physicians, and/or fellows of the National Postgraduate Medical College of Nigeria. Although respondents from all six geopolitical zones in Nigeria were represented as seen in Table 2, the majority of them were from the North-central (31, 30.4%) and North-West (30, 29.4%) geopolitical zones. The least represented regions were the North-East (6, 5.9%) and South-East(6, 5.9%). geopolitical zones.

The top three common causes of industrial actions among medical doctors in the healthcare care system in Nigeria as cited by 54.4%, 36.7 % and 30.0% of respondents were poor remuneration, poor working conditions and failure of the government to keep promises. The least common causes cited by 3.3%, 2.2% and 1.1% of respondents were clashes between health workers, unreasonable demands by doctors and registrars were not considered important (Table 3). When asked about their opinion concerning industrial actions among medical doctors, about a third (28.4%) were in support of industrial actions but nearly half (49%) did not (Fig 1). The most common reasons given by respondents for non-support of industrial actions were that it affects the quality of training and practise (65.0%) and strikes were usually not effective 35.0% (Table 4). On the contrary, the most common reason given by 60% of respondents in support of industrial actions was that it is the only language the Nigerian government understands (Table 5).When asked about volunteering to provide services during industrial actions, the majority (84.3%) of respondents admitted they volunteer to provide services even when their professional association(s) declare a strike (Fig2).On a scale of preference, when respondents' opinion on support for industrial actions was compared to their professional ranks, trainee paediatricians (junior registrars and senior registrars) had significantly more support for industrial actions (p= 0.044) than consultant paediatricians (Table 6).

Table 1: Socio demographic characteristics of the respondents

Variables	Frequency	Percent
Age group		
25-34	20	19.6
35-44	42	41.2
45-54	23	22.5
55-64	4	3.9
NR*	13	12.7
Gender		
Male	45	44.1
Female	57	55.9
Marital Status		
Single	11	10.7
Married	91	81.2
Rank		
Junior Registrar	22	21.6
Senior Registrar	31	30.4
Consultant	49	48.0
Religion		
Christian	72	70.6
Muslim	30	29.4
Tribe		
Igbo	17	16.7
Hausa	16	15.7
Yoruba	29	28.4
Others	26	25.5
NR*	14	13.7

NR* No response

Table 2: Geopolitical zones of the hospitals of the respondents

Geopolitical Zone	Frequency	Percent
North-central	31	30.4
North-west	30	29.4
North-east	6	5.9
South-west	13	12.7
South-east	6	5.9
South-south	16	15.7

Table 3: Main reasons for industrial actions in Nigeria

Reasons	Responses		Percent of cases* (N=90)
	N	Percentage	
Poor working conditions	33	24.3	36.7
Poor management	12	8.8	13.3
Government failure to keep promises	27	19.9	30.0
Registrars are not considered important	1	0.7	1.1
Bad policies and poor health care funding	8	5.9	8.9
Registrars want time off the heavy workload	1	0.7	1.1
Clashes between health workers	3	2.2	3.3
Unreasonable demands by doctors	2	1.5	2.2
Poor remuneration	49	36.0	54.4

*cases are the total number of respondents who answered this question

Fig 1: Respondents' opinion concerning the support of industrial actions by medical doctors

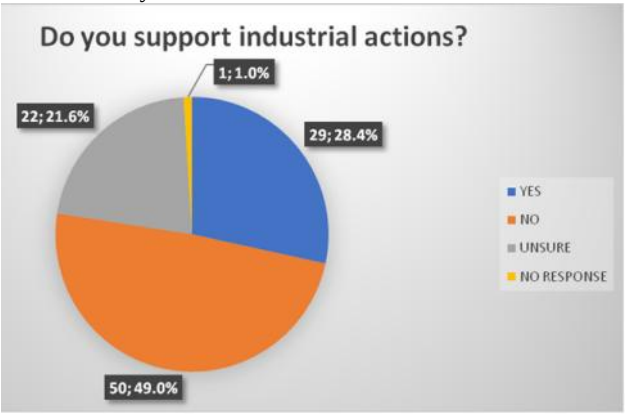

Table 4: Reasons given by some respondents for non- support of industrial actions

Reasons	Responses N	Percentage	Percent of cases* (N=40)
Affects the quality of training and practice	26	50.0	65.0
Contributes to decay in the health sector	3	5.8	7.5
Clients lose confidence in us	5	9.6	12.5
It is not always effective	14	26.9	35.0
It is unethical	4	7.7	10.0

*cases are the total number of respondents who answered this question

Table 5: Reasons given by some respondents for supporting Industrial action

Reasons	Responses N	Percentage	Percent of cases* (N=25)
Occasionally needed to redress the Health sector problems	1	3.2	4.0
It is the only language that the Government understands	15	48.4	60.0
When doctors are not well paid	5	16.1	20.0
When work conditions are harsh	5	16.1	20.0
It is the only way to get our demands met	4	12.9	16.0
Doctors are not appreciated	1	3.2	4.0

*cases are the total number of respondents who answered this question

Fig 2: Respondents' answers to whether they volunteer to provide services during industrial action

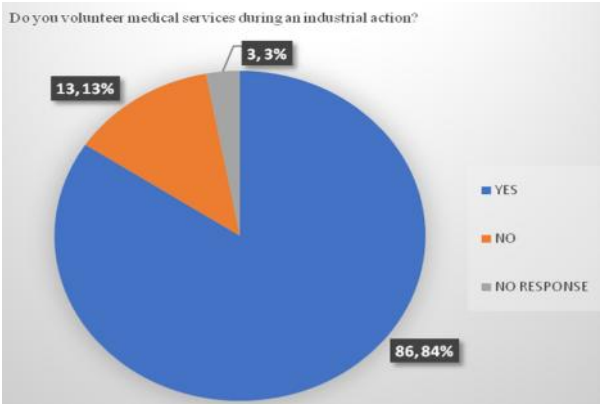

Table 6: Association between respondents' opinion on industrial action and their ranks

Rank	Do you support industrial action? Yes n (%)	No n(%)	Unsure n(%)	χ^2	P	95%CI
Junior registrar	9(32.1)	7(14.3)	5(22.5)	9.815	0.044 *	(0.044, 0.048)
Senior registrar	9(32.1)	11(22.4)	10(45.5)			
Consultant	10 (35.7)	31(63.3)	7(31.8)			

CI-confidence interval, * statistically significant

Discussion

The health workers from the North Central (NC) and North West (NW) geopolitical regions were the most represented in our sample population while the South East (SE) and North East (NE) were the least. The location of the conference in which the study was conducted was in the North West and the North Central region shares boundaries with the North West and so proximity could account for their high representation.

The recent trend of incessant industrial actions by medical doctors in Nigeria is a major cause for concern. Our study identified that the three main reasons cited by respondents as the causes of industrial actions were poor remuneration, poor working conditions, and failure of the government to keep to their promises of welfare to doctors. Our findings were in keeping with a study by Oleribe et al[5]where150 health workers from the six geopolitical zones of Nigeria identified poor staff welfare to be the most common reason for strikes. Similarly, Russo et al,[9] in a systematic review which included 70 strikes among health workers in low-income countries, spanning from 2009 to 2018, stated that the most commonly reported causes for industrial actions were issues about remuneration, followed by a protest against the sector's governance or policies and thereafter safety of working conditions. Poor remunerations and welfare of health workers were cited by most respondents as the main reason for industrial actions in this study.

This includes delayed payment of salaries, being owed for several months and a wide disparity in the remuneration of healthcare workers on the same grade levels across the three tiers of government.[3,10] Poor working conditions as the second commonest cause for industrial actions might also arise from poor management in government-owned hospitals. Unlike the findings in this study, healthcare leadership and management issues were cited as the most common cause of industrial actions in an earlier study by Oleribe et al.[3] Public hospitals are headed by clinical specialists who, though experts in their respective fields of medicine, do not necessarily have managerial training skills or experience in hospital management.[10] This gap in managerial skills then become evident because medical doctors can unintentionally approach hospital management with a 'clinical orientation' form of patient-centred leadership. Consequently, when the already limited resources

(money, manpower and materials) available to the hospitals are not judiciously utilised, employees become dissatisfied and are more likely to incite strikes. In similar studies in Nigeria, it has been proposed that management courses be incorporated into the medical curriculum beginning from preservice years.[5,11]Furthermore, the failure of the government to implement agreements cited by respondents in this study, as the third commonest cause of industrial actions compared favourably with findings from other studies among healthcare workers in Nigeria[3,5] It is worrisome that the government as at the time of this research was yet to amicably arrive at a compromise with the demands of medical doctors and the implementation of the 2014 National Heath Act was yet to be fulfilled.[3]The World Health Organization had stated that a strong health system should have a robust finance structure, well trained and remunerated workforce, sufficient and highly maintained facilities, adequate logistics for vaccines, medicine, technologies and a reliable health information system that is regularly updated.[12]The healthcare system in Nigeria, unfortunately, would not be able to attain a 'strong health system'if more sincerity is not displayed on the part of the government and signed agreements are not only on paper but fulfilled.

Our study revealed that majority of the respondents did not support industrial strike actions. First and foremost is the fact that paediatricians, like other doctors, have frequent exposure to patients and have fiduciary responsibilities to them. This perhaps makes medical doctors less committed to embarking on strikes to the detriment of patient care. It is possible that our finding buttresses the 'moral' intuitive nature of the medical doctor to save lives as is suggested by most respondents volunteering medical services even during industrial actions. Although in the study by Oleribe et al,[5] it was reported that medical doctors were the initiators of a majority of the strikes and parenthetically destabilized the healthcare system, it is plausible that embarking on industrial actions, were in fact, an unwanted yet unavoidable means to communicate their grievances due to the government's failure to satisfactorily tackle already recurring setbacks if healthcare services were to be improved upon. The structure of the public healthcare system in Nigeria makes the provision of healthcare services a shared responsibility between the government, the doctors and other allied healthcare workers. This arguably gives credence to support the opinion that doctors should not be perceived as the only factor responsible for instigating industrial actions. Medical errors could result from administrative improprieties or party-political gains as well as a shortage of personnel and use of substandard infrastructures.[13] These are unfavourable for patient care and often hazardous to doctors. When such persists and is beyond the control of doctors, would maintaining the status quo be morally correct because doctors are expected to uphold the vows of their professional obligation?[13]

Unsurprising was the finding that consultant paediatrician sopposed strikes compared to trainee paediatricians. Consultants are less likely to embark on industrial actions for several reasons: they are primarily considered as the custodians of 'proper ethical conduct', are either staff of the university and or the hospital, have the highest level of expertise and total responsibility of patients' care. They are also part of the hospital management and are considerably well remunerated. It was not readily explainable however, that about a fifth of the respondents was unsure about their response to this question. We hypothesise it may be due to the underlying question of morality between saving lives and supposed 'material gains'.

On the contrary, this study also demonstrated that fewer respondents (28.4%) mainly trainee paediatricians, support industrial actions because they believe it is the only means by which the government will understand their grievances. When the trainee paediatricians and other resident doctors alike continue to face staff welfare challenges such as failure on the part of management to sponsor resident's exams, update courses, delay or denial of their basic entitlements which include training sponsorship and promotions, coupled with the shortage of doctors, long working hours with outdated infrastructures and in poor working conditions like poor call rooms and meals,[3,5,13] it is anticipatable that some choose to support industrial actions. Another possible explanation is the apparent ailure of the medical association(s) to satisfactorily represent the more junior doctors and has been similarly reported in a study in Zimbabwe.[14]Our finding, however, contrasts the study by Omisore et al,[15] among health workers in a State Hospital in Ondo State, Nigeria where a higher proportion of respondents (40.0%) supported strikes and proposed the government meet the demands of the striking workers. The reason for the difference may be that respondents in Omisore's study were predominantly allied health workers, whereas our study comprised of only doctors.

The effect on the quality of medical training and practice, the fact that strikes are not always effective and loss of confidence in the healthcare system were the three main reasons cited by respondents who do not support industrial actions. These responses indicate that strikes disrupt service delivery, training and practice of the profession. These negative effects of industrial actions have been similarly documented in other studies which involved doctors other than paediatricians.[3,5] It is also noteworthy that the impact of strikes have far-reaching consequences other than those highlighted in this study and we believe it is harmful and disruptive to the Nigerian Healthcare system.

Our study has some limitations which include a high non-response rate. While this was noticed in this study, a response rate above 60% is significant and deductions made are statistically viable. We could not study the characteristics of the non-responders to determine if they were different from the responders and we did not explore other ways paediatricians would suggest to respond to grievances that incite industrial actions. Also, we focused only on paediatricians and trainees who were attendees at a conference. Therefore, the results of

this study may not necessarily be generalized to all paediatricians or trainee paediatricians in Nigeria.

Conclusion

This cross-sectional study has highlighted the common causes and consequences of medical doctors' industrial actions in Nigeria from the perspective of the paediatricians and trainee paediatricians. Our findings suggest industrial actions are not the paediatricians' preferred means of communicating grievances. Other methods should, therefore, be explored to limit the deleterious effects of industrial actions.

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