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Strike by State-Sector Doctors, the Dual Mandate and Inherent Contradictions in Public Health Management

NdukaezeNwabueze, Ph.D., LL. B., BL.

Associate Professor
Department of Sociology, Faculty of Social Sciences,
University of Lagos, Lagos
nnwabueze@unilag.edu.ng
nwabueze1955@yahoo.com

Abstract: *The major indices of public health care status in Nigeria tell a story of gross ineffectiveness, inefficiency and formidable operational obstacles. Doctors and other health professionals are key elements in the chain of difficulties as well as solutions. Specifically, the conditions of work of doctors and how well they are taken care of are as critical as health care infrastructure, the state of intra-health professionals' relations or issues of capacity and access among the citizens in determining the quality of care rendered to the people and system efficiency. The habit of doctors going on strike repetitively breaches the Hippocratic Oath and imperils the peoples' health. Among doctors, it is sign of unresolved labour grievances; of existence of gap between work and life expectations and reality. The factors associated with strike must be addressed so that the norms of the oath could once more become the infrastructure of doctors' professional conduct and practice which at the moment is characterized by normative contradiction. Using multistage sampling and structured questionnaire, the views of303 doctors across the country were sought on the crisis between the oath and doctors' strike. Among other factors, dissatisfaction with pay and allowances, status inconsistency, relative deprivation, blocked ascendancy; perceived status insecurity, unsatisfactory working conditions, unimplemented collective agreements, intra-sector rivalry and official policy inconsistency were mentioned as contributory. The Oath is blamed for exclusively rooting to secure the health of patients and the integrity of the profession while simultaneously neglecting the interest and working conditions of the professional. Deriving from the analyses, reinvigorating the National Health Insurance Scheme and shifting paradigmatically from state benevolent healthcare to entrepreneurial public health management are suggested to bring stability and efficiency to the system.*

Keywords: *Strike Dual mandate Hippocratic Oath Status inconsistency Enterprise healthcare Willingness to strike Bureaucratic red-tapism*

1. INTRODUCTION

While doctors are vital to cutting edge public health delivery, persistent strikes by those employed by and in the state sector jeopardizes effectiveness and efficiency of public health infrastructure and service delivery. Though strike is not inherently destructive, and may in fact be constructive, incessant and prolonged work stoppages impair the health of patients and erode confidence on the capacity of the state to protect the citizens. The Nigerian economy is riddled with strikes by state-employed (federal and state governments) physicians and this tends to subvert the realization of the Hippocratic Oath, a statement of some universal moral standards of medical practice that put the patient first. This raises the question as to why industrial strikes persist among public sector doctors in a way that contradicts the social values embedded in the oath. A gap has emerged between the oath ideal and doctors' working condition the closing of which is inevitable in bring industrial stability back to the health sector of the country.

Against this background the thematic proposal of this study is that persistent industrial strike and continued violation of the Hippocratic Oath by doctors connotes existence of systemic contradictions between ideals of the oath and the conditions under which doctors practice their profession. The underlying assumption is that industrial strikes are likely to continue in the public sector until this gap is bridged fully or substantially. Accordingly, this study aims to address a set of related objectives. First, emphasize the conflict-generating potential of the gap between the

ideals of the oath and the shortfall in doctors' actual working conditions. Second, the study will analyse and illuminate the implications of continuing industrial strike for public health efficiency and, thirdly, suggest measures to bridge the gap and thereby stem industrial disharmony in the sector

2. PROBLEM ARTICULATION – THE DUAL MANDATE

Each time doctors go on strike many commentators ask 'why should doctors strike? Many citizens who see their work as basically humanitarian find it difficult to reconcile the act of going on strike with the primary duty to save life. Some will ask 'if they strike what happens to the patients they swore to protect? Such people call doctors names at such times. Even government falls into the same trap exploiting that preconceived notion to whip up negative sentiment against doctors in strike periods. It is recalled that upon induction doctors have the Hippocratic Oath administered to them. According to this Oath, their primary allegiance is to the profession and first duty is the health of the patient. This though is without due consideration for the financial and psychological condition of a doctor or the organizational and physical situation of work. The issue is when they embark on strike are they not failing their obligation under the Oath?

There is a general belief among the public that doctors are relatively well paid for the services they render. This opinion is attributed one, to the way doctors carry their shoulders high in the hospital. So far, doctors appear to have failed to lay their message of inadequate remuneration in the public domain and this is a factor in their often being castigated during strike periods. The dilemma for the doctor is: which of the obligations should override the other – self on one hand or the profession, the patient, public service on the other? The doctor has the dual mandate to satisfy self or the profession without a clear guide as to the superior obligation. The dilemma presents in a number of contradictory ways; between professional standards and doctor's remuneration and other conditions of work. It is unclear whether there are conditions under which a doctor might be excused to ignore the Oath and press for better conditions or is allegiance to the Oath an iron law? Another face of the dilemma is whether state health care is mainly or strictly welfare service or can it also be organized as economic service? Does it give rise to only social obligations between parties (e.g. between state, doctor and patient) or does it involve enforceable legal obligations as well? Is the condition of work of the individual doctor also of interest to the Oath or not? There is a dilemma on the state. It is between the state as sovereign and state as employer and equal negotiating party with health sector unions in industrial conflict. Is the state party, regulator, adjudicator or executor in the sector or is it all of these together? Can the state combine these functions without contradictions such as abuse of power that may occasion inefficiency in the sector? Yet there are other dilemmas. There is the issue of double coincidence of superiority complex between doctors and state officials. There is outstripping of demand over supply of quality health service. State officials who plan and implement public health do not themselves use the facilities but are treated abroad at state expense. These are some of the contradictions that position public health as an arena of crisis, inefficiency, ineffectiveness and disappointment.

To clarify, it is mainly state-employed doctors that face the dilemma. Patients in public hospitals are oriented to believe that health care is social service and as such can be secured free of cost. On the other hand, for doctors in private practice, both patient and doctor understand from the outset that the transaction is strictly business implying fair reward for service and an agreement is often reached before service is given or received. Patients do not approach private clinic expecting the doctor to be benevolent, philanthropic or generous. Thus the dilemmas talked about are embedded in the system of state health care administration. Strikes, conflict and inefficiency persist in the sector owing to non-resolution of these contradictions. The public sector health reforms by the federal and some state governments may be understood in the context of finding a solution to these contradictions. Interrogation of the factors associated with government health system that produces these negative results is a key objective of this paper.

3. HIPPOCRATIC OATH AND THE DILEMMA

Hippocratic Oath is a traditional oath began around 1747 by physicians who pledge to practice medicine according to the ideals and moral principles put forth by the ancient Hippocrates (c. 460-377 B.C.E) though the wordings were not necessarily written by him (Etymology Dictionary, 2010). Though the oath takes diverse forms all over the world differing in its detail over time

from one locale to another, it is an ethical professional behaviour guide for physicians. It underscores the expected orientation of doctors towards their profession, other practitioners, the community and the patient. Though many medical schools administer one or another form of the oath, certainly not all schools do. The oath puts the patient first. The intent is to help sick people and avoid any harm to them. It prioritizes respect for the rights of patients and recognizes the special value of human life. Similarly, patient confidentiality and upholding of internally accepted standards of human rights is a key goal. In addition, respect of superiors in the profession and sharing of knowledge with professional peers is a valued intent (American Heritage New Dictionary, 2005).

Commendable as the intent of the oath might be, a survey of the oaths administered to freshly qualifying medical graduates in Nigerian medical schools in the last decade shows that while they share the universal values enshrined in the oath, they nonetheless appropriate different words to convey the ideals there being no generally accepted universal or standard oath. An important observation on the Oath is that while it emphasizes the priority of the patient and the interest of the profession, it is silent on the working condition of the doctor as care giver. This is a key source of behavioural dilemma for practising doctors. The expectation of doctors while in training is that they will be comfortable in life practicing medicine. Considering the length of training time and the rigour and stringent qualifications for admission, doctors may feel justified or entitled to expect the best working conditions from society. In addition, their service being essential, basic and humanistic, they may be excused for the high expectations of returns in terms of pay and other benefits. The reality is that in the lower rungs of the medical hierarchy conditions fall far short of expectation occasioning frustration, disappointment and feeling of betrayal. Doctors tend to perceive bias, imbalance or injustice in the spirit and letters of the Oath. Some doctors suggest that a complementary consideration of some minimum conditions of medical work and practice should be added as part of the construction of a modern oath so as to protect doctors and instil a sense of responsibility in those that will employ and deploy medical doctors. This unfortunately is not the case. Some argue that expecting doctors to give their best to patients without volunteering a thought on the work condition of the doctor leaves a gap which is identified as a likely source of the normative contradiction and industrial unrest in the health sector.

4. INDUSTRIAL STRIKE IN THE HEALTH SECTOR

Industrial strikes in the sector have mostly staged by state and federal government employees. Although nurses and other organized health professionals embark on strike action from time to time, medical and dental practitioners under the aegis of the NMA and the National Association of Residents Doctors have more frequently engaged in work stoppage than other groups. Since 1973/74 the NMA called nation-wide strike in 1964, 1975, 1978, 1982, 1984 and 1985. Fifteen years from the 1990 to the first half of 2000s was relatively peaceful. The temperament of the NMA leadership, attitude of government and general socio-economic and political condition prevailing in the country are among factors that determine occurrence of strike. Hostilities resumed from about 2007 when the NMA staged a 14–day warning strike from February 26 – March 4 and the main strike from 5 – 10 March. In Lagos State, the strongest state branch of NMA, doctors went on strike four times from 2010 to 2012. The 2012 industrial action lasted one month from May 1st. The state government whimsically sacked the 788 doctors in its employ claiming to have engaged 303 new doctors in their place. The matter was however amicably resolved.

On 18th December, 2013 NMA started a 5 – day warning strike with the threat that if its demands were not met an indefinite strike would follow on January 6, 2014. Though the main strike was averted, a similar scenario to the Lagos State episode of 2012 played out at the national level in 2014. On July 1st 2014, federal government doctors began an indefinite strike which lasted for eight weeks ending on 24th August, 2014. In the heat of the strike the Federal government announced the sacking of 16,000 resident doctors who make up 70% of doctors' workforce in Nigeria. While doctors considered the unpatriotic interpretation of remaining on strike in the face of the outbreak of the Ebola virus disease, doctors called off the strike after government reviewed some allowances and reinstituted the residency programme.

It has been a chequered history of work stoppages, industrial instability and unpredictable service environment in the public sector. Besides these recorded strikes some of the state branches of NMA all over the country (e.g. Rivers and Edo states) engaged in strike action at one time or the other in this period to press home their demand for better conditions. Issues in dispute include underfunding of the sector, non-implementation of agreements, low and discriminatory salaries and allowances and general poor working conditions, etc.

5. SITUATION ANALYSIS OF THE HEALTH SECTOR

The situation of inefficiency in the sector is a contributory factor as well as result of the incessant strike and instability being experienced therein. It is a condition that orchestrates primacy of patients' rights without complementarily emphasizing the necessity of optimal working condition for practitioners. Health sector situation analysis and evaluation is carried out under six sub-titles as follows:

5.1 Organizational Structure

Nigerian health care system can be divided into three broad sub-systems: government services, private medical services (both being orthodox) and traditional or alternative medical services. Owing to cash constraints traditional medicine is most affordable, available and accessible to a higher percentage of the population particularly the rural dwellers. Government medical services are structured into primary, secondary and tertiary care provided by the local government councils in Primary Health Centres (PHCs), state governments in general hospitals and the federal government in specialist and teaching hospitals and medical centres respectively. The activities and services of these tiers of government are coordinated, interfaced and regulated by the National Council on Health though substantial autonomy is left for the health care authorities at each level to decide on emergent issues. Patients pay for services except in special programmes such as HIV/AIDS, Tuberculosis, and ad-hoc free medical services by non-governmental organizations. About 90% of HIV / AIDS funds though are sourced from abroad. Only 3.75% of the population is catered for by the National Health Insurance Scheme and this is a key disincentive to assessing orthodox health care. Alternative medicine is bedevilled by discrimination by orthodox practitioners, lack of infusion of modern research, science and new technology, dosage problems, lack of universal standards of knowledge, training, practice and ethnics etc. Orthodox medicine is bedevilled by brain-drain, crisis in remuneration policy as between pay parity or unified scales versus special scales. Disagreement among health sector professionals, frequent work stoppage and preference for off-shore services by government top shots are the other problems. It is estimated that 7,000 Nigerians go to India alone annually for medical treatment. On the whole, about ₦250 billion is spent on medical tourism annually.

5.2 Financing

Governments at the three tiers budget for and finance their hospitals and health centres. Resource allocation to the sector is paltry. While the MDG initiative expects governments to spend 15% of their total annual budget on health, in 2013 the sector shared just 6.04% or 279.23bn out of a total budget of 4.94tr Naira.

The health budget is criticized for being tilted in favour of the rich and the elite as close to 70% of the country's health budget is spent on tertiary centres while primary care which caters to the poor, teeming citizens is starved of funds.

Owing to budget shortfall, equipment are absolute, remuneration is poor and services sub-standard in the public health system. Patients shoulder substantial veiled and overt expenses by themselves. Patients pay the total cost of services in private health systems and alternative service outlets which are more or less business enterprises. The frequent strikes in government facilities have pushed up the number of citizens that patronize private and alternative care outlets.

5.3 Planning and Regulation

The Federal and State Ministries of Health, the Medical and Dental Council of Nigeria, professional bodies such as the Nigeria Medical Association (NMA), Pharmaceutical Society of Nigeria, the Council and Association of Registered Nurses and Midwives, etc, set ethical standards and regulate patient care, health personnel behaviour and minimum standard of

equipment as well as drugs and administration. However, without a national legislative code on medical practice it is doubtful whether aggrieved patients or their relatives would be able to successfully proceed against erring health personnel that negligently infringe on patients' rights or those that do not exercise due diligence in caring for patients. The rate of hidden doctor error is high and this represents substantial unexplored dimension of denial of patient rights in the country.

5.4 Physical and Human Resources

Physical resources in health care comprises hospital buildings, beds, theatre equipment, ambulance services, technical support facilities and consumables, etc. The health care system generally shares the culture of low mechanization of production systems in the Nigerian economy. Budget constraints militate against procurement of adequate and up- to-date equipment in hospitals most of which are imported from overseas. The sample index of physical inadequacy in this sector is the population- hospital bed ratio in the country. It is less than 2 beds per 1000 people (UN,2011).

Human resources comprise health personnel of varied specializations, functions and expertise. They include doctors, nurses, pharmacists, radiographers, physiotherapists, technologists, and public health inspectors, etc. There is gross inadequacy of health care personnel in the country going by their number or quality.

Doctors lead the medical team and their situation constitutes a very vital index of health personnel resources in the country. There are, by NMA estimate in 2013, about 27,000 doctors in the country catering to the 160million people or a doctor-population ratio of nearly 1:6,000. This is ten times higher / worse than the WHO standard of 1:600. Close to 2,300 doctors are produced yearly in the country's 28 medical schools – 23 public and 5 private. To attain the WHO standard, 256,303 more doctors will need to be produced. At the current production rate, it will take 123years to produce enough doctors to attain the WHO benchmark or an additional 2,429 medical schools to bridge the gap instantly. The above statistics assume that all doctors produced in domestic medical schools will be retained within and not be attracted offshore by greener pasture. This is highly improbable. The personnel situations in the other health specializations are not far from the doctors' experience.

5.5 Provision of Services

A wide variety of public health services are provided by the system. There is primary, secondary and tertiary care. There is short-term out-patient care, long-term care for malignant and long lasting illnesses. There are pharmaceutical services, physiotherapy, mental health care, maternal and child health services and dental care. There are also optical, ambulance and preventive services. The quality of care obtained depends largely though on the financial capacity of the patient and the status of facility patronized. Poor people generally access lower quality health care.

However, the outbreak of the Ebola Virus disease in 2014 and the decisive way that the hierarchy of health agencies in the three tiers rose to contain it indicates that the potential to deliver quality health care inheres in the system. This brings to the table the question of system reform; reform that might unleash the hidden abilities trapped by poor motivation, inadequate remuneration, disabling structures, organization and management styles.

5.6 Health System Reform

Nwabueze (2014) detailed the urgency of the need, the direction as well as the challenges to health system reform in Nigeria. Total and comprehensive transformation of the sector is inevitable. Based on the observed system ineffectiveness and inefficiency, suggestion is made for a shift in public health philosophy and official policy from State charity characterized by state dominance and monopoly of service to enterprise health service framework involving public, private partnership. To change the method of financing patient bill the NHIS needs to be reinvigorated, its universalisation policy pursued decisively while discontinuing elitism and exclusivity in its coverage. Owing to the total rot in the system the reform should be introduced in all the tiers of health service facilities in the country. The need to integrate traditional and

alternative health care into the national policy is advocated. The policy should aim to attract doctors into the rural and semi-urban areas of the country in order to stop the disproportional concentration of skilled health personnel in the cities and urban centre

6. APPROACH TO THE STUDY

This is a national survey of Federal and state government-employed medical doctors in the country. NMA (2006) estimated the registered doctors in the country by 2005 to be about 25,000. About 11,292 of these were professional fee-paying practitioners. It was estimated that about 7,000 of that number was state-employed. The rest were in private practice. On the proportion employed at Federal or State level, the President of NMA (2004-2006) Prof. WoleAtoyebi estimated it thus: 'may be 50-50 or slightly different, close like a ratio of 52-48'. A total of 303 doctors were sampled in two categories for this study. Doctors were classified into those employed by the Federal or state government. The country was stratified into four health zones and a total of 187 of them were sampled from four Federal tertiary health facilities located in Lagos, Jos, Uyo and Kano representing the South West, North Central, East and North respectively. The number sampled from each institution was weighted to be proportional to the number of doctors employed in each of those facilities. Similarly, the country was stratified into North and South zones and one well-established state government-owned health facility was randomly selected from each zone. Accordingly, 116 doctors were sampled from Lagos (Lagos State University Teaching Hospital, LASUTH) and Makurdi (Benue State University Teaching Hospital, BENSUTH) representing South and North respectively. A pre-tested and pre-validated instrument, Doctors' Alienation and Strike Response Survey Questionnaire (DASRSQ) was administered to elicit responses from doctors on a wide range of questions including the correlates of willingness to strike and related matters. Fieldwork was carried out using multi-stage sampling technique to draw individual respondents from respective institutions. The data collected was processed using the SPSS package to facilitate correlation analysis.

7. WHY STRIKES PERSIST – RESEARCH FINDINGS

The survey of the opinion of state sector doctors reveals that the feeling of alienation from their employer, that is, the state among the two categories of employees is a key composite explicator of this behaviour. The analysis was carried out at two levels – all doctors and a comparative analysis of employees of the Federal government and employees of States (or region) governments.

i) Perception of public health sector working conditions and effect on the behavior of doctors

Up to 70.6% of doctors in state employment view the physical conditions in public hospitals as neither adequate nor satisfactory. This assessment pertains to dilapidated hospital buildings, poor sanitary conditions, unkempt office environment, ill-equipped laboratories, theatres, diagnostic aids, toilets, wheel chairs, etc. About half of all sampled (54%) value autonomy of self control at work. Close to 56% regard their job as secure while 64% complain that their work scheduled gives no allowance for leisure. While 87% rate inter-collegial relationship as 'very cordial', 74% describe their remuneration as 'unsatisfactory'. When all these are summed together 73% of doctors are 'not satisfied' with their work. Other reasons for non-satisfaction relate to their poor quality of life which their income and conditions is able to support. Only 28% of doctors live in 'own houses' while 67% are in rented or official quarters. Although over 80% live in fairly comfortable apartments (flats, bungalows, duplexes, etc.), the fact that they are not owner-occupier diminishes the appeal of the apartments. Close to 60% rate health as a priority sector to government but 90% rate funding of the sector as 'inadequate'. Close to 60% view the funding of the sector as government responsibility and as such over half of the sample thinks that government through subsidized National Health Insurance Scheme (NHIS) should pay the health cost of poorer citizen. Less than 5% are of the view that patients should bear full responsibility for their Medicare bill. Generally, doctors in state employment are less positive about enterprise health care option than private practitioners who live off enterprise health arrangement than social welfare health care. Over 90% rate equipments in public hospitals as 'inadequate' given advances in technology and the level in other countries while 82% disagree that public sector doctors 'are well taken care of'.

Against this unsavoury working environment, doctors understand that they need to support their union for it to be able to advance their cause. Over 80% voluntarily contribute check-off dues and 61% put up regular attendance at the Association's meetings. The NMA doubles as a trade union and as a professional association, sometimes engaging in conflicting functions that get members disagreeing on which direction they should go. Close to 65% describe NMA administration as 'democratic', 66% are willing to occupy executive position while 76% are 'very interested' in the Association election results and who gets to run their affairs. About 72% are willing to support any strike call by the Association because strikes are justified (97%) as legitimate grievance processing mechanism Sixty-seven percent t of doctors disagree with the view that the Association strikes too frequently. Over 90% does not see strike as confrontational to the employer. However, 78% detest violent industrial action, which they describe as counterproductive to the interest of members. In summary, there is tremendous collective consciousness and commitment to the union among doctors. They perceive unionism and strike actions as 'very effective' and 'dependable' means to improved working conditions.

ii) Dimensions of status inconsistency

The notion of status inconsistency or relative deprivation stems from the practice among doctors to compare their pay and other work conditions with other professions within and outside of their country of practice. Three dimensions of this phenomenon were identified as bearing significant relationship to the willingness of doctors to adopt strike as grievance processing mechanism. They are:

a) Decline of doctors' remuneration relative to other professions

A significant factor in state-sector doctors' high propensity to strike in Nigeria is a feeling that they are short-changed in the public services. In Annual Report 2004-2005, (NMA, 2006) doctors adduced statistical facts and figures to support the view that they have, since independence, suffered systematic decline in their salaries relative to other specified professionals in the service. They compared the position of the Medical Consultant/Specialist who was only .09 points of the CJN but higher than the rest in 1975 but which has become worse than all in the year 2003. The relative decline is illustrated in Tables 1 and 2 in Fig. 1

Table 1. *Comparison of the Basic Salary per annum of Top Grade officers in Nigeria between 1960 and January 1975*

s/n	Title	Salary	Ratio
1	Chief Justice of Nigeria	£3600	(1.0)
2	Medical Consultants (Specialists)	£3300	(0.91)
3	Justices of the Supreme Court	£3000	(0.83)
4	Head of Service (Federal)	£3000	(0.83)
5	Permanent secretary (Federal)	£2500	(0.69)

Source: NMA 2004/2005 Annual Report pp.80

Table 2. *Comparison of the Basic Salary per annum of Top cadre officers in Nigeria as at December 2003*

s/n	Title	Salary	Ratio
1	Chief Justice of Nigeria(CJN)	N1,346.589	(1.0)
2	Medical Consultants	N554,648	0.4(down from 0.91)
3	Justices of the Supreme Court	N1,104,200	0.81(down from 0,83)
4	Head of Service (Federal)	N1,150,000	0.85(up from 0.83)
5	Permanent Secretary (Federal)	N865,200	0.64(down from 0.69)
6	General or its equivalent in the Armed Forces	N1,194,600	(0.88)

Source: NMA, Annual Report 2004/2005 pp.80.

By 2003, the CJN earned close to 250% the annual basic salary of the Medical Consultant/Specialist. The NMA considered the length of time spent by doctors in training, the essential character of their functions and are unable to justify the decline which arose rather from political influence and not the contribution of the respective professions to national productivity. They argue that this trend does not end with the Specialist alone but permeates the entire salary structure to the lowest grade doctor. The discontentment is not just about how much they are paid but also its relativity. Thus in the 2007 and 2014 national strike and the 2012 Lagos Medical doctors' strike, wages and salaries remain the key bone of contention. The discrepancy is further illustrated graphically in Fig.1.

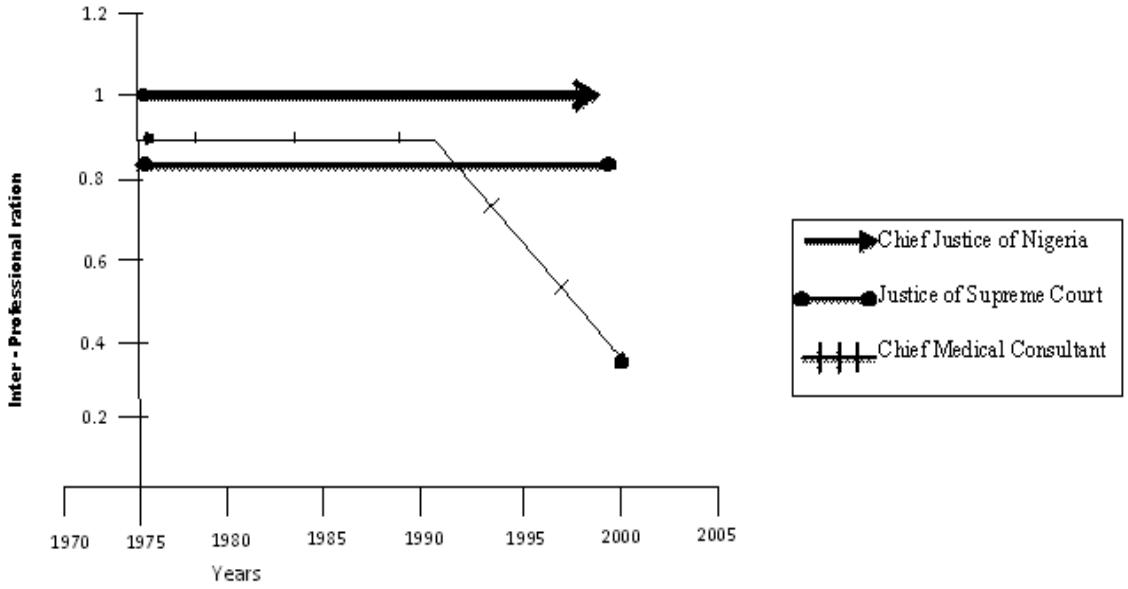

Fig 1. *Progression of Inter-Professional Wage Ratio of Doctors 1975 – 2003*

Source: NMA, Annual Report 2004/2005 pp.81

b) Discrepancy between educational qualification and remuneration

Among the factors explaining the discontentment among doctors with their salary is the length of time they spend in training, the rigor of medical training as well as the high and competitive admission criteria into the course. Most doctors (258 or 87.2%) consider their remuneration inadequate compensation for their intensive training, academic qualification and the professional content of their services. The result of the test of the association between these variables (X2=53.304, 4=6,c=0.60,p=0.983) indicates a strong disconnection between the doctors' assessment of their educational qualification and their remuneration which they see as unfair and inequitable. Correlation test result shows a positive association between status inconsistency and the readiness to support strike action.

c) Discrepancy between medical profession and being rich

The survey result shows that 264 (or 88.9%) of sampled doctors felt disappointed that their professional practice did not seem likely to lead to wealth or comfortable life. There is a general feeling among state-sector doctors that a doctor should be comfortable or at least be moderately wealthy out of the practice of the profession because of the important services they render to society. With an association test result of (X2=19.761.of =9,c=0.250,p=0.019), the frustration emanating there from and the idea of working in a 'wrong place' was a strong factor in supporting collective action for higher wages and conditions. Status inconsistency is a social psychological condition that connotes the existence of a gap between expectation and reality. It illuminates a yearning that employees, in this instance, hunger to fulfil. And as long as that desire is unsatisfied actions intended to redress the imbalance will continue. Doctors feel that they are well educated, that their services are essential and invaluable, that they deserve to be respected, to be

comfortable, well remunerated and perhaps stay ahead of the other professions. The deduction from the attitude of the state tends to be that while doctors are accepted as undeniably important, that other health professionals are equally indispensable in the health service chain. The truth though is that the terms and conditions of service of the non-doctor health professionals must also be factored into the process of meeting doctors' demand as they cannot be treated in isolation.

iii) Blocked Ascendancy

Most doctors in the study (286 or 97.0%) out of a sample of 295 perceive themselves as blocked ascendants, that is, as people denied of the right of being promoted when due and earned. The feeling is stronger though among lower grade doctors. The general notion is that bureaucratic bottlenecks have diluted and compromised the professional basis of determining promotability on the job making political and extraneous factors a priority. Looking at their career from historical perspective, most doctors opined that the criteria for promotion of doctors are more stringent today and upward mobility slower at present than it was in the 1960's and 1970s. The result shows a strong, positive association between feeling of blocked upward mobility and the willingness to support strike action. The association test result is X2=35.809, df=12, c=0.000, rs=0.248, p=0.329 and significant at p=0.01. This is a critical contributory element to the feeling by doctors that they are systematically being estranged from the State's scheme of important professions.

iv) Blockage of the technical interest of doctors

Association between availability of modern equipment and new technological diagnostic and prognostic aids and job satisfaction among doctors was shown to be an important factor in willingness to strike. Doctors define the lack of fundamental tools as a blockage of their professional and technical interest. Some described the mental torture of watching a patient die of an illness for which equipment to aid treatment exist but not locally available. Apart from that, the dearth of modern technology builds up skills obsolescence among doctors in such a situation relative to their counterparts in other parts of the world. Some doctors mentioned this as a strong consideration in the internal brain-drain from public to private practice and emigration to places with better equipment. About 289 (97%) out of 298 doctors associate the poor state of medical equipment in public hospital with the high propensity to strike. The association test result is given as X2=15.410,df=12, c=0.222,rs=0.094, p=0.105. The general feeling is that public hospitals in the country are ill-equipped, lacking new supplies and poor maintenance culture reducing the potent applicability of existing ones. Equipment update was identified as a direction that health sector transformation must address in order to sanitize the industry and institutionalize the standards of best global practice.

v) The Professional-Bureaucratic Dilemma

Generally, doctors complain about the frustrating bureaucracy in the health sector criticizing it for having little or, sometimes no respect for the peculiar pressures and demands imposed by the values of the medical profession. Though they generally express satisfaction with the level of freedom exercised in carrying out their official function in hospitals including responsibility for managing patients and all the members of the health team, they nonetheless are not happy with the slow process of procurement, of securing approvals during emergencies and the snail-speed processes of acceding to salary and wage demands.

The divergence results in strife, unrest and crisis because while bureaucracies emphasize hierarchy, strict compliance with existing rules and procedures or ritualism, centralized power, unified command, productivity and uniform pay structure etc, on one hand, the professions, on the other, emphasize autonomy, independence, expertise, collegiality, differentiated pay structure, creativity, etc (Elliot, 1972). By the operation of these divergent values there is fundamental normative conflict involving professionals employed in bureaucratic structures and organizations. Miller (1976) in a study of industrial scientists and engineers described its effect on professionals as 'work alienation' which results from strict control that discourages motivation of professionals. Hall (1968), Harris-Jenkins (1976) and McKelvey (1969) in separate studies corroborate the finding that professionals in bureaucracies tend to experience conflict of values and develop varieties of coping mechanisms.

8. DISCUSSION – SOCIAL THEORY AND ALIENATION STRIKE PERSISTENCE

A modified form of the classical Marxist theory of alienation was applied to explain the persistent restiveness among doctors in state employment and inefficiency in public health delivery system. A careful content analysis of literature discourses on alienation including Marx, 1848 (1976), Durkheim (1984), Weber (1958), Blauner (1964), Seeman(1972) and Gouldner (1979) identify conceptual synonyms of alienation to include separation from, estrangement from, indifference to, abandoned by not belonging to, withdrawal from, etc. In the study, Gouldner's dimensions of the concept were tested and it was found that a feeling of relative deprivation, institutionalized status inconsistency, blocked ascendancy, concern for the poor state of public health, bureaucratic-professional dilemma and a deep feeling of job non-satisfaction are correlates of the consistent indication to participate in collecting industrial action. As defined in this study, alienation connotes two related meanings. One is a feeling of (a) loss of belonging to the 'body' of the state, (b) loss of state protection by doctors. The same state is perceived to harbour discriminatory willingness to embrace and protect some selected professions in the service while relegating doctors. These feelings were nurtured by the factors cited above particularly, unsatisfactory terms and conditions of work and relative systematic status devaluation of the medical profession in the hierarchy of the service. The humiliation of mass sack and the suspension of Residency programmes during strike by government lend credence to this feeling. The rivalry between doctors and other health professionals and the ambivalence of government in the background matters contributes to felling of despondency, distrust and hopelessness.

As can be deduced from the attitude of doctors during strikes, they do not demand revolutionary seizure of state power but to remain leaders of the health team. Their limited aim is greater accommodation by state authorities, acceptance and admission back into the state mainstream with restored dignity, commensurate remuneration, due respect and professional recognition; nothing more. The operational dimensions of the traditional Marxist theory of alienation e.g. separation from product, from the labour process, estrangement from self and from others which feature prominently in the explanation of working class alienation and action do not seem to be significant explicators of alienation or its concomitants among members of the medical profession. Doctors are merely 'fighting' their way back to an erstwhile position of dominance, supremacy, and relevance in the 'body' of the state. It is a feeling among doctors collectively that their status is systematically being whittled down and the struggle to restore their supremacy in the sector that explains the persistence of strikes in public health facilities. They feel that they do not have what they are legitimately entitled to receive from the government and the 'subordinate' health professionals.

9. CONCLUSION

The preponderance of research evidence indicates that while no doctor likes to go on strike, they nonetheless do if only as a means of sorting out inherent contradiction existing between the ideals of the oath which they swear to during induction into the profession and the unsavoury conditions in which they work. Though strike contradicts primacy of patient care, unsatisfactory income, feeling of frustration, deprivation, lack of employer will to meet employee demands, doctors' rigidity and inflexibility over iron-cast patterns and established sector cultures and in-fighting among rival sector professionals contribute to persistence of conflict and system inefficiency. Some doctors sort out the dilemma by quitting public service and travelling abroad while some move to the private hospitals and yet a few leave the profession for politics, business or evangelisation.

Though strikes may result in meeting some demands, maximizing overall system efficiency will require more action than strikes can offer. Strikes will, at best, result in system reform but the rot in the sector is so deep and extensive that only a total transformation such as happened in China and partly in the USA are inevitable. Strikes will not heal the deep wounds in the sector neither can it sort out the inherent contradictions. Nwabueze (2014) criticized system reform while recommending a shift from doctor-centred State benevolent public health care to enterprise public health care. Like the telecommunication sub-sector, enterprise health care will open hospitals to public-private –partnership (PPP) with the private sector dominating through massive ingestion of domestic as well as foreign investment capital, boardroom management style, diverse managerial

expertise, system control by owners of enterprise rather than government, that is, a new philosophy of health care administration, management and service delivery.

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