

**A COACHING INTERVENTION FOR BURNOUT AMONGST
GENERATION Y MEDICAL DOCTORS**

By

KEITUMETSE KHOLOFELO DISEMELO

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SUPERVISOR: PROF. RUDOLF M. OOSTHUIZEN

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DECLARATION

NAME : KEITUMETSE KHOLOFELO DISEMELO

STUDENT NUMBER : 537 48506

DEGREE : PHD CONSULTING PSYCHOLOGY

A COACHING INTERVENTION FOR BURNOUT AMONGST GENERATION Y MEDICAL DOCTORS

I declare that the above thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE

DATE

ABSTRACT

A Coaching Intervention for Burnout Amongst Generation Y Medical Doctors

The aim of the research was to describe how Generation Y medical doctors working in the South African public health sector at a hospital in the Limpopo Province experienced a coaching intervention for burnout. Generally, there are limited empirically based coaching interventions for burnout, even for at-risk populations such as Generation Y medical doctors working in the South African public health sector. Burnout affects Generation Y medical doctors, the service they offer, private lives, and the recipients of their care.

Most research focuses on identifying the risk factors for Generation Y medical doctors working in the debilitating South African public health sector, and rarely on potential intervention. This study offers findings from a coaching intervention that could be incorporated into a bigger burnout intervention strategy in the South African public health sector. This would involve all stakeholders at the different levels to ensure that burnout is combatted on a long-term basis.

The study took a phenomenological approach using a collective case study method. The aim was to gather and analyse information to explore the experiences of a coaching intervention for burnout. The study was done in three phases, namely: Phase I – Pre-coaching intervention; Phase II – Coaching intervention; and Phase III – Post-coaching intervention.

The study incorporated the Maslach Burnout Inventory to quantify the level of burnout before (Phase I) and after (Phase III) the coaching intervention. The findings emphasised certain structural issues, the impact that neglecting burnout has on medical doctors, including Generation Y medical doctors, and how burnout affects patient care.

Certain recommendations were made for the public health sector, future research in the field of coaching psychology, and coaches/consultants working with burnout amongst Generation Y medical doctors.

Key terms

Generation Y; Generation Y medical doctors; South African public health sector; coaching intervention for burnout; burnout; Maslach Burnout Inventory- General Survey (MBI-GS)

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TABLE OF CONTENTS

DECLARATION	ii
ABSTRACT	iii
ACKNOWLEDGEMENTS	v
TABLE OF CONTENTS	viii
LIST OF TABLES	xii
ABBREVIATIONS	xiii
CHAPTER 1: SCIENTIFIC ORIENTATION TO THE STUDY	1
1.1 Introduction	1
1.2 Background and Motivation for the Research	3
1.2.1 The South African context of burnout in Generation Y medical doctors	5
1.2.2 Required care for Generation Y medical doctors in the public health sector	7
1.3 Problem Statement	9
1.3.1 Burnout as a growing challenge in developing countries with limited intervention	10
1.3.2 Required burnout interventions and current limitations	13
1.3.3 Research questions for the project.....	15
1.4 Aims of the Research Project	16
1.4.1 General aim of the research project.....	16
1.4.2 Specific aims of the literature review	16
1.4.3 Specific aims of the descriptive phenomenology study	16
1.4.4 Secondary aims of the study.....	16
1.5 My Evolving Interest in the Research Project	17
1.6 Paradigm Perspective	19
1.6.1 The disciplinary relationship	20
1.6.2 Research paradigm	21
1.6.3 Humanism as an underlying psychological paradigm	27
1.6.4 Theoretical approach	27
1.7 Research Design	34
1.7.1 Research approach.....	34
1.7.2 Unit of analysis.....	35
1.7.3 Research method	36
1.8 Findings	52
1.9 Conclusion	52
1.10 Contribution of the Study	53
1.11 Limitations	53

1.12 Recommendations for Future Research	54
1.13 Chapter Division	55
1.14 Chapter Summary	56
CHAPTER 2: DYNAMICS OF BURNOUT	57
2.1 Introduction	57
2.2 Conceptual Foundations of Burnout.....	58
2.2.1 Background.....	58
2.2.2 Defining burnout	58
2.2.3 Theoretical conceptualisation of burnout	60
2.3 Etiology of Burnout	70
2.3.1 Risk factors associated with burnout in Generation Y medical doctors.....	71
2.4 Biographical Variables as Risk Factors for Burnout	77
2.5 Implications for Burnout Amongst Generation Y Medical Doctors	81
2.5.1 Relationship between personality and burnout in Generation Y medical doctors.....	81
2.5.2 Other implications and risk factors for burnout.....	82
2.5.3 Positive factors against burnout.....	84
2.5.4 Burnout risk faced by Generation Y medical doctors in the public health sector	85
2.6 Burnout Manifestations.....	88
2.6.1 Burnout impact on the individual level	88
2.6.2 Burnout impact on the group level	93
2.6.3 Burnout impact on the organisational level.....	94
2.7 Critical Review of Burnout	96
2.8 Relevance of Burnout Interventions	97
2.8.1 General burnout interventions	99
2.8.2 Individual burnout interventions	101
2.8.3 Group burnout interventions.....	105
2.8.4 Organisational burnout interventions	107
2.8.5 Limitations of individual, group and organisational burnout interventions	108
2.8.6 Coaching intervention considerations	111
2.9 Theoretical Integration	115
2.10 Chapter Summary	117
CHAPTER 3: COACHING INTERVENTION FOR BURNOUT.....	119
3.1 Introduction	119
3.2 Conceptual Foundation of Burnout Interventions	119
3.3 Coaching Intervention for Burnout Amongst Generation Y Medical Doctors.....	122
3.3.1 Theoretical foundation for the coaching intervention	123
3.3.2 Contextualising of the coaching intervention	133

3.4	Conclusion	161
3.5	Chapter Summary	164
	CHAPTER 4: RESEARCH METHODOLOGY AND DESIGN	165
4.1	Introduction	165
4.2	Research Approach	165
4.2.1	Interpretivist paradigm: Descriptive phenomenology	168
4.2.2	Positivism paradigm	172
4.2.3	My ontological, epistemological and methodological perspectives	172
4.2.4	Humanism paradigm	175
4.2.5	Theories adopted in the research study.....	175
4.3	Research Strategy	181
4.3.1	Qualitative research strategy	182
4.3.2	Quantitative research strategy	183
4.4	Research Method	184
4.4.1	Research setting.....	184
4.4.2	Entrée and establishing research roles.....	185
4.4.3	Sampling: Phase I, Phase II and Phase III.....	186
4.4.4	Data collection method.....	189
4.4.5	Data collection procedure.....	193
4.4.6	Data analysis.....	197
4.5	Strategies Employed to Ensure Quality Data	202
4.5.1	Trustworthiness of qualitative research.....	206
4.5.2	Ethical considerations.....	214
4.6	Reporting	215
4.7	Chapter Summary	216
	CHAPTER 5: RESEARCH FINDINGS	217
5.1	Introduction	217
5.2	Coaching Intervention	217
5.2.1	Phase I: Pre-coaching intervention	218
5.2.2	Phase II: Coaching intervention	219
5.2.3	Phase III: Post-coaching intervention.....	220
5.2.4	Outline of the coaching intervention for burnout process	220
5.2.5	Participants	225
5.3	Themes That Emerged About Burnout	226
5.3.1	Theme 1: Lack of support.....	227
5.3.2	Theme 2: Broader challenges that affect the South African public health system	237
5.3.3	Theme 3: Burnout in Generation Y medical doctors.....	248

5.3.4	Theme 4: Burnout consequences in Generation Y medical doctors.....	263
5.4	Themes Relating to the Coaching Intervention	269
5.4.1	Theme 1: Opinions of the coaching intervention	270
5.4.2	Theme 2: Alterations to the coaching intervention.....	273
5.4.3	Theme 3: Benefits of the coaching intervention.....	275
5.4.4	Theme 4: Lessons gained from the coaching intervention	277
5.4.5	Theme 5: Implemented coping strategies.....	279
5.4.6	Theme 6: Post-coaching intervention experiences	282
5.5	Integrated Discussion	287
5.6	Chapter Summary	294
CHAPTER 6: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS.....		296
6.1	Introduction	296
6.2	Conclusions.....	296
6.2.1	General aim of the research project.....	296
6.2.2	Specific aims of the literature review	297
6.2.3	Specific aims of the descriptive phenomenology study	298
6.2.4	Secondary aims.....	298
6.2.5	General conclusion	300
6.2.6	Contributions of the research study	303
6.3	Limitations	305
6.3.1	Limitations of the literature review	305
6.3.2	Limitations of the empirical research	307
6.4	Recommendations.....	309
6.4.1	Recommendations for the public health sector department.....	310
6.4.2	Recommendations for future research in the field of coaching psychology.....	312
6.4.3	Recommendations for coaches/consultants	315
6.5	Chapter Summary	318
REFERENCE LIST		320
ANNEXURE A : ETHICAL APPROVAL FROM INSTITUTIONS		370

LIST OF TABLES

Table 5.1: Details of the ten participants in Phase II and six participants in Phase III of the study.....	226
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ABBREVIATIONS

Aids	Acquired Immunodeficiency Syndrome
CISD	Critical Incident Stress debriefing
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
MBI-GS	Maslach Burnout Inventory – General Survey
MSD	Multiple Stressor Debriefing
ProQOL	Professional Quality of Life Scale
Unisa	University of South Africa
WHO	World Health Organization

CHAPTER 1: SCIENTIFIC ORIENTATION TO THE STUDY

1.1 Introduction

This research focused on describing the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors in the South African public health sector. Generation Y (or millennials) are born between 1981 and 2000 (Generation Project, 2018; Kane, L., 2018). It is noted that generations have typical values and characteristics that impact job behaviours amongst many things. For the current study the interest is on Generation Y medical doctors working in the public health sector in South Africa, aged between 25 and 35.

The purpose of this chapter is to provide an overview of the scientific orientation of the study. The study used a convergent mixed methodology (Creswell & Creswell, 2018) in three phases that combined a descriptive phenomenological perspective and a quantitative measure of burnout. This was done in an attempt to identify the essential experiences of a group coaching intervention for burnout amongst Generation Y medical doctors working in the South African public health sector.

The aim was to describe the lived world of Generation Y medical doctors in a way that expands the understanding of their coaching intervention for burnout experience. This convergent mixed methodology stance was appropriate in this research as I sought to provide a comprehensive analysis (Creswell & Creswell, 2018). I measured the burnout level objectively before the participants were exposed to the coaching intervention in Phase I. Phase II exposed the participants to the coaching intervention, and Phase III measured the burnout level after the coaching intervention. I aimed to get further descriptions of the experience of the lived phenomenon, which was the group coaching intervention for burnout, from Generation Y medical doctors in Phase III. Thereafter, the findings were merged and findings concluded.

Phase I: Pre-coaching intervention for burnout in Generation Y medical doctors

In Phase I, the burnout level was measured in potential participants to select 16 participants to be exposed to the group coaching intervention for burnout amongst Generation Y medical doctors. The Maslach Burnout Inventory – General Survey (MBI-GS) was used as an objective measure of the last criterion for participation, which was a high level of burnout.

The criteria for the study were:

- Participants must be Generation Y (between 25 and 35 years of age).
- Participants must have a medical degree (MBChB).
- Participants must have been working at the Limpopo hospital for over 12 months.
- Participants must have experienced a high level of burnout as determined through three measures within the inventory, which was completed and scored in Phase I of the study.

As the process unfolded, as indicated in Chapter 5, the number of participants was adjusted to 18 participants who were invited to participate in Phase II. Although the participants were committed, only ten managed to attend the session.

Phase II: Coaching intervention for burnout in Generation Y medical doctors

In Phase II, the participants were exposed to the coaching intervention amongst Generation Y medical doctors. Initially, there were supposed to be several sessions, but due to how the process unfolded, there was only one coaching session of 4.5 hours for ten participants.

Phase III: Post-coaching intervention for burnout in Generation Y medical doctors

In Phase III, the MBI-GS was completed by six of the ten Phase II participants to confirm the level of burnout. This process evaluated the impact of burnout amongst Generation Y medical doctors after exposure to the coaching intervention for burnout.

As the researcher, I aimed to pose questions after the group coaching intervention for burnout to allow the phenomenon to represent itself without preconceived ideas. This required openness from my side throughout the process of discovery to see the world according to the Generation Y medical doctors. Instead of focusing on how things were, I had to focus on how they were experienced.

In this chapter I further expand on the background and motivation for the research, emphasising burnout as an issue for Generation Y medical doctors in the South African public health sector. The South African context of the research is also given, which highlights the prevailing conditions in the public health sector. Some burnout challenges manifest in this context, which put Generation Y medical doctors and the future of the profession in South Africa at a disadvantage.

The problem statement is presented together with the aims, paradigm perspectives, models, and theories of the research. The research design is discussed, which includes the research approach, trustworthiness of the study, and ethical consideration. Finally, the research methodology, which gives a brief summary of the phases of the research, is presented together with the chapter layout of the thesis. The chapter is concluded by a summary.

1.2 Background and Motivation for the Research

Carod-Artal and Vázquez-Cabrera (2013) described burnout as a matter that requires attention globally. It could affect an individual's psychological and physical well-being and, therefore,

an organisation's functionality. Burnout occurs in various workplace situations and in particular occupational groups (Innstrand, Langbelle, Falkum, & Aasland, 2011; Kane, L., 2019; Panagioti et al., 2016; Sorenson, Wright, & Hamilton, 2016; Werneburg et al., 2018), such as Generation Y medical doctors in South Africa, specifically those who are working in the public health sector (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018).

Burnout is seen to occur with various presentations related to the self, circumstances influenced by living conditions, and/or the organisation (Bährer-Kohler, 2013; Lemaire & Wallace, 2017). Its occurrence has been confirmed but with no definite verified origins (Bährer-Kohler, 2013). Burnout has been linked to persisting work stress (Embriaco, Papazian, Kentish-Barnes, Pochard, & Azoulay, 2007; Gitto & Trimarchi, 2016; Thomas & Valli, 2006; Weber & Jaekel-Reinhard, 2000), especially in environments of poor support (Shirom, 1989, 2009). Burnout is influenced by individual personalities, culture, the general public, and the workplace (Bährer-Kohler, 2013).

Although risk factors for burnout have been researched, more work needs to be done to conceptualise and develop comprehensive research-based interventions for the varied circumstances in the different job-related clusters that deal with human beings such as teaching and the medical field (Bährer-Kohler, 2013; Sorenson et al., 2016; Werneburg et al., 2018).

Burnout was described by Freudenberger (1974) as an inability to cope with job-related stress. Job-related stress is seen as one of the biggest well-being and safety challenges, be it physical or psychological, with an incident rate that increases rapidly (Bährer-Kohler, 2013; Sorenson et al., 2016; Werneburg et al., 2018). If job-related stress is not addressed, it often leads to burnout that affects individuals, organisations, professions, and society (Carod-Artal & Vázquez-Cabrera, 2013; Sorenson et al., 2016; Werneburg et al., 2018).

Various burnout theoretical and phase models (Freudenberger & North, 2006; Golembiewski, Munzenrider, & Stevenson, 1986; Leiter & Maslach, 1988; Lee, R.T. & Ashforth, 1996) have been developed. Although there are many descriptions of burnout, a standard definition is still being deliberated (Kaschka, Korczak, & Broich, 2011). Overall, burnout is described as emotional and physical exhaustion, reduced accomplishment or performance, together with an outlook of inadequacy, and depersonalisation or cynicism related to job stress (Houkes, Winants, Twellaar, & Verdonk, 2011; Maslach & Jackson, 1986).

1.2.1 The South African context of burnout in Generation Y medical doctors

According to Maslach, Schaufeli and Leiter (2001), professional stress syndrome, which incorporates burnout syndrome, has a high incidence of occurring in Western as well as developing countries. The destitute healthcare systems in developing African countries cause heavy workloads, which often lead to burnout in health workers such as Generation Y medical doctors who work in the South African public health sector (Carod-Artal & Vázquez-Cabrera, 2013; Dovlo, 2003; Mathias & Wentzel, 2017; Panagioti et al., 2016; Thomas & Valli, 2006).

There is a current pending health predicament in the whole of Africa, South Africa included, due to overwhelmed health structures. There is not enough health professionals to intervene in the increased manifestations and prevalence of HIV/Aids, advanced cancer, mental health illness, trauma, and untreatable diseases (Davhana-Maselesele & Igumbor, 2008; Dovlo, 2003; Mathias & Wentzel, 2017; Sanders, Dovlo, Meeus, & Lechmann, 2003; WHO, 2011).

The healthcare system in South Africa is burdened and crumbling at the seams, and is harming the public health sector (Erasmus, 2012; Kotzee & Couper, 2006; Mathias & Wentzel, 2017; Phalime, 2014). Historically, there has been financial disparity in South Africa, which has been instigated by apartheid (Kotzee & Couper, 2006; Mathias & Wentzel, 2017). The South African public health sector now faces ongoing challenges such as deficiencies and misdistribution of

resources, which have led to contradictory healthcare in the private and public sectors (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018; Stoyanov & Cloninger, 2011).

The private health sector is marred by high costs that are growing at a disturbing degree (Health-E News, 2018; Kotzee & Couper, 2006; Ngoepe, 2016; Spotlight, 2018). Historically, the private health sector in South Africa has been for the rich minority. Only recently has the middle class expanded, which resulted in more people receiving private health services (Health-E News, 2018; Kotzee & Couper, 2006). Although there are more people who use the private health sector, the public health sector is still underresourced. The public health sector is funded by taxpayers and it serves extreme numbers of South Africans in understaffed and most times mishandled and underresourced infrastructure (Coetzee, Conradie & Coetzee, 2018; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Phalime, 2014; Stoyanov & Cloninger, 2011). Furthermore, the public health sector is reported to have appalling labour practices that impair Generation Y medical doctors, their patients, and familial and societal systems (Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018).

Overall, there are fewer medical doctors, especially in the unpleasant public health sector in South Africa and particularly in the rural areas, for the increasing population and traumatic cases that require services (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017). Recently qualified Generation Y medical doctors are working in stressful conditions in the ailing public health sector in South Africa where they have to deal with distressing cases.

Junior people currently in their early life occupations are categorised as Generation Y (Kane, S., 2018; Macleod, 2008). Generation Y medical doctors in this study are taken as between age 25 and 35. Generation Y medical doctors, who are working as interns or doing

their community service year, have no choice but to work in the suffering public health sector if they are to qualify to practise medicine in South Africa. They work in difficult conditions where injustice and a pitiable working environment ensue (Erasmus, 2012; Phalime, 2014).

Erasmus (2012) labelled Generation Y medical doctors who work in the public health sector in South Africa as “slaves of the state”. Medical doctors are qualifying at younger ages (Erasmus, 2012) and their experiences whether alike or contradictory to other generations need to be reported. Supportive models and policies should be developed for the South African public health sector to ensure that Generation Y medical doctors stay and grow in the field of medicine while caring for themselves as individuals.

1.2.2 Required care for Generation Y medical doctors in the public health sector

This study focuses on medical doctors who are newly qualified, specifically Generation Y medical doctors. In South Africa, medical doctors who want to practise medicine independently are expected to spend at most two compulsory years in the public health sector following training in the various areas of medicine. During this time, they are fully employed as interns and as medical doctors who serve their community service in unfortunate circumstances in the public health sector (Erasmus, 2012).

Internships can vary from one to two years depending on university programmes (Erasmus, 2012). Even during their five- or six-year medical training, students are exposed to the public health sector as they need to rotate in various areas of medicine for certain periods of time (Dr Shoyeb, personal communication, Aug. 7, 2019; Erasmus, 2012). If doctors are to specialise in any medical field in South Africa, they have to receive additional training in the public health sector for a minimum time of about four years (Dr Shoyeb, personal communication, Aug. 7, 2019).

A significant amount of learning supposedly occurs during the years spent in the public health sector. However, Generation Y medical doctors are exposed to various demanding and traumatic circumstances such as poor resources, increased number of patients that the public health sector is meant to serve, appalling infrastructure (Hlatshaneni, 2019; Kotzee & Couper, 2006; Mathias & Wentzel, 2017; Phalime, 2014; Thomas & Valli, 2006), and unjust prejudiced working conditions with many illegal labour practices (Erasmus, 2012; Hlatshaneni, 2019). Furthermore, doctors are exposed to severe chronic and untreatable diseases (such as HIV-AIDS, Cancer, Resistant TB), which is a common reality in South Africa (Discovery Health, 2018; Hlatshaneni, 2019; Liebenberg et al., 2018). These combined with other subjective and collective influences such as personality traits, personal and work stressors, politics, government, society and the economy (Bährer-Kohler, 2013; Lemaire & Wallace, 2017) pose a risk of burnout to Generation Y medical doctors (Discovery Health, 2018; Hlatshaneni, 2019; Liebenberg et al., 2018; Mathias & Wentzel, 2017).

If job-related stress levels, which often lead to burnout syndrome, are not managed well, Generation Y medical doctors could experience high levels of dissatisfaction; increased reports of illness, whether physical or mental; increased absenteeism; high turnover; and/or decreased productivity. As a result, they might have difficulty to provide quality service to patients, which negatively affects their personal and family functioning (Discovery Health, 2018; Hlatshaneni, 2019; Embriaco et al., 2007; Lemaire & Wallace, 2017; Liebenberg et al., 2018; Thomas & Valli, 2006).

As early as 1994, there were already reported occurrences of burnout amongst Generation Y medical doctors working in the South African public health sector. In one study, 77.8% of Generation Y medical doctors who graduated from two English medium universities in South

Africa were found to have experienced symptoms consistent with burnout while Generation Y medical doctors in private practices experienced less burnout (Schweitzer, 1994).

Another study found that medical doctors in the public health sector, including Generation Y medical doctors, had more incidences of job stress than the average working population. Generation Y medical doctors had a likely inclination to view patients as non-human objects, which is usually a consequence of burnout (Thomas & Valli, 2006). High levels of burnout indicated by emotional exhaustion and depersonalisation were found amongst medical doctors, including Generation Y, in another study that was done in the Limpopo public health sector (Peltzer, Mashego, & Mabeba, 2003).

Younger employees are seen to have higher rates of burnout, which is mainly due to a lack of career experience (Mathias & Wentzel, 2017; Peisah, Latif, Wilhelm, & Williams, 2009; Petersen, 2019; Samra, 2019). Understanding feelings, hopes, cares, and concerns raised by Generation Y medical doctors is part of the essential ‘caring for the carers’ journey that I as the researcher was interested in. South Africa needs to understand, care for, and empower younger generations to develop into future leaders, professionals, and specialists (Discovery Health, 2018). It cannot be overemphasised that the experiences, challenges, and strengths of these doctors must be understood and supportive structures created to enable efficiency (Discovery Health, 2018).

1.3 Problem Statement

Currently, there are general proposed intervention approaches for burnout that have narrow empirical support (Bährer-Kohler, 2013; Sandstrom, Rhodin, Lundberg, Olsson, & Nyberg, 2005; Sorenson et al., 2016; Werneburg et al., 2018). This implies that there are no empirically investigated coaching interventions for burnout specifically in Generation Y medical doctors working in the South African public health sector (Discovery Health, 2018; Hlatshaneni, 2019;

Liebenberg et al., 2018). This necessitates the psychology field in South Africa to investigate the issue by doing scientific research and developing coaching interventions to combat burnout and promote ‘care of self’ for the Generation Y medical doctors while nurturing the continuing passion for the field.

In viewing the literature, the apparent lack of empirically based coaching interventions for burnout in the varying populations, specifically Generation Y medical doctors in the South African public health sector, informed the formulation of the research problem. Additionally, the research problem was informed by the proposed possible negative impact of burnout in Generation Y medical doctors in the context of the challenged South African public health sector.

1.3.1 Burnout as a growing challenge in developing countries with limited intervention

Employees in developing countries such as South Africa have to deal with increased levels of job stress due to the reality of their work environments, such as a low number of staff in the under resourced and ailing public health sector (Carod-Artal & Vázquez-Cabrera, 2013; Discovery Health, 2018; Hlatshaneni, 2019; Liebenberg et al., 2018; Mathias & Wentzel, 2017). This is aggravated by external factors such as extreme poverty, which leads to many people using the under resourced public health sector (Houtman, Jettinghoff, & Cedillo, 2007; Sirsawy, Steinberg, & Raubenheimer, 2016).

Health professionals in developing countries, who are likely in need of burnout interventions, might not be using burnout or job stress intervention strategies for various reasons. These reasons include lack of accessible interventions, and/or lack of resources such as time or funds to allow such interventions (Houtman et al., 2007; Liebenberg et al., 2018; Coetzee, Conradie & Coetzee, 2018). Another reason could be that developing countries have limited knowledge and/or appreciation of burnout; therefore, they do not prioritise dealing with work-related stress

and burnout, or they simply do not have the resources to tackle the challenges (Houtman et al., 2007; Liebenberg et al., 2018).

More developed countries are speedily advancing in terms of understanding burnout and burnout interventions (Cassitto, Fattorini, Gilioli, Rengo, & Gonik, 2003; Lemaire & Wallace, 2017). Understanding job stress in work environments that often lead to burnout and the need for interventions is still in the initiation stages for most developing countries, which include South Africa where burnout is likely to be stigmatised (Sorenson et al., 2016; Werner, Mittelman, Goldstein, & Heinik, 2012).

Sadly, burnout syndrome, especially without proper management, has severe consequences and costs at individual, societal, familial, organisational, and professional level. These consequences are even more detrimental in developing countries where more studies and interventions are still needed (Carod-Artal & Vázquez-Cabrera, 2013; Sorenson et al., 2016; Werneburg et al., 2018).

Generation Y medical doctors are deemed to be one of the health professions at higher risk for burnout. Starting during training, early intervention is needed to prevent repercussions such as depersonalising the client-doctor relationship and developing poor coping mechanisms (Discovery Health, 2018; Liebenberg et al., 2018; Howse, 2000; Mathias & Wentzel, 2017; Thomas & Valli, 2006). Generation Y medical doctors work extremely long hours in the South African public health sector as they are required to work 30-hour shifts with little or no provision for illness (Discovery Health, 2018; Erasmus, 2012; Grant, 2006; Hlatshaneni, 2019; Liebenberg et al., 2018; Sirsawy, Steinberg, & Raubenheimer, 2016). If Generation Y medical doctors get sick, a colleague, who is already working long hours in difficult situations dealing with a substantial workload, has to cover their shift (Grant, 2006), often posing risk to

themselves and their patients (Erasmus, 2012; Gitto & Trimarchi, 2016; Lemaire & Wallace, 2017).

Increased exposure of Generation Y medical doctors in the public health sector to high cases of trauma and/or severe chronic and untreatable diseases, such as HIV/Aids, results in increasing patient deaths and a higher burden of disease (Liebenberg et al., 2018). These factors add to the workload burden of Generation Y medical doctors in the public health sector and, in many cases, also makes decision-making more complex (Davhana-Maselesele & Igumbor, 2008; Erasmus, 2012; Gitto & Trimarchi, 2016; Liebenberg et al., 2018; Thomas & Valli, 2006), which increases the burnout rate amongst Generation Y medical doctors (Discovery Health, 2018; Erasmus, 2012; Thomas & Valli, 2006). Other factors found to cause job stress amongst South African medical doctors and that often lead to burnout are working overtime, making critical, on-the-spot decisions, and dealing with crisis situations continually (Discovery Health, 2018; Grant, 2006; Hlatshaneni, 2019; Lemaire & Wallace, 2017; Liebenberg et al., 2018; Sirsawy, Steinberg, & Raubenheimer, 2016).

Grant (2006) and other authors such as Liebenberg et al., 2018 explored the significance of burnout and the role it plays in the retention of junior doctors at some South African hospitals. The studies found that there has been an increase in the migration of medical doctors worldwide, with a significant exodus of Generation Y medical doctors from South Africa additionally an increased risk and need to exit the public health service (Grant, 2006; Liebenberg et al., 2018). The medical doctors who emigrate tend to be mostly Generation Y, male, and not yet specialised after having been exposed to only the public health sector as part of their training, compulsory internship, and/or community service years (Grant, 2006). This exodus and move from the public health sector medicine along with the effects of HIV/Aids, other epidemics, and traumatic cases vastly increase the workload and place extra strain on

Generation Y medical doctors who remain in the public health sector (Grant, 2006; Liebenberg et al., 2018).

According to my view as researcher, it was important in this current study to empower Generation Y medical doctors in the South African public health sector with an increased awareness of burnout and its consequences. Additionally, a specified coaching intervention of burnout for Generation Y medical doctors could not be overemphasised. Equally important, the study hoped to lead to discussions about better investments to improve working conditions to avoid burnout. Furthermore, to make decision makers in the public health sector aware of the prevention, management and treatment of burnout before it leads to problems that affect professionals, the sector, society and beneficiaries of their services (Erasmus, 2012; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Thomas & Valli, 2006).

1.3.2 Required burnout interventions and current limitations

There has been an increase in research in Africa that focus on understanding the occurrence and intervention of burnout (Carod-Artal & Vázquez-Cabrera, 2013; Discovery Health, 2018; Sorenson et al., 2016). Empirically investigated coaching intervention for burnout in Generation Y medical doctors in South Africa is rare. Regardless of burnout incidence, there are only a few well-designed scientific studies on the effectiveness of intervention and even more limited information about how interventions actually work (Haiten, Kinnunen, Pekkonen, & Kalimo, 2007; Le Blanc & Schaufeli, 2008; Sorenson et al., 2016; Werneburg et al., 2018).

Unless the effects of burnout and other causes of medical migration are emphasised and attempts are made to mitigate them, South Africa will continue to lose doctors to the global labour market, which will ultimately result in further detrimental standards of medical care situations it cannot afford to have (Discovery Health, 2018; Grant, 2006; Hlatshaneni, 2019; Liebenberg et al., 2018). The aforementioned studies indicated that South Africa is likely to

face a challenge in the future if burnout is not prevented or moderated, or if no coaching interventions with empirical evidence for Generation Y medical doctors are developed. Generation Y medical doctors stand to lose their passion for the medicine field, they risk a change of career, or they risk to develop maladjusted coping mechanisms. These mechanisms affect them negatively and personally, affect the patients they are meant to serve, and affect the various institutions where they are employed (Discovery Health, 2018; Hlatshaneni, 2019; Liebenberg et al., 2018).

Burnout is associated with a decreased effectiveness in the workplace, diminished job gratification, and shrunken obligation to the job or organisation (Carod-Artal & Vázquez-Cabrera, 2013; Lemaire & Wallace, 2017). There is a general need for better working conditions in the South African public health sector (Discovery Health, 2018; Erasmus, 2012; Grant, 2006; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Sirsawy, Steinberg, & Raubenheimer, 2016) where it is compulsory for Generation Y medical doctors to be trained or to work. The need for an empirically investigated coaching intervention for burnout cannot be overemphasised. Steps must be taken to mitigate the burnout experienced by Generation Y medical doctors.

Certain recommendations for interventions to alleviate burnout have been made in literature. Some are more relevant to the underresourced South Africa than others (Panagioti et al., 2016; Thanacoody, Bartram, & Casimir, 2009). Suggestions include mentoring programmes to provide coping resources, creative ways for hospital managers to assign shifts according to individual needs, and incentives to do unpopular shifts. However, although these strategies are mostly ideal, they are less applicable to the resource-scarce South African environment (Panagioti et al., 2016; Thanacoody et al., 2009).

In summary, burnout occurs in areas where work requirements surpass the support and resources available to employees (Lemaire & Wallace, 2017; Maslach, Jackson, & Leiter, 1996). It is characterised by an erosion of values, self-respect, essence, and determination, which at times is emphasised as an “erosion of the soul” (Gitto & Trimarchi, 2016). Therefore, burnout is not connected to people only, but rather to the workplaces; therefore, interventions should be aimed at more than self-improvement (Maslach et al., 1996). Lack of intervention is risky and a holistic intervention is needed. At the same time, the conditions in the South African public health sector make it challenging for intervention. This is the dilemma that the public health sector needs to overcome.

1.3.3 Research questions for the project

The main research question relating to the literature review is: What are the Generation Y medical doctors’ experiences of a group coaching intervention for burnout in order to explore its benefits and applicability?

Research questions to be addressed by the empirical study are as follows:

1. What are the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors working in the South African public health sector?
2. Is the group coaching intervention for burnout applicable and beneficial to Generation Y medical doctors working in the South African public health sector?
3. Will the data collected contribute to existing knowledge which aims to develop coaching interventions for burnout amongst Generation Y medical doctors working in the South African public health sector?

1.4 Aims of the Research Project

The following section discusses the general aim of the research project and the specific aims of the literature review and descriptive phenomenology study.

1.4.1 General aim of the research project

The general aim of the research is to describe the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors.

1.4.2 Specific aims of the literature review

The specific aim of the literature review is to review a group coaching intervention for burnout to determine its applicability and benefit to Generation Y medical doctors who are working in the South African public health sector.

1.4.3 Specific aims of the descriptive phenomenology study

The aim of the phenomenology study is to gather and analyse information to explore Generation Y medical doctors' experiences of a group coaching intervention for burnout.

1.4.4 Secondary aims of the study

The secondary aims of the study were:

- Through analysis of the data generated by the research, I aimed to contribute to the existing knowledge and to develop empirically based coaching intervention for burnout in Generation Y medical doctors working in the public health sector in South Africa.

- To add knowledge about awareness, prevention and intervention of burnout in Generation Y medical doctors in the South African public health sector context by evaluating a group coaching intervention for burnout.
- To formulate recommendations for (a) the public health sector department specifically to gain a deeper understanding of the experiences of Generation Y medical doctors; (b) for future research in this field of coaching psychology; and (c) for coaches/consultants.

1.5 My Evolving Interest in the Research Project

My interest in burnout started when I joined the field of psychology. I qualified as a clinical psychologist with a Master of Science (MSc) degree early at 22 years of age. I was excited and eager although many in the field – colleagues and even clients – believed I was too young to be a clinical psychologist. When I finally started working in the public health sector as a student psychologist, an intern and in my community service year, my expectations of the field were not met. The clients had serious social issues that were not necessarily psychological. The reality of the problems they presented with and the challenges they had to acquire funds or get transportation to see health professionals in the public hospitals was overwhelming.

The lack of proper infrastructure and resources in our units in the public health sector further added to the stressful experience. The need to limit clients to seven per day, as we were taught, was just a dream as we saw twice the number of clients daily who presented with social stressors. The reality of working in the public health sector to complete my community and internship years took a toll on me. Moreover, the need to continually prove to myself, my colleagues, my supervisors, my family, and my clients that I could be a clinical psychologist as young as I was, was an overwhelming burden. I was drawn to the psychology field and felt

it was my calling, but the reality of the South African public health sector and the impact it had on me were extremely negative.

The field itself was further complicated. I believe I was misunderstood at times. Even to date, psychology is still not fully valued in South Africa; for example, many people are continuously surprised that it takes more than seven years to qualify and that there are different psychology qualifications. Not everyone understands or appreciates the hard work that goes into qualifying nor what we as clinical psychologists actually do with clients. There is also at times conflict between the psychologists registered in the varying categories. This created considerable isolation in the field and work environment for me personally.

Thus, the complex reality of clinical psychology in the South African public health sector combined with my own reality – being a Generation Y black female clinical psychologist with personal experiences, stressors, aspirations of proving myself, aspirations to be a clinical psychologist, and my own personality amongst other things – led to my own personal experience of burnout.

I believe I developed emotional exhaustion and depersonalised to the extent that I did not want to be in the clinical psychology field anymore. No one seemed to know how to help me, but how could they when I myself did not understand or felt unable to explain what I was experiencing? Fortunately, I managed to deal with my experience with substantial effort in a way that became useful to me. I did not leave the field: I diversified and structured my work in a functional way because I still felt deep down that clinical psychology was my calling.

Throughout my journey, I also interacted with Generation Y medical doctors in the public health sector. I observed how Generation Y medical doctors attempted to cope with the limited resources available and other challenges in the public health sector. I began to realise that this burnout experience is real in the South African public health sector context. If not prevented

or dealt with, burnout is likely to lead to people, specifically Generation Y, prematurely leaving the profession or developing poor coping mechanisms. There was also the realisation of the terrible conditions that had to be endured in the public health sector, which could have an adverse negative impact on professionals, their families, society, patients and even employers.

Additionally, I realised from literature not only the severe consequences of burnout but also the limited coaching interventions available, the misunderstanding of burnout by other people or the affected, the possible misdiagnosis of burnout, and the associated stigma that limits intervention. I did a substantial amount of reading about burnout in South Africa amongst Generation Y medical doctors in the public health sector. This led to an increased interest about burnout, which sparked even more interest in Generation Y medical doctors lived experiences of burnout and possible interventions while working in the public health sector.

This study used a convergent mixed methodology (Creswell & Creswell, 2018) that incorporated an enormous qualitative portion. Qualitative research may be conducted to satisfy a researcher's desire to understand a topic or questions that emerge from the researcher's own personal experiences (Babbie, 2004). Therefore, I chose to pursue an understanding of the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors in the public health sector.

I chose a descriptive phenomenological approach as part of the qualitative method, which involves a full description and self-examination; therefore, bracketing my experiences continually throughout the research – before, during and after collecting data (Patton, 1990).

1.6 Paradigm Perspective

Scientific orientation to the study is established by my world views, stances and paradigms. This section introduces the paradigm that the study used to conceptualise the experiences of

Generation Y medical doctors of a group coaching intervention for burnout. Studies characteristically incorporate suppositions and viewpoints about the world that inform the explorations in research (Creswell, 2003; Lincoln & Guba, 1985).

1.6.1 The disciplinary relationship

The study is necessary and applicable to the discipline of industrial and organisational psychology and the developing field of consulting psychology as it focused on the employed individual (being the Generation Y medical doctor in an organisation) with the aim of getting empirical evidence of a group coaching intervention for burnout.

The industrial and organisational psychology discipline centres on studying and understanding human behaviour in the workplace using psychological theories and ideologies of organisations (Cascio, 2007). This field aims, amongst other goals, to increase efficiency in the workplace by addressing issues such as physical and psychological well-being, performance, satisfaction, and safety and health of its employees (Cascio, 2007).

Consulting psychology applies psychologists' specialised knowledge by consulting and using psychologically based consultation methods to address issues concerning human behaviour in various areas to assist individuals, groups and/or organisations to become more efficient, healthier and effective, and advance operational work environments (APA, 2000; Lowman 2016). Lowman (2016) stated that the developing field of consultation psychology incorporates industrial and organisational psychology, clinical psychology, social psychology, and counselling psychology, and builds on the theories thereof.

Burnout and coaching are often considered in some of the aforementioned psychology fields (Grant & Cavanagh, 2007). Coaching aims to augment the effectiveness and productivity of

organisations and well-being of its employees by using methods aimed at understanding and influencing work behaviour, attitudes and organisational structure (Grant & Cavanagh, 2007).

As the researcher, I am of the view that the consulting psychology discipline should play a crucial role in South Africa by researching and developing coaching interventions for burnout in the various health professionals, including Generation Y medical doctors, to promote sustainability of the professionals, the profession itself, and care for the society who stand to benefit from their services.

Research has determined certain risk factors for burnout. However, studies are needed to identify and evaluate potential preventative strategies and acknowledge burnout as an important consequent measure that threatens patient care and affects the quality of life of Generation Y medical doctors (Embriaco et al., 2007; Lemaire & Wallace, 2017; Panagioti et al., 2016; Sorenson et al., 2016; Werneburg et al., 2018).

The group coaching intervention for burnout aims to have a positive influence on the work and personal lives of Generation Y medical doctors. This could cascade through to the organisation and positively affect patients in the public sector and the medical profession as a whole. This research could add value to coaching interventions in the burnout field, specifically in Generation Y medical doctors, thereby influencing burnout prevention within the South African context.

1.6.2 Research paradigm

A paradigm can be described as a group of fundamental philosophies that represent a world view and defines the nature, the individual's place in it, and potential associations (Denzin, 1994; Denzin & Lincoln, 2003). Researchers make philosophical suppositions comprising a position regarding the ontology, which is the nature of the reality and highlights the

epistemology, which is how researchers know what they know (Creswell, 2013). A qualitative researcher further emphasises the axiology: the position of values, rhetoric or language, and methodology (Creswell, 2003). The philosophical assumptions in qualitative or quantitative research reflect a particular stance and shape the research by bringing in paradigms or world views (Creswell, 2007, 2013, 2016).

Ontological and epistemological outlooks on the world view are either objectivistic or constructivist, which affect the evident position of reality (Lather, 1986). Gephart (1999) classified research into three paradigms that could be fundamental philosophical epistemological postulations that guide research: positivism paradigm, interpretive paradigm, and critical post-modernism paradigm.

The study used convergent mixed methodology (Creswell & Creswell, 2018) that combined quantitative and qualitative methods. Therefore, both positivism and interpretive paradigms were used, which are discussed in the following sections.

1.6.2.1 Positivism paradigm

This section introduces positivism, which is one of the orientations within the research paradigm. I incorporated a burnout survey (MBI-GS) to objectify the level of burnout in the participants; therefore, an objective positivistic approach based on a pragmatism paradigm was also applied in the study (Guba & Lincoln, 1994).

Quantitative researchers aim to quantify and objectify data (Guba & Lincoln, 1994). The nature of reality assumed by positivism is pragmatism, which implies that a reality is assumed to exist (Guba & Lincoln, 1994). The MBI-GS burnout survey was included in this study to quantify the level of burnout in the participants before and after the group coaching intervention.

1.6.2.2 Interpretive paradigm: Descriptive phenomenology

This section introduces description phenomenology, which was one of the specified orientations within this research paradigm. In this study, I also used the descriptive phenomenological approach (Christensen, Welch, & Barr, 2017; Giorgi, 1985) as a specific scientific orientation that led to certain parts of the research depending on the interpretive paradigm.

I took a descriptive empirical phenomenologist researcher standpoint (Christensen et al., 2017; Finlay, 2008) to describe Generation Y medical doctors' experiences of a group coaching intervention for burnout. This perspective was appropriate as part of the research as I sought to obtain descriptions of the experience of the lived phenomenon (Christensen et al., 2017; Finlay, 2008;), namely, the Generation Y medical doctors' experiences of the coaching intervention for burnout.

I deemed the interpretive paradigm applicable as I aimed to describe experiences of a group coaching intervention for burnout amongst Generation Y medical doctors. The paradigm focuses on understanding and seeking meaning from individual experiences (Mason, 2002; Thanh & Thanh, 2015).

Qualitative researchers aim to study things in the natural settings to make sense of, or to interpret phenomena in terms of the meaning people bring to them. It consists of interpretative practice that makes the world visible (Denzin & Lincoln, 2003; Maritz & Visagie, 2009; Thanh, & Thanh, 2015). The qualitative phenomenological approach was relevant in the current study as it attempts to understand people in terms of their own definitions of their worlds (Christensen et al., 2017; Denzin & Lincoln, 2003; Maritz & Visagie, 2009).

I did not fully take a 'pure' phenomenological approach view (Christensen et al., 2017; Lindseth & Norberg, 2004), but rather endorsed the descriptive phenomenological approach

that allowed the description of the experiences of Generation Y medical doctors of the group coaching intervention for burnout. The methodological structure of descriptive phenomenology guided the research design, methodology and interpretation of data in this research project. I bracketed myself by discussing my own personal experiences with the phenomenon. It did not take me away completely from the research, but it helped me to have awareness of personal experiences, which I set aside so I could focus on the experiences of the participants in the study.

The data collection procedure involved exposing the Generation Y medical doctors to the questionnaire and the phenomenon, which was the group coaching intervention for burnout, using focus group coaching sessions. Systematic data analysis was followed (Moustakas, 1994).

In view of these paradigms, I explain the ontological postulations leading to epistemological and then methodological suppositions further in the next subsection.

1.6.2.3 My ontological, epistemological and methodological perspectives

Ontology establishes the framework or reality of the study (Nel, 2007). It focuses on philosophy and formulates the nature and structure of the world or reality that is studied (Terre Blanche, M.J., Durrheim, & Painter, 2006; Wand & Weber, 1993). Positivism implies a pragmatic perspective – realist ontology – being a belief in an objective world and a detached epistemological view point that people’s perceptions are either true or false, which indicates a possible methodology relying on the control or manipulation of reality (Walsham, 1995). Critics of interpretive constructionism and critical post-modernism emphasised the need for subjectivity in interpreting social reality and hence offered other possible theoretical, methodological and practical approaches to research (Gephart, 1999).

In this study, a combination of pragmatic and interpretive tradition was used to set up the ontology. Positivism was partially adopted to evaluate the objective level of burnout in participants in Phase I and Phase III. This indicates that a realist ontology, implying a belief in an objective reality, was taken in certain parts of the research, which emphasises that observations are either true or false and are determined by the external environment (Walsham, 1995).

Additionally, the interpretive framework (which is the view that reality consists of people's subjective experiences of the world and therefore an intersubjective epistemology) can be adopted together with the ontological belief that reality is socially constructed (Creswell & Creswell, 2018; Walsham, 1995). In this study, an interpretive framework was also taken in most part of the research where focus of the ontological interest was on the experiences and meanings (Whitley, 2002) of Generation Y medical doctors regarding a coaching intervention for burnout.

The participant's ontology is limited to the Generation Y medical doctor's experiences and the descriptive phenomenological stance, which focuses on describing the phenomenon instead of searching for one objective reality. The ontological assumptions of realistic ontology and interpretive tradition in the study are congruent with the research paradigms.

Epistemology describes the relationship between what can be researched and the researcher (Lincoln & Guba, 1985). Two epistemological stances were taken in the study as it was a mixed method study that combined a positivism approach and an interpretive view (Creswell, 2003). A positivism stance was taken in the research in sections where the objective questionnaire was used.

From an interpretive approach, the investigator and the investigated are coupled in researching conclusions; therefore, the researcher is a significant participant (Denzin & Lincoln, 2003)

unlike in the positivistic approach where the researcher's viewpoints are achieved without personal biases (Denzin & Lincoln, 2003). Thus, it is evident that interactional epistemological assumptions and position were fitting for the descriptive phenomenology methodology part of the study as I needed to develop rapport with the Generation Y medical doctors and rely on the relationship to obtain quality reflection of their experiences.

Based on the use of descriptive phenomenology as part of the study, which led to a certain ontological and epistemological perspective, an idiographic approach, being an all-inclusive representation that attempts to describe experiences of participants (Maykut & Morehouse, 1994), was also employed as I aimed to understand and describe the Generation Y medical doctors' experiences of a burnout coaching intervention (Maree & Van der Westhuizen, 2007).

Methodology is the applied stages of the study that echo a philosophy in the process of the study (Terre Blanche, M.J., Durrheim, & Painter, 2006). This study used a mixed method methodology that combined a positivistic methodology and an interpretive framework. The positivistic part of the study required using a survey (MBI-GS) and a scoring guide to determine the level of burnout in the participants before (Phase I) and after the coaching intervention (Phase III).

Interpretive traditions were also adopted in the current study, which do not have unyielding procedures as is the case with positivistic approaches (Christensen et al., 2017; Kaplan & Maxwell, 1994). The focus of interpretive tradition is to understand the subjective encounters of participants. The methodological approach allowed that I remain central in the process and interrelate continuously with the participants (Christensen et al., 2017; Reeves & Hedberg, 2003).

Meaning and not measurement-oriented methodologies were used (Reeves & Hedberg, 2003). These included using focus groups, bracketing my own biases, reflecting, and displaying

sensitivity and openness to new experiences that relied on a subjective relationship between myself and the Generation Y medical doctors. The descriptive phenomenology taken in the research guided the methodology.

1.6.3 Humanism as an underlying psychological paradigm

Humanism paradigm formed another boundary in my study. Humanism views the person as capable of becoming their own best experts (Joseph, 2003, 2006). Rogers (1959, 1963) essentially proposed the meta-theoretical perspective as an actualising tendency within human beings towards growth, development and optimal functioning. Some Rogerian attitudes, skills and behaviours were adopted in the various phases of the study as part of the coaching process to understand the Generation Y medical doctors' experience of the group coaching intervention for burnout.

1.6.4 Theoretical approach

Theoretical models, constructs and the methodological assumptions applicable in the study are discussed in this section.

1.6.4.1 Theories and models

i. Burnout model and description

This study contextualises burnout as described by Maslach and Jackson (1981) and the proposed process model by Leiter and Maslach (1998). According to Maslach and Jackson (1981), burnout is a three-dimensional construct consisting of core components and manifestations. The dimensions are increased emotional exhaustion, depersonalisation or cynicism/negative attitude towards several things (especially clients), and an increased tendency for negative evaluation of the self as lacking professional accomplishment or

competence (Maslach & Jackson 1981, 1986). Leiter and Maslach (1988) proposed a process model of burnout, which begins with emotional exhaustion, often leads to depersonalisation, and subsequently to reduced personal accomplishment.

Self-reporting scales have been used over time in various contexts. These scales seem to be reliable for measuring burnout (Alarcon, Eschleman, & Bowling, 2009). This study used the MBI-GS as part of the objective measurement of burnout. The scale was constituted in 1996 (Schaufeli, Leiter, Maslach & Jackson, 1996) and has various questionnaires for different settings.

ii. Generational theory

Some researchers label the generations as follows: traditionalists or veterans who were born between 1922 and 1945, baby boomers who were born between 1946 and 1964, Generation X who were born between 1965 and 1980, Generation Y (or millennials) who were born between 1981 and 2000 (Generation Project, 2018; Kane, L., 2018), and the upcoming Generation Z who were born from 2000 to the current date (Horovitz, 2012).

Each generation brings their own strengths to job situations. Understanding these strengths can lead to enhanced productivity and diminished oppositions in the generationally diverse workplace (Hamori, Cao, & Koyuncu, 2012; Kane, L., 2018; Zemke, Raines, & Fillipczak, 2000).

Although generations are defined in numerous ways, this study takes Generation Y to be people born between 1981 and 1991. Generation Y are needed as Generation X are retiring. However, Generation Y are reportedly seen to lose interest in their jobs quicker, which causes a high turnover in the workplace even where critical and highly skilled talent is needed (Crow & Stichnote, 2010; Golshan & Omar, 2011; Kane, L., 2018; Macleod, 2008). Organisations that

employ Generation Y need to attract and retain people by meeting the needs of the Generation Y worker (Kane, L., 2018). This includes the South African public health sector that employs Generation Y medical doctors.

Generational theory is not necessarily a science. There are similarities and differences within the generation and between generations (Mannheim, 1952). It is important to note that lived experiences often change or shape a generation's values, which results in the generation challenging older generational values. This often leads to tension or challenges. It is the defining point for understanding generations and what separates them (Macleod, 2008; Mannheim, 1952).

iii. Appraisal theories of stress, coping and burnout

Appraisal theories are seen as significant for coping and represent active formation of reality (Mahoney & Patterson, 1992). Human behaviour relies on implicit stimuli that draw attention to the importance of individual awareness, interpretation and experience of the world (Mischel, 1981). This viewpoint is similar to the theoretical stress model of Lazarus and Folkmans (1984). The appraisal theory of Lazarus and Folkman (1984) suggested that generalised convictions determine stress perception and reaction. Although the convictions are about the self, it is likely that these include general convictions about the world and others (Pretorius & Diedricks, 1994).

It can be proposed that when a person is confronted with stress, or if they have negative appraisals of the self, their family and/or support, they are likely to have self-doubt, have a perception of self as being unable to cope, and possibly withdraw from active coping. Positive appraisals of the self, family and support could lead to resourcefulness in dealing with stressful difficulties and problem-focused coping (Pretorius & Diedricks, 1994).

Burnout is described as a long-lasting psychological process linked to chronic job stress (Maslach & Leiter, 1997). The interaction of personal factors, coping, environmental factors, and an organisational context needs to be considered for a burnout diagnosis and intervention (Garrosa & Moreno-Jiménez, 2013; Panagioti et al., 2016). There are individual variations in response to burnout and the dynamics causing the differences need to be explained (Garrosa & Moreno-Jiménez, 2013; Lemaire & Wallace, 2017). Leiter and Maslach (1998) propose that burnout involves an interaction of attitudes and self-appraisal in a job context that requires emotional and personal capabilities to handle (Garrosa & Moreno-Jiménez, 2013; Gitto & Trimarchi, 2016).

Generation Y medical doctors need personal capabilities such as emotional resilience, emotional intelligence, positive attitudes to self and life, level of optimism, and emotional competence (Garrosa & Moreno-Jiménez, 2013; Gitto & Trimarchi, 2016) to respond to the physical and emotional demands of their workplace, which often lead to burnout. This is because burnout is explained not only as an automatic process caused by the organisational environment or chronic job stress, but also as a complex interaction of individual differences, work orientations, attitudes, and social and familial environment (Garrosa & Moreno-Jiménez, 2013). Burnout has also been linked to Lazarus and Folkman's (1984) appraisal theory, which proposed an appraisal of the situation, an appraisal of the available resources, and ways to respond, which determine the individual response. Lazarus (1999) emphasised that a stress response is the cognitive appraisal of stressor as a threat, challenge or damage/loss, and pointed out that stress is an emotional reaction.

It appears that burnout is linked to coping; its occurrence and maintenance is due to an inability to cope. Focus on an intervention for burnout should therefore not only be on chronic job stress

factors, but also on the poor ability of managing stress effectively (Garrosa & Moreno-Jiménez, 2013).

1.6.4.2 Constructs and concepts

i. Burnout

Although a unified definition of burnout is still being developed, most researchers agree that burnout is a syndrome that occurs amongst employees, especially those working with people in some capacity (Bährer-Köhler, 2013; Maslach et al., 1996; Sorenson et al., 2016; Werneburg et al., 2018). Burnout is composed of three factors: emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach et al., 1996).

Burnout is described as a psychological process and is typically a response to long-term exposure to work stressors (Maslach et al., 1996). It is characterised by emotional exhaustion with depletion of emotional and physical resources, disengagement or detachment from the job, and reduced feelings of personal job-related efficacy (Maslach, 1982).

The process model incorporated in the study suggests that emotional exhaustion is the preliminary central component that often leads to the other two factors, namely, depersonalisation, and reduced personal accomplishment (Leiter & Maslach, 1998; Maslach & Jackson, 1981). The consequences of burnout are potentially very serious for workers, their clients, and the larger institutions where they interact (Maslach et al., 1996).

ii. Coaching intervention

Various descriptions of coaching are presented as there is not an agreed standard definition of coaching yet (Passmore, Peterson, & Freire, 2013). Professional coaching employs certain

communication skills to support clients in developing different perspectives to their situations and thereby uncovering different solutions to achieve their goals (Cox, E., 2013).

Coaching is an ongoing relationship between the client and coach that facilitates change, growth and personal development. Consequently, it improves the efficacy of an organisation. Coaching is a process of inquiry and self-discovery aimed at increasing levels of mindfulness and accountability while providing the client with structure, support and feedback (Kilburg, 2000).

There are deliberations around whether coaching psychology should adopt the meta-theoretical perspective of the person-centred theory as opposed to the medical model, or whether it is fully therein (Joseph, 2006; Passmore, Peterson, & Freire, 2013). The implications for training and practice are being considered, but there is a general agreement that coaching is not focused on alleviating dysfunction or distress, but rather on facilitating well-being and favourable adjusted functioning (Joseph, 2006).

This is closely related to Rogers' (1959, 1963) person-centred approach, which is not about repairing dysfunction from a diagnostic medical stance, but rather about facilitation towards better functioning by using a non-judgemental environment and certain skills to promote inherent potential. According to Rogers (1959, 1963), the environment should promote congruence or genuineness, unconditional positive regard, acceptance, and, lastly, precise empathetic support.

Rogers (1959, 1963) proposed the meta-theoretical view as an actualising tendency within human beings towards growth, development and optimal functioning; basically, that people have an innate potential to become the best they can be (Joseph, 2003).

A person-centred coaching psychology approach was adopted in this study as I applied some Rogerian attitudes, skills and behaviours in the burnout coaching pre-intervention (Phase I), intervention (Phase II), and post-intervention phases (Phase III) to establish rapport with the group of Generation Y medical doctors. Furthermore, to facilitate an environment where they could begin to gain skills towards optimal functioning and where they could give a true indication of their experiences of the burnout coaching intervention.

iii. Generation Y medical doctors

Generation Y medical doctors are reckoned to have a higher risk of burnout. Early intervention is needed to prevent negative consequences such as developing poor coping mechanisms that affect their personal lives and beneficiaries of their services (Howse, 2000; Thomas & Valli, 2006).

Sources define the generational boundaries differently. Some sources state that Generation Y generally comprise people born between 1981 and 2000 (Generation Project, 2018; Kane, L., 2018). Another source states that Generation Y are those people born between 1978 and 1994 (Macleod, 2008). The label Generation Y is often applied to younger employees.

For the purpose of this study, the selected age criterion for participation was from 25–35 years of age; therefore, people born between 1981 and 1991 fall within the Generation Y boundary. This age bracket was chosen because scholars are expected to complete grade 12 in ordinary South African public schools at the average age of 18 (Department of Education, 1998). Thus, a person who completed a six-year degree and who worked for about 24 months in the public sector (which were two of the other criteria for participation in the current study), would be aged 25 on average. The age boundary was increased from 25 to 35 to allow for uncontrollable variables and to increase the possible numbers for participation of people who still fell within Generation Y age group.

1.7 Research Design

The research design connects the implementation of the research and the research questions (Durrheim, 2004). The following section discusses the research approach, unit of analysis of the current study, and the research method.

1.7.1 Research approach

The research approach of this study was a convergent mixed research approach (Creswell & Creswell, 2018) that combined quantitative and qualitative methods. Methodological triangulation was applied (Kopala & Suzuki, 1999), which aimed to enhance the credibility of findings and interpretations (Patton, 1990) either by triangulating different methods or by triangulating different sources (Kopala & Suzuki, 1999). The rationale for combining quantitative and qualitative methods in this current study was to triangulate different methods in an attempt to get a full picture of the phenomenon being studied.

The research approach in the study was contextual, qualitative, explorative, and descriptive as the researcher would study the data gathered in the environment (Creswell, 2003; Marshall & Rossman, 1999; Mouton, 2001) to achieve informed findings from this study. Additionally, quantitative data was used in the current research aimed at objectifying the level of burnout in the participants. The MBI-GS was used in Phase I (pre-coaching intervention) and Phase III (post-coaching intervention). The quantitative findings of the level of burnout were useful to validate the qualitatively explored findings of the study and to provide cross-validity checks and vice versa (Patton, 1990).

The MBI-GS was used as part of the data collection process in all the three phases of the study. It was used in Phase I to evaluate and measure the level of burnout objectively, which was the final criterion for selecting 16 participants for the study. In Phase II, some MBI-GS questions

were adapted and used as semi-structured guiding questions as part of the burnout coaching intervention. The level of burnout post-exposure to the coaching intervention was evaluated in Phase III.

The qualitative approach was also applied as it offered the opportunity to uncover the experiences (Creswell, 2003) of the group coaching intervention for burnout amongst Generation Y medical doctors. This approach focused on meaning, experiences, and understanding of the participants. The purpose of the exploration was to gain a richer understanding of the subjective experiences of the Generation Y medical doctors as a collective (Creswell, 2003; Mouton, 2001; Zucker, 2009).

The qualitative approach in the study was descriptive as little was known about the phenomenon to be researched (Babbie, 2004; Burns & Grove, 2005), namely, the group coaching intervention for burnout amongst Generation Y medical doctors. The current research described this phenomenon and aimed to explore the concepts as they are perceived and defined by real participants who were allowed to speak for themselves (Hoskins, 1998). A descriptive phenomenological approach (Finlay, 2008) was used to describe the Generation Y medical doctors' experience of the group coaching intervention for burnout.

1.7.2 Unit of analysis

Yin (1994) stated the importance of defining a unit of analysis as it promotes replication for comparison. The unit analysis for this current study was the descriptions and experiences of a group coaching intervention for burnout amongst Generation Y medical doctors.

1.7.3 Research method

The research method presents the setting of the research and entrée, and establishes researcher roles, sampling, data collection, interpretation of the data, strategies to ensure quality, ethics and reporting.

1.7.3.1 Research setting

The research setting for all the three phases of the study was a Department of Health hospital in the Limpopo Province where the participants, being Generation Y medical doctors, were employed. The participants were Generation Y (aged between 25 and 35), (Kane, L., 2018; Macleod, 2008), with medical degrees (MBChB) and high levels of burnout as measured by the MBI-GS.

1.7.3.2 Entrée and establishing researcher roles

I chose to do the study at the hospital in the Limpopo Province due to possible accessibility, available number of Generation Y medical doctors, and familiarity with the setting. Access to the hospital and Generation Y medical doctors was obtained following ethical approval from my own academic institution and the hospital ethics committee. The hospital ethics committee and my academic institution granted me written approval as the researcher to access and conduct the study with Generation Y medical doctors (see approval letters annexure A). The study was classified as a psychological risk at a low level (National Health Research Ethics Council (NHREC) Audit Implementation Report, 2018). Communication from the hospital's ethics committee was also given to managers of the Generation Y medical doctors so they would be open to the process.

The clinical manager invited 30 Generation Y medical doctors who met three basic criteria (aged between 25 and 35, MBChB degree, and employed at the Limpopo Province hospital in

the public health sector for over 12 months) to a meeting. The last criterion, namely, a high level of burnout, was to be measured by me in this meeting using an MBI-GS as part of Phase I.

The clinical manager introduced me to the Generation Y medical doctors at the meeting and left to ensure that the participants were relaxed and not influenced by his presence. I presented my background and introduced the research. I talked about the research aims, motivation for the study, requirements from participants, and the process. I emphasised the choice to participate, and that confidentiality and anonymity would be maintained. Non-interested Generation Y medical doctors were given a chance to leave the room.

Eighteen interested Generation Y medical doctors remained behind and completed the questionnaire, which included the MBI-GS and a consent form discussed and signed. After collecting the questionnaires, I explained the next step of the process, whereafter the meeting was terminated. The next step was scoring the MBI-GS and calling participants who met the last criterion for Phase II, which was a high level of burnout. The aim was to have 16 willing participants.

The MBI-GS forms were scored. All 18 doctors who completed the MBI-GS had a high burnout score, which meant that they met the last criterion for participation. All 18 purposively selected potential participants were asked to participate in the two focus group discussions (Phase II and Phase III) two days later. The decision was taken to invite all 18 because the number was still below the maximum number of participants for focus groups (Creswell, 2013). All 18 participants who were contacted were willing and committed to participate in Phase II and Phase III. I had a dual role as researcher and coach in the process.

1.7.3.3 The self as instrument

In qualitative descriptive phenomenological studies, the researcher becomes the primary instrument for collecting and interpreting data (Terre Blanche, M., Kelly, & Durrheim, 2006). Although biases are expected in the entire process, I continuously bracketed my own experiences as the researcher. I further expressed the data explicitly and honestly while following sound research procedures to reduce the negative impact of subjectivity on data collection, interpretation and reporting.

1.7.3.4 Sampling Phase I, II and III

Purposive sampling approach was used to select the relevant participants in terms of the research question (Babbie & Mouton, 2010). The aim of the study was not to generalise across the larger group of Generation Y medical doctors but to understand their lived experiences of the group coaching intervention for burnout.

For Phase I (pre-coaching intervention), I as the researcher conducted a literature review, applied for and received ethical approval for the research from my institution and the hospital and, lastly, had a panel discussion with clinical psychologists specialising in burnout about the proposed coaching intervention for burnout in Generation Y medical doctors. Additionally, Phase I aimed to screen the potential group of participants for the final participation criterion (high level of burnout), which was determined by their MBI-GS scores. The screening was conducted two weeks before the actual implementation of Phase II (the coaching intervention).

After finalising the group coaching intervention for burnout amongst Generation Y medical doctors, I approached the clinical manager at the hospital who then called a meeting for purposively selected Generation Y medical doctors who met the three main research criteria: Generation Y medical doctors between the ages of 25 and 35 (born within 1981 and 1991),

with medical degrees (MBChB), and who have been employed at the hospital in the Limpopo Province by the Department of Health for more than 12 months.

Thirty Generation Y medical doctors attended the meeting. The hospital's clinical manager gave a brief explanation of who I was and my interest in conducting the study. He left the room to reassure confidentiality and to not hamper willingness to participate in the study. I presented a brief background and the motivation for the study. I explained the planned research process and my expectations of the participants. I emphasised that there was no coercion to participate. I highlighted that the process would be confidential and anonymous. I asked if there were any questions. Questions were addressed for clarification whereafter non-interested parties were excused.

Twelve non-interest Generation Y medical doctors left the room and 18 remained behind. These 18 participants received the questionnaire containing the MBI-GS. Following completion of the questionnaire, 18 surveys were returned. I explained that the potential participants would be contacted until there were 16 willing participants who met the criteria for participation. Further arrangements would be made with the 16 selected participants. I asked if there were any further questions whereafter the meeting was adjourned.

The 18 MBI-GS surveys were scored. All Generation Y medical doctors who completed the questionnaire met the last criterion, which was a high burnout level score based on the MBI-GS. A decision was made to involve all 18 Generation Y medical doctors as everybody was willing to be exposed to the coaching intervention for burnout and talk about their experiences.

I needed to form two random focus groups. Originally, each group would consist of eight participants, but the group size was increased to nine. A typical sample size is between five and 25 participants who have direct experience with the phenomenon being studied (Creswell, 2013); therefore, a group with 18 participants was still within the acceptable range.

A random list was drawn up of the 18 participants. The potential participants were contacted telephonically two days after the meeting according to the random list. They were informed that they met the criteria and asked about their interest in participating in the study. All doctors were keen to participate in Phase II and III. They were told which group they were randomly assigned to.

Once they showed interest and committed to participating, dates were selected for the Phase II focus groups. There were some challenges in finding suitable dates. Reminders of the time and venues of focus groups were sent a week prior to the focus groups. Eight of the expected participants who were interested and had confirmed attendance excused themselves less than a week before the scheduled date for various reasons. I as the researcher and coach as part of discussion of the consent form emphasized that it was voluntary participation before the session begun and mentioned to them that they could leave at any time. Prior to the scheduled session, the team leader of the Generation Y medical doctors, after the intervention mentioned that she had noticed the low motivation of the group and attempted by all means to encourage attendance. This was noted during the actual coaching intervention process. Additionally, I emphasized this voluntary participation when it was highlighted during the group coaching intervention process that the team leader had encouraged participation in the study.

Phase II – the coaching intervention for burnout amongst the Generation Y medical doctors – commenced with ten participants who signed informed consent. Although there should have been four sessions, due to the challenges of attendance (see Chapter 5), the coaching intervention had to be adjusted to one session of 4.5 hours.

Some of the challenges that prevailed in securing two groups and dates suitable for all to attend the Phase II coaching intervention, led to adjustment of the group coaching intervention to fit reality. The challenges additionally some of the excuses from the eight participants who were

expected to attend the first focus group included low motivation, feelings of apathy, general fatigue, low morale, being on sick leave, unavailability of free time, and pressurised schedule. Even after being encouraged by their team leader, only one group of ten participants attended the session for Phase II.

Six months later, six of the ten participants in Phase II attended the Phase III (post-coaching intervention), which consisted of a final focus group and completion of the MBI-GS. The other four participants excused themselves.

1.7.3.5 Data collection in Phases I, II and III

i. Phase I: Data collection

Phase I data collection involved using an MBI-GS. The MBI-GS was part of a short questionnaire completed by the potential participants. It included biographical data and short questions about placement rotations at the hospital. The purpose of using the MBI-GS in Phase I was to get an objective measure of the levels of burnout in the potential Generation Y medical doctors in order to identify 16 keen participants who met the last criterion for participation.

The last criterion was a high level of burnout as determined by the MBI-GS scores. All 18 participants met the last criterion. The process unfolded as indicated in Chapter 5, and all 18 were invited to participate. The aim was to have two focus groups with nine participants in each focus group. In the end, only ten participants attended the Phase II session.

I as the researcher created profiles of the ten participants based on the MBI-GS and basic questions in the questionnaire. I further noted my observations and bracketed my perceptions, experiences, and biases in the session.

ii. Phase II: Data collection

Phase II data collection used unstructured qualitative guiding questions in the sessions whereby I as the researcher and the ten researcher participants worked together to arrive at the heart of the matter (Tesch, 1990). The duration of the focus group session was about 4.5 hours, which was audio-recorded. Open-ended questions were used to elicit experiences of the three burnout factors amongst Generation Y medical doctors. Where participants did not understand, or answered in a way that implied misunderstanding, the questions were rephrased. Based on the answers given, I had follow-up questions leading to in-depth description of the experiences of burnout. An amenable spontaneous approach was adopted throughout to ensure that the conversation flowed naturally (Patton, 1990). Quieter participants were included by asking their views to ensure that they were also heard in the group.

As the coach, I employed Rogers' (1959, 1963) skills in all phases, such as listening, reflecting, rephrasing, having empathy, using encouragers, using non-verbal listening skills, and having a non-judgemental attitude to ensure a facilitative environment for in-depth conversation with the participants. These skills were further incorporated to encourage elaboration, probing, and clarification of the experiences especially when participants gave short answers. Questions such as "Will you please elaborate further?" were issued to probe participants further on their experiences.

Towards the end of the focus group session, I wrapped up by asking the participants to describe their experience of the group coaching intervention. The coaching intervention focused on eliciting coping mechanisms of burnout and discussions around beneficial coping mechanisms. At the end of the focus group, the individual participants were asked to describe their experiences of the group coaching intervention for burnout in that session.

I made observation notes during the focus group sessions in Phase II. After the sessions, I made session notes while reflecting. I constantly bracketed my biases throughout the process. I continually listened carefully to the verbal statements and noted the non-verbal activities as the participants described their experiences of burnout, awareness of the consequences, and attempts at coping, if any. The audio tapes were transcribed verbatim, which were checked by another researcher a specialist in burnout, who signed a confidentiality agreement to protect the data. The researcher is a qualified clinical psychologist, a professor, who has a special interest in burnout and its impact in health professionals in the South African context. They were brought in to review and ensure minimal bias in the coding and interpretation of the findings.

iii. Phase III: Data collection

This phase consisted of a final focus group six months after Phase II was completed to explore the experiences of the entire coaching intervention for burnout amongst Generation Y medical doctors. The focus group was audio-recorded. Six participants of the ten from Phase II managed to attend the session to complete the MBI-GS to elicit the objective level of burnout six months after the coaching intervention was terminated. There was constant bracketing of my biases throughout the process, even during this phase. This was done to remove any prejudices or personal experiences that would overly influence what I ‘heard’ the participants saying (Leedy & Ormrod, 2015).

Bracketing can be more difficult if one has experienced the phenomenon under investigation, but it is essential for the researcher to understand the typical experiences that people had. Qualitative inquiry was used to collect data required and elicit experiences of the participants of the entire group coaching intervention for burnout amongst Generation Y medical doctors.

The inquiry looked at the experiences of the coaching intervention in the Phase II focus group session, and the time between Phase II and the last focus group session in Phase III.

I had a general plan of inquiry, not a specified set of questions (Babbie, 2004). The questions were unstructured guiding questions that led to follow-up questions based on the responses to gather in-depth description of the participants' experiences of the coaching intervention for burnout. Mason (2002) stated that this type of qualitative questioning is important for obtaining descriptions of individual's perceptions without leading with stern predetermined questions.

Where participants did not understand, or answered in a way that implied misunderstanding, the questions were rephrased. Based on the answers given, I had follow-up questions that led to a description of the experiences.

I asked participants to describe how they continued to experience the intervention in their daily lives since the previous session in Phase II. Their descriptions were noted verbatim. An amenable spontaneous approach was adopted throughout to ensure that the conversation flowed naturally (Patton, 1990). Quieter participants were involved by asking their views to ensure that their views were also heard in the group. The duration of the final focus group was about 120 minutes. Rogers' (1959) skills were used to encourage further elaboration, probing and clarification of the experiences, especially when participants gave short answers. Questions such as "Will you please elaborate further?" were issued to participants to probe their experiences further.

1.7.3.6 Recording, analyses and interpretation of the data in Phases I, II and III

i. Phase I: Recording, analyses and interpretation of the data

The 18 completed surveys by the group of potential Generation Y medical doctors were collected and scored. All 18 met the final criterion, which was a high level of burnout, and

were selected to participate. An individual can be classified as highly burnout if they have a high score on emotional exhaustion dimension and high on one of the other two dimensions being depersonalisation and personal accomplishment. I studied the surveys of the 18 participants to understand the participants and to also get an objective burnout score to compare with the participant's objective score in Phase III. The 18 completed questionnaires formed part of the analysis at the end of Phase III.

ii. Phase II: Recording, analyses and interpretation of the data

The participants signed informed consent to be recorded before the session commenced. The session in Phase II was audio-recorded. I also made observation notes during the focus group session. After the session, I made session notes while reflecting. Bracketing was done throughout during this phase. The raw verbatim data collected via audio recorders together with the noted observations were transcribed and typed in Phase II and would be used as part of the analysis in Phase III.

Descriptive phenomenological analysis and coding were done to organise the data in Phase II. Observations were highlighted in the Phase II session. Data was reread to further uncover deeper meanings of the Generation Y medical doctors' experiences of the coaching intervention for burnout. Results of the analysis were checked by my supervisor and a clinical psychologist researcher who is a burnout specialist, to confirm themes extracted.

Data in Phase II was interpreted using the descriptive analysis technique suggested by Creswell (2003). Creswell (2013) suggested that after transcribing interviews, the statements in the focus group that relate to the experience of the group coaching intervention should be identified. The actual views, thoughts, and feelings of the intervention session and the practical application that were gathered by the Generation Y medical doctors were noted.

Secondly, I separated the relevant information from the irrelevant information. This was followed by breaking down the relevant information into smaller phrases or segments that reflected a specific thought. The statements were grouped into measurement units. Segments, the phrases or statements, were grouped into categories that reflected various meanings or aspects of the experience of the group coaching intervention as the process preceded and concluded in the fourth session.

I then sought deviating viewpoints. This implied that I searched for various ways that the respective participants experienced the coaching intervention in the different focus group sessions. Lastly, I focused on constructing a combination of viewpoints to develop an overall description of the group coaching intervention for burnout as Generation Y medical doctors experienced it in the different focus group sessions. The data in Phase II was verified and scrutinised by the participants to ensure that it was a true reflection of their experiences. Additions or changes were made where needed.

iii. Phase III: Recording and interpretation and analyses of the data

The final focus group was Phase III of the study, which six participants attended. The focus group session was audio-recorded as participants in Phase II gave written informed consent. I made observation notes during the focus group sessions in Phase III. After the session, I made session notes while reflecting. Throughout the data collecting process and even in this phase, I bracketed my experiences as this is an essential part of the process to understand the experiences of Generation Y medical doctors of the coaching intervention for burnout.

The focus group questions were unstructured. I as the researcher listened carefully to the description of the experiences that related to the phenomenon, namely, experiences of the group coaching intervention for burnout amongst Generation Y medical doctors.

The raw verbatim data collected via audio recorder was transcribed and typed as part of the analysis together with the noted observations. Descriptive phenomenological analysis and coding were done to organise the data. Observations were highlighted. These included non-verbal behaviours and expressions to add more depth to the collected information (Kelly, 2007).

Data was reread to uncover deeper meanings of the Generation Y medical doctors' experiences of the coaching intervention for burnout. Descriptive phenomenological data analysis required that I build on the research questions and work through the data transcripts from the focus group. The same steps followed in Phase II were followed here. I highlighted the significant statements, sentences or quotes that provided an understanding of how participants experienced the phenomenon.

The participants completed the MBI-GS in the final focus group. Once completed, I collected and scored the MBI-GS forms. The scores in Phase III were compared with the scores in Phase I to further understand the participants' views of the intervention compared with the actual impact thereof. The participants' views and experiences of the group coaching intervention in Phase II and Phase III were compared with their objective scores of burnout.

The data collected was interpreted, findings were drawn up and linked back to the research problem of the study. The interpretation was reviewed and findings in Phase III were linked to data in Phase II and Phase I. Additionally, the interpretation in Phase III was linked to literature. The data in Phase III was verified and scrutinised by the participants to ensure that it was a true reflection of their experiences. Additions or changes were made where needed. The findings are given in Chapter 5 of the study.

Conclusions were drawn regarding the experiences of the Generation Y medical doctors of the group coaching intervention. This analysis phase included outlining of how the aims were met,

answering research questions, and discussing whether the conclusions in relation to the formulated problem were met. Recommendations were made for the group coaching intervention for burnout and for future research, and the limitations highlighted. These are illustrated in Chapter 6 of the study. Data, field notes and transcriptions will be stored safely for five years following conclusion of the study.

1.7.3.7 Strategies employed to ensure quality data and trustworthiness

Creswell (2013) believed that validation in qualitative research employs established validation strategies to document the accuracy of studies by the researcher. In qualitative studies, the credibility of the study depends on the researcher's ability and determination, which makes the researcher an instrument (Golafshani, 2003). Validity, reliability, generalisability and objectivity are described through strategies of trustworthiness in qualitative studies (Lincoln & Guba, 1985; Sinkovics, Penz, & Ghauri, 2008).

The criteria of Lincoln and Guba (1985) are still commonly used in recent research, which use terms that adhere to a more naturalistic research and that are removed from positivistic research terms. The terms are credibility, transferability, dependability, confirmability, and authenticity. These are alternatives to internal and external validation, reliability and objectivity (Lincoln & Guba, 1985).

Credibility, similar to internal validity, ensures that findings are from the participant's perspective (Dyson & Brown, 2006; Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008). Transferability, similar to external validity, is the ability to generalise the findings to similar settings as the study (Dyson & Brown, 2006; Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008). Dependability, like reliability, is achieved when the research findings' methods are transparent in order to achieve consistency (Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008). Confirmability, like objectivity, is the

need for the researcher to display limited bias in interpretation (Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008).

Authentic inquiry was added as a fifth criterion later (Christians, 2000), which was linked to fairness (Maritz & Visagie, 2009). Techniques and strategies are needed to operationalise these terms and translate them into practice (Creswell, 2013, 2016).

This study employed certain validation strategies suggested by Creswell and Miller (2000) namely credibility, transferability, dependability, confirmability and authentic inquiry. These were achieved in the study through the use of methods such as bracketing, member-checking, triangulation and detailed description of the setting, participants, and methods. I used bracketing from the onset of the study, which is part of clarifying the researcher's biases. Throughout the entire research process, I stated my position, biases or assumptions so that the reader can understand all that could affect the research inquiry. I, as expected when clarifying researcher bias, commented on past experiences, biases, prejudice, and orientations that likely shaped my approach and interpretation in the study (Merriam, 1988). Ongoing bracketing was done to ensure personal biases were put aside so that the perspectives heard was those of the participants and not the researcher.

Member-checking was done by seeking the views of the findings and interpretations (Erlandson, Harris, Skipper, & Allen, 1993; Lincoln & Guba, 1985; Merriam, 1988) of the Generation Y medical doctors who participated in the study. This technique is considered to be important in establishing credibility (Lincoln & Guba, 1985). The data in Phase II and Phase III was verified and scrutinised by the participants to ensure that it was a true reflection of their experiences. Triangulation of methods was employed in the study, which is a verification technique that enhances credibility of findings and interpretations (Lincoln & Guba, 1985; Patton, 1990).

Dependability ensures the reader that findings occurred as reported, which can also be enhanced by this strategy. Detailed observation notes and reflection notes were kept to further enhance dependability (Lincoln & Guba, 1985).

Data collection and interpretation were lengthy processes to present the data accurately. Every attempt was made to get a clear account of the experiences of the coaching intervention for burnout amongst Generation Y medical doctors. Interpretation in the study was done to ensure limited biasness. I aimed to provide an accurate presentation of data by giving extracts from the data and used explicit verification procedures. I aimed to ensure that data collection was done using particular stated strategies to ensure an authentic inquiry. The reliability was enhanced as I obtained detailed notes and used quality equipment for recording and transcription (Silverman, 2005). Transcription was done of both verbal and trivial, but often crucial pauses, plus overlaps. Coding is also important to ensure reliability and the quality of the study based on phenomenological standards (Creswell, 2013; Polkinghorne, 1989).

Detailed description of the setting, participants, and methods are given to allow readers to make decisions regarding transferability (Erlandson et al., 1993; Lincoln & Guba, 1985; Merriam, 1988). I have provided a detailed description of the design and methodology taken in this study so that the reader can follow my trail of thought and understand how my opinions and actions were rooted and developed (Kelly, 2007). I have provided a transparent methodology that was incorporated to arrive at the findings and have further indicated the steps taken to analyse the data to arrive at these findings.

Peer review for an external check of the research process and coaching intervention for burnout was done to further confirm that the group coaching intervention for burnout was appropriate (Lincoln & Guba, 1985). The group coaching intervention for burnout amongst Generation Y

medical doctors was scrutinised and discussed with a panel of clinical psychologists who have experience in treating burnout.

I focused on giving a truthful account of the experiences of the Generation Y medical doctors. I indicated the steps followed during the entire research process in a clear manner that will allow the study to be replicated if another researcher aims to duplicate the study in a similar sample set. The findings are transferable to other contexts. A common understanding of the phenomenon (Creswell, 2013) was reached as all participants were purposively selected based on certain criteria. All participants were exposed to the phenomenon, namely, the group coaching intervention for burnout amongst Generation Y medical doctors.

The mixed method used in the study is a form of triangulation in which different types of data provide cross-validity checks (Patton, 1990). The quantitative data was collected from the MBI-GS. It was used to quantify burnout in Phase I and Phase III.

MBI-GS is a common burnout self-reporting scale used to screen professional burnout worldwide (Maslach et al., 1996; Kaschka et al., 2011). The MBI-GS is a reliable tool that has been used in South Africa by researchers in several studies with similar samples (Peltzer et al., 2003; Thomas & Valli, 2006). Even though the validity of the MBI-GS has been criticised (Korczak et al., 2010), it is currently the most valid measurement method as participants report their own level of burnout (Alarcon et al., 2009).

1.7.3.8 Ethical considerations

The proposal was submitted for ethical clearance through the proper channels at my academic institution and at the setting where the research was conducted. It was conducted by myself in an ethical manner under supervision, where both I as the researcher and my supervisor were bound by an ethical code of psychology. The panel of clinical psychologists, who have

experience in burnout and assisted with comments about the group coaching intervention for burnout amongst Generation Y medical doctors in Phase I, are also bound by the ethical code of psychology. Participants were rendered privacy and confidentiality, and mutual consent was given to ensure that they were not coerced into participating or harmed in any way.

Confidentiality was maintained as participants used pseudonyms within the focus groups. Their real names are not quoted in the study. I assured them that their information and the data collected would be stored safely with limited access.

Should intervention be needed on a long-term basis or to address other issues that could be evoked by participating, an external network of private practice professionals was identified to participants. Each participant had medical aid and could use the professionals at their own cost.

1.8 Findings

Although there is no specific structure for reporting phenomenological studies, the reader should come to understand exactly what it was like to experience the phenomenon under study (Polkinghorne, 1989). A first-person qualitative reporting style was used to report on the findings of the research. Discussion of major themes was done and linked back to literature. Implications and suggestions regarding methods of intervention were given for the group coaching intervention for burnout amongst Generation Y medical doctors.

1.9 Conclusion

Based on the findings that alluded to the experiences of the group coaching intervention for burnout amongst Generation Y medical doctors, a conclusion is given about the specific population and recommendations made for future research.

1.10 Contribution of the Study

Findings in the current study indicated that there is burnout and associated risk in Generation Y medical doctors working in the South African public health sector, which is not prioritised by stakeholders of the public health sector. According to the Generation Y medical doctors, there were certain benefits from being exposed to the group coaching intervention for burnout. This implies that the coaching intervention met their needs, and that it was beneficial and applicable.

This research has made a contribution to the existing body of knowledge in terms of empirically based coaching interventions for burnout in Generation Y medical doctors working in the public health sector. Contributions were made regarding the creation of awareness, prevention and intervention for burnout within the participants and other stakeholders in the South African public health sector. There was also empirical evidence to show that there is a need for ongoing coaching interventions.

The findings of the study emphasised the need for further research on burnout and coaching interventions for burnout amongst different populations including the Generation Y medical doctors who are employed in the public health sector in South Africa.

1.11 Limitations

Although I bracketed my experiences and views of the topic, there is still a small bias, which is a risk during this reflective thinking process involving self-reflection and self-awareness of knowledge or experiences in the area to be researched (Ahern, 1999). I did my best to focus on the phenomenon that was being studied. I consciously made my preconceived notions as explicit as possible and diligently reported on the process of the study.

Coaching was done in the form of focus groups. Focus group methodology relies heavily on assisted discussion and leads to large volumes of qualitative data from the field notes,

recordings and verbatim transcriptions, which might be overwhelming to analyse. In focus groups, the most outspoken can dominate the discussion. Therefore, it was essential to encourage the more reserved participants. Additionally, confidentiality can be a limitation in focus group as it cannot be guaranteed by the researcher.

Transcription of interviews can be a lengthy process and there was a need to formulate questions during the focus groups based on what transpired: attention had to be paid to the responses and questions (Wengraf, 2001). Wengraf (2001) referred to it as double attention.

The size of the sample was adequate for a qualitative study. Participants were selected by the researcher. Thus, findings cannot be generalised to the entire population of Generation Y medical doctors working in the public sector in different provinces in South Africa.

1.12 Recommendations for Future Research

Based on the study, the findings, impact, experience of the participants, and recommendations for future research were suggested. There is a need to repeat the study with a similar sample and with a bigger sample size of Generation Y medical doctors in the different public sectors. Future studies should incorporate the recommendations made from the current study's actual group coaching intervention for burnout amongst Generation Y medical doctors. Recommendations are given in Chapter 6:

- For the public health sector department, specifically to gain a deeper understanding of the experiences of Generation Y medical doctors.
- For future research in this field of coaching psychology.
- For coaches/consultants.

1.13 Chapter Division

This research thesis contains the following chapters:

Chapter 1: Scientific orientation of the study

This first chapter gave a background and motivation for the research. It formulated the problem statement, articulated the aims and questions of the research, and presented a summary of the research design and methodology in the study. This chapter provided an overview of the scientific orientation of the study. The study used a convergent mixed methodology that combined a descriptive phenomenological perspective and quantitative measure of burnout in an attempt to identify the essential experiences of a group coaching intervention for burnout amongst Generation Y medical doctors in the public health sector, South Africa.

Chapter 2: Dynamics of burnout

This chapter gives a background on burnout, lack of intervention and its implications for Generation Y medical doctors in the South African public health sector.

Chapter 3: Coaching intervention for burnout

This chapter gives a foundation of the different interventions recommended for burnout and emphasises the limited empirically based interventions specifically for the at-risk population, which is Generation Y medical doctors working in the South African public health sector. It further gives the group coaching intervention for burnout used amongst the Generation Y medical doctors in this specific study.

Chapter 4: Research methodology and design

The research design and the methodology of this study are presented in this chapter.

Chapter 5: Research findings

The findings of the data analysis including interpretations are presented in this chapter.

Chapter 6: Conclusions, limitations and recommendations

This chapter concludes the study, highlights its limitations, and makes recommendations.

1.14 Chapter Summary

This first chapter gave a background and motivation for the research. It formulated the problem statement, articulated the aims and questions of the research, and summarised the research design and methodology in the study. It essentially gave an overview of the scientific orientation of the study. Chapter 2 focuses on the impact and background of burnout expanding further to the South African context where burnout affects Generation Y medical doctors.

CHAPTER 2: DYNAMICS OF BURNOUT

2.1 Introduction

This chapter aims to describe burnout and its implications. The chapter contextualises the possible impact of burnout amongst Generation Y medical doctors employed in the South African public health sector. Conceptual foundations of burnout are given and the definition of burnout is discussed. Furthermore, there is a section on the theoretical conceptualisation of burnout. Burnout models and contextualisation of burnout for the current study are given, which expand on the proposed process model by Leiter and Maslach (1988). Burnout is also explained according to the process model as a three-dimensional construct that consists of three core components and manifestations.

The chapter focuses on the aetiology of burnout in terms of the risk factors associated with burnout in Generation Y medical doctors, namely, occupational stress, job setting, work conditions, and biographical details. The chapter further describes the burnout experience overall and discusses the health experience, coping mechanisms, and stress experienced in relation to burnout in Generation Y medical doctors.

The chapter focuses on the resilient positive factors against burnout and discusses burnout risk faced by the Generation Y medical doctors in the public health sector in the South African context. The chapter deliberates about burnout manifestations and the relevance of interventions at individual, group and organisational level. It concludes by giving the limitations of individual, group and organisational burnout interventions as well as intervention considerations for Generation Y medical doctors in the South African public health sector. There is also a critical review of burnout, theoretical integration and a summary of the chapter at its completion.

2.2 Conceptual Foundations of Burnout

2.2.1 Background

Burnout linked to job stress is one of the challenges in the workplace affecting the physical and mental health of employees as well as their productivity (Lemaire & Wallace, 2017; Weber & Jaekel-Reinhard, 2000). It is influenced by personal character traits, societal factors, organisation-wide dynamics and other aspects such as negative changes to traditional support systems (Panagioti et al., 2016; Weber & Jaekel-Reinhard, 2000). Burnout can manifest in different ways and affect the employee as an individual, in a group, in an organisation, and in society. It affects the beneficiaries of services and the profession itself. Research is still needed to define burnout and understand its aetiology (Milićević-Kalašić, 2013).

Certain interventions, management and prevention options have been suggested in various studies; however, more empirical studies are needed to provide information for the options (Milićević-Kalašić, 2013; Sorenson et al., 2016; Werneburg et al., 2018). This section examines the definition and theoretical conceptualisation of burnout and contextualises burnout for the current study.

2.2.2 Defining burnout

Burnout was first described by Freudenberger (1974) as a syndrome comprising progressive emotional exhaustion, reduction of motivation or demoralisation, and lack of professional accomplishment arising from chronic job stress. Burnout consists of three factors: emotional or physical strength exhaustion, depersonalisation or cynicism, and a lack of personal accomplishment or competence (Maslach & Jackson, 1986) resulting from prolonged occupational stress or frustration (Nuallong, 2013; Panagioti et al., 2016). This consequently

leads to lowered production, as well as increased absenteeism, healthcare costs and personnel turnover (Felton, 1998; Mathias & Wentzel, 2017; Thomas & Valli, 2006).

Various theoretical models have been proposed and which have subsequently been analysed critically (Taris, Le Blanc, Schaufeli, & Schreurs, 2005). There are still debates regarding a standardised meaning of burnout (Bährer-Kohler, 2013; Cox, T., Tisserand, & Taris, 2005).

Compassion fatigue syndrome, which is characterised by the negative aspects of providing care to those who have experienced extreme or traumatic stressors, has received substantial attention recently (Sorenson et al., 2016; Stamm, 2010). These negative responses include feelings of being overwhelmed by work, which are distinguished from feelings of fear associated with the work (Mathias & Wentzel, 2017; Stamm, 2010). Burnout is described as a construct that falls within compassion fatigue syndrome (Stamm, 2010). Burnout is a psychological term that signifies long-term feelings of exhaustion, unhappiness, being overwhelmed, being disconnected, and often seen as being ‘out-of-touch’, as well as a diminished interest or insensitivity in a work environment (Maslach & Leiter, 1997; Stamm, 2010).

Secondary traumatic stress or vicarious trauma refers to another concept that falls within compassion fatigue syndrome (Stamm, 2010). This is the actual re-experiencing of a client’s trauma that health workers hear or observe and that affect them at a personal and professional level (Mathias & Wentzel, 2017). Secondary traumatic stress is characterised by preoccupation and ruminative thoughts of people one has helped; though rare and not often reported, it does exist as it affects a number of people (Stamm, 2010).

On the positive side of helping, there is the contrasting concept of compassion satisfaction that is often linked to job satisfaction and feeling good about helping (Stamm, 2010). Compassion satisfaction, contrary to compassion fatigue, is often seen with people who are satisfied with helping and those who believe they can make a difference (Stamm, 2010).

Compassion fatigue syndrome, which incorporates burnout and reduced level of job satisfaction (Stamm, 2010), is seen within Generation Y medical doctors. This is often due to elevated job stress that lead to poor coping mechanisms such as self-medication, numbness and aggression (Howse, 2000; Lemaire & Wallace, 2017; Panagioti et al., 2016; Thomas & Valli, 2006).

2.2.3 Theoretical conceptualisation of burnout

2.2.3.1 Burnout models

Most models and researchers believe that burnout gradually develops over time secondary to occupational stress (Nuallong, 2013). Burnout is experienced individually and is expressed over time at a personal level while affecting other areas such as family, social settings, society and/or the organisation (Bährer-Kohler, 2011; 2013; Gitto & Trimarchi, 2016).

The respective burnout models suggest different stages of burnout (Nuallong, 2013) including: the 12-stage burnout cycle (Freudenberger & North, 2006); four stages of burnout (Gorkin, 2004); three stages of burnout (Girdin, Everly, & Dusek, 1996); and five stages of burnout (Miller & Smith, 1993). Additionally, there are models by Golembiewski et al. (1986); Lee, R.T. and Ashforth (1996); Pines, A. and Aronson (1988); job demands-resources (JD-R) model of burnout (Demerouti, Bakker, Nachreiner & Schaufeli, 2001) and the process model by Leiter and Maslach (1988).

Most descriptions concur that burnout is an idiosyncratic experience of emotions and negative attitudes towards the job and employees that cause problems of practice and emotional order to people themselves and to the organisation (Constantino, De Souza, De Assis, & Correia, 2013; Gitto & Trimarchi, 2016). Burnout is seen as one of the responses to chronic job stress. Burnout differs from stress as it is exhaustion that not necessarily involves work, but that is

rather a subjective experience of emotions, negative attitudes and behaviours towards work and/or co-workers, clients, users or the organisation, which are usually absent in stress (Constantino et al., 2013). These attitudes or feelings cause problems of performance and emotional order to the employee, which escalates to the organisation (Constantino et al., 2013; Gitto & Trimarchi, 2016).

The subsections that follow briefly describes the various burnout models.

i. Twelve-stage burnout cycle (Freudenberger & North, 2006)

The 12-stage burnout cycle aims to emphasise psychodynamic details of the burnout process (Freudenberger & North, 2006). The model begins with unrealistic expectations of the likely affected and then refers to certain possible phases until burnout develops (Freudenberger 1974; Freudenberger & North, 2006). The model by Freudenberger and North (2006) present burnout as disjointed phases not necessarily in sequential order or based on severity. The stages include (Freudenberger & North, 2006):

1. Compulsion to prove oneself: People are said to have an ideal inherent image of self, which leads to them working hard for colleagues to be aware of this image.
2. Working harder: To ensure one is not thrown away.
3. Neglecting of own needs: Overdedication to work that creates a misbalance by abandoning other areas of life such as family life and self-care.
4. Displacement of conflicts: There is an awareness that life is spiralling out of control but with an inability to identify the cause. Somatic indications of stress are probable, for example, headache, sleep disturbance, and lower back pain.

5. Revision of values: In order to continue with prioritising work at the expense of caring for self and relationships, there is an increased need to avoid self-conflict by blunting emotions.
6. Denial of emerging problems: Severe dislike of social contact with others even if it is minor. This likely leads to pessimism, callousness, aggression, and accusing of others.
7. Withdrawal: Extreme reduction of social contact and separating of self.
8. Obvious behavioural changes: Seen by close people, and occurs due to overwork.
9. Depersonalisation: Loss of connection with self.
10. Inner emptiness: This amplifies within, and there is an attempt to overcompensate by increasing impulsive activities such as substance use, sexual activity or overeating.
11. Depression: Mood and cognitive symptoms of depression are likely to occur, such as hopelessness or fatigue.
12. Burnout syndrome: At this stage, there is probably a desire to get away from the situation that could be coupled with suicidal thoughts. Treatment should be sought immediately.

ii. *Four stages of burnout (Gorkin, 2004)*

The four stages of burnout is a self-checking process with common circumstances found in people with burnout (Gorkin, 2004). Gorkin's (2004) four stages idea differs from the 12 stages of Freudenberger and North (2006). The four stages of Gorkin are perceived from the view of those affected by burnout and are given in a checklist whereas the 12 stages are from a practitioner's view (Nuallong, 2013).

The suggested stages by Gorkin (2004) include:

1. Physical, mental and emotional exhaustion: Feeling exhausted after a long day at work.
2. Shame and doubt: Experiencing of a profound loss and change as unattainable.
3. Pessimism and insensitivity: Chronic uncertainty and susceptibility at times turn into irritability.
4. Disappointment, powerlessness and crisis: Coping seems to be undoing, and susceptibility increases to clinical depression. It may be time for some medical or professional counselling.

iii. Three stages of burnout (Girdin et al., 1996)

Girdin et al. (1996) proposed stages that show the burnout process sequentially with a symptom checklist. A criterion is met if at least two symptoms occur at any level. The three stages of the model by Girdin et al. (1996) were intended as precise diagnostic criteria with cut-off points. These can be beneficial for the researcher to diagnose and to follow up on burnout scores.

The systems of Gorkin (2004) and Freudenberger and North (2006) focus on what burnout looks like without the distinct levels of severity (Nuallong, 2013).

The three proposed stages of Girdin et al. (1996) are:

1. Stress arousal: A stage of physiological and psychological responses that includes persistent irritability, ongoing anxiety, high blood pressure, insomnia, and/or forgetfulness. Other symptoms include heart palpitations, somatic complaints (headaches, stomach cramps and gastrointestinal problems). There is an ongoing debate that stress arousal and burnout are different constructs (Smith, K.J., Davy, & Everly, 2006).
2. Energy conservation: If an effort to deal with stress fails, the following is likely: procrastination, excessive time off, sexual dysfunction, persistent tiredness in the morning, social withdrawal, pessimism, resentment, increased substance use, lethargy, and/or lack or loss of spirituality (Smith, B.C. S, 2008).
3. Exhaustion: People at this stage will be aware that something in their life has gone wrong. The realisation may lead to sadness or depression; chronic somatic problems such as headaches, continuing mental and physical fatigue; need to retract interaction with family/friends/social circles; and/or suicidal ideation.

iv. *Five stages of burnout (Miller & Smith, 1993)*

Miller and Smith's (1993) five stages emphasise the defining moment from idealism to burnout. The final stage concentrates on resilience. The stages in this burnout cycle are:

1. The honeymoon: The person enters the workplace and the job is still ideal. The employee is highly motivated and enthusiastic. There is a strong drive to deliver and to derive pleasure from the job, colleagues, and even the organisation.

2. The awakening: The ideal and pleasure views fade. The person realises that their expectations of the occupation are unmet. Their needs are not satisfied even by rewards or recognition. They feel the occurrences in their life are a mistake and they cannot cope with it. When attempts at putting in more effort and hours do not change how they feel, they develop exhaustion and frustration, which escalates into a reduction of perceived professional competence and ability.
3. Brownout: Chronic fatigue and irritability are blatant. The lifestyle of the affected is changed drastically in an attempt to escape disturbances. Impulsive activities are often seen (such as promiscuity, substance use/abuse, shopping splurges). Sadly, job performance and productivity decrease drastically. Projection of the downfall is often seen by pessimism attitudes, detachment, and/or criticism of others.
4. Full-scale burnout: If the brownout stage is not resolved, it leads to full-scale burnout. Despair is a common presentation that lasts for several months and at times up to several years. The person feels an overwhelming sense of failure and a discouraging damaged self-esteem and confidence.
5. Phoenix phenomenon: If help is sought after, the person is able to improve and become more realistic in terms of their career expectations and goals.

v. *Models by Pines, A. and Aronson (1988); Golembiewski et al. (1986); and Lee, R.T. and Ashforth (1996)*

Pines, A. and Aronson (1988) proposed a one-dimensional model. It states that physical, emotional, and mental exhaustion are triggered by continuous participation in emotionally involved circumstances. Schaufeli, W., Enzmann, and Girault (1993) added that this model is not limited to human service professions. Research emphasises the need to study burnout in different situations and workplaces (Cox, T. et al., 2005; Schaufeli, W.B., 2003).

The phase model of Golembiewski et al. (1986) stated that subdomains start low when burnout is low; as burnout increases, there is an increase in components from depersonalisation to an increased reduced personal accomplishment and, finally, an increase in emotional exhaustion.

Lee, R.T. and Ashforth (1996) stated that emotional exhaustion is seen at the beginning of burnout. It leads to an increase in depersonalisation and, subsequently, a decrease in personal accomplishment, which is the stance taken by the Leiter and Maslach's (1998) process model.

Leiter and Maslach's (1998) process model was applied in this current study and is discussed in the subsection that follows. A decrease in personal accomplishment is found to develop directly from emotional exhaustion and independently of depersonalisation (Lee, R.T. & Ashforth, 1996; Leiter & Maslach, 1988; Taris et al., 2005).

vi. Job Demands-Resource Model

The job demands-resources (JD-R) model proposes that working conditions fall into two categories job demands and job resources related to job outcomes. Demerouti, Bakker, Nachreiner & Schaufeli (2001) found that job demands are related to the exhaustion component of burnout, whereas lacking job resources primarily related to disengagement. Job demands are physical, psychological, social or organisational aspects of the job that require sustained physical and/or psychological effort and are linked to physiological and psychological consequences (Demerouti, et al, 2001; Bakker & Demerouti, 2007). Job resources on the other hand are aspects that could be physical, psychological, social, or organizational aspects of the job that are functional in assisting one to achieve work goals; or in reducing demands associated with physiological or psychological consequences; and could stimulate growth and development. These include career opportunities, coaching, autonomy or role-clarity (Demerouti, et al, 2001; Bakker & Demerouti, 2007).

Strain and burnout occur as a response to imbalance between demands on the individual and resources available to deal with demands (Bakker & Demerouti, 2007). Physical and social resources available in the work setting additionally personal resources employee has within such as personality traits are two psychological processes that play a role in job strain and motivation. Both types of resources are mediators of employee wellbeing (for example engagement). Outcome of continual job strain is health impairment process which put one at risk for burnout; while outcome of increased job and personal resources is a motivational process which leads to low cynicism, performance, or higher work engagement. Job resources could be an intrinsic or extrinsic motivational role (Demerouti, et al, 2001; Bakker & Demerouti, 2007). This model can be applied to any occupational setting irrespective of job demands and resources involved.

vii. Process model by Leiter and Maslach (1988)

Unsatisfactory work conditions may lead to long-term feelings of emotional exhaustion, depersonalisation, cynicism, lack of involvement at work, and a low level of personal accomplishment. This view led to the development of the MBI-GS (Maslach et al., 2001) and Leiter and Maslach's process model (1988).

Maslach et al. (2001) postulated that burnout is likely to occur when there is a disconnection between the organisation and the individual regarding what they called the main areas of work life: values, fairness, community, reward, control, and workload. The process model explains burnout as a process that begins with emotional exhaustion, which likely leads to depersonalisation and, consequently, to decreased personal accomplishment (Leiter & Maslach, 1988). This model is described in more detail and contextualised for the study in the next section.

2.2.3.2 *Contextualisation of burnout for the current study*

This study will contextualise burnout as described by Maslach and Jackson (1981) and the proposed process model by Leiter and Maslach (1988). Burnout according to Maslach and Jackson (1981, 1986) is a three-dimensional construct. The three constructs are increased emotional exhaustion; depersonalisation or cynicism, thereby implying a negative attitude towards several aspects, especially clients; and, lastly, an increased tendency for negative evaluation of self as lacking professional accomplishment or competence (Maslach & Jackson 1981, 1986).

Leiter and Maslach (1988) proposed a process model for burnout, which begins with emotional exhaustion, often leads to depersonalisation and, subsequently, reduced personal accomplishment. The three constructs are defined in the following subsections in more detail.

i. Emotional exhaustion

Emotional exhaustion is explained as the depletion of psychological resources (Maslach & Jackson, 1986; Nuallong, 2013). Emotional exhaustion is considered to be a key feature and the most noticeable in the manifestation of burnout (Milićević-Kalašić, 2013).

The process model suggests that emotional exhaustion occurs before elevated cynicism and decreased feelings of personal accomplishment occur (Leiter & Maslach, 1988). Exhaustion is a feeling of being strained beyond one's ability and being depleted of emotional and physical resources; this emotional exhaustion state is the strain component of burnout (Helkavaara, 2013). Common within this component are symptoms of tiredness or emotional exhaustion, somatic symptoms, decreased emotional resources, and a feeling that one has nothing left to give to others, or an experience that the employee cannot give themselves anymore at a psychological level (Milićević-Kalašić, 2013).

ii. Cynicism or depersonalisation

According to the process model (Leiter & Maslach, 1988), cynicism or depersonalisation occurs following the emotional exhaustion component and its negative affectivity often leads to a self-protective reaction (Maslach et al., 2001; Schaufeli, W. B., 2003; Shirom, 2009). Cynicism component is the interpersonal context component of burnout (Nuallong, 2013) typically consisting of negative pessimistic insensitive attitudes and feelings about clientele, and a detachment from work that can lead to dehumanising view of patients, work and/or workplace relationships (Nuallong, 2013; Ryan, 1971). In extreme cases, this dehumanised view of patients can lead to an extent where employees view patients as undeserving of their services (Maslach et al., 1996). When this second burnout component develops, there seems to be an extreme move towards the negative and the employee presents with signs such as undesirable health, diminished energy, feeling detached, pessimism or being critical, and/or destructive outlooks of work, organisation, or colleagues (Maslach et al., 1996).

Depersonalisation is a dysfunctional psychological coping attempt, though initially it might be a protective factor, that often leads to extreme negative outcomes as the burnout process unfolds (Bakker, Schaufeli, Sixma, Bosveld, & Van Dierendonck, 2000).

iii. Lack of professional competence

Lack of professional competence, which is the final component according to the process model (Leiter & Maslach, 1988), is the occurrence of poor involvement at work and diminished personal accomplishment. This is a self-evaluation component referring to feelings of insufficiency and lack of competence (Maslach & Leiter, 2008). It develops due to having a negative view of any personal accomplishment; losing competence and productivity; being inclined to evaluate preceding or existing accomplishments at work negatively (Maslach & Jackson, 1981); or having a negative view of self-efficacy (Evers, Brouwers, & Tomic, 2002).

It is a negative perception of self, especially in the work context, and an extreme feeling of dissatisfaction about job accomplishments (Maslach et al., 1996). This type of view is indicative of a distorted thinking pattern and an incongruous view of self, which often leads to a lack of involvement at the workplace as well as having feelings of decreased work performance or ability to complete tasks (Nuallong, 2013). If this negative view continues, the employee is at risk of developing a self-inflicted view of self as a disappointment (Fink, 2007).

There seems to be an indirect relationship between the two initial burnout dimensions (emotional exhaustion and depersonalisation) and personal accomplishment, which implies that high emotional exhaustion or cynicism reports would not necessarily lead to lower personal accomplishments (Onder & Basim, 2008).

2.3 Etiology of Burnout

The direct causes of burnout are often indistinct (Schaufeli, W.B. & Enzmann, 1998) and linked to a dynamic process (Korczak, Huber, & Kister, 2010) that develops over time (Schaufeli, W.B. & Enzmann, 1998) with presentations linked to the individual, their context and/or their organisation (Bährer-Kohler, 2013). Burnout is seen as a brutal occurrence: as people are exposed to emotionally challenging conditions, burnout will likely increase in consequence (Kumar, 2011).

There are hypotheses that personal character traits of employees, psychosocial job environment, sociodemographic traits, social relationships, and lifestyle outside work are likely to determine the risk of burnout (Gitto & Trimarchi, 2016; Milićević-Kalašić, 2013). Certain risk factors have been linked to increasing burnout. Some are discussed in the section that follows.

2.3.1 Risk factors associated with burnout in Generation Y medical doctors

Africa is facing an imminent catastrophe in health (Dovlo, 2003). Good progress has been made, but generally gains seen previously, especially for poor societies, are being eroded by the increasing incidence of chronic and/or untreatable diseases, severe decreased life expectancy, and the poor state of the health sector that is facing many challenges (Dovlo, 2003).

Health workers, including Generation Y medical doctors, are finding themselves in this impending calamity. South Africa is not excluded from the health sector challenges mentioned here as the crisis is specifically growing in the public health sector (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Phalime, 2014; Thomas & Valli, 2006).

This current study emphasises the observed impact in medical doctors as it aims to understand the experience of a group coaching intervention amongst Generation Y medical doctors who have developed burnout, which is often seen as a poor coping mechanism against occupational stress (Bakker et al., 2000; Costa, Somerfield, & McCrae, 1996; Lemaire & Wallace, 2017; Maslach et al., 2001; Panagioti et al., 2016; Schaufeli, W.B., 2003; Shirom, 2009).

Occupational stress is likely to develop due to the predicament in the public health sector where Generation Y medical doctors are forced to have their initial training experience and work environment (Dr Shoyeb, personal communication, Aug. 7, 2019). The same source indicated that medical doctors use this sector for further specialisation, and could not do it any other way.

The main sources of occupational stress of medical doctors, including Generation Y in South Africa working in public health sector, that could subsequently lead to burnout include but are not limited to: understaffing, lack of resources, lack of control, difficult work schedules, inadequate security, poor career advancement, prioritising others' needs over their own,

expectations that are not met by the reality of the job environment, and poor salaries (Discovery Health, 2018; Gitto & Trimarchi, 2016; Hlatshaneni, 2019; Liebenberg et al., 2018; Panagioti et al., 2016; Thomas & Valli, 2006).

Burnout syndrome is common in professionals whose work includes continuous demands and extreme dealings with people with physical and emotional needs, and professionals whose work is associated with chronic rather than occasional job stress (Carod-Artal & Vázquez-Cabrera, 2013; Gitto & Trimarchi, 2016; Lemaire & Wallace, 2017). Chronic job stress found in Generation Y medical doctors due to previously mentioned factors, such as poor working conditions, is likely to lead to poor job performance, which could affect the beneficiaries of their health services negatively (Discovery Health, 2018; Erasmus, 2012; Panagioti et al., 2016), could affect their own personal lives, and further add potential risk to the already understaffed public health sector by increasing staff turnover (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018; Thomas & Valli, 2006).

Some risk factors are discussed in more detail in the subsections that follow. These factors are linked to the sample of the current study, namely, Generation Y medical doctors in the public health sector.

2.3.1.1 Occupational stress as a risk for burnout in Generation Y medical doctors

Burnout is depicted as a condition that is characterised by emotional and physical strength exhaustion, reduced personal accomplishment, feelings of insufficiency, and depersonalisation (Houkes et al., 2011; Melamed, Shirom, Toker, & Shapira, 2006; Panagioti et al., 2016). Burnout is associated with prolonged exposure to job stress or frustration (Felton, 1998; Gitto & Trimarchi, 2016; Weber & Jaekel-Reinhard, 2000) that is seen in diverse contexts and career groups (Bährer-Kohler, 2013; Gitto & Trimarchi, 2016; Innstrand et al., 2011; Lemaire & Wallace, 2017).

Maslach et al. (2001) suggested that burnout develops when there is a disconnect between the organisation and the individual regarding the main identified areas of work life: values (working with conflicting values), fairness (working in an unfair environment), community (working with minimal support), reward (working with unsatisfactory rewards, which could be monetary, prestige or positive feedback), control (working with diminished control), and workload (working too much). These are significant dimensions that, if mismatched between workplace and individuals, could lead to high levels of burnout (Maslach et al., 2001).

Unsatisfactory work, as that experienced in the South African context by Generation Y medical doctors and other professionals (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Phalime, 2014; Thomas & Valli, 2006), may lead to long-term effects such as those associated with burnout. Therefore, unsatisfactory work can lead to emotional exhaustion, depersonalisation and cynicism, lack of involvement at work, and having a low level of personal accomplishments (Carod-Artal & Vázquez-Cabrera, 2013). Chronic high job demands and working in demanding roles with chronic exposure to stressors are proposed to be triggers of burnout (Maslach & Jackson, 1986; Maslach & Leiter, 1997).

Burnout is described as a psychological process that could develop in reaction to chronic job stress, especially when working with people (Ahola & Hakanen, 2007; Ahola et al., 2006; Lemaire & Wallace, 2017). Intrapersonal features gradually develop in the work context such as having unrealistic job expectations, narcissistic qualities, and unrealistic high expectations of self; ruminating over past mistakes; or having ongoing doubts about one's ability to accomplish tasks (Grosch & Olsen, 2000; Hlatshaneni, 2019; Wei, Mallinckrodt, Russell, & Abraham, 2004).

Individuals often enter the workplace with unrealistic expectations of the work environment (such as incentives, career development, culture, and values in the organisation), themselves (ability to fulfil tasks or deal with pressure), or colleagues (being helpful). Once these expectations are not met, stress develops or increases, which subsequently leads to maladapted coping strategies such as substance abuse, avoidance and depersonalization. With poor coping strategies, chronic job stress becomes progressively worse, which leads to burnout (Carey, 2017; Cherniss, 1980b; Kane, L., 2018; Maslach, 1976, 1982; Rella, Winwood, & Lushington, 2009).

Burnout development is exacerbated by other factors such as generational value mismatch between generations (Kane, L., 2018; Leiter, Frank, & Matheson, 2009; Stephey, 2008); lower hardiness (Garrosa & Moreno-Jiménez, 2013; Kelley, 1994); professional value (Leiter et al., 2009); or age as younger people have been found to have higher levels of burnout due to their lack of professional experience (Mathias & Wentzel, 2017; Peisah et al., 2009; Wu, Zhu, Wang, Wang, & Lan, 2007).

Generation Y medical doctors working in the South African public health sector are exposed to severe job stressors and are often even referred to as “slaves of the state” due to their work environment (Erasmus, 2012). Job stress is higher in South African physicians than in European or United States physicians (Discovery Health, 2018; Grant, 2006; Hlatshaneni, 2019; Liebenberg et al., 2018). This has a negative effect on the retention of skills and the quality of care in the South African public health sector (Discovery Health, 2018; Grant, 2006; Hlatshaneni, 2019; Liebenberg et al., 2018).. There are serious problems in the South African public health sector systems that could lead to severe occupational stress, which often leads to burnout (Discovery Health, 2018; Grant, 2006; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018). This puts Generation Y medical doctors at risk for developing

burnout, having a reduced interest in specialising, or choosing to leave the medical field; furthermore, there is an emigration risk to greener pastures in developed countries and high turnover amongst many other negative occurrences (Discovery Health, 2018; Grant, 2006; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018; Phalime, 2014).

Studies have found burnout as an issue generally found in medical doctors and other health professionals from very early in their careers (Gitto & Trimarchi, 2016; Lemaire & Wallace, 2017; Mathias & Wentzel, 2017; Panagioti et al., 2016). Systemic interventions have been suggested to reduce impairment in younger medical doctors due to burnout aimed at improving educational and professional perspectives (Discovery Health, 2018; Msaouel et al., 2010). Thus, there is a need to ensure that burnout is dealt with from the early stages of Generation Y medical doctors' journeys as factors such as life, societal and work challenges are likely to affect the development and maintenance of burnout.

2.3.1.2 Job settings and work conditions as risk factors for burnout

Job settings are becoming more challenging due to changes brought on by globalisation; leading to problems that have been found to pose a risk for physical and psychological problems including burnout (Maslach & Jackson, 1986; Maslach & Leiter, 1997). Workload (from the organisational view, workload refers to productivity; from the personal view point, it refers to time and energy) is becoming more intense and is demanding more time (Maslach & Leiter, 1997; Maslach et al., 2001). Life demands are increasing while employees are expected to still be productive while dealing with overwhelming tasks and multiple roles at home and at work and therefore needing to put in greater effort (Maslach & Leiter, 1997; Maslach et al., 2001). Burnout is found in a number of work scenarios but people have been found to be at a higher risk in certain fields such as medicine and nursing, mental health, social services, teaching, and law enforcement (Discovery Health 2018; Maslach, 1982, 2003).

Health professions are vulnerable, especially medical doctors, specialists, nurses, mental health workers, social workers, emergency workers, chronic disease personnel, and dentists (Discovery Health, 2018; Felton, 1998; Lemaire & Wallace, 2017; Mathias & Wentzel, 2017; Thomas & Valli, 2006; Wagaman, Geiger, Shockely, & Segal, 2015). Certain health placements have been found to increase the risk of burnout occurring, even in the South African public health sector because of constant contact with patients in need of a high level of care, increased death occurrences, and challenging work environments such as oncology, Aids patient care units, and internal medicine (Gitto & Trimarchi, 2016; Thomas & Valli, 2006).

Burnout is reinforced by a high workload and complexity. It is influenced by a combination of societal, organisational, and individual features (Gitto & Trimarchi, 2016; Leiter et al., 2009); time pressures; work conflicts; problems of leadership; bullying; poor team collaboration (Kaschka et al., 2011; Panagioti et al., 2016); disorganised work environment; lack of control (Cerimele, 2011); lack of resources (Ten Brummelhuis, Ter Hoeven, Bakker, & Peper, 2011); need for but lack of flexibility (Weber & Jaekel-Reihard, 2000); lack of autonomy (Nahrgang, Morgeson, & Hofmann, 2011); and job uncertainty (Msaouel et al., 2010).

Other factors that influence burnout in health professionals, and specifically medical doctors, are workload; poor staff complement; limited work experience; type of rotations; type of conditions or nature of cases dealt with (especially those the medical doctors felt they had little control over); management styles in the departments; personal experience of trauma; changes due to development in the country that leads to higher occurrences of disease; emotional factors; personality; working in rural versus urban areas; working in public versus private sector; gender; and age (Gitto & Trimarchi, 2016; Lemaire & Wallace, 2017; Panagioti et al., 2016; Sprang, Clark, & Whitt-Woosley, 2007).

The work and labour conditions for Generation Y medical doctors in the South African public health sector are reported as concerning (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018). In addition to the reality of these conditions, Generation Y medical doctors are often exposed to actual traumatic cases that include chronic diseases such as HIV/Aids (Davhana-Maselesele & Igumbor, 2008; Discovery Health, 2018; Dovlo, 2003; Mathias & Wentzel, 2017; Sanders et al., 2003; WHO, 2011). Being exposed to severe and at times uncontrollable occupational related stressors in the public health sector often leads to job stress, which leads to an increased risk of burnout syndrome in South African Generation Y medical doctors (Discovery Health, 2018; Peltzer, Mashego, & Mabeba, 2003; Phalime, 2014; Thomas & Valli, 2006).

Generation Y medical doctors in the South African public health sector are furthermore expected to work in understaffed conditions for long hours. Should they fall ill or go on leave, there is no provision for replacements as hospitals are understaffed (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018). This implies that Generation Y medical doctors are constantly working under pressure. Because of a shortage of senior staff members in the various sections of the public health sector, Generation Y medical doctors find themselves making decisions that they would not ordinarily have to make under ideal conditions when there is enough staff members at all levels in all units (Discovery Health, 2018; Erasmus, 2012). The system is under pressure and continually experiencing even more pressure. The beneficiaries of Generation Y medical doctors and the public health sector also suffer.

2.4 Biographical Variables as Risk Factors for Burnout

Biographical variables such as gender, age, marital status, education, psychiatric disorders, and neurobiological features have also been researched as possible risk factors. In this regard,

Aydemir and Icelli (2013:134) stated, *“there is a lack of population-based epidemiological studies in the area of burnout because of the nature of the disease. Thus, biographical variables observed in studies are often derived from case-control studies that are considered insufficient for generalizability”*.

The current study considered the biographical variables of age, qualification as a medical doctor, and the working environment as risk factors. The sample consisted of Generation Y qualified medical doctors aged between 25 and 35 years working at a public hospital in the Limpopo Province, South Africa, for more than 12 months. The study also considered tenure, race, occupational level, and business unit as biographical variables.

Poor coping strategies can often develop due to chronic job stress found in the public health sector in Generation Y medical doctors and progressively become worse until the person burns out (Cherniss, 1980b; Maslach, 1976, 1982; Mathias & Wentzel, 2017; Rella et al., 2009).

This burnout development is exacerbated by other factors such as generational value mismatch (Kane, L., 2018; Leiter et al., 2009; Stephey, 2008) and age as younger people have been found to have a higher level of burnout due to their lack of professional experience (Discovery Health, 2018; Peisah et al., 2009; Wu et al., 2007). Workers have been found to develop increased tolerance for the reality of their work environment and their expectations as they age, which implies that the risk for burnout likely decreases with age (Milićević-Kalašić, 2013).

Generation Y, who are currently in the workforce, are likely to be suffering generational value conflict in the workplace that is similar if not worse than what was experienced by former generations. The upcoming Generation Z are likely to experience an even bigger conflicting value gap (Discovery Health, 2018; Kane, L., 2018; Leiter et al., 2009; Stephey, 2008).

Of the new medical doctors qualifying in South Africa, there is an elevated percentage who fall in the Generation Y category (Dr Shoyeb, personal communication, Aug. 7, 2019).

A medical doctor's journey in South Africa includes training partially in academic hospitals in the public health sector environment while studying for certain periods. Once a medical doctor qualifies, they need to work in the public sector in the various placements as fully employed interns and as medical doctors serving their community (Dr Shoyeb, personal communication, Aug. 7, 2019).

Often Generation Y medical doctors find themselves in placements with serious challenges while rotating various areas of medicine. It is during this period that occupational stress, which could lead to burnout, is a high risk because of the challenges of being junior doctors, being in challenging environments, and having to work with cases from various rotations and departments((Dr Shoyeb, personal communication, Aug. 7, 2019).

Hamori et al. (2012) suggested that organisations need to offer aspiring young employees a more balanced menu of development opportunities and recognise the unique needs of each employee. The authors further stated that as much as they would want the situation to be different or change quicker, they want to see organisations succeed. Hamori et al. (2012) found that young high achievers with solid academic records and degrees from leading institutions were constantly looking out for new work opportunities. This implies that Generation Y medical doctors could be seeking to leave the public sector or even the profession due to negative experiences combined with their age-related experiences that lead to burnout.

The findings of other biographical studies often vary and are contradictory: some studies found that men and women are likely to experience burnout similarly with women being more prone to emotional exhaustion, while men are more prone to depersonalisation (Maslach, 2003; Viehl,

Dispenza, McCullough & Guvensel, 2017). Mostly, it appears that younger people are more prone to burnout (Discovery Health, 2018; Maslach, 2003; Mathias & Wentzel, 2017).

There have been various findings about being married: one study found single people experienced burnout more, while the burnout rate for divorced people was between the burnout rate for married and single people (Maslach, 2003).

Some studies stated that the following factors put people at a higher risk of experiencing burnout: being female, white, or of a younger age; working in rural areas; working in the South African public sector as a medical doctor; being in a hospital ward rotation that requires being on call overnight; having ward responsibilities; having an increased patient load; and working in the mental health profession (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018; Peltzer et al., 2003; Sprang et al., 2007; Viehl et al., 2017). Other risk groups included unmarried men; divorced women (Ahola et al., 2006; Soares, Grossi, & Sundin, 2007); and women overall (Roth et al., 2011), especially in multi-functional roles (Innstrand et al., 2011).

One study found that senior doctors had less job satisfaction than younger doctors, which is what motivates and gives an individual a sense of achievement and fulfilment, but overall it seemed that doctors in South African public sector hospitals showed below average scores, which indicates that the job is no longer fulfilling (Discovery Health, 2018; Hlatshaneni, 2019; Thomas & Valli, 2006). Emotional exhaustion was found more in female medical doctors whereas reduced personal accomplishment was found more in male medical doctors (Peltzer et al., 2003).

2.5 Implications for Burnout Amongst Generation Y Medical Doctors

2.5.1 Relationship between personality and burnout in Generation Y medical doctors

Individual variation needs to be considered when dealing with burnout. Burnout is a personal experience that is a reaction consequent to work stress. Individual characters that influence the experience of burnout include but are not limited to personality traits (Alarcon et al., 2009; Bakker et al., 2000), predispositions to psychological distress (Mealer, Burnham, Goode, Rothbaum, Moss, 2009), and genetic susceptibility (Middeldorp, Cath, & Boomsma, 2006).

Hobfoll (1989) proposed that responding to challenges in the environment can be seen as a person's function of their disposition, perception, makeup and context in which the stressor occurs. Certain personality traits are found to be high contributors for developing burnout. These traits include low levels of hardiness, external locus of control, low self-esteem, coping styles seen as passive-defensive, Type A behaviours (competitive, impatient and ambitious), perfectionism, increased sensitivity, introversion, and neuroticism (Gustafsson, Personn, Eriksson, Norberg, & Strandberg, 2009).

Other risk factors or constructs researched at the individual level that have been found to influence burnout include but are not limited to Type D personality (irritable, prone to worry and pessimistic), negative affectivity, big five factors (neuroticism, extraversion, agreeableness, openness, and conscientiousness), alexithymia, dispositional optimism, and proactive personality (Mommersteeg, Denollet, & Martens, 2012; Oginska-Bulik, 2006).

Personality has been found as a likely influence for the manifestation of, and predisposition to burnout as some people are more prone than others for developing burnout even when they experience similar situations (Cherniss, 1980a; Lazarus, 1966; Maslach, 1978). Although some individuals are at high risk for burnout based on their personality profile (Cherniss, 1980a;

Maslach, 1982; Pines, A., Aronson, & Kafry, 1981; Scott, 2017), having a specific personality trait does not automatically lead to burnout (Carroll & White, 1982; Maslach, 1982). There is also a need to constantly consider other factors such as societal, environmental, familial, and organisational factors.

There is an emphasised need to look at the individual experience of burnout, which could be predisposed by personality factors that further influence development of burnout and could be crucial in the development of intervention thereof. From a salutogenesis point of view, burnout causes and interventions could be understood by examining personal psychological factors. Salutogenic personality constructs such as a sense of coherence (Antonovsky, 1987), hardiness (Kobasa, 1979); locus of control (Rotter, 1996); and learned resourcefulness (Rosenbaum, 1989) could lower the experience of burnout if elevated.

There are limited studies in the South African context that have investigated the relationship between personality and burnout where Generation Y medical doctors are concerned. Personality factors and how they affect the development of burnout could very well apply to Generation Y medical doctors working in the public health sector. Studies are essential to verify the level of impact if any as compared with studies done elsewhere. The current study focused on the participants' experience of the group coaching intervention and brought in some demographic variables. There is still room for more research to be done regarding how the specific demographic variables affect the development, maintenance, and intervention or prevention of burnout in Generation Y medical doctors.

2.5.2 Other implications and risk factors for burnout

One study has found that social and organisational factors that manifest at a personal level as internal factors (such as personal self-esteem and organisation-based self-esteem) are important to intervene against job stressors (Bosco, Masi, & Manuti, 2013). The findings indicated a need

to strengthen personal resources and develop organisational policies and improvements, such as promoting a supportive work environment to increase loyalty of workers, which could transform into improved job performance and hopefully a decreased burnout risk (Bosco et al., 2013; Lemaire & Wallace, 2017; Panagioti et al., 2016). Other risk factors for burnout include poor self-esteem and diminished resilience, which are also risks for job stress (Walter et al., 2013).

Nonetheless, burnout spreads across genders, races, professions, and societies. It is a multi-faceted condition associated with internal and external factors in a job context over time. Risk factors occur at an individual and organisational level (Lemaire & Wallace, 2017; Walter et al., 2013).

Burnout is often influenced by living conditions, age, gender, sector, job, employment status, environment, societal factors, interaction of stress in a job, and coping (Bährer-Kohler, 2013; European Agency, 2009; Lemaire & Wallace, 2017; Panagioti et al., 2016). Additionally, burnout is affected by intrinsic motivation, empathy (Gitto & Trimarchi, 2016; Ten Brummelhuis et al., 2011; Wagaman et al., 2015), and neuroticism, which typically presents as anxiety, lack of self-respect, susceptibility to guilt, and low self-esteem (McCrae & Costa, 1987).

Societal aspects have been found to influence burnout (Mathias & Wentzel, 2017; Weber & Jaekel-Reinhard, 2000) through diminishing traditional support systems, changing values (Bährer-Kohler, 2013), and individualisation (Fischer & Boer, 2011). For educated women, their socio-economic position, work objectives, and the expectation to work varying hours place pressure on them.. These factors are all important when predicting burnout (Howick, 2017; Rosin & Korabik, 1991).

There are also gender-based differences in perceptions and reactions to stressors, which explain why women have higher emotional exhaustion scores than their male counterparts whereas men have higher depersonalisation scores (Howick, 2017; Schaufeli, W.B. & Enzmann, 1998).

More studies are needed on Generation Y medical doctors in the South African public health sector for burnout intervention. Due to the lack of current studies for burnout intervention, this study focused on experiences of a burnout coaching intervention amongst Generation Y medical doctors.

2.5.3 Positive factors against burnout

Alarcon et al. (2009) studied the relationship between burnout and some salutogenesis constructs such as hardiness, which is a personality construct that focuses on commitment, control and challenge (Kobasa, Maddi, & Kahn, 1982; Maddi, 1999). Hardiness is the ability to endure stressors without severe negative experiences such as physical or psychological distress (Maddi, 1999; Somoray, Shakespeare-Finch, & Armstrong, 2017).

Findings indicated a positive relationship between hardiness and the three concepts of burnout (Alarcon et al., 2009; Da Silva et al., 2014). This implies that hardy individuals tend to perceive stressors as challenges they can overcome; therefore, they generally had lower burnout scores. Resilient and protective factors against burnout include positive personal life events, attitude, or perception of life (Da Silva et al., 2014; Dyrbye et al., 2009; Somoray, Shakespeare-Finch, & Armstrong, 2017). Furthermore, a higher self-rated emotional intelligence is associated with less burnout, and less burnout is associated with a higher patient satisfaction and higher job satisfaction. Additionally, being an older doctor (Awa, Plaumann, & Walter, 2010; Discovery Health, 2018; Weng et al., 2011), and having participatory and delegative management styles in the departments are associated with less burnout (Panagioti et al., 2016; Thomas & Valli, 2006).

Literature suggests that socio-economic, individual, and work-related resources may accumulate over the course of life and act as protective factors for older employees; thus, the risk of burnout syndrome decreases with increasing age (Hakanen, Schaufeli, & Ahola, 2008; Lee, J., Lim, Yang, & Lee, 2011).

Other listed protective factors include resilience, extraversion, good nature, openness, social networks (Awa et al., 2010), emotional resilience, which is referred to as self-regulation (Bandura, 2001; Caprara & Cervone, 2000), hardiness, optimism, and emotional competence skills (Alarcon et al., 2009; Da Silva et al., 2014; Garrosa & Moreno-Jiménez, 2013; Gustafsson et al., 2009; Riolli & Savicki, 2003).

Early identification of job stress is essential to prevent burnout from developing, which is often characterised by depersonalisation of the provider–patient relationship (Felton, 1998; Lemaire & Wallace, 2017; Panagioti et al., 2016; Schweitzer, 1994; Thomas & Valli, 2006). It is a challenge to the healthcare of professional that must be recognised and treated early (Felton, 1998, Schweitzer, 1994; Sorenson et al., 2016; Thomas & Valli, 2006; Werneburg et al., 2018). Some resilient factors could be present in Generation Y medical doctors working in the public health sector. This requires further research.

2.5.4 Burnout risk faced by Generation Y medical doctors in the public health sector

There is an indication of the need for organisational support and the requirement to acknowledge that the experience of burnout often starts very early in the professional journey of Generation Y medical doctors in the South African public health sector (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Peltzer et al., 2003; Sirsawy, Steinberg, & Raubenheimer, 2016).

The studies further emphasised the need to recognise and address occupational stress and other influencing factors that often lead to the experience of burnout. There is a need to recognise burnout early in self or others; develop strategies to prevent burnout in the organisation; maintain and develop human resources such as Generation Y medical doctors; educate about caring for the health professions; focus on junior doctors to prevent feelings of helplessness, which predispose burnout; and have support structures in place to assist Generation Y medical doctors (Discovery Health, 2018; Erasmus, 2012; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Peltzer et al., 2003).

South Africa's health system, and specifically the public health sector, faces various problems in spite of some attempts made by government to address the issues, which include overall shortages of resources and misdistribution of resources to health workers (Discovery Health, 2018; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017). While some studies have identified the major problems, few studies aimed at providing interventions and solutions going forth to the health system, including the South African public sector (Kotzee & Couper, 2006; Liebenberg et al., 2018; Sorenson et al., 2016; Werneburg et al., 2018). The history of apartheid in South Africa has created an enormous challenge for the health sector (Kotzee & Couper, 2006).

The South African government decided to retain health professionals in the public sector, specifically Generation Y medical doctors, by including an internship year and a community service year in the public sector as part of their curriculum (Dr Shoyeb, personal communication, Aug. 7, 2019; Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Peltzer et al., 2003). If Generation Y medical doctors want to specialise in the various fields of medicine, it implies a minimum of four years in the public sector as part of their training.

Medical doctors are qualifying younger (Dr Shoyeb, personal communication, Aug. 7, 2019), and are often referred to as Generation Y medical doctors (Kane, L., 2018; Macleod, 2008). After many years of schooling with aspirations and motivations to become medical doctors, Generation Y medical doctors often are met with the challenging public health sector during their training, but more so when they have to work as interns or serve their community years.

Staff morale in the public health sector was found to be incredibly low with higher levels of job stress than average working populations (Discovery Health, 2018; Hlatshaneni, 2019; Mathias & Wentzel, 2017; Thomas & Valli, 2006), which increases Generation Y medical doctors' risk for burnout. The impact of occupational stress (often being burnout or poor job satisfaction) has negative consequences for the recipients of their care. This has a potential cost to the public health sector due to the potential impaired performance of medical doctors, and the need to retrain doctors and do additional recruitment due to increased staff turnover (Discovery Health, 2018; Hlatshaneni, 2019; Thomas & Valli, 2006). The study by Thomas and Valli (2006) showed an increased tendency to see patients as objects rather than human beings, which is a serious consequence of occupational stress that often leads to or is seen in burnout.

Burnout risk is elevated in public hospitals – even in South Africa for health professionals (Davhana-Maselesele & Igumbor, 2008; Discovery Health, 2018; Hlatshaneni, 2019; Mathias & Wentzel, 2017), which predisposes professionals, including Generation Y medical doctors, to severe impairments, physical and psychiatric presentations, and high levels of occupational stress (Discovery Health, 2018; Hlatshaneni, 2019; Thomas & Valli, 2006). This puts the sector at risk for brain drain or Generation Y medical doctors making unplanned immediate changes of profession (Discovery Health, 2018; Dovlo, 2003; Hlatshaneni, 2019; Kotzee & Couper, 2006; Phalime, 2014).

Critical concerning consequences and severe manifestations of impairment have been found in Generation Y medical doctors. These are secondary to the environment, occupational stress and overlap with the burnout experience. The manifestations include: psychiatric illness such as increased drug use, addictions and elevated admissions in psychiatric hospitals; depression; increased road accidents; higher likelihood to commit suicide than the general population; psychosomatic illnesses; higher incidence of other emotional problems, which often result in other symptoms such as marital conflict; and increased patient risk due to mistakes (Discovery Health, 2018; Ellis, 1996; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Peltzer et al., 2003; Gitto & Trimarchi, 2016; Goldman, 2018; Near, Rice, & Hunt, 1980; Panagioti et al., 2016; Sonneck & Wagner, 1996; Thomas & Valli, 2006).

2.6 Burnout Manifestations

Burnout is a process that occurs as a result of negative impact and manifesting consequences in numerous scenarios including personal or individual, inter- and intrapersonal, organisational, and societal contexts (Somoray, Shakespeare-Finch, & Armstrong, 2017; Fischer & Boer, 2011; Panagioti et al., 2016; Viehl et al., 2017).

2.6.1 Burnout impact on the individual level

Development of burnout is reportedly from interaction at the individual and environment levels (Maslach & Leiter, 1997). According to Maslach and Leiter (1997), occurrences at the individual level, such as high hopes of self, reduced influence, and/or desire to meet the requirements of the environment, influence the development of burnout. At the environmental level, Maslach and Leiter (1997) stated that unmet expectations, reduced control, and/or value conflict together with individual characteristics influence the development of burnout.

Burnout appears in various ways and is commonly associated with physical, affective or emotional, behavioural, motivational and/or cognitive changes (Felton, 1998; Lemaire & Wallace, 2017; Panagioti et al., 2016; Schaufeli, W.B. & Enzmann, 1998; Thomas & Valli, 2006). At times, burnout overlaps with mental disorders (Hemmeter, 2013; Nuallong, 2013). This is referred to as professional exhaustion syndrome, which is increased by factors such as social and economic insecurity (Constantino et al., 2013). Burnout develops within certain contexts linked to work and is influenced by various factors that contribute to its development (Hemmeter, 2013).

Pines, A. and Aronson (1988) summarised burnout signs as physical presentations, psychological presentations, and changes in behaviours at work that overlap at times. Physical presentation could be (Pines, A. & Aronson, 1998):

- Lowered immune system, which could lead to recurrent flu/colds.
- Appetite and eating habits changes, which could lead to reduced or increased weight.
- Headaches (migraine, tension) and breathing problems.
- Sleep disturbances and gastrointestinal challenges.
- Frequent complaints of aches and pains, especially tension.

Psychological presentations could be (Pines, A. & Aronson, 1998):

- Negative emotional presentations such as anger, frustration, guilt, anxiety, apathy, discouragement, hopelessness, and pessimism.
- Attitudes of negativity such as cynicism, self-doubt, and worthlessness.
- Overlap with psychiatric presentations such as poor concentration or difficulties such as substance abuse.

- Occurrence of difficulties in interactions and relationships that often lead to conflict within, with others at work, or home.
- Low morale and decreased sense of worth.

Changes in behaviours at work could involve (Pines, A. & Aronson, 1998):

- Dehumanisation or victimisation of patients.
- Withdrawal, isolation and/or physical distancing from colleagues or patients.
- Increased absenteeism.
- Being prone to making mistakes.
- Increased risk-taking.
- Undercommitment and disengagement.
- Decreased job effectiveness.

Chronic job stress can have ramifications for workers, their families, and recipients of their care (Carod-Artal & Vázquez-Cabrera, 2013; Discovery Health, 2018). It has physical, mental, behavioural and financial costs. Professional distress can lead to manifestations such as anxiety, depression, divorces or broken relationships, alcoholism, substance abuse, and even suicide attempts or suicide completion (Ahola et al., 2008; Goldman, 2018; Hlatshaneni, 2019; Middaugh, 2007;).

Being distressed, overworked, and overburdened combined with other personal and societal factors could lead to counterproductivity at work in relation to recipients and colleagues. Unhealthy behaviours could develop in an attempt to cope secondary to the distress, or self-destructive behaviour or burnout often develop (Ahola et al., 2008; Carod-Artal & Vázquez-Cabrera, 2013; Discovery Health, 2018; Middaugh, 2007).

2.6.1.1 Burnout diagnosis and other illnesses

Burnout is seen as a concerning psychological distressing syndrome that requires intervention. It is not classified as a medical or psychiatric condition, but an additional diagnosis to a specific psychiatric disorder; however, without a unified definition it is a great cause for concern (WHO, 1992). Burnout has been seen as a serious diagnosis in Sweden since 1997 (Friberg, 2009; Schaufeli, W.B., Leiter, & Maslach, 2009) and it was reportedly added to the Mental Health Reference Book in the 1970s (Felton, 1998). In the list of mental and behavioural disorders related to work, the Brazilian Ministry of Health refers to burnout as professional exhaustion syndrome (Constantino et al., 2013).

Although burnout was not listed as a disorder in the disease category of the *Diagnostic Statistical Manual of Mental Disorders IV-TR* or *Diagnostic Statistical Manual of Mental Disorders V* (APA, 2000, 2013), the *ICD-10 Classification of Mental and Behavioural Disorders* recognised burnout as part of a group of conditions that require attention (Z73.0 code) and was listed under problems related to life management difficulty where it is described as state of total exhaustion (WHO, 1992).

The *Diagnostic Statistical Manual of Mental Disorders V* has an ‘educational and occupational problems’ category that falls under ‘other conditions that may be a focus of clinical attention’ (APA, 2013). Within the occupational problems listed there is ‘other problems related to employment’ presented with a V code (from the ICC-9-CM) and Z code (from the ICD-10-CM). This category should be used when an occupation problem is the focus of clinical attention or affects the individual’s treatment prognosis, diagnosis or course.

Problems with employment or in the work environment include unemployment; job change; threat of job loss; job dissatisfaction; stressful job schedule; uncertainty about career choices; sexual harassment; conflict with boss, supervisor or colleague, or others in the work

environment; hostile work environment; other psychosocial stressors related to work; and many other problems related to employment/occupation (APA, 2013:723). Burnout would then be put into ‘educational and occupational problems’ category as the issues listed in this category are not mental disorders; the category was included to focus on possible presentations that could be met in clinical practice and to give a systematic listing that could be useful for documenting issues (APA, 2013).

WHO’s International Classification of diseases (ICD -11) recently classified burnout as a “syndrome” in the same category as in the ICD-10 but now with a more detailed definition. It is described as resulting from workplace stress that is not successfully managed. The ICD-11 lists possible signs of burnout as: feelings of energy depletion or exhaustion; increased mental distance from job or feelings of negativism or cynicism related to one’s job and lastly reduced professional efficacy (WHO, 2019). Burnout is secondary to job stress and is linked directly to work. It is important to distinguish physical stress and psychiatric presentations from burnout. Burnout has a similar presentation as job stress, especially the late stages of burnout, which seem to overlap with some mental distress diagnoses such as chronic fatigue, depression, stress, neurasthenia or fatigue syndrome, and adjustment disorder (Kupfer, Frank, Perel, 1989; Nuallong, 2013; Schaufeli, W.B. & Buunk, 2003). For instance, the late stages of burnout can seem like depression because of the overlap of certain indications such as sadness, fatigue, poor concentration, low energy, and dysphoria (Schaufeli, W.B. & Buunk, 2003).

Physical stress overlies with the onset of burnout, and the late presentation of burnout with psychiatric problems (Kupfer et al., 1989; Nuallong, 2013). The need for early discrimination and intervention cannot be overemphasised; certain symptoms overlap, but when one unpacks the presentation and the occurrence of burnout, subtle differences can be found between burnout and the other presentations (Kupfer et al., 1989; Nuallong, 2013).

The main difference from mental illness distress diagnoses is that burnout is related to job stress and occurs with non-specific physical symptoms that often overlap with mental disorders (Nuallong, 2013). An occurrence of overlapping depression-like symptoms include chronic fatigue, weight change and loss of appetite (Schaufeli, W.B. & Enzmann, 1998).

Burnout is different than stress as burnout often leads to disengagement and blunted emotions. Primarily, it leads to emotional rather than physical harm, a loss of motivation and drive, and a sense of hopelessness and helplessness. Stress, on the other hand, usually leads to over-engagement and overreactive emotion. Primarily, stress causes or presents with physical harm, loss of physical energy and, in addition, often causes disintegration, sense of urgency and hyperactivity (Nuallong, 2013).

There are overlaps between stress and burnout such as substance dependence (Schaufeli, W.B. & Enzmann, 1998) and sex performance related problems (Kahill, 1988). Other factors often affect development of burnout such as work–family conflict, role strain or job insecurity (Van Bogaert, Clarke, Roelant, Meulemans, & Van de Heyning, 2010). Sleep problems, often seen in burnout syndrome, could explain the mental fatigue and emotional exhaustion; exhaustion which often far outweighs the other two burnout components cynicism and depersonalisation (Kanai, Meyer, & Ebersole, 2009).

2.6.2 Burnout impact on the group level

Burnout could affect the functioning of Generation Y medical doctors as a group as their overall productivity drops, which leads to negative consequences in their personal functioning, employee turnover, and it affects the beneficiaries of their services (Discovery Health, 2018; Erasmus, 2012; Lemaire & Wallace, 2017).

The group of Generation Y medical doctors are exposed to chronic stress in the South African public health sector and are therefore at elevated risk of developing burnout. If there are occurrences of burnout symptoms within the group, it will lead to reduced productivity at the group level overall (Discovery Health, 2018; Erasmus, 2012; Lemaire & Wallace, 2017). When one person is affected and has to be absent from work, the remaining few Generation Y medical doctors have to take over the person's duties even if they are already burdened by their own duties in the limited infrastructure of the public health sector (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Lemaire & Wallace, 2017; Liebenberg et al., 2018). This leads to them being even more burdened, which is likely to lead to more absenteeism and an even bigger breakdown of the group's functioning (Discovery Health, 2018; Erasmus, 2012). It can also lead to the doctors reconsidering the field or working in the South African context (Grant, 2006; Liebenberg et al., 2018). The impact of burnout at individual level affects the other levels, namely, the group, organisation, society, and the beneficiaries of the Generation Y medical doctors' services. The European Union reported that about 60% of absenteeism is related to job stress (Cox, T., Griffith, & Rial-González, 2000).

2.6.3 Burnout impact on the organisational level

Burnout is a growing challenge in the professional world. It is seen as a major concern in health occupational groups and caregivers. It affects people from all walks of life and at all levels, whether personal, societal or organisational (Bährer-Kohler, 2013; Panagioti et al., 2016; Valente et al., 2011; WHO, 2008; WHO, 2019). The consequences of burnout, which are often linked to various mental and physical health problems, are seen to be severe and occur in various ways that affect the individual, family, organisation and society (Milićević-Kalašić, 2013; Liebenberg et al., 2018).

Burnout often lowers production, causes employee dissatisfaction, increases absenteeism and healthcare costs, leads to high personnel turnover linked to high organisational costs, diminishes satisfaction with the care offered and decreases the ability to provide quality care (Discovery Health, 2018; Liebenberg et al., 2018; Panagioti et al., 2016; Thomas & Valli, 2006; Weng et al., 2011). It becomes costly to the self, employer and society in general (Bährer-Kohler, 2013).

Burnout can be devastating to individual employees, their families, the organisation and society as it affects productive people who find themselves at risk for long-term sick leave, early retirement and, in worst-case scenarios, it affects their morbidity or mortality (Milićević-Kalašić, 2013). Burnout further increases the risk for mental and physical health problems (Alarcon, 2011; Panagioti et al., 2016) and increases job turnover, which affects the profession as a whole as well as society.

At a personal level, it can negatively affect an individual's professional development and increase suffering of familial systems due to the loss of bread winners. Furthermore, it could lead to employees leaving their professions, experiencing decreased job satisfaction, and seeing patients as objects (Discovery Health, 2018; Hlatshaneni, 2019; Liebenberg et al., 2018). Occasionally, burnout could lead to psychiatric/psychological issues or physical problems that might incapacitate workers; therefore, affecting the public health sector system (Panagioti et al., 2016; Weng et al., 2011).

Psychiatric issues, which could develop as a result of burnout, could affect the already strained workload and numbers of Generation Y medical doctors in the public health sector. Psychiatric issues include chemical abuse, severe aggression (Ulrich, 2006), depression symptoms or clinical depression (Peterson, Bergström, Samuelsson, Åsberg, & Nygren, 2008), or adjustment disorder (Bährer-Kohler, 2013). Other presentations include tiredness, sleep disturbances

(Ekstedt, Soderstrom, & Akerstedt, 2009; Ekstedt et al., 2006), irritability, cynicism, and lack of concentration (Bährer-Kohler, 2013). There are other related physical and mental health conditions such as headaches, musculoskeletal pain, fatigue, sleep disorders, gastrointestinal disorders, cardiovascular disorders, immunodeficiency disorders, respiratory system disorders, sexual dysfunction, and substance use (Melamed et al., 2006; WHO, 2008).

2.7 Critical Review of Burnout

Burnout affects developing and developed countries; however, health professionals in developing countries are under more pressure. For example, Generation Y medical doctors working in the South African public health sector, which serves a large portion of the population, are at an increased risk due to the high workload, the severe traumatic cases they handle, and poor understaffed infrastructure (Bährer-Kohler, 2013; Davhana-Maselesele & Igumbor, 2008; Discovery Health, 2018; Dovlo, 2003; Hlatshaneni, 2019; Kotzee & Couper, 2006; Liebenberg et al., 2018; Mathias & Wentzel, 2017; Peltzer et al., 2003; Thomas & Valli, 2006).

The lack of research regarding effective interventions, limited resources for interventions, and health professionals in developing countries (including the South African public health sector) not using prevention strategies for burnout further exacerbate the pressure on health professions. Generation Y medical doctors may be at an extremely high risk of developing burnout (Bährer-Kohler, 2013; Discovery Health, 2018; Sorenson et al., 2016; Werneburg et al., 2018). Burnout is a dynamic process without conclusive scientific proof of its causes (Schaufeli, W.B. & Enzmann, 1998) and without any unified international definition (Korczak et al., 2010; WHO, 2019), but that has debilitating effects on various systems.

According to Maslach and Jackson (1981) and the proposed process model by Leiter and Maslach (1988), burnout is a dynamic three-dimensional construct. The core constructs are

emotional exhaustion, depersonalisation or cynicism (implying a negative attitude towards several matters, especially clients) and, lastly, increased tendency for negative evaluation of self as lacking professional accomplishment or competence (Maslach & Jackson, 1981, 1986). The proposed model of burnout begins with emotional exhaustion, which often leads to depersonalisation and, subsequently, to reduced personal accomplishment (Leiter & Maslach, 1988). The process model was used in the current study together with a self-reporting scale (MBI-GS), to determine the objective level of burnout in the participants.

Burnout interventions are limited and those that are available have limited pragmatic evidence; thus, there is room for more research (Milićević-Kalašić, 2013; Sorenson et al., 2016; Werneburg et al., 2018). In the South African public health sector, research is needed even more as burnout is reportedly on the increase in various professionals but with no specific interventions (Bährer-Kohler, 2013). The lack of intervention for specific professions such as the Generation Y medical doctors working in the South African public health sector with empirical evidence cannot be overstated (Bährer-Kohler, 2013; Discovery Health, 2018; Liebenberg et al., 2018; Sirsawy, Steinberg, & Raubenheimer, 2016). If specific interventions are not developed, the South African society, the beneficiaries of services, the personal lives of the Generation Y medical sector, their employer and even the medical profession with limited scarce professions and specialists will be at a high risk.

2.8 Relevance of Burnout Interventions

Burnout, a job-related social construct (Leiter & Durup, 1994; Sorenson et al., 2016; Werneburg et al., 2018), is a challenge for health in all areas of the world (Bährer-Kohler, 2013; Kane, S., 2019; Panagioti et al., 2016). Burnout seemingly affects both developing countries, such as South Africa, as well as developed countries (Bährer-Kohler, 2013). The consequences and reality of burnout are being dealt with in developed countries (Bährer-Kohler, 2013;

Discovery Health, 2018; Hlatshaneni, 2019). However, developing countries such as South Africa have only very recently slowly been attempting to deal with the reality of burnout (Bährer-Kohler, 2013; Discovery Health, 2018; Hlatshaneni, 2019; Liebenberg et al., 2018; Sorenson et al., 2016; Werneburg et al., 2018).

Sadly, the impact of burnout is felt greater in developing countries where there are other co-existing challenges: health, infrastructure, burden of disease, societal, political and/or shortages of staff, specifically the medical doctors who are the focus of this study (Bährer-Kohler, 2013; Mathias & Wentzel, 2017). This means that even if the reality and research regarding burnout are growing in developing countries such as South Africa, there are other serious challenges that negatively affect, limit and delay a greater understanding of burnout in the specific context and intervention thereof.

In extreme cases, burnout can have serious long-term consequences that overlap with, or lead to the development of certain severe psychiatric disorders such as depression, anxiety disorders, sleep disorders, chronic fatigue syndrome, somatic disorders (Hemmeter, 2013; Kaschka et al., 2011), or even physical conditions (Constantino et al., 2013). Thus, early prevention or intervention is crucial as it could prevent further consequences that would alleviate some psychiatric diagnoses (Kupfer et al., 1989).

This need for early intervention adds to the burnout burden for South Africa, where there is a delay in burnout intervention (Discovery Health, 2018; Hlatshaneni, 20019; Liebenberg, 2018). This implies that Generation Y medical doctors are not dealing with burnout as early as possible due to the context they find themselves working in. Therefore, they are at risk for occurrences of, or overlaps with other serious secondary manifestations such as psychiatric disorders, familial conflict, poor productivity and physical illnesses, which pose a negative impact on

society, the individuals and the profession (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018; Sirsawy, Steinberg, & Raubenheimer, 2016).

2.8.1 General burnout interventions

Schaufeli, W.B. and Enzmann (1998) reviewed over 30 approaches and determined that cognitive-behavioural strategies to combat burnout combined with organisational interventions seemed to be the most successful.

Haiten et al. (2007) compared two interventions for burnout, namely, a traditional and a participatory intervention. The traditional method is an intervention at an individual level while the participatory is at individual-organisational level. The study by Haiten et al. (2007) found participatory intervention at an individual-organisational level is more effective for combating burnout. Although studies by Halbesleben, Osburn, & Mumford (2006), Haiten et al. (2007) and Le Blanc & Schaufeli (2008) found empirical evidence for action research approaches, more studies are still needed.

Specific inclusion and exclusion criteria for burnout still need to be clarified. Due to this incomplete conceptualisation of burnout in literature, intervention, whether it be the prevention or management thereof, is limited (Milićević-Kalašić, 2013). Longitudinal studies are needed to finalise its conceptualisation further: there is a need for a holistic approach to prevent, manage or treat burnout based on evidence that has identified the serious occurrence and impact of burnout (Milićević-Kalašić, 2013; Sorenson et al., 2016; Werneburg et al., 2018).

It has also been observed that effective treatment is not only essential, but that it should also be timely and consistent (Sorenson et al., 2016; Werneburg et al., 2018); that solution approaches should be at the individual and institutional level; and that there is a need to

distinguish between the two intervention strategies (Lemaire & Wallace, 2017; Maslach & Goldberg, 1998; Panagioti et al., 2016; Sorenson et al., 2016; Werneburg et al., 2018).

Preventative approaches for burnout are encouraged, which are likely to improve the work environment and the ability to cope with stress (Carod-Artal & Vázquez-Cabrera, 2013; Sorenson et al., 2016; Werneburg et al., 2018). Approaches could be primary preventative measures that avoid or remove burnout factors, secondary measures that emphasise early recognition or intervention, or tertiary measures that rehabilitate people or teach them to cope with the consequences of burnout (Carod-Artal & Vázquez-Cabrera, 2013; Leka, Griffiths, & Cox, 2004; Sorenson et al., 2016; Werneburg et al., 2018).

General recommendations for dealing with compassion fatigue syndrome, specifically burnout, include parallel efforts from the individual (such as early detection, self-awareness and self-care) and systemic intervention by increased organisational awareness and support (Felton, 1998; Lemaire & Wallace, 2017; Sandstrom et al., 2005). The organisation could take certain steps in an attempt to intervene, which include redesigning jobs, relooking conditions, and making supportive services available (Felton, 1998; Sandstrom et al., 2005; Schaufeli, W.B. & Enzmann, 1998; Sorenson et al., 2016; Van Dierendonck, Schaufeli, & Buunk, 1998; Werneburg et al., 2018).

Other suggestions for burnout intervention include establishing workload standards (for example, maximum hours worked per day, week, and month); improving recruitment and retention of new trainees; introducing productivity aides, such as enhanced information systems; and expressing appreciation for the clinician as a cherished resource (Sorenson et al., 2016; Thanacoody et al., 2009; Werneburg et al., 2018).

Expressing appreciation may help to mitigate burnout, which can be done in a number of ways: rewarding financially or verbally, furthering their education, and implementing programmes

that allow them to manage the emotional components of their role creatively and to learn and cultivate life- and practice-enhancing skills (Sorenson et al., 2016; Thanacoody et al., 2009; Werneburg et al., 2018).

It has also been suggested that a sense of community is built in the workplace to cultivate a social support network (Barak, Nissly, & Levin, 2001; Panagioti et al., 2016). To reduce turnover and increase work-related knowledge and employee self-efficacy, one study proposed investing in training and job-related education (Barak et al., 2001). Other strategies identified are staff retreats, four-day workweeks and an increase in staff size (Barak et al., 2001). Although these strategies are mostly ideal, they are less applicable to the resource-scarce South African environment.

2.8.2 Individual burnout interventions

A study by Awa et al. (2010) confirmed the view that person-directed interventions could reduce burnout, thereby improving occupational mental health. Their findings further supported the notion that better results could be achieved by conducting person-directed interventions in combination with organisation-directed interventions (Awa et al., 2010; Lemaire & Wallace, 2017; Panagioti et al., 2016). For one to explain and do burnout interventions, there is a crucial need to consider the active and passive processes, transactions of people in their contexts, and response processes (whether active or passive) in the organisational environment (Garrosa, & Moreno-Jiménez, 2013).

Work conditions or occupational stress alone do not lead to burnout; it is mediated by a person's work orientation and attitudes (Cherniss, 1980b; Panagioti et al., 2016). Therefore, burnout needs to be dealt with on several levels including an individual level. This implies that the need to focus on the individual is crucial in burnout interventions (Ruiz, 2019). On an individual level, the focus is on managing self; elevating of self-confidence; and/or promoting self-care

with the hope that this would lead to the use of active coping strategies in the work context where the occupational stress is experienced (Bandura, 1986; Ruiz, 2019). According to Carod-Artal and Vázquez-Cabrera (2013), self-management is encouraged, which refers to the interventions, training, and skills used by people experiencing burnout to take care of themselves effectively and to learn how to do so. Self-management could promote self-care approaches for personal health (physical and mental), and personal competence skills such as communication or flexibility could be imparted, which could assist in dealing with burnout (Carod-Artal & Vázquez-Cabrera, 2013; Ruiz, 2019).

As part of the burnout intervention at an individual level, psychotherapeutic cognitive behaviour therapy interventions for individuals (Ruiz, 2019) have also been recommended if required together with psychotropic medications (Kaschka et al., 2011). Whether these medications, such as antidepressants, are required would be determined by the presentation of the individual with burnout (Kaschka et al., 2011).

At the individual level, suggestions for burnout intervention with the aim of managing, preventing and/or treating it before or after occurrence include but are not limited to:

- Ensuring self-care and self-management for burnout, which implies self-observation and awareness (Kravits, McAllister-Black, Grant, & Kirk, 2010).
- Regulating self and action (Forgas, Baumeister, & Tice, 2009) whereby one takes responsibility of their actions and ‘the self’ in the experience of burnout (Ruiz, 2019).
- Promoting self-esteem (Pierce & Gardner, 2004) and/or self-efficacy (Doménech Betoret, & Gómez Artiga, 2010); increasing resources within the self and outward (Bakker, Demerouti, & Euwema, 2005; Lee, R.T. & Ashforth, 1996; Ruiz, 2019); and advancing emotional intelligence (Weng et al., 2011).
- Maintaining and enhancing social support (Van Dierendonck et al., 1998).

- Doing communication training (Ernold, Schneider, Meller, Yagil, 2011) and coping skills training (Lazarus, 1966; Ruiz, 2019) together with obtaining work and family life balance (Ladengard, 2011).
- Enhancing cognitive and problem-solving skills could reduce burnout (Sasaki, Kitaoka-Higashiguchi, Morikawa, & Nakagawa, 2009; Ruiz, 2019).
- Promoting resilience, which has been linked to less emotional exhaustion or cynicism (Menezes de Lucena Carvalho, Fernández Calvo, Hernández Martín, Ramos Campos, & Contador Castillo, 2006). Personal characteristics such as optimism and hardiness have been correlated with less burnout (Da Silva et al., 2014; Otero-Lopez, Santiago Marino, & Castro Bolano, 2008).
- Managing personal stress and developing interpersonal skills, which have been found to have a negative correlation with two components of burnout, namely, cynicism or depersonalisation, and reduced personal accomplishment or personal inefficiency (Panagioti et al., 2016; Taormina & Law, 2000).
- Establishing a psychosocial work environment, which has been found to affect the development or prevention of burnout (Lemaire & Wallace, 2017; Weber & Jaekel-Reinhard, 2000); additionally, observing sociodemographic characters, such as age, gender, and marital status (Maslach, 2003); establishing social relations and networks outside or at work (McMurray et al., 2000); and strengthening personality aspects (Alarcon et al., 2009; Da Silva et al., 2014) as these aspects may influence burnout. Therefore, promoting positive social relations, strengthening intrapersonal traits, supporting at-risk groups, and creating awareness of risk to reduce burnout.

It seems most of the limited researched and attempted interventions in literature are based more on the individual where the focus is on removing the self from work and/or strengthening

internal resources to develop better coping strategies (Lemaire & Wallace, 2017; Maslach et al., 2001; Panagioti et al., 2016). It appears that the interventions deal more with the emotional exhaustion component of the burnout construct with minimal emphasis or impact on the other two burnout dimensions, namely, cynicism/depersonalisation and reduced personal accomplishment/personal inefficacy with a reduced lack of involvement at work (Maslach et al., 2001; Sorenson et al., 2016).

Individual interventions aim to enable people to use individual and social resources to develop resistance to occupational stress and beneficial coping strategies, thus reducing the risk of burnout (Ruiz, 2019). Organisational interventions aim to improve working conditions while minimising external stressors and promoting social support (Karl & Fischer, 2013; Panagioti et al., 2016).

The emphasis of literature on individual interventions is due to various reasons, some being that changing the organisation is not possible at times (Maslach & Goldberg, 1998; Sorenson et al., 2016; Werneburg et al., 2018). Generally, the assumption has been that an intervention aimed at the individual is easier, cheaper and that the underlying individual causality and responsibility view is associated with better long-lasting outcomes (Maslach et al., 2001). The individual intervention assumptions are considered in this current study and focus is more on the experience of a group of individual Generation Y medical doctors working in the public sector.

These assumptions are adopted in the current study due to the reality that changing the workload and schedules of Generation Y medical doctors in the public sector could be a complex task that requires many unavailable resources. Currently there are limited staff and resources, and difficult working conditions for the medical doctors (Kotzee & Couper, 2006; Mathias & Wentzel, 2017).

For the current study there were discussions with the organisation through the manager of the Generation Y medical doctors. Access was requested for the research and the organisation was aware of the study. This was to ensure that not only was there accessibility, but also that the Generation Y medical doctors were supported when going through the coaching process. Furthermore, so that the organisation could determine after the process whether the findings were beneficial in increasing awareness and whether the intervention could be adopted for the organisation.

2.8.3 Group burnout interventions

Rothmann (2003) stated that limited studies have been conducted in South Africa regarding interventions to prevent/manage burnout in a multicultural context. The researcher was of view that little research was done regarding effectiveness of intervention to manage work engagement and prevent or manage it. The focus of most research studies in South Africa is on identification of the occurrence of burnout and some recommendations for intervention. The recommended burnout interventions are what is available in literature and these are not always actually researched further (Liebenberg et al., 2018; Sirsawy, Steinberg, & Raubenheimer, 2016). I am of view based on my literature search that there are still limited empirically supported interventions for burnout in the South African context.

Group interventions, for people in similar burnout risk situations such as the generation Y medical doctors in the current study, seem also to be the norm (Ahola, Toppinen-Tanner & Seppänen, 2017). A group intervention is an individual intervention that is applied to a group setting (Yalom, 1995). The current study took individuals from a similar working environment with elevated burnout levels and intervened at an individual level using focus groups in a group coaching intervention. It was a collective case study method aimed at assisting at an individual and group level.

Examples of group level interventions include presenting educational programmes on risk factors; scheduling risk groups for employees and managers; raising awareness at all levels in all sectors; advancing family and social support; improving healthy work-home balance; and assisting the affected (Ahola, Toppinen-Tanner & Seppänen, 2017; Cassitto et al., 2003).

Another type of group intervention is group based behavioural therapy (Anclair, Lappalainen, Muotka & Hiltunen, 2017). Researchers have showed that the level of burnout decreased amongst participants in intervention groups group based behavioural therapy (Anclair et al., 2017; Salmela-Aro et al., 2004). Furthermore, negative emotions and tendencies towards negative action regarding work decreased amongst those in the intervention groups compared with the control group (Anclair et al., 2017; Salmela-Aro et al., 2004).

Stress management workshops, mindfulness and peer collaboration programmes are forms of group intervention found to be effective in alleviating burnout in other studies (Anclair et al., 2017; Cooley & Yovanoff, 1995). One study evaluated the effects of two interventions (a series of stress management workshops and a peer collaboration programme) on factors known to correlate with actual turnover (burnout, job satisfaction, and organisational commitment) (Cooley & Yovanoff, 1995). Findings indicated that dependent variables improved as a function of the intervention, thus suggesting that the programmes show promise of providing on-the-job support for professionals at risk of burnout or exiting the field. In addition, participants perceived the targeted skills and strategies to be practical and gained valuable ways of preventing and alleviating job burnout (Cooley & Yovanoff, 1995).

Peterson et al. (2008) studied the importance of peer support by testing the effect of participating in a reflecting peer support group on self-reported health, burnout and perceived changes in work conditions. The peer support groups in the current study used a problem-based method to identify several categories of experience: talking to others in a similar situation,

gaining knowledge, creating a sense of belonging, having self-confidence, ensuring structure, relieving symptoms, and changing behavioural. It was then concluded that peer support groups as seen in the study could be a useful and comparatively inexpensive tool for alleviating work-related stress and burnout (Peterson et al., 2008).

2.8.4 Organisational burnout interventions

Burnout intervention options for employers, organisations and society that have been suggested in research include but are not limited to:

- Identifying early signs of burnout and engagement (Maslach & Leiter, 2008); providing awareness and education of burnout to reduce the stigma; and promoting intentions to seek help (Leka & Cox, 2008).
- Providing ongoing preventative organisational interventions (Bergerman, Corabian, & Harstall, 2009; Sorenson et al., 2016) and workplace coaching for individuals, groups and/or management (Ladengard, 2011; Panagioti et al., 2016).
- Providing supervisory and co-worker support (Lemaire & Wallace, 2017; Paisley & Powell, 2007; Shimazu, Shimazu, & Odara, 2005); ensuring employee participation in decision-making; promoting stress management resources and individual skills (Gray-Stanley & Muramatsu, 2011; Leka & Cox, 2008; Panagioti et al., 2016).
- Promoting job resources (Nahrgang et al., 2011).
- Promoting a supportive work environment to create a balanced work environment with balanced effort and reward (Panagioti et al., 2016).
- Decreasing job demands and increasing job resources to reduce emotional exhaustion (Jourdain & Chenevert, 2010; Gregory, Menser, & Gregory, 2018).

- Implementing employment or organisational policies that promote a family-friendly environment, which could improve staff retention, employee job commitment, and job satisfaction (Bosco et al., 2013; Brough & O’Driscoll, 2005; Lo, 2003).
- Increasing identification with the organisation to improve variables associated with work and the organisation, such as job attitude, performance and satisfaction, which could reduce burnout (Van Dick et al., 2008; Panagioti et al., 2016).
- Promoting training to strengthen personal resources including self-esteem, self-efficacy and assertiveness improving resilience (Awa et al., 2010; Gregory, Menser, & Gregory, 2018).
- Investing in burnout prevention for managers and all other individuals to create a climate where communication is improved and aimed at reducing stigma (Milićević-Kalašić, 2013).

2.8.5 Limitations of individual, group and organisational burnout interventions

Individual intervention limitations

There are limitations to individual, group and organisational strategies. Limitations are reported for individual strategies because application in the workplace is often limited. Even though one is able to learn new ways of coping, the workplace does not always allow their practice. There needs to be some form of agreement from the organisation to allow such interventions to work (Gregory, Menser, & Gregory, 2018; Maslach et al., 2001). Furthermore, adding to the existing complexity, some studies reported reduced emotional exhaustion, very few studies reported a change in depersonalisation/cynicism and a reduced accomplishment/personal inefficiency (Ahola, Toppinen-Tanner, & Seppänen, 2017; Maslach et al., 2001). But because emotional exhaustion is seen as a crucial dimension of burnout (Milićević-Kalašić, 2013), its reduction is an important part for any intervention.

Some reported limitations for the individual interventions studies were as follows: there was usually no control group; individual-focused interventions not consistently sufficient to tackle severe burnout and a lack of longitudinal assessment (Ahola, Toppinen-Tanner, & Seppänen, 2017; Maslach et al., 2001).

Group intervention limitations

Although there has been limited research regarding the effectiveness of group coaching intervention or collective case study interventions in burnout clients (Sorenson et al., 2016; Werneburg et al., 2018), there is evidence that group interventions can affect participating clients as it offers individuals the opportunity to see the progression of burnout in themselves and in others (CSAT, 1999; Yalom, 1995). It also gives them an opportunity to debrief and think of ways to cope in an atmosphere of support and hopefulness (CSAT, 1999; Yalom, 1995).

The restorative factors associated with group interventions, as defined by Yalom (1995), specifically addressed the instillation of hope, the universality experienced by group members as they see themselves in others, the opportunity to develop insight through relationships, and a variety of other concerns specific to the support of substance-abusing clients and their recovery. Research suggested that improvement as a result of group intervention occurs within a brief duration of time, typically two or three months, which indicates that short-term group interventions can be as fruitful as long-term group interventions to promote transformation (Garvin, Gutierrez & Galiinsky, 2004).

With time-limited group interventions, the cost-benefit ratio could increase since the coach or therapist in the group could use the power of the group to support change within all group members. A prepared, well-trained group therapist can meet the needs of 8–12 clients in about

the same amount of time as an individual session, especially when there are more directive approaches such as cognitive-behavioural or psycho-educational groups (CSAT, 1999).

Organisational intervention limitations

Limitations have been reported regarding organisational interventions. Burnout is postulated to occur due to a disconnection between the organisation and the individual in six areas of work life: values, fairness, community, reward, control, and workload (Maslach et al., 2001). Organisational interventions should ideally focus on these six areas. Further interventions should involve management who could review their managerial styles. Managers could also benefit from educational interventions for their individual skills and attitudes to increase awareness of positive skills and attitudes while reducing negative ones that often lead to occupational stress in employees (Maslach et al., 2001). To create a better tolerance of the workload, emphasis should be on the mismatches between value and reward, or area of fairness and equity, in individuals who are affected or at risk for developing burnout rather than focus on workload, which is not always under the control of the individual (Maslach et al., 2001).

Research on organisational interventions are also still incomplete (Maslach et al., 2001; Sorenson et al., 2016), but studies found that interventions that focus on workload, fairness and equity mismatches significantly decrease emotional exhaustion between six months and a year after intervention, but the other two aspects, namely, depersonalisation/cynicism and reduced accomplishment/personal inefficiency, did not change (Gregory, Menser, & Gregory, 2018; Van Dierendonck et al., 1998).

An organisational intervention that combines a managerial and educational approach focusing on managers and employees has advantages and adds value. Emphasis in this approach would be on building engagement between the individuals and work while working towards a closer

alliance with the mission of the organisation (Panagioti et al., 2016; Rothmann, 2003; Van Dierendonck et al., 1998).

A setting that supports intervention-building engagement rather than reduce burnout enhances accountability of the intervention as the affected person also has to take certain actions (Gregory, Menser, & Gregory, 2018; Maslach et al., 2001). Unfortunately, this sort of intervention and most other organisational interventions are complex and costly as they require investment in terms of money, time and effort. Collaboration is required to achieve such an integrated intervention, which is not always achieved (Maslach et al., 2001).

2.8.6 Coaching intervention considerations

According to the researcher in this current study, it is important to empower Generation Y medical doctors in the South African public health sector with an increased awareness of burnout and its consequences. A specified group coaching intervention of burnout for Generation Y medical doctors cannot be overemphasised. Equally important is the need to make better investments to improve poor working conditions, which often lead to burnout. To prevent, manage and treat burnout, decision makers at provincial and national level in the public sector need to be involved to create awareness within the different environments (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018; Panagioti et al., 2016; Sirsawy, Steinberg, & Raubenheimer, 2016; Thomas & Valli, 2006) before it leads to further problems affecting the professionals, sector, society and beneficiaries of their services.

There are serious problems in the South African public health sector systems that could lead to severe occupational stress, which often leads to burnout. This puts Generation Y medical doctors at risk to emigrate to greener pastures in developed countries, which leads to a high staff turnover (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Kotzee & Couper,

2006; Liebenberg et al., 2018; Sirsawy, Steinberg, & Raubenheimer, 2016). Generation Y medical doctors, who are working as interns or serving their community service year, have no choice but to work in the ailing public health sector if they are to qualify to practise medicine in South Africa. They work in unfortunate difficult conditions filled with unfairness (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Liebenberg et al., 2018; Mathias & Wentzel, 2017).

One study emphasised the severe and unfair conditions in the public health sector, which suggested that the younger Generation Y medical doctors who are starting their careers in the South African public health sector are “slaves of the state” and their environment. Their working conditions breach many laws, thereby making it a case for the Human Rights Commission (Erasmus, 2012). There is still a long way to go to bring change to this sector (Discovery Health, 2018; Hlatshaneni, 2019; Liebenberg et al., 2018).

Occupational stress is often linked to poor working conditions in the South African public health system where Generation Y medical doctors are forced to work (Erasmus, 2012; Kotzee & Couper, 2006; Mathias & Wentzel, 2017). Reducing occupational stress, which is likely to lead to burnout syndrome experience, would likely reduce the occurrence of burnout and its consequences that put the profession, workers’ personal lives, their patients and recipients of healthcare at risk, therefore further increasing societal costs (Mathias & Wentzel, 2017).

Some suggestions to reduce occupational stress in the ailing South African public health sector system include installing electronic time recording in state hospitals, terminating unpaid overtime for junior medical doctors, limiting the shifts of newly qualified medical doctors to a maximum of 16 hours, and requesting the Human Rights Commission to investigate the working conditions of medical doctors (Erasmus, 2012).

Based on a study in a South African public hospital on medical doctors, including Generation Y, Thomas and Valli (2006:1168) recommended the following for public sector hospitals to address occupational stress, which often leads to burnout:

- Implementing organisational change: prioritising committed representatives; hiring more medical doctors; ensuring functional occupational health and safety committees; ensuring flexible working hours; having regular staff meetings; developing clear job specifications; using special skills separate to medical doctor's regular tasks; ensuring reasonable overtime work; continuing professional development and skills development opportunities; giving management training to department heads; ensuring medical doctors take mandatory annual and study leave; doing regular performance assessments with career planning; and presenting effective employee wellness and assistance programmes.
- Focusing on stress management aimed at the medical doctor, including Generation Y as the employee; giving training on stress and its effects; teaching coping strategies including time management; building a support system; and ensuring relaxation.
- Ensuring competitive salary packages at provincial and national level; extending post-graduate training to non-academic hospitals; implementing standardised overtime policies and policies for job security for foreign medical doctors.

Recommendations were also made by Kotzee and Couper (2006); Sirsawy, Steinberg & Raubenheimer (2016) and Liebenberg et al. (2018) based on their research for medical doctors, including Generation Y, working in rural areas in the public health sector in South Africa. This is where Generation Y medical doctors often find themselves serving their internship and community service years. The recommendations included: increasing salaries for rural placements; ensuring career progression; providing continuing medical education; increasing

support by specialist consultants; improving rural referral systems and infrastructures; making essential medical instruments and medicine available (Kotzee & Couper, 2006; Liebenberg et al. (2018).

Kotzee and Couper (2006) also recommended strengthening hospital management; increasing the role of medical doctors in management; improving working conditions; establishing private-public collaborations; increasing leave allocations; providing adequate support for junior medical doctors; improving hospital environments; providing recreational facilities, improving accommodation; recognising and appreciating work; and providing incentives for medical doctors willing to stay in the public sector, especially rural placements.

Another study was of view that the biggest challenges in generation Y medical doctors is the lack of resources to practice medicine which is often the case in South African public health sector and the 36-hour shifts intern medical doctors are mandated to work which hospital mismanagement reportedly abuses (Discovery Health, 2018). One researcher is additionally looking into systems that include empathy training for the medical students as it is reported that empathy could be protective factor against developing burnout contrary to the unspoken rule of “don’t get too involved”.

Burnout is a personal experience caused by occupational stress. It has dire consequences at all levels (personal, societal, familial, and occupational). Due to varying reasons, some people seek help while others do not. It is alarmingly high in South African generation Y medical doctors (Discovery Health, 2018; Hlatshaneni, 2019; Liebenberg et al., 2018). Fears of humiliation, being labelled weak, incapable, unprofessional or a failure are some of the reasons that prevent generation Y medical doctors in South Africa from seeking help I dealing with anxiety, depression and burnout (Discovery Health, 2018).

There is a need to empower generation Y medical doctors experiencing burnout and the managers who have to manage them to use internal resources to promote coping and to further adjust the working environment by improving conditions and staffing (Liebenberg et al., 2018; Panagioti et al., 2016).

2.9 Theoretical Integration

According to some theories (Selye, 1936), stress is a non-specific reaction of the body. Lazarus and Folkman's (1984) model depicts stress as a cognitive challenge which Ladengard (2011) stated implies that a person experiences a situation, perceives and evaluates it, and eventually searches for solutions or responses. Burnout has been distinguished from stress. Burnout is seen as the result dysfunctional coping, thereby implying that burnout occurs due to a combination of stress factors linked to the occupation and ways of coping of the individual (Schaufeli, W.B. & Enzmann, 1998).

Individual coaching to enhance personal coping competencies, such as communication, has been seen to reduce burnout . Other research work differentiated between coping strategies and coping style. Coping styles are relatively stable forms that indicate stable personal variables or styles that influence the way of coping not emanating directly or only from the problem while coping strategies are situationally specific (O'Driscoll, Brough, & Kalliath, 2009). Jang, Thordarson, Stein, Cohan, and Taylor (2007) proposed that coping styles are related to personality. Therefore, understanding the function of coping in the process of burnout is essential and not just to describe ways of coping as positive or negative in burnout (Garrosa & Moreno-Jiménez, 2013).

Nonetheless, enhancement of coping, which is characteristic of resistance to stress (Costa et al., 1996), could assist in overcoming burnout. These characteristics are also influenced by work

activity and the specific relevant socio-cultural aspects of coping that need to be considered as well (Garrosa & Moreno-Jiménez, 2013).

Work stress is not just simple exhaustion but rather complex negative emotions ranging from exhaustion, sadness, despondency, irritation or hopelessness, for example, which leads to exhaustion as the core emotional syndrome. Even the activity of coping is complex and varied, and is not just about resisting stress as the organisation and its culture play a role and influence the burnout experience and how one copes. (Garrosa & Moreno-Jiménez, 2013).

Various studies have suggested different ways of coping, such as problem-focused solving and emotion-focused coping (Lazarus & Folkman, 1984); and active or passive coping (Pines, A.M., 2009). Even within positive psychology there is proactive coping, anticipatory coping, and preventative coping (Aspinwall & Taylor, 1997; Schwarzer, 2001). Coping from a positive psychology view point (Dewe, 2008) is described as a search for meanings and perceptions that generate positive emotions and behaviours in the work setting that would lead to a state of communicative well-being, professional and self-development, and more personal experiences and resources that would increase professional competence (Hobfoll, 1998).

Maslach (1976) stated that burnout involves attitudes, self-appraisals, and appraisal of others within the social and work context. The interactions within the contexts have an emotional component that require emotional and personal competencies to control and manage the emotional reaction (Maslach, 1976). Professional employees have to take charge of their thoughts, images, and emotions to manage their own and other people's emotions; this means that a high level of broad personal resources and strategies is required to handle different situations, including ones that often lead to burnout (Maslach et al., 2001). Emotional and personal competencies could allow proper planning, management and regulation of own experiences in response to the physical and mental demands of the job (Maslach et al., 2001).

Emotional resilience can act as a protective factor in case of burnout (Garrosa & Moreno-Jiménez, 2013).

Burnout is based overall on what is found in research and mentioned in this section. It requires a holistic look at the individual's experience. The intervention would not only need to assist with the emotions linked to the experience, but also to elicit possible coping strategies within the person at an individual level. For the current study, the burnout intervention amongst Generation Y medical doctors was a group coaching intervention aimed at providing an environment of engagement within the group while enhancing coping skills within the participants.

The focus was on using Rogerian skills to promote an environment whereby growth from within could hopefully happen. Burnout was measured objectively before and after the intervention, and the phenomenon under study formed part of the questioning. This chapter completed its stated aim in conceptualising and integrating the existing literature on burnout and its intervention further by emphasising the risk of burnout and possible impact on Generation Y medical doctors within the South African public health sector.

2.10 Chapter Summary

This chapter provided background on burnout, the lack of intervention, the implications of burnout, and the context of Generation Y medical doctors in the South African public health sector. The specific aim of the literature review in the study, namely, to review a group coaching intervention for burnout in order to see its applicability and benefit in Generation Y medical doctors in South Africa working in the public health sector, was theoretically achieved.

The chapter discussed the conceptual foundation of burnout. It defined and contextualised burnout theoretically. The chapter described the aetiology of burnout and risk factors associated

with burnout in Generation Y medical doctors. It detailed the proposed model for burnout, burnout manifestations, and its risks and consequences. It emphasised the general concern of health professionals, specifically Generation Y medical doctors working in the public health sector. The challenges with burnout presentation, outcome and management were discussed.

The chapter provided details on the burnout experience and burnout manifestations specific to Generation Y medical doctors in the public sector. It described the impact of burnout, and the relevance and limitations of burnout interventions at an individual, group and organisation level, which brought specific context to the study. The chapter considered the burnout interventions that are usually recommended, the recommended interventions from various studies in South Africa, and what the intervention would focus on in the current study.

Burnout and intervention considerations for Generation Y medical doctors in the South African public health sector were reviewed. The chapter ended with a theoretical integration of burnout and the proposed group coaching intervention approach thereof.

Chapter 3 focuses on the actual group coaching intervention for burnout amongst Generation Y medical doctors in the public health sector.

CHAPTER 3: COACHING INTERVENTION FOR BURNOUT

3.1 Introduction

This chapter highlights literature on general recommended interventions for burnout and emphasises the lack of properly designed scientific based interventions for burnout in the various populations including Generation Y medical doctors working in the South African public sector. It further examines the limited empirical evidence regarding the effectiveness of the generally available recommended burnout management, treatment and prevention interventions. The chapter concludes by giving the foundation of the group coaching intervention for burnout used amongst Generation Y medical doctors in the current study and provides the actual group coaching intervention for burnout used in the study.

3.2 Conceptual Foundation of Burnout Interventions

This study contextualised burnout as described by Maslach and Jackson (1981) and the proposed process model by Leiter and Maslach (1988). Burnout according to Maslach and Jackson (1981, 1986) is a three-dimensional construct that consists of three core components and manifestations. The three constructs are increased emotional exhaustion, depersonalisation or cynicism, which implies a negative attitude towards several matters, especially clients and, lastly, increased tendency for negative evaluation of self as lacking professional accomplishment or competence (Maslach & Jackson 1981, 1986). Leiter and Maslach (1988) proposed a process model of burnout, which begins with emotional exhaustion, often leads to depersonalisation and subsequently to reduced personal accomplishment.

Burnout is linked to job-related stress and can be reinforced by the workplace. It regularly overlaps with psychological disorders and the stress experience but is independent of both. It is seen as a process that develops over time (Schaufeli, W.B. & Enzmann, 1998). Burnout is

often linked to certain risk factors such as psychosocial work environment, sociodemographic characteristics of employees, social relationships, and lifestyles outside work and personality aspects (Milićević-Kalašić, 2013). Burnout affects at a personal, group, organisational and societal level. Burnout is linked to dysfunctional coping (Costa et al., 1996). The subjective perception of stress depends on appraisals, which are not necessarily made consciously by the person in a stressful situation (Lazarus, 1974).

Very limited empirical studies have been done on burnout interventions and there seems to be no specific treatment for burnout (Hemmeter, 2013; Sorenson et al., 2016; Werneburg et al., 2018), particularly for Generation Y medical doctors employed in the South African public sector. Despite increasing incidence of burnout, there are few scientific studies regarding the value of intervention and limited information regarding how interventions actually work (Haiten et al., 2007; Le Blanc & Schaufeli, 2008; Werneburg et al., 2018). Maslach et al. (2001) stated that there has been a great need for effective interventions for burnout that focus on treating burnout after, or preventing it before it occurs, but there has been very limited systemic research (Gregory et al., 2018).

There is no formal diagnosis of burnout due to the lack of symptoms that could fulfil criteria the warning signs or presentations of burnout can be treated or coached, prevented or managed before they develop into secondary manifestations of physical or psychological disorders (Hemmeter, 2013; Panagioti et al., 2016). Symptom manifestation of burnout should be treated and many studies highlight the need for intervention studies (Marine, Ruotsalainen, Serra, & Verbeek, 2006; Lemaire & Wallace, 2017; Panagioti et al., 2016).

A systematic review was done that categorised intervention strategies for burnout into person-directed and work-directed strategies (Marine et al., 2006). Person-directed intervention strategies include cognitive behaviour therapy, relaxation and massages. Work-directed

intervention strategies include attitude change and communication, support from colleagues, changes within the organisation and, lastly, participatory problem-solving and decision-making (Lemaire & Wallace, 2017; Marine et al., 2006; Panagioti et al., 2016; Sorenson et al., 2016; Werneburg et al., 2018). According to the aforementioned researchers, there has been limited evidence to support the effectiveness of either approach to reduce burnout in healthcare workers. However, they concluded that such interventions could lead to benefits that might be visible from up to six months to a number of years. The findings from the review further led to the conclusion that a thorough stress management programme with supporter sessions over a two-year period might possibly produce better outcomes for treating burnout in employees (Marine et al., 2006).

General suggestions for burnout intervention in literature included a need to focus on a combination of self, organisational and situational factors (Felton, 1998; Lemaire & Wallace, 2017; Panagioti et al., 2016; Sorenson et al., 2016; Werneburg et al., 2018). Models of coping with burnout focus on individual and outside influences such as organisational, environmental, familial and societal factors (Cooper, Dewe, & O'Driscoll, 2001; Panagioti et al., 2016).

Prevention and intervention strategies could be individual or group directed, or focused on the organisation, or a combination of both (Lemaire & Wallace, 2017; Panagioti et al., 2016; Sorenson et al., 2016; Walter et al., 2013; Werneburg et al., 2018). The prevention, management and intervention for burnout that comprise parallel efforts could include, for example, presenting individual worker sessions, having group meetings, ensuring better top-down communication, recognising individual worth, redesigning jobs, introducing flexible hours, giving full orientation to job requirements, making employee assistance programmes available, and/or mentoring of employees in different jobs (Felton, 1998; Kumar & Mellso, 2013; Panagioti et al., 2016). Individual interventions and workplace-based interventions have

both shown therapeutic and preventative results (Kumar & Mellso, 2013; Panagioti et al., 2016).

The job environment and stressors need to be included in all intervention and prevention programmes for burnout (Lemaire & Wallace, 2017; Panagioti et al., 2016; Walter et al., 2013). The intervention for burnout ideally should be interdisciplinary to involve medicine, psychological and societal expertise that influence the job environment (Weber & Jaeckel-Reinhard, 2000). To ensure such holistic interventions, there has been a suggestion that burnout centres similar to cancer centres should be initiated where there are multi-disciplinary integrative interventions (coaching, medical, psycho-educational etc.) that aim to prevent, manage, and treat burnout (Milićević-Kalašić, 2013).

3.3 Coaching Intervention for Burnout Amongst Generation Y Medical Doctors

This section introduces the theoretical foundation and the actual coaching intervention for burnout that was used in the study for Generation Y medical doctors working in the South African public health sector. The study was done in three phases over a seven-month period. The focus of the overall group coaching intervention was at the individual level. Phase I was the pre-coaching intervention for burnout amongst Generation Y medical doctors; Phase II was the coaching intervention for burnout amongst Generation Y medical doctors; Phase III was the post-coaching intervention for burnout amongst Generation Y medical doctors.

Phase I of the study involved getting ethical approval from the academic institution and the hospital's ethics committee for approved access. The study was classified as a psychological risk at a low level (See approval letters in annexure A). A literature review and panel discussion with four clinical psychologist specialists in burnout were done to finalise the group coaching intervention for burnout amongst Generation Y medical doctors.

Additionally, it entailed selecting 16 participants for Phase II and Phase III using three criteria. The fourth and final criterion of participation involved using an objective tool, the MBI-GS, in Phase I.

Phase II was the signing of the informed consent and actual exposure to the group coaching intervention. This was meant to be done in three focus group sessions. However, due to various challenges that unfolded as described in Chapter 5, the group coaching intervention was adjusted after a discussion with my supervisor to one focus group session of 4.5 hours. Initially 16 participants divided into two groups of eight were envisaged; but 18 were interested and were invited to participate. Only ten of the 18 attended the session.

Phase III targeted to elicit the participants' descriptions of their experiences after the group coaching intervention for burnout and to evaluate the overall effect of the coaching intervention. This was done in a focus group session a month after the intervention. The session was attended by six participants. Their descriptions of their experiences and their objective measures of burnout after the intervention were used as empirical evidence for the coaching intervention for burnout amongst Generation Y medical doctors.

3.3.1 Theoretical foundation for the coaching intervention

3.3.1.1 Person-centred coaching psychology

Person-centred coaching psychology was regarded as relevant to form the foundation of the group coaching intervention process for burnout amongst Generation Y medical doctors. There are deliberations around whether coaching psychology should adopt or if it is fully within the meta-theoretical perspective of the person-centred theory as opposed to the medical model (Joseph, 2006; Van Zyl, Stander, & Odendaal, 2016). There is agreement that coaching is about facilitating well-being and optimal functioning (Joseph, 2006), which is closely linked to

Rogers' (1959, 1963) person-centred approach that is not about fixing dysfunction and adopting a diagnostic stance such as the medical model. The focus is more on facilitating clients towards more optimal functioning by using the environment where people are likely to realise their inherent potential (Rogers 1959, 1963). It advocates for using certain skills to achieve that environment. The environment according to Rogers (1959, 1963) has to have three elements to facilitate the client towards more optimal functioning: congruence or genuineness; unconditional positive regard and acceptance; lastly accurate empathetic understanding.

Some Rogerian attitudes, skills and behaviours were applied in the burnout coaching intervention to establish rapport with the group of Generation Y medical doctors and to further facilitate an environment where the participants can begin to gain skills; hopefully towards optimal functioning (Rogers, 1959, 1963). I as the coach in the group coaching intervention used the following combination of Rogerian attitudes, skills and behaviours in no order of significance (Rogers, 1959, 1963):

- Using a stop-and-pay attention skill, which is applied to ensure that a comfortable, non-threatening atmosphere is created for interaction using physical listening, facial expressions, and tone of voice.
- Asking appropriate questions, which are used to indicate that the coach is following the topic and is showing interest.
- Restating, which means that the listener repeats or summarises what was said to clarify, demonstrate interest, and grasp what the participants say correctly.
- Paraphrasing, which is encapsulating what was said to ensure dominant features are depicted and explored.

The following skills were also used (Rogers, 1959, 1963): reflection of feelings and listening for feelings as they speak even when the participants do not actually verbalise any emotion (discretion is key to ensure it is not focused on emotions); summarising, which implies putting together several statements into a theme and confirming with the speaker if the meaning is accurate.

Lastly, the following Rogerian attitudes, skills and behaviours (Rogers, 1959, 1963) were combined: sharing, which is important to indicate reactions appropriately, discretion is taken about what is said and how it is said in a way that supports the speaker and moves on; acknowledging of differences as there were areas of differences and withholding of judgement while listening to allow speakers to make their points while listening with an open mind. A response could be made after one has thought about what to say.

Rogerian coaches should aim to enhance an environment of congruence or genuineness; unconditional positive regard and acceptance; and accurate empathetic understanding while at the same time facilitating clients to learn and apply the same to their personal lives (Joseph, 2006). This approach to coaching was deemed relevant to the current study that aimed to explore a group coaching intervention for burnout amongst Generation Y medical doctors working in the public sector. They were given the opportunity to describe their experiences of the intervention while their objective levels of burnout before and after the intervention were measured.

3.3.1.2 Stress intervention models

Certain practices from two stress intervention models were incorporated into the group coaching intervention. These models are the Critical Incident Stress Debriefing (CISD) (Everly & Mitchell, 2010; Mitchell & Everly, 1996) and the Multiple Stressor Debriefing (MSD) models (Armstrong, Lund, McWright, & Tichenor, 1995). I adapted some aspects of these two

models using other suggested intervention strategies for burnout in literature. Incorporating the two stress intervention models in the following sections seemed appropriate to promote validity of the group coaching intervention.

i. Critical Incident Stress Debriefing model

CISD is a structured group discussion designed to alleviate symptoms, assess follow-up requirements, and offer coping strategies (Davis, 2013; Everly & Mitchell, 2010). CISD has been implemented in various contexts and was beneficial in certain contexts. It is evolving as more focus is placed on multi-layered approaches as the need for psychological interventions is growing rapidly due to increasing pandemics, trauma, and other disasters (MacDonald, 2003). CISD has been applied to hospital staff by researchers such as Caine and Ter-Bagasarian (2003); Narayanasamy; Owens (2001) and Davis (2013). It has been used by Moola, Ehlers & Hattingh (2008); Pillay (2008) and Kusel (2016) in a South African context.

A critical incident is defined in the CISD model as an incident that happens outside the common experiences of a person, thereby challenging their ability to cope (Everly & Mitchell, 2000). This incident could lead to a crisis by overwhelming psychological defences and coping mechanisms (Everly & Mitchell, 2000). The Generation Y medical doctors are exposed to trauma and cases in difficult environments, which could be described as critical incidents. These incidents are likely to overwhelm them and cause traumatic and crisis reactions such as burnout (Liebenberg et al., 2018). The cases include incidents such deaths of patients, trauma cases, and diseases (Discovery Health; 2018; Hlatshaneni, 2019). The CISD model explains a crisis as a response to a situation where psychological balance is disrupted, usual coping mechanisms fail, and there is an indication of functional distress or impairment (Everly & Mitchell, 2000). Burnout based on this definition could be seen as some form of crisis that

often leads to maladapted reactions that require some form of intervention (Discovery Health; 2018; Hlatshaneni, 2019; Liebenberg et al., 2018).

CISD is a short-term intervention where client's sense of control is overwhelmed and could benefit from a brief, solution-focused intervention that may alleviate the increasing experience of distress and traumatic symptoms (Everly & Mitchell, 2010; Mitchell & Everly, 1996). This intervention is not psychotherapy but aims to alleviate the intensity of the challenge as well as acute signs of distress and dysfunction-reducing risk factors. CISD restores functioning through a higher level of care if needed by using psychological change mechanisms such as reframing, catharsis processing, cognitions modelling, and group dynamics (Everly & Mitchell, 2000).

CISD is a seven-stage solution that is a purposeful cognitive intervention with the following phases: introductory; fact exploration; cognitive or thought; reaction; symptom discussion; teaching and re-entry with the focus on the importance of coping strategies and recommendations for long-term counselling (Everly, 1995).

CISD works through early intervention, permits cognitive processing that precedes increased experience of symptoms, and aims to express emotions related to the trauma. Reformation of memories can happen by sharing verbally with others, which creates a sense of hope that they can overcome and shows how to overcome. It lastly emphasises cognitive affective integration that initiates holistic recovery (Everly, 1995). The group process in this type of intervention allows for dynamics such as cohesion, modelling, hope for self, demystification, peer support, and sense of care (Yalom, 1995), which are essential in certain health professions (Everly, 1995).

ii. *Multiple Stressor Debriefing intervention*

The second stress intervention model is the MSD that aims to discuss challenges at work in a group format (Armstrong et al., 1995). More research regarding the effectiveness of MSD is still required. MSDs are encouraged for all, including those with less prominent stress symptoms (Armstrong et al., 1995). It focuses on psycho-education in four phases: disclosure of events, feelings and reactions, coping strategies, and termination (Armstrong, O'Callahan, & Marmar, 1991; Armstrong et al., 1995). It has been researched and applied in the South African context (van Den Heever, 2013)

The participants in the MSD model are encouraged to share a number of experiences while the facilitator aims to support them while they process traumatic/stressful events, which leads to resolution and completion of the experience (Armstrong et al., 1995). The model does not imply that those exposed would finish processing their experiences immediately at the completion of the group sessions, but rather that it promotes ongoing processing even after the sessions (Armstrong et al., 1995). The authors further stated that MSD aims to normalise stress reactions and facilitates education on coping strategies. It aims to assist with transitioning to a home environment subsequent to a traumatic occurrence.

Armstrong et al. (1995) mentioned that debriefing is not psychotherapy nor an analysis of historical events in the initial phase, but rather a reflection of negative and positive aspects of a job. Precise instructions for participation need to be stated so expectations are clear (Armstrong et al., 1995). The members describe recent occurrences in their stressful or traumatic work. The second phase follows and focuses on exploring and describing feelings, thoughts, and reactions of negative and positive events written in the first phase (Armstrong et al., 1995).

Beneficial coping strategies and potential stress responses are discussed in the third phase and previously used coping strategies are identified (Armstrong et al., 1995). Facilitators assess potential maladaptive coping mechanisms such as self-medication using substances and reckless impulsive behaviours (Daniels & Scurfield, 1994). The last phase involves reflection of positives and lessons learned. This model could be used during an actual disaster experience (Armstrong et al., 1991).

iii. Adopted assumptions for current burnout coaching intervention

Burnout is ongoing and is not necessarily caused by one specific incidence or crisis; it is usually a consequence of overwhelming events at work that lead to occupational stress, which subsequently leads to burnout (Maslach & Leiter, 1997). I adapted some CISD techniques such as the suggested intervention process and the small homogeneous group. Further, as in the case of the CISD model, I structured the group coaching intervention for burnout amongst Generation Y medical doctors not as psychotherapy but more as psycho-educational therapy (Mitchell & Everly, 1996). The initial group coaching intervention was structured as 3 Phases. Phase I was the Pre- Coaching Intervention amongst Generation Y medical doctors and focused on finalization of the coaching intervention to be used in the study and selection of participants who met the final criteria being high levels of burnout based on the completed Maslach Burnout Inventory (MBI-GS).

Phase II was the Coaching Intervention for burnout amongst generation Y medical doctors. It initially comprised of the group coaching intervention process in three sessions (Session 2 to Session 4) for the selected potential 18 participants (in two groups of nine selected from Phase I). The identified Generation Y medical doctors who met the criteria were exposed to the burnout coaching intervention in this phase. Due to the process that unfolded as discussed in Chapter 5, Phase II sessions had to be adjusted, which changed from three focus group sessions

to a single session of 4.5 hours with one group of ten participants. Phase III was Post Coaching Intervention Phase 6 months' post Phase II. It comprised of one focus group session and completion of the MBI. Additionally, reflection on the experiences of the group coaching intervention for burnout amongst generation Y medical doctors.

The CISD and MSD processes are suggested for traumatic events where coping methods are overwhelmed and there is an exhibition of considerable distress, impairment or dysfunction (Mitchell & Everly, 1996). Burnout is seen as dysfunctional coping mechanism where there is distress, dysfunction or impairment due to occupational stress caused by numerous events.

I incorporated certain practices from the two stress intervention models, namely, CISD (Everly & Mitchell, 2010; Mitchell & Everly, 1996) and MSD (Armstrong et al., 1995), into the group coaching intervention to promote validity in the process. I also incorporated other suggested individual based intervention strategies for burnout in literature such as those suggested to build personal resilience (Discovery Health, 2018). These include exercises, rest, healthy nutrition, mindfulness and formation of new enjoyable hobbies (Discovery Health, 2018).

From the CISD model, I viewed the cases of Generation Y medical doctors in their difficult working environments as critical incidents that are likely to overwhelm them and cause traumatic and crisis reactions such as burnout (Everly & Mitchell, 2010). Burnout based on this definition could be seen as some form of crisis that often lead to maladapted reactions that require some form of intervention (Everly & Mitchell, 2010). CISD is a short-term solution that is focused on cognitive intervention (Everly & Mitchell, 2010) and so was the group coaching intervention for burnout amongst Generation Y medical doctors used in the current study.

The MSD model practices were also applied. For example, participants in the MSD model are encouraged to share their experiences and integrate them into their lives while the facilitator

aims to assist them in processing the experiences, leading to resolution and completion of the experience (Armstrong et al., 1995). This was also the aim of the group coaching intervention for burnout amongst Generation Y medical doctors.

The MSD model does not conclude that members stop processing their experiences immediately at the end of the group sessions and therefore promotes ongoing processing even after the sessions (Armstrong et al., 1995). I also encouraged this as the coach in the coaching intervention for burnout amongst Generation Y medical doctors.

Some of CISD's seven stages of intervention (Everly, 1995) as well as some of the four phases of MSD's psycho-education (Armstrong et al., 1995) can be seen within the group coaching intervention.

3.3.1.3 Guiding focus group questions for the coaching intervention

Items from two scales were incorporated into the guiding questions used in the group coaching intervention for burnout amongst the Generation Y medical doctors. These two scales were the MBI-GS (Maslach et al., 1996) and the Professional Quality of Life Scale (ProQOL 5) (Stamm, 2009).

Self-reporting scales have been used in various contexts and have been found to be reliable for measuring burnout (Alarcon et al., 2009). MBI-GS is a common burnout self-reporting scale used to screen professional burnout worldwide (Kaschka et al, 2011; Maslach et al., 1996). The MBI-GS is a reliable tool that has been used in South Africa by researchers in several studies with similar samples (Peltzer et al., 2003; Thomas & Valli, 2006). Even though its validity has been criticised (Korczak et al., 2010), MBI-GS is currently the most valid measurement method as participants report their own personality, habits and level of burnout (Alarcon et al., 2009).

ProQOL 5 (Stamm, 2009) measures pleasure resulting from being able to do work well. It also measures the presence of hopelessness and difficulties in dealing with work or in working effectively. Lastly, it measures work-related secondary exposure to extremely stressful events (Stamm, Higson-Smith, Hundall, & Stamm, 2016). The ProQOL is the most frequently used measure of the negative and positive effects of helping others who are exposed to distress and trauma (Stamm et al., 2016). It has been in use since 1995 with several revisions; ProQOL 5 being the latest (Stamm, 2009; Stamm et al., 2016). The ProQOL has subscales for compassion satisfaction, burnout and compassion fatigue (Stamm, 2009). The Cronbach's alpha test for reliability and internal consistency for ProQOL were as follows (Stamm et al., 2016):

- Cronbach's alpha for compassion satisfaction was acceptable ($\alpha = 0.88$, $n = 1130$).
- Cronbach's alpha for burnout was acceptable ($\alpha = 0.75$, $n = 976$).
- Cronbach's alpha for compassion fatigue was acceptable ($\alpha = 0.81$, $n = 1135$).

A reliability coefficient of 70 or higher is considered acceptable in most social science research situations.

The guiding questions in the group coaching intervention for burnout were grouped based on the three burnout factors (emotional exhaustion, depersonalisation, and personal achievement), which were measured by the MBI-GS (Maslach et al., 1996). Therefore, the guiding questions that influenced the attention of the intervention in the focus groups as part of coaching in Phase II were grouped into emotional exhaustion, personal achievement, and depersonalisation factors. A fourth group of guiding questions and intervention emphasis in the focus groups were based on the ProQOL 5 items that focused on a combination of compassion fatigue and burnout factors.

The MBI-GS items were used as guiding questions because the Maslach burnout model was used to conceptualise burnout in this specific study. The MBI-GS (Maslach & Jackson, 1981) was used as part of measuring burnout objectively. Guiding questions were selected from ProQOL 5 to ensure that multiple sources for guiding questions were used to further validate the group coaching intervention. ProQOL 5 measures burnout, compassion fatigue and secondary traumatic stress (Stamm, 2009). Both the scales have been found to be dependable tools. Overall, I incorporated guiding questions based on the two scales to promote validity in the process.

3.3.2 Contextualising of the coaching intervention

A descriptive phenomenological collective case study approach (Englander, 2007; Giorgi, 1997; Husserl, 1998/1913; Moran, 2000) using focus groups (Krueger, 2000) was incorporated for data collection and analysis. Some MSD (Armstrong et al., 1995), CISD (Everly & Mitchell, 2010; Mitchell & Everly, 1996), and Rogerian skills (Rogers, 1959; 1963) were incorporated in the coaching process. The focus of the intervention was at the individual level and participants described their experiences of the group coaching intervention for burnout amongst Generation Y medical doctors.

The descriptions of their experiences and their objective measure of burnout after the intervention were used as empirical evidence for the current group coaching intervention. As the researcher, I gave feedback to the hospital to ensure that the organisation was involved at some level.

The aim in phenomenological research is to confront the phenomenon through the person's descriptions (Giorgi, 2009; Moran, 2000). In order to understand the experience of the group coaching intervention, I needed to understand and become acquainted with burnout experience as a phenomenon. Thereafter, I had to intervene in the professional lives of the Generation Y

medical doctors and become familiar with the group coaching intervention for burnout as a phenomenon.

I as the researcher began by understanding the burnout situation so that the analysis of the experience of the group coaching intervention for burnout as a phenomenon was connected to a specific context (Englander, 2012). Understanding the situation is important to discover the meaning of the experienced phenomenon. The actual situations are likely to differ between the various participants, which make it different from a quantitative experiment that often looks at one experiment or a similar situation (Englander, 2012).

The phenomenon is the subject of investigation, and not the participants or the empirical situation. However, the situation is important to provide context. The person needs to describe the phenomenon while the researcher considers that is not about getting accustomed with the person and their complexity, but rather about first getting familiar with the phenomenon (Englander, 2012). The phenomenon in the current study is the experience of a group coaching intervention for burnout amongst the Generation Y medical doctors employed in the South African public health sector.

The first phase of the study involved obtaining ethical approval (see annexure A) and organising the group coaching intervention for burnout amongst Generation Y medical doctors. Additionally, it entailed selecting participants for Phase II and III. In Phase II and III, I documented all observations in all sessions and audio-recorded the sessions. Further reflective notes were made after each session. These would form part of the analysis of the data.

A phenomenological descriptive stance was taken. Before data collection proceeded, I wrote a full description and did a self-examination of my experiences, thereby bracketing them (Patton, 1990). This was not a single but an ongoing event.

Bracketing is a technique whereby one puts aside beliefs or knowledge about the phenomenon under investigation prior to and throughout the phenomenological study to demonstrate validity (Ahern, 1999; Carpenter, 2007). Bracketing should be done consistently throughout the research process, and not only during the data collection and analysis phase (Chan, Fung, & Chien, 2013). There may be a small bias during this reflective process involving self-reflection and self-awareness of knowledge or experiences in the area of burnout (Ahern, 1999). The researcher would inevitably influence the research process even if the researcher puts aside assumptions, but bracketing could help minimise the influence of the researcher throughout the research (Chan et al., 2013).

In phenomenological research, questions should not be predetermined as the researcher should ideally follow the participants' prompts because questions might be leading into consciousness (Ray, 1994). Semi-structured focus groups using prepared open-ended questions and with primed probes could be used in this sort of inquiry (Morse & Richards, 2002). The questions should not be directive but rather steer the discussion; the researcher could probe further based on the responses (Lindlof & Taylor, 2002; Smith, J.A. & Osborn, 2003). The researcher needs to approach the process with an open mind and curiosity, which allows the participants to express themselves freely (Chan et al., 2013).

The list of open-ended questions were prepared as a guide. It consisted of research questions that considered a range of issues that needed to be covered in the research focus groups and that were developed around the research aims (Chan et al., 2013). These guiding questions were based on items in the MBI-GS and ProQOL 5, which are discussed in detail in Section 3.3.1.

The guide is a good basis for preparing questions that should be covered in the focus groups. It can also assist one in thinking about questions to pursue an area of interest in a manner that

still allows the participants to elaborate or further introduce new issues that were not covered by the researcher (Chan et al., 2013). The questioning or interviewing process, which was incorporated in the current study, started with open-ended questions followed by probing questions based on what was said to ensure clarification or allow elaboration or probing of interesting issues that arose (Lindlof & Taylor, 2002; Chan et al., 2013).

Focus groups were used in this study using the phenomenological approach as part of the burnout group coaching intervention for burnout amongst Generation Y medical doctors working in the public sector in Limpopo Department of Health. Focus groups can be between one and two hours with six to 12 participants (Krueger, 2000; Morgan 1997). The current study had one group consisting of ten participants. The focus group session lasted about 4.5 hours. The rationale for this size was to include enough participants to yield diversity in information and to avoid having a group that is too large, which would make some participants feel uncomfortable in sharing their thoughts and feelings (Krueger, 2000; Morgan 1997). It also allowed for findings to still be valid even if there were dropouts. The group had one focus group session in Phase II and a final session in Phase III.

The participants were given notepads to make notes if they so wished to do so. The notepads were for their own personal use and not part of the analysis of data. The researcher brought extra notepads in Phase III for the participants in case they did not bring their original notepads and wanted to make notes.

I audio-recorded and later transcribed the two focus group sessions, which were used as part of the data analysis process. I made reflection notes after each session, which were typed and also used as part of the data analysis process.

3.3.2.1 Phase I: Pre-coaching intervention for burnout in Generation Y medical doctors

i. Description and process of Phase I, Session 1

The process of Phase I, Session 1 entailed the following:

- Applying for ethical approval at the academic institution and the setting where the study would take place.
- Doing a literature review and having a panel discussion with burnout specialists to finalise the coaching intervention for burnout amongst Generation Y medical doctors.
- Selecting 16 willing Generation Y medical doctors who met criteria at the hospital in the Limpopo Province to participate in Phase II and Phase III of the study.

A literature review was done and a panel discussion was held with clinical psychologists who are burnout specialists. The inputs and literature were incorporated to finalise the group coaching intervention for burnout amongst Generation Y medical doctors.

I obtained ethical approval at my own academic institution. Furthermore, I was granted written approval as the researcher by the hospital's ethics committee to access and conduct the study with the Generation Y medical doctors (see annexure A). The hospital ethics committee also communicated with the managers of the Generation Y medical doctors so they would be open to the process.

The clinical manager called a meeting for 30 Generation Y medical doctors who met the first three basic criteria for participation (between 25 and 35, with an MBChB degree, and employed at the public health sector hospital in the Limpopo Province for more than 12 months). I was present at this meeting. I would measure the last criterion, namely, a high level of burnout, as part of Phase I at this meeting using an MBI-GS. The clinical manager introduced me to the

Generation Y medical doctors in the room, gave a brief overview of my research, encouraged participation, and explained that participants or non-participants would not be victimised.

The clinical manager left the room to ensure that participants were relaxed and that they did not feel pressured to participate. I presented my background and introduced the study. I continued by talking about the research aims, motivation for the study, requirements from participants, and the process. I emphasised that it was their choice to participate, and that confidentiality and anonymity would be maintained in the study. I explained the criteria for participation and stated that I required 16 participants. I further explained the other selection process, which was to use the MBI-GS to determine the final criterion, namely, a high level of burnout. Questions from participants were answered whereafter I excused the non-interested Generation Y medical doctors and thanked them for their time. They were given a chance to leave the room. Eighteen interested Generation Y medical doctors remained behind.

The remaining Generation Y medical doctors were interested in the study and met the age, working experience and qualification criteria. Informed consent was discussed and signed by all. They were handed the questionnaire, which included the MBI-GS. The MBI-GS was used to screen objectively for participants who met the final criterion to participate in the study, which was a high level of burnout.

The questionnaire included a biographical section that had to be completed together with the inventory (MBI-GS). The biographical section comprised the following:

- Name (could be a pseudonym).
- Contact details (mobile number and email address).
- Date of birth.
- Age.

- Gender.
- Marital status (various statuses were provided for selection).
- Race.
- Qualifications.
- Which year did you graduate at medical school (MBCbB degree)?
- How long have you been working at the hospital?
- Which rotations have you covered at the hospital? (A list of possible rotations was provided so that the participant could tick appropriate rotations.)
- State your current rotation. How long have been there?
- Where was your previous rotation? For how long?
- Which rotation at the hospital was the most challenging emotionally? List some challenges you have experienced. How did you resolve the challenges? Did the challenge affect your regular presentation at work?
- Why did you become a medical doctor?
- How do you feel about being a medical doctor now and why? Any regrets?
- What would you like to see at the hospital for medical doctors?
- Did you have many sick leave days at any particular rotation? State the number of days taken for the rotation.
- Indicate the number of breaks taken per year. (Options of certain periods were given for the participant to select.)
- What is your average resting time in a day? (Options of certain periods were given for participant to select.)
- Caseload per week. (Options of certain numbers were given for participant to select.)

- Burnout is a metaphor often used to describe a process of mental or emotional exhaustion secondary to work:
 - i. Do you think you have experienced or are experiencing burnout secondary to work? (Y/N).
 - ii. If answered Y for (i); list some of the experiences or challenges you have experienced that led you to that conclusion.
 - iii. If answered Y for (i); how long did you experience these for? Did you attempt to deal with them?
 - iv. If answered Y for (i); how did you deal with them? Do you believe you dealt with them successfully?

I collected the questionnaires and answered any questions regarding the research. I described the process going forward and that the MBI-GS would be scored for everyone. I explained that there would be a random list with all the potential participants who met the final criterion, namely, a high level of burnout as determined by the MBI-GS.

I clarified that the potential participants would be contacted telephonically from the random list until I had 16 willing participants for the study. The 16 willing participants would also be given a date for a follow-up meeting where they would sign a consent form and be given details of the next phase. I answered any questions regarding the study. Once all questions were dealt with in the meeting and the process clarified, the Generation Y medical doctors were dismissed. Screening was done two weeks before the envisaged Phase II.

I scored the 18 questionnaires and checked that the other criteria (age between , qualification, working experience over 12 months in the South African public health sector) were met based on the biographical section. Based on the MBI-GS score, all 18 participants had high burnout scores, and they were added to a random list. Following a discussion with my supervisor, a

decision was made to invite all 18 participants to participate in the study as they would still fit typical focus group criteria (Creswell, 2013).

I phoned the purposively selected 18 potential participants according to the random list to acquire participants for the study. All were willing and committed to participate in Phase II and Phase III. The willing participants were randomly allocated into two groups of nine participants. They were given potential dates, times, and venues for the various focus group sessions as well as my contact details. The sessions were scheduled at venues outside the hospital. I played a dual role as researcher and coach in the process.

3.3.2.2 Phase II: Coaching intervention for burnout amongst Generation Y medical doctors

Phase II comprised the group coaching intervention process in three sessions (Session 2 to Session 4) for the selected 18 participants (in two groups of nine selected from Phase I). The identified Generation Y medical doctors who met the criteria were exposed to the burnout coaching intervention.

Due to the process that unfolded as discussed in Chapter 5, Phase II sessions had to be adjusted, which changed from three focus group sessions to a single session (Session 2) of 4.5 hours with one group of ten participants. Chapter 5 explains some challenges that led to participants cancelling their attendance and the need to adjust the group coaching intervention for burnout amongst Generation Y medical doctors.

i. Description and process of Phase II, Session 2

The process of Phase II, Session 2 entailed the following:

- Signing informed consent for participation and audio-recording.
- Understanding Generation Y medical doctors' experience of burnout.

- Doing psycho-education to increase awareness of burnout.
- Establishing the burnout conflict dimension that participants struggle with the most.
- Exploring and describing thought and cognitive processes associated with the events and the experience of burnout.
- Exploring feelings experienced by the participants.
- Exploring and discussing positive or negative reactions to the events that lead to burnout.
- Discussing symptoms secondary to the event and the reactions.
- Understanding coping strategies used previously and identifying maladaptive coping mechanisms.
- Obtaining perceptions of the situation or coping ability and appraisals.
- Increasing resistance towards burnout, improving coping strategies, increasing awareness of self and reactions, and doing appraisals to promote self-care, and prevent and manage burnout.
- Facilitating the reduction of emotional exhaustion while promoting coping strategies for the current and future experiences.
- Giving feedback of group coaching intervention sessions and their experience.

The aims of Phase II, Session 3 and Session 4 were also incorporated in Session 2:

- Increasing resistance towards burnout, improving coping strategies, increasing awareness of self and reactions, and doing appraisals to promote self-care, and prevent and manage burnout.
- Facilitating the reduction of emotional exhaustion while promoting coping strategies for current and future experiences.

- Practising coping strategies and evaluating learning.
- Exploring feelings experienced by the participants.

ii. Phase II, Session 2: Introduction

Ten of the 18 participants who were initially keen to participate arrived for the group session two weeks after the completion and scoring of the MBI-GS. I explained the need to adjust Phase II sessions from three focus group sessions to a single session (Session 2) of 4.5 hours. The group agreed to it. The informed consent form was explained whereafter it was signed by the participants. The informed consent form discussed the aim of the study and the participation criteria. It further emphasised what the research involved and clarified the role of the participants who were being exposed to a group coaching intervention and would then be required to share their experiences. The aims of the different phases were explained:

- Phase I: Selecting the participants by using an objective tool.
- Phase II: Exposing participants to the group coaching intervention for burnout in focus groups.
- Phase III: Focusing on sharing experiences of the group coaching intervention for burnout.

The potential long-term aim was to create a voice that is supported scientifically. This could initiate discussions to hopefully address any overwhelming burnout experiences that were stated. Additionally, knowing the experiences would give an indication of the burnout coaching intervention needs of Generation Y medical doctors. Being aware of the experiences could contribute to determining whether the group coaching intervention for burnout is beneficial. It could be adapted specifically for Generation Y medical doctors in the public health sector

hospital in Limpopo, which would in turn benefit medical doctors and beneficiaries of their services.

Furthermore, discussion of the informed consent form highlighted that the questions in the focus groups would be open-ended discussions of participants' experiences at work that are linked to burnout. The MBI-GS inventory allows feelings that are linked to burnout to be rated. This led to me stressing that being in the study is voluntary and that no one was under any obligation to consent to participating and that they could withdraw at any time and without giving a reason.

Anticipated inconveniences of taking part in this study were discussed. I mentioned that no permanent risks were envisaged but there could be some emotional discomfort while sharing information. Should there be any discomfort, there was a network of professionals in Limpopo Province that the participants could explore for emotional support. I also mentioned that there was a possibility that participants who were severely affected by burnout could relive trauma when hearing about patients or that they could present with other overwhelming challenges. I indicated that I was a trained clinical psychologist and would be able to observe and refer them accordingly. The participants were further informed of the possibility of such emotions being imminent. They were made aware that they were allowed to quit the study and that there were referral systems available to them.

Confidentiality was discussed. I explained that the focus group sessions would be recorded for use during data analysis. I mentioned that the recordings of the focus groups and consent forms obtained would be regarded as confidential. I added that the findings would be published or presented in such a way that individuals would not be identifiable. Names would not be recorded anywhere and no one would connect the participant to the responses as they will be given a fictitious code number or a pseudonym. Everyone will be referred to in the data, any

publications, or other research reporting methods such as conference proceedings using their code or pseudonym. I added that apart from myself, the supervisor would also have access to the raw data. Furthermore, the answers could be reviewed by people responsible for ensuring that research is done properly, which include members of the Research Ethics Committee of the University of South Africa (Unisa). I stated that records that could identify participants would only be available to the researcher, supervisor, and the main people working on the study unless participants gave permission for other people to see the records. All these people would maintain confidentiality. The anonymous data could be used for other purposes such as research reports, journal articles, and conference presentation. A report of the study could be submitted for publication, but individual participants would not be identifiable in such a report.

I reiterated that it is sometimes impossible to make an absolute guarantee of confidentiality/anonymity when focus groups are used as a data collection method. A focus group is a qualitative interactive data collection method. A facilitator facilitates an open-ended discussion to give respondents the opportunity to answer and structure their thoughts, experiences, perceptions, and attitudes towards the topic. While I made every effort to ensure that no person could be connected to the information shared during the focus group, I cannot guarantee that other participants in the focus group would treat information confidentially. I did, however, encouraged all participants to do so. For this reason, I advised participants not to disclose personal and sensitive information to the focus group. I explained that hard copies of questionnaires would be stored for a period of five years in a locked cupboard/filing cabinet at the researcher's office for future research or academic purposes.

Future use of the stored data would be subject to further research ethics review and approval if applicable. The recordings would be destroyed after five years and the consent forms and the

completed inventories would be shredded. I underlined that no payment or reward was offered, financial or otherwise, for participation in the study.

I explained that the study received written ethical approval from the Research Ethics Committee of the College of Economic and Management Sciences, Unisa; and that a copy of the approval letter can be obtained from myself. I added that the study further received approval and permission from the hospital in the Limpopo Health Department; and that a copy of the hospital's approval and permission letter can be obtained from myself.

I mentioned that I could be contacted if anyone wanted to be informed of the final research findings. I explained that the findings would be reported in the form of a thesis and likely to be published in future. I mentioned that participants were welcome to contact me about any aspect of this study. If they had any concerns about how the research has been conducted, they could contact my supervisor. I explained that I would contact the group after the last focus group session to set up an appointment when the data collected has been transcribed and analysed to ensure that the analysis was a true reflection of what was said in the focus group. Further explanation and briefing of the research process were done. The actual steps for the two sessions and their requirements were discussed.

Once informed consent was signed and discussed, formal introductions were done and the group members gave their preferred pseudonyms. Goals were set at the start of the session to ensure that there was no discrimination or disorganisation in the group. The basic focus group rules included that I would be both facilitator and coach. I reiterated the need to respect the other participants and their processes and to give one another a chance to talk. Confidentiality and anonymity needed to be maintained; therefore, it was important not to take the focus group discussion and share it with others outside the group. Participants were encouraged not to share too personal information. I alerted them of reminders of the last session and how I would

appreciate their attendance. I also informed them to arrive 10 minutes before the start of the focus group, and to excuse themselves if they are not able to make the appointment. I repeated that they could withdraw from participation without giving a reason. I then answered any questions the participants had.

Other rules were as follows:

- There should be opportunity for all participants to speak: the coach would call on a person to speak.
- Everybody in the group is there to grow and therefore there is no right or wrong answer.
- Pseudonyms would be linked to the responses. No proper names will be in the findings to protect group members' identities.
- The sessions would be audio-recorded, and I would take notes during the session. Reflection notes would be made after each session.
- Participants could make their own notes on the notepads provided, but there was a need to protect the real names if direct quotes are made.
- Some experiences expressed are very personal and these should remain in the group.
- If someone is uncomfortable or feeling uneasy, please let me the facilitator know.

The process for the session was described. The process would explore certain aspects such as emotions, thoughts and coping strategies. This would be followed by action plans that could be applied outside the focus group environment.

iii. *Phase II, Session 2: Exploration of the three burnout dimensions*

The following subsection provides the structured guiding questions for the intervention based on the MBI-GS and ProQOL questionnaires. The first three groups of questions were based on the MBI-GS and the last group on the ProQOL.

The first group of questions and focus of the intervention were on emotional exhaustion, which is described as a state of reduction of mental and psychological resources (Maslach & Jackson, 1986; Nuallong, 2013); the first and most discernible sign in the manifestation of burnout (Milićević-Kalašić, 2013). The following were asked for the emotional exhaustion dimension (the focus group general guiding questions are given below followed by the actual question and the actual item from the questionnaire in italics):

1. Describe the feelings you experience as a result of work. Describe how work makes you feel emotionally.

(I feel emotionally drained from my work – Item 1)

2. Let us explore the feelings at the end of day. How would you describe the feeling at the end of your workday?

(I feel used up at the end of the workday – Item 2)

3. How do you usually feel when you get up in the morning to come to work?

(I feel fatigued when I get up in the morning – Item 3)

4. Describe what working with people the entire day does to you. Depending on the answers, the researcher would then follow up with: Would you say that working with people puts a strain on you? If yes, how so?

(Working with people all day is really a strain for me – Item 6;

Working with people directly puts too much stress on me – Item 16)

There was a short discussion about their understanding of burnout. I used a flipchart to explain burnout based on Maslach and Jackson (1981) and the proposed process model based on Leiter and Maslach (1988). The explanations on the flipcharts basically emphasised that burnout according to Maslach and Jackson (1981, 1986) is a three-dimensional construct that consists of three core components and manifestations; namely, increased emotional exhaustion, depersonalisation or cynicism/negative attitude towards several issues (especially clients), and an increased tendency for negative evaluation of self as lacking professional accomplishment or competence. Additionally, I explained Leiter and Maslach's (1988) process model of burnout, which begins with emotional exhaustion, often leads to depersonalisation, and subsequently to reduced personal accomplishment.

The three dimensions were described briefly. Emotional exhaustion symptoms were mentioned, such as tiredness or emotional exhaustion, somatic symptoms, decreased emotional resources, and a feeling that one is depleted and overextended (Helkavaara, 2013) with nothing left to give at a psychological level (Milićević-Kalašić, 2013). The group was told that according to the process model, emotional exhaustion is the strain dimension and comes before increased cynicism and reduced feelings of personal accomplishment (Leiter & Maslach, 1998).

Secondly, depersonalisation or cynicism/negative attitude was described as the development of a negative cynical insensitive attitude and feelings about clientele, including detachment from work, which often leads to patients, work and/or relationships in the job being viewed in a dehumanised manner (Nuallong, 2013; Ryan, 1971). In extreme cases, the dehumanised view of patients leads to a view that patients are not worthy of their services (Maslach et al., 1996).

In this component, there seems to be a severe move towards the negative. Professionals present with indications such as undesirable health; diminished energy; feeling detached; pessimism or being critical; or destructive outlooks of work, organisation, or other employees (Maslach et al., 1996).

The last dimension was discussed. Reduced accomplishment or personal inefficiency is a negative perception of personal accomplishment, loss of competence and productivity, plus the inclination to evaluate prior or existing accomplishments negatively at work (Maslach & Jackson, 1981) or negative view of self-efficacy (Evers et al., 2002); basically viewing of self in a negative manner especially in relation to one's work with clients and a feeling of dissatisfaction about accomplishments on the job (Maslach et al., 1996). Lastly, I emphasised that if negative views persist, employees are at risk to experience a view of self as an extreme failure (Fink, 2007). After the discussion, the following were asked:

1. From the explanations and your understanding of burnout, would you say that you feel burnt out from your work? Give a full description of the experience of burnout. What is your individual experience of emotional exhaustion, depersonalisation and personal accomplishment, if there are any?

(I feel burnt out from my work – Item 8)

2. Are there specific events or causes that you link to your experience of burnout (be it emotional exhaustion, depersonalisation and personal accomplishment)? Be as detailed as possible. How has this experience affected your life? Provide details of areas that have been affected.

3. Let us look at your job and what it does it does to you. How do you feel about your job?

(I feel frustrated in my job – Item 13; I feel I'm working too hard on my job – Item 14)

4. Do you feel you have strength to carry on in this job, the environment and circumstances?

(I feel like I'm at the end of my rope – Item 20)

The second group of questions and focus of the intervention was on cynicism or depersonalisation, which follows emotional exhaustion according to the process model (Leiter & Maslach, 1988) and it is negative affectivity, which often leads to a defensive reaction (Maslach et al., 2001; Schaufeli, W.B., 2003; Shirom, 2009); it is the interpersonal context dimension of burnout (Nuallong, 2013). The following were asked for the depersonalisation dimension:

1. Certain coping mechanisms are used by various individuals. Describe any other manner in which you find yourself treating patients. Do you find yourself treating patients as if they were impersonal objects to cope? Explain.

(I feel I treat some patients/clients as if they were impersonal objects – Item 5)

2. Looking back to how you were before qualifying and now, describe what has happened to your feelings towards people? Wait for responses. Follow up with: Do you have concerns about been hardened emotionally?

(I've become more callous (unfeeling) towards people since I took this job – Item 10;

I worry that this job is hardening me emotionally – Item 11)

3. State and elaborate on your level of care to the outcome of some of your patients.

(I don't really care what happens to some patients/clients – Item 15)

4. Do you feel blamed by the patients for some of their problems?

(I feel that patients/clients blame me for some of their problems – Item 22)

Reduced accomplishment or personal inefficiency is the final dimension such as emergence of a lack of involvement at work and low personal accomplishment. It is a self-evaluation dimension referring to feelings of insufficiency and lack of competence (Maslach & Leiter, 2008). The following were asked for that dimension:

1. Do you believe that you have an understanding of how your patients feel about things?

(I can easily understand how my patients/clients feel about things – Item 4)

2. Do you deal with all of the problems your patients have effectively?

(I deal very effectively with the problems of my patients/clients – Item 7)

3. From your experience, do you believe that your work is influencing other people's lives positively?

(I feel I'm positively influencing other people's lives through my work – Item 9)

4. Looking at your energy levels, what has the experience been like for you?

(I feel very energetic – Item 12)

5. Think back to your interaction with patients. Are you able to create a relaxed atmosphere with them? What makes it difficult if so? What makes it easier?

(I can easily create a relaxed atmosphere with my patients/clients – Item 17)

6. Looking at you work, has there ever been a time when you were able to feel overjoyed after working with patients? If so, are you still able to feel this euphoria now?

(I feel exhilarated after working closely with my patients/clients – Item 18)

7. Describe the number of worthwhile accomplishments in this job.

(I have accomplished many worthwhile things on this job – Item 19)

8. Are there a number of emotional problems that you need to deal with in the work environment? How often do they occur? Describe how you deal with them.

(In my work, I deal with emotional problems very calmly – Item 21)

The following questions focus on compassion fatigue and burnout factor items used for focus group questions from the ProQOL. The following were asked:

1. Describe your feelings. Would you say you are generally happy? Would you describe yourself as connected to others?

(I am happy – Item 1, burnout factor;

I feel connected to others – Item 4, burnout factor)

2. Would you describe yourself as a sensitive person? Has it always been this way? Do you feel you are overly sensitive? Have you been told that you are overly sensitive? Give details of your experiences with traumatic cases that you see at work. What sort of cases? How did they impact on you? How did you cope?

(I am an unduly sensitive person – Item 29, burnout factor;

I am losing sleep over a person I help's traumatic experience – Item 8, burnout factor)

3. What is your experience of the amount of work? What do you think about the system or structure at work or generally at the hospital?

(I feel overwhelmed by the amount of work or size of my caseload I have to deal with –

Item 21, burnout factor;

I feel bogged down (too much drawn into my work) by the system – Item 26, burnout factor)

4. How do you feel about being a helper now?

(I feel trapped by my work as a helper – Item 10, burnout factor;

I like my work as a helper – Item 12, compassion fatigue factor;

My work makes me feel satisfied – Item 18, compassion fatigue factor;

I get satisfaction from being able to help people – Item 3, compassion fatigue factor;

Because of my work as a helper, I feel exhausted – Item 19, burnout factor;

I believe I can make a difference through my work – Item 22, compassion fatigue factor)

5. How do you feel about where you are?

(I am the person I always wanted to be – Item 17, burnout factor)

6. What is your feeling towards being a helper? How do you feel about your future as a helper?

(I plan to be a helper for a long time – Item 24, compassion fatigue factor;

I have thoughts that I am a ‘success’ as a helper – Item 27, compassion fatigue factor;

I am happy that I chose to do this work – Item 30, compassion fatigue factor)

7. How do you deal with the work and pressure or events that lead to the negative experiences above? How do you cope? What are the positives and negatives? Suggest any better way of coping?

(I have beliefs that sustain me – Item 15, burnout factor;

I have more energy after working – Item 6, compassion fatigue factor;

I have happy thoughts and feelings about those I help and how I could help them – Item 18, compassion fatigue factor)

iv. *Phase II, Session 2: Coaching on coping strategies*

Burnout is the result of dysfunctional coping; therefore, appraisals of work, self, stress, and ability to cope are important (Lazarus, 1966) as well as the need to develop adjusted coping strategies. The group discussed beneficial coping strategies that created an awareness of maladapted coping strategies. Based on what the Generation Y medical doctors struggled with the most, the researcher gave examples of negative coping strategies. Normalisation was done of the burnout experience, which was followed by psycho-education of beneficial coping strategies used before and alternative ones using visual aids.

The following were asked to elicit and discuss coping strategies and view/perceptions of situations:

1. Describe the situations or events that cause negative (such as burnout) and positive experiences within you that happens in your work environment? Describe the experiences in detail.
2. What have you done previously in an attempt to cope with these negative situations or events that often lead to negative experiences?
3. What is your view of your ability to cope or deal with the situations/events that lead to the negative experiences?
4. Describe the support you have for your experiences.

The questions were followed by a discussion of negative and alternative coping strategies. I wrote the responses on flipchart paper, starting with a typical situation/event that often leads to burnout based on the participants, the negative coping strategies that were used before as

suggested by the participants, and possible alternative coping strategies as discussed in the group. There was also a discussion on why the coping strategies were considered negative or why they were seen as positive or beneficial.

v. *Phase II, Session 2: Termination of session*

There was a summary of the discussion around burnout and the experiences of the Generation Y medical doctors. Furthermore, the negative coping strategies used by the Generation Y medical doctors were discussed and alternative coping strategies were suggested to be attempted in the work context until the next session.

There was a reflection of feelings at the end of the session and a discussion of the lessons learned. A feedback process was done to deepen the Generation Y medical doctors' experiences of the intervention. The participants were each asked the following:

1. Describe how you are feeling following the session?
2. What have you learned?
3. What will you embrace and what do you think you will remember the most?

To conclude the session, there was action plan discussions for the weeks before the next session; this was done with the hope to have an ongoing process even after the session. The needs for the next session were discussed, which were practising or applying the coping strategies until the next session. The venue, time and date for Phase III Session 3, which was originally session 5, were discussed. The availability of the researcher in-between sessions was discussed and the session was closed.

3.3.2.3 *Phase III, Session 3: Post-coaching intervention for burnout*

i. Phase III, Session 3

The aim of Phase III was to elicit experiences after the group coaching intervention for burnout amongst the Generation Y medical doctors and to assess the overall effect based on their level of burnout. The burnout level was evaluated using the MBI-GS. Also, the burnout group coaching intervention, the positives, and lessons learned were evaluated. The action plan for future prevention and intervention was discussed.

ii. Phase III, Session 3: Introduction

Everyone was welcomed to the session. All participants were reminded of the rules set previously to ensure that there was no discrimination or disorganisation in the group (see Section 3.3.2.2, p. 147). The researcher described the process that would be followed during the session to explore emotions, thoughts and coping strategies after the previous session. This would be followed by action plans that participants could apply outside the session.

iii. Phase III, Session 3: Exploration of experiences, challenges and assumptions and self-assessment

There was an exploration of emotional exhaustion, depersonalisation and personal accomplishment following the Phase II session. The following questions were used to elicit and explore the emotions and experiences of burnout following exposure to the group coaching intervention for burnout amongst Generation Y medical doctors:

1. Describe the experiences of the past weeks.
 - How were the past weeks?
 - Describe the experiences of burnout (being emotional exhaustion, depersonalisation and personal accomplishment) following the intervention.
2. Describe any negative experiences or events or challenges at work in detail.
 - What emotions or feelings did the experiences elicit?
 - How did you cope?
 - Were there any opportunity to attempt to use the coping strategies discussed previously?
 - Any challenges with the coping strategies?
 - What were the results?
 - How were you feeling after your attempt at coping?
 - How are you feeling now?
 - Looking back, was it the best or better way to cope if any? Explain why or why not?
 - Should you add or remove anything from your coping strategies that you used?
 - What would one be the best way to handle these challenges going forward?
 - What should be used for you to cope in future?
3. What are the views of others? What should the person add or remove from their coping strategies? Elaborate. Were there old non-beneficial coping strategies used?
4. Describe your feelings.
 - Would you say you are generally happy?
 - Would you describe yourself as connected to others?
 - How are you feeling in the morning about going to work?
 - Are there any changes following the last session? Elaborate.

(I am happy – Item 1, burnout factor;

I feel connected to others – Item 4, burnout factor ProQOL)

5. How do you feel about being a helper now? How do you feel about your future as a helper?

(I feel trapped by my work as a helper – Item 10, burnout factor;

I like my work as a helper – Item 12, compassion fatigue factor;

My work makes me feel satisfied – Item 18, compassion fatigue factor;

I get satisfaction from being able to help people – Item 3, compassion fatigue factor;

Because of my work as a helper, I feel exhausted – Item 19, burnout factor;

I believe I can make a difference through my work – Item 22, compassion fatigue factor;

I plan to be a helper for a long time – Item 24, compassion fatigue factor;

I have thoughts that I am a success as a helper – Item 27, compassion fatigue factor;

I am happy that I chose to do this work – Item 30, compassion fatigue factor)

6. How do you feel about where you are?

(I am the person I always wanted to be – Item 17, burnout factor)

iv. *Phase III, Session 5: Objective evaluation of burnout levels*

The MBI-GS was completed and it was compared with the Phase I score in the analysis to determine if the intervention reduced burnout levels.

v. *Phase III, Session 3: Evaluation of the coaching intervention*

Each participant was asked the following:

1. Describe the experience of the coaching intervention for burnout.

2. What did you struggle with in the coaching intervention? What did it lack? What are the challenges you have with it?
3. What would you add or change to the coaching intervention you were exposed to? State your reasons.
4. What would you always remember from the experience? Lessons learned?

vi. Phase III, Session 3: Termination and way forward

The discussion around burnout and the experiences of the group coaching intervention amongst the Generation Y medical doctors were summarised. The negative and alternative coping strategies that should be applied in the work context were discussed. The group reflected on their feelings and the lessons learned. Feedback process was done to deepen the Generation Y medical doctor's experience of the intervention.

The following were asked to each participant to achieve this:

1. Describe how you are feeling following exposure to the coaching intervention for burnout?
2. What have you learned?
3. What will you take forth and what do you think you will remember the most?

To conclude the session there was a discussion of possible future stressors and anticipated ways of coping. There was action plan discussions for each individual for future coping strategies. Participants should attempt to elicit self-management in order to prevent, manage and intervene burnout in order to cope now and in the future with the hope of ongoing processing even after the closure of the sessions.

The last session of the group coaching intervention was then closed. I thanked everyone who participated. I explained that after the data collected has been transcribed and analysed, I would contact the group to set up an appointment to ensure that the analysis is a true reflection of what was said in the focus group. The participants were reminded about the information in the consent form. This included recapping that participants who wanted to be informed of the final research findings. I gave them my contact details. I explained that the findings would be accessible 6 months after collection of data. I mentioned that participants could contact me if they required further information about any aspect of this study. If they had any concerns about the way in which the research was conducted, they could contact my supervisor.

3.4 Conclusion

There are generally limited burnout interventions with empirical evidence (Haiten et al., 2007; Hemmeter, 2013; Le Blanc & Schaufeli, 2008; Maslach et al., 2001; Sorenson et al., 2016; Werneburg et al., 2018) as emphasised in the chapter. The current study was divided into three phases. Phase I of the study was the pre-coaching intervention for burnout amongst Generation Y medical doctors; Phase II was the coaching intervention for burnout amongst Generation Y medical doctors and, lastly, Phase III was the post-coaching intervention for burnout amongst Generation Y medical doctors. The study was done in three phases over a seven-month period and the focus of the overall group coaching intervention was at the individual level. Summarised description of the process followed in the phases is given.

Phase I of the study in summary included the ethical approval application, literature review and organisation of the group coaching intervention for burnout amongst Generation Y medical doctors, and selection of participants for Phase II and III following signing of consent form and completion of the Maslach Burnout Inventory (MBI-GS). The ethical approval and literature search to develop a proposal and a group coaching intervention among generation Y medical

doctors was done a year prior to the commencement of focus groups. Once ethical approval was achieved (see annexure A), the group coaching intervention finalized, entry given, and generation Y medical doctors identified in Limpopo Province; session one of Phase I was arranged. Following completion of consent form and questionnaire, and termination of the session, scoring was done by myself over 3 days. Participants for Phase II were contacted and the session for that phase arranged 2 weeks' post termination of Phase I session.

Phase II comprised the actual implementation of the coaching intervention for burnout amongst ten Generation Y medical doctors. The group coaching intervention had to be adjusted for the ten available participants and it was one focus group 4.5 hours long instead of three focus groups.

Phase III targeted to elicit descriptions of the experiences by the Generation Y medical doctors after the coaching intervention for burnout and to evaluate the overall effect of it. This was done in a focus group session six months after the termination of the intervention in Phase II. Burnout intervention studies usually recommend 3 months or more to evaluate impact (Ruiz, 2019). Six participants from the ten in Phase II attended. Their descriptions of their experiences and their objective measures of burnout from the MBI after the intervention were used as empirical evidence for the group coaching intervention for burnout amongst Generation Y medical doctors.

I aimed to elicit coping strategies for burnout using the group coaching process for the Generation Y medical doctors. The group coaching intervention focused on Generation Y medical doctors and their experiences in an attempt to strengthen their values towards their work and to enhance coping within the context of the medicine field in the South African public health sector. The exploration of their experiences of burnout and focus on self-management in the coaching intervention hoped to elicit an adaptable inner coping style to help Generation

Y medical doctors deal with their work reality in the public health sector and the consequent burnout.

The current study aimed to additionally give empirical evidence of a group coaching intervention for burnout amongst Generation Y medical doctors working in a public sector in South Africa based on their descriptions of the coaching intervention and the objective burnout measure post-intervention. I am of the view that there will be a need to incorporate findings from the current coaching intervention into a bigger burnout intervention strategy in the public sector in South Africa, which would involve all the stakeholders at the different levels in order to ensure that burnout is combatted in the future on a long-term basis.

This group coaching intervention in the study could be an essential step in stimulating discussions about burnout in the public health sector in Generation Y medical doctors as well as its preventions, management and intervention. This study hoped to empower Generation Y medical doctors leading to benefits in the self, the work environment improving the perception of work and promoting chances of the public health sector becoming a preferred employer. Of course, much work still needs to be done to address the public health sector infrastructures.

Intervention for burnout could assist in reducing turnover of Generation Y medical doctors; it could reduce the risk of them leaving the profession prematurely and permanently, and improve their personal lives, which could have been affected negatively by the experience of burnout. This study hopes to increase awareness: generally, of the occurrence of burnout and its serious implications, hopefully leading to discussions in the public health sector about burnout intervention, management or prevention.

3.5 Chapter Summary

This chapter introduced literature that emphasised the lack of properly designed scientific and effective interventions specified for burnout in the various at-risk populations including Generation Y medical doctors. It further examined the limited empirical evidence of the available recommended burnout management, treatment and prevention interventions. Lastly, it concluded by giving the foundation for the group coaching intervention used in the study, which focused on the individual level. It further provided detail regarding the coaching intervention for burnout in Generation Y medical doctors that was used in the current study.

The general aim of the research was achieved mainly in the process described in this chapter. Additionally, the chapter reviewed the group coaching intervention for burnout in order to see its applicability and benefit to Generation Y medical doctors working in the public health sector in South Africa.

CHAPTER 4: RESEARCH METHODOLOGY AND DESIGN

4.1 Introduction

This chapter discusses the research design, which is a strategy that stipulates the methods and procedures for collecting and analysing data (Creswell, 2013, 2016). As part of the research design, the chapter elaborates on the research approach, research strategy and the research method for the study. The research method section touches on the research setting, entrée, research roles, sampling, data collection method, data collection procedure, and analysis.

The chapter furthermore expands on the strategies employed to ensure quality data. This includes discussing trustworthiness of qualitative research, credibility, transferability, dependability, confirmability, and ethical considerations. The chapter ends by describing reporting in the current study.

4.2 Research Approach

I used a convergent mixed methodology that combined qualitative and quantitative approaches during this study (Creswell, 2013; Creswell & Creswell, 2018). Mixed methodology is a form of triangulation in which different types of data or collection methods provide cross-validity (Creswell & Creswell, 2018; Patton, 1990). The current study was mostly qualitative and used the descriptive phenomenological method from an interpretive paradigm. Focus groups were used for data collection to achieve this. At the same time, it adopted and included a quantitative approach to an extent by incorporating the completion of a survey (MBI-GS) as a part of the method of data collection, which falls within the positivism paradigm.

A paradigm signifies assumptions and beliefs researchers have in common regarding the nature and conduct of research (Kuhn, 1977; Lincoln, Lynham, & Guba, 2011). The paradigm denotes

the philosophical, theoretical and methodological aspects of the research (Mouton, 2001; Lincoln et al., 2011). A research paradigm is a comprehensive system of interrelated practices and thinking that outlines the nature of inquiry along three scopes: ontology, epistemology, and methodology (Terre Blanche, M., Kelly & Durrheim, 2006).

Gephart (1999) classified research into three paradigms: positivism, interpretive and critical post-modernism. These are fundamental philosophical epistemological assumptions that guide or influence research. Whether the paradigm chosen is positivistic, interpretive or constructionism, each shapes the manner in which research is conducted and each perspective has propositions regarding the world view (Henning, Van Rensburg, & Smit, 2004).

Ontological and epistemological aspects emphasise the world view as either objectivistic or constructivist, which affects the apparent position of reality (Lather, 1986). Lather's (1986) view is that paradigms reflect beliefs about the world we live in or want to live in. Guba (1990) stated that the paradigm or world view is principles that guide action. Paradigms vary according to the set of principles and change repeatedly (Creswell, 2013).

Qualitative researchers make certain philosophical expectations that consist of a stance towards ontology, which is the nature of the reality and emphasise the epistemology. This is how researchers know what they know (Creswell, 2013; Creswell & Creswell, 2018). Further roles of the values, namely, the axiology, language or rhetoric, and methodology used in the process (Creswell, 2003) are some suppositions made by researchers in qualitative work. The philosophical postulations reflect a specific viewpoint taken by researchers when they choose qualitative research and shape their research by bringing in paradigms or world views (Creswell, 2013; Creswell & Creswell, 2018).

Qualitative researchers aim to study entities in natural situations. Their aim is to make sense of, or to understand phenomena in terms of the meaning people bring to them. It consists of

interpretative practice that makes the world perceptible (Creswell, 2013; Creswell & Creswell, 2018; Denzin & Lincoln, 2003). The qualitative phenomenological methodology was relevant in the current study as it attempted to understand people in terms of their own definitions of their worlds (Denzin & Lincoln, 2003; Giorgi, 2009; Moustakas, 1994).

Conversely, quantitative researchers aim to quantify and objectify data. The nature of reality assumed by positivism seen in quantitative research is pragmatism; implying that reality is assumed to exist (Creswell & Creswell, 2018; Guba & Lincoln, 1994). The positivism view was taken to some extent as part of the study in order to quantify the level of burnout in the participants before and after the group coaching intervention was implemented. Collecting data in two different manners was an effort to enhance the findings and give a more comprehensive analysis (Creswell & Creswell, 2018).

In this study, I used the descriptive phenomenological approach (Giorgi, 1985, 1997) as a specific scientific orientation, which led to a reliance on the interpretive paradigm. Because it was a convergent mixed methodology (Creswell & Creswell, 2018), I incorporated a positivistic approach, which led to a small inclusion of the positivistic paradigm (Gephart, 1999). I deemed the interpretive paradigm as applicable as it is centred on understanding and pursuing sense from individual experiences (Mason, 2002), which was the aim of the study: to describe Generation Y medical doctors' experiences of a group coaching intervention for burnout. The positivistic paradigm was important to help objectify the level of burnout before and after implementing the group coaching intervention and to validate the data by triangulating the methods (Guba & Lincoln, 1994; Mertens & Hesse-Biber, 2012). Triangulation assisted with establishing validity in the study.

4.2.1 Interpretivist paradigm: Descriptive phenomenology

4.2.1.1 Phenomenology

This section introduces phenomenology, which was the precise orientation within the interpretive research paradigm. Researchers such as Giorgi (1985, 2009) developed phenomenological research. There are several phenomenological approaches to choose from that emphasise describing a lived experience (Garza, 2007; Moran, 2000).

A descriptive empirical phenomenologist researcher position (Finlay, 2008) was taken in the current study in an attempt to describe the experience of a group coaching intervention for burnout by Generation Y medical doctors. This position was appropriate in this research as I aimed to get descriptions of the experience of a lived phenomenon (Finlay, 2008), namely, the Generation Y medical doctors' experiences of the coaching intervention for burnout.

Other phenomenology researcher positions that share a similar focus of describing lived experience (Finlay, 2008) include but are not limited to: lived experience (Van Manen, 1990), interpretative phenomenological analysis (Smith, J.A. & Osborne, 2003), life world (Ashworth, 2003; Dahlberg, Dahlberg, & Nystrom, 2008), and heuristic researcher (Moustakas, 1990). Husserl (Husserl, 1998/1913), one of the founders of phenomenology, was followed by others with varying philosophical suppositions but that seem to rest on the common fundamental view (Creswell, 2013) that studies are lived conscious experiences of people (Van Manen, 1990) and that gather explanations of the experiences and not explanations or analyses (Moustakas, 1994).

I did not fully take a 'pure' phenomenological approach (Lindseth & Norberg, 2004) but rather endorsed the descriptive phenomenological approach. This allowed for description of Generation Y medical doctors' experiences of the group coaching intervention for burnout. The

descriptive phenomenology methodological structure guided the research design, methodology and interpretation of data in this research project.

Defining features of phenomenology includes emphasising the phenomenon to be explored, which is phrased in a single concept (Creswell, 2016). I needed to identify a specific concept or phenomenon to study. The phenomenon in the current study was experiences of a group coaching intervention for burnout amongst Generation Y medical doctors. I had to collect data from individuals in a group. The size of the group could be between three and 15 people who experienced the phenomenon. The aim was to answer how they experienced it (Creswell, 2016). The exploration of the phenomenon in this study was with a group of Generation Y medical doctors who were exposed to the group coaching intervention for burnout. The context within which the phenomenon needed to be understood was the South African public health sector.

Phenomenology requires some understanding of comprehensive philosophical postulations. These are abstract concepts that researchers need to identify in research projects (Creswell, 2013). Phenomenological studies centre around description of the common meaning for individuals of their lived experiences of a phenomenon (Creswell, 2013). The emphasis is on expressing what participants have in common as they experience the phenomenon and with the intended purpose to consolidate the individual experiences of a phenomenon to a description of the universal essence (Creswell, 2013). In other words, it is based on the impression that lived experiences of people involve subjective as well as objective experience of sharing with others.

Bracketing out is important in phenomenology studies: it is not possible to be completely unbiased, but I discussed my personal experience with the phenomenon so that I would be able to report on the experiences of others. I aimed to report on the essence of the shared experience

of the phenomenon, namely, the common experience of the group coaching intervention for burnout amongst Generation Y medical doctors. Several steps were followed to achieve this, such as identifying common statements and themes, and obtaining descriptions of their experiences within the context (Moustakas, 1994).

I as the researcher and coach identified a phenomenon and collected information from the identified Generation Y medical doctors who experienced the coaching intervention and worked on developing a multi-factorial description of the essence of the experience of all individuals (Creswell, 2016). The multi-factorial description consisted of what they actually experienced and how they experienced it (Moustakas, 1994).

Philosophical presumptions of phenomenology exist; these include the need not to have presumptions as a researcher (Stewart & Mickunas, 1990). In this approach, one needs to rid all judgements and biases, which is a process called bracketing according to Husserl (Stewart & Mickunas, 1990).

Phenomenology research holds a subjective-objective perspective that is not fully accepted and implies that it lies between qualitative and quantitative research (Stewart & Mickunas, 1990). Flowing from this is the refusal of subject-object dichotomy and phenomenology that emphasises that the reality of an object is only perceived within the meaning of the subjective experience of an individual (Stewart & Mickunas, 1990).

I bracketed myself continually by discussing personal experiences with the phenomenon. It did not take me completely away from the research but it did help me to be aware of personal experiences, which I set aside so I could focus on the participants' experiences in the study.

Giorgi (2009) saw bracketing as important: it is not aimed at forgetting past knowledge but rather being aware of it so it does not affect the course of determining experiences. It is not

easy though ideal; however, readers ultimately decide whether the researcher focused purely on the participants' descriptions or whether they brought themselves into the picture (Creswell, 2013; Moustakas, 1994; Van Manen, 1990).

4.2.1.2 Descriptive phenomenology

This section introduces descriptive phenomenology as the explicit orientation within this research paradigm. In this study, I used the descriptive phenomenological approach as the scientific orientation (Giorgi, 1985; Mayoh & Onwuegbuzie, 2013). Descriptive phenomenology was deemed appropriate because when applied to research, a phenomenological method is the interpretive approach to the study of the phenomenon, its nature and meanings (Finlay, 2008). The interpretive paradigm stands to be sensitive to the social setting involving the view of individuals and their unique interpretations, understandings and meanings as a primary source of data (Mason, 2002).

The aim of this type of phenomenological research is to describe the lived world in a way that expands understanding of the human being's experience (Dahlberg et al., 2008; Vagle, 2014). The challenge for the researcher is to help participants express their world as directly as possible and to clarify such that the lived world is uncovered (Finlay, 2008; Vagle, 2014). Meanings are exposed based on how the researcher poses questions as well as their attitude. The researcher should aim to be open to seeing the world differently and emphasise not how things are, but how they are experienced (Dahlberg et al., 2008; Finlay, 2003). The aim is to allow the phenomenon to represent itself without preconceived ideas; this requires openness to be maintained throughout the process of discovery (Finlay, 2008; Vagle, 2014). This seemed to be adequate based on the aim of the current study of lived experiences of the group coaching intervention of burnout amongst Generation Y medical doctors.

4.2.2 Positivism paradigm

Walsham (1995) stated that the positivism position suggests that scientific knowledge is made up of facts and reality. According to the same author, ontology supports the idea that reality is independent of social construction. This means a researcher should adopt an objective perspective with a belief in objective and realist ontology. Additionally, the researcher should have a disconnected epistemological position based on the conviction that knowledge is real and perceptions can be right or wrong (Crowther & Lancaster, 2008; Easterby-Smith, Thorpe, & Jackson, 2008; Walsham, 1995). The educational basis for old-fashioned instruction is supported by this pragmatist and objective view of information. The nature of reality assumed by positivism is realism, which implies that reality is assumed to exist (Guba & Lincoln, 1994; Ramanathan, 2008).

I incorporated to a small extent a positivistic approach (Crowther & Lancaster, 2008; Easterby-Smith et al., 2008; Gephart, 1999) because the study used a convergent mixed methodology (Bryman, 2006; Creswell & Creswell, 2018; Shannon-Baker, 2015). Quantitative researchers aim to quantify and objectify data (Crowther & Lancaster, 2008; Easterby-Smith et al., 2008; Guba & Lincoln, 1994). This approach was incorporated to quantify the level of burnout in the participants before and after the group coaching intervention. In view of the paradigms, I further explain the ontological assumptions leading to epistemological and then methodological assumptions in the next session.

4.2.3 My ontological, epistemological and methodological perspectives

This study, being mixed methodology, incorporated ontological, epistemological and methodological perspectives from largely an interpretive paradigm and, to some smaller scale, a positivism paradigm. Ontology establishes the framework, reality or target of the study (Nel, 2007), namely, the philosophy concerned with articulating the nature and structure of the

world or reality that is studied (Terre Blanche, M., Kelly & Durrheim, 2006; Wand & Weber, 1993).

Walsham (1995) stated that a positivistic stance maintains that scientific knowledge is based on facts with its ontology seeing reality as being independent of social construction; therefore, the world (or reality) can be predicted, identified and manipulated. A positivism view implies that the researcher adopts an objectivistic perspective (realist ontology), a belief in an objective world, and a detached epistemological stance based on the belief that people's perceptions are either true or false, thus indicating a possible methodology that rely on the control or manipulation of reality (Walsham, 1995). Generally, the pedagogical foundation for traditional styles of teaching is reinforced by this realist and objectivist view of knowledge (Collins, 2010; Walsham, 1995). Critics of interpretive constructionism and critical post-modernism emphasise the need for subjectivity when interpreting social reality; hence, offered alternative theoretical, methodological and practical method to research (Gephart, 1999).

A modified objectivistic perspective (called post-positivism) was introduced. It mentions that although the object of inquiry exists outside and independent of the human mind, it needs to be perceived with total accuracy by our observations (Creswell, 2013; Given, 2008; Phillips, 2009). In other words, even if total objectivity is sought after, it is not always achievable; it is an important ideal to regulate scientific knowledge.

Thereafter, critical realistic ontology was introduced (Cook & Campbell, 1979), which led to the need to balance experimental and quantitative methods with qualitative methods to gather broader information especially outside readily measured variables (Gephart, 1999). This critical realist ontology (Cook & Campbell, 1979) included post-positivism, a modified objectivists perspective suggesting that classical post-positivism (Given, 2008), though ideal, could be limited for regulating exploration for information as complete objectivity is not

possible to achieve. Therefore, positivism was supplemented by the need to use qualitative methods to gather comprehensive information (Gephart, 1999).

Walsham (1995) argued that interpretive tradition has no correct or incorrect theories. Willis (1995) added that this view promotes that there is no single correct method to obtain knowledge. The interpretive approach derives constructs from the field by an in-depth examination of the phenomenon of interest (Walsham, 1995). It is concerned with understanding the world from subjective experiences of individuals using meaning (versus measurement) oriented methodologies such as interviewing that rely on a subjective relationship between researcher and participants (Reeves & Hedberg, 2003).

Positivism was partially adopted in the study to evaluate the objective level of burnout in participants. A realist ontology implying a belief in an objective was taken together with a disconnected epistemological stance and methodology. Positivism suggests that the researcher should adopt an objective perspective as the study is of a stable and unchanging reality (Crowther & Lancaster, 2008; Easterby-Smith et al., 2008; Walsham, 1995).. In contrast to positivism, the interpretive framework is based on the belief that reality consists of people's subjective experiences of the world; therefore; an intersubjective epistemology may be adopted together with the ontological belief that reality is socially constructed (Crowther & Lancaster, 2008; Easterby-Smith et al., 2008; Walsham, 1995). This study brought together positivism and an interpretive framework in the different phases of the study.

An idiographic approach was taken in the current study. This is an all-inclusive representation that attempts to describe experiences of participants, which is contrary to a nomothetic approach that examines large groups of participants to establish behaviour rules that can be generalised to larger populations (Barlow & Nock, 2009; Maykut & Morehouse, 1994).

4.2.4 Humanism paradigm

Rogers (1959, 1963) essentially proposed the meta-theoretical standpoint as an actualising tendency within human beings towards growth, development and optimal functioning. This humanistic perspective encourages a need to study people in their natural environments (DeRobertis, 2013). A qualitative approach is commonly used where a humanistic view is adopted (Whitley, 2002). In order to understand the Generation Y medical doctors' experience of the coaching intervention for burnout, I as the researcher adopted a humanistic paradigm that formed another boundary in this study.

The humanism paradigm views the person as capable of becoming their own best experts, which is relevant in the current study which focuses on intervening at a personal level (DeRobertis, 2013; Joseph, 2003, 2006). Some modern advances in psychology and other diverse areas, such as coaching, take on a humanistic standpoint even if at times there is no direct mention of humanistic psychology influence (DeRobertis, 2013).

A humanistic coaching approach was taken in this study together with a humanistic perspective of a human being's ability for potential growth, which can be elicited by a coach providing the right empathetic environment using certain skills. Some Rogerian attitudes, skills, and behaviours were adopted in the various phases of the study as part of the group coaching process in order to understand the Generation Y medical doctors' experience of the coaching intervention for burnout.

4.2.5 Theories adopted in the research study

4.2.5.1 Burnout

Leiter and Maslach (1988) proposed a process model of burnout, which begins with emotional exhaustion, often leads to depersonalisation and, subsequently, to reduced personal

accomplishment. Burnout is defined as a psychological response to chronic work stress, which is characterised by emotional exhaustion with depletion of emotional and physical resources, disengagement or detachment from the job, and reduced feelings of personal job-related efficacy (Maslach, 1982). This is typically a response to long-term exposure to job stressors (Maslach et al., 1996).

The consequences of burnout are potentially incredibly serious for workers, beneficiaries of their services, and the larger institutions where they interact (Maslach et al., 1996). Self-reporting scales have been used over time in various contexts and seem to be reliable when measuring burnout (Alarcon et al., 2009). This study used the MBI-GS to measure burnout objectively. Some questions in the inventory were adapted as part of the semi-structured questions in the coaching intervention for burnout in the Generation Y medical doctors. The scale was constructed by Maslach and Jackson (1981) and has various questionnaires for different settings.

4.2.5.2 Generational theory

It has become a trend as part of talent management strategies and management styles to adapt in order to accommodate generational differences in the workplace (Kane, L., 2018; Zemke et al., 2000). Research shows the importance of acknowledging generational differences and understanding the different generational values, perceptions and needs that influence management styles of a generationally diverse workforce (Hamori et al., 2012; Kane, L., 2018; Macleod, 2008; Petersen, 2019; Samra, 2019; Zemke et al., 2000).

Each generation is shaped by different events: events that shaped their values, attitudes, behaviours, personal and lifestyle characteristics, and perception of work (Generation Project, 2018; Kane, L., 2018; Macleod, 2008; Samra, 2019; Zemke et al., 2000). The theories are often based in other populations such as the United States, but South Africa has had unique

experiences that likely shaped South African generations differently. For example, born-frees who were born after the struggle of apartheid in South Africa are reportedly different than people born during the struggle (Mattes, 2012). These born-frees are classified as Generation Y (Kane, L., 2018; Macleod, 2008; Petersen, 2019) and the upcoming Generation Z (Horovitz, 2012; Kane, L., 2018).

Retaining Generation Y talent in the developing South Africa is generally challenging because of existing talent and skills shortages (Masibigiri & Nienaber, 2011; Samra, 2019). This implies that retaining Generation Y medical doctors in the medical profession and public health sector is likely to be even more challenging in South Africa. The burnout experience, often linked to occupational stress, with no intervention in the Generation Y medical doctors working in difficult conditions in the public health sector is likely to further influence or limit the ability to retain the Generation Y medical doctors negatively. This emphasises the need to have sound burnout coaching interventions for Generation Y medical doctors in the South African public health sector.

4.2.5.3. Stress and coping theories

Appraisals are seen as significant for coping and establishing active construction of reality (Mahoney & Patterson, 1992). Fortitude is described as the sum of three domains of appraisal: awareness of self, family environment, and support from others (Pretorius & Diedricks, 1994). This implies that the concept categorises perception or appraisal into three areas: self, family, and others. Fortitude is further influenced by perceived level of support, satisfaction with the support and beliefs about the efficacy of using the support (Pretorius & Diedricks, 1994). The three domains have been studied separately. There has been a suggestion that these actually represent wider domains, which are the interaction of the realms (self, family, support or others)

that institute fortitude, which is important for further research as well as intervention (Pretorius & Diedricks, 1994).

Human behaviour depends on coded stimuli that highlight the importance of individual perception, interpretation and experience of the world (Mischel, 1981). This outlook is compatible with Lazarus and Folkman's (1984) appraisal theory referred to generalised convictions that determine stress perceptions and response.

Although the convictions refer to self-convictions, it is likely that these could include general convictions about the world and others (Chang, Ferris, Johnson, Rosen, & Tan, 2011; Pretorius & Diedricks, 1994). Therefore, it can be hypothesised that when exposed to a stressor, those with negative appraisals of self, family and/or support are prone to self-doubt, perceptions of not being able to cope, and disengagement from active coping efforts (Chivaneh, 2013; Pretorius & Diedricks, 1994). On the other hand, positive appraisals of the self, family and support could lead to self-reliance when facing stressful demands and more problem-focused coping (Chivaneh, 2013; Pretorius & Diedricks, 1994). Burnout is linked to chronic work stress. It is a long-lasting psychological process (Maslach & Leiter, 1997) with an interplay of personal factors, coping ability and appraisal, environmental factors, and organisational context (Garrosa & Moreno-Jiménez, 2013; Panagioti et al., 2016).

There are individual differences at times in response to burnout. The process of the differences needs to be adequately researched (Garrosa & Moreno-Jiménez, 2013; Lemaire & Wallace, 2017). Maslach & Leiter (1997) state that burnout involves attitudes, self-appraisal and others in a work context. Furthermore, burnout requires emotional and personal competencies to manage the interaction. Generation Y medical doctors need personal resources, such as regulation of emotions, emotional resilience, attitudes to life, level of optimism, and emotional

competence (Garrosa & Moreno-Jiménez, 2013) to respond to the physical and emotional demands of their workplace experiences that often lead to burnout.

Burnout should not only be seen as a routine progression caused by the workplace on its own or chronic job stress, but should rather be explained as a complex interaction of individual differences, work orientations, attitudes, and social and familial environment (Garrosa & Moreno-Jiménez, 2013; Gitto & Trimarchi, 2016). This insight is linked to Lazarus and Folkman's (1984) appraisal theory, which is an interactional and transactional model of differential responses to stress. Appraisal theory firstly suggests a component of appraisal of the situation or context and, secondly, an appraisal of the available resources and ways to respond (Lazarus and Folkman 1984). Lazarus (1999) emphasised that the stress reaction is a cognitive appraisal of the stressor as a threat, challenge or damage/loss, and that it is linked to emotions as core elements. In other words, stress is an emotional response.

The MBI-GS that is used to obtain an objective level of burnout assesses emotional exhaustion as a dimension (Maslach & Jackson, 1981), which illustrates the importance of emotions as core elements of the stress response. Burnout as a process of chronic job stress provokes emotional work responses; therefore, it is crucial to understand the type and effect of emotional responses (Gitto & Trimarchi, 2016; Garrosa & Moreno-Jiménez, 2013). Linking to the transactional process of stress from Lazarus and Folkman (1984): the work response to stress is likely to induce complex emotions that are consequential to the transaction between the contexts and the person depending on perceived meaning (Lazarus & Cohen-Charash, 2001).

Work stress based on this view could lead to exhaustion and other emotions (Gitto & Trimarchi, 2016; Garrosa & Moreno-Jiménez, 2013; Lemaire & Wallace, 2017). This exhaustion as the core of the emotional syndrome in burnout could also be due to an interactive and accumulative complex number of emotions such as sadness, disillusion, despondency, tedium, resignation,

irritation, or hopelessness. From this, burnout is seen not as a response to exhaustion, but rather as a multi-faceted emotional, transactional reaction, which rests on the person's systems of meanings, the situations, and work occurrences. At the same time, burnout syndrome cannot be reduced to just an emotional syndrome even though it is an important aspect (Gitto & Trimarchi, 2016; Garrosa & Moreno-Jiménez, 2013; Lemaire & Wallace, 2017). In understanding burnout one realises that burnout is linked to coping: its occurrence and maintenance is due to an inability to cope and it is not so much chronic job stressors but rather the poor ability to manage them successfully (Garrosa & Moreno-Jiménez, 2013).

Stress and coping are two independent processes. There are several models or theories that explain stress development and ways of coping with stress. It has been suggested that burnout could be the result of an interaction between the processes of stress and coping (Leiter et al., 2009). Lazarus and Folkman (1984) proposed two categories of coping, namely, problem-focused and emotional-focused coping. Problem-focused coping is usually aimed at changing the situation whereas emotional-focused coping is aimed at changing a person's cognitions and emotions. Both coping mechanisms are used depending on the context (Lazarus & Folkman, 1984). Research has been growing to define more specific, concrete approaches of coping, which has increased the number of theories regarding coping (Aldwin, 2007; Chivaneh, 2013).

Pines, A.M. (2009) proposed that coping with burnout is either active whereby effort is made to change the causes of burnout or passive whereby the situation is avoided. Cherniss (1980b) suggested a third coping mechanism, namely, distancing or avoidance, which is a defensive way of coping. Studies by Schaufeli, W.B. and Enzmann (1998) showed that avoidance coping is linked to emotional exhaustion and depersonalisation; active coping is linked to personal accomplishment; problem-solving focus is related to decreasing the stressor; and emotional-focused coping is linked to increased strain (Chang et al., 2011; Chivaneh, 2013). Forms of

coping have been found to come not necessarily from the direct nature of the problem but from personal styles (Chivaneh, 2013; O’Driscoll et al., 2009). Therefore, variation is seen in certain studies of coping strategies as situation specific and coping style, which are indicative more of steady personal traits.

The present study took a theoretical standpoint that burnout is the result of dysfunctional coping (Schaufeli, W.B. & Enzmann, 1998). The study aimed not to determine strategies or coping styles of Generation Y medical doctors but rather to investigate Generation Y medical doctors’ in-depth experiences of a group coaching intervention for burnout in order to explore its benefits and applicability to promote an adjusted coping process.

4.3 Research Strategy

This section introduces the research strategy used in the current study. It was a mixed convergent methodology study that used triangulation methods, which combined quantitative and qualitative methods that implied using both a positivism paradigm and an interpretive paradigm (Creswell, 2003, 2013; Creswell & Creswell, 2018; Mertens & Hesse-Biber, 2012; Shannon-Baker, 2015).

The study was mostly based on a qualitative research strategy approach and to a smaller extent incorporated a quantitative strategy. The rationale for combining quantitative and qualitative methods in this current study was to triangulate in an attempt to get a full picture of the phenomenon being studied (Kopala & Suzuki, 1999; Shannon-Baker, 2015). The phenomenon was the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors. The study was done in three phases, namely:

- Phase I – Pre-coaching intervention;
- Phase II – Coaching intervention; and

- Phase III – Post-coaching intervention.

4.3.1 Qualitative research strategy

There are various methodologies that either typically conform to a positivistic/scientific or interpretivists/anti-positivism paradigm (Galliers & Land, 1987; Shannon-Baker, 2015). Galliers and Land (1987) suggested 14 methodologies overall for either paradigm. I largely used a descriptive/interpretive methodology and overlapping collective case study methodology (Galliers & Land, 1987; Yin, 2002) as I used a phenomenology approach to describe the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors. It was a collective case study (Mouton, 2001; Zucker, 2009) based on a group of Generation Y medical doctors employed at a hospital in the Limpopo Province.

There are multiple definitions and understandings of a case study. According to Bromley (1990:302), a case study is a “*systematic inquiry into an event or a set of related events which aims to describe and explain the phenomenon of interest*”. Case studies are often seen with qualitative approaches.

According to Yin (1994, 2002), the case study design necessitates research question(s), its intentions, unit of analysis, idea how to link data to intentions of research, and interpretation of findings’ criteria. The number and type of case studies depend on the purpose of the inquiry (Stake, 1995; Yazan, 2015). An instrumental case study could be used to provide insight into an issue; an intrinsic case study to gain a deeper understanding of the case; and a collective case study to inquire about a particular phenomenon using a number of cases (Stake, 1995). The researcher is expected to record, construct, present, and produce a profile or facts while clarifying and producing the history, meanings and understandings (Stake, 1995).

The current study used a phenomenological approach and a collective case study to provide a general understanding using a number of instrumental cases (Harling, 2002). The phenomenon can be many different things: a programme, event, activity, problem, or individual(s) (Harling, 2002). The purpose of case study research may be exploratory, descriptive, interpretive, or explanatory (Mariano, 2000; Yazan, 2015; Yin, 2002). Other no less important implications include the impact of the method itself on moving the description of a phenomenon to intervention (Zucker, 2009). For this study, the phenomenon was the group coaching intervention for burnout experienced by Generation Y medical doctors. This study focus was on describing the experiences of the phenomenon by the Generation Y medical doctors as a collective.

4.3.2 Quantitative research strategy

I used survey methodology by incorporating the MBI-GS (Maslach & Jackson, 1981) to get an objective measure of the level of burnout in the Generation Y medical doctors. This meant that as it was a convergent mixed methodology approach, a certain portion of the study fell within a quantitative approach. The quantitative approach is characterised within the positivism/scientific paradigm (Galliers & Land, 1987; Ramanathan, 2008). The shortcoming of using this method alone is that it can limit the understanding of insights related to the causes or processes involved in the phenomenon (Galliers & Land, 1987; Ramanathan, 2008). Hence, I chose to incorporate it with a qualitative approach. This enabled me to understand the Generation Y medical doctors' description of the experiences of the group coaching intervention fully in conjunction with the objective level of burnout before and after the intervention in order to get a better understanding of the experiences of the intervention and actual impact on the level of burnout of Generation Y medical doctors.

The MBI-GS was used as part of data collection in all three phases of the study. In Phase I, it was used to assist in the evaluation and to give an objective measure of the level of burnout, which was the final criterion for selecting participants for the study. In Phase II, some MBI-GS questions were adapted and used as semi-structured guiding questions as part of the burnout coaching intervention. In Phase III, the MBI-GS evaluated the level of burnout post-exposure to the group coaching intervention for burnout. I scored the MBI-GS in Phase I and Phase III. The quantitative findings of the level of burnout were useful to validate the qualitatively explored findings of the study and to provide cross-validity checks and vice versa (Patton, 1990).

4.4 Research Method

4.4.1 Research setting

The research setting for all the three phases of the study was a Department of Health hospital in the Limpopo Province where the participants, being the Generation Y medical doctors, were employed for more than 12 months. The participants were aged between 25 and 35 (born between 1981 and 1991) and considered Generation Y (Kane, L., 2018; Macleod, 2008), with medical degrees (MBCChB), and high levels of burnout as measured by the MBI-GS in Phase I of the study.

The Generation Y medical doctors are exposed to the inherent public health sector challenges and stressors in their job environment. They are placed in the following five major rotations: psychiatry, family medicine, obstetrics and gynaecology, internal medicine, and paediatrics. They are expected to rotate every 10 weeks in these five major areas. When placed in a specific rotation, they are expected to be on call (working a 24-hour shift) every third weekday and at times over alternate two weekends. Following a 24-hour shift, the Generation Y medical doctors work half-day the following day.

As interns and medical doctors serving their community years, the Generation Y medical doctors are supervised by specialists in their areas of placement. The Generation Y medical doctors participate in ward rounds, present academic case studies, and run clinics and mortality meetings where the prevention and cause of death are discussed under supervision. If placed in a certain area, they need to see the patients in the various wards and casualty. For example, they see paediatric patients in other wards, such as oncology, orthopaedics, burn unit, renal, casualty or intensive care unit.

Their key performance areas include target number of patients, service delivery, outreach, self-development for competence, and skills improvement (Dr Shoyeb, personal communication, Sept. 20, 2013).

4.4.2 Entrée and establishing research roles

The researcher is the crucial instrument of data collection in qualitative research (Creswell, 2003, 2007, 2013). I as the researcher and coach in the study aimed to be a voice for the participants and intended to be open-minded by entering the field with an open curious stance with my own judgements suspended (bracketing) while developing insight into the experiences (intuiting) (Creswell, 2007, 2013). As the researcher, I had different roles throughout the process, which included being an interviewer to collect data, being a clinical psychologist to be aware of any severe presentations in the participants that could lead to a need for referral, and being a coach to facilitate the group coaching intervention for burnout additionally analyse and interpret the data. As preparation for these roles, I engaged in thorough self-examination and mastered interpersonal and communication skills; furthermore, data analysing and interpretation skills (De Vos, Strydom, Fouché, & Delpont, 2005).

I chose to do the study at the hospital in the Limpopo Province due to its possible accessibility, available number of Generation Y medical doctors, and familiarity with the setting. Access was

obtained following ethical approval at my own academic institution and the hospital's ethics committee. The hospital's ethics committee granted me written approval as the researcher to access and conduct the study with the Generation Y medical doctors. The study was classified as a psychological risk at a low level (see approval letters in annexure A). Communication from the hospital's ethics committee was also given to the managers of the Generation Y medical doctors so they would be open to the process.

4.4.3 Sampling: Phase I, Phase II and Phase III

The purposive sampling approach was used as the criterion for the relevant participants to be selected in terms of the research question (Babbie & Mouton, 2010). The aim of the study was not to generalise across a larger group of Generation Y medical doctors but rather to understand their lived experiences of the group coaching intervention for burnout.

For Phase I – Pre-coaching intervention for burnout in Generation Y medical doctors – I as the researcher applied for ethical approval at my academic institution and hospital where the study would take place. It was approved by both institutions and I was given access. I did a literature review and had a panel discussion with clinical psychologists who has experience working with burnout about the proposed group coaching intervention. The panel comprised of four clinical psychologists. There was a professor who has been researching burnout; supervising psychology and medical students; training, supporting and offering intervention for health professional students in the Limpopo Province since 2005. There was additionally in the panel clinical psychologist who was a doctorate graduate, another a doctorate student who had submitted their thesis awaiting results and lastly one working on their PHD proposal. All four were joint appointees employed in the health department and at the university, additionally running part time practices. They were involved with training and supporting all health professionals in the Limpopo Province including medical students, registrars and specialists in

the Limpopo Province. They additionally were involved in different research topics including burnout in medical doctors. Their inputs were noted and incorporated into the proposed group coaching intervention for burnout in Generation Y medical doctors.

When the group coaching intervention was finalised, I approached the clinical manager at the hospital who then called a meeting for purposively selected Generation Y medical doctors who met the three main research criteria. The initial three criteria for participation in the study were Generation Y medical doctors between the ages of 25 and 35 (born within 1981 and 1991), with medical degrees (MChB), and who have been employed at a hospital by the Department of Health in the Limpopo Province for more than 12 months. Exclusion criteria was age above 35 or less than 25, period of employment in the public health sector in the Limpopo Province that was below 12 months and an incomplete medical degree.

Thirty possible participants showed up for the meeting. The hospital's clinical manager greeted everyone and briefly explained the potential study and that its intention was to assist them. After the introduction, the clinical manager left the room to reassure confidentiality and not hamper the Generation Y medical doctor's willingness to participate in the study. I gave a brief background of myself and the motivation for the study. I explained the planned research process and my expectations of the participants, and emphasised that there was no coercion to participate. I emphasised the choice to participate, and that confidentiality and anonymity would be maintained. After opening the floor to questions, non-interested Generation Y medical doctors were given a chance to leave the room.

Twelve doctors left the room and 18 interested Generation Y medical doctors remained behind to complete the informed consent form and questionnaire which included an MBI-GS. After collecting the forms, I explained the next step of the process, whereafter the meeting was terminated. The next step was scoring the MBI-GS and calling participants who met the last

criterion for the next phase, namely, a high level of burnout. The aim was to have 16 willing participants.

The MBI-GS were scored. All 18 participants who completed the MBI-GS had a high burnout score, which meant that they met the last criterion for participation, namely, a high burnout level score based on the MBI-GS. Sixteen participants who were willing to talk about their experiences were needed to form two random focus groups of eight participants each. A typical sample size is between five and 25 participants who have direct experience with the phenomenon being studied (Creswell, 2013). As all 18-people met the final criterion for participation, and 18 was still within the maximum sample size of 25, a decision was taken after consultation with the supervisor to invite and include all 18 Generation Y medical doctors in the focus groups. There would be two groups of nine participants.

A random list of the 18 participants was drawn up. The potential participants were contacted telephonically two days after the meeting according to the random list. They were informed that they met the criteria and asked about their interest in participating in the study. All doctors were keen to participate in Phase II and III. They were told which group they were randomly assigned to. They were given the potential date, time and place for the first focus group. I explained that they would have to sign an informed consent form and that there would be 18 participants instead of 16, therefore nine in a group.

Phase II – the coaching intervention for burnout amongst the Generation Y medical doctors – commenced. The 18 participants were meant to attend four sessions in their individual groups. Each focus group was envisaged to run between one and two hours. Instead, due to certain challenges that are elaborated in Chapter 5, the coaching intervention had to be adjusted. There were ten available participants who attended a single focus group session that lasted 4.5 hours as one group.

Six months later, six of the ten participants attended Phase III – post-coaching intervention for burnout amongst Generation Y medical doctors. It consisted of a final focus group and completion of the MBI-GS.

4.4.4 Data collection method

Convergent mixed method data collection (Creswell & Creswell, 2018) was used, which combined MBI-GS within the context of focus groups (Mertens & Hesse-Biber, 2012). Data was collected in phases by means of focus group discussions (Krueger, 2000; Rubin & Rubin, 1995). To assist in data collection, there were observational notes made of participants' non-verbal cues and the dynamics and process between the participants in the focus groups. The focus groups were audio-recorded (Creswell, 2003, 2007). I used facilitative communication techniques such as probing, paraphrasing and summarising with minimal verbal responses (Burns & Grove, 2005). Data was collected in the focus groups in the different phases until the sample had been saturated as was evident by repeating themes (Poggenpoel, 2000). The discussions were open-ended to allow the respondents the opportunity to answer and structure their thoughts in several dimensions (Krueger, 2000).

Phase I was aimed at selecting participants for the group coaching intervention for burnout amongst Generation Y medical doctors. The MBI-GS forms were completed whereafter they were scored immediately to identify participants who met the criteria for Phase II and Phase III. Phase II was a focus group as part of the designed coaching intervention for burnout for ten identified Generation Y medical doctors from Phase I. During Phase III, the focus group discussed the process of the coaching intervention for burnout in Phase II and completed the MBI-GS to evaluate impact of the intervention.

4.4.4.1 Maslach Burnout Inventory: General Survey

The MBI-GS (Maslach et al., 1996) was used in the study as part of the questionnaire in Phase I. Questions were incorporated in the focus group discussion in Phase II and it was completed again in Phase III. The MBI-GS is a common burnout self-reporting scale used to screen professional burnout worldwide (Maslach et al, 1996; Kaschka et al., 2011; Liebenberg et al., 2018). Even though its validity has been criticised (Korczak et al., 2010), it is currently the most valid measurement method as participants report their own personalities, habits and level of burnout (Alarcon et al., 2009). It has been used by various South African researchers with similar populations (Peltzer et al., 2003; Liebenberg et al., 2018; Sirsawy, Steinberg & Raubenheimer, 2013; Thomas & Valli, 2006). Clinical validity of the MBI-GS was researched in one study which concluded validity of the 3- factor structure of MBI, partial differentiation of burnout from other syndromes and the ability to discriminate between burnout and non-burned out employees (Schaufeli, Bakker, Hoogduin, Schaap & Klader, 2001). Wheeler, Vassar, Worley & Barnes (2016) found that emotional exhaustion (EE) dimension subscale produces largest and most consistent coefficient alpha estimates with studies reporting values at or above 0.80; the depersonalization (DA) and personal accomplishment (PA) subscales were both lower and less consistent. Major implication is that although MBI-GS subscales provide adequate internal consistency for research purposes, none meet rigorous standard for diagnosis use. This implies that interpretation of subscales should be done cautiously additionally that MBI-GS scores, specifically the EE subscale even with the high coefficient alpha scores, should be used in applied research settings to categorize individuals but not recommended for clinical decisions.

The MBI-GS is a five-point rating scale that contains 22 items that represent three subscales for the three burnout factors: emotional exhaustion (nine items), depersonalisation (five items), and reduced personal accomplishment (eight items) (Maslach et al., 1996). Emotional exhaustion mostly describes job-related exhaustion feelings (score range 0–36); depersonalisation focuses on self-esteem and behaviours towards recipients of care (score range 0–20); and, lastly, reduced personal accomplishment focuses on the ability to cope with challenges of a people-focused environment (score range 0–32) (Maslach et al., 1996).

According to the manual, the three measures within the inventory are scored to indicate the level of burnout. A high burnout score is greater than 30 for emotional exhaustion, greater than 12 for depersonalisation, and less than 33 for reduced personal accomplishment (Maslach et al., 1996). Moderate burnout scores are between 18 and 29 for emotional exhaustion, between 6 and 11 for depersonalisation, and between 34 and 39 for reduced accomplishment (Maslach et al., 1996). Low burnout scores are less than 17 for emotional exhaustion, less than five for depersonalisation and greater than 40 for reduced personal accomplishment (Maslach et al., 1996).

The MBI-GS is used extensively in research applicable to human services though it was developed to include all workers and not specifically those in human service areas (Huang, Chuang, & Lin, 2003; Innstrand, Epnes, & Mykeltun, 2004). The MBI-GS has a three-dimensional description of emotional exhaustion, depersonalisation or cynicism, and reduced personal accomplishment or inefficacy (Maslach et al., 1996). The psychometric inquiries have shown emotional exhaustion, and not depersonalisation and personal accomplishment, as the only consistent dimension (Kaschka et al., 2011).

The MBI-GS was used in all phases of the study. In Phase I, it was completed by the potential participants as part of the questionnaire to assist with selecting participants for Phase II. The

MBI-GS was an objective measure of the last criterion for participation (high level of burnout). In Phase II, some MBI-GS questions for the three factors were adapted as guiding questions for the burnout coaching intervention. In Phase III, participants completed the MBI-GS so that the level of burnout after being exposed to the group coaching intervention could be determined objectively to evaluate the impact of the coaching intervention. Furthermore, the researcher evaluated the participants' subjective experience of the group coaching intervention in Phase III.

4.4.4.2 Phenomenology methodology in the focus groups

Three steps are suggested for phenomenological studies (Lindlof, 1995): Firstly, the researcher should be conscious of prejudices they hold about the object of the study; this awareness assists in deconstruction of the text. Secondly, the researcher brackets the text encountered without their preconceived notions. Lastly, the researcher groups data into clusters and synthesises the clusters into a unified arrangement with the intention of bringing the crux of the object to the surface (Lindlof, 1995).

According to the model used in the study and the MBI-GS, the burnout factors are emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach & Jackson, 1981). The ontological position taken in the study implied that experiences of the Generation Y medical doctors are meaningful social reality the research question was designed to explore. Another epistemological position affected the need to understand the experiences of Generation Y medical doctors by conversing with them (Mason, 2002). Qualitative interviewing used in the study led to an in-depth inquiry of the participants' experiences and there was constant bracketing of my own experiences as part of the phenomenological methodology. Phenomenological study targets to understand perception, perspectives and understanding of a particular situation; basically, answering what it is like to experience the phenomenon. As the

researcher, I wanted to gain a better understanding of the phenomenon, namely, the experiences of the group coaching intervention for burnout amongst Generation Y medical doctors.

I as the researcher and coach identified a phenomenon and collected information or data from the identified Generation Y medical doctors who experienced the group coaching intervention. I worked on developing a compound description of the crux of the experience for all individuals (Creswell, 2013; Creswell & Creswell, 2018). The multi-faceted description consisted of what they actually experienced and how they experienced it (Moustakas, 1994).

The self in qualitative descriptive phenomenological studies is a primary instrument for collecting and interpreting data (Creswell & Creswell, 2018; Terre Blanche, M., Kelly & Durrheim, 2006). Biases are expected in the entire process, but to reduce the negative impact of subjectivity on the data collection, interpretation and reporting, I continuously bracketed my own experiences as a researcher and further expressed the data explicitly and honestly while following sound research procedures.

4.4.5 Data collection procedure

The data collection procedure involved exposing Generation Y medical doctors to the phenomenon. As the researcher, I continually bracketed myself to be aware of personal experiences, which I set aside so I could focus on the experiences of the participants in the study (Giorgi, 2009).

4.4.5.1 Phase I: Data collection

Phase I data collection involved using an MBI-GS. The MBI-GS formed part of a short questionnaire completed by the potential participants that included biographical data and short questions about placement rotations at the hospital. The purpose of using the MBI-GS as part of the questionnaire in Phase I was to measure the levels of burnout in the 30 potential

Generation Y medical doctors objectively to identify keen participants who met the last criterion for participation (a high level of burnout determined by the MBI-GS scores). I as the researcher created profiles of the 18 participants in the focus groups based on the MBI-GS and the basic questions in the questionnaire. I further noted my observations and bracketed my perceptions, experiences and biases in the session.

4.4.5.2 Phase II: Data collection

Phase II data collection involved using MBI-GS questions to guide the focus group session for the group of ten participants. There were meant to be three focus group sessions for two groups of eight participants. However, due to the process that unfolded as indicated in Chapter 5, there was a single focus group session of 4.5 hours that was attended by ten participants. Unstructured qualitative guiding questions were used in the sessions where I as the researcher and the ten participants worked together to get a clear description of their experiences of the group coaching intervention (Tesch, 1990). The session was audio-recorded.

In Phase II, MBI-GS based questions were used as open-ended questions to elicit experiences of the three burnout factors amongst Generation Y medical doctors. Where participants did not understand or answered in a way that implied misunderstanding, the questions were rephrased. Based on the answers given, I had follow-up questions leading to in-depth description of the experiences of burnout. The group coaching intervention focused on eliciting coping mechanisms for burnout and discussions around beneficial coping mechanisms. Thereafter, individual participants were asked to describe their experiences of the coaching intervention for burnout in the focus group session.

A flexible spontaneous approach was adopted throughout to ensure that the conversation flowed naturally (Patton, 1990). Quieter participants were involved by asking their views to

ensure that their views were also heard in the group. The duration of the focus group session was 4.5 hours.

As the coach, I employed Rogers' (1959) skills in all phases, which included listening, reflecting, rephrasing, showing empathy, using encouragers, applying non-verbal listening skills, and having a non-judgemental attitude to ensure a facilitative environment for in-depth conversation with the participants. These skills were further incorporated to encourage elaboration, probing and clarification of the experiences especially when participants gave short answers. Questions such as "Will you please elaborate further?" were issued to participants to probe their experiences further.

I made observation notes during the focus group sessions in Phase II. After the sessions, I made session notes while reflecting. Bracketing was done throughout during this phase. I continually listened carefully to the verbal statements and noted the non-verbal activities as the participants described their experiences of burnout, awareness of consequences and attempt at coping if there was any. The raw verbatim data collected via audio recorders together with the noted observations were transcribed and checked by another researcher.

4.4.5.3 Phase III: Data collection

Phase III consisted of a final focus group six months after Phase II was completed to explore the experiences of the group coaching intervention for burnout amongst Generation Y medical doctors. This was audio-recorded as well. They were asked to describe how they continued to experience the intervention in their daily lives since Phase I. Their descriptions were noted verbatim.

The participants further completed the MBI-GS to elicit the objective level of burnout six months after the group coaching intervention for burnout was terminated. There was constant

bracketing of my biases throughout the process to suspend any preconceived notions or personal experiences that would unduly influence what I 'heard' the participants say (Leedy & Ormrod, 2015). Bracketing can be more difficult if one has experienced the phenomenon under investigation, but it is essential for the researcher to gain an understanding of people's typical experiences. The qualitative inquiry was used to collect the data required and to elicit experiences of the entire coaching intervention. The inquiry viewed the experiences of the group coaching intervention amongst the Generation Y medical doctors in all the focus group sessions and the time in-between the sessions.

I had a general plan of inquiry rather than a specific set of questions (Babbie, 2004). Unstructured guiding questions led to follow-up questions based on the responses to gather an in-depth description of the participants' experiences of the coaching intervention for burnout. Mason (2002) stated that this type of qualitative questioning is important and key in obtaining descriptions of individual's perceptions without leading with rigidly predetermined questions.

Where participants did not understand, or answered in a way that implied misunderstanding, the questions were rephrased. Based on the answers given, I had follow-up questions leading to a description of the experiences. An adaptable spontaneous method was adopted throughout to promote a natural flow of the conversation (Patton, 1990). Quieter participants were involved by asking their views to ensure that their views were also heard in the group. The duration of the final focus group was about 120 minutes.

When participants gave short answers, I used Rogers' (1959) skills to encourage further elaboration, probing and clarification of the experiences. Questions such as "Will you please elaborate further?" were issued to probe the participants' experiences further.

4.4.6 Data analysis

Recorded focus groups for Phases II and Phase III were transcribed verbatim and analysed using the descriptive analysis technique of Tesch (Tesch 1990). A literature control was performed to judge the findings of this current study by reflecting the findings in the light of present literature to establish similarities and differences, and to recontextualise the data appropriately to the research design (Creswell, 2003, 2007; Morse, 1994). Yin (1999) stated that with case studies, the standard is to do a case analysis by providing a detailed description of each case and to present the themes within the case. This, according to the same author, is followed by analysis of themes across cases, a cross-case analysis, and an interpretative phase, where the researcher reports the lessons learned from the analysis. This was the analysis approach for this study.

There are different views about literature theory and its place in case studies (Harling, 2002). Some theories are of the view that literature theory can be absent from studies that focus on describing the case and its issues (Stake, 1995) while others state that it guides the case study in an exploratory way (Yin, 1994, 2002).

Another view is that theory can be employed towards the end of the study. At this stage, it provides an after perspective in which other theories are compared and contrasted with the theory developed in the case study (Creswell, 2013). Harling (2002) viewed existing theory as the starting point to direct the initial set of questions asked by the researcher. The researcher, according to the same author, uses theory to filter and organise the data received, which confirms existing theory. Harling (2002) emphasised that the researcher should not allow existing theory to predetermine the findings. For this study, Harling's (2002) view of the use and significance of literature was incorporated.

4.4.6.1 Phase I: Analyses and interpretation of the data

I collected and scored the 18 completed surveys of the group of potential participants. Eighteen met the final criterion, which was a high level of burnout. All 18 Generation Y medical doctors were invited to participate. I studied the surveys of the 18 participants to understand them and to get an objective score to compare with the participants' objective scores in Phase III. Only ten of the 18 participants participated in Phase II, and six of the ten participated in Phase III. Their questionnaires formed part of the analysis at the end of Phase III.

4.4.6.2 Phase II: Analyses and interpretation of the data

As informed consent for recording has been signed, the session in Phase II was audio-recorded. I made observation notes during the different sessions for the two groups of participants and afterwards during reflection. Reflection was done following each session. Bracketing was done throughout this phase. The raw verbatim data collected via audio recorders together with the noted observations were transcribed and typed in Phase II as part of the analysis in Phase III.

Descriptive phenomenological analysis and coding were done to organise the data in Phase II. Observations were highlighted in the session of Phase II. Data was reread to further uncover deeper meanings of the Generation Y medical doctors' experiences of the group coaching intervention for burnout.

Data in Phase II was interpreted using the descriptive analysis technique suggested by Creswell (2003). Creswell (2013) suggested that after transcribing the interviews, statements should be identified that relate to the experience of the group coaching intervention for burnout amongst the Generation Y medical doctors. The actual views, thoughts and feelings of the intervention session and the practical application gathered from the Generation Y medical doctors were noted.

Secondly, I separated relevant and irrelevant information. The relevant information was broken down into smaller phrases or segments that reflected a specific thought. I grouped the statements into measurement units. Segments (the phrases or statements) were grouped into categories that reflected various meanings or aspects of the experience of the group coaching intervention as the process preceded and concluded in the last session. I then sought deviating viewpoints. This implied that I searched for various ways in which the different participants experienced the coaching intervention for burnout in the various focus group sessions.

Lastly, I focused on constructing a combination of viewpoints to develop an overall description of the group coaching intervention for burnout as the Generation Y medical doctors experienced it in the focus group sessions. The data in Phase II was verified and scrutinised by the participants to ensure that it was a true reflection of their experiences. Additions or changes were made where needed.

4.4.6.3 Phase III: Interpretation and analyses of the data

The final focus group was Phase III of the study. As an informed consent form for recording has been signed, the session in Phase III was audio-recorded. I made observation notes during the sessions and also afterwards when I was reflecting. Throughout the data collection process, I bracketed my experiences as this is an essential part of understanding the participants' experiences of the coaching intervention for burnout. The focus group questions were unstructured. I as the researcher listened carefully to the description of the experiences that related to the phenomenon.

The raw verbatim data collected was transcribed and typed as part of the analysis together with the noted observations. Descriptive phenomenological analysis and coding were done to organise the data. Observations were highlighted, which included non-verbal behaviours and expressions to add more depth to the collected information (Kelly, 2007).

Data was reread to further uncover deeper meanings of the Generation Y medical doctors' experiences of the group coaching intervention for burnout. Phenomenological data analysis required that I build on the research questions and work through the data transcripts. The same steps followed in Phase II were followed here. I highlighted the significant statements, sentences or quotes that provided an understanding of how participants experienced the group coaching intervention.

Moustakas (1994) referred to this first stage of analysis as horizontalization. I established clusters of meaning (Creswell, 2013, 2016) from the significant statements to form themes. This led to textural description: I used the significant statements and themes to write a description of what the participants experienced (Creswell, 2013, 2016). Based on the significant statements and themes I wrote a description of the context or setting that influenced how the participants experienced the group coaching intervention for burnout. This is referred to as imaginative variation or structural description (Creswell, 2013). Moustakas (1994) added that researchers need to write about their experiences, context and situations that influenced the experiences. I shortened this and reflected the personal statements at the beginning of the phenomenology or included them in the methods discussion of the role of the researcher (Creswell, 2013, 2016; Marshall & Rossman, 1999).

From the structural and textual descriptions I wrote a multi-faceted account, which is referred to as an essential invariant structure (or essence) (Creswell, 2013) to present the crux of the phenomenon focusing on the common experiences of the participants. This implies that all experiences have an underlying structure. This description could be one or two paragraphs that conveys an understanding of the feeling for the phenomenology and what it is like for the Generation Y medical doctors to experience the phenomenon (Polkinghorne, 1989). Analysis

involved searching for meaning units that reflected various aspects of the experience and integrating the units into a typical experience (Leedy & Ormrod, 2015).

A systematic data analysis was followed, which involved getting significant statements from the narrow unit of analysis, on to the broader meaning units, and finally detailed descriptions that focused on what was experienced and how it was experienced (Moustakas, 1994). This ended with a descriptive passage to discuss the essence of the experience of the Generation Y medical doctors emphasising the 'what' and 'how'. This essence is the culminating aspect of phenomenological study (Creswell, 2013).

The participants completed the MBI-GS in the final focus group. I scored the MBI-GS and compared the Phase III scores with the Phase I scores to further understand the participants' views of the group coaching intervention compared with the actual impact. The participants' views and experiences of the group coaching intervention in Phase II and Phase III were also compared with their objective scores of burnout.

The data collected was interpreted, findings drawn up, and linked back to the research problem. The interpretation and findings in Phase III were reviewed and linked to data in Phase II and Phase I. Additionally, the interpretation in Phase III was linked to literature. Conclusions were drawn regarding the experiences that Generation Y medical doctors had of the group coaching intervention for burnout. This analysis phase included outlining how aims were met, research questions answered, and discussions on whether the conclusions in relation to the formulated problem were met.

Recommendations were made for the group coaching intervention for burnout and for future research, and the limitations highlighted. Data, field notes and transcriptions will be stored safely for three years following conclusion of the study. The data in Phase III was verified and scrutinised by the participants to ensure that it was a true reflection of their experiences.

Additions or changes were made where needed. The analysis was verified and scrutinised by a second researcher, who is a clinical psychologist with experience in burnout. The clinical psychologist signed an informed consent form agreeing to maintain confidentiality of the data. The person is also bound by the Health Professions Council of Psychology ethical conduct.

4.5 Strategies Employed to Ensure Quality Data

Validity in qualitative research means that methods are applied to ensure accuracy of findings from not only the researcher but the participant and reader's account (Creswell & Miller, 2000; Gibbs, 2007). Reliability means establishing that the research approach is constant in other similar research projects (Gibbs, 2007).

Creswell (2013) deliberated that validation in qualitative research is implementing recognised validation approaches to document accuracy of studies by the researcher. In qualitative studies, the researcher is an instrument; therefore, credibility of the study rests upon their ability and determination (Golafshani, 2003). Validity, reliability, generalizability and objectivity are described in qualitative studies using strategies of trustworthiness (Lincoln & Guba, 1985; Sinkovics et al., 2008).

Lincoln and Guba's (1985) criteria are still commonly used, and terms applied adhere to more naturalistic research removed from positivistic research terms. The terms are credibility, transferability, dependability, confirmability and authenticity, which are alternatives to internal and external validation, reliability and objectivity (Lincoln & Guba, 1985).

Credibility, similar to internal validity, upholds that the researcher's findings are from the participant's perspective (Dyson & Brown, 2006; Lincoln & Guba, 1985; Sinkovics et al., 2008). Transferability, linked to external validity, is the ability to generalise the findings to similar settings as the study (Dyson & Brown, 2006; Lincoln & Guba, 1985; Sinkovics et al.,

2008). Dependability, like reliability, is achieved when research methods are transparent in order to attain uniformity (Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008). Confirmability, like objectivity, is the need for the researcher to display limited bias in interpretation (Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008).

A fifth criterion was introduced later, namely, authentic inquiry (Christians, 2000), which was linked to fairness (Maritz & Visagie, 2009). Techniques and strategies are needed to operationalise the strategies of trustworthiness (Creswell, 2013).

This study employed the following validation strategies from the eight suggested by Creswell and Miller (2000): credibility, transferability, dependability, confirmability and authentic inquiry. These were achieved in the study through the use of methods such as bracketing; member checking; lengthy data collection and interpretation; full description of the setting, participants and methods; peer review and triangulation of methods.

I used bracketing from the onset of the study, which is part of clarifying researcher biases. Throughout the entire research process, I stated my position, biases or assumptions so that the reader understood what could affect the research inquiry. I, as expected when clarifying researcher bias, commented on past experiences, biases, prejudice and orientations that likely shaped my approach and interpretation of the study (Merriam, 1988). Ongoing bracketing was done to ensure personal biases were put aside so that the perspective heard was that of the participants and not the researcher.

Member-checking was done whereby I obtained the views of the findings and interpretations (Erlandson et al., 1993; Lincoln & Guba, 1985; Merriam, 1988) of the Generation Y medical doctors who participated in the study. This technique is considered to be significant for

establishing credibility (Lincoln & Guba, 1985). The data in Phase II and Phase III was verified and scrutinised by the participants to ensure that it was a true reflection of their experiences. Triangulation of methods was employed in the study, which is a verification technique to enhance credibility of findings and interpretations (Lincoln & Guba, 1985; Mertens & Hesse-Biber, 2012; Patton, 1990).

Dependability is concerned with ensuring the reader that findings occurred as reported. To enhance dependability in this study detailed observation notes and reflection notes were kept. Data collection and interpretation were lengthy in an attempt to give a truthful presentation of the data. Every attempt was made to get a clear description of the experiences of the group coaching intervention for burnout amongst the Generation Y medical doctors. The study was interpreted thoroughly to ensure narrow biasness in interpretation. I aimed to provide an accurate presentation of data by giving extracts from the data and used obvious procedures of verification. I aimed to ensure that data was collected using stated strategies to ensure an authentic inquiry. The reliability was enhanced as I obtained detailed notes and used quality tape for recording and transcription (Silverman, 2005). Verbal statements, crucial pauses and overlaps were transcribed. Coding is also important in ensuring reliability and the quality of the study based on phenomenological standards (Creswell, 2013; Polkinghorne, 1989).

The setting, participants and methods were described in detail to allow transferability (Erlandson et al., 1993; Lincoln & Guba, 1985; Merriam, 1988). I have provided a detailed description of the design and methodology taken in this study so that the reader can follow my trail of thought and understand how my opinions and actions were rooted and developed (Kelly, 2007). I indicated the steps taken to analyse the data and provided transparent methodology incorporated to attain findings.

The research process and coaching intervention for burnout was peer-reviewed as an external check to further enhance appropriateness of the coaching intervention (Lincoln & Guba, 1985). The coaching intervention for burnout amongst Generation Y medical doctors was scrutinised and discussed with a panel of clinical psychologists with experience in burnout before collection of data. Their inputs were incorporated in the final intervention.

I focused on giving a truthful account of the experiences of the Generation Y medical doctors and indicated the steps followed in the entire research process. This was given in a clear manner that would allow for replication and transferability of findings to other contexts if another researcher aims to duplicate the study with a similar sample set. A common understanding of the phenomenon (Creswell, 2013) was reached as all participants were purposively selected based on certain criteria. All of them were exposed to the phenomenon, namely, the group coaching intervention for burnout amongst Generation Y medical doctors.

The convergent mixed method used in the study is a form of triangulation in which different types of data provide cross-validity checks (Creswell & Creswell, 2018; Mertens & Hesse-Biber, 2012; Patton, 1990). The quantitative data was collected from the MBI-GS in all phases of the study. It was used to quantify burnout in Phase I and Phase III. Additionally, some survey questions were incorporated in Phase II as part of the coaching intervention.

MBI-GS is a common self-reporting burnout scale used to screen professional burnout worldwide (Kaschka et al., 2011; Maslach et al., 1996). The MBI-GS is a reliable tool that has been used by researchers in South Africa in several studies with similar samples (Peltzer et al., 2003; Thomas & Valli, 2006). Even though its validity has been criticised (Korczak et al., 2010), the MBI-GS is currently the most valid measurement method as participants report their own personalities, habits, and levels of burnout (Alarcon et al., 2009).

4.5.1 Trustworthiness of qualitative research

This section addresses the trustworthiness of the study.

Creswell and Miller (2000) focused on eight strategies frequently used by qualitative researchers: prolonged engagement and persistent observation in the field (Lincoln & Guba, 1985); triangulation of sources, methods or investigators (Lincoln & Guba, 1985); peer review or debriefing for an external check of the research process (Lincoln & Guba, 1985); negative case analysis where the researcher refines the working hypotheses as the inquiry progresses (Lincoln & Guba, 1985); clarifying researcher bias from the onset of the study so the reader understands the researcher's position and any biases or assumptions that affect the inquiry (Merriam, 1988); member-checking, which is the soliciting of participants views of the credibility of the findings and interpretations (Lincoln & Guba, 1985; Merriam, 1988); rich thick description of the participants or setting for readers to decide on transferability (Erlandson et al., 1993; Lincoln & Guba, 1985; Merriam, 1988); and, lastly, external audits to examine the process and reports to assess accuracy (Erlandson et al., 1993; Lincoln & Guba, 1985; Merriam, 1988).

Creswell (2013) suggested that qualitative researchers need to employ at least two validation strategies in any given study. The validation strategies were described in the different steps of the research to confirm understanding of how the strategies were applied to achieve validation, credibility and transferability of the project. This study employed credibility, transferability, dependability, confirmability and authentic inquiry as validation strategies from the eight suggested by Creswell and Miller (2000). These are discussed in the subsections that follow.

4.5.1.1 *Credibility*

Credibility, similar to internal validity, ensures that the researcher's findings are from the participant's perspective (Dyson & Brown, 2006; Lincoln & Guba, 1985; Sinkovics et al., 2008). Credibility is accountability for the research process and includes actions in preparation of the research, authority of the researcher, reflection notes, participants' control of the data, and peer group evaluation (Maritz & Visagie, 2009). Credibility could be associated with internal validity (Dyson & Brown 2006; Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008). It is about truth-value and truth in reality; a twofold task to carry research in a manner that the likelihood of the findings being credible is improved and to have findings approved by constructors of multiple realities studied (Maritz & Visagie, 2009).

Certain activities are not a prerequisite for achieving credibility but are said to increase the probability that credible findings will be produced, for example (Lincoln & Guba, 1985:301–314):

- Continued engagement, sustained observation and triangulation.
- Peer debriefing to test working hypotheses that are developed and to provide an external check of the inquiry process.
- Negative case analysis to improve the hypothesis until it accounts for all know cases without exception.
- Referential adequacy, which implies testing archived data against raw data using external analysis to check preliminary findings and interpretations against raw data.
- Interpretations and findings are tested against members or stakeholders from where the data was collected originally.
- Reflectivity by using a reflective journal and field notes.

Maritz and Visagie (2009:23–26) summarised the following as important to ensure credibility:

- Time sampling that samples the different possible situations such as social settings, times of day, week or season.
- Interview technique that emphasises facilitative communication as seen in skills such as probing, clarifying, summarising, reflecting, giving minimal responses, being silent and doing pilot interviews.
- Structural coherence seen through a logical flow of argumentation that presents a holistic picture or report.
- Referential adequacy whereby references used are current, relevant and accounted for in the reference list.
- Triangulation.
- Authority of the researcher seen through their training in research methodology, the academic supervisor, degree of familiarity with the phenomenon, and the ability to conceptualise data using a multi-disciplinary approach.

To ensure credibility in the current study, the researcher used observational notes and facilitative communication in the focus groups including probing, clarifying, summarising, reflecting, giving minimal responses and being silent. The theoretical framework of the study was relevant, applied and referenced. My academic supervisor was available for peer reviewing to ensure credibility of the findings. I used bracketing from the onset of the study, which is part and parcel of clarifying of researcher biases. Throughout the entire research process, I stated my position, biases or assumptions so that the reader understood all that could affect the research inquiry. I, when clarifying researcher bias, commented on past experiences, biases, prejudice and orientations that likely shaped my approach and interpretation in the study

(Merriam, 1988). Ongoing bracketing was done to ensure personal biases were put aside so that the perspective heard was the participants' and not the researcher's.

Bracketing may be difficult as interpretations of data include assumptions that the researcher brings to the topic (Van Manen, 1990). I as the researcher had to decide how and in what way my personal understandings were introduced into the study. Bracketing, though it has challenges, is still essential in qualitative and phenomenological studies, which note that subjectivity exists and that the self is an instrument in the process. Therefore, a new definition of bracketing (epoch) could be one that emphasises suspension of our understandings in a reflective manner so to encourage inquisitiveness (LeVasseur, 2003).

The data in Phase II and Phase III were verified and scrutinised by the participants to ensure that it was a true reflection of their experiences. Member-checking was done whereby I sought the views of the findings and interpretations (Erlandson et al., 1993; Lincoln & Guba, 1985; Merriam, 1988) from the Generation Y medical doctors who participated in the study. This technique is considered to be critical in establishing credibility (Lincoln & Guba, 1985).

4.5.1.2 Transferability

Transferability is described in Maritz and Visagie (2009) as proficiency of the research to be applied in other comparable contexts. The researcher is not expected to initiate the transfer but to describe the process in such a manner that other researchers could follow similar steps.

Transferability is linked to external validity or an ability to generalise the findings to similar settings as in the study (Dyson & Brown, 2006; Lincoln & Guba, 1985; Sinkovics et al., 2008). However, Lincoln and Guba (1985) stated that transferability is somewhat different than external validity. Lincoln and Guba (1985) mentioned that the researcher is not necessarily there to provide an index of transferability but rather to provide a base that makes transferability

judgements of the data on potential appliers; therefore, providing data for future researchers to determine whether transferability applies. To ensure transferability, an impenetrable description is needed of the sampling process, demographics of participants, and findings, which have to be described in depth with quotations from the focus groups and recontextualised in the literature (Maritz & Visagie, 2009).

To ensure transferability in the current study, a full description of the sampling process, demographics of participants and findings are described in depth with direct quotations from the focus groups and contextualised within the literature. The Generation Y medical doctors' external environment that is linked directly to their experiences was mentioned to create full context. Detailed descriptions of the setting, participants and methods must be given to allow the reader to make decisions regarding transferability (Erlandson et al., 1993; Lincoln & Guba, 1985; Merriam, 1988). I provided detailed descriptions of the design and methodology taken in this study so the reader could follow my trail of thought and understand how my opinions and actions were rooted and developed (Kelly, 2007). I provided a transparent methodology that was incorporated to arrive at the findings. Furthermore, I indicated the steps taken to analyse the data to arrive at the findings.

4.5.1.3 Dependability

Dependability, like reliability, is achieved when the research findings' methods are transparent to achieve uniformity (Dyson & Brown, 2006; Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008). According to Maritz and Visagie (2009), dependability is an indication that the findings are constant. In other words, an independent researcher would get similar inferences if given the data to analyse. Triangulation is relevant in ensuring such consistency in the findings (Maritz & Visagie, 2009).

The researcher would need to ensure that the code-recode procedure is well structured and executed (Maritz & Visagie, 2009). All aspects of the research would need to be described fully, including the methodology, sample characteristics, process and data analysis. Further data quality checks and peer review would need to be done. There should also be an audit trail to ensure that the research process is logical, traceable, documented and could thus be authenticated (Maritz & Visagie, 2009).

Dependability of the current study was achieved by stating the methodology, sample characteristics, process, and data analysis in detail. Further data quality checks and a peer review were done. There is an audit trail to ensure that the research process is logical, traceable, documented and can therefore be authenticated. Triangulation of the process, findings and literature was done, which is relevant to ensure that the findings are consistent.

Dependability ensures the reader that findings occurred as reported, which can also be enhanced by this strategy. Detailed observation notes and reflection notes were kept to enhance dependability (Maree & Van der Westhuizen, 2007). Data collection and interpretation were laborious in an attempt to give an accurate presentation of the data. Every attempt was made to get a clear account of the experiences of the coaching intervention for burnout amongst the Generation Y medical doctors.

4.5.1.4 Confirmability

Confirmability like objectivity in positivistic research is the need for the researcher to demonstrate restricted bias in analysis (Dyson & Brown, 2006; Lincoln & Guba, 1985; Maritz & Visagie, 2009; Sinkovics et al., 2008). This refers to measures taken to prevent biasness in the researcher (Maritz & Visagie, 2009). Triangulation could be used to achieve this by using multiple methods of data collection used, focus groups, field notes and observation, multiple investigations, multiple theoretical perspectives, multiple investigators, multiple populations

as stakeholders, and multiple facilitative communication techniques (Maritz & Visagie, 2009). Confirmability in the current study was incorporated to prevent biasness of the researcher; triangulation was achieved using multiple methods of data collection such as focus groups that were audio-recorded, observation notes, and a survey (MBI-GS) for an objective view of burnout and reflection. Additionally, there were many theoretical perspectives, interaction with my academic supervisor and the use of multiple facilitative communication techniques. Triangulation of methods was employed in the study, which is a verification technique that enhances credibility of findings and interpretations (Lincoln & Guba, 1985; Patton, 1990), and peer review that is an external check of the research process and coaching intervention for burnout (Lincoln & Guba, 1985).

4.5.1.5 Fairness and authentic inquiry

A fifth criterion was introduced later, namely, authentic inquiry (Christians, 2000), which is linked to fairness (Maritz & Visagie, 2009). The researcher has the ability to show a range of different realities or fairness based on concerns, issues and underlying values. Four types of authenticity were stated by Christians (2000): ontological, educative, catalytic, and tactical.

Ontological authenticity describes the researcher's understanding of the phenomenon being studied as seen in statements by participants about their growth, debriefing interviews, and the audit trail. Educative authenticity is the ability to help people appreciate the construction of others. Catalytic authenticity is evident through participants' testimony of change, researcher follow-up, and researcher debriefing interviews. Tactical authenticity is established by empowering others; for example, participant statements of change, researcher follow-up, joint assessment of empowerment, and researcher debriefing interviews.

According to Lincoln and Guba (1985), fairness is similar to authentic inquiry and refers to a quality of balance. All views, perspectives, claims, concerns and voices are apparent in the text. The researcher prevents marginalisation by acting positively with respect to inclusion.

I as the researcher aimed to achieve fairness and have an authentic inquiry as I reported on views, claims, concerns, perspectives and making the voice heard in the text of the Generation Y medical doctors experiences. Interpretation in the study was done attentively to ensure limited biasness in interpretation. I aimed to provide an accurate presentation of data by giving extracts from the data and I used explicit procedures of verification. I aimed to ensure that data was collected using particular stated strategies to ensure an authentic inquiry. The reliability was enhanced as I obtained detailed notes and used good quality tape for recording and transcription (Silverman, 2005). Verbal and non-verbal communication (as seen in the focus groups) were transcribed.

Coding is also important for ensuring reliability and the quality of the study based on phenomenological standards (Creswell, 2013; Polkinghorne, 1989). I focused on giving a truthful account of the experiences of the Generation Y medical doctors and indicated the steps followed in the entire research process in a clear manner to ensure transferability of findings to other contexts. This allows other researchers to duplicate the study with similar sample sets.

4.5.1.6 Quantitative data validity and reliability

As this was a convergent mixed methodology study, the MBI-GS was used to quantify burnout in Phase I and Phase II. Additionally, some survey questions were incorporated in Phase II as part of the group coaching intervention for burnout. The MBI-GS is a valid and reliable tool to measure burnout, which has been used by researchers in South Africa in several studies with similar samples (Thomas & Valli, 2006; Peltzer et al., 2003).

4.5.2 Ethical considerations

The proposal was submitted for ethical clearance through the proper channels at my academic institution and at the setting where the research was conducted. The proposal was submitted for ethical clearance at Unisa, the supervisory academic institution, and the hospital's ethics committee. The study was classified as a psychological risk at a low level (see approval letters annexure A). Psychological risks may be experienced during participation and/or afterwards as a result of participation in the research (National Health Research Ethics Council (NHREC) Audit Implementation Report, 2018). These include anxiety, stress, fear, confusion, embarrassment, depression, guilt, shock, loss of self-esteem and/or latered behaviour. Low risk is research studying a non-controversial topic through interview, survey or participant observation (National Health Research Ethics Council (NHREC) Audit Implementation Report, 2018). Participants are ordinary citezens in terms of their health, social status and or development. As such there is little potential for discomfort on the part of the participant; where such potential does exist the predicted discomfort or inconvenience would be minor. Post hoc analysis of existing documents where anonymity is assured like student assessment and patient's records. Standard survey and interviewing of employees on uncontroversial topics where standard protocols are in place such as informed consent, voluntary withdrawal and confidentiality (National Health Research Ethics Council (NHREC) Audit Implementation Report, 2018).

Participants were made aware of the referral network that was available to them, which comprised several identified professional colleagues in the Limpopo Province in the private/public sector for instances where there was such a need. This external network of private practice professionals was established for when interventions were needed on a long-term basis

or for other issues that could be evoked in the process. Each participant had medical aid and could use the professionals at their own cost.

The purpose of the study was explained to the participants and it was their choice to participate. An informed consent form explained all the details of the study, which was signed by participants following their understanding of the study (Amdur, 2003).

Rapport building and debriefing of the participants were part of the focus group discussions. There were no foreseen risks or discomfort, but there was continuous evaluation of the participants. The research was conducted in an ethical manner under supervision, where both I as researcher and my academic supervisor were bound by an ethical code of psychology. The participants were given rendered privacy, confidentiality and mutual consent to ensure that they were not coerced into participation or harmed in any way.

Confidentiality and anonymity were respected by keeping recordings anonymous and ensuring that recordings and consent forms were stored in a safe and secure place, where only I as the researcher had access. Confidentiality was also maintained as the participants used pseudonyms in the focus groups and their real names were not quoted in the study. I further assured participants that their information and the data collected would be stored safely with limited access.

4.6 Reporting

There is no specific structure for reporting phenomenological studies but the reader of the research should come to understand exactly what it was like to experience the phenomenon under study (Polkinghorne, 1989). A first-person qualitative reporting style was used to report the findings of the research. Major themes were discussed and linked back to literature. The

implication of the group coaching intervention for burnout amongst Generation Y medical doctors and suggestions on methods of intervention were given.

4.7 Chapter Summary

The research design and the methodology of this study were presented in this chapter, which indicated the procedure followed to achieve the general aim of the research, namely, to describe the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors. The chapter elaborated on the research approach, research strategy, and the research method for the study. It expanded on the setting, entrée and establishing of research roles, sampling, data collection method and procedure, and analysis. Strategies employed to ensure quality data were discussed, including trustworthiness of qualitative research, credibility, transferability, dependability, confirmability and ethical considerations.

The chapter ended with a discussion on reporting in the current study. The next chapter focus on the findings of the data analysis including interpretations. The final chapter draws conclusions to the study, highlights any limitations and makes recommendations.

CHAPTER 5: RESEARCH FINDINGS

5.1 Introduction

This chapter details the research findings for the current study. The study primarily focused on a group coaching intervention for burnout amongst Generation Y medical doctors working in the public health sector at a hospital in the Limpopo Province, South Africa. It commences by summarising the phases of the coaching intervention and explaining how the sessions transpired. Thereafter, the themes that emerged about burnout are discussed. The discussion is followed by exploring the themes related to the coaching intervention. It concludes with an integrated discussion, hypotheses and a chapter summary.

5.2 Coaching Intervention

The study was completed in three phases. Phase I was the pre-coaching intervention; Phase II the coaching intervention; and Phase III the post-coaching intervention. The initial criteria for participation were aged between 25 and 35 (Generation Y), a medical degree (MChB), and current employment in the public health sector at a hospital for more than 12 months. The last criterion that had to be met was a high level of burnout as measured by the MBI-GS in Phase I. Participants who met all criteria in Phase I were eligible to participate in Phase II and Phase III of the study.

Due to difficulties in securing willing participants at the same time for focus group sessions in Phase II, the coaching intervention had to be adjusted slightly to fit into the limited available free time and pressurised schedules of the Generation Y medical doctors. Phase I (Session 1) went ahead as planned. Thereafter, the original planned coaching sessions for Phase II (originally Sessions 2–4) were combined into one session of 4.5 hours. I only managed to get one group of ten participants instead of two groups of eight participants as was envisaged.

Phase II entailed exposing the group of ten participants to the coaching intervention. Phase III (originally Session 5) went ahead as planned six months after the implementation of Phase II, but with only six participants.

The focus of the group coaching intervention for burnout amongst Generation Y medical doctors remained as had been planned on creating an environment for catharsis, giving support, debriefing, having peer group discussions, promoting understanding of their shared experiences, and promoting beneficial coping strategies.

5.2.1 Phase I: Pre-coaching intervention

The study was submitted for ethical approval from research committees at the hospital and my tertiary institution (Unisa). Approval was received to proceed (see annexure A). I finalised the group coaching intervention for burnout amongst Generation Y medical doctors after incorporating inputs from a panel discussion with clinical psychologists who are specialists in the field of burnout. Thirty participants were identified for participation from the available Generation Y medical doctors rotating at different specialities in at the hospital. The areas of speciality were family medicine; obstetrics and gynaecology; internal medicine; general surgery; orthopaedics; anaesthesiology; and paediatrics. The aim of Phase I was to obtain access to the hospital and to finalise the group coaching intervention and to select a minimum group of 16 participants who met the final criterion for participation, which was a high level of burnout as measured objectively by the MBI-GS.

The clinical manager invited 30 Generation Y medical doctors who met the initial criteria to a meeting on my behalf. The clinical manager introduced me and left the room. I introduced the study and excused non-interested participants. Eighteen people remained to complete the MBI-GS for selection. After the group completed the form and I addressed questions, the group was

released. I scored the questionnaires and all 18 Generation Y medical doctors met the final criterion for participation in the focus group, which was a high level of burnout.

The 18 qualifying and willing participants were randomly listed and all were invited to participate in the two focus group discussions (Phase II and Phase III) two days later. After a discussion with my supervisor, we decided to invite all 18 people as the group size would still be within the expected focus group size (Creswell, 2013). Initially, two groups with nine participants each were envisaged. Once the Generation Y medical doctors showed interest and committed to attend, they were randomly allocated to a group and given a potential date, time and venue for the first focus group.

Due to the circumstances that prevailed (which included low motivation, feelings of apathy, general fatigue, low morale, being on sick leave, unavailability of free time, and pressurised schedule), eight participants excused themselves less than a week before the first focus group. Even after being encouraged by their team leader, only one group of ten participants attended the session for Phase II. After the difficulties, I faced in securing a group and dates suitable for all to attend the Phase II coaching intervention, the group format had to be adjusted to fit reality.

5.2.2 Phase II: Coaching intervention

The focus group session started slowly but with time, participants seemed to lower their guard; it could be that the focus group was a platform that fitted their need for debriefing and that they were comfortable with the approach taken in the group coaching intervention. The low morale also likely had implications on trust issues of the participants as they seemed neither to trust the system nor my presence. Their attendance had been encouraged by their team leader after seeing how low their motivation levels were, this was mentioned during the session. It was again mentioned to the participants before the session and once I was made aware of how their

team leader had encouraged attendance during the process, that it was voluntary participation and they could leave at any time.

The final group only consisted of ten (six females and four males) Generation Y medical doctors at the hospital from the initially 18 participants who were willing to participate and met the full criteria. All participants signed informed consent forms agreeing to participation and audio-recording. The eight absent participants had various reasons for non-attendance: two were on sick leave secondary to the pressure and stress at work; two had their planned annual leave; two had to work (they were on call) and were unable to take time off due to not securing a doctor in their place; one was post-call; and one had an unforeseen family commitment. The venue was an easily accessible lodge nearby. The session was 4.5 hours with a short lunch.

5.2.3 Phase III: Post-coaching intervention

Phase III was a session that took place six months after termination of Phase II. Four Generation Y medical doctors from the ten that participated in Phase II could not make it to the session for various reasons: one had to work; one was post-call; one took annual leave; and one was off sick. Of the six participants who were able to make it, four were females and two were males. The session focused on evaluating how they were generally coping after being exposed to the intervention and to gather more feedback on their experiences of the group coaching intervention for burnout.

5.2.4 Outline of the coaching intervention for burnout process

The three phases in the study proceeded as follows:

5.2.4.1 Phase I: Pre-coaching intervention (Session 1)

Phase I was aimed at conducting a literature review, applying for and receiving ethical approval for the research from my institution and the hospital, and lastly having a panel discussion with various specialists about the proposed group coaching intervention for burnout amongst Generation Y medical doctors. Phase I aimed at screening the potential group of participants for the final criterion of participation, which was a high level of burnout as determined by MBI-GS scores. The screening was conducted two weeks before the actual implementation of the coaching intervention in Phase II.

The clinical manager called the 30 Generation Y medical doctors who met the first three criteria of participation to a meeting on my behalf. The manager introduced me and left the room. I spoke briefly about the study and excused the non-interested parties whereafter 12 people left the room. Eighteen consenting participants voluntarily completed the MBI-GS for screening purposes for the final criterion. I collected the questionnaires and responded to any questions the group had. I also summarised what Phase II and Phase III would entail should they meet the final criterion and still be interested in participating in the study. The meeting was adjourned and the participants released.

I scored the questionnaires and all 18 who completed the MBI-GS met the final criterion of participation in the study, which was a high level of burnout. I contacted all 18 telephonically two days after the meeting and all voiced interest in participating in Phase II and Phase III. The qualifying participants were notified of the possible date, time and venue for the focus groups. However, there were some challenges in getting all participants on the potential dates. A suitable venue was organised for the focus groups. Reminders of the focus group were sent a week before the agreed date.

5.2.4.2 Phase II: Coaching intervention (Session 2)

Eight of the expected participants who were interested and had confirmed attendance excused themselves from participation less than a week before the scheduled date for various reasons.

The group coaching intervention session for burnout amongst Generation Y medical doctors started with welcoming tea. It was a 4.5-hour session with a lunch that was served. The participants were late. Once six have arrived at the venue, they signed an informed consent for participation and recording and the session began. I as the researcher and coach as part of discussion of the consent form emphasized that it was voluntary participation before the session begun and they could leave at any time. The team leader noticed how low the Generation Y medical doctors' motivation levels were and encouraged attendance. This was noted during the actual coaching intervention process. Additionally, I emphasized this voluntary participation when it was highlighted during the group coaching intervention process that the team leader had encouraged participation in the study. The participants were greeted and reminded of the information in the signed informed consent to participate. The rules of the focus group were explained, which included that the sessions would be recorded and notes taken. The use of pseudonyms and confidentiality of the content were reiterated. The participants were also reminded that the final research report would not use real names. Participants had to allow everybody a chance to speak. It was open communication with no need to spare my feelings as the facilitator. Mobile phones had to be on silent.

After the rules were explained, there was an ice breaker to relax the group. The remaining participants joined in during the ice breaker exercise. They signed their informed consent forms for participation and recording. The purpose and format of the sessions were discussed and the participants were informed of the final session (Phase III) to be held six months after the initial session. The participant's expectations were discussed, which led to a short discussion of the

background of my experiences with burnout, my qualifications, and lastly the reason for my interest in the study.

The session continued and certain questions were posed. The first part of the session focused on discussing experiences of working as a medical doctor in the public health sector at the hospital. I requested that they state their pseudonym before speaking for the first time. Each participant was given a chance to speak. The first question was: “What has been your experience of working at the hospital in the Limpopo Province?”. A discussion of burnout followed. The questions were:

- How do you understand burnout?
- How was completing the questionnaire?

The definition of burnout and the process model of burnout were discussed. The third discussion point started with my story and personal experiences of burnout. The question posed was: “What has been your experience of burnout?”. The risk factors for burnout were explained whereafter the discussion was summarised.

The group had lunch. On return, the discussion focused on individual experiences of the manifestation of burnout. The question posed was: “What has your experience been?”. Each participant was given a chance to speak and the quieter participants were encouraged to speak about their current experiences and coping strategies. Ways of coping were suggested including relaxation and breathing exercises.

Each participant was given the opportunity to pose any questions or comments they had. Thereafter, the session returned to a feedback discussion and each participant was given a chance to comment. The questions posed were as follows:

- What have you gathered about burnout and your personal experiences at the workplace?
- Were your expectations met by the coaching intervention for burnout amongst Generation Y medical doctors in public health sector in Limpopo Province?
- What could I have added to the coaching intervention?

The participants were thanked for their time and inputs and they were informed about the follow-up session date in six months (Phase III). The group coaching intervention for burnout amongst Generation Y medical doctors' session was closed.

5.2.4.3 Phase III: Post-coaching intervention (Session 3)

Phase III was primarily a feedback discussion done six months after the coaching intervention for burnout amongst Generation Y medical doctors. The session reflected on their experience of work after being exposed to the group coaching intervention for burnout. The focus was on obtaining feedback on their experiences of the actual group coaching intervention.

Questions were posed and each participant was given a chance to respond to the question. The questions were:

- How are you doing post the coaching intervention for burnout amongst Generation Y medical doctors?
- What is your experience and coping strategies now at work?
- Were your expectations met for the coaching intervention for burnout amongst Generation Y medical doctors?
- What could I have added to the coaching intervention for burnout amongst Generation Y medical doctors to make it more beneficial for you?

5.2.5 Participants

5.2.5.1 Phase I: Pre-coaching intervention (Session 1)

There were 30 potential participants who met the initial criteria for participation, namely, aged between 25 and 35 (Generation Y), with a medical degree (MBChB), and been employed in the public health sector at the hospital for more than 12 months. The final criterion was a high level of burnout as measured by the MBI-GS in Phase I. Eighteen of the 30 potential participants completed the MBI-GS questionnaire and all 18 met the final criterion for participation.

5.2.5.2 Phase II: Coaching intervention (Session 2)

The details of the ten participants who made it to the session in Phase II are summarised in Table 5.1. Participants all had a medical degree (MBChB) and were in their compulsory second year of work in the public health sector at the hospital. They were part of the 18 Generation Y medical doctors who met the last criterion of participation, which is a high level of burnout as was measured in Phase I of the study.

5.2.5.3 Phase III: Post-coaching intervention (Session 3)

Six participants were able to participate in Phase III of the study (post-coaching intervention, Session 3). Four were female (Participants 1, 3, 5 and 8) and two were male (Participant 6 and 7). Their details are shown in Table 5.1.

Table 5.1: Details of the ten participants in Phase II and six participants in Phase III of the study

	Age	Race	Gender	Marital Status	Phase III Participation
Participant 1	25	black	female	single	Yes
Participant 2	25	black	female	single	Yes
Participant 3	27	black	female	single	No
Participant 4	27	black	female	single	No
Participant 5	26	black	female	married	Yes
Participant 6	27	black	male	single	Yes
Participant 7	28	black	male	single	Yes
Participant 8	25	black	female	single	No
Participant 9	27	white	female	married	Yes
Participant 10	27	black	male	single	No

5.3 Themes That Emerged About Burnout

During Phase II – the coaching intervention for burnout amongst Generation Y medical doctors – participants signed informed consent. They were engaged in the discussion. Questions were asked that focused on their experiences of working as Generation Y medical doctors in the public health sector in a hospital in the Limpopo Province, South Africa. Before answering for the first time, they had to state their pseudonyms. The discussion focused on what burnout is and how it manifests. The discussion continued about coping strategies participants had attempted to employ. It concluded by making suggestions and encouraging them to adjust their coping strategies. The session reflected on what they had gained. It concluded by giving feedback on the group coaching intervention for burnout amongst Generation Y medical doctors.

This section explores the four themes that were evident about the burnout experiences of the Generation Y medical doctors working in the public health sector in a hospital in the Limpopo Province. The participants articulated their perceptions of their experiences of working as medical doctors in the public health sector. Burnout aspects could be summarised into four themes. The first theme that emerged was a lack of support; the second was that there are broader challenges in South Africa that affect public health; the third theme was the burnout experience in Generation Y medical doctors; and the fourth theme was the burnout consequences in Generation Y medical doctors. The four themes related to the burnout experience are discussed in the subsections that follow.

5.3.1 Theme 1: Lack of support

Theme 1 that emerged in relation to burnout was a lack of support. The Generation Y medical doctors highlighted poor management support; poor psychological and team support; and poor support as juniors in training as subthemes in describing how they feel they are not supported adequately. Each subtheme is given in the subsections that follow together with the participants' attestations, a discussion and a working hypothesis.

5.3.1.1 Subtheme 1.1: Poor management support

The participants felt that there was an overall neglect of responsibility by management at all levels, from direct clinical managers to actual public health sector heads, towards themselves as Generation Y medical doctors. They reported a shared experience of a lack of support by all stakeholders regarding the actual work and a lack of emotional support from management. Furthermore, they reported feeling isolated and being unheard because the challenges they face are not addressed even when the challenges are verbalised. These challenges boiled down to overall terrible working conditions in the public health sector which they are coerced into and exposed to daily as part of their training to be independent medical doctors.

This perception of poor support from management and the public health sector in South Africa is illustrated in a statement by Participant 7: *“We feel not taken care of and we were hoping that the relevant senior people and Public Health Department in South Africa could hear our plea for the terrible working conditions”*.

The participants felt generally unsupported even by senior staff members they work with, which is illustrated in the following quotation by Participant 1: *“There is lack or minimal support from hospital management and senior doctors”*. Participant 6 stated, *“I feel like we are learners thrown in the deep end and expected to know what to do”*.

This lack of support seems to lead to feelings of a lack of cohesion, poor sense of belonging, helplessness, frustration and a perception that their views or inputs do not matter, and that they are not valued or taken seriously as professionals. Quotes suggesting this observation include the following from Participant 2: *“During training in another province, there was a sense of belonging and there was improvisation and the unit worked; here in Limpopo at we are isolated, people are tired not willing to do over what is expected. We do not operate as a team here”*. Additionally, Participant 10 voiced the following: *“Management is not open to outside the box thinking regarding how we do calls etc., they are not flexible at all”*.

The Generation Y medical doctors are aware of how the South African public health sector system and poor working conditions are affecting senior medical doctors negatively, which reduces their own level of commitment and drive as junior medical doctors. This is illustrated by this quote from Participant 6: *“We do have a handful of committed supportive senior doctors but they are so few. It is sad that they might also change due to the poor working conditions”*.

The Generation Y medical doctors seemed concerned that there are few mentors who are still committed and they fear that the working conditions might affect the few potential mentors negatively. The situation and perception thereof makes it difficult for Generation Y medical

doctors to aspire to be like some seniors because the seniors who are meant to be mentors are themselves overburdened and drowning because of the public health sector in South Africa. They seem to discern that the senior medical doctors, being the consultants/specialists and even the medical officers' doctors, are negatively affected by the public health sector system in South Africa. The same affected consultants/specialists and senior doctors are expected to mentor them as Generation Y medical doctors, which is counterproductive. This is derived from the following statement by Participant 3: *“Consultants are from the same system; therefore, they learn this horrible treatment of junior staff medical doctors and poor coping strategies as if it is ‘normal’ and it was passed on to them; when they become seniors, they pass it on to junior medical doctors”*.

Generation Y medical doctors view their so-called trainers and mentors as lacking and being unable to be of value to them primarily because they are also, according to their collective view, affected negatively by the public health system in South Africa. A quote by Participant 4, which was strongly supported by Participants 5, 8 and 9, added to this observation: *“When the interns complain, or seek help from senior medical doctors we are told how spoon-fed we are or how we complain a lot. They tell us that when they were interns they ran casualty alone, so we should just do it”*.

5.3.1.2 Subtheme 1.2: Poor psychological and team support

Generation Y medical doctors indicated a perceived lack of leadership and organisational guidance leading to poor psychological and team support. Participant 2 made the following statement: *“We need an intern coordinator who actually cares supports and listens to us. As interns, we need someone we can voice our concerns and struggles in the department”*. Participant 10 stated, *“Team building is needed at all levels. We are functioning as individuals in a failing system whereby we are not supported”*.

The participants continually emphasised unsatisfactory coordination of the programme and poor departmental support, which led to them feeling unheard, isolated, not part of a team and unsupported. Participant 5, for example, stated, “*We need well-structured induction and orientation programme on arrival to the hospital. Also, proper support services for junior doctors*”.

The Generation Y medical doctors felt that their personal pleas and challenges were not heard: even aspects they raised in the group coaching intervention session would not be heard, especially because they were junior medical doctors. Participant 4 stated the following to this effect, which was supported strongly by the other participants: “*Even this coaching intervention: I am not sure if they will take serious; the issues we raise here and the fact that we need constant help to cope will be seen in the findings of the study, but I doubt if they will take it seriously*”.

They reiterated the lack of psychological (emotional) support and a sense of being overwhelmed with no one to notice or assist them. The Generation Y medical doctors were overwhelmed by the workload and the type of medical cases they had to cope with. Participant 3 supported this point by stating, “*More support structures are needed to help us debrief. Support for the work also especially for challenging cases*”. Participant 9 added, “*We need availability of psychologists for debriefing sessions*”. Additionally, Participant 8 stated, “*Support group is needed that meets regularly to share our experiences and to also share coping strategies*”.

The participants seemed to feel voiceless, and yet they are expected to deliver in spite of the challenging working conditions they encounter daily. It seems that they feel stuck because they need to go through this process of working in the South African public health sector in order to qualify as independent medical practitioners. However, the very process they are coerced to go through is destroying them and they feel that they cannot do anything about it.

The Generation Y medical doctors seemed to feel as if they have insufficient coaching on how to get family, in-group and organisational support. They felt hopeless and frustrated in the failing public health sector system in South Africa; they were aware that the system was affecting them negatively, as was the case with their seniors.

They noticed that the negative effect cascaded to their families too. Their family members do not know what is going on or how to help; yet family members need to deal with Generation Y medical doctors who are displaying certain changed behaviours because they are not coping with the public health sector. This dilemma is seen in the following quote made by Participant 9 and supported by other participants: *“Partners (husband and wives) need to be made aware so to understand how to assist us, to also understand the workload and signs of burnout”*, to which Participant 5 added, *“My partner did not know what to say or how to help me. It was even made worse because I did not understand what I was going through. I would keep it all in and be irritable with my family because of the work stress”*.

The Generation Y medical doctors verbalised a lack of support for the workload, difficult cases and ethical issues they faced. They seemingly agreed that they tended not to communicate some challenges to seniors or management, especially regarding ethical dilemmas because of a lack of platforms to voice such concerns and a lack of trust in the system/senior staff members. They kept quiet at times because of a fear of victimisation, which they feared might negatively affect their completion of the programme to become independent practitioners. This is seen in these quotes from the participants. Participant 1 stated, *“Certain departments are at times not doing things ethically right and as an intern I feel I cannot say something without it affecting my progress; therefore, I keep quiet”*. Participant 9 stated, *“It is discouraging to see medical doctors, our seniors, acting unethically and we as juniors cannot do anything about it”*.

5.3.1.3 Subtheme 1.3: Poor support as juniors in training

The Generation Y medical doctors seemed to feel unsupported and devalued just because they were juniors. They were of the collective view that medical training in South Africa is militarised. They felt that they have been given a raw deal in that their trainers and mentors are from the same system of militarised training so they themselves do not know any different and can only offer what they know. They experienced the system as a hierarchy; they are at the bottom as juniors, and therefore should just follow orders from the people at the top.

They additionally felt that their seniors were also struggling but needed to survive, so they continued giving the same treatment to juniors that they received when they were juniors. The cycle of destruction carries on. This is suggested by the following quote from Participant 6: *“The problem is the training is militarised where we are told what to do by consultants and senior medical doctors and treated like robots. We cannot be creative; and we the junior doctors are low on the food chain, therefore treated as nobodies”*. Another Generation Y medical doctor, Participant 10, mentioned the following: *“We are disregarded because we are juniors, and treated like we do not matter and that our opinions or inputs do not matter”*.

Participant 3 said, *“We are professionals yet the work we are expected to do is not line with training as it involves us for example convincing patients to take medication because the seniors will blame us if there is a defaulter; and at the same time we also are given work that is far beyond our scope because we run wards on our own with very complicated cases and have to deal with traumatic cases in an ‘abnormal manner’ as we are taught by the system additionally we also get workload and working hours, that are far beyond human capabilities”*.

The Generation Y medical doctors mentioned that rotations were the most challenging. They highlighted the following rotations in the description their experiences (the number that follows

in parentheses is the number of participants who highlighted the rotation as either the most, average or less challenging):

- The most challenging rotations were obstetrics and gynaecology (6); internal medicine (4); anaesthesiology (1); surgery (1); psychiatry (1); and paediatrics (1).
- The average challenging rotations included internal medicine (2); surgery (2); paediatrics (2), family medicine (1); obstetrics and gynaecology (1).
- The less challenging rotation were orthopaedic (4); anaesthesiology (3); paediatrics (2), psychiatry (3); internal medicine (2); and surgery (1).

The participants cited certain reasons that made the rotations challenging. Participant 3 stated and was highly supported by others: *“The reason some of these rotations are challenging is the limited support from seniors (medical officers, consultants/specialists, registrars) in the specific rotation”*. Participant 7 added, *“The rotations with challenging cases where we are expected to handle them alone as a junior are the worst”*. Participant 2 said, *“It was an overwhelming responsibility the rotations with no support from seniors and with the high workload with very sick and complicated patients”*. Participant 4 stated, *“I have lack of interest in the field but am forced to do the rotation hence I did not look forward to work while placed in some of the rotations”*.

All participants stated the hours, inflexibility, lack of support, isolation, dealing with challenging cases they are expected to handle alone, and increased workload as contributors to a lack of enjoyment in the most challenging rotations.

5.3.1.4 Discussion

Theme 1 in the findings is the lack of support. The three subthemes for the main theme are: poor management support; poor psychological and team support; and poor support as juniors

in training. Perception of support as poor or lacking from management and stakeholders for the Generation Y medical doctors regarding their work, personal issues, teamwork and training as juniors seems to be one of the main contributors to their experience of burnout.

Burnout involves attitudes, self-appraisal and appraisal of others within a certain context (Maslach, 1976, 1978). The Generation Y medical doctors have developed a sense of helplessness and a negative view, which is a typical cognitive symptom that is prominent at an individual level (Ohue, Moriyama & Nakaya, 2011). From the perception they now have, certain occurrences, such as a distrust of management, negativism, pessimism, blaming, and the feeling of not being appreciated, are likely to occur at an interpersonal level (Schaufeli, W.B. & Enzmann, 1998). This is what the Generation Y medical doctors are presenting with at some level: they have an overall pessimistic view of support. They could rightly have a need to protest against the type of support they are given, but the focus should be more on developing management strategies that are beneficial to them even if their support or view thereof never changes.

Overall, the Generation Y medical doctors' experiences while working in the public health sector have led them to believe that the senior medical doctors they are working with are also negatively affected by the public health sector system in South Africa. They believe that the maladjusted coping strategy seen in these seniors because of the public health sector system is common; it is what they as Generation Y medical doctors are expected to adopt to and make peace with. It is a never-ending cycle that is learned. This was emphasised by the following quote by Participant 4: *“Medical officers and registrars, even consultants, seem traumatised themselves. Everyone in the system is expected to adopt an unhealthy way of coping at work and make peace with the abnormality”*.

The Generation Y medical doctors, like many young workers, seemingly had an expectation of how work conditions and the support therein should be ideally (Maslach, 2003); however, the experience they are having now in their current working environment far contradicts their expectations. Furthermore, most are working for the first time. They have no previous work experience, knowledge, coping strategies, or resilience concepts to tap into for coping with a difficult working situation (Maslach, 2003), such as the public health sector where they are employed. Typically, the first bout of burnout is likely to happen in the first year of working, and people have difficulty in managing it, they are at a higher risk of leaving a profession entirely or changing jobs. Those who handle it, stay on to do well in their career (Maslach, 2003); hence, it is important to develop an intervention and create awareness regarding all levels of burnout and its debilitating effects in Generation Y medical doctors working in the South African public health sector.

Risk factors for burnout include high work expectations, high levels of occupational stress, role conflict, low levels of participation in decision-making, and a lack of resources and feedback from the organisation (Maslach et al., 2001). These seem to be risk factors that the Generation Y medical doctors are exposed to daily, which seemingly led to their current perception of a lack of support from those meant to be supporting them.

Maslach et al. (2001) postulated further that the disconnect between an individual and the organisation regarding what they referred to as six main areas of work life (values, fairness, community, reward, control, and workload) increases the risk for burnout. Looking at just this one theme of lack of support in the study, it appears that the Generation Y medical doctors are challenged in all six areas postulated.

The Generation Y medical doctors seem to be continually experiencing to a low extent what is described as double-bind messages by the theory of Gregory and colleagues as cited in (Gibney,

2006). They are told that they are juniors but, on the contrary, they are expected to handle cases that are far beyond their expectations. It seems that they constantly have to move between receiving two contrasting messages. The first message is that they are not good enough because they are mere juniors. This is combined with their poor living, working and labour conditions. The second extreme message is that they are superhumans who are expected to survive long work hours; to depersonalise in order to deal with severe chronic traumatic cases; and to not be frustrated by poor management, poor resources, lack of infrastructures, workload and not in need of support structures.

Oscillating between these contrasting messages seemingly creates a constant dilemma within the Generation Y medical doctors. They had their own expectations after qualifying as professional medical doctors about how they would be treated and the environments they would work in. Now they have to deal with double-bind messages from the work environment and its management where they are meant to grow to become independent practitioners.

This can create a great deal of confusion and promote the development of cognitive distortions regarding their abilities, which hampers them from developing adjusted coping strategies (Lemaire & Wallace, 2017; Mathias & Wentzel, 2017; Ohue et al., 2011; Schaufeli, W.B. & Enzmann, 1998) as is evident with the Generation Y medical doctors who are presenting with burnout manifestations. This experience has led to several negative views that are debilitating to them personally (Ohue et al., 2011; Panagioti et al., 2016; Schaufeli, W.B. & Enzmann, 1998) regarding the public health sector and stakeholders.

5.3.1.5 Working hypothesis

The findings that were stated under the first theme for the burnout experiences, which is a lack of support, led to the following working hypothesis: Perception of lacking overall support is

one of the main factors contributing to the Generation Y medical doctors' experience of burnout while working in the public health sector in Limpopo Province, South Africa.

5.3.2 Theme 2: Broader challenges that affect the South African public health system

The second main theme highlighted was that there are broader challenges in South Africa that affect the public health system, which impact Generation Y medical doctors. The participants highlighted subthemes when describing their feelings about the broader challenges in the South African government that negatively affect the public health sector and, subsequently, the level of care they deliver.

The participants highlighted high volumes of patients/workload; limited staff, infrastructure, knowledge and resources for workload; mismanagement of funds in the South African public health sector; and compromised learning and teaching due to workload as subthemes. These emerged as the broader challenges in South Africa that affect the public health system, which affect them negatively as the Generation Y medical doctors working in the South African public health sector. The following subthemes emerged from the discussions with the participants: challenges and lack of solutions as a microcosm of the government and unlawful public sector expectations of Generation Y medical doctors; and unlawful public sector expectations of Generation Y medical doctors. Each subtheme is given in the subsections that follow with the participants' attestations, a discussion and working hypothesis.

5.3.2.1 Subtheme 2.1: High patient volumes/high workload

There was a sense from the group of participants that the inadequate management of referral system leads to an overload of patients in South African public sector tertiary hospitals. This is seen in this quote from Participant 7: *“Primary health system is failing, affecting us at a*

tertiary level, here at the hospital. We are overburdened with seeing all patients, from all over the province even those who could have benefitted from going to a primary health care clinic”.

The group suggested a need to review the workload and referral system instead of carrying on as is by overburdening the public health system and the caregivers like themselves. Participant 6 stated the following in support: *“Overburdening the system and the limited health caregivers will lead to compromised care for the beneficiaries of the public health sector; whom cannot afford any type of care”.* There was another statement from Participant 3 that further reinforced this subtheme: *“There is a need for revision of certain departments like obstetrics and gynaecology workload especially in the one hospital. We are servicing so many patients from so far out in the province that they come to us already complicated and they could have been helped in primary health care clinics or if there were more staff members or more hospitals available in the province”.*

5.3.2.2 Subtheme 2.2: Limited staff, infrastructure, knowledge and resources for workload

The Generation Y medical doctors experienced that the workload is abnormally high and that the cases are often overwhelming for the limited number of staff members, infrastructure and resources available in the South African public health sector. This implies that they as junior medical doctors are expected to handle complicated traumatic cases with no support and little knowledge. They verbalised an urgent need to increase the number of staff members, both juniors and seniors; the infrastructure; and the resources for the public health sector as seen in these quotes from participants. Participant 1 stated, *“Hiring of more medical doctors is needed immediately to reduce the workload”*, to which Participant 5 added, *“We are overwhelmed by seeing many patients, and we are always so short-staffed”*. Participant 4 reinforced the view by stating the following: *“The cases we see are so traumatic and we as juniors are expected to*

handle them on our own without support of senior staff members, within limited infrastructures, knowledge and resources”.

The infrastructure issues are also evident as a great concern for the participants. It appears that not only are the infrastructure issues affecting patients, but also Generation Y medical doctors. There was this quote from Participant 8: *“We need proper on-call rooms ... We have poor on-call rooms”*. Participant 10 said, *“There is inadequate attention to facilities and human resource”*, and Participant 9 stated, *“Lack of supplies and medicine; infrastructures are needed. This affects the quality of care”*.

Most felt that the infrastructure and resource challenges will never be resolved as is evident in this quote from Participant 1: *“Lack of equipment and limited staff. These challenges we face we will never resolve”*.

5.3.2.3 Subtheme 2.3: Mismanagement of funds in the South African public health sector

There was a strong view that mismanagement of funds in the public health sector leads to poor resources (such as staff complement and medicines) and infrastructure (such as equipment, on-call rooms, accommodation, hospitals, and primary healthcare clinics) or lack thereof. Thus, mismanagement compromises the level of care given by Generation Y medical doctors, even for patients who had minor curable diseases. The participants highlighted this subtheme when describing their experiences. Participant 2 stated, *“I am disappointed with the public health system in South Africa; I do not know where money is being spent. The resources are not doing what they are meant to be doing; there is a shortage of staff and at times medicine, and poor infrastructures due to poor management of funds. This leads to me feeling like I am not doing anything impactful in my work”*.

The participants reinforced how the poor level of care that occurs because of mismanagement and lack of resources affects not only the lives of patients, but also them personally as Generation Y medical doctors having to work in such conditions. The participants seemed to feel frustrated, inadequate, and let down by the public health sector, which lead to feelings of disappointment, hopelessness and helplessness. This was seen in the following statement by Participant 4: *“Our patients suffer because of wasteful and mismanagement of funds, which lead to limited staff and at times drugs”*. Participant 3 added, *“I had a patient with curable diseases who improved on antibiotics; the weekend came, I was off. There was shortage of staff, poor monitoring of the patient, and the patient demised. I feel I failed as a doctor and that the system failed me”*.

5.3.2.4 Subtheme 2.4: Compromised learning and teaching due to overwhelming workload

Newly qualified Generation Y medical doctors have to attend mandatory teaching tutorials in various placements at the hospital. The patient overload leads to compromised teaching time according to the group of participants. They were of the view that they themselves, senior staff members, and other professionals were overwhelmed by the high patient volumes, most of who had traumatic and chronic conditions. From their point of view, it seemed that consulting day to day to get through the high number of patients is the priority of the South African Department of Health, not increased learning and offering improved service for the beneficiaries of the Generation Y medical doctors' services.

The beneficiaries, based on the view of the group, are offered poor services in terrible conditions and are put at risk because the caregivers meant to offer the services are not cared for by the Department of Health. Statements made to support this included what was said by Participant 9: *“I would like to see more teaching rounds and practical presentations being implemented. But the poor working environment does not allow”*. Participant 6 added, *“We do*

not get enough teaching and lectures which can help us manage especially in rotations where we have no senior supervision. It can help build up our confidence”. Participant 2 stated, *“Intern tutorials (teaching) should be weekly (once a week) but we hardly get any tutorials”.*

The statements indicated that the Generation Y medical doctors have a yearning for learning. They noticed some gaps in their knowledge where they need assistance from seniors in order to grow. However, because of the public health system in South Africa, specifically currently in the Limpopo Province, they do not get adequate learning and teaching opportunities that are part of their training and that they hope to receive before becoming independent medical practitioners. The participants felt they are given responsibilities not meant for them as junior doctors and, at times, without senior supervision.

5.3.2.5 Subtheme 2.5: Challenges and lack of solutions is a microcosm of the government

South Africa is facing certain challenges as a developing country emanating from a difficult history of imbalance and apartheid. The participants felt that government has not stabilised yet and has not found adjusted solutions for the many challenges. Some participants believed solutions would never be found in future because the root causes have not begun to be tackled. Instead there is a significant amount of maladministration, corruption and wasteful expenditure, which is distracting the development of a functional public health sector.

The participants felt that visible problems, such as corruption, and the South African leadership crisis of the ruling government have led to many challenges in public systems that need to function properly to cater for the high population. One such dysfunctional department is the overwhelmed mismanaged public health sector. This view was expressed by a participant: *“I feel hopeless because the problem in public health department is caused by broader problems in South African government and I feel sad that the issues may never be resolved*

because the root cause is not being dealt with. Health issues we see in the public health sector are a mere symptom of a much bigger problem”.

As raised by the participants, another issue that is affecting the shocking public healthcare system is the South African government’s inadequacy to handle illegal immigrants. The participants were of the view that the current public health system is inadequate for the many South Africans who cannot afford private healthcare. As insufficient as it is, it sadly is additionally severely overloaded by the many illegal immigrants who also cannot afford private healthcare.

This view was suggested by Participant 7 who stated, *“The problem is bigger than we realise. If public health sector in South Africa should be fixed, there needs to be intervention in many other areas. For example, there should be intervention regarding illegal immigrants, who need healthcare, and use the underresourced and understaffed public hospitals which are overwhelmed already by South Africans who cannot afford private health care. If we want to resolve the issues of public health sector, we need to deal with a government that is arrogant; they know that something should be done, but will they ever do something? I doubt”.*

There was a sense that the Generation Y medical doctors needed to force themselves to be patriotic so they could be motivated to work in the difficult conditions and give back to South Africa. This is seen in this quote from Participant 10: *“We as medical doctors are forced to be patriotic in order to motivate ourselves to get up and face the difficult conditions daily”.*

5.3.2.6 Subtheme 2.6: Unlawful public sector expectations of Generation Y medical doctors

Generation Y medical doctors are forced to work under illegal abnormal working hours, unlawful labour practices, and poor working conditions with high patient numbers with limited resources (poor infrastructure, staff complement and support structures) (Erasmus, 2012). The

public health sector is failing the beneficiaries and caregivers, including Generation Y medical doctors (Erasmus, 2012). Participant 5 emphasised this by stating, *“The medical doctors are not expected to take breaks, or to have lunch. We are expected to work ALWAYS”*. Participant 8 said, *“We are expected to work a full day even after a call. We have long working hours’ unmanageable and challenging workload”*. Participant 6 said, *“We need regulated overtime as per HPCSA”*.

Another concern noted by the group that is unlawful and adds to the poor labour conditions is inadequate accommodation in the doctors’ quarters as accentuated by Participant 1: *“We are housed in poor accommodation and exposed to poor living conditions at the doctor’s quarters”*. Participant 3 added, *“We need proper and comfortable accommodation, with at least basic needs like proper bathrooms and toilets, safety, water, and working stoves”*.

The public health sector in South Africa puts Generation Y medical doctors and their beneficiaries at risk. Certain quotes from participants to support this include the following: Participant 8 said, *“The working hours impact my productivity and attention to detail”*, to which Participant 10 added, *“If I do not eat before call, if the call starts, I forget to eat”*. Participant 3 said, *“Driving after a call or a long day is really risky for me or other drivers in the road”*.

The participants felt coerced to always be healthy because the system cannot afford to have them off sick; therefore, they are constantly working under pressure. Participant 9 was quoted as saying the following to support this view: *“I cannot be sick or take time off and enjoy it because we are short-staffed continually”*.

Participants agreed that their work expectations in reality from the South African public health sector are above their own scope of competence. They were of the view that they are taking responsibility and making decisions junior medical doctors should not be making. Some quotes supported this, including Participant 7 who said, *“Responsibility we are given is not for juniors.*

And at the same time, we are expected to do mundane tasks". Participant 3 was noted as saying, *"Workload is challenging and we have no support"*.

5.3.2.7 Discussion

Overall, this theme emphasised the collective view that generational Y medical doctors have poor working conditions, work long hours, see large numbers of patients, and are expected to deliver where there is a lack of resources. They also specified that their workplaces are severely understaffed with poor inflexible support for the workload, lack of support for traumatic chronic cases they feel are meant to be dealt with by seniors, and no support for their own emotional needs to cope with the trauma they face daily.

They verbalised a need for debriefing and getting assistance to develop adjusted coping strategies. At the same time, they feel helpless and hopeless that there will never be change because seniors and some stakeholders were mostly trained and exposed to the same dysfunctional South African public health system; therefore, they also function with poor coping strategies and burnout symptoms.

Caregivers commonly develop intense emotions towards those they care for, often prioritising the recipient's needs over their own. While helping and caring for others can be extremely fulfilling, it can also drain a person's emotional reserves (Lemaire & Wallace, 2017). The health system and society in general almost expect caregivers such as doctors to prioritise others at their own expense and work in poor conditions such as the public health sector with severe limitations, without protecting or supporting them. Doctors mostly enter the profession expecting to reap rewards for helping and saving lives. Yet, the very care they provide in these challenging conditions of the South African public health sector subjects them to the risk of severe burnout. The reality they face in their working conditions is not what they expected, which came as a shock for most of them; sadly the system does not offer processes to help them

with the shocking reality. Moreover, they themselves do not have adjusted coping strategies or past experiences to tap into in order to cope. They then go into a helpless, hopeless mode and do the bare minimum that they can to survive.

Certain work-related incidents could lead to gradually developing burnout such as feeling like one has little or no control over work; lack of recognition for good work; unclear or overly demanding job expectations; or working in a chaotic or high pressure environment (Maslach et al., 2001). Generation Y medical doctors are exposed to these work-related incidents daily. They had a shared view that work overload (increased number of patients) due to poor referral systems, unfair working conditions (lack of sufficient rest, hours they work); increased number of traumatic cases with no support (such as supervision, debriefing); and limited infrastructure and resources (such as staff members, equipment, medicines, primary healthcare facilities) deprive them of the pleasure that could be derived from working as medical doctors who are fulfilling their passion. They felt that their working experience in the South African public health sector has taken an opportunity away from them to learn and grow in the field of medicine.

Generation Y medical doctors know their limitations in terms of knowledge and skill, yet in the overburdened public health sector in South Africa, they are given responsibilities beyond their ability and are constantly dealing with traumatic cases (Thomas & Valli, 2006). They are responsible for people's lives but do not feel equipped. The public health sector in South Africa does not offer the opportunity to equip them and comes across as being unconcerned. They are coerced into working in a failing public health sector system and expected to manage. It is as if they are set up to fail and not treated like the professionals that they are.

The health system is dilapidated in South Africa, as in most African developing countries, due to the human resources crisis, understaffed hospitals and clinics, lack of resources, difficult

work schedules, poor career advancement, poor management of resources, and low job satisfaction (Thomas & Valli, 2006). Furthermore, there is a high incidence of severe and chronic untreatable diseases that Generation Y medical doctors need to deal with (Davhana-Maselesele & Igumbor, 2008).

There is a crisis in the health system due to the poor conditions that Generation Y medical doctors have to work in, which include burnout risk. However, the dilemma is that conditions such as burnout are not prioritised for prevention or management because of a lack of resources in developing countries or a mismanagement of resources. As a result of the crisis in the public health department, the well-being of caregivers and the service levels given to their beneficiaries are not prioritised.

The expectations that Generation Y medical doctors have of their work environment, the treatment from other professionals and stakeholders, and the expected reward for their work are not met in their working reality in the South African public health sector. They expected to be valued and appreciated, and not to be the lowest on the priority list. They expected to be rewarded in all possible ways for saving lives and to work in an environment where saving lives is made possible, yet the limitations they face are contrary to what they expected.

The situation leaves them baffled to say the least, which affects their professional identity they are developing as medical doctors (Goldie, 2012; Newman & Newman, 1991). They develop all sorts of negative feelings that put them at risk for burnout. The experience could also affect their entire way of being, their view of self, and negatively influence other arenas in their lives going forward because the impact is so deep within their core.

Their passion for saving lives and their desire to help others was met with numerous frustrations and is now becoming an unexpected lived nightmare. The continuous relationship with people in need and disadvantaged patients without personal relaxing time due to the pressure and poor

public health systems have led to apathy, loss of enthusiasm, frustration, and drained emotional reserves (Gitto & Trimarchi, 2016; Lemaire & Wallace, 2017; Mathias & Wentzel, 2017).

To complicate matters, Generation Y medical doctors have no coping strategies, support systems or empathetic advisors in the public health system. They are left to find their own solutions and survive, which can lead to more complications such as having feelings of isolation, developing poor coping strategies, suffering from severe burnout, and developing severe mental health issues.

5.3.2.8 Working hypothesis

The Generation Y medical doctors shared their experiences about the broader challenges in South Africa that affect the public health system. They deal with the challenges daily and described what affected them negatively as Generation Y medical doctors working in the South African public health sector.

These challenges were given by the participants and were listed as the following subthemes: high volumes of patients/workload; limited staff, infrastructure, knowledge and resources for workload; mismanagement of funds in the South African public health sector; compromised learning and teaching due to workload; challenges and lack of solutions as a microcosm of the government and unlawful public sector expectations of Generation Y medical doctors.

The working hypothesis derived from burnout experience Theme 2 and its subthemes is: There are broader challenges in South Africa affecting the public health sector that contribute to the development of burnout in Generation Y medical doctors working in the public health sector.

5.3.3 Theme 3: Burnout in Generation Y medical doctors

The third theme highlighted was the actual experience of burnout by Generation Y medical doctors. The participants underlined subthemes in describing how they feel the working conditions have had a negative impact on them as Generation Y medical doctors, leading to the experience of burnout. These subthemes were: normalisation of trauma (depersonalisation); emotional exhaustion; reduced personal competence and burnout manifestation before group coaching intervention exposure. Each subtheme is given in the following subsections with the participants' attestations, a discussion and working hypothesis.

5.3.3.1 Subtheme 3.1: Normalisation of trauma (depersonalisation)

A characteristic of burnout is depersonalisation, cynicism or a negative attitude, which is the occurrence of a negative cynical insensitive attitude and feelings about clientele. It includes detachment from work, which leads to feeling dispassion towards patients and viewing work and/or relationships in the workplace in a dehumanised manner (Nuallong, 2013; Ryan, 1971).

In extreme cases, this dehumanised view of patients leads to an extent that the professional views the clients as undeserving of their services (Maslach et al., 1996). There seems to be an extreme move towards the negative with professionals presenting with indications such as undesirable health; diminished energy; feeling detached; cynicism or being critical; or destructive outlooks of work, organisation, or colleagues (Maslach et al., 1996). This cynicism was present in the Generation Y medical doctors.

The participants reported that they felt that they were expected to adapt poor coping mechanisms as seen in senior medical doctors in order to cope with the poor abnormal and unlawful working conditions in the public health sector where they were coerced to work. It came across as if they felt that they were expected to learn how to depersonalise and normalise;

for example, they had to depersonalise the daily trauma they come across to cope with working in the public health sector.

They observed that the seniors were not coping and saw that stakeholders have done nothing to assist them. The senior medical doctors training the Generation Y medical doctors were themselves trained in the same malfunctioning system and the participants are of view that the cycle of poor coping mechanisms will continue and be taught to them as juniors entering the system, because it is all their seniors know. Some quotes by the Generation Y medical doctors to support this are given.

Participant 1 stated, *“Trauma and death are made to seem normal and we are exposed to this right from university level”*. Participant 2 added, *“A patient is lost and no one cares, and apparently, I need to learn to stop caring which is not easy”*. Participant 7 emphasised, *“The seniors are not taught how to deal with the trauma in them let alone in assisting us, therefore we conclude that it is how life is supposed to be and carry on”*.

Participant 10 stated, *“If the seniors say it is normal, they are there to initiate us to this system with its ‘new normal’ it seems we need to accept as normal to treat death and trauma like they are nothing. And once you go through the system, once you become a senior you end up doing unto others how it was done to you. It is an ongoing cycle”*.

Participant 3 said, *“The senior doctors’ deal with death like nothing happened, and we are expected to do the same and move on quickly to other patients as if ‘death’ is normal. The units like (oncology) where there was a lot of trauma and death were difficult for me to handle; especially the children’s deaths. Yet I had to face it like I was okay”*.

Generation Y medical doctors are coerced to work in the public health system that is not functional. They seem to have the same system with its poor working conditions to look

forward to in future, because of what they see in their seniors. They notice that the public health system in South Africa has the potential to change a person for the worse, like the seniors seemingly were changed, and they cannot escape the very system. The Generation Y medical doctors fear they will end up like the “far gone” senior medical doctors. This perpetuates a sense of helplessness, frustration and being stuck. They deal with trauma and ethical dilemmas that they are told is the norm; therefore, they need to as Participant 8 said, *“learn to just push through and do what is expected”*.

As much as the Generation Y medical doctors are expected to normalise the trauma and experiences, it is not easy for them. One of the Generation Y medical doctors, Participant 9 stated, *“It is difficult to see and work with colleagues that do not care anymore”*. Participant 4 added, *“I struggle to certify people as dead so often as if it is ‘normal’”*. Lastly, Participant 2 said, *“I had an ethical dilemma whereby I was expected to perform termination of pregnancies (TOPs) so often and yet it is the norm, and I had no one to talk to about it. I had to do it because if I didn’t I would have to deal with a complicated backstreet termination which the patient would end up doing because they feel they have no other choice”*.

The typical reaction of health professionals to their work environment and its burdens is usually negative cognitions such as *“my ability to participate is over”*, and *“I still want to help but I cannot do it anymore”* (Maslach, 1982). The experience leads to an affected feeling like they have nothing left to give. One common way of ridding these feelings is for them to decide to avoid emotional involvement by reducing time and personal involvement with patients, colleagues and, in the extreme, people in their personal lives. Isolating has its own challenges as humans are made to care; therefore, the person becomes task oriented, emotionally blunted, normalises what is abnormal, becomes rule focused, and genuinely does not cope (Gitto & Trimarchi, 2016).

Most Generation Y medical doctors seem to describe their seniors as going through such an experience. They are frustrated because they feel they are expected to depersonalise in a similar manner as their mentors. They are struggling with being coerced to develop such a maladjusted coping mechanism. At the same time, they are feeling stuck because they do not seem to have the skills or because many mentors are showing them different adjusted coping strategies. This leads to negative feelings such as helplessness, hopelessness, and isolation. They want to change, yet they are not assisted to achieve this change.

5.3.3.2 *Subtheme 3.2: Emotional exhaustion*

Emotional exhaustion is described as a reduction of mental and psychological resources that influence the ‘amount’ of mood; for example, diminishing mental energy (Maslach & Jackson, 1986; Nuallong, 2013). This appears to be a key dimension that is considered as central and most obvious in the manifestation of burnout (Milićević-Kalašić, 2013). Exhaustion basically is a feeling of being overextended and depleted of emotional and physical resources; this emotional exhaustion state represents the strain dimension of burnout (Helkavaara, 2013). The MBI-GS scores before exposure to the group coaching intervention showed that all participants had high emotional exhaustion scores; most had low depersonalisation scores; and a smaller number had moderate and high scores for emotional exhaustion and depersonalisation. Most participants had moderate and low scores for personal competence. According to Leiter and Maslach (1988), emotional exhaustion is the initial and core component of burnout.

Some descriptions of experiences by the participants indicated that they experienced emotional exhaustion. Participant 6 stated, “*Sisters have tea breaks and lunch; there was a sister who during resuscitation said it is her tea time and left the room, and a new sister had to come in. I had to now explain what was happening to catch the new sister up during a hectic*

resuscitation. The sister who left just disengaged and left with no emotions. I felt so exasperated, exhausted and frustrated and yet I could not leave, or make her stay”.

Some shared experiences include negative emotions because of the challenges they face daily. A supporting quote made by the Participant 7 was: *“We see many patients and are under pressure, at times we deal with difficult patients who default treatment and do not co-operate and there is a need to bargain with them or convince them. This leads to a lot of anger towards patients and consultants blame us for not being able to convince patients of treatment”.*

The group of participants had commonly noticed how the poor working conditions and increased pressure had a negative impact, which was evident in their own personality changes and certain behaviours. These changes affect interpersonal relationships with colleagues and significant others (family and social), even self-functioning. They also noted to have feelings of hopelessness, unappreciation, fatigue, diminished interest in work, and being constantly overwhelmed.

Quotes from participants stated in view of this include the following. Participant 9 stated, *“Work stress is making me emotional; affecting my home life”*, to which Participant 6 added, *“My fiancé is constantly asking if he did something wrong”*. Participant 1 mentioned, *“I feel devalued constantly because of this work”*. Participant 5 added, *“I know my limits and yet they are pushed beyond here. I am not coping”*. Participant 2 said, *“Time passes and I am missing out on small moments because I am not myself due to my work”*.

Some Generation Y medical doctors collectively reported to have *“reduced empathy and increased irritability”*. Quotes by the participants to support this include the following. Participant 3 said, *“With the ongoing pressure, it becomes difficult to understand when peer colleague is off and I must fill in for them”*. Participant 4 stated, *“This work and environment*

makes one harsh; like I would leave patients because it is 4 pm and another doctor must take over, so I just leave before the other arrives”.

The work seems to take a little bit of them away and it consumes them, while they struggle to cope with it. Participant 7 is quoted as saying, *“I took time off – sick leave – per rotation, it is hard and still it is not enough”*, and Participant 8 added, *“The work is overwhelming. No time for myself, no time to study or get enough sleep”*.

All Generation Y medical doctor are feeling overwhelmed and watching as they go deeper into the sense of being overwhelmed. They feel they do not have coping mechanisms to handle the work cases, workload, environment, working conditions or expectations. There is a learned helplessness that leads to them being on ‘autopilot mode’. This puts them at risk for depersonalisation, which is a sign of burnout.

Supporting quotes from participants include the following. Participant 10 said, *“I am barely coping with increased poor adaptation to the environment”*; Participant 2 was noted as saying, *“I have no coping mechanism – as long as I am alive, I wake up and just go to work and come back”*. Participant 5 added, *“My work is changing me for the worse, draining me and impacting me negatively in all spheres of life; and I do not know what to do”*. Participant 1 mentioned, *“I try to relax; I have been burnt out for so long and functioning now on autopilot. I have ideas to do other things but cannot do anything. I am physically and emotionally tired. I believe it is not how life is meant to be, yet I have been doing it for 2 years now”*.

Certain situations or ethical dilemmas cause more frustration, touching on their human element. Quotes from participants to support this include the following. Participant 6 stated, *“I am challenged a lot by mothers who neglect their children”*; Participant 7 added, *“I cannot handle children dying”*; and Participant 9 said, *“I struggle with dealing with sickly dying patients and termination of pregnancies”*.

Another notable negative impact was the expressed physical exhaustion, leading to an increased risk of Generation Y medical doctors making mistakes at work. Worth noting as well was the negative impact that Generation Y medical doctors mentioned regarding their cognitive functioning. Quotes from the participants to support this concern include the following: Participant 3 stated, *“Working hours should be reduced; I believe it is abnormal for any person to work more than 24 hours”*; Participant 4 added, *“I have poor concentration most times because I am exhausted”*; lastly, Participant 8 said, *“I easily make mistakes because I am exhausted”*.

An experience of burnout before the group coaching intervention exposure was evident within the participants. The Generation Y medical doctors all viewed themselves as experiencing burnout when completing the questionnaire in the pre-coaching intervention phase. Reasons given could be grouped into physical and emotional exhaustion, negative cognitive impact they felt, and reduced view of competence, which affected the self and their work.

Some quotations from the Generation Y medical doctors to support the overall experience of burnout they were having before the group coaching intervention for burnout amongst Generation Y medical doctors include what was said by Participant 1: *“I experience of fatigue and increased need for sleep, always feeling tired”*; Participant 2 added, *“I am constantly irritable”*; Participant 5 said, *“I have decreased concentration”*; lastly, Participant 6 stated, *“I have not being able to concentrate or work effectively”*.

More quotations to support their experience of burnout before being exposed to the group coaching intervention include the following: Participant 9 said, *“I feel malaise (sickness, illness); I even had shingles secondary to stress”*; Participant 7 added, *“I am very forgetful suddenly”*; lastly, Participants 8 and 10 stated, *“I am always feeling sad (crying before every*

call and at home)” and *“I find myself dreaming and thinking about patients constantly, not being able to switch off work”*.

Participant 5 mentioned the following: *“I have decreased ability to think since being here”*; Participant 6 stated, *“I have become moody and impatient”*; lastly, Participants 3 and 4 added, *“I have loss of interest in work-related subjects”* and *“I find it difficult to wake up to prepare for work”*.

There is a view that high empathy can cause greater emotional arousal and distress. Reducing empathy is a survival mechanism to cope with emotional stress. High empathy has been linked with a negative impact on health professionals’ mental health. Empathy can put one at risk for burnout, which is characterised by feeling exhausted, emotionally depleted, cynical, and often detached. With burnout, people tend to show less empathy for others, which is compassion fatigue (Wagaman et al., 2015).

The motivation to join the medical field is influenced by many factors: economic factors together with personal motivations and skills. There is a strong need in people who choose to become health professionals to help others. Some tend to be more empathetic while others want to be seen as great. Thus, the choice and character of the person entering the medical field can predispose them to developing burnout.

Caring, especially in difficult working environments such as the South African public health sector, comes at an extremely high personal price. The passion to help others can be fulfilling but, at the same time, come at a cost (Gitto & Trimarchi, 2016; Lemaire & Wallace, 2017). It can lead to drained emotional reserves, feelings of overwhelming exhaustion, depersonalisation or cynicism and a sense of professional inefficiency, which all constitute burnout.

The collective experience for the Generation Y medical doctors seem to indicate that they mostly feel depleted of physical and emotional resources to carry on. They also feel let down by their seniors and the stakeholders of the public health sector system as there seems to be no solution emanating from them. The combination of excessive workload, imbalance between job demands and skills, lack of job control (conflict situations or role ambiguity), insufficient gratification, collapsed sense of belonging (lacking teamwork, lack of respect), and prolonged stress have contributed to the experience of emotional exhaustion. The participants admit that emotional exhaustion leads to them making medical errors; giving reduced quality of care, which affects patient satisfaction; and developing poor coping strategies (Panagioti et al., 2016).

The coping strategies they are expected to develop seem to go against who they are and they struggling with this; for example, the modelled coping strategies include normalising trauma (depersonalisation), having reduced empathy, isolating themselves, and developing a 'do not care attitude' like the seniors, which is something they do not approve of for themselves. There are also overwhelming feelings participants developed that need attention; such as feelings of isolation, identity crisis, confusion, pessimism regarding future, frustration, hopelessness, helplessness, sadness, emotional depletion, emotional stress, and overall compassion fatigue.

5.3.3.3 Subtheme 3.3: Reduced personal competence

Another dimension of burnout is reduced accomplishment or personal inefficiency. It is due to a negative perception of personal accomplishment, loss of competence and productivity, plus an inclination to be evaluated negatively to preceding or existing accomplishments at work (Maslach & Jackson, 1981). It is negative view of self-efficacy (Evers et al., 2002); basically viewing of the self in a negative manner especially in relation to one's work with clients and a feeling of dissatisfaction about accomplishments on the job (Maslach et al., 1996). If this

negative view persists, individuals are at risk to experience a self-inflicted view of self as a disappointment (Fink, 2007).

The participants mentioned that they lost confidence in themselves as people and as medical doctors. Some participants were quoted as saying the following to emphasise this view: Participant 1 stated, *“Continually feel like I am not competent in doing this work”*; Participant 2 added, *“I lack confidence and doubt my own competence”*; lastly, Participant 6 said, *“I feel I failed as a doctor and that the system failed me”*.

The Generation Y medical doctors’ expectations, reasons for entering medicine, and ideal ideas of the medical field were not met by the reality of the working conditions in the public health sector in South Africa. Most had entered the medical field for certain reasons, which they deem are not being met, or are diminishing quickly because of the reality of working in the public health sector. Some entered the field with the hope of providing help for the sick and the vulnerable; to fulfil a dream; to fulfil a passion to help; because they have a passion for people; and to be challenged to be a great medical doctor, but the reality of working conditions is not meeting their expectation as seen in the following quotes. Participant 9 stated, *“I wanted to help and educate people in community with health issues. Not doing this currently”*; and Participant 10 added, *“I had desire to help and impact people’s lives. Not seeing this now in reality”*.

The statements made by the participants included the following: Participant 5 said, *“I enjoyed working with people. But it is not easy in these conditions”*; Participant 6 emphasised this by stating, *“I love working and changing people’s lives. Wanted to help those who cannot help themselves; positively influence others, while supporting my family. It is difficult to see this positive impact I have now in these working conditions”*.

More statements made by the participants include the following: Participant 6 stated, *“It started in grade 3, I helped a friend with a nose bleed and he appreciated the help. I felt a feeling I could not explain and I liked it. I enjoy especially when patients express their gratitude towards care received. It is not always the case in reality”*; Participant 7 added, *“I wanted a challenging job that would not get me bored. Helping people through pains and succeeding through it is so great when it does happen but rarely in this job now”*. Participant 8 said, *“I loved science and humanism, so medicine offered the opportunity to combine both. My choice, being medicine, is bit exhausting now”*; and lastly Participant 7 added, *“I always wanted to be a medical doctor growing up, since childhood. I got the motivation from family. I didn’t know it would be like this tough”*.

The reality of the working environment in the public health sector seems to have taken away the passion and confidence of the Generation Y medical doctors when entering the medical field, therefore, leaving them feeling incompetent. They feel let down by the public health sector in South Africa that was meant to appreciate them for wanting to save lives, to care for them, and to equip them with more knowledge to improve saving lives.

5.3.3.4 Discussion

Burnout constructs are increased emotional exhaustion, depersonalisation or cynicism, implying a negative attitude towards a number of aspects especially clients and, lastly, increased tendency for negative evaluation of the self as lacking professional accomplishment or competence (Maslach & Jackson 1981, 1986). Leiter and Maslach (1988) proposed a process model of burnout, which begins with emotional exhaustion, often leads to depersonalisation and, subsequently, leads to reduced personal accomplishment. Potential presentation of burnout can be emotional, social, cognitive or physical.

The participants' reports in the pre-coaching intervention phase could be summarised into indications of burnout, which are categorised as fitting the burnout constructs, namely, depersonalisation, emotional exhaustion, and/or reduced personal competence. There were, for example, reported emotional indications typical in emotional exhaustion burnout construct being: impatience, irritability, frustration, depressive reactions, feelings hopelessness, and powerlessness. There were also reported burnout consequent behaviours that are typical in individuals who are burnt out, such as:

- Social effects: avoiding professional contacts, withdrawal, and irritability at home.
- Physical indications: sickness and fatigue.
- Cognitive signs: diminished concentration and/or productivity, inability to cope, and loss of initiative.

The Generation Y medical doctors are likely feeling as if they have been stripped of their power to save lives and are not being rewarded for their empathy. They are feeling shocked by the reality they are facing. Furthermore, their identity (Goldie, 2012; Newman & Newman, 1991) is being challenged, which was wrapped around being medical doctors.

Developing countries have challenges in their systems, such as the public health sector. South Africa faces the same situation (Davhana-Maselesele & Igumbor, 2008; Phalime, 2014; Thomas & Valli, 2006). Health caregivers often find themselves working in terrible conditions in the South African public health sector. Caring for the caregiver is usually not a priority to government. Sadly, Generation Y medical doctors feel that there is a great deal of corruption, mismanagement, lack of resources, and basically no concern for health workers and the conditions they work in in South Africa. Health and wellness of public health sector workers are not prioritised and yet they are expected to render services to many people in understaffed

and underresourced infrastructure under unlawful labour conditions. They are expected to provide proper services without being affected negatively (Erasmus, 2012).

Over and above the many challenges that Generation Y medical doctors face is the reality of poor working and unlawful labour conditions in the South African public health sector (Erasmus, 2012). They are expected to work in understaffed conditions for long hours. Should they fall ill or go on leave, there is no provision for a stand-in as the hospitals are understaffed (Erasmus, 2012). This implies that the Generation Y medical doctors are constantly working under pressure. Because of shortages of senior staff members in the various sections of the public health sector, Generation Y medical doctors find themselves making decisions that they would not ordinarily have to make under ideal conditions should there have been enough staff members at all levels in all units (Erasmus, 2012).

The system is continually under pressure, which affects the Generation Y medical doctors, their beneficiaries, the public health sector itself, and other stakeholders. In this current study, many conditions that are deemed unlawful and the expectations from the public health sector in South Africa were mentioned by the Generation Y medical doctors in their experiences. These include being overloaded by work, working long hours, and having to make decisions that should not be made as a junior medical doctor.

The findings showed a shared experience amongst Generation Y medical doctors of a hypothesised loss of power. They probably felt some kind of power and sense of control when they completed their medical degree. They were ready to save lives. Another view I have is that Generation Y medical doctors likely developed and are still developing an identity wrapped around their qualification: a professional identity (Goldie, 2012; Newman & Newman, 1991). Unfortunately, once they entered the public health sector, that identity was shattered by the reality of their work environment; therefore, leading to them question who

they really are and a struggle to attempt to deal with it. It is almost as if they are experiencing an identity crisis (Newman & Newman, 1991).

They are in young adulthood and some are starting towards the middle age stages of development as based on Newman's revision of Erikson's psychological stage model (Newman & Newman, 1991). The dilemma and main process for the young adulthood stage is intimacy versus isolation with the main focus on mutuality with peers. The resulting virtue and positive self-description could be 'love': "*I can be intimate with another*". However, on the other hand, the negative self-description leading to a crisis could be 'exclusivity': "*I have no time for others so I will shut them out*" (Newman & Newman, 1991).

The middle age stage dilemma and process is productivity versus stagnation; person environment fit and creativity. The resulting virtue and positive self-description could be 'care': "*I am committed to making the world a better place*". However, on the other hand, the negative self-description leading to a crisis could be 'rejectivity': "*I do not care about the future of others, only my own future*" (Newman & Newman, 1991). Younger adults experience more major life changes and need to deal with role shifts from entering young adulthood. This period of development is innate with changes and potential difficulties.

The Generation Y medical doctors are at negative risk when they enter a difficult working environment such as the public health sector in South Africa because of their developmental stage. The experience of burnout further puts them at risk for a possible developmental crisis in the young adulthood phase as well as the middle age phase. The crises of both stages, namely, exclusivity and rejectivity, could have a long-lasting impact on their personality and emotional functioning. Burnout itself is a negative outcome that could exacerbate exclusivity and rejectivity as attempted coping strategies for the participants. Their professional identity as

medical doctors is also at risk because of their experience of burnout that developed secondary to the working environment (Goldie, 2012; Newman & Newman, 1991).

The struggle occurs within for them, seemingly because they are not prepared for it and therefore have no way of coping with it. Additionally, it is a struggle because the public health sector in South Africa is so pressurised that it does not allow for one to reflect within and learn coping strategies at one's own pace. Furthermore, the public health sector does not offer prioritised support for those affected by, or at risk of burnout. This then can lead to maladjusted coping strategies and incidents of burnout as seen in this study. Burnout presents itself in different ways. In the study it was seen in the themes that emerged, which had an underlying overall feeling of negativity about their support, mentors they had, work overload, themselves, and even the medical field.

Another probable shared experience looks at compassion and empathy. The need to show compassion and empathy is one of the common motivators for most entrants into the medical field (Gitto & Trimarchi, 2016), including those in the current study. There is a perception that the two motivators are in themselves adequate reward for the long hours and the training in the field. However, once the Generation Y medical doctors enter the field and have to work in the public health sector, there is a realisation that compassion and empathy are not enough. In fact, compassion and empathy can cause more harm, which is presented in the form of burnout.

Overall, there is a disconnection between what was expected and the actual experience of Generation Y medical doctors working in the public health sector. This disconnect puts them at risk for burnout. Burnout in itself is a subtle, often unwanted and misunderstood experience. It leads to people feeling like they have nothing more to offer. It can be an uncomfortable, confusing time when a person is burnt out, even more so with the current Generation Y medical doctors when it is motivated by some form of identity crisis (Goldie, 2012; Newman &

Newman, 1991), an unadaptable environment such as the public health sector, and other overwhelming experiences regarding key motivators for entering the field such as compassion and empathy versus the reality. Burnout can cause conflict within themselves, but also within the context of the workplace and other areas such as the home environment.

5.3.3.5 Working hypothesis

The working hypothesis derived from burnout experience Theme 3 and its subthemes is: Working environment in the public health sector has led to the experience of burnout in Generation Y medical doctors, motivating for a need for constant intervention.

5.3.4 Theme 4: Burnout consequences in Generation Y medical doctors

The fourth theme highlighted was burnout consequences in Generation Y medical doctors. The participants underlined subthemes in describing how they feel about their working conditions in the public health sector, which led to burnout and certain negative consequences to them as Generation Y medical doctors. These subthemes are diminished trust for the public health sector; decreased interest in the field of medicine; compromised patient and self-care; and overwhelmed coping strategies before group coaching intervention exposure. Each subtheme is given in the following section with the participants' attestations, a discussion and working hypothesis.

5.3.4.1 Subtheme 4.1: Diminished trust in the public health sector

The overall work experiences Generation Y medical doctors are exposed to seemingly led to burnout experience, which exacerbated or steered to disappointment, frustration, diminished trust in the public health sector, and sadness they feel for patients who have no other choice but to use the failing public health sector in South Africa. This is seen in the following quotations from participants. Participant 1 said, "*I feel sad for patients because they cannot*

afford private health care, it's sad that things like poor resources means they can't receive help in the South African public health sector; their only option". Participant 2 added, "I do not trust the public health hospitals in South Africa to recommend them for my own family". Participant 5 stated, "I am disappointed with the public health system in South Africa, specifically the Limpopo Province".

5.3.4.2 Subtheme 4.2: Decreased interest in the field of medicine

There was a common view of enforced diminished interest in the medical discipline or specialisation due to the working conditions in the South African public health sector that the Generation Y medical doctors were exposed to. This is suggested by the following that was said by Participant 5: *"The work and the environment removes the passion and drive to specialise. Limpopo Health seems to be doing very terribly in this regard, because you do not get specialists or registrars; it is full of chronic medical officers"*. Participant 3 stated, *"I loved paediatrics, now never would I dream to specialise in it"*, and Participant 7 added, *"Many days I ask why I am in this field – medicine. I want to retire at 30; I am exhausted and medicine is killing me"*. This view of decreased interest in the medical field was further emphasised by the following statements:

Participant 6 said, *"I have always wanted to be a medical doctor since the age of 3. After seeing the reality and state of Public Health Department in South Africa I do not want to specialise. I would just be medical officer, go to work and knock off. There are chronic medical officers in Limpopo and I will likely join them"*;

Participant 5 added, *"Even at school, it is same poor conditions in hospital. So, I ask now where do I start to specialise? Passion is sucked out; a shell is what goes to work"*.

This statement was also made by Participant 8, *“I wanted to specialise in obstetrics and gynaecology. I hate obstetrics now following rotation it; and increased litigation that often occurs because the medical doctors are being sued is adding to the demotivation. Therefore, I need to find another specialty which I would hopefully fall in love with and have the strength to pursue”*.

Participant 10 stated, *“It is difficult to practice medicine in Limpopo. Even in specialising; if I ever do I will go to another province hoping it is a different experience”*.

More Generation Y medical doctors added their views, which included Participant 4 who said, *“I do not personally see myself practising medicine for the rest of my life; based on the experiences I have encountered since entering the field”*; Participant 3 said, *“Registrar posts were cut, therefore all aspirations to grow also cut. After experiencing the Limpopo Health not sure if I want to specialise here”*; and lastly Participant 8 said, *“I avoid hanging out with people in medicine field, because I want to run far away from it”*.

There was an overall view of diminished appreciation of medicine by the Generation Y medical doctors due to the reality of working conditions in the South African public health sector. Some testimonials made by the participants were as follows: Participant 7 stated, *“I experience regret for entering the field, sometimes due to the bad facilities, long working hours that are discouraging”*. Participant 5 declared, *“I have no regret of being a medical doctor but feel overwhelmed by the workload, working hours, poor conditions, system and the challenges I face daily”*; and, lastly, Participant 2 asserted, *“I have regrets linked more with ethical dilemma of doing termination of pregnancies, at the same time knowing that if it is not done by me it will be done ‘backstreet’ causing danger for the patient which I will have to deal with because they will come here for admission”*.

5.3.4.3 Subtheme 4.3: Compromised patient and self-care

The participants noted the negative impact of working conditions (such as overload, poor resources and infrastructure, and long working hours) on the level of care given to patients. They also noted how these conditions influence them as caregivers and in their own personal lives. Quotations from the Generation Y medical doctors supporting this are as follows: Participant 1 stated, *“Dealing with too many sick patients and lots of deaths compromises care I give”*. Participant 2 added, *“When overworked and discouraged you tend to be careless and do not put as much attention into the work”*.

The Generation Y medical doctors emphasised how the poor working conditions, especially working long hours without rest, increase the negative risk for their own safety and the safety of the patients they care for; this was suggested by the following quote from Participant 3: *“Working long hours without rest, we have to risk and go up to 30 hours. After 24 hours of being awake, working with no breaks, I tend to not be productive”*.

5.3.4.4 Subtheme 4.4: Overwhelmed coping strategies before coaching intervention exposure

The Generation Y medical doctors often highlighted their feelings of being overwhelmed or having limited coping strategies before being exposed the group coaching intervention. Some participants stated that they chose certain support measures, which included seeking spiritual support, team support or help from experienced health caregivers. Quotations from participants to support this included what was said by Participant 9: *“To cope, I kept the faith that all will be well and befriended the experienced nurses”*; Participants 8 and 5 added, *“Prayer also helps”* and *“Teamwork with other junior medical doctors, trying to help each other”*.

Some engaged significant others for support as seen in the following statements: Participant 5 said, *“I sought support from family, husband and church friends”*; Participant 2 added,

“I learned to speak about some challenges with family, though I do not want to overburden them”; and, lastly, Participant 8 mentioned, *“I started socialising more with family members and colleagues”*.

Some participants attempted taking time-outs and engaging in self-care. Quotes alluding to this from participants included the following: Participant 4 stated, *“I attempted to get an hour or so breaks during calls; but in certain rotations it is not so possible”*. Participant 7 supported this statement by saying, *“I signed up for gym, not able to attend”*, to which Participant 6 added, *“I started reading about non-work-related subjects”*; and, lastly, Participant 10 mentioned, *“I am going to gym”*.

Based on responses by the participants, it appears there were some who attempted to reframe the challenge in order to be able to cope. Some quotes from the participants to this effect included what was said by Participant 10: *“I took the challenges as character and confidence building for me as a medical doctor”*, and Participant 5 stated, *“The challenges taught me to be a part of a team”*. Participant 8 added, *“I would remind myself that I will be ending a difficult rotation soon. So, I just need to wait it out, told myself it will be over”*. Participant 4 is quoted as saying, *“I forced myself to remember that I have to go through rotations I do not like, like surgery, to qualify to practice”*; and, lastly, Participant 1 said, *“I had to find a way to deal with ethical dilemmas; I convinced self that TOP (termination of pregnancy) is better to it than to deal with complication of unsafe abortion”*.

There were some indications of self-stimulation by some participants, for example, Participant 2 who said, *“I take energy drinks”*. Others alluded to adjusting their lifestyles to accommodate work demands as seen in the quote from Participant 3: *“I struggled to cope as the challenges are beyond my control. I had to reduce social life and other activities in an attempt to get enough sleep”*. Participant 4 stated that she accepted the situation as beyond her

control though she remained feeling frustrated, which led to her adopting a learned helplessness stance: *“I have no authority to do anything about the challenges in the department, so I accepted that they are there and beyond my control”*.

Some admitted to having no coping ability whatsoever or a limited coping style. Statements were made from participants such as what was said by Participant 5: *“I became withdrawn, not coping at all”*; and Participant 9 stated, *“I kept it all to myself and became irritable. Then I would burst; it doesn’t work at all this approach”*. More statements were made by participants, which included what was said by Participant 1: *“I am not coping at all”*; Participant 6 stated, *“I signed up for gym but never used it. I am too fatigued most times to try use gym as a coping mechanism”*. Additionally, two Generation Y medical doctors, Participants 9 and 10 said, *“I am too exhausted to attend anything the intern coordinator tries to organise for us to de-stress”* and *“I avoid hospital and anything or anyone linked to it. It doesn’t help though”*.

5.3.4.5 Discussion

Burnout spills over and affects all areas of life as well as long-term changes. It is a gradual process that starts out in a subtle manner and gets worse over time. Although burnout can be associated with stress, stress is about too much demand whereas burnout is having nothing left to give. If not understood, burnout can be debilitating and cause negative consequences that compromise the level of care and the caregiver such as what is seen in the Generation Y medical doctors working in the public health sector at the hospital.

They seem to be experiencing burnout and related consequences such as diminished trust in the public health sector; decreased interest in the field of medicine; compromised patient and self-care; and overwhelmed coping strategies. Burnout generally makes a person feel as if they have nothing left to give, which can lead to certain manifestations depending on the character

of the person or the experience and perception thereof. Negative experiences and feelings are common when one is experiencing burnout. Coping strategies can typically be overwhelming.

There is an underlying sense of helplessness in coping or facing the working environment as seen with the participants' collective experience. Even more so with the Generation Y medical doctors because this is mostly their first working experience; therefore, they cannot draw from previously gained coping skills and sadly have no support structures to learn from.

They are left to find their own way in dealing with what they face; this can be incredibly frustrating and lead to blaming of mentors, rejecting the public health sector system, and having feelings of isolation amongst many other overwhelming feelings. They would additionally need to admit that they are not coping and in need of help, which is never easy for most people.

5.3.4.6 Working hypothesis

The working hypothesis derived from burnout experience Theme 4 and its subthemes is: The public health sector work environment is likely to lead to the experience of burnout and its consequences in Generation Y medical doctors.

5.4 Themes Relating to the Coaching Intervention

Certain themes were identified about the experience of burnout and the group coaching intervention for burnout amongst Generation Y medical doctors working in the public health sector in the hospital. The previous section indicated the four major themes and associated subthemes that emerged from their burnout experiences.

This section explores the six main themes and related subthemes that were derived from the experiences of the group coaching intervention. The participants articulated their perceptions

of their experience of the group coaching intervention for burnout. The themes are summarised into six broad themes, namely:

- Theme 1: Opinions of the coaching intervention;
- Theme 2: Alterations to the coaching intervention;
- Theme 3: Benefits of the coaching intervention;
- Theme 4: Lessons gained from the coaching intervention;
- Theme 5: Implementation of coping strategies; and
- Theme 6: Post-coaching intervention experiences.

The six themes are discussed in the subsections that follow with the participants' attestations, a discussion, and working hypothesis.

5.4.1 Theme 1: Opinions of the coaching intervention

The first main theme to be highlighted was the overall view of the group coaching intervention for burnout amongst Generation Y medical doctors. The main question posed was: "How did you feel about having to come through for this coaching intervention session?". The participants highlighted to have had "*excitement at the idea of intervention*" and some "*lack of interest developed into appreciation*" as subthemes when describing their experiences of the coaching intervention. The subthemes are discussed below, followed by a discussion and working hypothesis.

5.4.1.1 Subtheme 1.1: Excitement at the idea of intervention

Some participants welcomed the idea of a coaching intervention with the hope of sustainability as they feel they need intervention constantly. This is indicated by the following that was said by Participant 1: "*Excitement I had about this intervention because my first year of working in*

the public health sector was terrible; I wish the intervention could happen more often”, to which Participant 2 added, *“I’m hoping we get this sort of debriefing sessions regularly because we need them to cope”*.

The other participants also perceived the group coaching intervention as an opportunity that was provided for self-reflection, which they deemed was essential. It was seen in the following quotes: Participant 5 stated, *“The MBI-GS questionnaire made one think and reflect. And to look within which I hardly do nowadays because of the work pressure”*. Participant 6 added, *“Even the coaching intervention session created a need to introspect and reflect within which is important”*.

At the same time, they were cynical about whether stakeholders would respond positively and hear their pleas for better working conditions in the South African public health sector. They were doubtful that stakeholders would even follow the current study. They deemed that the findings would show that they are overwhelmed and in need of help, and emphasised how the help is beneficial. The following quotes were from participants supporting this view: Participant 10 said, *“I do not know whether the stakeholders would take the research to heart, they seem not to care about us”*. Another Generation Y medical doctor, Participant 7 added, *“This research and intervention will show we are overwhelmed because of the poor working conditions and that we need help continually to cope, and how we benefitted from your intervention, but I wonder if they will take it to heart”*.

5.4.1.2 Subtheme 1.2: Lack of interest developed into appreciation

Some participants were a bit sceptical and not looking forward to the group coaching intervention session. The intern leader, who also attended, had reportedly pre-empted that the Generation Y medical doctors would not attend due to low morale and encouraged them to attend. This came out during the group coaching intervention process. I as the researcher and

coach emphasized voluntary participation in the beginning and even at this time. Once the coaching intervention session got underway, their previous reluctance turned into appreciation of the experience. This is supported by the following quotes from the Generation Y medical doctors: Participant 6 said, *“Initially I was not looking forward to it, came only because it was encouraged. I realise though I would have missed out if I stayed away”*. Participant 4 added, *“I imagined it will be PowerPoint boring presentation. But glad it was not”*. Participant 3 reiterated, *“The idea of it being run by a clinical psychologist led to some weariness, because I have never been to a clinical psychologist. I am honestly pleasantly surprised by how it unfolded”*.

5.4.1.3 Discussion

Burnout is misunderstood by people experiencing it and those around them. A further misunderstanding is the needed intervention that is not prioritised or sought after. The development of burnout is gradual and it can isolate people even if it is a shared group experience. It is only when one speaks to someone in a similar position that one realises they are not crazy, weak or alone in their experiences (Bährer-Kohler, 2011).

Additionally, there is considerable stigma related to professional psychologists and most psychological interventions. For one to seek help, they need to admit that there is a problem, look within in self-reflection, and be comfortable with being vulnerable (Vogel, Wade & Haake, 2006). It is not easy to admit that and many people such as Generation Y medical doctors do not want to admit they are struggling, especially when people are expecting them to cope.

The Generation Y medical doctors resisted the group coaching intervention idea as expected, likely because of a combination of factors such as their personalities; experiences; state of mind; burnout experience (which includes cynical attitudes, helplessness, exhaustion –

emotionally and physically); lack of trust for the system and towards anyone whom the system sends to assist them (Bährer-Kohler, 2011); and the natural common resistance and stigma associated with psychological interventions (Vogel et al., 2006).

5.4.1.4 Working hypothesis

The working hypothesis derived from coaching intervention experience Theme 1 and the subthemes is: The Generation Y medical doctors are expected to experience some negative and positive feelings towards the coaching intervention for burnout amongst Generation Y medical doctors.

5.4.2 Theme 2: Alterations to the coaching intervention

The second main theme highlighted was proposed changes or additions to the group coaching intervention for burnout amongst Generation Y medical doctors. The main question posed was: “Is there anything that you wish could be changed or added to the coaching intervention for burnout amongst Generation Y medical doctors?”. The participants highlighted no proposed alterations as a subtheme in describing their experiences of the group coaching intervention. The subtheme is followed by a discussion and a working hypothesis.

5.4.2.1 Subtheme 2.1: No proposed alterations

All participants in the Phase II and Phase III sessions perceived the group coaching intervention process for burnout amongst Generation Y medical doctors to be adequate. They were comfortable with my approach and me as the coach. The Generation Y medical doctors made the following statements: Participant 2 stated, “*Nothing really needs to be added or changed in the coaching intervention process*”; Participant 5 added, “*The approach of the coaching intervention and you as the coach worked for me*”. Two Generation Y medical doctors,

Participant 1 and 8 stated, “*Can we do this again soon and keep all as was, in terms of numbers and the approach and you as the coach*” and “*It felt informal and worked well for us*”.

5.4.2.2 Discussion

Interventions should be customised to suit the client. Effort was taken to ensure that the Generation Y medical doctors’ needs would be met in the group coaching intervention for burnout amongst Generation Y medical doctors. It was always about them, which they picked up, hence they felt heard and understood.

I as coach consciously created an environment that emphasised a humanism paradigm and qualities thereof such as unconditional positive regard and reflection of feelings, which promoted a sense of being heard (Rogers, 1959). The study was a qualitative, descriptive phenomenological approach that took an interpretive stance, which promoted sensitivity to the social setting involving the view of Generation Y medical doctors and their unique interpretations, understandings and meanings (Finlay, 2008; Mason, 2002).

The aim of this type of research is to describe the lived world in a way that expands the understanding of the human being’s experience (Dahlberg et al., 2008); therefore, the questioning in the study aimed to achieve this with the Generation Y medical doctors.

5.4.2.3 Working hypothesis

The working hypothesis derived from the coaching intervention experience Theme 2 and the subtheme is: A customised coaching intervention for burnout amongst Generation Y medical doctors where they feel heard, understood, have shared experiences, and understand their own experiences will promote growth within.

5.4.3 Theme 3: Benefits of the coaching intervention

The third main theme was the highlighted benefits of the group coaching intervention for burnout amongst Generation Y medical doctors. The question posed was: “Is there anything you enjoyed best or that stood out for you about the coaching intervention and its approach?”. The participants highlighted the intimacy of the group, the group being comfortable, and one-on-one interaction as subthemes when describing their experiences of the group coaching intervention for burnout amongst Generation Y medical doctors. The subthemes are followed by a discussion and working hypothesis.

5.4.3.1 Subtheme 3.1: Intimacy of the group

There was an overall appreciation of the group size, which led to them being open, feeling heard and having shared experience to normalise their experience. This was seen in the following quotes from the participants: Participant 1 stated, “*The size was just perfect; not too big and overwhelming*”; to which Participant 3 added, “*I could be open because of the size of the group and the way you gave each person a chance to speak. I felt heard. Also felt like I am not going crazy because my colleagues are going through similar experiences*”.

5.4.3.2 Subtheme 3.2: Comfortable group and one-on-one interaction

There was a shared view that the interaction as a group with me as their coach was a good fit because they still received one-on-one attention. Each person was given a chance to speak. All commented that they felt understood and listened to, and that the shared experiences led to them bonding as a team, normalising their personal experiences, and humanising one another.

There was a view that a safe environment was created where they could be vulnerable in front of the others and yet be empowered to go forth. Some quotes indicating this view are included. Participant 2 said, “*I felt we were all heard. Each of us was given a chance, not one talking*

over the other. It was not just you talking and we listening"; Participant 5 added, *"I felt safe and comfortable"*. Participant 6 stated, *"It made us reflect. It was not formal presentation with boring PowerPoint slides"*.

More quotes from the Generation Y medical doctors linked to the observation included the following: Participant 8 said, *"We got to know the others better in this – not just as a colleague"*; Participant 7 added, *"It promoted cohesion for us as group and encourages doing things outside the workplace as a group to relieve stress"*.

There was a general sense of normalisation of the experiences of burnout and feelings of being supported and not being alone. Statements like the following were made by Participant 3: *"I feel I am not going crazy or alone in experiencing negative emotions"*.

There was a shared opinion that I as the coach was relatable and that the approachability enhanced the interaction. Quotes that follow from the participants indicated this: Participant 1 said, *"Your openness and honesty, easy going manner was helpful for us"*; Participant 4 added, *"You are relaxed and comfortable even about your experiences of burnout that made us comfortable"*. Two Generation Y medical doctors, Participant 9 and 10 added, *"You made us feel safe and relaxed"*, and *"You were very professional in an 'informal human' manner"*.

5.4.3.3 Discussion

It is not easy to open up and be vulnerable. Therefore, the coach in any intervention such as this one in this current study needs to prioritise the needs of the clients, which in this case are the Generation Y medical doctors. Their needs, including a comfortable group size, one-on-one discussions, and feeling comfortable with the coach, were met.

They were able to relate to me, which created an environment where they could open up. I consciously made it a point to develop rapport and trust with them as individuals and as a

group. This created a session where they could interact with me and with one another, which developed peer support, normalised their burnout experiences, and created a sense of cohesion they never felt even though they have known one another. Again this way of intervening was possible because the study took on a qualitative, descriptive phenomenological humanism approach of me as coach (Finlay, 2008; Mason, 2002; Rogers, 1959) as stated in the previous discussion section of Theme 2 of the coaching intervention theme.

5.4.3.4 Working hypothesis

The working hypothesis derived from the coaching intervention experience Theme 3 and the subtheme is: A coaching intervention for burnout that promotes being heard and understood by the coach meets the needs of the Generation Y medical doctors, and normalises and creates understanding own experiences will be of benefit for them.

5.4.4 Theme 4: Lessons gained from the coaching intervention

The fourth main theme highlighted was about the lessons gained from the coaching. The main question posed was: “Is there anything you taking with from today?”. The participants highlighted the following subtheme in describing their experiences. The subtheme is followed by a discussion and working hypothesis.

5.4.4.1 Subtheme 4.1: Benefit and skills gained

There was an overall view that there was a significant gain and benefit from attending the sessions. There was a wish for sustainability of services of this nature. To support this, Participant 8 said, “*We truly gained from this experience, I wish there could be more sessions for support like this continually*”. There was verbalised empathy for colleagues who could not attend, but could have benefitted as they did. Participant 10 stated, “*The absent participants missed out because we really did benefit*”.

There was an awareness of the indications of burnout, the potential ability to adjust, and the ability to refer others because of increased recognition of burnout presentations. The Generation Y medical doctors supported this view: Participant 3 said, *“I gained an increased awareness of depersonalisation, emotional exhaustion and reduced professional competence manifestations in myself and the colleagues (including the seniors)”*; and Participant 1 added, *“This awareness will create less personalisation when attacked by senior doctors and conscious coping strategies in dealing with personal stress”*; lastly, Participant 5 noted, *“The junior medical doctors who are actually on sick leave, really needed this. Thank you”*.

A few other Generation Y medical doctors made statements such as these: Participant 2 said, *“We as medical doctors always want to come across as having it together and that emotional things are not for us, because we are expected to cope as if we are not humans, thank you for reminding us that we are humans and it is ok”*, to which Participant 4 added, *“Working with medical doctors who do not care is sad, thank you for reminding us that it is ok to be different and still care”*.

There was unexpected benefit from the group coaching intervention that was verbalised by the participants. Participant 9 said, *“It was a pleasant surprise how much value we got from this coaching intervention”*, and Participant 7 declared, *“We appreciate the leader of our group encouraging attendance, else we would have missed out on what we needed”*.

5.4.4.2 Discussion

According to the feedback from participants, certain lessons, benefits and skills were gained from the group coaching intervention for burnout. The coaching intervention for burnout tapped into the Generation Y medical doctors’ needs and hence it was evident that they were open to the experience. Once they were open to the intervention, it led to an overall learning of skills and appreciation of the benefit. Being heard and understood in the group coaching

intervention environment led to catharsis, support, and normalisation, which promoted cohesion that assisted them to develop some hope and to gain from the session (Finlay, 2008; Mason, 2002; Rogers, 1959).

5.4.4.3 *Working hypothesis*

The working hypothesis derived from the coaching intervention experience Theme 4 and the subtheme is: Generation Y medical doctors will benefit from attending and having their needs met in the coaching intervention for burnout amongst Generation Y medical doctors.

5.4.5 Theme 5: Implemented coping strategies

The fifth main theme highlighted was that the Generation Y medical doctors implemented coping strategies after being exposed to the group coaching intervention for burnout. The participants highlighted the expansion of their coping strategies. The reframing of challenges helped them to develop a positive outlook, which were the subthemes in describing their experiences of the group coaching intervention. The discussion and working hypothesis follow.

5.4.5.1 *Subtheme 5.1: Coping strategies expanded*

Coping strategies were expanded and participants gained a better understanding of burnout and its impact on the self and others. There was also awareness for needed self-care activities. Statements made to support this from the participants included: Participant 1 stated, “*This motivated me to care for self even more*”, and Participant 2 added, “*I will develop more hobbies outside medical field. I now have seen the need for self-reflection and have increased awareness*”, and, lastly, from Participant 3: “*When the intern group leader suggests activities outside of work will make it a point to attend seeing it is a beneficial way to de-stress that we can adopt*”.

There was a shared view of learned burnout manifestation and related self-treatment, referral and self-care. Quotations from the Generation Y medical doctors to support this theme included: Participant 6 said, *“I learned of secondary traumatising, which I often experience from hearing, seeing or working with trauma. I see now that I need to find a professional to vent out, not to traumatise family members/friends or pass on the trauma”*; Participant 5 stated, *“Need to take charge of my mind, and perceptions. Additionally, my thoughts, emotions/feelings and actions/reactions; which is all I can take charge of and change”*.

More supporting quotations from the Generation Y medical doctors included: Participant 4 noted, *“I know that I was called to do this and I was reminded of this. The negative experiences I will not personalise and let them define me”*; Participant 7 added, *“Will appreciate more attempts of leader of our intern group who organises certain events; and make more effort to attend”*.

A few more attestations were made by the Generation Y medical doctors, which included: Participant 10 stated, *“Will identify a mentor and clinical psychologist to offload to regularly”*; and Participant 9 said, *“I will use relaxation and breathing exercises I gathered here”*; and, lastly, Participant 8 stated, *“I need to talk more about my experiences at work instead of trying to process them alone, because then I end up snapping at everyone”*.

5.4.5.2 Subtheme 5.2: Reframing of challenges and developing of a positive outlook

The participants gained the ability to reframe challenges and develop a positive outlook. The Generation Y medical doctors verbalised a better understanding of senior doctors and potential ways to cope. Quotes from the participants to support this theme are: Participant 1 stated, *“This awareness I gained from the coaching intervention will create less personalisation when I feel attacked by senior doctors and conscious coping strategies in dealing with personal stress”*; and Participant 2 stated, *“Understanding that the environment, managers, health department*

and public sector, difficulties are not in my control; therefore, I need to work on what I can control which is my thoughts, actions and emotions”.

More quotations to suggest this from the participants were: Participant 3 said, *“I understand that the failing system is not a reflection on me”*; and Participant 4 stated, *“The senior medical doctors themselves are burnout therefore we all need intervention”*; and, lastly, Participant 5 said, *“Going forth at least I understand they are burdened too and I would need to work on me personally”*. There was an awareness about not being alone in this experience of burnout, which was emphasised by Participant 6 saying, *“I know I am not alone and what I feel is also felt by other junior medical doctors”*, and Participant 7 stated, *“This session created cohesion in our group”*.

Based on observation, the Generation Y medical doctors learned to be change agents. This was suggested by Participant 4: *“What I gathered from the coaching session I gave to my fiancé helped him process some of the things he was going through”* and another, Participant 8 added, *“I would not want to be like senior medical doctors going forth to the junior medical doctors, if I am still in the Department of Health public sector”*.

5.4.5.3 Discussion

Bauer, Hafner, Kachele, Wirsching and Dahlbender, (2003) found that supervision groups that are moderated by psychotherapists, including an external coach for employees and their superiors, are most effective at preventing burnout. A communication climate about burnout without stigmatisation is crucial. It is also key to have coaching to enhance and build cognitive competence and promote self-regulation. Overall, there is a consensus in literature (Bauer et al., 2003; Maslach et al., 2001; Ruiz, 2019; Walter et al., 2013) that investing in individual mental health of employees and prevention for burnout will give a return on investment for

employers. This applies to the hospital where the study was done in the South African public health sector.

The experience of the coaching intervention led to participants expanding their coping strategies, reframing challenges and developing positive outlooks.

5.4.5.4 Working hypothesis

The working hypothesis derived from the coaching intervention experience for Theme 5 and the subthemes is: There will be benefits and applicability from the coaching intervention for burnout amongst Generation Y medical doctors, though there might be some limitations.

5.4.6 Theme 6: Post-coaching intervention experiences

The sixth main theme highlighted were the experiences after exposure to the group coaching intervention of burnout amongst Generation Y medical doctors. The question posed was: “How are you doing post the coaching intervention?”. The participants highlighted the following subthemes in describing their experiences six months after the coaching intervention. The subthemes are followed by a discussion and working hypothesis.

5.4.6.1 Subtheme 6.1: Failing health system and lack of support

The participants seemed to be somewhat motivated to continue positively in the face of challenges in the public health sector. They were aware of the burnout experience and what is required to overcome it, which the public health sector system is unable to offer for them. Therefore, they need to find ways to help and focus on the themselves in order to survive.

Some quotations from the participants to support this view include: Participant 1: *“The system is really failing us still, but I am still trying”*; Participant 2 added, *“The support structures still need to be placed for us ASAP. I always have in mind and apply where possible what we*

discussed in the session". Participant 5 stated, *"Management needs to be more supportive. I struggle but at least I know now what I can control and that I am not alone and also that it is not a reflection on me"*; to which Participant 6 added, *"There is still lack/minimal support from hospital management and senior doctors. But post-coaching intervention session we almost understand that it is like that because the system promoted this and it is what they know therefore we need to focus on making sure I am able to constructively cope"*; and, lastly, Participant 7 stated, *"There still needs to be change in public health sector and broader government in South Africa. I focus on what I can do and doing my best not what I cannot change"*.

5.4.6.2 Subtheme 6.2: Coping strategies continually under pressure

There was a shared notion that even though they were ready to face challenges in the different rotations with a gained coping and reframing ability, their coping strategies (discussed in Subtheme 6.4) were constantly under pressure, especially in certain placements. Quotations from Generation Y medical doctors in support of this view included: Participant 9 mentioned that, *"Some placements are harder than others still, but I have in the back of the mind coping strategies I need to access"*; Participant 1 added, *"Some senior medical doctors are harder to handle than others, but I continually bear in mind that they are also struggling in a failing system"*; and, lastly, Participant 2 stated, *"I have on and off days. I wanted to specialise in paediatrics, but I see paediatrics consultants working longer hours than us, so not sure still. I am going to surgery and the call roster is not for us to influence, that is going to be a strenuous rotation. I can't wait for it to go by"*.

5.4.6.3 Subtheme 6.3: Need for ongoing coaching and debriefing sessions

There was continual mention from the participants of the need for sustainable and consistent support for coping; career path development; repeat of the interaction; and relationship with

coach and challenging cases. Certain quotes from the participants supporting this view included: Participant 5 said, “*We need regular debriefing and support sessions for emotional/psychological beings*”; Participant 9 stated, “*We need ongoing coaching intervention in order to cope*”. Additional statements made by the Generation Y medical doctors to support the view included: Participant 1 stated, “*I need assistance with dealing with stress regarding specialisation. Because of the negative experiences in public health sector, it takes away some of the pleasure in specialising in certain fields, I feel we need ongoing debriefing in order to choose a specialty objectively and to also not move away from the field because we are burnt out*”; and Participant 2 stated, “*When can we see you again, this was so helpful?*”.

5.4.6.4 Subtheme 6.4: Post-coaching intervention implemented coping strategies

Generation Y medical doctors mentioned that they implemented certain coping strategies after the group coaching intervention session although they still experienced a high level of burnout, especially emotional exhaustion construct. The implemented coping strategies included self-care strategies, being aware of burnout and applying coping strategies. These are discussed in the subsections that follow.

i. Self-care strategies

There was a shared notion from the participants that they started to focus on caring for themselves in the midst of all the difficult working conditions in order to prevent their burnout from becoming worse. It appears as if they seemed empowered by the self-care strategies even though they still need more support in the long run and need the conditions to change for the better.

Some quotes from the participants to this view are: Participant 1 said, “*I have some self-care strategies which I implemented: I am spacing out of calls, sleeping early, doing other things,*

meeting people and reflecting so I am not on autopilot missing out on life's precious moments". Participant 2 emphasised that they organised themselves to experience less strain: *"Public health system still same but working in flexible rotations where one can suggest or create a good environment for self-care like paediatrics made it easier"*; Participant 5 added, *"Working with less severely ill patients made it easier to cope. For example, at paediatrics we were able to arrange that we start early and can finish before 6 pm. Unlike oncology where I am always working with very sick patients, some dying"*.

ii. *Awareness of burnout and application of coping techniques*

The group indicated that they are more aware and have a better understanding of burnout; therefore, they are able to identify it in themselves, which makes it more manageable. A statement from Participant 5 alluded to this: *"Indications of burnout I experienced before are now more manageable because I am able to identify them (have awareness of them) and I know I am not going crazy or alone"*.

The awareness has also made them more mindful of what coping strategies work for them and those that exacerbate the negative experience. This was seen in this statement from Participant 9: *"I have my days, but now I talk more about what I experienced at work instead of keeping it in. When do we see you again for next session? Can we arrange? This was so helpful"*.

The coping techniques include an ability to identify out-group connections/activities for minimal detachment to become energised between work times. Statements from the Generation Y medical doctors indicating this included: Participant 7 stated, *"I am now meeting other people, making time to do other things outside of work and not with people from my work"*, to which Participant 6 stated, *"I exercise and gym more; I am forcing to have the time"*.

They became potential change agents by using learned awareness and experiences of self-care. Quotations from the participants to support this statement included: Participant 5 said, *“I showed the notes to my husband when he was going through something and it helped him process some of the things”*, to which Participant 7 added, *“I will be able to identify burnout and suggest to someone to seek help”*; and, lastly, Participant 1 said, *“I am more understanding that the senior medical doctors are also under pressure, burnout, though it does not excuse some of their behaviours; I wish they could see the need to seek help and for stakeholders to assist everyone in this regard”*.

5.4.6.5 Discussion

Generally, suggestions for burnout intervention in literature include a need to focus on a combination of self, organisational and situational factors (Felton, 1998). Prevention and intervention strategies could be individual or group directed, organisational focused or a combination of both (Walter et al., 2013). Overall, an integrative interdisciplinary approach to burnout that incorporates prevention, medical, psycho-educational and communication promotion has been recommended. This study focused on individual intervention within a group and did not really aim to change the public health sector system. The study rather aimed to create the ability to cope within the situation.

Post-coaching intervention experiences as Theme 6 of the coaching intervention led to certain subthemes that include: failing of public health systems and a lack of support; coping strategies continually under pressure; need for ongoing coaching and debriefing sessions; and coping strategies implemented after the group coaching intervention.

The participants seemed to be still under pressure as the public health sector system was still the same, but the difference was that they seemed to have something to tap into in an attempt to cope. Therefore, individual focus from the coaching intervention seemed to have some

benefit for them as individuals and as a group. At the same time, one needs to note that the benefits from the coaching intervention for burnout are likely to be short-lived because the Generation Y medical doctors are constantly under pressure as the public health system remains the same, if not becoming worse. They might experience even more pressure from their own life challenges; therefore, ongoing coaching intervention sessions for debriefing are essential for them and are highly recommended.

The participants felt heard in the coaching session, which is what their environment never offers. Their participation in the study and starting the process benefitted them, and cannot be underestimated. They still need to learn and cope in the environment, but at least they have been given some understanding of what they are experiencing. This can empower them to develop coping strategies and to make certain decisions about the actual field of medicine.

5.4.6.6 Working hypothesis

The working hypotheses derived from the coaching intervention experience Theme 6 and the subthemes are:

1. The public health sector might not change, but the coaching intervention for burnout amongst Generation Y medical doctors will afford the participants some skills they can tap into in an attempt to cope with burnout going forward.
2. There will be a need for ongoing coaching intervention for burnout amongst Generation Y medical doctors in order to maintain the ability to cope somewhat with the public health sector.

5.5 Integrated Discussion

The power of debriefing and merely having one session to get Generation Y medical doctors to see how they could look within to create coping strategies for themselves even if the situation

never changes should not be underestimated. Even if the public health sector system in South Africa continues to be dysfunctional and does not change, giving Generation Y medical doctors an opportunity to look within for coping strategies and taking charge of what they can could make their work situation more bearable. Individual interventions have some benefit at some level, although the benefits might be limited or the intervention is needed more frequently; however, the limitations should not cause one to take such interventions for granted.

Even though the burnout remained after the group coaching intervention and the public health system was unchanged, there was an undeniable positive impact from the group coaching intervention at an individual and even at a peer group level that the participants appreciated. There was a shift in how they experienced their difficult working environment, the senior doctors, their peer colleagues, and even their own internal experiences.

In summary, based on their responses that were articulated as themes, the following could be concluded as being evident: there was a paradigm shift in terms of how they viewed the senior doctors and also in how they would attempt to react to the environment and the senior doctors going forth. They had an awareness and understanding of burnout, which might make it slightly more manageable.

Additionally, there was normalisation of the experience of burnout coupled with the promotion of the need for self-care. Furthermore, there was a realisation of being in control only of the self (which is thoughts, feelings, actions/reactions) and the link between thoughts/feelings/actions/reactions. Based on the findings, there was a sense of empowerment for them to be change agents. Basically, for them to be key advocates who are willing to initiate change, especially in future as senior medical doctors in the South African public health system and also in how they deal with stressors and treat the junior doctors who will come after them.

The impact was also indicated in how there was an increased potential empathy for current senior doctors and future junior doctors; increased awareness of the need for debriefing continually in order to cope in the field; and promotion of the original passion to specialise in spite of the current conditions.

They mentioned that they would need a debriefing session in future to be able to choose a medical specialty objectively and not based on their current experiences, which were clouded by burnout. This is indicative of an awareness in them of how the current working environment has the potential to affect their passion for medicine negatively, which they should not allow. There was an enhancement of a change in perspective regarding their skill, qualification and ability, which promoted support amongst themselves as Generation Y medical doctors.

The study found that similar factors and stressors that often lead to burnout in other studies, are found for the Generation Y medical doctors in the current study. These factors lead to poor job satisfaction and increasing occupational stress. Findings have indicated that burnout risk is elevated in South African public hospitals for health professionals, which predisposes Generation Y medical doctors to severe impairments, physical and psychiatric presentations, and high levels of occupational stress (Davhana-Maselesele & Igumbor, 2008; Thomas & Valli, 2006). High levels of burnout from work stress were found in the current study.

Six influences of burnout, namely, workload; lack of control over decision-making; insufficient reward; feelings of impersonal relationships and teamwork undermined; lack of fairness (regarding trust, openness, and respect); and conflict of values between job and personal core values are stated in research as major influential areas causing the three dimensions of burnout (Maslach & Leiter, 1997).

Burnout is also influenced by individual and socio-economic environmental factors; perception of how colleagues are and critique additionally tendency to blame self for own illness with

reduced likelihood to seek out help (González-Morales et al., 2011; Hlatshaneni, 2019); heavy workload and long hours, sleep deprivation often leading to pressures of isolation which start in medical school (Discovery Health, 2018); unmet expectations of the workplace, professional pressure combined with limited experience (personal and life) and high expectation of self (Discovery Health, 2018; Hlatshaneni, 2019); stress of caring for patients in resource-constrained environments of public health sector in South Africa combined with stress of student loans and financial obligations to families and everyday stressors; expectation from society to be well rounded, all knowing and high achieving as medical doctors which the generation Y medical doctors expect of themselves (Discovery Health, 2018); personality traits, for example, lower hardiness as found in Garrosa and Moreno-Jiménez (2013) and Kelley (1994); and poor coping strategies (Maslach et al., 2001; Schaufeli, W.B., 2003; Shirom, 2009). These factors could add to the risk of burnout in Generation Y medical doctors. The combination of the aforementioned factors interacting at different levels was found to be underlying to the experience of burnout by the Generation Y medical doctors in the current study.

Burnout constructs are increased emotional exhaustion; depersonalisation or cynicism, implying a negative attitude towards a number of entities, especially clients; and an increased tendency for negative evaluation of self as lacking professional accomplishment or competence (Maslach & Jackson, 1981, 1986). All three constructs were found in the study with emotional exhaustion being high before and after the coaching intervention; this dimension has been found as the major core for the burnout experience as seen in the current study.

Factors that affected the current participants were similar to other studies. The current study found that factors that contributed to burnout were a combination of societal, organisational and individual factors, which were reinforced by a high workload and complexity. This is

similar to other studies (Leiter et al., 2009; Leibenberg et al., 2018; Sirsawj, Steinberg, & Raubenheimer, 2013). These factors as seen in the current study included time pressures; work conflicts; problems of leadership, bullying, poor team collaboration (Kaschka et al., 2011; Discovery Health, 2018; Hlatshaneni, 2019); disorganised work environment; a lack of control (Cerimele, 2011); low job satisfaction (Thomas & Valli, 2006; Discovery Health, 2018; Hlatshaneni, 2019); lack of resources (Ten Brummelhuis et al., 2011; Sirsawj, Steinberg, & Raubenheimer, 2013); need for but a lack of flexibility (Weber & Jaekel-Reinhard, 2000); and lack of autonomy (Nahrgang et al., 2011).

Other factors that influenced burnout and were found also in the Generation Y medical doctors were workload; career progression; work schedules; poor staff complement (understaffing); limited work experience; certain rotations; types of condition or nature of cases dealt with; cases the medical doctors felt they had little control over; participation in decision-making; management styles in the departments; poor career advancement opportunities with limited influence on performance appraisals; managing infectious patients (for example, HIV/Aids and terminal stage cancer patients); and working in the public sector versus private sector (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Leibenberg et al., 2018; Peltzer et al., 2003; Schweitzer, 1994; Sirsawj, Steinberg, & Raubenheimer, 2013; Sprang et al., 2007; Thomas & Valli, 2006). Besides this reality, were the poor working and labour conditions in the South African public health sectors for Generation Y medical doctors (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Leibenberg et al., 2018; Sirsawj, Steinberg, & Raubenheimer, 2013).

The impact of burnout has negative consequences on the recipients of care; potential cost to the public health sector due to potential impaired medical doctors' performance; and the need to retrain doctors and for additional recruitment due to increased staff turnover (Thomas &

Valli, 2006; Leibenberg et al., 2018). This became evident in how the Generation Y medical doctors verbalised difficulty in providing proper care; their need to move away from the field of medicine or retire early without specialising; and to move away from the public health sector.

Customised intervention strategies have been suggested to secure the profitability and health of the workforce (Gregory, Menser & Gregory, 2018; Ruiz, 2019). Workplaces, especially the South African public health sector, are influenced by economic, social and political forces, which generate an atmosphere that is susceptible to burnout more severe than before (Discovery Health, 2018; Erasmus, 2012; Hlatshaneni, 2019; Maslach et al., 2001; Leibenberg et al., 2018; Sirsawj, Steinberg, & Raubenheimer, 2013). Due to the unavailability of resources such as funds, time and/or staff in disadvantaged/developing countries such as South Africa, it has been found even at the hospital that customised interventions are not only scarce but that there is also no flexibility in terms of prioritising the interventions because of the poor underresourced workplaces (Leibenberg et al., 2018). Even in this study, the group who were meant to participate in the study could not all find the time or flexibility to attend the sessions even though it could potentially benefit them. The findings indicated the need for burnout interventions at all levels (senior doctors and other health professionals) and that solutions were required to address the severe forces affecting the entire ailing public health system.

Prevention of burnout needs care for the self and self-regulation; this implies living healthy, getting sufficient sleep, doing physical activities, getting healthy nutrition, consuming alcohol moderately, applying relaxation techniques, doing hobbies, cognitive behaviour focused intervention and cultivating relationships. Furthermore, part of prevention for burnout is the need to reduce workload (Leibenberg et al., 2018; Ruiz, 2019). With the current practices at the hospital, which are reflective of the South African public health sector that coerces medical

doctors to work, it is difficult to implement even some self-care strategies never mind environmental and work-related strategies.

The study focused on creating awareness of burnout and promoting coping strategies. The objective of the group coaching intervention for burnout amongst Generation Y medical doctors was furthermore to alert members in the workplace of its existence, the severe consequences of, and the need to prevent or intervene in terms of burnout while promoting health.

The group coaching intervention for burnout amongst Generation Y medical doctors managed to create awareness especially for the participants. It created an environment for catharsis and normalisation; promoted more effective coping strategies for the self; and made Generation Y medical doctors heard by stakeholders.

The workload and practices at the hospital were not changed after the group coaching intervention; therefore, their burnout level, specifically the emotional exhaustion levels as seen by the MBI-GS scores, was still high. However, the difference after exposure to the group coaching intervention was that the Generation Y medical doctors knew what the burnout experience was; they could consciously attempt certain adjusted coping strategies and cognitive behaviour skills learnt to take more charge of their thoughts-feelings-actions and reactions cycle to cultivate change in their perspectives; and knowing they were not alone cultivated more support amongst themselves. This supports the finding that either individual interventions and/or workplace-based interventions could show therapeutic and preventative findings (Kumar & Mellsop, 2013).

There has been limited evidence to support the effectiveness of either a person-directed (including cognitive behaviour therapy, relaxation and massages) or work-directed intervention (attitude change, communication, support from colleagues, changes within the organisation,

participatory problem-solving, and decision-making) (Marine et al., 2006). The current group coaching intervention was person-directed with limited work-directed focus as there was no change to the workload and no participatory decision-making. The awareness of the experience of burnout within self and others reduced the feelings of loss of control and emphasised a shared experience with the other peers, which empowered the Generation Y medical doctors to consciously work on gaining back control of matters they could control, which were their thoughts, feelings and actions. They were made aware of possible support structures and support was destigmatised, which could be helpful in future if one is feeling overwhelmed.

Six months after the group coaching intervention there was some benefit that was evident in the participants based on their functioning and changed attitude. There is still more work to be done to ensure sustainable coping strategies, as the Generation Y medical doctors still had high levels of burnout, specifically the core dimension (emotional exhaustion). This indicates that they are still at risk for personal negative experiences, which might lead to further deterioration or development of pathology that will affect their level of care, and as a result, their beneficiaries.

5.6 Chapter Summary

The general aim of the research to describe the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors was achieved in this chapter. The specific aim of the literature review of the study was achieved, namely, to review a group coaching intervention for burnout in order to see its applicability and benefit to Generation Y medical doctors working in the public health sector in South Africa. Furthermore, the aim of the phenomenology study was reached, which was to gather and analyse information to explore Generation Y medical doctors' experiences of a group coaching intervention for burnout.

The chapter gave details of the research findings of the current study. It summarised the implemented coaching intervention for burnout amongst Generation Y medical doctors. Furthermore, it described the themes that emerged regarding the experiences of burnout for Generation Y medical doctors working in the South African public health sector at a hospital in the Limpopo Province. The chapter concluded with an integrated discussion about all the findings in the study and working research hypotheses.

The next chapter provides the conclusions drawn from the study, highlight the limitations and makes recommendations.

CHAPTER 6: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter discusses the conclusions drawn from the study, highlights the limitations, and makes recommendations. A qualitative, narrative writing style is followed to report the research findings. The previous chapter gave the findings, and interpreted and linked them to the literature review. Based on the findings and interpretation thereof, conclusions regarding the Generation Y medical doctors' experiences of the burnout group coaching intervention are reported in this chapter. The methodology, findings and participant limitations are described. The chapter makes recommendations for (a) the public health sector department specifically to gain a deeper understanding of the experiences of Generation Y medical doctors, (b) for future research in this field of coaching psychology, (c) and for coaches/consultants.

6.2 Conclusions

In this section, conclusions are drawn in terms of the research aims formulated in Chapter 1. Based on the findings, this section discusses the general, phenomenology, specific and secondary aims of the research project. The general conclusions of the study are also described.

6.2.1 General aim of the research project

The general aim of the research was to describe the experiences of a coaching intervention for burnout amongst Generation Y medical doctors. The study took on a phenomenological approach and the aim was to gather and analyse information to explore the experiences of Generation Y medical doctors of a group coaching intervention for burnout. This was achieved in Chapter 5.

The findings illustrated in Chapter 5 gave a detailed description of the Generation Y medical doctors' experiences of burnout and the coaching intervention. The findings also focused on understanding whether there was benefit based on the participants' own views of the group coaching intervention as it was or if there was a need to alter the coaching intervention somewhat so that it could benefit the participants. The latter part was the specific aim of the study: to review the group coaching intervention for burnout in order to see its applicability and benefit to Generation Y medical doctors working in the South African public health sector. This is discussed in the next section.

6.2.2 Specific aims of the literature review

The specific aim of the literature review was to review a group coaching intervention for burnout in order to see its applicability and benefit to Generation Y medical doctors working in the South African public health sector. This was achieved in Chapter 2 and Chapter 3.

There was comprehensive description of the experiences of the coaching intervention for burnout amongst Generation Y medical doctors. The experiences led to a conclusion of its attained benefit and its reasonable applicability to participants working in the South African public health sector. The participants verbalised gain from participating in the study and mentioned that the group coaching intervention suited their needs. They added that there was nothing that should be changed or added to the group coaching intervention they were exposed to and the manner in which it was presented.

Although participants still experienced burnout after being exposed to the group coaching intervention for burnout, and the challenges in the public health sector have not been addressed (for example, the public health sector was not changed in terms of systems, workload or their view of management support), they still appreciated certain gains from the process. The

participants mentioned that they acquired coping strategies and awareness regarding burnout that made them more self-empowered in spite of their working environment.

6.2.3 Specific aims of the descriptive phenomenology study

The aim of the phenomenology study was to gather and analyse information to explore Generation Y medical doctors' experiences of a group coaching intervention for burnout. This was achieved in Chapter 5.

I attempted to set aside my biases about the possible experience of the group coaching intervention. The descriptive phenomenological approach to the study allowed me to explore the perceptions, perspectives, and feelings of the Generation Y medical doctors about the coaching intervention. They worked in the public health sector, were exposed to poor conditions, and experienced burnout. Taking a descriptive phenomenology stance allowed me to gather genuine information in a more natural and non-threatening manner. Thus, the specific aim of the descriptive phenomenology study was achieved.

6.2.4 Secondary aims

The secondary aims were threefold as indicated in Chapter 1:

- Through analysis of the data generated by the research, I aimed to contribute to the existing knowledge and intend to develop empirically based group coaching interventions for burnout in Generation Y medical doctors working in the public health sector in South Africa.
- To add knowledge about awareness, prevention, and intervention of burnout in Generation Y medical doctors in the South African public health sector context by evaluating a group coaching intervention for burnout.

- To formulate recommendations for (a) the public health sector department specifically to gain a deeper understanding of the experiences of Generation Y medical doctors; (b) for future research in this field of coaching psychology; (c) and for coaches/consultants.

The secondary aims were achieved in Chapter 5 and Chapter 6.

There are currently limited empirically based coaching interventions for Generation Y medical doctors working in the public health sector (Sorenson et al., 2016; Werneburg et al., 2018). The findings in the current study showed empirically based benefits for the participants' exposure to a group coaching intervention for burnout amongst Generation Y medical doctors. It also provided empirical data regarding the needs of participants that should be incorporated in the coaching intervention for them to gain from the process. The study emphasised the importance of customised interventions that should keep the client in mind and increase awareness of the negative impact of burnout. The need for burnout prevention and the promotion of the positive impact of the intervention are thus emphasised, which focuses on prioritising the client to make them feel heard and empowered.

This research has definitely added to existing knowledge intended to develop empirically based group coaching interventions for burnout in Generation Y medical doctors working in the public health sector. The study increased participants and other stakeholders' awareness of burnout in the South African public health sector. It also helped to add to knowledge that could lead to prevention and intervention in terms of burnout.

6.2.5 General conclusion

This section provides the general conclusion for the study.

The main research question as stated in Chapter 1 was: “What are the Generation Y medical doctors’ experiences of a group coaching intervention for burnout in order to explore its benefits and applicability?”. From the findings, it can be concluded that the main research question was addressed. The experiences of the Generation Y medical doctors were captured together with its meaning. Based on the exploration of the themes it can be concluded that the group coaching intervention for burnout amongst Generation Y medical doctors is beneficial and applicable when dealing with burnout for the participants.

The main research questions of the study, stated in Chapter 1, were also addressed:

1. What are the experiences of a coaching intervention for burnout amongst Generation Y medical doctors working in the South African public health sector?
2. Is the coaching intervention for burnout applicable and beneficial to Generation Y medical doctors working in the South African public health sector?
3. Will the data collected contribute to existing knowledge which aims to develop coaching interventions for burnout amongst Generation Y medical doctors working in the South African public health sector?

The Generation Y medical doctors’ experiences of burnout and the group coaching intervention for burnout were explored together with its meaning. The study not only concluded that burnout interventions are beneficial and applicable in the burnout field, but it also contributed to existing knowledge aimed at developing coaching interventions for burnout amongst Generation Y medical doctors working in the South African public health sector.

The findings point to structural issues regarding poor management, lack of team support, and being voiceless. There is also unsatisfactory coordination of the training programme for Generation Y medical doctors in the public health sector and a lack of a structured induction programme. There was an indication that participants had high expectations of working in a functional working environment, whereby their needs were met and supported and in turn they would deliver good health services. The reality, contrary to their expectations, is that working conditions in the South African public health sector are poor, which leads to an overwhelming negative experience. The experience included feelings of hopelessness and being stuck in a situation that was unavoidable as they were coerced to go through this process to qualify as independent practising medical doctors.

The findings additionally emphasised certain points. Firstly, there is lack of awareness by management about how they neglecting their control and support duties affect Generation Y medical doctors. As such, they do not provide the needed support and team building, and senior staff do not guide junior doctors.

Secondly, service delivery is not monitored and management does not supervise activities; therefore, the management team was found to be lacking in terms of what is expected of them regarding training Generation Y medical doctors.

Thirdly, the impact of burnout on medical doctors, including Generation Y medical doctors, and how burnout affects patient care are being neglected. Burnout is obviously experienced by most caregivers in the public health sector, yet neither prevention nor management is prioritised, which puts professionals and their patients at risk.

Lastly, older generation doctors who are in management and senior positions seem to be struggling to deal with and meet the needs of the Generation Y medical doctors in the work environment. This struggle between different generations seemingly leads to the older

generation medical doctors handling the younger generations in a way that Generation Y medical doctors are not pleased with. Certain features have been noted to be common within Generation Y (at times referred to as millennials) in a working environment. For example, they tend to be more achievement oriented; like flexible times; are team oriented; crave attention; are technology driven; and are likely to approach seniors as equals if no line is drawn, but if boundaries are clear, they are highly probable to show seniors the utmost respect and work tirelessly to impress (Kane, L., 2018).

Generation Y are described as being confident; having high expectations; being ambitious; not being afraid to raise questions when something is unclear; preferring not to work as hard as past generations but rather spending life in a meaningful way; and aiming to retire in their thirties or forties (Generation Project, 2018; Kane, L., 2018).

The reality is that Generation Y medical doctors are placed in a rigid environment such as the South African public health sector, which is highly stressful and does not give them flexibility, and a sense of achievement or belonging in a team. It erodes their confidence and limits the ambition they aspire to have in their working environments. This situation leads to unmet expectations, and puts them at risk for burnout and a potential loss of identity. The poor working conditions exacerbate burnout and development of poor coping strategies. The findings in this study indicated not only the need to address burnout, but also to promote an understanding of the Generation Y medical doctor's needs in the public health sector.

Generation Y medical doctors, based on their utterances, felt that they benefitted and gained from the group coaching intervention for burnout amongst Generation Y medical doctors. They truly felt understood and empowered; additionally, they understood what they were experiencing and likely what their seniors are experiencing too. The awareness of burnout and having coping strategies to work towards led to them being motivated to consciously not allow

the experience of burnout in the poor working environment to determine their future in the medical field and for it not to change their identity or way of being for the worse.

After the exposure to the group coaching intervention, they saw the importance to consciously cope, to care for the self, to focus on what they could control, and to learn how not to personalise the experience as being reflective of personal failure. The group coaching intervention process allowed them to start working on not losing their ambition, confidence and initial passion for entering the medical field. It gave them a sense of hope to carve out how they would like to work and be as medical doctors in the future beyond the poor working conditions and overwhelming experience that forms part of their compulsory training.

The coaching intervention promoted how by making an effort to cope and by changing their perspective of their working environment, they could still feed into the Generation Y persona where they are typically achievement oriented. Additionally, it promoted how there might be a need to postpone the feeling of a sense of achievement to a later time due to the current working environment. At the same time, it emphasised the temporary state of where they are now. The idea of working on the self and working on what is within their own control was continually reiterated in the process.

Based on the feedback from the participants about their experiences in the session, it could be concluded that the group coaching intervention for burnout amongst Generation Y medical doctors working in the public health sector (Limpopo Province, South Africa) is applicable and beneficial for this specific population.

6.2.6 Contributions of the research study

This section details the contributions made by the study. According to the Generation Y medical doctors, there were certain benefits to the exposure to the group coaching intervention

for burnout, which implies that it met their needs and that it was beneficial and applicable. This research contributed to the existing body of knowledge in terms of empirically based coaching interventions for burnout in Generation Y medical doctors working in the public health sector. There were also contributions regarding the creation of awareness, prevention and intervention for burnout within the participants and other stakeholders in the South African public health sector.

Findings indicate that burnout and its associated risks in Generation Y medical doctors working in the South African public health sector are not prioritised by stakeholders of the public health sector. This study provides evidence that Generation Y medical doctors and stakeholders of the Department of Health need to be aware of burnout.

The group coaching intervention for burnout was designed specifically for Generation Y medical doctors; hence, it led to the kind of beneficial experience they had as participants. The group coaching intervention approach was suitable to them and therefore rapport could be developed with ease.

Humanism, phenomenological and a qualitative approach made Generation Y medical doctors feel understood, comfortable and open to the coaching process, thus leading to them gain from the process. It was non-threatening, informal and allowed for self-reflection. Matching a coach to the group is also important. In this regard, we were a good fit as they could relate to me. Coaches should suit the client in future interventions in order for the client to gain from the coaching intervention.

There was also empirical evidence to show that there is a need for ongoing group coaching interventions for Generation Y medical doctors working in the public health sector. The intervention benefitted the participants: they gained an increased understanding of burnout within the self, seniors and peers, and they gained some coping skills. However, the benefits

could be short-lived, which is probable because the poor working environment in the South African public health sector remains a reality as does the burnout experience.

The participants are continually under pressure and might experience other stressors as they face life. This could put their gained skills from the group coaching intervention under more pressure. Therefore, there is a need for ongoing coaching intervention sessions such as these and, additionally, ideally a change in the entire South African public health sector's functioning.

It is thus concluded that the data contributed to existing knowledge aimed at developing empirically based group coaching interventions for burnout amongst Generation Y medical doctors working in the South African public health sector.

6.3 Limitations

This section focuses on the limitations of the research study. The limitations in terms of the literature review are presented first, which are followed by limitations of the empirical research.

6.3.1 Limitations of the literature review

The limitations of the literature review are noted and discussed in this section. There was limited available prior research on empirically based coaching interventions for burnout amongst Generation Y medical doctors working in the South African health sector, which means that this study was one of a few attempting to address the gap. There is a need for more studies to develop empirically based coaching interventions for affected population so that finding could be compared and more knowledge gained.

Burnout exists, which affects Generation Y medical doctors and essentially recipients of their care. This leads to certain negative consequences such as poor coping strategies and, in some

cases, early departure from the medical field. In spite of this, there seems to be limited solution-focused research to combat burnout in Generation Y medical doctors working in the South African public health sector. Most research focused on identifying problems that lead to burnout in Generation Y medical doctors.

Furthermore, research and coaching interventions for burnout amongst Generation Y medical doctors working in the South African public health sector should include the environment and public health sector stakeholders. Burnout needs to be addressed at the individual, group and system level so that there can be long-term change and benefit.

Due to the complexities and cost of involving organisations in interventions studies, studies mostly focus on individual and group level intervention. There is also a need for more studies to address the paradigm shift regarding the management style for managers to be able to handle Generation Y medical doctors who are the products of the beginning of the fourth industrial revolution. Their view of the world and work ethics are defined differently than those of previous generations. With ageing employees with previous generational beliefs that are very traditional, management style in the workplace becomes a huge stumbling block for growth for the younger generation. This tends to bring a great deal of stress and feelings of not being understood. Massive conflict emerges, leading to a communication breakdown that breeds complexities that lead to a massive drop in morale and subsequent fatigue and burnout.

Both groups' lack of understanding of each other and ways of bridging the gap are not expanded upon in literature and only expressed as the groups being dismayed by each other. Such information is critical for the unavoidable transition that needs to happen in the public sector where many employees are older and have to hand over to the incoming younger generation, of which most are in the category of Generation Y medical doctors.

6.3.2 Limitations of the empirical research

Limitations of the empirical research are discussed in this section.

The first limitation to be noted is sample size. The limited number of participants is a limitation in that most doctors in the public health sector seem to be affected (as seen by the scores on MBI-GS) but could not attend. This implies that more people are experiencing burnout and are likely not noticing or understanding their experience, which leads to poor coping mechanisms that propagate the negative cycle. There could also be multiple medical mistakes because of exhaustion, workload, and lack of monitoring of complex cases.

Another limitation worth noting is that diverse groups of health professionals could have benefitted from the study as well, such as other generations of medical doctors whose views about the public health sector could be compared with the views of Generation Y. Other professionals such as nurses could also be included to see if the problems are profession-specific for the same age groups. Future studies could use the findings from this study to generate more questions and hypotheses to bring out more aspects to explain the dynamics regarding self-care of Generation Y medical doctors at this specific public health hospital.

Participants who were meant to attend did not all attend. The study went ahead and the original group coaching intervention plan was adapted to be for fewer people who were grouped in one group and had fewer sessions. The adapted coaching intervention session was adapted because their absenteeism confirmed the difficulties and challenges that the Generation Y medical doctors face. The challenges that put them at risk for burnout include inflexible hours, lack of replacements when sick, pressurised working conditions, lack of trust for the system and whatever the systems brings to them.

Coaching was done in the form of focus groups. The focus group methodology relies heavily on assisted discussion and leads to large volumes of qualitative data from the field notes, recordings and verbatim transcriptions that might be overwhelming to analyse. In focus groups, the most outspoken can take over the discussion and therefore it was essential to involve more reserved participants.

The study incorporated a collective case study method in the group coaching intervention of burnout amongst Generation Y medical doctors. Although research on effectiveness of group intervention or collective case study interventions in burnout clients has been limited (Sorenson et al., 2016; Werneburg et al., 2018), there is substantial circumstantial evidence that it can have an impact on participating clients as it offers suffering individuals the opportunity to see the progression of burnout in themselves and in others; it also gives them an opportunity to debrief and think of ways of coping in an atmosphere of support and hopefulness (CSAT, 1999; Yalom, 1995).

Phenomenology, as the methodology used, has its own limitations. Results cannot be generalised and researcher bias can be difficult to determine or detect. However, the method is helpful in creating an understanding of a lived experience and brings meaning to it, which was one aim of the study. The approach is helpful for changing policies or developing new theories.

Self-reported data has potential biases that the reader should bear in mind. Data from the participants could not necessarily be verified independently, but what was said by the participants gave meaning to their experiences of burnout and should not be disregarded. Measures were taken to remove my own biases as a researcher. Although some biases could remain, they seemingly did not adversely influence the study and its findings.

The MBI-GS used in the study has been shown to have certain limitations and studies have recommended further psychometric work to refine content or the use of other burnout measures (Wheeler et al., 2011). MBI-GS could however be used in applied research settings to categorize individuals but not recommended for clinical decisions. This implies that interpretation of subscales additionally that MBI-GS scores, specifically the EE subscale even with the high coefficient alpha scores, should be done cautiously (Wheeler et al., 2011). The one measure deemed more appropriate for generation Y medical doctors in South African context is the MBI-HSS (Liebenberg et al., 2018); the use of the MBI-HSS is recommended for future research in coaching interventions for Generation Y medical doctors.

The mixed methodology approach taken in the study incorporating phenomenology and a positivistic paradigm was not essential. Phenomenology approach alone with the use of the questionnaire under the approach would have sufficed as a methodology for the study without incorporating positivism.

The last limitation was that the study only focused on Generation Y medical doctors. Management was not interviewed, which could have brought more value to the project to establish why management could be so neglectful of what seems to be key in the training of these Generation Y medical doctors. Being Generation Y medical doctors and being trained by older medical doctors could be a reason for not being able to reach out to one another. Future studies could focus on the doctors and the organisation to determine how their stories interact and how the gaps can be addressed.

6.4 Recommendations

This section focuses on the secondary aim of the study, namely, (a) to formulate recommendations for the public health sector department specifically, (b) to gain a deeper

understanding of the experiences of Generation Y medical doctors for future research in this field of coaching psychology, (c) and for coaches/consultants.

6.4.1 Recommendations for the public health sector department

Some studies suggested that burnout should be treated as an organisation-wide problem (Lemaire & Wallace, 2017; Panagioti et al., 2016). This is also reflected in the findings of the current study that South African public health sector stakeholders need to be involved in the prevention and management of burnout.

The following section makes recommendations based on the findings for the public health sector. Intervention at management level is recommended, which should include training and presentations about:

- What burnout is and how it manifests itself.
- The impact of workload on the wellness of caregivers.
- Promotion of the needs of Generation Y medical doctors in training. There is a need to understand what to do to get the best from Generation Y medical doctors by understanding their work environment expectations and what they would need to prevent and manage burnout.
- Organisational control and monitoring of midlevel managers and senior staff/supervisors to evaluate how they are coping with workload. Should burnout manifest, managers' ability to deal with Generation Y medical doctors should be evaluated and training skills offered if needed.
- Obtaining awareness of the plight of young Generation Y medical doctors and putting measurements in place for proactive support and early intervention to prevent burnout.

The next section makes recommendations to public health sector stakeholders for supporting Generation Y medical doctors. Intervention to support Generation Y medical doctors should include:

- Regular training of supervisors to enhance empathic understanding of those they are training by infusing awareness of how they affect trainees, and what to do to lessen the negative impact on the trainees.
- Regular debriefing of Generation Y medical doctors to enhance their self-care capacity while delivering patient care.
- Understanding Generation Y medical doctors' way of functioning in order to know how to support them; for example, using electronic communication and forming WhatsApp groups to have continued support could assist Generation Y medical doctors. Knowing that they are mostly achievement driven should guide how they can be kept interested in what they are doing and giving them work that motivates them. Generation Y medical doctors are also known to like flexibility and openness versus secrecy about issues at work. They might not understand why they are not being involved in management planning sessions, which probably is what takes management away from them most of the time and that is seen as a lack of visibility that is key for mentoring, support and team support.

Based on their studies in South African public hospitals with medical doctors, including Generation Y medical doctors, researchers have made some recommendations for hospitals in the public health sector to address occupational stress that often leads to burnout (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Leibenberg et al., 2018; Sirsawj, Steinberg, & Raubenheimer, 2013; Thomas & Valli, 2006). At an organisational level, their recommendations included: implementing flexible hours; increasing staff; having regular

meetings; offering competitive salary packages at provincial and national levels; ensuring reasonable overtime work; giving management training; ensuring that mandatory annual and study leave are taken; increasing support by specialist consultants; improving rural referral systems and infrastructures; ensuring availability of essential medical instruments and medicine; doing regular performance assessments with career planning; and implementing effective employee wellness and assistance programmes (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Leibenberg et al., 2018; Sirsawj, Steinberg, & Raubenheimer, 2013; Thomas & Valli, 2006).

Additionally, there was recommendations for strengthening hospital management and increasing the role of medical doctors in management; improving working conditions; establishing private-public collaborations; ensuring adequate support for junior medical doctors; improving hospital environments; providing recreational facilities; improving accommodation; recognising and appreciating work done; and providing an incentive for medical doctors willing to stay in the public sector, especially in rural placements (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Leibenberg et al., 2018; Sirsawj, Steinberg, & Raubenheimer, 2013; Thomas & Valli, 2006).

These organisational recommendations would likely benefit the Generation Y medical doctors in the current study as well based on the concerns the Generation Y medical doctors raised about the work environment and management.

6.4.2 Recommendations for future research in the field of coaching psychology

This section gives recommendations for future research in the field of coaching psychology based on the findings of the current study.

Future studies should be done that could focus on the Generation Y medical doctors and the public health sector stakeholders including senior medical doctors and management to see how the different group's perspectives interact and how probable gaps within the groups can be addressed.

Future studies could also include diverse groups of health professionals working in the public health sector who could benefit from burnout coaching intervention. It could be different generations of medical doctors (mostly senior or in management) and their views about the public health sector could be compared with the views of Generation Y medical doctors. Other professionals such as nurses could also be included to evaluate whether the problems seen within the Generation Y medical doctors are profession-specific or occur within the same age groups across the professions. Future studies could use the findings from this study to generate more questions and hypotheses to bring out more aspects to explain the dynamics on self-care of Generation Y doctors at this specific hospital or any other public health sector unit.

Petersen (2019) referred to a term 'millennial burnout', describing how millennials (born between 1981 and 1996) were a generation who were suffering from burnout. Millennial burnout is similar to work burnout (Samra, 2019) and millennials seem to suffer higher levels of burnout, which is indicative that they face complex problematic environments (Samra, 2019). Petersen (2019) stated that burnout is a shared generational experience, not implying that it is experienced the same by everyone or limited to millennials.

The current study's findings not only showed the occurrence of burnout in Generation Y medical doctors due to the working environment, but also alluded to the underlying dynamics that interplay within Generation Y medical doctors as a group and as individuals that put them at risk for developing burnout. The findings in the current study indicated the need for research in the field of coaching psychology to empirically investigate the occurrence of burnout and

these underlying dynamics to work towards research-based solutions for the Generation Y medical doctors' dilemma.

The study was focused on the individual and touched on the group level. The findings showed the interrelatedness of the individual, group, and organisational/systemic as key in addressing burnout holistically and for long-term benefit in Generation Y medical doctors. Future studies should aim to intervene at all three levels, namely, individual, group, and organisational/systemic, thus addressing issues even at managerial level.

Emotional exhaustion is seen as a central aspect of burnout (Milićević-Kalašić, 2013) and its reduction is seen as an important part of any intervention. The current study indicated a similar level of emotional exhaustion objectively before and after exposure to the intervention. The study further showed a verbalised sense of benefit and gain from the group coaching intervention of burnout amongst Generation Y medical doctors. This implies that the impact they felt might be short-lived because emotional exhaustion remains. Further research in the coaching field of burnout is needed to identify empirically how to intervene for burnout and get an objective reduction of the burnout dimensions, specifically the emotional exhaustion dimension, so that Generation Y medical doctors could gain long-term benefit.

I am of the view that there will be a need to incorporate findings from the current group coaching intervention for burnout amongst Generation Y medical doctors into a bigger burnout intervention strategy in the South African public health sector, which would involve all stakeholders at different levels in order to combat burnout in the future on a long-term basis.

Future research is lastly essential to assist in the development of a new measure of burnout which has proven validity and reliability in a multi-cultural SA context. Burnout tool used in the study MBI-GS is used to merely categorize burnout for research purpose and not diagnosis. WHO (2019) mentions that burnout is listed as an occupational phenomenon that could lead

someone to seek care in the International Classification of Diseases (ICD-11). It was in the previous classification (ICD-10) in the same category but the latest ICD-11 definition is now more detailed. WHO is embarking on development of evidence based guidelines on mental well-being in the workplace (WHO, 2019). This indicates progress has been made and will continue to occur regarding understanding of burnout. There is a need to research and develop more tools to assist in the diagnosis, prevention and intervention of burnout specifically in the South African context.

6.4.3 Recommendations for coaches/consultants

Certain recommendations are made for the coaches/consultants aiming to assist Generation Y medical doctors working in the South African public health system with burnout.

It is recommended that consultants/coaches working in this area should demonstrate a thorough knowledge about the dynamics of generational differences between Generation Y and older generations in the public sector. This knowledge is necessary for the consultant/coach to be able to move the affected out of the difficult space they could be experiencing. Such knowledge will lead to the development of relevant intervention material and workshop items, and will help with scheduling and developing strategies for sustainable intervention.

The recommended interventions should thus be based on the participants' needs with the coach/consultant being flexible in adapting the actual intervention based on how the process develops. The participants should be prioritised and the coach/consultant should be led by the participants so that they feel heard and actually benefit. The coach/consultant should be a facilitator and not come across as a teacher with a formal presentation. The coach/consultant should aim to be approachable and empathetic, and ensure everyone is given an opportunity to share when facilitating a group. The coach/consultant should create a safe, interactive, informal environment where anything can be said openly without fear. It is important for the

coach/consultant to note and set aside their own biases in order to be able to intervene to critically and objectively for burnout amongst the Generation Y medical doctors.

The potential misunderstanding or lack of awareness of burnout manifesting in Generation Y medical doctors cannot be overemphasised. The coach/consultant should be attuned to identify and manage it in the intervention process. The stigma of admitting that help is needed and resistance can also be expected as part of the process. The aim for the coach/consultant should be, as seen in Rogers' approach, to create an environment where catharsis and internal growth can be nurtured.

In the intervention, the coach/consultant needs to note the individual dynamics that Generation Y medical doctors bring and also the function of their system. Efforts to cope with burnout should also be understood. The system includes stakeholders such as management and senior medical doctors in the various placements and the public health sector department. The coaches/consultants applying thorough organisational development strategies for system diagnosis should be studied to help create relevant dyads and systemic interactive dialogues for intervention that will benefit both groups and the organisation in general.

It seems that the bulk of the limited researched and attempted interventions in literature are more individual based where focus is on removing self from work and/or strengthening of internal resources whereby one develops better coping strategies (Lemaire & Wallace, 2017; Maslach et al., 2001; Panagioti et al., 2016).

Individual interventions, such as the group coaching intervention applied in the current study, aim to enable people to use individual and social resources to develop resistance to occupational stress and to develop beneficial coping strategies, which reduces the risk of burnout. Organisational interventions are aimed more at improving working conditions while minimising external stressors and promoting social support (Karl & Fischer, 2013; Panagioti

et al., 2016). Organisational interventions tend to be more expensive and are proposed for the long term, hence research on interventions tends to focus more on the individual level.

At an individual level, certain suggestions that could contribute to the reduction of burnout have been made in research, even in the South African context (Discovery Health, 2018; Hlatshaneni, 2019; Kotzee & Couper, 2006; Leibenberg et al., 2018; Sirsawj, Steinberg, & Raubenheimer, 2013; Thomas & Valli, 2006). There was a suggestion for presenting personal stress management training that focuses on being aware of stress and its effects; teaching coping strategies including time management and cognitive behaviour therapy skills; building support system; relaxing; and developing interpersonal skills (Kotzee & Couper, 2006; Panagioti et al., 2016; Ruiz, 2019; Taormina & Law, 2000; Thomas & Valli, 2006).

Additionally, recommended individual intervention as emphasised in the current study included self-care and self-management, which implies self-observation and awareness (Kravits et al., 2010); self and action regulation (Forgas et al., 2009), whereby one takes responsibility of their actions and the self in the experience of burnout; promotion of self-esteem (Pierce & Gardner, 2004) and/or self-efficacy (Doménech Betoret, & Gómez Artiga, 2010); increasing resources within the self and outward (Bakker et al., 2005; Lee, R.T. & Ashforth, 1996) and emotional intelligence advancement (Weng et al., 2011). Furthermore, maintenance and enhancement of social support (Van Dierendonck et al., 1998); training in communication (Ernold et al., 2011) and coping skills (Lazarus, 1966) together with work and family life balance (Ladengard, 2011); promotion of cognitive and problem-solving skills (Sasaki et al., 2009); promotion of resilience (Menezes de Lucena Carvalho et al., 2006); and personal characteristics such as optimism and hardiness, which have been correlated with less burnout (Alarcon et al., 2009; Otero-Lopez et al., 2008; Da Silva et al., 2014).

Certain aspects may influence the development or prevention of burnout. These include: psychosocial work environment (Lemaire & Wallace, 2017; Weber & Jaekel-Reinhard, 2000); sociodemographic characters such as age, gender, and marital status (Maslach, 2003); and social relations and networks outside or at work (McMurray et al., 2000). Therefore, promoting positive social relations, strengthening intrapersonal traits, supporting at-risk groups; and creating awareness of risk are encouraged in an attempt to reduce burnout.

The above recommended individual-focused interventions for burnout could be beneficial for the current Generation Y medical doctors based on how they presented and the findings in the study. The coaches/consultants working with a similar intervention groups could also research and apply some of the recommended individual level interventions to aim on assisting in reduction of burnout in Generation Y medical doctors working in the public health sector.

6.5 Chapter Summary

The threefold secondary aims of the study as given in Chapter 1 were: (a) to contribute to existing knowledge intended to develop empirically based coaching interventions for burnout in Generation Y medical doctors working in the public health sector in South Africa; (b) to add knowledge about awareness, prevention and intervention of burnout in the Generation Y medical doctors in the South African public health sector context by evaluating a group coaching intervention for burnout; and (c) to formulate recommendations for the (i) public health sector department specifically, to gain a deeper understanding of the experiences of Generation Y medical doctors, (ii) for future research in this field of coaching psychology, (iii) and for coaches/consultants were achieved in this chapter.

The following objectives were all reached in this chapter:

- The general aim of the research was to describe the experiences of a group coaching intervention for burnout amongst Generation Y medical doctors.
- The specific aim of the literature was to review a group coaching intervention for burnout in order to establish its applicability and benefit in Generation Y medical doctors working in the public health sector in South Africa.
- The specific aim of the descriptive phenomenology study was to gather and analyse information to explore Generation Y medical doctors' experiences of a group coaching intervention for burnout.

The chapter detailed conclusions drawn from the study and highlighted its limitations. It made recommendations for the public health sector in South Africa, future research in coaching psychology and for coaches/consultants aiming to intervene in burnout amongst Generation Y medical doctors.

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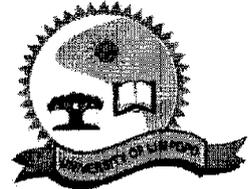
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ANNEXURE A : ETHICAL APPROVAL FROM INSTITUTIONS

UNIVERSITY OF LIMPOPO
Polokwane Campus



Office of Research & Publications

08 May 2014

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SOUTH AFRICA

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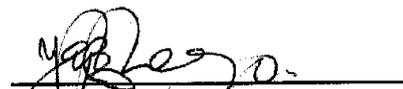
Dear Ms KKE Mashego

The Project: A coaching intervention for burnout amongst Generation Y medical doctors
– Served on the Sub Committee for Research & Ethics at PMHC on 06.05.2014.

Recommended for approval with minor corrections:

Submit for our records :

1. A final clearance document from the university to replace the conditional approval that was based on the approval for access into the complex.
2. Application form with all signatories that were withheld by the requirement in 1 above

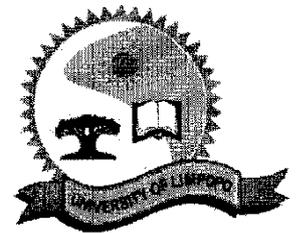


Prof T-AB Mashego
Deputy Chairperson of Ethics Subcommittee,
Polokwane



LIMPOPO
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REPUBLIC OF SOUTH AFRICA

**ETHICS COMMITTEE
CLEARANCE CERTIFICATE
UNIVERSITY OF LIMPOPO
POLOKWANE MANKWENG HOSPITAL
COMPLEX**



PROJECT NUMBER : PMREC – 80/2014

TITLE : A coaching intervention for burnout amongst Generation Y medical doctors

RESEARCHER : Ms KKE Mashego

ALL PARTICIPANTS : N/A

Supervisor : Prof RM Oosthuizen

DATE CONSIDERED : 06 May 2014

DECISION OF COMMITTEE

- Recommended for approval

DATE : 08 May 2014

PROF A J MBOKAZI
Chairperson of Polokwane Mankweng
Hospital Complex Ethics Committee

NOTE: *The budget for research has to be considered separately. Ethics committee is not providing any funds for projects.*

Ref #: 2014/CEMS/IOP/005

ETHICS REVIEW COMMITTEE: DEPARTMENT OF
INDUSTRIAL AND ORGANISATIONAL PSYCHOLOGY

STUDENT: TUMI MASHEGO (student number: 53748506)

SUPERVISOR: Prof R Oosthuizen

This is to certify that the application for ethics clearance submitted by
TUMI MASHEGO (Student number: 53748506)

For the study

A COACHING INTERVENTION FOR BURNOUT AMONGST GENERATION Y
MEDICAL DOCTORS

The application for ethics clearance for the above mentioned research
was reviewed by IOP unit committee on 06/06/2014 in compliance with
the Unisa Policy on Research Ethics. Please be advised that the
research ethics review committee needs to be informed should any
part of the research methodology as outlined in the Ethics Application
(Ref. Nr.: 2014/CEMS/IOP/005), change in any way.

The Research Ethics Review Committee wishes you all the best with
this research undertaking. Kind regards,

Dr O M Ledimo (On behalf of the IOP Department Ethics Committee)