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What happens to health professionals when the ill patient is the health care system? Understanding the experience of practising medicine in the Romanian socio-cultural context

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Objectives. Our aims were to investigate the sources of work strain and stress, and the way in which they are experienced by Romanian health professionals in a work context shaped by the ongoing 20 years long reform of the national health care system.

Design. An exploratory, qualitative design was used to investigate medical professionals' perceptions of stress and work strain.

Methods. Twenty eight interviews and two focus groups were conducted with 38 physicians, residents and nurses, between the age of 26 and 53. A semi-structured interview guide was used for data gathering and the major themes were identified using thematic analysis of the transcripts.

Results. Three themes emerged in the analysis: governance and health system management, scarcity of resources, and health system reputation. Health professionals described the image of a suffering health system, exhausted by an inconsistent management plan, underfunded and understaffed; a system that is a constant source of discontent, bitterness and doubts for them and their patients.

Conclusions. Romanian health professionals' experiences reveal a health care system which after 20 years of reform managed to shape a learned helplessness culture within the medical community and drive a large proportion of its workforce across the borders.

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Statement of Contribution

What is already known on this subject? Cultural, political, and socio-economic factors influence the work context and shape the employees' working experience.

What does this study add? We describe Romanian health professionals' (HPs) relationship with the national health system, the work environment it creates, and its impact on the quality of their work experience. We draw on HPs' experience to understand how the socio-economic and political context shapes a culture of learned helplessness and blame against the health system, within the medical community, and the exodus of Romanian HPs searching for working opportunities abroad.

Health workers are among the professionals most exposed to chronic job-related stress (Leiter & Maslach, 2009; Schaufeli, Maassen, Bakker & Sixma, 2011). The pressure of dealing with patients' suffering, poor prognoses or death, having to control the way they manifest their own emotions, working long hours, or under time pressure represent just a short list of the emotional, interpersonal, or physical demands that they face in their daily activities. Health professionals' chronic work stress was related to physical and psychological health problems (Schaufeli, Bakker, Van der Heijden & Prins, 2009; Shirom & Melamed, 2005), at the individual level, and turnover intentions (Hayes *et al.*, 2006; Sjögren, Fochsen, Josephson & Lagerström, 2005), decreased work satisfaction (Chiron, Michinov, Olivier-Chiron, Laffon & Rusch, 2010), and suboptimal care (Farenkopf *et al.*, 2008), at the organizational level.

Most research on what contributes to job strain, stress, and burnout has focused on individual and proximal work and interpersonal characteristics. Less attention has been paid to the cultural and socio-economic context in which an organization is embedded, which also shapes the work experience of employees (Maslach, Schaufeli & Leiter, 2001). The aim of this exploratory, bottom-up, qualitative research was to investigate how the particularities of the Romanian healthcare system shape HPs' work experience and the demands they face on a day-to-day basis. We argue that the perceived unfairness of the way the health system addresses the needs of HPs and their patients, and the lack of trust in its managing capability, adds to the well-known sources of work strain and stress.

The social, economic, and political context of the Romanian health system

In the early 1990s, the Romanian healthcare system began its transition from a state-controlled, centralized model to a more market-orientated one (Bara, van den Heuvel & Maarse, 2002). After failing to reach the objectives of improving the health status of the population, optimizing the efficient use of funding, and improving patients' and HPs' satisfaction, the initial enthusiasm and commitment turned into a generalized disappointment (Bara *et al.*, 2002; Scîntee & Vlădescu, 2006). Two characteristics of the Romanian social, economic, and political context were identified as having a negative impact on the healthcare reform and its outcomes: (1) the low starting point at the very beginning of the transition period, legacy of the former communist regime; and (2) the lack of strategic planning and legislative coherence after 1990, result of the

political instability (Bara *et al.*, 2002; Scîntee & Vlădescu, 2006; Vlădescu, Scîntee, Olsavszky, Allin & Mladovsky, 2008).

During the communist regime, the medical system was considered to be an unproductive area of economy, and little financing was directed towards it. In the late 1980s, 2.2% of the GDP was spent on the health care in comparison with the average expense of 5.4% of the GDP in the Eastern European countries (Bara *et al.*, 2002). As a result, at the beginning of the 1990s, Romania was situated at the bottom of the list ranking European countries in terms of health system performance and quality of care indicators (Scîntee & Vlădescu, 2006). The percentage of GDP directed towards the health system constantly increased during the reform years, but it remains the lowest in comparison with those of other European countries in the area (WHO, 2012).

The financial difficulties led to important structural and cultural consequences. No major investments were made in medical infrastructure and equipment in the last 30 years (Vlădescu *et al.*, 2008); the state monopoly over the medical services let little room for private practice and contributed to a healthcare culture in which concurrence or personal initiative among HPs were not exercised (Bara *et al.*, 2002). The practice of informal payments became frequent and perpetuated after 1990 to a magnitude that is difficult to estimate. Studies cited by Vlădescu *et al.* (2008) show that one in three respondents living in an urban area consider them to be legitimate and that more than half of the participants declared giving informal payments because it is customary. As a result, the Romanian health system is frequently described in the national and international media as a system on the edge of collapse, unable to provide high-quality medical services, and marked by corruption (Holt, 2010).

After 1990, the Romanian political scene made it difficult to develop and implement a coherent long-term strategy in the health system. The health minister has changed 21 times in the last 22 years (Romanian Health Ministry, 2012), and the reform was often a confusing mix of step-by-step planned experiments, overnight changes, and decision implemented in the absence of the appropriated infrastructure (Vlădescu *et al.*, 2008). For example, the Health System Reform law, first adopted in 2006, was amended no fewer than 58 times over the last 6 years (Romanian Health Ministry, 2012). In 2010, the Government decided to reduce salaries of employees working for the state, including medical personnel, with 25%. This was accompanied by the freezing of all new hiring in a system already facing chronic understaffing. Recently, legislative proposals to change the Hospitals' Law led to street protests at the beginning of 2012.

After 20 years, words like 'reform', 'transition', 'transformation', or 'change' are still the most commonly used attributes to describe the Romanian medical system. While the expected reform results are still to be achieved, little is known about its impact on the quality of medical care and the quality of the work experience of the medical personnel.

Purpose

Our aims were to investigate whether the particularities of the national health system bring specificity to the way HPs experience work stress. We focused on identifying the sources of work strain and the way they are perceived by HPs working in the Romanian healthcare system, trying to understand the context it creates and its impact on practising medicine in Romanian hospitals. We discuss themes that were pervasive across the discourses of all the categories of HPs we interviewed – physicians, nurses, and residents.

The study was conducted as part of a larger European Union Seventh Framework Programme Project (ORCAB), investigating organizational culture, quality of care, and job burnout in hospitals in several countries across Europe.

Method

Data were collected using semi-structured interviews. Drawing on Kvale (1996) methodology, three interviewers conducted interviews with 38 HPs (13 doctors, 13 registered nurses, and 12 medical residents) from several medical and surgical departments: internal medicine, general surgery, paediatrics, dermatology, pneumology, infectious diseases, orthopaedics, gynaecology, ophthalmology, transfusions, anaesthesiology, endocrinology, rheumatology, and general practitioners. Ten of the participants were men, and 28 were women. The age range of the participants was between 26 and 53. Data were collected using 28 individual interviews and two focus groups (one with five residents and one with five nurses). Participants were informed about the aims of the study, and they all consented to take part in the interviews, which took between 25 and 55 min. All participants agreed to the interviews being tape-recorded. Data were gathered between October 2010 and May 2011, in Cluj-Napoca, a city with tradition in medical training and several university hospitals. The study was approved by the ethical committee of the hospital where we collected data.

Transcript analysis followed the steps described by Braun and Clarke (2006), as it follows: familiarization with data, initial coding, searching for themes, reviewing themes, defining, and naming the themes. Every interview was analysed and coded by each of the three interviewers. The key emerging themes were inductively extracted from the interviews through the understanding of the whole text and the connections between parts. These themes were further explored in depth, moving from structural analysis to critical interpretation of the text.

Results

Three major themes and eight subthemes depicting the particularities of the Romanian health system were described by HPs as having a negative impact on the quality of their working life and their physical and mental health: (1) governance and health system management (frequent legislative changes and top-down decision making); (2) scarcity of resources (lack of medical supplies and equipment; shortage of staff; and underpaid personnel); and (3) health system reputation (health system reflected in the media; patients' mistrust; and being asked for favours). Each of these themes and their subthemes are described and illustrated below.

Governance and health system management

A major source of stress mentioned by participants was the frequent legislative changes. Participants doubt the capacity of the Romanian administration to manage the health system reform, mentioning that 'this constant pressure for reform might lead to a disaster if the necessary organizational and technical infrastructure is not in line with the structural reform', as one doctor said. More than half of the HPs we have interviewed described themselves as being overwhelmed by the unpredictability and the speed of the legislative changes.

Every day you have to be up to date with the legislation. Every day the Health Law changes, every day the Hospitals' Law changes, there's a new clause (Doctor).

Chaotic leadership and faulty communication about the health reform process created resistance, a sense of uncertainty about the future, a 'fear of the unknown', as one nurse mentioned. The result of these continuous changes is a growing sense of doubt about one's ability to help others and a constant struggle to find the path in an unstable environment, as it was mentioned by some participants. The existing policies were often perceived as unfair and lacking transparency, reflecting mainly the political views of the ruling parties and not the real needs of the health system.

The majority of participants complained about the way decisions are taken and implemented within the medical system. Although decentralization is considered to be an explicit goal of health reform, participants described a very centralized health system, functioning based on a top-down decision-making process. The tension between HPs' aims and the aims of the management was present in all accounts. HPs perceive that important decisions are taken by people who are not familiar with the real problems of the health system, the barriers, and the needs they face on a day-to-day basis, people who do not understand the implications of these decisions.

The thing that upsets me most is the fact that important decisions are taken by people that have nothing to do with the system, and this has a negative impact on us and on our patients (Nurse).

When referring to this process, they often described themselves as if they were 'puppets handled by an unseen puppeteer', having no control over what happens to them. Others talked about the sense that there is a 'large gap, and no bridge for communication' between them and the managers or an unseen curtain, which makes the communication a 'dialogue between deaf people'.

The abilities, skills, and competencies of those involved in management were questioned by many participants, and feelings of mistrust were explicitly expressed as in the following statements made by three doctors:

Bad leaders are bad for the health – not just for the health of patients, but also for our health (Doctor).

I don't know how much of these stuff come out of their brains or they've just translated some European regulations that we have to implement. It's like unscrewing the screw that you don't have (Doctor).

In my opinion, whoever is in charge, he is either ill-advised or has no clue about what is happening (Doctor).

These powerful remarks about the decision-making process suggest HPs' difficulty in working with management structures that have different priorities from theirs, leading to feelings of frustration and anger. The distance and the faulty communication between HPs

and administrative personnel give rise to attitudes of resignation and helplessness, accompanied by disheartening feelings:

What can we do? Nothing.... (Resident)

[...] we have to stick to a plan, as I said. The main objective is to see an exact number of patients per month, and spend an exact amount of money, which you are not allowed to exceed. But you are not allowed to see fewer patients or spend less money either' (Doctor).

Some HPs felt they have to obey the rules imposed by the management, others felt rather alienated by an organization that does not support or value their work, while others expressed direct opposition and critical distancing from it. Those who seemed to believe more strongly in the value of their profession used stronger words in blaming the system and the people in charge of it.

Scarcity of resources

Virtually, all respondents agreed on how stressful and frustrating it is to work in a medical system that is chronically underfunded. Lack of medical supplies and equipment was described as a constant of their daily activities. The financial problems of the health system were exacerbated over the last 2–3 years by the economic crisis, leading to a 'health system that is almost in clinical death' or 'a system that is functioning on the edge of breaking down' as two doctors stated. According to our participants, the accumulation of debts in the system has a strong negative impact on the quality of the medical services provided to the patients: 'We are obsessed with how to control the deficit, rather than thinking of how to provide better services'. To stress how fragile the current health system is, HPs used comparisons with the old communist regime, saying that 'it used to function better than the present one' (Doctor). Another participant used a visual metaphor to describe the lack of resources in medical organizations: 'the Romanian health system is like a Schaizer cheese, it has lots of holes and it barely manages to stay in one piece'. (Doctor)

Although sophisticated equipment was bought in some clinics, doctors have a hard time finding funds when it needs repairs or supplies. They also described situations in which expensive equipment was bought, but the hospital had no money to pay the border taxes: 'We've learned to take these absurd situations as if they were normal' (Resident).

For some HPs, the lack of proper medical equipment has a pervasive effect leading to feelings of being incompetent and the fear of failing to give a correct diagnostic:

When you work, for example, with an ultrasound machine with a probe that works at 50% of its full capacity, you start being afraid that you will fail (Doctor).

Some participants mentioned that the efforts to cope every day with the lack of resources led to a sense of pride: 'it taught us to develop our clinical sense. And because of that, in many cases, we are better than the doctors in Western Europe, who are relying a lot on high-tech equipment.' (Doctor)

However, most of HPs described frequent situations in which they feel exhausted because they need to worry about the lack of supplies more than they worry about their patients' health status.

This is the ugliest part lately...it is not the patients' problems, not the way they progress, or how you expect them to progress... it's the fact that you don't have drugs... (Nurse).

Frustration, guilt, embarrassment, and feeling of shame were reported by HPs when having to address patients and their families and ask them to buy their own medical supplies and drugs. Doctors, nurses, and residents spoke of situations in which they felt betrayed because they had to act in ways that jeopardize the trusting relationship they should have with their patients.

You get very depressed when you end up working in a hospital [...] where you have to send your patient to the pharmacy to buy his own painkiller (Nurse).

In fact, the patient pays twice for the same medication, first to the medical insurance system, and second when they really need it. This is not right! (Resident)

These two statements are examples that support the idea that HPs perceive the health system as being unfair and affecting the dignity of both patients and HPs.

The feeling of unfairness is exacerbated by the political interference in the medical act, as some participants mentioned. They complained about the wide spread of favouritism when accessing funds and hospitals that have a privileged position because their managers are members of the political parties in power.

All participants referred to the shortage of staff as being another major factor leading to extra burden and strain. Having insufficient personnel means that HPs are confronted with excessive work volume and that they are forced to do tasks that are either below or above their competency. HPs frequently referred to situations in which they had to see more patients than it should be allowed, in which they were overwhelmed by the number of patients.

There's too much work for only one person occupying this position. Sometimes the department is so busy, way more than it should be allowed... and the work volume is huge. There are days in which I don't have the time to take a sip of water (Doctor).

They talked about being forced to choose between patients and sacrificing the quality of the medical act in order to make sure that they see all the patients who need medical assistance.

Take this week, for example. On Monday, we were two colleagues on duty, me and another colleague. And we had four general anaesthetics on four tables. It is difficult to supervise everything, to fill in all the papers, to make sure... (Nurse).

They described feelings of guilt and sometimes even anger for not having the time to show genuine consideration and compassion for their patients.

There were cases in which I had to supervise 20 to 30 patients, and you have to monitor them, and send them to investigations, and take probes, and write prescriptions, and do all the work. There's no time to talk to them (Nurse).

Due to the shortage of staff, HPs are forced to take secretarial and administrative duties because there is no one else to fulfil them. Residents in particular often described feelings of frustration because they spend their workday doing tasks that are under their qualification and not doing the job they were trained to do.

We don't spend enough time with patients because of the paperwork we have to do: writing the register book, registering those who come into the hospital, writing the prescriptions, calling the family members to come and pick up the prescription and go buy them... (Resident).

Exhaustion, a sense of being overwhelmed, feelings of time urgency, lack of control, and guilt for not being able to accomplish all their tasks were present in most participants' accounts.

Underpaid personnel was another recurrent theme in the discourses of the participants we have interviewed. Salaries were often described as a source of frustration, discontent, and bitterness, being referred to as an indicator of the lack of gratitude and disrespect towards the medical profession in Romania.

A doctor or a nurse spends 5–6 days a month doing night shifts, being on call from early in the morning till 13:00 the next day; being away from their families. [...] In my opinion, the payment in Romania is disrespectful! (Nurse)

They often spoke about the amount of training, responsibility, and sacrifice that their jobs require and the unbalanced salary they receive in return for their effort.

The salary seems almost symbolic when you think about the work we put into it, about the level of responsibility we have, and also the long period of training that we need to do. [...] I don't want to talk about the financial component of my work because I feel embarrassed by it (Resident).

Why would you want to work in a Romanian public hospital where doctors feel under-valued, over-managed or bad managed? (Doctor)

Some participants referred to feelings of shame for not being able to provide for their families and embarrassment for having to accept under-the-table payments from patients.

In their opinion, the amount of money HPs get in return for their work is the result of an unfair social hierarchy in Romania and an indicator of the level of appreciation and gratitude that the Government and the Romanian society has towards the medical profession.

Health system reputation

The third theme we identified was the health system reputation, which was often described as having a negative impact on the doctor–patient dynamic. Although this

theme was not as pervasive as the first two, we consider it an important theme as the discourse around it was often highly emotional.

The most salient theme discussed by the participants was the way the health system is reflected in the media. They spoke about how their professionalism and integrity have been steadily undermined by the media and how they always feel under media scrutiny. Serious medical errors, minor mistakes, petty corruption, arrogance, and favouritism or other kinds of unprofessional behaviour of some HPs are more and more vividly discussed on TV, in the newspapers, and on forums and blogs. Although they admit that there are cases of extreme unprofessional behaviour in hospitals, participants mostly referred to an unfair image of the health system portrayed in the media. In several cases, they spoke about how this image adds to a sense that they are not appreciated for the effort they put into practising medicine in a health system that seems to work against them.

Most of the time, media reflects a very bad image of the health system... in some cases they might be right. But [...] they never see the good side of things, the fact that there are lots of doctors and nurses that save hundreds of lives and do their work out of passion for a salary that is very small (Nurse).

Movies and plays like *The death of Mr. Lazarescu* or the *Community's Hospital*, describing the Romanian health system and the doctors, are seen across the Globe and now everybody thinks that the fiction from a movie or a play is the exact reality of Romania. Even though they might be based on real cases, they describe a reality that is darker than it really is (Doctor).

The second subtheme identified as a source of work strain was patients' mistrust. The present-day legislation gives patients total freedom in choosing their health providers, increasing patients' participation in decision making. This is a clear departure from the old medical system, in which patients had little freedom to choose, in which they were required to use a specific health centre, and to maintain a rather silent and obedient relationship with the medical staff. Within this new medical context, older HPs in particular feel that the patients question their authority and doubt their knowledge. Their discourse often revealed defensive rationalization, like in these statements of two doctors:

Everywhere in the world people die in hospitals, so people die in Romanian hospitals also.

They just don't get that we are not Gods... Ultrasound exam can have a 40% error rate.... But they are quickly ready to press charges at the College of Physicians, at the police, in mass-media (Doctor).

In other cases, HPs talked about being offended by patients doubting their expertise and complained about patients' behaviour:

You are entitled to Google search as much as you want and then come and say: 'I've seen or I've read something' – everybody is entitled to do that... and I might tell you that maybe you Google searched and you found something I didn't know, nobody's perfect, God forbid... but maybe I saw 150,000 cases of scarlatine and maybe your son is the only case that you've ever seen (Doctor).

They described feeling of anger and frustration when patients question their morals and professional ethics and show disrespect towards them based on stereotypes and misconceptions about the medical staff.

When from the other side of the door there's someone looking at me as if saying: 'I know how things work around here to get a good treatment, and what matters for you'... there is huge source of stress from the very beginning, and a reciprocal mistrust (Doctor).

The third source of stress related to doctor–patient dynamic that was mentioned by some of the interviewees is being asked for favours for 'special patients'. Those who described this kind of situations also explained that they feel that they cannot refuse answering to them because they work in a highly hierarchical system, and the social network is very important. At the same time, they complained about how these interventions interfere with the existing programme, upsetting them and their other patients.

You see, this office has two doors; common people come through this one, and through the other one come all the 'favours'. And when they start coming from both sides, and they come two or three at the same time, I start getting angry and I sometimes yell at some of them (Doctor).

I work with a timetable and it is very stressful that every day I am called by someone in the hospital, and we are more than 400 employees, and asked to take care of someone for them. 'You see, I have family member, I have a friend ... I have someone'. And these interventions are really stressful (Nurse).

Being asked for favours adds to the pressure of working with insufficient personnel and lacking the proper instruments for planning and organizing the work day.

Discussions

The aims of this study were to identify Romanian HPs' understandings of the healthcare system and its impact on how they experience work-related strain. Our research design and methodology were built on the premise that cultural and socio-economic contexts shape the work environment and employees' working experience as much as the more local, proximal organizational context (Maslach *et al.*, 2001). The three themes that emerged in our analysis – governance and health system management, scarcity of resources, and health system reputation – describe a suffering health system facing management failure, chronic understaffing, long-term underfunding, and lack of face validity.

Although most medical systems in Central and East Europe faced similar challenges during the communist regime and struggled implementing healthcare reforms in the 1990s (Balabanova & McKee, 2002a; Balabanova, McKee, Pomerleau, Rose & Haerpfer, 2004; Dimova *et al.*, 2012; Gaal, Szigeti, Csere, Gaskins & Panteli, 2011; Gjorgjev, Bacanovic, Cicevalieva, Sulevski & Grosse-Tebbe, 2006; Habicht & Kunst, 2005; Sagan *et al.*, 2011), the unique mixture of political instability and financial constraints clearly nuanced the experience of the Romanian healthcare system (Vlădescu, Galan, Olsavszky & Scîntee, 2009; Vlădescu *et al.*, 2008). To this date, Romania is still at the bottom of the lists ranking health systems' performance, having the highest rates among EU members in

cardiovascular diseases, infantile mortality, tuberculosis, cervical cancer, or hepatitis B (Vlădescu, Astărăstoae & Scântee, 2010). The lack of financial resources, legislative unsteadiness, and faulty management is not reflected only in the health status of the population (Vlădescu *et al.*, 2008; Vlădescu *et al.*, 2009), but also in the working experience of HPs and the quality of their organizational life on a day-to-day basis. Previous research has shown that continuous restructuring within the medical system, even in developed countries with more economic resources, diminishes employee satisfaction and psychological well-being (Burke, Ng & Wolpin, 2011) and increases the risk of developing burnout symptoms (Glasberg, Norberg & Söderberg, 2007; Locock, 2003; Morrison & Smith, 2000).

Good leaders are capable of overseeing the pressures to which the system, the organizations, and the individuals within it are exposed to during organizational changes (Firth-Cozens & Mowbray, 2001; Heifetz, Grashow & Linsky, 2009). They are also capable of understanding when and how these forces threaten to break the fragile equilibrium between the elements of the system and help keeping it functioning as a whole. It appears that the leaders of the Romanian healthcare system neglected to consider the reactions of the already overwhelmed medical personnel to the pressures added by all these changes and, even more importantly, neglected to consider the mutations that the organizational behaviour suffered over the last 20 years, up the point where counterproductive and dysfunctional practices are massively adopted and transformed into norms.

Studies in the field of organizational change have shown that continuous organizational instability, the lack of predictability, and the feelings of frustration that it generates typically results in two different kinds of reactions among employees: a passive, almost numbed, acceptance of all changes (Campbell & Martinko, 1998; Martinko & Gardner, 1982, 1987) or a rejection reaction, manifested by leaving the organization (Harvey, Harris & Martinko, 2008). Our findings and also the official data about the number of HPs who decide to leave the country (Vlădescu *et al.*, 2010; Romanian College of Physicians, 2012) indicate a similar pattern within the Romanian Health System.

A culture of learned helplessness seems to have developed among HPs, diluting their interest and willingness to engage in change when new opportunities are offered. Similar to what Martinko and Gardner (1982) describe, new initiatives for change are received with discouragement and resignation, which seems to fuel a self-fulfilling prophecy cycle, as they are perceived as failures from the very beginning. The culture of 'there's nothing to be done' appears to be pervasive across job positions and, even more worrying, across age ranges. Less top-down initiatives, doubled by encouraging bottom-up decision making, might help diminish the drifting feelings described by the HPs referring to themselves as powerless 'puppets'.

Once they become part of an organization, young professionals implicitly learn 'the right way' to think, act, and feel within that particular organization (Hoff, Pohl & Bartfield, 2006; Schein, 2004). Although no official data exist, anecdotic reports on how Romanian young professionals are taught to adopt current practices and ways of behaving within the systems have been published in the media, most often related to bribery practices (e.g., Bilefsky, 2009). Informal payments are not unique to the Romanian medical system. The practice has been reported in many Central and Eastern European countries (Balabanova & McKee, 2002b; Gaal, Evetovits & McKee, 2006; Lewis, 2007; Vian, Grybosk, Sinoimeri & Hall, 2006). However, studies show that in Romania, almost 70% of the hospitalized patients reported giving under-the-table payments, a number much higher than in Bulgaria, Croatia, Czech Republic, Hungary, or Russia (Lewis, 2007). Informal payments are offered for being admitted into the hospital, for receiving better accommodation while

hospitalized, for getting prescriptions for free medication, for being seen by the doctor before anyone else waiting the line, or even for getting any kind of medical attention at all (Ensor, 2004).

Informal payments are often pointed out as a form of corruption. At the same time, they are the symptoms of an underfunded system, badly managed, and lacking individual accountability, in which under-the-table payments are rarely, if ever, punished. In many countries in which the health systems are facing financial difficulties, this practice is essential in keeping the medical system working, compensating for the low salaries of HPs who have to cover for the high costs of their training and provide for themselves and their families (Lewis, 2007). Informal payments became a norm, and they are perceived by patients as a way of manifesting their gratitude for the medical services received. In recent years, a public debate over legalizing these payments arose in Romania. The defenders of this proposal argue that the taxes collected would help filling the gap between the needs of the system and the existing budget. A co-payment system was also proposed as a solution for getting additional funds, meaning that part of the medical services would be paid by patients on the spot. There is a danger that introducing the co-payment system will fuel an equity problem in accessing medical care, feeding the existing social inequality, as argued by the head of the Romanian College of Physicians in *The Lancet* (Holt, 2010).

Although accepting informal payments has become a routine among many HPs, some experience feelings of shame, embarrassment, and guilt, leading to dissatisfaction with their clinical practice. As Davidoff (2002) points out, doctors may be particularly vulnerable to shame, because many of them are self-selected based on their perfectionism and commitment to care and cure ill people. The same feelings are experienced by HPs when failing to provide good quality of care due to lack of appropriate equipment and supplies. Feelings of inadequacy, or even helplessness in their professional role and in accomplishing their duties, undermine their sense of self-worth and make them feel less valued by patients and by society. This is fuelled also by the HPs' image of corruption and incompetency that is portrayed in the media. Trying to distance themselves from these feelings of shame and guilt, HPs redirect their negative feelings, blaming the 'faulty' and unfair medical system. The well-known 'culture of blame' that has been described to characterize the medical profession (Waring, 2005) adds a particular characteristic within the Romanian healthcare system. It is not only about holding an individual accountable for a problem or an error, but also about holding 'the system' accountable for all the medical failures. In this respect, turning the 'culture of blame' into 'a culture of health and safety' (Khatri, Brown & Hicks, 2009) has different nuances and faces different challenges in Romania.

Rewards in any form – promotion, acknowledgement, or salary raises – play an important role in reducing stress, even when the effort required in fulfilling the tasks is very high (Pikhart *et al.*, 2001; Siegrist, 2010). Low salaries were identified as a source of stress leading to role disengagement, a symptom of burnout (Demerouti, Bakker, Nachreiner & Schaufeli, 2000; Franco, Bennett, Kanfer & Stubblebine, 2004). In a comparative study (Hasselhorn, Tackenberg & Peter, 2004), nurses from several countries in transition reported higher effort–reward imbalance, which was associated with higher levels of burnout as opposed to nurses from more stable economies. Although increasing salaries might be one of the long-term solutions to improve the quality of the working life of HPs, financial rewards only, in the absence of efficient structural and legislative changes, it will not be enough.

The events happening over the last 20 years resulted in a chronic loss of trust in the capacity of the healthcare managers and policy makers to find constructive solutions to

answer the needs of all the stakeholders within the medical system. Trust is an essential element within the health system, not only between HPs and patients, but also between HPs and healthcare managers. Research has shown that trust has a beneficial impact on many aspects of working life, including job satisfaction, burnout, effectiveness, and turnover intentions, all of which influence the quality of patient care (Firth-Cozens, 2004). However, trust is a fragile commodity that should be built through a participatory process of decision making driven by the recognition of the interdependence of all the stakeholders (Gilson, 2006). High bureaucratic organizations, like the one described by our participants, in which there is a large distance between health practitioners and senior managers, are likely to decrease the level of trust and willingness to engage in open communication (Avolio, Zhu, Koh & Bhatia, 2004; Edmondson, 1996). Our findings revealed that the inadequate communication of the reform goals and strategies had serious consequences, inducing a sense of uncertainty and lack of control among HPs. Research has shown that an inclusive leadership style that is issue-orientated, and encourages employees to share the goals of the organization and cooperate in achieving them, is crucial to improving staff retention and to reducing inter-professional and intra-professional conflicts (Lingard, Espin, Evans & Hawryluck, 2004; Lipshitz & Popper, 2000).

One can only presume the long-term implication of this never-ending reform process and the organizational values and practices that are born out of it, but a very concrete consequence is the fact that more and more HPs choose to 'leave the sinking boat'. A review of existing literature indicates that there is a strong positive association between existing working conditions and professional dissatisfaction, burnout, and HPs' turnover intentions (Freeborn, 2001; Tokuda *et al.*, 2009). The number of HPs who consider leaving the country is increasing every year (Vlădescu *et al.*, 2010). In 2010–2011 alone, more than 5,600 physicians requested documents certifying their studies and allowing them to work abroad in Western European countries like France, Italy, or Germany. This represents more than a quarter of the total number of 20,648 physicians who are currently working in the 396 Romanian hospitals in the country (College of Physicians, 2012). According to the College of Physicians estimates, by 2015 more than 50% of doctors will leave the country because of work conditions and low income, with severe consequences on the ability of health system to respond properly to the patients needs (Holt, 2010). Some adverse effects of the high HPs turnover rates include discontinuity of the care provided to patients, instability of the patient–physician relationship, and institutional unpredictability. However, leaving the healthcare system phenomenon is not characterizing only low-income countries, but it can be found in countries in which safe working conditions are not provided to the employees. For example, a study published in 2009 (Tokuda *et al.*, 2009) shows that the Japanese healthcare system is currently at risk of collapse because of the rapid increase in physician resignations in hospitals throughout Japan.

In 2008, an analysis coordinated by a presidential committee identified six priorities to be addressed in a long-term strategy for the healthcare system: financing, system organization, hospitals services, human services, primary care, and drug policy (Vlădescu *et al.*, 2010; Vlădescu *et al.*, 2009). Four years later, a coherent strategy is far from being implemented due to lack of agreement among political parties. In fact, public debate of the Hospitals' Law Proposal, at the begging of 2012, was the starting point of a political conflict and of street protests leading to the resignation of the Prime Minister and his Government.

Our study is not without limitations. We reflect on the experiences of HPs working almost exclusively in teaching hospitals, in a large university city in Romania. The

challenges they face and their way of portraying the healthcare system and its impact on work strain and medical practice might be different from the challenges other kinds of HPs (e.g., working in county non-teaching hospitals or small town hospitals) might perceive.

Conclusion

Over the last 20 years, the problems of the Romanian healthcare system have been frequently on the public agenda due to patients' safety incidents, under-the-table payments scandals, protests initiated by medical professionals, or worries about their large-scale exodus. Depending on the situation, HPs are either blamed for the health system's failures or depicted as its victims. Most often, statistics reflecting the poor performance of the system are invoked and used as arguments for initiating new legislative changes. Rarely had anyone investigated how these changes impact the day-to-day experience of HPs.

The main findings of our qualitative research indicate that the turbulent reforms and reorganizing of the healthcare system in Romania contributed to structural, organizational, and cultural barriers to HPs' satisfaction and well-being. This study also shows the complexity and interconnection between sources of work stress and strains, and their impact on developing a culture of the hopelessness and powerlessness among Romanian HPs, or a reaction of rejecting the system. Despite all these unprecedented pressures, many health workers still remain committed to their profession and vocation of care, but they are waiting for urgent, efficient changes.

Considering the results of our analysis, one must argue for the stringent need of a long-term strategy for the health system to stop the never-ending 'reforms' and their long-term consequences on the physical and psychological health of HPs as individuals, and the organizational health of the system as a whole. There is no 'magic bullet', no over-the-night change in the Romanian health system and the professional practice, which could help turn the medical system not only into one that provides safe health services to its patients and a safe working environment for its employees, but also into one that helps building wider and healthier societal values and norms (Loewy, 1998).

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