



Beyond Covid-19:

The Plight

of Egyptian Doctors



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**This study was prepared by a group of researchers at the
Social and Economic Justice Unit in the Egyptian Initiative for
Personal Rights.**

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A. Introduction

On March 11th 2020, the World Health Organization (WHO) declared the coronavirus a global pandemic. Governments have since put in action a wide range of measures and policies with the aim of reducing morbidity and mortality of the virus. The aim was to protect citizens and to save the healthcare systems from being overloaded.

In Egypt, on March 16th 2020, the Cabinet announced its decision to reduce the number of employees in government offices, to suspend flights, suspend studies in schools and universities, in addition to more restrictive measures that included a partial curfew. However, in order for these efforts to have yielded the expected results, full cooperation of all stakeholders was essential. The core of these stakeholders is naturally our doctors and medical teams.

On March the 25th of 2020, the Egyptian Ministry of Health made a nation-wide call, “Be a Hero”¹, for volunteering medical staff to support in the management and containment of the COVID-19 outbreak.

One year later, Egypt is mourning its 500th documented death among its doctors. This is happening at a time where the pandemic is having its highest toll on mortalities and morbidities, where community spread has become nation-wide and where the failure of communication between the medical syndicate and the ministry of health has gone public.

Health workforce is one of the six core building blocks of a health system.² To improve health service coverage, quality and outcomes, a serious con-

1- “Urgent “Ministry of Health requests volunteers to confront the emerging corona virus: Be a hero”, Al Watan News, 25/3/2020, <https://www.elwatan-news.com/news/details/4666969?t=push>

2- “Monitoring the Building blocks of health systems”, WHO, 2010 https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf.

sideration needs to be taken regarding health workers and their systems of management. This is especially true in the COVID-19 context. The new pandemic has shed lights on defects of health systems worldwide. It has shown how important is the discussion of health systems and public health, putting them on top of national agendas. The need for radical interventions regarding Egyptian doctors has always been presented. The call for a systematic and participatory intervention has always been there. Today, we are suffering from delayed discussions and interventions that come at a time where Egypt is taking its first steps towards a comprehensive health insurance scheme and is critically hit by global pandemic.

The WHO identified various issues regarding the Health Workforce. These include difficulties in the education, employment, deployment, retention, and performance of the health workforce. While it is essential to take these factors into consideration, this paper tackles retention of health workers in Egypt, with a focus on doctors, given that data about them, though still limited, are relatively more available than other medical staff.

Lack of retention of Egyptian doctors is a crucial issue at stake. Investigating the roots of the problem necessitates an extensive situation analysis of doctors' working environment and conditions, which touches upon other Health System Building Blocks, like Health Financing, Governance and Leadership, Access to Medicines and Service Delivery. Defects in mentioned building blocks mean less incentives for doctors retention in the public sector and, arguably, the country. This is why a critical review of these different aspects, from the doctors' point of view, will shed light on existing work environments and will reveal needed policies to retain Egypt's "White Army".

Why was there a need for more doctors in Egypt? What does this tell about the environment in which doctors work? How can this improve? What does the new health insurance system have to offer? And what are

the roles of other stakeholders? The COVID19 Pandemic is an opportunity to rethink the Egyptian Health System. This is an attempt to give a clearer picture about doctors in Egypt.

The aim of this paper is to initiate a conversation between stakeholders in order to find different pathways to improve conditions for Egyptian doctors. It includes extensive desk review and focus interviews with key informants and doctors, who are the center of the paper, to deepen the analysis and verify findings.

B. Status of Egyptian Doctors

The call for action by the ministry of Health reveals a well established shortage of doctors in the public sector and Egypt generally. Thousands of medical students graduate every year, don't they get registered in the ministry?

The problem of shortage of doctors was acknowledged by the minister of health before the outbreak, in January 2019.³ A study conducted in early 2019, by the Ministry of Higher Education and Research and the Technical Team of the Ministry of Health, investigates conditions of the medical practice in Egypt and the demands of its market. It outlines a gap, though non-quantified, in the number of practicing physicians in Egypt. This is proposed to be solved by educating and licensing more doctors. This is contrasted by a contemporary statement by a leading figure in the Medical Syndicate, Dr. Ossama Abdelhay, who highlights that «migration of doctors

3- "Minister of Health: We have a shortage of doctors ... and Egyptians doctors are the most competitive abroad", 13/1/2019,https://www.youtube.com/watch?v=mgxaHgRf_6A&ab_channel=TeNTV

is the problem”⁴. This is confirmed by the above mentioned study as well, that the number of doctors in Egypt who work in governmental, university and private hospitals is 82,000 doctors of all specialties out of 213,000 registered doctors. Only 38% of this workforce is licensed for practice, and 62% of all doctors either work outside Egypt or have resigned from governmental work or are on leave.⁵ While it is hard to find the actual study, its findings are available in multiple news outlets.

With these striking figures announced by public entities, one should ask why are Egyptian doctors leaving work in the government and in Egypt? This problem can be understood in the push and pull framework⁶, where, in this case, the push factors are more (or stronger) than pull factors. What repels doctors is a system not designed to maintain young and hardworking doctors.

Let’s take a look at the most significant push factors. A study⁷ classified them as a) financial factors related to salary structure and healthcare facilities b) professional factors related to the quality of medical training and working conditions and c) general sociopolitical factors related to the political climate and general security. Its cohort of Egyptian doctors experienced more pushing factors than pull factors from abroad.

4-”Dr. Osama Abdel-Hay: Our crisis is not in the number of doctors ... the crisis in the emigration of doctors!”, 17/9/2019, https://www.youtube.com/watch?v=zHmbvwEdR54&ab_channel

5- Mostafa M., ”The government begins efforts to bring back 60,000 doctors to work in Egypt”, Alborsa News, 22/5/2019, <https://alborsaanews.com/2019/05/22/1206635>

6- Schumann, M., Maaz, A., & Peters, H. (2019). Doctors on the move: a qualitative study on the driving factors in a group of Egyptian physicians migrating to Germany. *Globalization and health*, 15(1), 2.

7- Ibid.

This paper will tackle the first 2 categories, that are umbrella themes to focus on pay, training, career growth, security, supplies, medications and other working environment components (like Human Resources, Infrastructure, Technology and Governance) for doctors. It will also attempt to show changes happening to doctors' working environments and experiences with the new health insurance system in Port Said that was adopted in July 2019, 15 months before the date of writing this paper. It will also show how crucial are these factors given that they are interrelated with other health system building blocks.

Analysis will be based on desk review and interviews with a health system expert, a leading figure in the Egyptian doctors' syndicate, and two doctors who previously worked in the old insurance system and currently working in the new system, to give insights and make informed comparisons. Without claiming generalized representativeness, especially regarding doctors' experiences, these interviews give valuable input that serves as a guide for future research that would validate or negate the findings.

C. Doctors' Pay

There have been many calls from different stakeholders (academics, civil society and doctors) for the government to increase health spending in its budget. Egypt's constitution mandates the government to spend at least 3% of the country's GDP. This figure was not achieved for a long time until the new fiscal year's budget (FY20/21)⁸, only as a result of changing the definition of health spending to encompass more existing budget items instead of increasing investments in underfunded items. Doctors pay is one of those underfunded items.

8- Kassab B., "Business as usual: Egypt continues to cut social spending in 1st corona budget", Mada Masr, 4/5/2020, <https://www.madamasr.com/en/2020/05/04/feature/economy/business-as-usual-egypt-continues-to-cut-social-spending-in-1st-corona-budget/>

A starting monthly salary of doctors in the public sector is around 2000 EGP (125 USD) and it can take them a lifetime to earn 20,000 EGP (1250 USD). This makes it extremely difficult for Egyptian doctors to make a living, which makes them resort to the private sector or work abroad. El Sawahly H. (2019) cites studies from 2004, highlighting that salary scales in the government drive the physicians to supplement their income through practice in the private sector, a phenomenon often referred to as dual practice, or “Public to private Brain Drain”.⁹ These salary figures provide a rationale for the considerable number of doctors working abroad according to the study by the Ministry of Higher Education and the Ministry of Health’s technical team. It is well established that doctors salaries in the government are low.

Doctors Syndicate has always demanded not only for more to be invested in salaries of doctors, but also in a proper monthly Infectious Disease Allowance, that is only now worth 19 to 30 EGP (1.2 - 1.9 USD) since 1995.¹⁰ The Head of the Doctors Syndicate, Dr Hussein Khairy, praised the President’s decision to raise Medical Professions Risk Allowance by 75% for each category, which will vary between 500-1200 EGP (31 - 75 USD), while emphasizing that there is still a need for raising Infectious Disease Allowance. This has been of special importance during the COVID-19 pandemic where the casualties in medical doctors have reached 500 by

9- ElSawahly H., “Physicians’ Motivation in the Ministry of Health and Population Egypt: Challenges and Opportunities”, Thesis, American University in Cairo, 2019 <http://dar.aucegypt.edu/bitstream/handle/10526/5657/Heba%20AlSawahli%20Thesis.pdf?sequence=2>

10- “Egypt’s doctors’ syndicate says new allowance rise is inadequate”, Ahram Online, 13/3/2020, <http://english.ahram.org.eg/NewsContent/1/64/366317/Egypt/Politics-/Egypts-doctors-syndicate-says-new-allowance-rise-i.aspx>

April 2021.¹¹

With the new health insurance law implemented in Port Said, doctors pay was announced to be multiplied via the insurance's incentive. With a new financing mechanism, that is based on multiple sources parallel to the health ministry's budget, physicians would earn at least 10,000 EGP (625 USD) as a starting salary (so multiplied by 5). This is done by adding an incentive for doctors who work in the new system to the actual salary of the ministry. This is great news for young doctors, especially women who might prefer to work with the public sector. Despite the jump in physicians' incomes in Port Said, it has been reported that it may not be as attractive for older doctors, or young male doctors invested in the private sector in some specialties. The new salary schemes made doctors less concerned about infectious disease allowance given that their incomes multiplied by 5.

Higher salaries, indicating better financing models, need to be accompanied with solid governance measures. Interviewed doctors working in the new health insurance scheme agreed that it has happened many times that the incentive of the insurance was delayed (for more than a month) and not transferred to doctors on time. They also agreed that at a moment in time, they were told by the administration that 20% of the incentive will only be given for "exceptional efforts", that are not clearly defined. This decision is regarded as an unfair and implicit measure that will reduce doctors salaries regardless of previous contracted agreement, with no clear criteria, and has caused outrage among doctors.

Another issue raised was whether or not doctors prefer to be rewarded based on their performance evaluation. In the actual new system, a part

11- "Every day - Head of the Doctors Syndicate, Hussein Khairy: What was done today was a great achievement, but doctors are looking to increase the infection allowance", 2/4/2020, https://www.youtube.com/watch?v=H9ACW1ePLYk&ab_channel=ON

of the incentive (40%) is subject to change based on physician evaluation score. Supporting views say it is not fair to equate high performing and low performing doctors. Disfavoring views complain of the instability of income, especially with multiple instances of unfair evaluations and poor assessment tools that only “care about formalities and don’t look into the quality of the work”.

More quantitative research is needed to evaluate if doctors prefer performance based financing or not, if they have been subject to what they perceive as ‘unfair evaluation’ and whether they trust in the existing quality evaluation tools and decision making. The new scheme’s salaries are a great start for doctors but incomparable with salaries abroad so when Egyptian doctors come from other countries, at least the system should be well accommodating to them. This will be discussed in more detail in this paper.

Moreover, the implementation of the new health insurance scheme is planned to be rolled out in the coming 10 years. If the government wants to retain doctors, efforts should not only be invested in the long term vision of Universal Health Insurance, but to invest in parallel in existing structures and salaries of doctors including the infectious diseases allowance. This will be especially useful for the Egyptian government in the case of pandemics.

When asked about the overtime, doctors had different views. Seniors said that it is already hard to keep up with the currently exhausting shifts. But they agreed that the principle of institutionalizing overtime might be an incentive for doctors to fill in the gaps (of understaffing) as means for improving their income. A standalone study can be done concerning the overtime as an incentive and solution for doctors and how to implement it in both the old and new systems.

D. Training & Career growth

The literature clearly indicates that training related to career advancement is positive and recommended to be integrated in the health system, as a non monetary incentive for physicians, while on the contrary, its lack is a reason for dissatisfaction and frustration among doctors.¹²

A 2015 study shows that there is a lack of management skills and that poor training in such skills constitute a great challenge for the Egyptian healthcare system. In its survey, more than half the physicians mentioned that there is no training on organizational management. More than 80% of 225 physicians mentioned the lack of continuous training opportunities.¹³ There are recent efforts by the Egyptian government to invest in training doctors. These include the new Commission System, and training of the new health insurance system's doctors.

1. The New Commission System / El Taklif

One of the government's efforts in training is the new 'Commission' / Assignment / Taklif system¹⁴, announced at the end of October 2019, which is expected to provide benefits for doctors. In the old commission system, doctors are assigned according to the assignment law No. 29 of 1974. Upon their graduation, doctors have a year of Internship / Emtiyaz, then

12- ElSawahly H., Op. cit.

13- Elden, N. M., Rizk, H. I., & Wahby, G. (2016). Improving health system in Egypt: Perspectives of physicians. *Egyptian Journal of Community Medicine*, 34(1). https://ejcm.journals.ekb.eg/article_646_2f00220c-734333c1f587644a7ba95525.pdf

14- "Responsible at the Ministry of Health for the new system for assigning doctors: it brings benefits for the doctor and the patient", Masrawy, 9/11/2019, <https://www.masrawy.com/news/news-videos/details/2019/11/9/1667832/>

they are assigned to work in primary healthcare units for a period of two years. Then they apply for a “specialization” / Niyaba in a third following year, meanwhile doctors register for postgraduate studies (master’s degree or a fellowship), during which they need to attend trainings and pass tests to become a “Specialist”.

The Minister of Health, Dr Hala Zayed, and the Director General of the General Administration for Commission to the Ministry of Health were featured on multiple occasions explaining the new system. Through the new assignment system, the doctor will work in his specialty from the first day of assignment, and he will directly join the Egyptian Fellowship Program to receive vocational training from the first working day at the Ministry of Health. “Doctors will not be left to work without training, and when they pass the term of the Egyptian fellowship program and exams, they are promoted to specialists.”

Officials mentioned that the new program shortens 3 years of the career path a doctor used to spend without training and education, and the patient will benefit from the quality of service provided by a trained and educated doctor.¹⁵

The aims of the new commission system are what was needed by doctors, especially that there are actual challenges of limited postgraduate studies opportunities. However, there have been multiple objections to the application of the new system presented by the medical syndicate.¹⁶

15- Ibid.,

16- “The Syndicate’s general secretary explains the objections of the Syndicate and the young doctors to the new assignment system”, Egyptian Medical Syndicate Channel on Youtube, 5/11/2020, https://www.youtube.com/watch?v=Ju6k5ZDwRVA&ab_channel=EMSchanel

These can be summarized as follows:

1. There were no discussions with stakeholders, namely doctors, before the adoption of the system. There was also no written draft document and all information disseminated was through media and facebook. The immediacy of implementing the system was criticized given the lack of information for doctors which might affect their careers. The logistics and details are not clear regarding for example ‘What if a doctor is not accepted in the specialization they want, will they have another chance to apply? what will they do until the new cycle?’ and what about the status of doctors in the army, or the training logistics of doctors in remote areas where there are no adequate training facilities.
2. The new system implies an improved readiness of the training system. There are around 2000 graduates of the fellowship and the training system is expected now to train ALL medical graduate students (at least 8000 doctors). The syndicate has called for years the gradual investment in training capacities (increasing numbers of hospitals ready to train, have more trainers). How will the previous training system accommodate the integration of all doctors, with such a leap, is an open question. This can only be verified by the number of hospitals considered ready to train doctors, and number of trainers, which is pending on more information and worth further investigation. A partial response to this concern is a partnership announced in December 2019 between the Ministry of Health and Harvard Medical School¹⁷ for a Training of Trainers that aims to equip staff for medical training and clinical research. The protocol’s duration is 3 years, to be renewed, and the training lasts 9 months. The government will send 2-4 groups year-

17- "The Ministry of Health signs a memorandum of understanding with Harvard University to train the trainers for fellowship", Masrawy, 6/9/2019, https://www.masrawy.com/news/news_egypt/details/2019/11/6/1666099/

ly. Each group will comprise 200 PhD holders and potential trainers¹⁸. If applied, this will mean 400-800 trainers for 8000 graduates, which can be considered reasonable. Further research is needed to be done in this area with doctors who have travelled and trainees to give feedback on updates about this matter.

3. These changes will have implications on the existing healthcare system. In the old system a doctor stays for one year in the primary healthcare units, but there are many closed and underused units because of general shortage of doctors and the lack of their retention. In the new system: a doctor will go for only 3 months yearly (so not a full year), which means there will be a greater shortage of doctors in primary healthcare units, how will this gap be covered?

The ministry of Health responded to the Syndicate and conducted a meeting with unclear results¹⁹. But the issue was not solved even until June 2020 despite being addressed by the President Abdelfattah Al Sisi himself.²⁰ More research needs to be invested in updates regarding the new Commission system and how to ensure concerns raised by the Doctors' Syndicate are solved.

18- "Health Ministry: 3-year training period for doctors at Harvard", Al Watan News, 18/12/2019 <https://www.elwatannews.com/news/details/4489795>

19- "The Minister of Health invites Doctors Syndicate to an expanded meeting on the assignment", Masrawy, 23/11/2019, https://www.masrawy.com/news/news_egypt/details/2019/11/23/1675732/

20- "Doctors Syndicate in a letter to the government: "The assignment crisis has not been resolved"", Masrawy, 11/6/2020, https://www.masrawy.com/news/news_egypt/details/2020/6/11/1806990/

2. Training in the New Health Insurance System

The Ministry of Health has also partnered with the British government to train doctors for the new health insurance system. The first and second groups, of 35 physicians each, travelled to the UK for a week, to observe and learn about the functioning of the British National Health Service. Travels were done in the end of April 2019 and Mid July 2019.

One of the doctors working in Port Said and interviewed as part of this research was in the first group traveling to the UK. She enjoyed the learning experience per se, but gave insights on the lack of learning mechanisms to be integrated in the new system to benefit from the travels. She revealed her disappointment with the disinterest of authority to learn from what the trained doctors have to offer, especially that they travelled to observe working systems, digitalization, and referral system (she is a family doctor). She concluded that while the learning experience was enriching, it would be a waste of resources to send other groups, if the system they come back to does not listen or change for the better. This will be discussed in more detail in the following sections.

Continuous medical education and training within the health system is needed for doctors not only for medical but also managerial skills. While the need for infection control training was clear in the COVID19 context, management competencies need to be developed to manage facilities in cases of crises and in general. A main stakeholder in this equation is Princess Fatma's Academy for Medical Occupational Training, affiliated to the ministry of health, and previously known as the National Institute for Doctors' Training. This institution is especially relevant for international donors wanting to invest in improving the capability of the healthcare system to encounter new waves of COVID19, a need raised by Doctors Syndicate as well.

E. Security issues

The security of doctors in health facilities is at stake. It comprises two main points worth discussing: 1. Violence against doctors and 2. Medical Accountability Law

1. Violence against doctors:

On Friday, 3rd of January 2014, a man injured in a traffic accident went to Imbaba Public Hospital. He died within a short time due to the severity of injury. With his death, the family of the deceased committed acts of violence against the hospital and assaulted the doctors, while the security forces could not contain the situation.²¹

This is not an exceptional instance. In fact, the Doctors Syndicate presented reports indicating that the number of cases of assault on hospitals reached 600 cases over a period of only two years, which is an indication of the seriousness of the situation in terms of securing medical facilities and the possibility of conditions turning from bad to worse.²² Actual footages were made available for the public via youtube including in 2020^{23,24}, with high-

21- "With pictures, people destroy Imbaba Hospital", Masrawy, 3/1/2014
https://www.masrawy.com/news/news_egypt/details/2014/1/3/154399/

22- "The Ministry of Interior and the presidency failed to suspend the strike of Egyptian doctors", BBC, 6/1/2014, https://www.bbc.com/arabic/middle-east/2014/01/140106_egypt_doctors_strike

23- "Al-Matariya Police Officer assaulted the Matariya Hospital Doctors", 4/2/2016, https://www.youtube.com/watch?v=iQU3oin_Thk&ab_channel=aliabdelsalam

24- "People attack the doctors of Damietta University Hospital, destroying the reception", 21/6/2020, https://www.youtube.com/watch?v=8X-qVBlTjTQ&ab_channel=Tabibcom-%D8%B7%D8%A8%D9%8A%D8%A8%D9%83%D9%85

lights from the media.²⁵

There have been multiple strategies of doctors to make their voice heard regarding this issue. General Assemblies were made in the syndicate, there were calls for protests and strikes, and meetings with political leaders up to Ibrahim Mahlab (Prime Minister at the time) were conducted.

There were governmental efforts to tackle the issue of violence against doctors and hospitals since 2013. This can be seen by the inauguration of a new Department for Hospitals Security by the Minister of Interior, Mohamed Ibrahim and the Minister of Health, Mohamed Hamed. The policy was in response to a proposal by the Doctors Syndicate and was planned to start in Cairo and to be extended in 5 governorates as a first phase (Cairo, Giza, Qalyoubiya, Dakahlia and Alexandria).²⁶ In an interview with a representative of Doctors Syndicate, he said that the department has no impact and more can be done to protect Egyptian doctors and healthcare facilities.

It is worth mentioning that the Minister of Health, Dr Hala Zayed, released directives to hospital departments to publish posters in visible places containing the text “Dear Citizen, assaulting a health service provider is a crime punishable by law with imprisonment for a period of up to five years and a fine. You can file a complaint and obtain your right through a citizen service official or Director of the health institution.”²⁷ A functioning

25- “Dmc evening - | The attack on doctors is an ongoing series ... How do we face it? |”, DMC, 7/4/2020, https://www.youtube.com/watch?v=x1WgJP-KuYV8&ab_channel=dmc

26- “The Ministry of Interior officially opens the Hospital Insurance Department in Cairo”, Egyptian Medical Syndicate, 1/3/2013, http://www.ems.org.eg/our_news/details/393

27 “Means of hospital insurance”, Shorouk News, 22/8/2019, <https://www.shorouknews.com/columns/view.aspx?cdate=22082019&id=7a472325-b689-48e4-8c70-f3534368d163>

hotline for complaints was also created by the Ministry of Health, 16474, more research needs to be done on how cases of violence against doctors are handled by the team.

Understanding reasons behind acts of violence against doctors and facilities can help not only treat the problem but also prevent it. Tensions can start between patients and doctors because of lack of supplies, shortage in emergency doctors or beds, unrealistic expectations of patients, lack of institutionalized accountability mechanisms (or the lack of information and/or trust in them).

Major policy interventions for the issue of violence against doctors:

1. Public awareness campaign to change perceptions about doctors
2. Clear communication about patient rights and methods to hold doctors accountable
3. Identify gaps in existing complaint management systems and find solutions to improve them
4. Adopting harsher punishment for violence against doctor through legislation
5. Enactment of the law and creating supportive environments in facilities (and police stations) for doctors to claim their rights
6. Training of doctors and facility managers in handling cases
7. Improving security measures in health facilities
8. Ensuring there are enough supplies and doctors per facility

Not taking the issue of protecting doctors seriously not only humiliates doctors and makes them feel insecure, but also will give them a good reason to decide not to work in the public sector and in Egypt. Taking action, including with legislative reforms and intensifying security presence, will show doctors that the government is keen on keeping them as a valuable resource, as was done with public universities.

2. Medical Accountability Law

Many of the Syndicate's leadership were featured in the media calling for a law on Medical Accountability.²⁸ They denounce the issuance of deterrent penalties for the professional errors of doctors, and said that it was not acceptable to describe any medical error as a murder.

The Secretary General of the Medical Association, Dr Ihab Al Taher said in press statements that doctors should not be [legally] held accountable in cases of professional errors under the Penal Code, given that in the medical work there are many reasons why a patient might die, like for example: "Complications of the disease itself, complications of medical intervention, or professional error. In addition, most hospitals in Egypt suffer from the lack of treatment options." Al-Taher warned that continuing to characterize medical errors that lead to death as a murder «may lead doctors to stop treating complex cases." It happens that patients die in the largest medical centers in the world.²⁹

The implications of the existing system are the lack of protection of doctors, their imprisonment and undignified treatment. With the length of court proceedings, doctors' careers are frozen in the ministry. There is also lack of flexibility from the ministry to go and testify (unless counted as leave), and paying fines that can reach 50,000 EGP (3125 USD), which is worth 25 months of work in the public health sector. This is in contrast with an instance when suspects of killing a doctor were released on a 10,000 EGP (625 USD) bail, according to Dr Taher.

28- "Every day - Head of the Doctors Syndicate, Hussein Khairy: What was done today was a great achievement, but doctors are looking to increase the infection allowance", 2/4/2020, https://www.youtube.com/watch?v=H9ACW1ePLyk&ab_channel=ON

29- Egyptian Medical Syndicate: The characterization of any "mistake" as "murder" is unacceptable", Al Masry Alyoum, 26/11/2019, <https://www.almasry-alyoum.com/news/details/1047315>

A Medical Accountability Law would be a way to protect doctors and regulate the process of accountability regarding medical errors. It places the liability on the medical facility as a whole and not on the doctor personally. It has long been a call by doctors and can be a win for both Egyptian doctors and the health system as whole, since they will feel protected and will not leave for such a reason.

Mona Mina, a leader in the syndicate, admits there are errors committed by doctors, and that the proportion of errors might be more than international averages. She invites decision makers to invest in understanding why these errors happen, and provide improved working conditions for doctors that will reduce the margin of error. These include increased resources for infection control, development of clinical guidelines and continual learning and training opportunities for doctors, as will be mentioned later.³⁰

There are some cases of gross medical negligence that require deterrent penalties, but not every medical error is gross negligence. Such a law has been already drafted and discussed in a Parliament hearing, but was not adopted until now.

F. Supplies and Medications

Lack of supplies is not only a problem for patients but also for doctors, as it might be a source of tensions between the two parties that might have implications mentioned above compromising the security of doctors, facilities and other patients.

It is well known that there are cases in the old system where doctors tell

30- “Without restrictions, with Dr. Mona Mina, representative of the Egyptian Medical Syndicate”, BBC News, 28/2/2016, https://www.youtube.com/watch?v=DjgK7XNaIVQ&ab_channel=BBC-News%D8%B9%D8%B1%D8%A8%D9%8A

patients to buy cotton or syringes out of pockets from external pharmacies. Sometimes it has been the case with medications that needed to be prescribed to patients, but unavailable/not covered by the old insurance system. In the new system implemented in Port Said, there is a consensus that the supply chain management improved. With a few exceptions, medications are available all of the time and the new insurance system actually covers a lot more medications than the old system. This is given that the financing model of the new system is different and accredited hospitals have better financial resources, and expected to work with much higher quality standards, which is a great step forward for patients and doctors. This is especially the case with improved patient feedback systems in the new insurance facilities, which ensures accountability.

With the COVID19, there have been real and crucial shortages in Personal Protective Equipment (PPE) for doctors especially in the frontlines.³¹The government was criticized for sending medical assistance including PPE for countries like the US. Mona Mina, a syndical leader, once used the local proverb translated into: ‘What home needs cannot be given to the mosque’. While doctors in the new insurance system could afford to get them privately (in case they found), most of the doctors in the old system were left with very limited options.

PPE will be needed in the upcoming waves of COVID19 and the Doctors Syndicate has on its agenda an initiative to mobilize resources to provide what is needed for doctors on time. Doctors better prepared in a pandemic will do their job in mitigating the spread of the virus and will feel appreciated and protected. Tackling such an issue is important not only for the

31- “The Egyptian Medical Syndicate warns of a “complete collapse of the healthcare system in the country.”, Euronews, 25/5/2020, <https://arabic.euronews.com/2020/05/25/egyptian-doctor-s-syndicate-warns-complete-collapse-egyptian-health-system-due-coronavirus>

COVID19 upcoming waves but as a move from governmental authorities showing an interest and a prioritization of the rights of its most valuable resources.

G. Work environment

There are multiple factors in the work environment of doctors that affect their retention. These include: Human Resources, Booking, Infrastructure, Technology and Governance in Decision Making and Evaluation.

1. Human Resources

The 2016 study mentioned above³² documents that conditions for employment offered by the MOHP are determined by the Ministry of Finance in negotiation with the Central Agency for Organization and Administration. It shows that the human resource management function in the public sector is limited by a number of constraints. The MOHP lacks a national human resource plan. Although the MOHP has a computerized personnel database, it is not used for planning or for projecting future needs. It is said that The MOHP does not refer to job descriptions in recruitment. For that, (71.2%) of all surveyed physicians believe that there is bias in human resources recruitment and about half of them agree that there is no job description, with no significant difference by place of work.³³ This has improved with the new health insurance system, where there are dedicated HR departments needing to work efficiently in accredited health facilities.

32- Elden, N. M., Rizk, H. I., & Wahby, G. (2016). Improving health system in Egypt: Perspectives of physicians. *Egyptian Journal of Community Medicine*, 34(1). https://ejcm.journals.ekb.eg/article_646_2f00220c-734333c1f587644a7ba95525.pdf

33- Elden, N. M., Rizk, H. I., & Wahby, G., Op. cit.

In Heba ElSawahli's work, on the other hand, Abdel-Salam et.al (2015) confirmed that physicians who were satisfied with the job owed that to autonomy, clear job description, less paperwork, in spite of the long hours of work, inadequate security and poor career advancement.

ElSawahly also identified a general consensus among the participants to the following problems regarding human resource for health in Egypt, like improper composition of the workforce required for health service delivery. There is a lack of efficient or effective Human Resources for Health policy regarding recruitment, remuneration, career development, retention, job promotion or sanctions. While physician density used to be more than nurses, midwives, qualified paramedical staff, currently physician shortage in critical specialties is striking. The geographic imbalance in distribution of human resources reduces coverage in frontier and rural areas despite the relatively higher pay that is used to motivate physicians to serve there.

2. Understaffing and Booking

This under -coverage/ understaffing also has implications. The study by Abdo et al. (2015) showed that about two-thirds of physicians in their research had a moderate level of burnout and about one-quarter had a high level of burnout. Reasons entailed the overburdened health-care system in Egypt, especially the emergency sector, understaffing, especially among nursing staff, lack of resources, inadequate salaries, lack of control, and difficult work schedules.³⁴

This was confirmed in interviews with doctors in the new system imple-

34- Abdo, S. A., El-Sallamy, R. M., El-Sherbiny, A. A., & Kabbash, I. A. (2016). Burnout among physicians and nursing staff working in the emergency hospital of Tanta University, Egypt. *East Mediterr Health J*, 21(12), 906-915. <https://pubmed.ncbi.nlm.nih.gov/26996364/>

mented in Port Said. They agreed there is a shortage in doctors, even in Port Said, which puts a lot of pressure on doctors to finish their work. This is accompanied by booking mechanisms that can fill all doctors' time slots, which gives them no room for decent rest in the working day. An intervention can be made to better understand this phenomenon and to improve coordination between call center booking and physicians. Exhaustion of physicians is not only due to problems in booking and understaffing, but also because of the very limited timespan in which a doctor can spend with a patient (15 minutes), requiring both medical examination and extensive documentation and paperwork, which are useful per se (sometimes perceived as too much), but require more time with the patient (20-25 minutes). Meaningful breaks will also be helpful. Another booking insight is the feedback decision made by higher authorities that the elderly will be exempt from needing to book from the call center, "once they come, they are served". How can doctors serve the elderly coming ad hoc with their schedules being already full, which results in overbooking and may cause conflict. While the policy of easing procedures for the elderly is inclusive, it needs revision to ensure doctors can practically apply it without overlapping with other patients' scheduled times.

Engaging more doctors also requires more nursing staff, which is deemed already insufficient in talking with interviewed doctors. It should be mentioned that if patient time increases for doctors to better manage a case, doctors announced targets (in the new system) will need modifications since they will serve less people per shift, hence needing more doctors too.

3. Infrastructure:

i. Clinics Design

Another reason for the shortage of doctors is the simple incapacity of facil-

ities' design to accommodate more doctors. For example, there are Family Medicine Centers with only 2 clinics, which means there are only 2 doctors per shift, which can be greatly expanded with design interventions to accommodate more clinics and needed HR as mentioned.

ii. Doctors Housing

Part of what is needed in infrastructure work to improve retention of doctors, and to incentivize them to go to remote areas for service, is doctors housing. The Syndicate has many times talked about this in the media. While this area is only identified in this research, it requires more extensive research capacities that are beyond the timeframe of this study.

4. Technology

One of the encountered doctors appraised the real efforts of the General Authority for Healthcare to digitalize the health system. She calls for even less reliance on paperwork in relation to the use of technology, as she sees great potential in technological tools in easing doctors' work and retention of data generally.

There have been comments about technological tools made available for doctors. First, participants agreed that devices are really slow, hindering the workflow of doctors, especially with the mentioned short time period with the patient. Second, it is preferred to use PCs instead of tablets; with the daylong usage, batteries are drained and devices need to be charged all the time which shortens their lifespan, a PC can be a more efficient way for technology use in healthcare facilities, which is done in others countries too like the UK. Third, it is better to buy full versions of used software used for the International Code for Disease ICD10, where all disease codes

are prescribed from. Incomplete software versions mean incomplete lists of diseases to be prescribed, so doctors try to prescribe the nearest condition available on the software, which makes data not usable for research and health analytics. Fourth, the user interface can be more doctor friendly. It should also give a space for doctors to add their own observations to the patient, which is important for medico-legal purposes. It should also allow them to see summaries of patient data in the record. Fifth, it will be helpful to ensure that prescription tools are in sync with the pharmacy's database, to ensure all prescribed medications are available periodically.

With this feedback said, digitalization is crucial for health system reform, and the positive steps of the government to upgrade working systems of doctors are immensely appreciated and promising. These insights were collected to collectively take steps in this direction.

5. Governance:

i. Decision Making

In a survey, less than 40% of physicians think that the decision making process in the healthcare sector is done on scientific basis.³⁵ There are no reliable figures on the actual number of doctors in the new health insurance system which might merit extra research, but the encountered doctors agreed there are issues regarding decision making in the new system too. Trust in this process needs to be regained. How?

1. By showing doctors that the administration is seeking their benefit which will be reflected on the patient, instead of putting them in adversity.
2. By demonstrating that the administration is keen on financially remunerating without attempts to reduce doctors salaries

35- Elden, N. M., Rizk, H. I., & Wahby, G., Op. cit.

3. Gaining support for decisions is guaranteed when doctors are systematically consulted on matters relating to their work (all doctors met favored a participatory approach to decision making where medical managers do regular meetings with doctors to communicate a willingness of the General Authority for Healthcare to take a decision, get their feedback and communicate it back to the GAH, while actually listening to what doctors have to say (given they are the front-liners and they pay the price of volatile working systems)).
4. Doctors need to be informed early enough about decisions and implementation should be preceded by a transitory period. There are numerous instances where doctors are faced with a decision that is to be implemented immediately. This includes rescheduling shifts (which has implications on doctors travels for example), or removal of booking requirement for the elderly, or the short notice and obligation for doctors to travel and attend a training in Cairo, with no flexibility, an incident famed as the Minya Incident, where a road crash happened to 15 female doctors, and resulted in the death of three female doctors and the injury of 12 with various injuries.³⁶ More time for doctors to adapt can ensure decisions are applied as needed while giving them the space to adapt, and it will reinforce their trust in the decision-taker.

Furthermore, even before the pandemic, the Doctors Syndicate, which is the official body representing medical doctors in Egypt, has had its historical disagreements with the Ministry of Health. The Doctors Syndicate always complained about its exclusion from participating in health decision-making, but matters took a sharper turn with the pandemic. From the first months of the pandemic, the Doctors Syndicate was critical of the

36- "Today ... an emergency general assembly of the Doctors Syndicate to discuss the implications of the Minya accident", Youm7, 2/2/2020 <https://www.youm7.com/story/2020/2/7/4620572>

Ministry of Health on several levels. From the poor provision of training for doctors to deal with COVID-19, the lack of personal protective equipment and supplies, and from the deficiencies in places designated for isolating and treating doctors. This dispute has epitomized when the Ministry of Health and Population announced its policies regarding testing of medical personal in contact with COVID-19 positive patients³⁷. This protocol instructed hospitals not to test these contacts or isolate them; instead, the ministry saw it sufficient to disinfect the places in which the discovered positive case were found. No need to close the facility or sections in which the positive case among the medical team was discovered. The ministry of health organized a meeting with the President of the Doctors' Syndicate,³⁸ after which the differences subsided relatively. However, one year later, the disputes have escalated again with the slow pace of vaccination of medical staff, the attempt of the Ministry of Health to reduce the number of documented victims,³⁹ and with the failure to provide material compensation to the families of the victims of the medical staff. This is of course in addition to the continuous lack of inclusion in the decision making process.

ii. Doctors' Evaluation

In the old system, a standard evaluation sheet is used for reviewing performance of all employees. The performance review in the public sector does not necessarily relate to promotion, which renders its usage rather limited. For that, more than 57% of surveyed physicians in a study mentioned that

37 The medical syndicate objects on the ministry's protocol for testing medical teams, May 2020, <https://www.elwatannews.com/news/details/4770317>

38 Meeting of the head of Medical Syndicate with the government, May 2020, <https://gate.ahram.org.eg/News/2411562.aspx>

39 Statement by the medical syndicate, April 25th 2021 <https://www.facebook.com/Egyptian.Medical.Syndicate/posts/4054424467912264>

there are no monthly records with performance indicators.⁴⁰

In the new system, there are improved evaluation tools that are done by multiple stakeholders (like the medical manager, HR, Information Technology). It was pointed out that these tools can be better designed to focus on doctors' quality of work more than formalities. There were complaints in some instances of perceived unjust evaluations, only done to give doctors less of their incentives and cut the costs. It will also be better to ensure that every evaluator is judging areas relating to their scope. When asked, doctors agreed on an anonymous 360 degrees feedback, that allows doctors to evaluate staff who are higher in the hierarchy. This allows for mutual evaluations, not only top down ones, and promotes a culture of good governance and trust.

H. Conclusion

To conclude, there is a crucial problem regarding doctors retention in Egypt, which was directly reflected in the management of COVID-19 pandemic. There are multiple factors that push doctors away, which include pay and working environment in its broad term, including issues like security, supplies, human resources, governance and training. Each of these was explained in this paper through desk review and focus interviews with relevant stakeholders (doctors and experts). In some areas there are clear policy interventions that need to be done, while others require further research to identify the possible solutions for reform in the current context.

40- Elden, N. M., Rizk, H. I., & Wahby, G., Op. cit.