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Quality of work life: A unique motivational dynamic for oncology doctors in public health

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Orientation: Public health challenges affect doctors' motivation, retention and service delivery. Understanding their quality of work life will shed light on managing the impact of these challenges.

Research purpose: This study aimed to construct an understanding of oncology doctors' quality of work life in a public hospital.

Motivation of the study: Variability in conceptualising quality of work life points to the need for context-specific research to address unique work challenges and employee motivation. Quality of work life is especially relevant in public healthcare oncology units, where job demands are high and resources to support quality medical services are low.

Research approach/design and method: The study followed a hermeneutic phenomenological approach and qualitative design. Data were gathered from nine oncology doctors using virtual, semi-structured interviews and analysed through interpretive phenomenological analysis.

Main findings: Findings highlight the need to address lower-order needs (hygiene factors) to manage contextual limitations and work–life balance challenges that hamper the quality of work life experience. Higher-order needs (motivational factors) help participants to deal with hygiene factors and facilitate quality of work life. Doctors' career identity supports their coping in this context and is reflected in commitment to meaningful work and achievement drive.

Practical/managerial implications: A holistic quality of work life approach directed at managing lower and higher order needs is proposed, with policies and interventions to ameliorate doctors' quality of work life experience.

Contribution/value-add: The research contributes to the body of knowledge on quality of work life, especially in public health. Recommendations aim to enhance doctors' motivation and retention in public hospitals, in view of quality patient care.

Keywords: quality of work life; oncology doctors; public hospitals; career identity; motivation; hygiene factors; motivational factors; well-being; interpretive phenomenological analysis.

Introduction

The healthcare industry constitutes a uniquely challenging, ambiguous and uncertain work context (Nayak et al., 2017). Healthcare professionals are at all times required to deliver essential, life-saving services to overwhelming volumes of people (Maphumulo & Bhengu, 2019). The workload, irregular work schedules and work conditions in hospitals and healthcare facilities, as well as the innately traumatic and emotionally taxing type of work, exacerbate turnover and necessitates attending to healthcare employees' quality of work life (QWL) (Nayak et al., 2017; Parveen et al., 2016). In the healthcare context, QWL has been defined as the extent to which healthcare employees experience satisfaction of personal goals while also achieving organisational goals (Brooks & Anderson, 2005). Furthermore, QWL is a motivational phenomenon and continues to be increasingly significant in the healthcare sector because it aims to enhance employee motivation and satisfaction to produce better service standards (Parveen et al., 2016; Saygili et al., 2020). Considering its universal importance to employee motivation and retention in healthcare, researchers call for continued in-depth and context-specific QWL research in the industry (Alowna et al., 2021; Ramawickrama et al., 2017). To heed the call, this study focussed on oncology as a unique healthcare context.

Oncology care has become a prioritised service. Globally, cancer is a critical public health challenge because it is a predominant cause of death and presents a consistent and incrementally growing incidence rate (Siegel et al., 2020; Sung et al., 2021). The rise in cancer incidences in Africa are described as unprecedented and expected to double by 2040 (Kayamba et al., 2021). In the African context, this overwhelming increase in the need for cancer care exacerbates QWL concerns in an already overburdened oncology system (Wentzel et al., 2019). In developed countries such as Britain and the USA, with strong economic growth and stable socio-economic resources, QWL concerns are less because work is supported by ample resources, healthy work hours and effective work–life balance policies (Letooane, 2013). Developing countries, such as Africa, require attention to unique QWL concerns because they are characterised by insufficient resources, gender inequities, poor work conditions, extensive work hours and ineffective work–life balance policies (Letooane, 2013). These QWL concerns have impacted South African oncology doctors' motivation, optimal functioning and ability to deliver quality healthcare services and feed high turnover rates and staff shortages (Lubuzo et al., 2019; Soobramoney, 2019). Several studies report oncology employees to suffer from stress, burnout, depression, helplessness, hopelessness, compassion fatigue and job dissatisfaction (Guveli et al., 2015; Magnavita et al., 2018; Wentzel et al., 2019). Vidal-Blanco et al. (2019) identify emotional well-being, compassion fatigue, burnout syndrome and compassion satisfaction as components of QWL in healthcare. The authors emphasise that if the QWL of oncology staff is not attended to, their emotional distress and physiological problems could accumulate and extend to negatively affect the quality of patient care. In the context of constantly needing to enhance QWL in healthcare and the unique challenges in oncology care, the aim of this study was to construct an understanding of oncology doctors' QWL by exploring their lived experiences of working in an oncology unit.

Findings contribute to the study of QWL in a South African oncology healthcare context. The study takes an in-depth exploratory approach to the subjective, context-specific experiences of QWL. Findings sensitise policy makers and healthcare management to the motivational dynamics inherent to QWL and highlight the need for QWL policies and programmes to motivate and retain oncology doctors in public healthcare by enhancing their unique QWL experience in this context. Next, a conceptual perspective is provided to the QWL construct, which is followed by a discussion of the research design and the findings of the study. The article concludes with a discussion of the findings, its implications, limitations and recommendations for further research.

Quality of work life

The significance of QWL in healthcare is widely recognised (Elshahat et al., 2019), yet definitional disparities exist (Jaiswal & Mahila, 2014; Zubair et al., 2017). Literature, for example, often use QWL and work motivation as interchangeable constructs (Kocman & Weber, 2018). It is also often compared with job satisfaction, conceptualising QWL as the degree to which employees experience personal and life fulfilment at work (Nayak et al., 2017; Swamy et al., 2015). Others distinguish motivation and job satisfaction as antecedents or outcomes of QWL (Acharya & Anand, 2020; Sushil, 2013). Comprehensive definitions conceptualise QWL as based on favourable workplace facets or dimensions that are important for motivation and job satisfaction (Leitão et al., 2019; Sari et al., 2019) and relate QWL to the quality of the employee–environment relationship and the effects of work on employee effectiveness (Sattar et al., 2018; Sumathi & Velmurugan, 2017).

Jaiswal and Mahila (2014) acknowledges QWL as a framework of technological, physical, psychological and social facets that determine a favourable work environment and culture. Identification of these facets has led to establishing QWL as a multidimensional construct consisting of various objective work dimensions that determine the favourability of the work place. Literature reports various QWL dimensions such as fair compensation and recognition, career development opportunities, good relationships, job security and a safe and healthy work environment, a collaborative and participatory organisational culture, ample resources and work–life balance (Jaiswal & Mahila, 2014; Narehan et al., 2014; Nilgün, 2017; Swamy et al., 2015). When an organisation fosters a positive working environment based on these QWL elements, it can increase employee job satisfaction and motivation (Ngcobo, 2012) as well as commitment, performance and productivity (Usha & Rohini, 2018). As organisations strive to improve their employees' QWL by fostering these QWL dimensions, they must, however, remain mindful of the subjective and context specific nature of QWL (Dahie et al., 2017). Individuals' context-specific experiences and subjective motivational needs determine their perception and sense of QWL (Letooane, 2013). In this study, QWL was conceptualised as being contingent upon subjective, situation-specific employee perceptions of work-related aspects, which, if well managed, drive their satisfaction and motivation.

Literature substantiates the relevance of QWL to motivational theory (see Narehan et al., 2014; Sari et al., 2019), which also impacted the interpretation of data in this study. Maslow's (1943) theory bases motivation on the satisfaction of a hierarchy of needs (safety, esteem, physiological, social or affiliation needs and self-actualisation) and claims that meeting lower order needs takes precedence over higher level, unique employee needs (Narehan et al., 2014). Herzberg et al. (1959) used the two factor theory to categorise higher and lower order employee needs as satisfiers or dissatisfiers (Verma & Sharma, 2018). Olasupo et al. (2019) contend that QWL results from employees finding satisfaction in challenging and involving tasks (an example of a higher order need), whereas dissatisfaction is the outcome of poor working conditions (resembling lower order need).

The subjective nature of QWL may lead to variable outcome results in different contexts; however, its correlation with motivation and satisfaction of healthcare employees seems to be widely reported. A study on doctors' QWL by Srivastava et al. (2019), for example, found a significant positive correlation between QWL and job satisfaction and a negative relationship between burnout and QWL. Zaman et al. (2021) and Mayakkannan (2020) in addition to the significant relationship between job satisfaction and QWL found this correlation to be moderated by specific organisational conditions. The impact of contextual conditions on QWL is also evident from research performed in Polish hospitals, revealing poor management as an inhibitor of QWL (Storman et al., 2022). The hospital study by Fanya and Kusumapradja (2020) found a link between age, length of service and QWL, indicating subjective factors' influence on QWL.

Research design

The exploratory and descriptive nature of the study was well suited to its underlying hermeneutic phenomenological (HP) approach and qualitative strategy, employing qualitative methods of data collection and analysis.

Research approach

A HP approach was followed to explore doctors' lived experiences of working in an oncology unit and derive a hermeneutic understanding of their QWL in this context. The HP approach is rooted in the interpretive-constructivist paradigm and accordingly the researchers' relativist ontology and relational and subjective epistemology directed methodological choices. From this position, the researchers ascribe to multiple, subjective realities that are co-constructed in a relational context. The power of HP lies in its ontological exploration of lived experience and in an epistemology that assumes co-constructed meaning grounded in a hermeneutic interpretation of phenomenological experience (Churchill, 2018; Crowther & Thomson, 2020; Kafle, 2011; Laverty, 2003). The findings thus provide an inter-subjective interpretation of QWL as co-constructed from participants' lived experiences and researchers' meta-theoretical preconception of the research phenomenon (Suddick et al., 2020). Participants' lived experiences constitute the data studied by the researchers to make meaning of the research phenomenon (Churchill, 2018), which in the case of this study was QWL.

Research strategy

The study followed a qualitative research strategy by using qualitative methods aimed at exploring, describing and elucidating the research phenomenon (Vidal-Blanco et al., 2019). Semi-structured interviews were conducted virtually with nine participants and interpretive phenomenological analysis (IPA) was used to analyse and interpret the data.

Research method

This section presents the research setting, entrée and establishing researcher roles, the sampling strategy and participants, data collection, data recording and analysis and strategies to ensure quality research.

Research setting

The study was conducted in an oncology unit in a public sector, provincial hospital in South Africa. The hospital is a tertiary or referral specialist hospital that provides wide ranging oncology care services to the community while simultaneously offering work-integrated specialist training to medical professionals. The oncology unit serves a population of about 4 million and is fully accredited for oncology specialist training. Doctors are employed as medical officers, registrars and specialists. Medical officers are entry-level positions, while a registrar is a specialist training position. A doctor takes up the registrar position for 4–5 years and on completion of the training period, registers with the Health Professions Council of South Africa (HPCSA) as an oncology specialist. The oncology unit has seven medical officers, three registrars and three specialists. Daily, between 8 and 21 new patients are admitted and approximately 90 patients receive either chemotherapy, radiotherapy or brachytherapy.

Entrée and establishing researcher roles

The oncology unit's Head of Department (HOD) acted as gatekeeper for the study. The HOD shared research details with the doctors and only with their written consent, provided willing participants' contact information to the researchers. Doctors were then individually contacted and appointments scheduled. Consent and information sheets were reviewed in each interview to ensure the participant's understanding of confidentiality, voluntary participation and the right to withdraw from the research. Participants gave permission to record the interviews and confidentiality was assured by using pseudonyms and reporting information in a non-identifiable manner. Pseudonyms used refer to a participant as an oncology medical doctor (OMD). OMD1 thus refers to participant one and so forth.

Research sample and participants

Purposive sampling was used to select participants rich in experience about the research phenomenon and willing to share their experiences (Alase, 2017; Laverty, 2003). Small, purposeful samples are appropriate to HP and IPA studies (Alase, 2017; Peat et al., 2019) as the focus is on eliciting rich narratives about the lived experiences related to the research phenomenon (Laverty, 2003). Only qualified doctors working in the oncology unit for at least three years were included as participants. The gatekeeper facilitated identification of and contact with participants who met the inclusion criteria. Nine doctors participated and included six females and three males. Three were medical officers, five were registrars and one was a specialist. The participants' biographic details are depicted in Table 1.

TABLE 1: Biographical information of participants.

Characteristics	Number
Gender	
Male	3
Female	6
Age range (years)	
30–39	5
40–49	3
50–60	1
Position	
Medical Officer	3
Registrar	5
Specialist	1
Experience in oncology (years)	
3–4	3
5–7	4
10–14	2

Data collection

Data were collected via Microsoft Teams, over the course of a month between 7 August and 7 September 2020. Semi-structured interviews were conducted, using open-ended interactive questions, enabling exploration of relevant experience (Alase, 2017; Singh et al., 2019). Introductory questions were asked to establish rapport and to elicit a broad narrative about who the participant is and how they came to work at the hospital, as well as the role they fulfil. This was followed by topic-specific questions concerned the 'whatness' and 'howness' of experience (Smith & Osborn, 2007), such as 'when you go to work every day what do you look forward to?' and '… what do you not look forward to?' Other specific questions included were 'what challenges do you face on a daily basis and how do you deal with these?', 'how does management empower your quality of work-life?' and 'If you could change one thing, what would it be?' Questions were elaborated on through probing of pertinent issues, utilising phrases such as 'tell me more about …' (see Crowther & Thomson, 2020; Mselle et al., 2018). No further interviews were conducted after data saturation was reached, which was evident after the 9th interview analysis, when any new interpretation could be categorised and explained into already constructed themes.

Data recording

Participants gave permission for the interviews to be recorded, and the otter.ai software (see Mselle et al., 2018) was used to transcribe the recordings. Researcher field notes about interview observations constituted useful additional data to support review of interview transcriptions and analysis of the data.

Data analysis

For data analysis, IPA procedures outlined by Peat et al. (2019), and Smith and Osborn (2007) were followed. Case by case, noteworthy data sections were recorded and initial themes or recurring patterns were identified (Peat et al., 2019). Themes were then categorised into subordinate or superordinate, and linked to relevant verbatim extracts. Cases were iteratively analysed by observing patterns in their verbatim text that aligned with and further developed themes conceptualised in and across all the cases (Crowther & Thomson, 2020). The hermeneutic circle was applied by moving between individual interviews and the whole data set and by iteratively listening to and re-reading the data throughout the analysis process. Researchers' intuition and preconceived theoretical understanding of QWL enabled meaning making about the research phenomenon. As part of the interpretive process and meaning making, a reflexive journal, reflexive dialogue with texts, and critical questioning and interrogation of researcher interpretations (Alase, 2017; Laverty, 2003) were conducted between the researchers. The emphasis was on constructing meaning rather than establishing interpretive correctness (Kafle, 2011). A thematic narrative was ultimately constructed as reflected in the 'Findings' section, with verbatim quotes to highlight the participants' voices in accordance with IPA specifications.

Strategies to ensure quality

Credibility was enhanced by checking correctness of interview transcripts with participants and by incorporating pertinent verbatim textual accounts in the findings to ground interpretations in the data (Singh et al., 2019). Interviews took approximately 60–90 min to allocate adequate time to establishing rapport (Singh et al., 2019). Rapport was established by showing authenticity and genuine interest during introductions, using a conversational tone and by showing gratitude, thanking the doctors for their time and willingness to participate. The researcher further attempted to put the participant at ease by explaining to them strategies to ensure confidentiality and their right to withdraw at any time. Transferability was addressed by detailed description of the research setting, pre-determined inclusion criteria and purposive sampling, as well as providing the participants' biographic profile. Dependability was ensured through continuous data collection until saturation was reached, and the extent of saturation was agreed upon by both researchers co-reflecting on the possibility of new insights. To supplement the recordings, observational notes were captured in a reflexive journal, and rich verbatim quotes from participants were used to construct credible interpretations. To ensure authenticity, multiple verbatim extracts were provided for each identified theme, giving the participants a voice in the findings.

Ethical considerations

Ethical clearance was granted by UNISA-CAES Health Research Committee (2020/CAES_HREC/092) as well as the Department of Health (DOH) (NHRD Ref: KZ_202005_016). Hospital management also approved the study and appointed the oncology unit's HOD as gatekeeper. Participants provided written consent, and data were anonymised with pseudonyms and stored in password-protected files.

Findings

Five themes were constructed from the data to understand the QWL of oncology doctors in the context of this study. The themes denote that the QWL of oncology doctors is related to their experiences of contextual limitations to optimal functioning, work–life balance challenges, the importance of support as integral to their functioning, a commitment to meaningful work and a drive for achievement and development. The five themes with their sub-themes are visually presented in Figure 1. This is followed by a thematic discussion grounded in the participants' verbatim data.

Theme 1: Contextual limitations to optimal functioning

Participants explained how their work was constantly hindered by contextual limitations. Contextual limitations manifested as lack of medical resources, staff constraints and poor infrastructure.

Sub-theme 1.1: Lack of medical resources

The lack of resources inhibits doctors to perform their duties effectively. According to OMD7, the lack of medical resources inhibits his optimal functioning and service delivery 'if we could have enough drugs, instruments, also a quick replacement and procurement of equipment' it would support the QWL in the oncology unit. Similarly, OMD2 observed 'there are some inefficiencies in the system. We [*are*] short of drugs, which is challenging. All these drugs stockouts make it difficult' and OMD1 confirms 'the access to more advanced drugs in terms of chemotherapy, we are very limited in what we can offer'. When OMD3 blames the lack of medical resources for creating unfavourable medical care conditions, her feeling helpless and frustrated is clear: 'So, I don't look forward to bring patients some sub-optimal treatment. I think we do them a great injustice … that's not fair'. Feeling as frustrated by limited medical resources impacting on the quality of patient care, OMD1 expresses some frustration as well: 'So, it means us chopping and changing and adopting a regimen, which is substandard and it's not what's best for the patients'. Finally, limited oncology services in the whole province are a problem. 'Currently, only two centres are providing oncology in [*the province*]' (OMD7), which inhibits doctors' job satisfaction, as OMD5 yearns 'I wish we could have earlier treatment for patients and reduced waiting time for patients and also, more oncology departments in the province'.

Sub-theme 1.2: Staff constraints

Staff constraints pertain to staff shortages as well as staff members' language constraints. Staff shortages in the context of the oncology unit have a negative effect on doctors' QWL. For OMD6, much of the poor service delivery 'was down to staffing constraints'. OMD8 confirms that the 'lack of oncologists is a huge challenge' and describes it as 'the oncology crisis that I was exposed in'. The need for more doctors and specialist expertise was highlighted by OMD7 saying that service delivery and doctors' motivation would improve 'if the resources, and in resources I mean human resources [*increase*], that is more doctors addressing the shortages of specialists'. The effect on their QWL is evident in how OMD8 explains that the shortage of oncologists leads to work overload and fatigue: 'Those oncologists that are here have to basically do double work and it can lead to fatigue'. Staff shortages inhibit timely service delivery, causing doctors not to look after their own physical well-being 'and it's usually, you know, the volume of patients we see, they are so many such that now, you are rushing time. So, you end up not getting lunch or nothing' (OMD4). Similarly, a participant reflects that therefore, doctors' levels of stress are affected negatively:

> '[*T*]he number of patients that you know is sitting there … and the fact that they're all coming in early in the morning and you might only see them at 12 o'clock or 2 o'clock in the afternoon … there's pressure on it'. (OMD2)

Exacerbating the work overload and inefficiency brought about by context-specific limited human resources is the shortage of staff fluent in patients' native languages – a poignant issue in the African healthcare context. According to OMD2, 'the language barrier is an issue' between doctors and patients, 'it's challenging and difficult to communicate

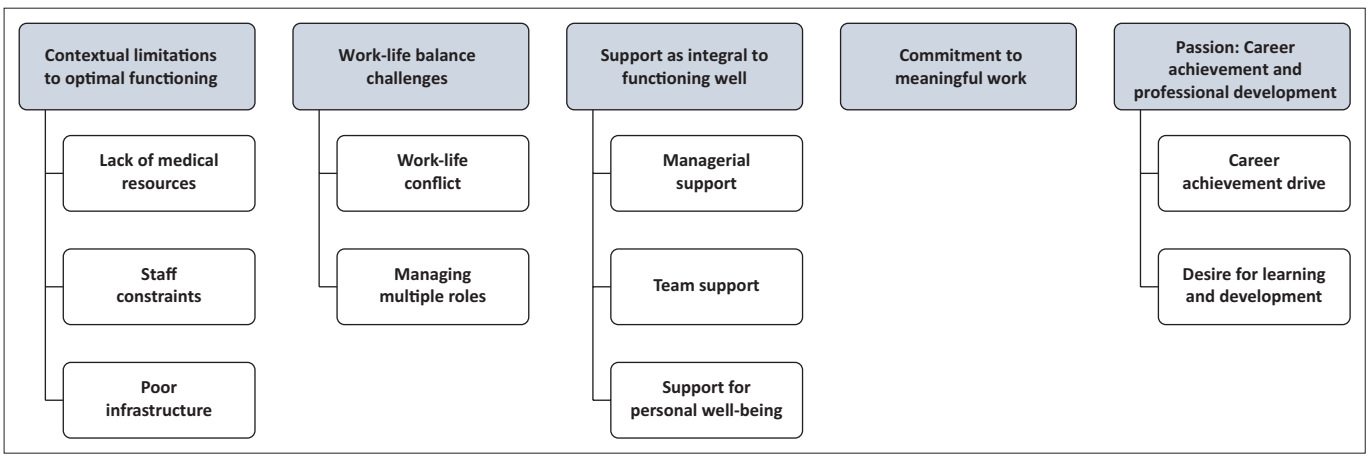

FIGURE 1: Summary of findings: Themes and sub-themes.

with some patients', affecting doctors' satisfaction with the patient care they offer.

Sub-theme 1.3: Poor infrastructure

The oncology work context is further characterised by poor infrastructure, significantly affecting doctors' QWL. For example, OMD6 highlights 'I have a huge issue with optimal ventilation I don't think management over here enhances our quality of life … with respect to cleanliness, I am not happy with that, either'. OMD9 concurs with the issues of ventilation 'The clinics and our radiotherapy don't have much ventilation' and adds limited space and noise as barriers to QWL in the oncology unit:

> 'Ah, the department is a bit congested. They can open up the space more … so that we can get more natural air and the working environment will be better. We have no space it's very noisy'. (OMD9)

Participants observed how the contextual infrastructure does not support their QWL because it inhibits their capacity to handle the high volume of patients with quality care.

Contextual limitations, such as medical and human resource shortages and poor infrastructure, lead to work overload, fatigue, stress and feelings of helplessness, as observed by OMD4: 'The challenges here are the work load. It's crazy, that's one thing that's like really takes my energy away'. It has a demotivating effect: 'I do not look forward to complicated patients and depending on the advancement, knowing that you can't assist them and knowing that you can't do much to help' (OMD5). Contextual limitations are demoralising to doctors as they have limited control over what affects their service delivery.

Theme 2: Work–life balance challenges

To enhance QWL, work should not be so stressful or time consuming that other life functions necessary to being human are lost or disrupted (Swarochi et al., 2018). Participants' narratives included reflections on their challenges in balancing work and life demands as well as multiple roles. In this context, work is characterised by both work and the necessity to study as the hospital is a specialist training site.

Sub-theme 2.1: Work–life conflict

Reflections denote time-based strain on the ability to balance work–life demands, as observed in the dissatisfaction of OMD6 with the constant and inconsistent need to work over time: 'we still haven't managed to improve our working times'. In other instances, it is the time and effort demand from both personal life and work life that conflicts:

> 'Mmm, that's a mess. That's a mess, unfortunately. I mean, … me cooking in the morning because my kids go to school. … But it's a 24-hour job … . So, I've had to wake up at four in the morning so that I can get at least two hours done.' (OMD1)

The workload also interrupts this dimension as OMD4 states 'I'm saying it's just the volume of work. You know, that gets to you because it's like, you know, you're exhausted already, you haven't even rested'. This is also evident in OMD7's words reflecting on being a registrar (which implies working and studying) balanced with child care responsibility 'I am studying as a registrar which is a challenge considering our type of work. I have a daughter…'.

Sub-theme 2.2: Managing multiple roles

Multiple roles of being a professional, a parent and an academic constitute unique work–life demands in this oncology section. Those studying, wished there could be days set aside for academic work as they believed this would help to create a balance:

> 'I am working towards becoming a specialist and completing my research, but the challenge in trying to progress is the time to study and family life. Coupled with busy work schedules, so I think time off for research would really help.' (OMD5)

Such multiple roles and the resulting conflicting work–life demands affect the participants' psychological well-being, as reflected in a participant's continued struggle to create a balance:

> 'Yeah, it's a struggle hey, I don't do it too well. I think work takes up my hours here and the minute I'm in the car I'm thinking of what's next to do for my other half of my life. And that takes up all my time and then I get up in the morning and start thinking about work again.' (OMD3)

Taking care of personal, academic and work demands poses strain on participants:

> 'That's a difficult one. It still is a struggle. I think what added more stress and strain is the studying part. So it's not easy to balance … . So it's a bit of a challenge with the volume of patients we are seeing you are exhausted already.' (OMD4)

Participants' experiences of their workload and multiple roles demonstrate the influence of time strain on their QWL experiences and general well-being (see Kleiner & Wallace, 2017), because it resulted in them struggling to cope with work–life balance challenges.

Theme 3: Support as integral to functioning well

It was evident throughout the interviews that participants' QWL is strongly affected by them finding support in various ways, including managerial support, team support and well-being support from HR, psychological services and family or religion.

Sub-theme 3.1: Managerial support

Firstly, support from their relationship with management seems important. For some, the poor relationship affected their QWL negatively, like with a participant remembering:

> 'I mean, he will take off with you in front of colleagues and take off with you in front of people of other departments and other disciplines and it's sort of a bit of a disrespectful approach, sort of embarrassed you in that situation. He wasn't very approachable. You couldn't ask him anything without him being upset with you for silly things. It was a bit of a difficult place to work.' (OMD1)

For others, the experience of a good relationship with immediate supervisors has a positive effect:

> 'Specialists are my immediate management. The relationship is good; they are accessible, approachable and willing to listen to my problems. We discuss patient care together. I learn from them which gives me the confidence to perform procedures.' (OMD7)

A participant expressed the need for the managerial support to extend to hospital administration:

> 'If the administration management could be more involved in being present to address our resource constraints. You know to have procurement managers come to the clinic more often.' (OMD7)

Sub-theme 3.2: Team support

Apart from managerial support, team support was also a noteworthy mention, with a participant emphasising the importance of teamwork:

> 'When someone is not there, you realise what they bring into the department … So, it is important for the department to have teamwork, we don't want to leave anyone, we want teamwork.' (OMD9)

To further assert the notion of team support as essential to QWL, OMD7 notes: 'There is no programme provided, but at a departmental level, we have team building activities, lunch and so on'.

Sub-theme 3.3: Support for personal well-being

To cope with their stress and QWL demands, participants sought psychological support, either internal or external to the organisation:

> 'He [*J*]ust felt more comfortable and it made more sense to go into the private sector to use the employee wellness programmes which, you know, it was more than just what an HR member could deal with.' (OMD2)

Others indicated the need for psychological support internally:

> 'They could introduce well-being programmes because at times you are overwhelmed. Just having an opportunity to speak to a professional, there is a need for access to psychologists or group therapy. Doctors also get mental issues. They end up committing suicide so that support is needed.' (OMD7)

In addition to psychological services, OMD6 emphasises the need for and value of 'exercise programmes and staff wellness days' but highlights how time constraints and work overload make it difficult to utilise such support services:

> '[*B*]ut unfortunately, the reality is we're fully booked for months to months. And as doctors, we do not have the capacity to be going to workshops and things that are not scheduled around work.' (OMD6)

As a result, some participants relied on spiritual and family support. OMD5, for example, observes 'I cope through prayer and my family is very supportive. My wife is the biggest support structure as well as my mom'. Similarly, a participant counted on her supportive spouse:

> 'I have a wonderful husband. So, he is more of the mom than the dad in the traditional sense if you know what I'm saying he does a lot more with the kids than I do.' (OMD6)

The findings indicate that various types of support, internal or external, seem to improve participants' QWL experiences.

Theme 4: Commitment to meaningful work

From the data, it was clear that doctors find meaning and purpose in what they do and thus strongly identify with the helping nature inherent to their profession. Specifically, they deem it to be meaningful and personally rewarding to help others. For OMD6, 'I've always had an interest in oncology … if you take into account vocation and wanting to help people, you can make a difference', and OMD4 reiterates about being a doctor in the oncology unit 'I like it. Yeah, that's one thing that I've actually realised, being here … even with the patients, they constantly come to say thank you, you've helped me'. Some mentioned that purposeful service delivery (making a difference by helping patients) gives them deep satisfaction. As a case in point, OMD3 expressed the deep satisfaction that comes from seeing happy patients: 'It's been your patient. You see them at the 3-month visit, the 6-month visit, and the 1-year visit and they are still okay'. The reflection of OMD6 offers another example of deep enjoyment in the helping work they do: 'You can offer them a lot of emotional support and you can offer them symptomatic support so that also makes it an incredibly rewarding experience'. So, despite the contextual and work–life challenges they face, participants derive work satisfaction from helping others resulting in a commitment to professional service delivery. This energises them:

> 'I feel like, I'm more in touch with my patients. Of which it makes me really feel good about the job that I'm doing … That makes me feel that I'm making a difference.' (OMD4)

Similarly, a participant relates deep satisfaction to helping patients as well as their family members:

> 'You know you've made a difference to that person and you've helped them through a really difficult time … you make people feel valued and appreciated so I really enjoy that part of it.' (OMD2)

Responses here show that, despite dissatisfaction with insufficient resources, the desire to help and engage with patients is very important to the doctors. They derive meaning, purpose and deep satisfaction from their profession. Meaning and purpose, as expressed by doctors, reflect their commitment to their work and in this sense promote their QWL.

Theme 5: Passion - Career achievement and professional development

Despite the limiting contextual nature of the oncology unit, participants still expressed a passion for their jobs. Passion was expressed in a drive for career growth and

achievement as well as in a need for continued learning and development.

Sub-theme 5.1: Career achievement drive

In the words of OMD9, the need for career progression and becoming a medical specialist exemplifies how he is driven by the need for achievement: 'I see myself, I want to be a specialist and apply, hopefully, if everything goes well, they choose me. I want to be a specialist, an oncologist'. So too, OMD2 is driven towards achievement, persisting in applying for promotion despite not controlling or knowing the outcome: 'I have applied for a post, I'll go to the interview, but I can't control whether I get the post or not'. Opportunities for career advancement also inspire:

> 'From medical officer, I've moved now to a registrar … to specialise. So, I've got development in terms of now moving to complete my registrar programme, and thereafter becoming a specialist and contributing as an oncologist to South Africa.' (OMD8)

Similarly, another particpant is driven by a need to achieve in her career: 'I see myself, I want to be a specialist and apply, hopefully, if everything goes well, they choose me. I want to be a specialist, an oncologist.' (OMD9)

Sub-theme 5.2: Desire for learning and development

Participants' words show how passion is also expressed in a desire for learning and skills development. For example, a participant explains how continuously enhancing professional knowledge enables better service delivery and treatment:

> 'I look forward to learning new things. Look there is always new things to learn in oncology. I look forward to meeting new patients and the challenge to try and ascertain treatments, not all about treating but learning also … There are so many things that you can physically do for a patient, Learning new procedures and the change because of research. I love the change and just to keep updating myself.' (OMD7)

Being motivated by specialist training opportunities and positions, OMD1 emphasised the need for more training facilities in different institutions to aid career progression: 'We can adapt that and say that academic facilities should be provided, not only in XYZ only, but in other institutions'. Participants are clearly motivated by the opportunity to advance in their careers and to update their skills and knowledge.

Discussion

This study explored oncology doctors' lived experiences to derive an understanding of their QWL. Findings describe how oncology doctors' QWL are negatively impacted by contextual limitations and work–life balance challenges and positively affected by work and non-work support systems, their commitment to doing meaningful work and their drive for achievement and development.

Contextual limitations manifesting as a lack of medical and human resources and poor infrastructure impede participants' QWL. Poor QWL has been attributed to resource shortages and deprived working conditions in other studies (Brugha et al., 2020). Contextual limitations with regard to oncology care in South Africa have also been identified as related to staff and medical shortages (Soobramoney, 2019) and stemming from limited socio-economic growth, lack of financial resources (Letooane, 2013) and weak governance and poor management in South African public healthcare (Rispel et al., 2016). Contextual limitations, therefore, seem to be a primary driver of doctors' poor QWL experiences as they lead to work overload, fatigue, helplessness and stress, which affects their ability to provide optimal healthcare negatively. The work context in this study exacerbates the QWL issue for oncology doctors, especially because the South African public healthcare system is challenged with inadequate resources, management problems, the burden of rising patient volumes and poor infrastructure (Maphumulo & Bhengu, 2019). The workload and stress associated with cancer care places oncologists' well-being at risk and makes them susceptible to burnout and compassion fatigue (Kleiner & Wallace, 2017), furthermore impacting negatively on doctors' work–life balance (Murali & Banerjee, 2018; Murali et al. 2019).

The QWL of oncology doctors in this study was also found to be negatively affected by consequent work–life balance challenges resulting from work overload, long working hours and multiple role responsibilities. Work–life demands that exacerbate stress levels and imbalance engagement in both work and personal life, invariably affect one's QWL (Bhende et al. 2020) and a balanced, humanised work environment should be created for optimal QWL and work satisfaction (Brousseau et al., 2019; Swarochi et al., 2018).

While various job stressors negatively impact QWL, perceived support reduces stress and improve QWL (Eisapareh et al., 2020). This was also evident in this study's findings, which demonstrate oncology doctors' perceptions of managerial, team, internal or external psychological support and family support as having a positive bearing on their QWL. The findings confirm similar research relating leadership, organisational and supervisory or managerial support (Lejeune et al., 2020) and team or colleague support (Lejeune et al., 2020; Nayak et al., 2017) to the QWL of healthcare workers. Ultimately, both work and non-work-related support appear to be essential for oncology doctors' QWL.

Despite their dissatisfaction with contextual limitations, much of the participants' contentment stems from being able to provide a helping service to their patients. The doctors' professional service orientation presented as an internal drive and commitment to meaningful work, which demonstrated a positive impact on their QWL. Their unwavering commitment to doing meaningful work may alleviate some of their adverse experiences and improve their sense of QWL. Nayak et al. (2017) confirm that there is a positive relationship between QWL and work commitment.

The participants' need for achievement and professional development also contributes to their QWL. According to Páez-Cala and Castaño-Castrillón (2019), QWL relates to motivational and educational needs fulfilment. Similarly, Al-Maskari et al. (2020) relate employees' QWL to being able to offer meaningful contributions to their organisation while simultaneously pursuing professional advancement and career development. Participants' commitment to meaningful work and their achievement and development drive may be definitive of a unique career or professional identity, acting as an intrapersonal strength resource that helps them to cope with contextual limitations and work–life balance challenges.

To construct a dynamic and holistic understanding of oncology doctors' QWL, the motivation theories of Maslow's (1943) and Herzberg et al.'s (1959) were applied to categorise the constructed QWL themes into (1) hygiene or extrinsic motivational factors (themes 1 to 3) and (2) motivational or intrinsic factors (themes 4 to 5). Contextual limitations, work–life balance challenges and external support resources (themes 1 to 3) are pertinent to establishing the day-to-day QWL experience and relate to objective QWL dimensions, as well as basic, lower-order need satisfaction. Commitment to meaningful work and achievement and development drive (themes 4 and 5) are proposed to reflect the doctor's career identity and build job satisfaction by playing on higher-order needs or intrinsic motivational factors to positively affect QWL. While motivational factors are linked to intrinsic factors that may lead to a favourable QWL, their absence may not lead to a poor QWL (Leitão et al., 2021). Yet, in this study context, without a strong career identity, the oncology doctors may not cope well in a poor QWL work setting. Accordingly, meeting oncology doctors' higher-order needs may alleviate job dissatisfaction caused by unfavourable hygiene factors (Verma & Sharma, 2018). There may thus be a unique balancing dynamic between motivational and hygiene factors in establishing a more consistent and sustainable QWL for oncology doctors.

Implications

It is evident that the QWL of oncology doctors in a South African public healthcare setting is composed on the balance of their intrinsic and extrinsic needs, with the reality that they currently need to rely mostly on their internal motivational drives (purpose, commitment and achievement) to sustain their QWL in the oncology work setting. The question is how long such reliance on internal strength resources can be viable and sustainable. The study's findings therefore advocate for organisational accountability in driving workplace humanisation and imply that QWL is contingent upon efforts of both the organisation and employees. Currently employees must rely on intrinsic motivational sources, which may lead to burnout and exit soon after qualification. Management should devise strategies to improve doctors' QWL by addressing contextual limitations observed in the findings. In the resource-constrained healthcare context, management should engage with oncology employees to develop creative, workable ideas to address resource and staff constraints and poor infrastructure. Ultimately, management should be upskilled in financial management, and corruption should be eroded to enlarge the finance pool needed to support contextual improvements. The study raises awareness of the need for psychological support services (such as an employee assistance programme), workload management, resourcing and improved facilities to assist participants and other healthcare professionals with their daily challenges. There is a need to establish work-relevant strategies to attain work–life balance and avoid burnout and fatigue. The fact that doctors still love and are passionate about their jobs shows that QWL should not only focus on hygiene factors such as support resources but also on sustaining higher-order motivational needs. Inscribing QWL strategies in policy is necessary (Hardjanti et al., 2017). As such it is important to include in policy, parameters for reasonable work hours, well-being and work–life balance strategies as well as career-related developmental incentives and opportunities.

Based on the findings, it is proposed that doctors' career identity is an important factor in their overall QWL. Their career identity relates to their career drive and passion for meaningful work, which are motivational and thus supportive of their QWL. Career identity exemplifies career objectives and outcomes that professionals set based on their socialised values and needs (Lee & Ahn, 2021). Leitão et al. (2021) found a correlation between QWL dimensions: career progression, opportunity for growth and development and career identity and motivational factors. In this study's oncology context, it is, however, evident that doctors' career identities may be constantly taxed as they are challenged to do identity work in an effort to cope and motivate themselves in a work environment that is characterised by poor, demotivating contextual QWL aspects. Identity work is regarded as the subjective, emotional and collective processes and strategies used by professionals to construct a strong and congruent self-concept (Martin et al., 2020).

Limitations

Data collection was delayed because of coronavirus disease 2019 (COVID-19) restrictions and some of the interviews were postponed because of unforeseen occurrences brought about by the pandemic. The poignant effect of COVID-19 on the work context and especially in healthcare may thus have unknowingly impacted the results. The context-specific nature of the study and its small sample size presents a high participant identification probability. Hence, including verbatim data in presenting the results was performed with caution and selective representation of data may have caused some of the richness in narratives to be lost. Similarly, the context specificity affects confidence in the transferability of the findings to other healthcare settings although this is also a strength of the study in the sense that its recommendations can be very pertinently regarded in this study context.

Recommendations

The findings provide valuable practical information for management and government in the healthcare sector, sensitising them to effective QWL programmes and policies that need to be implemented. Non-fulfilment of doctors' extrinsic needs was found to be a noteworthy cause of poor QWL, yet intrinsic needs seem to play a supporting role. The unique challenges in developing countries' public healthcare facilities, calls for hospital management to be innovative in working towards supporting doctors' QWL (Hardjanti et al., 2017). As such, QWL research in private healthcare may provide valuable guidance to public hospitals in the establishment of pro-QWL policies and programmes focussed on contextual support and resources. The QWL research is, however, also needed to confirm the proposed interplay of motivational needs in understanding context-specific QWL for different healthcare professionals. The potential significance of career identity in the QWL experience require further research. Studies confirming how doctors' QWL can be enhanced through career identity will develop a more well-rounded understanding of its role and relatedness to the QWL and will shed light on how supporting professionals' career identity work can better the QWL experience in resource-constrained or uniquely challenging occupations. Career identity is a significant strength resource for healthcare professionals. Therefore, researchers should also consider the impact of QWL facets on the career identity of doctors in public hospitals. Comparative studies with the career identity of doctors in private hospitals may highlight the effect of contextual limitations on doctors' career self-efficacy. Finally, research exploring the experience of QWL and career identity in the context of gender, race and career-life stage boundaries are recommended as these may provide unique QWL insights related to diversity.

Conclusion

Based on the oncology doctors' work–life experiences, this study accelerates understanding of how motivation manifests in QWL in public healthcare. Given the unique work setting, the government and public hospitals should invest in improving working conditions and doctors' higher-order needs satisfaction. A combination of this realisation and career identity development could enhance oncology services. The constraints imposed by inadequate resources consistently emphasise the importance of satisfying higher-order needs. Quality of work life is thus attainable when the higher-order needs of esteem and actualisation are satisfied regardless the contextual constraints and challenges. As a result, higher-order needs aid in moderating the negative experiences and promote a sense of QWL. Nonetheless, ineffective management of lower-order needs and their associated factors may expose doctors to burnout and compassion fatigue, which has a negative impact on long-term tenure.

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Competing interests

The authors have declared that no competing interest exists.

Authors' contributions

L.S. conceptualised and executed the study under the supervision of A.B. For this manuscript both authors contributed to the rationale and methodology sections. L.S. completed the literature review and did all the field work and data analysis. A.B. guided data analysis and reviewed and synthesised the final analysis for this manuscript. All authors discussed the findings, its implications and recommendations and contributed to the writing of this manuscript.

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Data availability

The data that support the findings of this study are not openly available because of the personal nature of the information shared, small sample and possible identifiability of participants as a result.

Disclaimer

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any affiliated agency of the authors.

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