AN EXPLORATION OF THE NATURE OF A PRIVATE GENERAL MEDICAL PRACTICE AS A SOCIAL SYSTEM: A CASE STUDY

By

Henriette Visser

Submitted in fulfilment of the requirements for the degree of Masters in Sociology in the Faculty of Arts at the Nelson Mandela Metropolitan University

January 2009

Supervisor: Professor F J Bezuidenhout
AN EXPLORATION OF THE NATURE OF A PRIVATE GENERAL MEDICAL PRACTICE AS A SOCIAL SYSTEM: A CASE STUDY

By

Henriette Visser

Submitted in fulfilment of the requirements for the degree of Masters in Sociology in the Faculty of Arts at the Nelson Mandela Metropolitan University

January 2009

Supervisor: Professor F J Bezuidenhout
DEDICATION

To André and Ilse-Mari who have taught (and are continuing to teach) me more than you will find in any textbook.
# LIST OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF CONTENTS</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>xi</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>xii</td>
</tr>
<tr>
<td>KEYWORDS</td>
<td>xiii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xiii</td>
</tr>
<tr>
<td>LIST OF DIAGRAMS</td>
<td>xiii</td>
</tr>
</tbody>
</table>

## CHAPTER ONE
THE PRIVATE GENERAL MEDICAL PRACTICE IN SOUTH AFRICA: AN OVERVIEW

1.1 Introduction 1
1.2 Defining a private general medical practice 2
1.3 External Challenges for the Private General Medical Practice 4
1.4 Internal Challenges for the Private General Medical Practice 5
1.5 Skills Development and Training 9
1.5.1 Skills Development 9
1.5.2 Need for further research 10
1.6 The Employer (Medical Practitioner) 12
1.7 Summary 13
References 14
## CHAPTER TWO
CHOICES PERTAINING TO VALIDITY AND RELIABILITY:
RESEARCH METHODOLOGY

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Introduction</td>
<td>16</td>
</tr>
<tr>
<td>2.2</td>
<td>Research Questions</td>
<td>17</td>
</tr>
<tr>
<td>2.3</td>
<td>Research Objectives</td>
<td>18</td>
</tr>
<tr>
<td>2.3.1</td>
<td>General Research Objective</td>
<td>18</td>
</tr>
<tr>
<td>2.3.2</td>
<td>Specific Research Objectives</td>
<td>18</td>
</tr>
<tr>
<td>2.4</td>
<td>Target Group</td>
<td>19</td>
</tr>
<tr>
<td>2.5</td>
<td>Research Methodology</td>
<td>21</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Research Methods</td>
<td>21</td>
</tr>
<tr>
<td>2.5.2</td>
<td>Research Procedures</td>
<td>22</td>
</tr>
<tr>
<td>2.5.2.1</td>
<td>Social Survey</td>
<td>22</td>
</tr>
<tr>
<td>2.5.2.2</td>
<td>Case Study</td>
<td>23</td>
</tr>
<tr>
<td>2.5.3</td>
<td>Research Techniques</td>
<td>24</td>
</tr>
<tr>
<td>2.5.3.1</td>
<td>Structured Questionnaires</td>
<td>24</td>
</tr>
<tr>
<td>2.5.3.2</td>
<td>Content Analysis Techniques</td>
<td>24</td>
</tr>
<tr>
<td>2.5.3.3</td>
<td>Sociometric Test</td>
<td>25</td>
</tr>
<tr>
<td>2.5.3.4</td>
<td>Overt Observation</td>
<td>26</td>
</tr>
<tr>
<td>2.5.3.5</td>
<td>Unstructured Interview</td>
<td>28</td>
</tr>
<tr>
<td>2.6</td>
<td>Research Process</td>
<td>28</td>
</tr>
<tr>
<td>2.6.1</td>
<td>Orientation Phase</td>
<td>28</td>
</tr>
<tr>
<td>2.6.1.1</td>
<td>Preliminary observations in a practice</td>
<td>28</td>
</tr>
<tr>
<td>2.6.1.2</td>
<td>Literature review</td>
<td>29</td>
</tr>
<tr>
<td>2.6.1.3</td>
<td>Presentation to PEGP members to introduce them to the research and obtain permission for initial surveys</td>
<td>29</td>
</tr>
<tr>
<td>2.6.1.4</td>
<td>Structured questionnaires to practices</td>
<td>29</td>
</tr>
<tr>
<td>2.6.1.4.1</td>
<td>Questionnaire 1: Practice Demographics</td>
<td>29</td>
</tr>
<tr>
<td>2.6.1.4.2</td>
<td>Questionnaire 2: Staff demographics and soft skills needs</td>
<td>30</td>
</tr>
</tbody>
</table>
CHAPTER THREE
THEORETICAL APPROACHES TO THE UNDERSTANDING
OF THE GROUP AS A SOCIAL SYSTEM

3.1 Introduction 36
3.2 Models and Theories 36
3.2.1 The Quasi-mechanical Model 37
3.2.2 The Organismic Model 37
3.2.3 The Conflict Model 38
3.2.4 The Equilibrium Model 39
3.2.5 Symbolic Interactionism 40
3.3 The nature and dynamics of a social system 41
3.3.1 Analytical Frameworks 41
CHAPTER FOUR
THE PRIVATE GENERAL MEDICAL PRACTICE AS A SOCIAL SYSTEM

4.1 Introduction
4.2 Structural elements in the private general medical practice
   4.2.1 Group goals
   4.2.2 Group composition
   4.2.3 Norms and values
   4.2.3.1 Procedural norms determined by laws
   4.2.3.2 Procedural norms decided by general practitioners / practice management / practice staff
   4.2.4 Sanctions
   4.2.5 Roles
   4.2.6 Status
   4.2.7 Leadership
   4.2.8 Communication networks
4.3 Group process in the private general medical practice
   4.3.1 Group development

References
5.3.1 The greater environment of the social system 107
5.3.1.1 Health care within the South African context 107
5.3.1.2 Influence of social institutions 108
5.3.1.2.1 Economic factors 108
5.3.1.2.2 Political factors 109

5.4 Data relating to the case study 109
5.4.1 General medical practitioners 110
5.4.2 Physical location and human resources 111
5.4.2.1 Geographical locations 111
5.4.2.2 Building 111
5.4.2.3 Technology 113
5.4.3 Employment and human resources-related information 113
5.4.4 Practice support staff locations and movements 116
5.4.4.1 Receptionists 116
5.4.4.2 Girl Friday 117
5.4.4.3 Nursing staff 117
5.4.4.4 Debtors’ clerk 117
5.4.4.5 Cashier 118
5.4.4.6 Practice manager 118
5.4.4.7 Patients 118
5.4.4.8 Location of GPs and movements 119
5.4.5 Intra-personal communication [between practice support 119
staff members]
5.4.5.1 Day-to-day interactions 119
5.4.5.2 Formal communication 122
5.4.6 Sociometric analysis 123
5.4.6.1 Results relating to attraction based on the 1\textsuperscript{st} and 2\textsuperscript{nd} task 124
attraction choices
5.4.6.2 Results relating to attraction based on 1\textsuperscript{st} and 2\textsuperscript{nd} task 126
CHAPTER SIX
CONCLUDING DISCUSSION AND RECOMMENDATIONS

6.1 Introduction 139
6.2 Competencies and soft skills development 139
6.3 Socio-political, legal and socio-emotional external environment 143
6.4 Internal environment of the PGMP as a social system 145
6.4.1 Practice support staff sub-system 145
6.4.2 General medical practitioner sub-system 147
6.5 Practice location, physical practice layout, staff placement and movements, and technology 148
6.6 Human capital and resources management 150
6.7 Communication and interactions [between practice support staff members] 152
6.8 Sociometric relations 154
6.9 Concluding remarks 158
6.10 Assessment of research objectives 161
6.11 Summary 163
References 164
<table>
<thead>
<tr>
<th>ADDENDUM ONE</th>
<th>Demographic questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDENDUM TWO</td>
<td>Support staff questionnaire</td>
</tr>
<tr>
<td>ADDENDUM THREE</td>
<td>Sociometric questionnaire</td>
</tr>
<tr>
<td>ADDENDUM FOUR</td>
<td>Letter of approval from NMMU Ethics Committee</td>
</tr>
<tr>
<td>ADDENDUM FIVE</td>
<td>Letter of approval from Private General Medical</td>
</tr>
<tr>
<td></td>
<td>Practice used for case study</td>
</tr>
<tr>
<td>ADDENDUM SIX</td>
<td>Matrix for direct observation of instances of</td>
</tr>
<tr>
<td></td>
<td>interpersonal interaction</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

With the deepest gratitude to:

My supervisor, Prof. Frans J. Bezuidenhout - thank you for your patience, support and the many late nights. You are a slave-driver extraordinaire!

The participating practices of the PEGP. Without you the research could not have happened.

My parents, Pieter and Ilse. Your never-ending encouragement and belief in me helped me through many a difficult moment. Thanks Mom, for availing me of your analytical skills and to Dad for surviving the onslaught of technology!

All the friends who put up with my antisocial behaviour and took up the position of surrogate parents. Your support meant everything.

My family, for loving me despite this thing!
ABSTRACT

This research study explores in general the nature of a private general medical practice [PGMP] and whether analysis of the PGMP as a social system can lead the Group Dynamics Practitioner towards developing interventions that will enhance group effectiveness in the PGMP support staff group. The main assumption is that, through the application of a framework of analysis based on that of G. C. Homans and the AGIL functional prerequisites developed by T. Parsons, a structured analysis of the external and internal variables that impact on the PGMP as a social system can be undertaken. The findings of the analysis would lead to the formulation of interventions that would improve the performance effectiveness of the PGMP as a social system.

Following a two-questionnaire survey of 17 practices that provided demographic information as well as soft skills training needs, a single PGMP was identified for the case study. Data pertaining to the group as a social system were collected, and by using direct observation, content analysis and a sociometric test, the practice support staff sub-system, being the main focus of this research, could be analysed. By linking the findings to the elements of the framework of analysis, areas of ineffective group functioning could be identified and interventions suggested.

This research indicates that the choice of soft skills is associated with the nature and size of the practice, as well as the dynamics of the sociometric patterns characteristic of the relations within the practice support staff subsystem; that while some practice support staff have preferences for sociometric task and socio-emotional relations outside their work clusters, these seem to serve as a buffer against clique forming, thus enhancing the function of integration within the social system as a whole; and that the
physical practice layout, and the interaction dynamics that it creates, tend to hinder integration between the members of the practice support staff group, as a social subsystem.

**KEYWORDS**
Framework of analysis; Group behaviour; Group effectiveness; Performance; Performance effectiveness; Private general medical practice; Qualitative methodology; Social system; Sociometric analysis; Soft skills training.

**LIST OF TABLES**
Table 1.1 Problems in the PGMP linked to group structure and process
Table 2.1 Staff particulars per private general medical practice
Table 4.1 Establishing Expectations
Table 5.1 Staff particulars per private general medical practice
Table 5.2 Competency type and rating of its importance for task performance
Table 5.3 Competencies in order of importance
Table 5.4 Competencies in order of importance relating to size of practice
Table 5.5 Frequency of cluster interaction per day
Table 6.1 Summary assessment of the outcomes of performance effectiveness of the PGMP case study and recommendations

**LIST OF DIAGRAMS**
Diagram 3.1 AGIL paradigm
Diagram 3.2 Combined construct of Parsons’ AGIL-PARADIGM and Homans’ framework of analysis
Diagram 4.1 Depiction of the PGMP as a social system
Diagram 5.1 Physical layout of practice
Diagram 5.2 Daily movements and interactions within the practice support staff group

Diagram 5.3 1st and 2nd task attraction choices

Diagram 5.4 1st and 2nd task rejection choices

Diagram 5.5 1st and 2nd socio-emotional attraction choices

Diagram 5.6 1st and 2nd socio-emotional rejection choices

Diagram 5.7 Practice layout and sociometric task and socio-emotional relations

Diagram 5.8 Daily interactions and sociometric patterns [1st choices only]

Diagram 5.9 Cluster formations within the practice support staff sub-system

Diagram 6.1 Proposed new surgery outlay
CHAPTER ONE

THE PRIVATE GENERAL MEDICAL PRACTICE IN SOUTH AFRICA: AN OVERVIEW

1.1 INTRODUCTION
South Africa’s health system consists of a large public sector [medical services provided by the State] and a smaller, but fast-growing private sector. This varies from the most basic primary healthcare services provided at state-run rural clinics, to highly specialised technologically advanced services in the private sector.

The public sector is under-resourced and over-utilised, while the private sector that is run mainly on commercial lines, caters for the middle- and high-income earners who are mostly members of medical aid schemes\(^1\). There are currently 124 medical schemes in South Africa with around 7.1 million beneficiaries\(^2\).

This chapter aims to provide an overview of the nature, problems and challenges within the context of private general medical practices [PGMPs], and is the foundation for the chapters that follow within this dissertation.\(^3\)

---

\(^1\) Medical Aid Scheme: A form of insurance whereby a member, for a set monthly fee, is guaranteed certain medical services. Medical schemes are subject to the Medical Schemes Act no. 131 of 1998 and are regulated by the Council of Medical Schemes, a statutory body (Council of Medical Schemes).


\(^3\) See p.17, paragraph 2.2 of this dissertation for Research Questions.
1.2 DEFINING A PRIVATE GENERAL MEDICAL PRACTICE

A general medical practitioner (GP), or family doctor, is a medical doctor whose practice is not orientated to a specific medical speciality, but instead, covers a variety of medical problems in patients of all ages\(^4\).

General medical practitioners in private practice choose to work in communities of their own choice and consult mostly on a fee-for-service basis\(^5\). As such, general practitioners [GPs] are generally the first port of call for the patient in search of health care, and they act as gatekeepers for appointments to specialists and hospitals.

Private General Medical Practices [PGMPs] vary greatly in their nature because of many different factors. This diversity is evident in the geographical location of the practice; the number and type of staff employed; the scale and type of premises used; the standards of furnishing and equipment; the way in which the practice is organised; and in availability and scope of supporting medical services (Jones et al., 1978: 25). While the PGMP is traditionally based on a fee-for-service model, the phenomenon of managed healthcare has been making steady inroads into PGMPs since the mid-1990s, especially in practices serving populations with lower end incomes\(^6\).

General Practitioners in private practice can be seen [contrary to doctors employed in the public sector] as independent contractors who are free to run


\(^5\) Fee-for-Service is a system whereby the service provider [general practitioner] receives a fee for every service, such as consultation, tests, and procedures, rendered.

\(^6\) Managed Care is a system whereby healthcare delivery is managed with the aim of controlling costs. Doctors [known as service providers in the industry] receive a monthly capitation fee for every managed care patient. This covers a series of predetermined consultations, services and medicines, irrespective of how many [or few] times the patient sees the doctor for consultations.
their business or arrange their professional practice as they wish. They may practice singly, in partnership, or in association\(^7\) with other GPs or in some cases, with professionals from other disciplines, such as dentists and physiotherapists.

While GPs in private practice experience freedom to organise their own business as they deem appropriate, resulting in variety and flexibility, they also have the responsibility to ensure that the patient receives an adequate and quality service. The patient chooses which GP to go to, and a personal [and usually continuing] relationship ensues. This places a responsibility on GPs to organise their practice in a manner that would ensure a continuing and trusting relationship.

In addition to their clinical responsibilities, GPs also have administrative and financial functions within their practice. The complexities of administration, finance and technology are continually increasing, and many practitioners find their formal medical training inadequate for dealing with the daily demands of managing a surgery (Evans, 2004).

To maintain the doctor-patient relationship, as well as manage the daily administration of the PGMP, the GP needs practice support personnel that are both qualified for and competent in their positions, as well as willing to assist in achieving the purpose and goals of the practice.

---

\(^7\) Doctors who practice in association with each other share premises, staff, administration and other overheads, but not income.
1.3 EXTERNAL CHALLENGES FOR THE PRIVATE GENERAL MEDICAL PRACTICE

For the PGMP to sustain itself, it needs to respond effectively to the impact that external environmental [e.g. economic, political and/or socio-economic] conditions may have on it.

Areas that were previously exclusively assigned to certain race groups have become culturally diverse since the democratic elections of 1994. This also reflects in the patient demographics of PGMPs in these areas. Furthermore, both the GPs and the practice support personnel are required to deal with cultural diversity on a daily basis, and often in a direct and personal manner.

Other challenges are: changes in applicable laws; the inability of the public healthcare system to provide adequate services; information and administration overload from institutions like medical aid administrators and the practice’s accompanying inability to adequately filter and process this information; the lack of relaying information relating to these conditions to the support personnel; no or poor training to enable understanding of new medical policies and procedures that will and do affect the livelihood of a medical practice; and, changes in patient and personnel demographics that require understanding and accommodation (Satinksy and Curnow, 2006: 24).

The impact of the external environment on PGMPs, demand that both the GPs and support staff members need to create an internal environment in which they can work interdependently towards the purpose and goals of the practice.

By creating a performance effective internal environment characterised by *structural components* [including group composition, goals, roles, norms and values, sanctions, status, leadership, and communication patterns] and *group*
processes [such as cohesion, social influence, power, performance, decision-making, conflict, and interaction] the PGMP is enabled to sustain itself.

Per definition, the social system consists of various components that are in an interdependent relationship with each other. From this point of view, a PGMP is viewed as a social system with interdependent sub-systems. In turn, the social system [e.g. PGMP] is in an interdependent relation with a larger social system, [i.e. the community or society in which it operates] and the PGMP needs to find constructive ways to deal with these challenges in order to sustain itself.

1.4 INTERNAL CHALLENGES FOR THE PRIVATE GENERAL MEDICAL PRACTICE

A review of literature points to a number of non-clinical related problems characteristicall found in medical practices. Broadly speaking these can be divided into two categories: those that relate to the practice as a social system [PGMP], and those that relate to sub-systems [e.g. practice support staff, medical doctors] within the social system. These problems can also be divided into those that relate to structure, and those that relate to process.

It is sometimes difficult to differentiate between problems that relate to either structure or process, as these are in an interdependent relationship, and therefore a problem caused in the one will also impact on the other.

While the sub-systems [i.e. the GP sub-system and the practice support staff sub-system] work together towards the purpose and goals of the practice [i.e. social system], each also has to deal with their own challenges, as a lack of dealing in, or an inappropriate dealing with these problems and challenges may result in the disorganisation of the practice as a social system.
It is not possible to list all non-clinical problems and challenges characteristic of a PGMP, but the following table [1.1] provides an indication of some of the important structural and processual problems that may threaten performance effectiveness within the practice.

Many of these problems that pose challenges can be linked to performance effectiveness, and require intervention at these levels. One such intervention is through research and another through skills training and development.

---

8 See Chapter Four for a discussion of group structure and process and the impact on the PGMP.
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SOCIAL SYSTEM</th>
<th>NATURE</th>
<th>ELEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADMINISTRATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inefficient supply purchasing</td>
<td>Support staff sub-system</td>
<td>Structure &amp; process</td>
<td>Communication, role performance</td>
</tr>
<tr>
<td>Inadequate and inaccurate coding of claims</td>
<td>Support staff sub-system</td>
<td>Process</td>
<td>Role performance, training</td>
</tr>
<tr>
<td>Infrequently and improperly updated fee schedules.</td>
<td>Support staff sub-system</td>
<td>Process</td>
<td>Role performance, communication</td>
</tr>
<tr>
<td>Resistance to change(^9)</td>
<td>Support staff sub-system</td>
<td>Structure &amp; process</td>
<td>Cohesion, integration, conflict, role performance, norms &amp; values</td>
</tr>
<tr>
<td><strong>PLANNING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive overtime and overstaffing</td>
<td>GP sub-system</td>
<td>Structure &amp; process</td>
<td>Group composition, cohesion, conflict</td>
</tr>
<tr>
<td>Lack of adequate performance evaluation systems</td>
<td>Support staff sub-system</td>
<td>Structure &amp; process</td>
<td>Role performance, norms &amp; values, goals, sanctions, training</td>
</tr>
<tr>
<td>Resistance to change(^11)</td>
<td>Support staff sub-system</td>
<td>Structure &amp; process</td>
<td>Cohesion, integration, conflict, role performance, norms &amp; values</td>
</tr>
<tr>
<td><strong>FINANCES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate and inaccurate coding claims</td>
<td>Support staff sub-system, GP sub-system</td>
<td>Process</td>
<td>Role performance, training</td>
</tr>
<tr>
<td>Poor billing practices</td>
<td>Support staff sub-system</td>
<td>Process</td>
<td>Role performance, training</td>
</tr>
<tr>
<td>Petty theft and embezzlement</td>
<td>Support staff sub-system</td>
<td>Structure</td>
<td>Norms and values</td>
</tr>
<tr>
<td>Excessive overtime and overstaffing</td>
<td>GP sub-system</td>
<td>Structure &amp; process</td>
<td>Group composition, cohesion, conflict</td>
</tr>
<tr>
<td><strong>STAFFING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High staff turnover(^12)</td>
<td>Support staff sub-system, GP sub-system</td>
<td>Structure &amp; process</td>
<td>Structural and processual elements</td>
</tr>
<tr>
<td>Unclear job expectations(^13)</td>
<td>Support staff sub-system</td>
<td>Structure &amp; process</td>
<td>Roles performance, cohesion, goals, integration, conflict, norms &amp; values</td>
</tr>
<tr>
<td>Lack of adequate performance evaluation systems</td>
<td>Support staff sub-system</td>
<td>Structure &amp; process</td>
<td>Role performance, norms &amp; values, goals, sanctions, training</td>
</tr>
<tr>
<td>Negative work relationships(^14)/(^15)</td>
<td>Support staff sub-system</td>
<td>Structure &amp; process</td>
<td>Conflict, cohesion, integration,</td>
</tr>
</tbody>
</table>

\(^9\) See Chapters 4, 5 and 6
\(^13\) Capko, J. 2005. *Get Better Results with Staff Performance Standards.* *Family Practice Management.* October, 12 (9): 40-4
<table>
<thead>
<tr>
<th>GP sub-system</th>
<th>communication, goals, norms &amp; values</th>
</tr>
</thead>
</table>

**TRAINING**

| Inappropriate telephone etiquette\(^{16/17}\) | Support staff sub-system | Structure & process | Norms and values, goals, role performance, training, interpersonal communication |
| Negative feedback\(^{16}\) | Support staff sub-system | Process & structure | Interpersonal communication, role performance, cohesion, integration |
| Lack of adequate performance evaluation systems | Support staff sub-system | Structure & process | Role performance, norms & values, goals, sanctions, training |

**PATIENT RELATIONS**

| Inadequate access by patients to doctors\(^{19}\) | Support staff sub-system | Structure | Norms & values, goals |
| Inappropriate telephone etiquette | Support staff sub-system | Structure & process | Norms and values, goals, role performance, training, interpersonal communication |
| Resistance to change | Support staff sub-system | Process & structure | Cohesion, integration, conflict, role performance, norms & values |

**MANAGEMENT**

| Lost productivity (seeing fewer patients in order to ensure no overtime) | GP sub-system | Process | Role performance, norms & values, power & authority |
| Lack of training in management | GP sub-system | Structure & process | Role performance |
| Negative work relationships | Support staff sub-system | Structure & process | Conflict, cohesion, integration, communication, goals, norms & values |
| Resistance to change | Support staff sub-system | Process & structure | Cohesion, integration, conflict, role performance, norms & values |

---


1.5 SKILLS DEVELOPMENT AND TRAINING

1.5.1 SKILLS DEVELOPMENT

With the promulgation of the Skills Development Act (no. 97 of 1998), and the subsequent establishment of the South African Qualifications Authority (SAQA), the door was opened to every employee in South Africa to improve his/her knowledge, competencies and skills in a structured and methodical manner.

Larger medical practices, i.e. with payrolls that exceed R500 000.00 per annum, contribute towards the Skills Development Fund by means of the monthly Skills Development Levy, a part of which is refundable upon submission of a Workplace Skills Plan [WSP]. However, preliminary enquiries by the researcher indicate that irrespective of the size of the medical practice, few understand the logistics behind the WSP, and/or how to develop and execute the WSP for skills development. Not doing this or not being able to develop and execute a WSP may directly relate to poor worker morale and other factors that impact negatively on the personal development of personnel and group performance effectiveness within a medical practice [see Tables 5.2, 5.3 and 5.4 in Chapter Five].

There is also a lack of suitable training options for practice support personnel, as existing training options usually consist of single sessions (morning, or full day), and more often than not, only address operational issues. During her preliminary research, the researcher could find no training options that were specifically geared towards personal empowerment and teamwork, or competence and skills training that relate to these aspects.
From evidence that was obtained through this research, there is a need for soft skills development. Related to this, the absence of a holistic approach\(^\text{20}\) to skills development in a medical practice that would enhance performance effectiveness of the practice as a social system is noticeable.

While skills training is important, identifying and relating the root of the problem to its impact on the practice as a social system, would require further research.

1.5.2 NEED FOR FURTHER RESEARCH

Due to the lack of formal holistic training opportunities, PGMP support staff members, excluding the professional nursing personnel and a few practice managers, are mostly trained in-house, either by a predecessor or through experiential learning, increasing the likelihood of “poor habit” formation or transference. A lack of training and skills development, together with ineffective team or group functioning, may continue to produce an undesirable effect on both personal growth and team functioning, with the end-result of performance ineffectiveness.

Where training courses are offered, these are often aimed at specific work-related competencies (e.g. bookkeeping), while practice management and reception courses (usually one day or less) are usually general in nature, and without adequate depth. The courses on offer are repetitive, with few or no follow-up courses that allow for further development of new skills or enhancement of existing skills.

\(^{20}\) Holistic approach: This implies that skills training and development should be developed from the outcome of a needs analysis, and should contain interventions at the cognitive, affective and behavioural levels, while enabling an understanding of their importance in terms of sustained performance of a social system – in this case, the PGMP.
Due to the nature of the business, there seems to be little interaction between personnel of different practices, and they seem to work in relative isolation, with little or no peer support. This is not the case with the medical practitioners who, due to the nature of the prescriptions of the Health Professions Council of South Africa, are required to attend training on a regular basis\textsuperscript{21}, and are therefore provided with opportunities to meet with peers. Furthermore, practice support staff often find themselves having to sail the ship alone, as their employers are, by the nature of their profession, behind closed doors or out on call, and generally inaccessible.

Many practice support staff have little or no formal training beyond matriculation, and therefore have little prospect of climbing the career ladder towards financial and personal fulfilment. They may feel disempowered by their situation, which may lead to a decrease in morale and motivational levels. This seriously affects group or team relations and performance effectiveness. Thus, while the situation on the surface may seem smooth, there is in fact instability. In turn, this has consequences for the effective functioning of the practice as a social system.

Further to this, practice support staff members are expected to deal with stressful situations. Some of these include: high workload; multitasking on a continuous basis; dealing with difficult and/or culturally diverse patient base; dealing with a seemingly impenetrable bureaucracy created by medical schemes and their administrators; witnessing and experiencing trauma, and even death; interpersonal difficulties between themselves and colleagues; and, in the case of group practices, associations and partnerships, having to fulfil the needs and expectations of more than one employer at the same time.

The researcher is of the opinion that ineffective or selective training and/or the absence of a holistic WSP, linked to the nature of the actual type of work and to the nature of the work environment, creates an environment that is not always conducive to personal development or group and/or team effectiveness. Research is therefore required to provide greater insight into how this and other factors that affect the PGMP as a social system can be managed towards performance effectiveness through appropriate recommendations.

1.6 THE EMPLOYER (MEDICAL PRACTITIONER)

As previously mentioned, the nature of the profession necessitates consulting behind closed doors. This, amongst other things, implies that these employers are generally inaccessible to their personnel. Many medical practitioners are by nature of their primary role, not interested in matters of an administrative nature, and also lack adequate training in practice management.

Employers are more interested and concerned with their personnel’s ability to manage their practices, and, to assure a smooth running or functioning practice. Not being extensively trained in the areas of management, administration and leadership, they often are unable to offer help when their support staff encounter problems, especially when the problems are intra-group relational.

Personnel performing duties for which they are not adequately trained may lead to shortfalls in practice administration and functioning, and this could result in practice ineffectiveness. These problems vary from inadequate debtor protocols and failure to deal with bureaucracies, to inadequacies in
group and/or team performance, conflict management and inter- and intra-
personal communication. These problems could result in loss of revenue,
diminished personnel morale, lead to a high staff turnover, and decrease in
patient numbers.

1.7 SUMMARY
It can be reasoned that the factors that were mentioned can have a negative
impact on the quality of service that is offered to patients, and who will, if the
service is not at the level of their expectations, leave the practice for another
in the hope that this will satisfy their needs. In turn this could have an
adverse affect on the practice’s ability to sustain itself as a social system.

It is for this reason that the researcher believes that the analysis of a PGMP
as a social system may lead to insight and understanding with the aim to
suggest recommendations to enhance performance effectiveness.

Chapter Two offers information regarding the research process, including
research questions, research objectives and research methodology. Chapter
Three provides a theoretical overview on the group as a social system, while
Chapter Four focuses on providing an understanding of the Private General
Medical Practice as a social system. In Chapter Five the research findings are
presented with recommendations regarding the improved functioning of the
PGMP support staff group as a social system in Chapter Six.
REFERENCES


CHAPTER TWO

CHOICES PERTAINING TO VALIDITY AND RELIABILITY:
RESEARCH METHODOLOGY

2.1 INTRODUCTION
The researcher, in her capacity as a manager in a private general medical practice (PGMP), became aware of a need for soft skills training and development for the support staff of PGMPs. This was supported by research that was completed as an assignment during the researcher’s study towards the BA Honours degree in the field of Group Dynamics. Later, during the current research this was supported by a review of literature [also see Table 1.1], a survey to identify competencies important to practice support staff working in PGMPs, and the results of a sociometric analysis of the intra-relations between practice support staff members.

Subsequent questioning of practice support staff members at various PGMPs on the type and nature of skills also drew attention to the fact that training was limited to half-day or one-day workshops that focused exclusively on operational skills. In addition, training options are generally not focused on the soft skills development needs of support staff in PGMPs, and, follow-up training with greater depth is seldom available. Further to this, no training could be identified where practice support staff of PGMPs could gain specific knowledge and insight into their intra-relational environment and its importance for group performance effectiveness.
During the years in which the researcher was employed as a practice manager (the researcher graduated as a pharmacist and then completed a post-graduate diploma in medical practice management), she became aware of intra-group relational problems among the practice support staff at that specific PGMP. Completion of the Honours assignment on group dynamics brought realisation that the nature of intra-relational problems present in the interaction between the practice support staff group, had group dynamics significance. In addition, it became clear that physical environmental factors, such as the practice layout and the physical placement of the support staff members, could also lead to interpersonal and intra-group problems affecting the dynamics and effectiveness of the practice support staff as a group, with negative consequences for the practice as a social system.

Motivated by this, a decision was made to research the dynamic nature of a practice support staff group as an important sub-system within the PGMP. However, these dynamics cannot be fully understood without analysing the practice support staff sub-system within confines of the larger social system.

This chapter is an exposition of the methodological choices that were made to ensure a valid and reliable research outcome.

2.2 RESEARCH QUESTIONS

Against the background of this introduction as well as the contents of Chapter One, four research questions directed this research. These are:

2.2.1 What competencies do practice support staff deem important to enable the effective functioning of a PGMP?

2.2.2 What internal [structure and processes] and external variables [e.g. stakeholders, economy, legal requirements, etc.] affect the functioning of the private general medical practice as a social system?
2.2.3 Apart from the medical practitioner sub-system, what impact from a group dynamic perspective can the support staff sub-system have on the functioning of a PGMP as a social system?

2.2.4 What suggestions can a Group Dynamics Practitioner-researcher recommend that will enhance performance effectiveness within a PGMP?

2.3 RESEARCH OBJECTIVES

2.3.1 GENERAL RESEARCH OBJECTIVE
The aim of this research is to analyse a private general medical practice [PGMP] with the aim

- to explore its nature and dynamics, with emphasis on the practice support staff sub-system
- to recommend enhanced performance effectiveness that will result in improved functioning of the practice as a social system.

2.3.2 SPECIFIC RESEARCH OBJECTIVES
2.3.2.1 To provide an understanding of a private general medical practice as a social system [see Chapters One, Three and Four].
2.3.2.2 To analyse the functioning of the support staff group as a sub-system within a private general medical practice [see Chapters Three, Five and Six].
2.3.2.3 To suggest recommendations for enhanced and on-going performance effectiveness of a private general medical practice as a social system [see Chapters Four, Five, and Six].
2.4 TARGET GROUP

The Port Elizabeth Group Practice [PEGP] was founded in 1995. It is a consortium of private general medical practices [PGMPs] within the Nelson Mandela Metropole, representing most suburban areas and serving patients from all income groups. The main purpose of the PEGP is to provide a comprehensive medical after-hours service to their patients. This goal is achieved through collaboration between the general medical practitioner members of the PEGP who rotate their after-hours services. The collaboration and rotation of after-hours services also enable medical practitioners in private general practice to rely on assistance from each other by taking care of each other’s patients in the practitioners’ absence, and, to enhance the quality of their own and family life by improved management of their after-hours services.

These private practices mostly serve medical aid patients on a fee-for-service\textsuperscript{22} basis, with varying portions of their turnover constituting private\textsuperscript{23} (non-medical aid) and/or managed health care\textsuperscript{24} patients. The representation of the latter two types of patients is largely determined by geographic location and patient income.

In order to identify a target group as a unit of study, a survey was performed in which eventually seventeen [17] PGMPs of the 28 practices within the PEGP consortium participated [see Table 2.1]. This survey provided information on the demographic composition of the PGMP, especially its practice support staff complement.

\textsuperscript{22} Fee-for-Service is a system whereby the service provider (general practitioner) receives a fee for every service, such as consultation, tests and procedures, rendered.

\textsuperscript{23} Private patients are patients who are not on medical aid or whose medical aid option does not include consultation fees.

\textsuperscript{24} Managed Care is a system whereby healthcare delivery is managed with the aim of controlling costs.
In nature, PGMPs belonging to the PEGP consortium are similar. However, larger practices offer a variety of services to their patients, and therefore require a larger support staff contingency. Guided by the research questions and the first two specific research objectives, it was decided to randomly select one of the medium sized PGMPs belonging to the consortium group, as a case to study.

Whether small or large, all PGMPs are regarded as social systems. Thus, by selecting a medium sized practice to analyse, this would allow the researcher to generalise findings to larger practices, and also to extrapolate findings to serve as guidelines for smaller practices who may later expand their services.

Besides the 61 respondents that participated in the survey, the PGMP that was selected as a case to study consists of 9 females, all permanent employees at a suburban practice in Port Elizabeth. At the time of the fieldwork there were three general practitioners in association at the practice. Five of the support staff had been with the practice longer than 5 years, two between two and four years, and the remaining two staff members for less than one year.\(^{25}\)

\(^{25}\) While the three GPs opted not to directly participate in the research, they were available to answer questions should the researcher require this.
TABLE 2.1: STAFF PARTICULARS PER PRIVATE GENERAL MEDICAL PRACTICE

<table>
<thead>
<tr>
<th>Practice Number</th>
<th>Number of General Practitioners</th>
<th>Reception</th>
<th>Admin</th>
<th>Nursing</th>
<th>Total Number of Support Staff</th>
<th>Total Number of Practice Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small-sized practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice 1</td>
<td>1</td>
<td>1</td>
<td>26</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Practice 3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Practice 10</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Practice 11</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Practice 12</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Practice 13</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Practice 16</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>28</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Practice 17</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Medium-sized practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice 2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Practice 5</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Practice 6</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Practice 9</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Large-sized practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice 4</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Practice 7</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Practice 8</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Practice 14</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Practice 15</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>39</td>
<td>28</td>
<td>23</td>
<td>90</td>
<td>133</td>
</tr>
</tbody>
</table>

2.5 RESEARCH METHODOLOGY

2.5.1 RESEARCH METHODS
To understand the functioning of a PGMP and performance effectiveness of the practice support staff group, both knowledge and insight are needed. This being the case, it would allow for a combination of quantitative and

---

26 Receptionist performs all administrative duties.
27 A temporary receptionist is employed to cover times when the regular receptionist is off.
28 Functions are outsourced.
qualitative research methods to be implemented to assure achievement of the envisaged research objectives.

While this research is focused on the study of a selected PGMP as a social system, it was also necessary to extend the research to the broader medical practice environment to survey the training and development needs of those non-medical staff [referred to as practice support staff] that work within PGMPs. Data obtained with this survey also enabled the selection of a PGMP as a case to study. The survey required quantitative research methodology decisions, while the focus on intra-relational performance effectiveness required a qualitative research methodology.

Furthermore, subjective experiences, as well as actual interactions between the staff members working within the PGMP required a qualitative research approach to enable reliable and valid deductions.

The following sections describe how qualitative and quantitative methodology guided this research.

2.5.2 RESEARCH PROCEDURES
2.5.2.1 Social Survey
A survey was conducted in member practices of the PEGP consortium using two questionnaires. The first [Addendum 1] was directed to either a General Practitioner within the PGMP or to the practice manager. Due to the nature of the answers that were sought, any one of the General Medical Practitioners or a practice manager could complete the questionnaire. Questionnaire 1 requested data on the demographics and geographical location of the practice.
A second questionnaire [Addendum 2] was directed to each of the practice support staff and had to be individually completed. Surveyed was: the qualifications of the respondent; job title and description; perceptions relating to certain training and development skills that are important in the performance of the respondent’s duties within the PGMP, and to the practice as a whole.

The results of the questionnaires provided answers to the research question 2.2.1 and enabled the researcher to achieve research objectives 2.2.2 and 2.2.3.

2.5.2.2 Case Study

Cresswell (1998 in De Vos et al., 2002: 275) defines a case study as an in-depth analysis of a system that is bound by time and/or place. As such it dictates that the selected object (i.e. the group) is treated as a whole. Cilliers (1970: 66) explains that the function of the case study is to describe the case in terms of its observable characteristics, and it therefore requires an intensive examination of the specific variables involved in the case.

While it can be argued that the study of a single case may not provide one with sufficient information regarding the wider population, and that one should guard against making broad generalisations based on a single case, the researcher is of the opinion that this can be overcome by implementing various research procedures and related research techniques to assure validity and reliability through triangulation.

---

29 See paragraph 2.4, p.19 for a description of the target group.
2.5.3 RESEARCH TECHNIQUES

2.5.3.1 Structured questionnaires

Two separate structured questionnaires were administered to the 28 practices that belong to the PEGP consortium. The results from the questionnaires provided information towards research objective 2.3.2.1 [the structural composition of a PGMP and skills development], and to an extent, answers to research question 2.2.3 and research objective 2.3.2.3 [suggested content of an intervention program to enhance the effectiveness of the PGMP as a social system]. To acquire further information, and to assure triangulation, the researcher implemented other research techniques [as is indicated in this section].

After three follow-up solicitations, 17 of the possible 28 questionnaires that were sent to a PGMP to complete was returned. While not all of the 90 practice support staff completed the second questionnaire, 61 questionnaires were returned. Eight of the nine practice support staff that worked within the PGMP that was selected as a case to study returned their questionnaire. The ninth member joined the practice only after completion of this phase of the research.

2.5.3.2 Content analysis techniques

Documents such as minutes of meetings, agendas, internal office memos, job descriptions, employment contracts, office rules and disciplinary procedures were used to gain greater insight into the nature of the functioning of the PGMP that was selected as a case to study (Cilliers, 1970: 40). Specifically, the researcher analysed the official practice documentation to gain information pertaining to:

- **Group structure**: organisational norms and values, roles and status, disciplinary procedures (sanctions), and lines of communication.
- **Group process:** forms of interaction, communication content, and decision-making.

- **Environmental factors impacting on the practice:** letters from medical schemes and representative doctors’ groups\(^{31}\); the impact of medical council decisions; and, implications of changes in the law that may provide information regarding enforced changes in office procedures, which may result in both structural and process changes within the respondent group that is being studied.

Although the contents of these documents were not used directly in the actual research, it did provide insight to enable the contents of Chapter Four, and to an extent Chapters Five and Six.

### 2.5.3.3 Sociometric Test

Sociometry is the measurement of attraction patterns between the members of a group. It is used to measure the patterns of acceptance and rejection, or, liking and disliking between the members of the group, and it provides information about the sociometric status of each group member.

This knowledge may be effectively utilised to reduce conflict and to improve intra-group communication and relations, as it provides an objective analysis of the group’s subjective dynamics, and is useful when planning interventions within and for the group (Hoffman, 2001\(^{32}\)).

There are a number of variables that impact on the sociometric status of a group. One of these is the physical environment of the group. The physical

---

\(^{31}\) The general practitioners belonging to PEGP also belong to the PEGP IPA through which they are, in turn, affiliated to ASAIPA, a national representative body that acts as independent forum for negotiations with Government and medical aids.

outlay of a PGMP practice may adversely influence the nature and dynamics of group member relationships. With this in mind, an analysis of sociometric patterns was done, together with observations of support staff interactions.\textsuperscript{33}

2.5.3.4 Overt Observation

One advantage of overt or direct observation is that participants can be observed in their environment without being disturbed by the researcher. For this reason the technique is regarded as having high external validity.

The purpose of using direct observation in this research was two-fold:

- To identify communication and interaction patterns [structural] and note communication content [processural].
- To identify the impact of physical factors, for example, work station allocations on communication patterns and dynamics, sub-group formations, and types and dynamics of interaction.

Observations were structured by developing diagrammatical observation sheets that enabled recording of the interactions between the members of the group. Prior to the period of observation, the researcher explained her research intentions. However, what exactly she would be observing was not explained to the members of the target group. All observations were either recorded immediately or immediately after leaving the PGMP.

The practice building was sold to a developer after commencement of the case study, but before the period of observation. A new, custom-designed, up-market practice was envisaged on another site. The support staff were under the impression that the research would provide information that would assist in the physical planning of the internal layout of the new practice. This also reduced the Hawthorne effect.

\textsuperscript{33} See Addendum Three for an example of the Sociometric questionnaire used in this research.
Through observation of the frequency of interaction between the members of the practice support staff\textsuperscript{34}, as well as the outcome of the sociometric analysis, the researcher was able to gather comparative information that would serve to validate her deductions. By linking these observations to the activity of the group, further insights in the dynamics of group behaviour and performance could be obtained.

A number of steps in using direct observation, as proposed by the USAID Center for Development Information and Evaluation (1996)\textsuperscript{35} served to guide the researcher in her observations. These are: determining the focus [developing direct observation forms i.e. listing the items to be observed and providing adequate space in which to record observations]; selecting the site of observation [i.e. where the observer will position him/herself to conduct observations]; deciding on the best timing [i.e. enabling reliable and valid observation outcomes]; conducting the field observation [i.e. allowing for a certain level of rapport to develop before starting actual observation and ensuring that there is sufficient time allowed for the activity]; completion of documents [i.e. either during observation or immediately after], and analyzing the data.

Site observations took place over a period of two weeks. This afforded sufficient time to assess whether the observations indicated an ‘entrenched pattern’ of interaction and behaviour. To enhance reliability of observation, observations were always conducted at the same time, and sporadic visits to the practice at various unannounced times were also made to undertake observations. Informal interviews, questioning and discussions during tea time with members of the practice support staff served as triangulation.

\textsuperscript{34} See Addendum Six for an example of the matrix used during direct observation.  
2.5.3.5 Unstructured interview

The purpose of interviews was two-fold:

- To informally obtain information on attitudes towards training and skills development; the need for effective teamwork, and the problems encountered in the practice.
- To provide clarification on uncertainties and deductions that was made by the researcher. This ensured reliability and validity.

As previously mentioned, these informal interviews took place during site visits especially during staff tea and lunch breaks.

2.6 RESEARCH PROCESS

2.6.1 ORIENTATION PHASE

To assure that the set research objectives would be achieved, the researcher identified those research activities relevant to her research. These will now be discussed.

2.6.1.1 Preliminary observations in a practice

As part of the researcher’s BA Hons (Group Dynamics) degree research requirement, she observed a PGMP support staff group for three consecutive days during October 2004. The purpose of this study was to identify various elements of group structure and process in a work group using direct or overt observation.

Although the study was not intended to lead to an intervention, the results indicated that the functioning of the group may be enhanced by certain group dynamic interventions. The study also indicated that training in certain soft
skills may be beneficial to the performance effectiveness of the group. This led the researcher to believe that an in-depth study of the PGMP as a social system, may lead to findings and indicate specific interventions that would enhance the performance effectiveness of the group.

2.6.1.2 Literature review
Through the course of 2005, a systematic review of literature was undertaken. This enabled the researcher to define key concepts, uncover problems associated with PGMPs in South Africa, gain an understanding of the group as a social system, conceptualise relevant soft skills that would enhance performance effectiveness within a PGMP, and to decide which research methods would best serve her research.

2.6.1.3 Presentation to PEGP members to introduce them to the research and obtain permission for initial surveys.
The rationale of the proposed research was presented at a general meeting of the member doctors of the PEGP in August 2005 to solicit their permission to launch this research within the PEGP consortium. The attendees were unanimous in the belief that this research may benefit practices in the PEGP group. Seeking permission from an institution that is intended to be the subject of an investigation is in line with the expectations of the Nelson Mandela Metropolitan University [NMMU] Ethics Committee for Human Research [see Addendum 4].

2.6.1.4 Structured questionnaires to practices.
Two questionnaires were compiled to gather information about the PGMPs that belong to the PEGP consortium.

2.6.1.4.1 Questionnaire 1: Practice demographics [see Addendum 1]
This questionnaire to be completed by a General Practitioner or a designated practice manager was developed and was sent to the 28 practices belonging
to the PEGP consortium during November 2005. This questionnaire contained questions relating to the following aspects: size of the practice [number of doctors and number of practice staff]; the geographic location of the practice; the socio-economic group that was mainly served by the practice; and, whether the practice mainly served medical aid, managed care or private patients.

2.6.1.4.2 Questionnaire 2: Staff demographics and soft skills needs analysis [See Addendum 2]

The researcher developed and distributed this second questionnaire to the practice support staff during February 2006. It requested information on the formal education of the practice support staff member, her job description, and duties. The respondent was required to indicate the need for further soft skills development, and to prioritise the order of their importance with reference to the execution of duties within the practice.

The results of the two questionnaires would assist the researcher to compile a profile of a typical PGMP and to identify a target practice for observation and in-depth analysis.

2.6.1.5 Analysis of questionnaires and identification of target practice.

Making use of a computerised spreadsheet program, the data collected in the questionnaires were analysed [See 2.6.1.4.1, 2.6.1.4.2 and Addendums One and Two].

The researcher asked her promoter, Prof F.J. Bezuidenhout, to select a medium sized PGMP to serve as the target group for the case study.
2.6.1.6 Permission from target practice doctors and employees to conduct further research and to clarify research and answer any questions they may have.

Consent was sought in November 2006 from the medical practitioners to use the practice as a case study and to conduct the research during normal working hours on the practice premises. A letter of consent was obtained from the doctors [see Addendum Five].

2.6.1.7 Identification of documents

A number of practice documents were identified that would potentially assist with the research. These included minutes of practice meetings, internal memos, job descriptions, duty sheets, employment contracts, disciplinary processes, dispute management guidelines, laws applicable to employers, profession-specific laws and professional guidelines [for both doctors and professional nurses] as provided by the HPCSA\textsuperscript{36} and South African Medical Association\textsuperscript{37}.

2.6.1.8 Planning for Sociometric Questionnaires.

At the practice meeting of February 2007, it was decided that the support staff members of the target PGMP would individually complete the sociometric test during normal working hours on a day when one or more of the general practitioners was off duty. The office of the medical practitioner not on duty was used to administrate the sociometric test. This provided sufficient space and privacy.

\textsuperscript{36} Health Professions Council of South Africa.

\textsuperscript{37} South African Medical Association: A professional association for private medical practitioners that assists doctors on many fronts from the provision of standardised documents to acting as a trade union for its members.
2.6.2 IMPLEMENTATION PHASE

2.6.2.1 Content Analysis
Upon receiving consent, the researcher immediately requested and commenced analysing the practice documents [see 2.6.1.7] for information regarding organisational values, norms and official communication structures and processes [i.e. formal meetings].

2.6.2.2 Sociometric Tests
The sociometric tests were administered by the researcher during May 2007 on a day that only two doctors were present in the office.

2.6.2.3 Overt or Direct Observation
This part of the implementation proved slightly problematical. To achieve valid and reliable results, observations needed to be conducted when all group members [medical practitioners and practice support staff] were present. This was achieved in the first two weeks of August 2007. The researcher spent a minimum of four hours per day, at varying times of the day, to observe the group at work, but at consistent times over a period of two weeks. In other words, week two followed the same observation time schedule as week one.

2.6.3 CONCLUDING PHASE
During this phase, the data was processed into tables, lists, and graphical representations [sociometry] that would allow for a clear presentation. The data were analysed and the findings, together with recommendations are contained in chapters 5 and 6.

---

38 In other words, week two followed the same observation time schedule as week one.
2.7 CHAPTER OUTLINE

*Chapter One* provides a perspective on private general medical practices within the South African health care environment, and the need for soft skills training of support staff to enhance effectiveness within the practice environment. In *Chapter Two*, the methodology is discussed. *Chapter Three* presents a theoretical view on the group as a social system, and the focus of *Chapter Four* provides an understanding of a Private General Medical Practice (PGMP) as a social system. In *Chapter Five* important findings are presented, and linked to this, *Chapter Six* provides important recommendations for enhanced group functioning of support staff as a sub-system within the Private General Medical Practice that is viewed as the dominant social system.
REFERENCES


Rauterberg, G. W. N.D. *Direct Observation*. Located at: http://www.idemployee.id.tue.nl/g.w.m.rauterberg/lecturenotes/UFTdirectobservation.PDF [Retrieved on 30 September 2007].


CHAPTER THREE

THEORETICAL APPROACHES TO THE UNDERSTANDING OF THE GROUP AS A SOCIAL SYSTEM

3.1 INTRODUCTION
A common purpose of analysing groups as social systems is to enable insightful understanding of group functioning, performance, and effectiveness. This knowledge can be applied by researchers and/or Group Dynamics Practitioners to enhance performance effectiveness of groups.

In the first part of this chapter, the researcher briefly outlines various approaches that give understanding to group functioning, while in the second part, she places focus on the functionalist perspective. In the third part of this chapter, against the background of her research objectives, the focus is moved to a construct, developed from a combination of contributions by Parsons (1951) and Homans (1950) that will serve as a tool to analyse group functioning.

3.2 MODELS AND THEORIES
While each model or theory attempts to contribute to the understanding of group behaviour and performance from their distinct perspective, it is usually a combination of these that provide greater insight into group functioning. The focus in the following section is not to discuss the detail of the models, but to introduce the notion of a group as a social system.
3.2.1 THE QUASI-MECHANICAL MODEL

This model assumes that people are interchangeable, and that individual personalities or differences are insignificant in the functioning of the group (Zeuschner, 1992: 58; Downey, 1969: 441). From this point of view, groups are approached as if they are machines with various parts and functions. The group’s actions are categorised and quantified, thus implying that the group’s dynamics is a mathematical proposition.

The main limitation of this model is that it does not take into account group emotion, norms, beliefs, and values, thereby de-emphasising both their significance and impact on group behaviour and group performance. As a result the quasi-mechanical model is not effective in explaining the dynamics of group behaviour in the light of group functioning and performance effectiveness.

3.2.2 THE ORGANISMIC MODEL

While Durkheim introduced the concept of society as an organism in the 19th century, Herbert Spencer\(^{39}\) expounded on this concept (Mills, 1967: 13). This model equates the group to a biological organism that forms, grows, reaches a state of maturity, and then dissolves. The analogy is also made to the different biological functions of an organism, e.g. when the group divides roles and tasks amongst its members in order to function optimally (Downey, 1969: 445).

In essence the group, through its membership, brings a number of elements that need to combine in order to assure growth and maturity. These elements are certain temperaments, needs, patterns of behaviour, ideas, and limitations. As the group develops, it will generate norms, values, beliefs, and goals in order to secure its survival and achievements.

This model allows for a greater complex analysis of a group, taking into account change, development and a variety of internal factors that produce their own dynamics within the group. Contrary to the quasi-mechanical model, the organismic model recognises that a change in membership will change the course of the group’s development, and will without doubt, impact on the quality of its functioning and performance.

The process of birth to dissolution of a group [whenever the latter is reached], should not be interfered with, as this is viewed as a ‘natural process of development’. Therefore, any intervention would impact on this ‘natural process’, and group members will ‘act out of character’ when they know that they are being observed. This will lead to the Hawthorne effect\(^{40}\), seriously jeopardising the results of the observations made by the researcher. To a certain extent, this limits the use of this model.

### 3.2.3 THE CONFLICT MODEL
This model explains that the nature of the group and its functioning is the result of an endless series of conflicts caused by a shortage of freedom, position, and resources within the group (Mills, 1967: 14; Podgórecki & Los, 1979: 171).

This model maintains that for a group to organise itself into a functioning unit, it needs to limit the control of some of its parts on others (Farley, 2000: 73). For example, when some members are more competent or more powerful and carry more prestige than other members, they will be rewarded differently. This results in conflict between the members with adverse effects on group functioning.

\(^{40}\)Hawthorne Effect: A tendency of research subjects to act atypically as a result of their awareness of being studied.
This model is limited in that it mainly provides retrospective explanations of why the group continued to exist and is not predictive of the future of the group. The model also denies the existence and importance of satisfied members, and ignores that mutual respect and trust, as well as friendship and affection, may prevent conflict within a group.

Also, the Conflict Model regards scarcity of resources as universal to all groups, thereby overlooking the fact that some groups do enjoy affluence. It also ignores the importance of conflict-free areas in group change, where change occurs as a result of consensus, rather than through conflict. The organismic model views change as a natural process, rather than a result of contentions over interests and desires, as the Conflict Theory does.

### 3.2.4 THE EQUILIBRIUM MODEL

Bales (1965), in Chang, Duck, & Bordia (2006: 327)\(^{41}\), propose that a group continuously divides its attention between task-related and socio-emotional needs. For the group to maintain a balance, any change that occurs will result in opposing actions or reactions in order to ensure that the system returns to its former state of equilibrium.

Chang, Duck, and Bordia (2006: 327) continue with Bales’ argument that a drive towards achievement of the group’s goal will result in a disruption of group solidarity, and, will in turn be followed by efforts to pull the group back together again. This deflects energy from the drive towards goal achievement, resulting in a renewed effort towards reaching the group’s goal. Eventually equilibrium will be reached between the push towards goal achievement and the efforts to improve group solidarity.

\(^{41}\)Bales, R. F. 1965. *Adaptive and Integrative Changes as Sources of Strain in Social Systems.* In Hare, A. P. , Borgotta, E. , Bales, R. F. (Eds.) *Small Groups.* 127-131
The model is valuable in the sense that it organises complex and interdependent phenomena coherently and simplistically. However, it lacks in-depth explanation with regards to change and the impact of external events and influences on the functioning of a group.

3.2.5 SYMBOLIC INTERACTIONISM

Symbolic interactionism is a term that Herbert Blumer (1969) gave to several lines of thinking originating with George Herbert Mead (1937) and Charles Horton Cooley (1909) (in Turner and Stets, 2005: 102) Three important underlying premises are:

- *Human beings act toward things on the basis of the meanings they ascribe to those things.*
- *The meaning of such things is derived from, or arises out of, the social interaction that one has with others and the society.*
- *These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he / she encounters* (Anderson, 1999: 59).

These premises imply that the individuals have the ability to interpret the actions of others and that the responses are based on the meaning that is attached to actions, and not the action itself. Symbols and their significance thus give meaning to human interaction (Holliday, 2002: 5). It is for this reason that symbolic interactionists undertake qualitative research to study social interaction (Liamputpong & Ezzy, 2005: 6).

Opportunity for analysis of a group as a social system are offered through the application of an analytical framework developed by Homans (1950), and the AGIL-functional prerequisites that explain the functional dynamics of a social system, as well as the pattern variables that relate to group member
behaviour that was developed by Parsons (1951). These are discussed in the next section.

3.3 THE NATURE AND DYNAMICS OF A SOCIAL SYSTEM

3.3.1 ANALYTICAL FRAMEWORKS

3.3.1.1 G C Homans

G C Homans developed a theoretical framework that is explained in his work *The Human Group* (1950) to enable analysis of a group as a social system. Through systematic analysis of five groups previously studied by other researchers, Homans identified specific variables and elements that enabled him to develop this framework. His work elaborated on the nature of the group as a social system, and how the different variables impact on the development of the group over time.

Homans developed the framework as follows (Homans, 1950):

1. He prepared an initial framework of reference based on empirical examples of the most basic components of social systems, thereby allowing for the use thereof in the analysis of any social system.

2. He followed this by a detailed description of the groups that were studied by other researchers, indicating the nature and composition of these groups, as well as the activities within these groups.

42 The groups studied were an industrial work team of the Western Electric Factory in Chicago, named the Bank Wiring Observation Room Group as described in *Management and the Worker* (1939) by J. F. Roethlisberger and W. J. Dickson; the Norton Street Gang, a male gang from the slum area of Boston, as described by B. F. Whyte in his book *Street Corner Society* (1943); a kinship group in a primitive community on Tikopia, a small Polynesian island as described by Raymond Firth in his book *We, the Tikopia* (1939); the town of Hilltown in New England, as described by D. L. Hatch in his work *Changes in the Structure and Function of a Rural New England Community since 1900* (1948), and; a company called The Electric Equipment Company, described by C. M. Arendsberg and D. MacGregor in *Determination of Morale in an Industrial Company* in the Journal Applied Anthropology (1942).
3. Using the initial framework of analysis, Homans systematically analysed these groups. By so doing, he was able to develop a set of propositions [called *analytical hypotheses*] pertaining to the relationship between the different variables referred to in his framework of analysis.

4. As the data developed, Homans developed new concepts, thereby expanding the initial framework of analysis.

Homans, through his analysis of groups, focused attention on important features of the groups, e.g. status and leadership. He also made empirical generalisations in terms of the basic behavioural elements that he isolated and conceptualised. Besides this, he also analysed the impact of the external environment on the group’s functioning, and the response of the group to this.

He identified the following elements that were eventually used within a framework to analyse the dynamics of group behaviour and functioning:

i. **Activity**

Activity is measured by productivity, efficiency, and similarity of activity among the members of the group, and is defined as that which the group should be busy with, to achieve its goals.

Within the field of industrial behaviour, productivity refers to the ratio of a work unit’s outputs to its inputs. The premise is that the more output produced from a given input, the higher the productivity of that unit will be. Therefore, when evaluating a group’s *productivity* one should, amongst other things, consider what the group’s goals are and whether the group is achieving these goals. Similarly, it is also important to remember that the end product is the result of the combined ideas, knowledge, and skills of the group members, and their interaction with one another. The effective utilisation of these elements of productivity will determine the *efficiency* of the group.
When assessing the nature of the group’s activity, one also needs to consider the individual activities of the group members, and the level of similarity between these activities. It follows that people, who perform similar activities, will tend to interact more with each other than with those who perform activities of a differing nature.

The type of activity, its duration and frequency, the number of persons involved in a specific activity and the relatedness between the various activities of the group, will have a direct impact on performance and affectivity of the group (Wallace, 1983: 68).

ii. Interaction
Interaction refers to the notion that an activity of one person is followed by an activity of another person. Interaction varies according to three elements. These are: frequency or how often interaction takes place between the group members; the time taken or duration of such an interaction and the sequence of activities during the interaction.

iii. Sentiment
Sentiment is defined as the feelings of group members towards fellow group members and the group’s activities. Sentiments develop as a result of interaction between the group members, and may vary according to the number of persons sharing the sentiment, the group members’ conviction regarding the sentiment, and the intensity of the sentiment.

iv. Norms
Norms are the rules that determine the behaviour of individual members of the group in a given situation. While not all group members behave according to the norms of the group, the members are generally aware of
these norms. These norms are accepted by them as correct until otherwise determined.

While one can differentiate between formal norms, such as professional ethics guiding the behaviour of general medical practitioners or the rules regarding office dress code, and informal norms [such as not interrupting a colleague who is speaking on the telephone], norms according to Homans, reflect the collective conscience of the group. In other words, norms prescribe to the members of the group how they must or ought to behave or what is expected of them in a given situation.

v. Total Social system
The group is defined as an organised unit with definite boundaries that sets it apart from the larger environment in which the group exists. The social system consists of the activities, interactions and sentiments of the group members, as well as the underlying interdependent relations between these elements during the time of the group’s activity. Together these elements and the outcome of their relationships form the social system. Thus, everything that does not form part of the social system forms part of the environment within which the group exists. While the total social system consists of both the internal and external system, the environment consists of physical, technical and social environmental elements. Collectively these form the total social system.

The total social system comprises of:

a. The external system
The external environment refers to the condition and relational outcome of the elements of activity, interaction and sentiment in so far as they enable the group to maintain and sustain itself within its environment (Homans, 1950: 108). The external system as referred to by Homans is the relationship the
group has with its environment in order to survive. In other words, survival is viewed in terms of the members of the group achieving their goals.

**b. The internal system**

The internal system develops as a result of the frequent interaction between the members of the group. According to Homans the internal system develops *an expression of the sentiments towards one another developed by the members of the group in the course of their life together* (Homans, 1950: 109-110). In other words, Homans differentiates between those relations that develop within the group among the members of the group and that are not related to the group’s survival - this he refers to as the internal group system - and those relations that develop between the members of the group and its environment to assure goal attainment and survival – this he refers to as the external system. Thus it is clear that both the internal and external system interact upon and with each other. This gives character to the total social system.

By using his analytical framework to analyse behavioural patterns that were identifiable within the five groups he studied, Homans was able to develop a set of analytical hypotheses that depict the relationship between the three basic behavioural elements - activity, sentiment and interaction – as well as between these elements and functioning norms.

Further to this, Homans identifies a number of empirical recurring patterns of behaviour pertaining to social status, leadership, relationships to third parties, power and influence, social disintegration, and social conflict.

Homans keeps account with the fact that the small group does not function in isolation, but needs to exist and continue to exist in a larger social environment. He acknowledges that relationships and variables in the group’s
internal environment are, to an extent, affected by factors in the external environment and therefore takes a major step in the holistic analysis of the small group.

3.3.1.2 Talcott Parsons
Talcott Parsons, a Functionalist, was concerned with the problem of social order and how, if individuals pursue their interests, order can be attained and sustained. The answer to this question enables an understanding of how social systems [for example, teams and organisations] are able to maintain and sustain themselves. Parsons is of the opinion that both functional prerequisites [AGIL] and pattern variables contribute to the sustainability of a social system. However, he emphasised that values and norms are to be seen as the key to social order (Knapp, 1994: 191). Thus, when group members deviate from these values this leads to a state of disequilibrium within the social system that threatens the survival of the system. Conflict or the impact of external factors on the social system stimulates adjustment of the parts of the system to move towards a new equilibrium, and, if necessary, perform new functions in order to ensure its maintenance (Goode, 1969:41).

Parsons’ framework [AGIL] allows the researcher to examine the structural characteristics of a social system [where structure refers to the formal and informal patterns of behaviour], and how this brings a certain order and predictability to the interactions of the members of a social system (Forte, 2007: 165). This order is required if the group is to attain its goals.

To enable a better understanding, both functional prerequisites and pattern variables are discussed below.
3.3.1.2.1 Functional prerequisites

The premise of the *AGIL Paradigm* is that any system, if it is to sustain itself in some form of recognisable continuity [equilibrium], must fulfil at least four requirements. If one or more of these functional prerequisites, which are regarded as fundamental to all social systems and subsystems, fail to satisfy needs, the social system will experience a state of disequilibrium. Parsons identified four functional prerequisites: *adaptation*, *goal-attainment*, *integration* and *latency* [AGIL] (Manning, 1989).

- **Adaptation** refers to a social system’s ability to maintain equilibrium in the face of environmental pressures and internal strains. Members of the social system will be urged to conform to the group’s values and norms in exchange for rewards, service or information.

- **Goal-attainment** refers to the system’s ability to satisfy its goals, both of the system as a whole, as well as of the individual members within the system. The individual member is urged to conform for the sake of becoming more powerful within the group, with others indicating their willingness to follow a person’s leadership if he or she conforms.

- **Integration** refers both to the compatibility of the different components of the system, as well as the maintenance of the boundaries between the system and its environment. A group member is urged to conform for the sake of acceptance into the group, whilst other group members may threaten to withdraw friendship or positive regard if undesired behaviour continues.

- **Latency**, [pattern maintenance and tension maintenance], indicates the function of guaranteeing maintenance of the minimal social structure of the system, referring to the socialisation of the individuals constituting the system. Members are encouraged to conform on the basis of common
values, or commitment to a purpose. The members will reinforce values in each other that will lead to the desired behaviour and react negatively to values in the other persons that may lead to nonconforming behaviour.

The *AGIL-paradigm* can be expressed as follows, and indicates the non-hierarchical interdependence of the functional prerequisites.

<table>
<thead>
<tr>
<th>Adaptation</th>
<th>Goal-Attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latency</td>
<td>Integration</td>
</tr>
<tr>
<td>(Pattern maintenance,</td>
<td></td>
</tr>
<tr>
<td>Tension Maintenance)</td>
<td></td>
</tr>
</tbody>
</table>

**DIAGRAM 3.1: AGIL PARADIGM (MANNING, 1989: 67)**

The researcher, while taking note of the various contributions to the understanding of group behaviour and functioning, became aware of the fact that a combination of the contributions of Parsons and Homans, as explained in the above mentioned sections, could serve as a construct for analysis of a social system. This is explained in the following section.

### 3.3.2 COMBINING HOMANS AND PARSONS

A construct for the analysis of group functioning was developed. This construct includes the components of the *AGIL-paradigm* [see Diagram 3.1] as proposed by Parsons, as well as the elements of the framework of *analysis*, as developed by Homans [see 3.3.1.1]. By so doing, the result
gives insight into the dynamics of interdependence [i.e. between the components of a group as a social system] through interaction. The framework as developed by the researcher is depicted in diagram 3.2 and explained thereafter.

Diagram 3.2: Combined construct of Parsons’ AGIL-paradigm and Homans’ framework of analysis. (Where P=Parsons and H=Homans)

3.3.2.1 Components of the construct

The construct depicts a social system existing within a physical, technical and social environment. Over time, through interaction, as the group moves through the phases of group development (Tuckman, 1965: 387) it develops a distinct internal and external sub-system. Four functional prerequisites, as detailed by Parsons (1951), are required to attain and maintain a state of equilibrium that enables performance effectiveness and thus the survival of
the social system. In essence this implies that the social system creates its characteristic structures and processes for performance and survival.

### 3.3.2.2 Dynamics of the construct

Central to the construct, and also per implication to the understanding of the contributions of Parsons and Homans to the systems approach, is *interaction*. Interaction can be described as the dynamic mechanism that is cause for the social system and its sustained performance.

In essence, a need in the external environment of a social system results in creating a social system to meet this need. Through interactive and interdependent processes, a social system develops over time to establish clear internal and external sub-systems for its performance effectiveness and its survival. To enable survival [i.e. performance effectiveness], all systems and their sub-systems need to be maintained. This occurs through a process of interaction and interdependence that creates a state or condition of *equilibrium* through which this is made possible.

While each system has components that interact with each other, their sub-systems also interact. The nature and quality of interaction will influence the quality of performance effectiveness of the social system as a whole and *vice versa*. In other words, if one or more of the components are in a state of disequilibrium, the other components will also be affected. Likewise, when the external environment is in a state of disequilibrium the internal and external sub-systems of the social system will also be affected. The response to such disequilibrium will cause the external sub-system to respond to ensure survival of the social system. This in turn will have an effect on the internal sub-system of the social system.
Homans (1950) identifies group activity, sentiments and norms as important for the survival of a social system, both internally and externally. Sentiments and norms [Homans] play a primary role within the function of pattern maintenance and integration [Parsons], while activity [Homans] plays a significant role within the function of goal-attainment [Parsons]. Sentiments also have a primary role within the functions of adaptation and integration [Parsons]. Pattern variables are linked to norms and sentiments, and in essence, are linked to all four the functional prerequisites through interaction.

While a case can be made that activity, sentiments and norms [elements] influence the outcome of the functional prerequisites as a whole, and this construct does acknowledge this, it also views that the elements of the social system [as indicated by Homans] can have either a primary or secondary, or direct or indirect impact on the functioning of a social system, and more specifically, through their relatedness with each of the functional prerequisites. Adaptation, for example, as a functional prerequisite, ‘operates to the outside’ of the social system, as it is linked to the external environment. This being so, sentiments have a primary role and activity a secondary role. A medical practice that does not maintain cleanliness [i.e. the activity of cleaning] will soon lose its patients [i.e. the sentiment of cleanliness], no matter the quality of the service.

This example can be extended to the other functional prerequisites. Sentiments develop over time through interaction, and assist in the development of norms. Sub-groups and teams [sub-systems] within an organisation [e.g. the PGMP as a social system] responsible for cleanliness should also internalise this sentiment [i.e. a function of pattern maintenance].

By working together as a group and/or team [i.e. the function of integration], they will assure cleanliness [i.e. the function of goal-attainment].
patients will notice the clean physical environment [i.e. external subsystem], and again return for health care [i.e. function of adaptation]. While cleanliness is a sentiment, it can also be viewed as an important activity within the practice.

3.4 SUMMARY

In combining the framework of analysis [Homans] with that of the functional prerequisites and pattern variables [the latter as a quality for interaction] as developed by Parsons, the Group Dynamics Practitioner is provided with a construct to undertake a comprehensive analysis of the group as a social system, this especially to assess performance effectiveness.

Chapter Four provides further insights into the structural and process variables associated with the dynamics of group functioning, and in particular with reference to the PGMP.
REFERENCES


CHAPTER FOUR

THE PRIVATE GENERAL MEDICAL PRACTICE
AS A SOCIAL SYSTEM

4.1 INTRODUCTION

Members in a group are not randomly connected to each other, but there are patterns and regularities that remain relatively constant, and serve to organise the group into a stable functional unit with identifiable structures and processes.

These structural components are developed by general and specific behavioural expectations in the group in a given situation, and help to create stable patterns of relations that reflect norms, values, roles, status, attraction, and communication patterns within the group, to enable performance effectiveness (Forsyth, 2006: 11).

Although the structural components can be isolated, there exists an inter-relationship or interdependence between them that creates a structural dynamic on which group functioning is reliant. These components help the group to achieve and sustain its structure and achieve its purpose. In addition, processes of group formation and development, together with socialisation and group identity, also emerge and aid the development of these structures.

In terms of Parsons (1951) and Homans (1950), these structures and processes assist to create the intra- and inter-relational social environment or
subsystem of a social group, while the group functions within a physical environment. Through interaction, structure and processes are created and developed - the one influencing the other. Both the internal and external environments influence each other causing changes in both the structure and processes of a group.

Against the background of Chapter Three, the structures and processes characteristic of a group will be discussed with specific reference to the private general medical practice [PGMP] as a social system.

4.2 STRUCTURAL ELEMENTS IN THE PRIVATE GENERAL MEDICAL PRACTICE

4.2.1 GROUP GOALS
All PGMPs share the same general goal, namely to provide a quality clinical service that satisfies patient needs and compels them to return for future visits (Hoerl, 1996). However, the specific objectives of individual practices may vary greatly as a result of variations in the significant environment in which they have to survive [economical, political, patient demographics, expectations, and culture], differing needs and expectations of the doctors in the practice, and the differences between the various practice support staff groups. Some PGMPs may aim to provide only basic primary healthcare services, whilst others may take on the character of a “one-stop shop”, where patients have access to a comprehensive range of medical and complimentary facilities in a single locality.

---

For the PGMP to achieve its goal(s) successfully, the group members need to align themselves with the group goal and accept it as the *group goal, i.e. the desirable outcome sought by the group*. They need to recognise that the group goal may differ from *individual goals*, and be willing to elevate it above their own goals when it comes to making decisions that impact on the group (Seijts & Latham, 2000: 106).

This is best illustrated by means of an example. At the centre of the group goals, are patients and their needs. When making a decision regarding business hours, the group should consider whether service quality, not just clinical quality, will play a role in the patient’s decision to visit the practice. The group may consider extending consulting hours so that patients may schedule appointments at their convenience, resulting in a change from working normal office hours to shifts. This may be against the individual goals of the group members who would now be expected to sacrifice quality time with their family, or participation in league sport. However, if they have aligned themselves with the group goal, they will be convinced of the necessity of such a change and show willingness to adapt their personal lives to some extent in order to accommodate these changes.

In a sense, this example also indicates the difference between the goals of the social system [i.e. the PGMP] and the goals of the sub-system [i.e. the practice support staff], as well as the personal goals of the members of the group. For quality performance effectiveness, it is important that all members of the group have a clear idea of what the goals are and accept to work towards them. Similarly, members of a sub-system [e.g. practice support staff] may develop their own goals, but never counter to those of the dominant social system [e.g. the PGMP]. Through interaction, members of sub-systems may decide on common goals to achieve, while taking into account the goals of each individual that is part of the sub-system.
4.2.2 GROUP COMPOSITION

*Group size* influences the relative contribution of group members to the group. Members' contribution to the group can be measured by the nature of their activity and interaction with other members of the group, as well as the extent to which these contribute towards the purpose and goals of the group. Over time, a hierarchy of participation will develop. Research (Joubert & Steyn, 1965: 151; Latané *et al.*, 1979: 824) indicate that the larger the group, the less time there is for individual participation, and that persons who belong to higher levels of the hierarchy tend to contribute more relative to those that belong to lower status levels. This indicates a tendency for *centralisation of communication* in larger groups. In the smaller PGMP with fewer members, one would therefore expect more participation by all members of the group, while in larger practices, one should take special cognisance of the fact that a hierarchical structure may exist that may exclude certain members from meaningful participation in the group processes.

Apart from group size, each member of the group brings a unique combination of attributes, experience, knowledge, skills, and attitudes. These merge together with those of the other group members. The differences between the group members [diversity] influence individual, as well as group performance, and may influence the group’s structure significantly.

For the group to complete its tasks and achieve its goal, it requires the right combination of knowledge, skills, and abilities [KSA’s]. However, possessing the right KSA’s is not the only determinant of a group’s success. Differences such as race, gender, ethnicity, and age not only affect the way that other people view individuals, but also the way that individuals perceive themselves, and can therefore be instrumental in the development of different types of relational structures within the group.
4.2.3 NORMS AND VALUES

Each member brings to the group a general sense of what is right and wrong and what behaviours are desirable and undesirable (Zucker, 1987:445). These are called values and the group will, over time, develop its own set of values, to include a combination of the individual values, but not necessarily all individual values, as well as the values developed specifically for the group.

Group members in the employment of a PGMP are expected to subscribe to the basic values held by the Hippocratic Oath\textsuperscript{44}. These include loyalty, honesty, confidentiality, empathy, humility, and respect.

Norms are specific rules that dictate how people should act in a given situation, and are usually an expression of the values held by the individual person or the group. For example, the PGMP value of confidentiality would be supported by the following statement in the Hippocratic Oath: \textit{That whatsoever I shall see or hear of the lives of men or women which is not fitting to be spoken, I will keep inviolably secret} \textsuperscript{45}.

Norms are classified as conventional, proscriptive, prescriptive or procedural (Bezuidenhout, 2004: 25). \textit{Conventional norms} have been internalised through the process of primary socialisation, and are generally applicable to most social situations, but may differ from one individual to another or from one social context to another. Individual group members bring these norms into the group situation where socialisation takes place through communication and interaction. As is the case with values, members of the group decide, in the course of the socialisation process, which norms are

\textsuperscript{44} Health Professions Council of South Africa. \textit{Ethics / Professional Conduct - Hippocratic Oath}. Located at http://www.hpcsa.co.za [Retrieved on 27 November 2007].

applicable in the group’s context. Once accepted, members are expected to internalise these norms. Members of a PGMP would regard helpfulness as a required value for the group. The norm, help group members in their tasks when one is available to do so, would be the accompanying norm.

*Proscriptive norms* are the expression of the unspoken expectation of how people ought to behave. For example, it will be expected that receptionists ought to behave in a friendly manner towards patients who visit the practice, regardless of how those patients behave.

*Prescriptive norms* define how people must behave in a social situation. When answering the telephone, for example, the receptionist should clearly identify the practice and herself.

*Procedural norms* explicitly state the behaviour expected from a person in a given contextual situation such as when attending a meeting. A number of laws and practice protocols are examples of procedural norms that govern the business practices of the PGMP. These will be briefly discussed.

### 4.2.3.1 Procedural Norms determined by laws

Laws provide *a rule of conduct or action prescribed or formally recognised as binding or enforced by a controlling authority*.

The general practitioner, and by extension their practice, is governed by the Health Professions Council of South Africa (HPCSA) with whom they must be registered to practice. *The Health Professions Council of South Africa [HPCSA]* is a statutory body, established in terms of the Health Professions Act no. 56 of 1974 with a mandate to protect the public, all consumers of

---


47 From here on referred to as the Council.
health care services, and to provide guidance on educational, professional and ethical issues to practitioners 48.

The Council is tasked with setting, maintaining and applying fair standards of professional conduct and practice in order to effectively protect the interests of the public. All the professions registered with the Council are represented by one of twelve professional boards49. The Medical and Dental Professions Board60 provides guidelines to medical and dental practitioners in the form of:

- Ethical Rules of Conduct for practitioners registered under the Health Professions Act, 1974 as published in the Government Gazette no 29079 of 4 August, 2006
- The National Patients’ Rights Charter
- Policy documents on Undesirable Business Practices, and
- Provision of professional guidelines on various issues, for example the keeping of patient records and management of patients living with HIV.

The Council may furthermore institute disciplinary proceedings against any person registered with it, following allegations of unprofessional conduct. The Council also possesses the powers to submit such a person to disciplinary process in terms of the relevant regulations.

The Basic Conditions of Employment Act (no.75 of 1997)51 as amended by the Basic Conditions of Employment Amendment Act, 2002 (South Africa. Department of Labour, 2007) applies to all employers and workers except members of the National Defence Force, National Intelligence Agency, South

51 Referred to as the Act.
African Secret Service and unpaid volunteers working for charities. The purpose of the Act is:

*To give effect to the right to fair labour practices referred to in section 23(1) of the Constitution by establishing and making provision for the regulation of basic conditions of employment; and thereby to comply with the obligations of the Republic as a member state of the International Labour Organisation; and to provide for matters connected therewith* (South Africa. Department of Labour, 2007: 3).

The Act provides guidelines for the regulation of work hours, leave allocation, record keeping, remuneration, termination of employment, procedures for management of grievances, disciplinary and legal processes, and the protection of employees against discrimination. Employee contracts may differ from the Act only if it applies a law that is more favourable to the employee, or if conditions of the employment contract are more favourable than those stated in the Act.

The PGMP is regulated both from a professional, as well as a business perspective, by a number of laws dealing with specific issues as broad as patients’ rights on the one hand, to unemployment insurance, income tax and Value-Added Tax on the other hand. General laws like the *Tobacco Products Control Amendment Act (no.12 of 1999)* apply, while laws dealing with pharmacies, dispensing, and nursing are applicable, depending on whether the PGMP employs professional nursing staff and runs its own dispensary.

---

4.2.3.2 **Procedural norms decided by general practitioners / practice management / practice staff**

Within the framework of the laws previously discussed, each practice will develop specific norms [also called protocols] that govern behaviour and practice processes on a day-to-day basis. These will include, for instance, practice opening and closing times and patient intake management, and will depend on a variety of factors unique to the individual PGMP. For example, a doctor may have an external appointments officiating as Occupational Health Officers at local factories, resulting in them not being available during certain times.

PGMPs will differ in the way they apply protocols regarding, for instance, dress code, with some providing only general guidelines and others insisting on the support staff wearing uniforms. One practice will work on a first come, first serve basis, while another may insist that patients book appointments, and only see emergency cases without bookings.

While practices may differ slightly in the procedure followed, most will have set systems for dealing with telephone calls, appointments by pharmaceutical representatives, booking of specialist appointments, bed and theatre bookings at hospitals, and the management of pathology specimens.

Similarly, practices will differ in how administrative functions are performed. A doctor with an occupational health appointment who spends much time outside his or her practice, and has a resultant small patient base, may require a single employee to manage both reception and administrative duties. In contrast, a practice with four doctors and extended working hours may have a manager with relevant qualifications overseeing a number of staff that is usually clearly divided into formal departments, with the flow of information and resources similarly delineated.
Procedural norms are usually developed by means of a decision-making process that involves the identification of the issue or problem, the generation of possible solutions, the selection of a solution and the implementation thereof (Kreitner, Kinicki, & Buelens, 2002: 386). To what extent the group is involved in the implementation of this decision-making process will differ from one PGMP to another depending on the managerial style of the doctor or practice manager and/or the issue at hand.

4.2.4 SANCTIONS
For the group to function effectively, it needs to maintain its norms. Sanctions create pressure on the individuals to conform, and can be either positive [rewards] or negative [punishment] in nature (Popenoe, 1980: 111).

The employment practices of the PGMP are governed by the Basic Conditions of Employment Act (no.75 of 1997), and is bound to the guidelines regarding disciplinary practices therein. The practice may also have a system of annual performance bonuses which is used as a way to thank personnel members for their contributions.

The group itself will develop its own sanctions over time. For example, a person who behaves in the expected manner and provides help and support to fellow group members may be invited to lunch, while the person who does not ask questions before performing an action and makes mistakes as a result, will not be entrusted with tasks that require initiative.

4.2.5 ROLES
A person’s role within the group is determined by the resources they bring into the group in terms of knowledge and experience, the needs of the group [both to maintain balance of the group’s internal environment, and to satisfy
the demands placed on the group by the external environment], as well as the person’s individual needs (Williams, 1996: 30).

Bales (1950) identifies two role structures within a group. The first is the task role. This role should be well-defined by the person’s job description that should describe the activities a group member needs to perform in order to help the group to achieve its purpose and goals. The socio-emotional role, on the other hand, focuses on those activities that members perform to promote positive relationships within the group.

Bales (1969) found that certain group members would engage more in task than socioemotional activities than other group members, and as a result, earn task leadership status within the group. He also found that the person in the group who engaged most in task activities was generally not the same person who performed the most socio-emotional activities (Bales in Borkowski, 2005: 316). While the actions of the group member with an orientation to task completion will assist the group to move towards the accomplishment of its goals, these same actions may result in the development of tension in the group, as the socio-emotional needs are placed second to the group’s task needs. In order for the group to regain its equilibrium, another member must assume the role of socioemotional leader, and act to reduce interpersonal tension created in the course of task completion. For example, a debtors clerk will have to discuss non-compliance of payment with a patient. This is the task of the debtors clerk. The nurse may not know of this discussion, but sense that the patient is stressed. Dealing sympathetically with the patient will ease the stress of the patient.

Assuming a role in a group will serve to connect group members to each other, allow them to express themselves, and contribute to the group’s
activities in a meaningful way, thereby adding to the individuals’ happiness and the group’s effectiveness. However, individuals may be unhappy in their roles (role stress) for a number of reasons, creating tensions within themselves and the group. These tensions could result in decreased satisfaction and reduced productivity. *Role stress* occurs for a number of reasons (Forsyth, 2006: 184):

- *Role ambiguity* occurs when the individual is unclear about what is expected of him in a certain role. This may result from a lack of clarity regarding the role itself, or the behaviours associated with that role.
- *Role conflict* is experienced when the person experiences inconsistencies concerning the other group members’ expectations regarding their role.
- *Inter-role conflict [role strain]* sometimes happens when a person is expected to fulfil more than one role in the group and finds that the behaviours expected for one role are inconsistent with those expected for the other.
- *Intra-role conflict* occurs when behaviours that make up a single role seem to work against each other.
- *Person-role conflict* is seen when the behaviours expected from a certain role go against the individual’s values, attitudes, temperament, needs or preferences.

To ensure that role stress is minimised, the group members should:

- be provided with complete job descriptions;
- be provided with training regarding appropriate behaviour patterns for individual roles;
- have their individual characteristics taken into account as far as possible when roles are allocated. For example, a nurse who is naturally caring and sympathetic would not be ideal in the role as a tough debt collector;
• not be assigned multiple roles where at all possible, or work out a system whereby one role is allowed to take preference over the other, depending on the circumstances. In the smaller medical practice it may be found that the receptionist, who is expected to receive the patients and make them feel welcome in the practice, also doubles as debtors clerk tasked with confronting patients regarding outstanding payments, resulting in role strain. A solution might be that she focuses on her role as receptionist when the doctor is in the practice and seeing patients and in the debt collecting role when the doctor is conducting clinics or assisting in theatre away from the practice.

In addition, the nature of role and relational behaviour can also be explained in terms of the five pattern variables developed by Parsons (1952) [i.e. affectivity versus affective neutrality; private versus collective interest; universalism versus particularism; achievement versus ascription; specificity versus diffuseness]. According to Parsons, people interact in a formal and/or personal manner depending on the context. Values govern interaction, influencing whether, for example, the context calls for affectivity or affective neutrality. For example, for the PGMP to remain financially healthy, effective debtors control is a necessity. The role of the receptionist as the face [public relations] of the practice, demands that she exhibits self-gratification [affectivity] and not allow the fact of non-payment [affective neutrality] to change the way [with warmth and empathy] that patients are received in the practice.

4.2.6 STATUS
Over time, as the group develops clearly identifiable and stable patterns of behaviour, it also reflects the position or status held by the individual in the group. This process is called status differentiation (Schultz et al., 2003: 108).
The status held by an individual within a group is linked with the rights and responsibilities that are associated with his/her role, power and authority in the group. Forsyth (2006: 187) states that status patterns are often hierarchical or centralised, and that generally, the high status members will make more decisions, take on greater responsibility, and interact and communicate more with the rest of the group than the group members who have a lower status.

While individuals, through education, skills, and competence development, as well as relevant experience, may achieve a status, the group also assigns statuses to the members based on personal characteristics, such as race or gender [ascribed status]. Furthermore, through interaction, the group will develop informal patterns of attraction [liking] and rejection [disliking]. Group members who feel or are attracted to each other tend to develop stronger and more positive interpersonal ties with each other than with the other members of the group [see Chapter Five]. This will result in each member of the group being assigned a sociometric status. Collectively this creates a sociometric status structure within the group (Moreno, 1934:7).

Observation and knowledge of both the formal and informal status structures within the group are important, as it will add insight to the understanding of the ‘real’ social structure of the group, and what, if any, interventions will be most suitable to address relational problems within the group.

4.2.7 LEADERSHIP

Kreitner et al. (2002: 451) defines leadership as the ability of an individual to influence, motivate and enable others to contribute toward the effectiveness and success of organizations of which they are members. They also differentiate between managers and leaders, stating that managers will typically perform functions associated with planning, investigating, organising,
and control, while leaders tend to deal with the relational aspects within the

group. This distinction highlights the fact that leadership is not restricted to
people in particular positions or roles, and that an informal leader can
effectively bring about change in a group.

In the PGMP, leadership involves the provision of a bridge between the
general practitioner(s) and the practice employees (Migliore, 2004\textsuperscript{53}). The
practice manager or group leader must be able to communicate the vision
and strategy to the practice employees in such a way that the group aligns its
goals to coincide with the vision and strategy as set out. Furthermore, the
practice manager should assist the general practitioners to relate effectively
to the staff and also the staff members to each other.

Far from being the general practitioners’ lackey, the group leader must also
be able to stand up for the group and challenge the \textit{status quo} when
something is not in the best interest of the group.

\textbf{4.2.8 COMMUNICATION NETWORKS}

Each group has identifiable patterns [\textit{networks}] of communication along
which information flows. Studying these networks can give one insight into
how best to distribute information in the group and can act as an indicator of
the inter-member relations in the group (Laubscher, 2004: 7).

It is usually easy to detect \textit{formal communication networks}, associated with
the hierarchical structure of the group. In this instance, communication will
usually flow from the group leader to the rest of the group or from the group
members to the group leader. For the group to function effectively, it is

\textsuperscript{53} Migliore, S. L. 2004. \textit{Hiring an Executive in a Medical Practice}. Located at:
important that information flow is such that all the members of the group have access to key information. This will enhance the effectiveness of the group.

In the PGMP one would find hierarchical communication patterns between the practice manager and the rest of the group, but also expect the group members to be able to interact freely with one another regarding common issues. Informal communication patterns are not as easily detected, and require careful observation or the administration of a sociometric test\textsuperscript{54}. The direction, duration and frequency of the informal communication may reveal more information about the group’s informal intra-relations and structure than do the formal communication patterns.

Communication patterns do not only reveal information about the flow of information in the group, but also provides information about the behaviour [guided by group norms and values] that is expected by group members and of the expected behaviour [roles] within the group by the different members. To an extent, this indicates the inner preferences that group members have for relating to each other [see Parsons’ pattern variables, Chapter Three].

For communication to take place efficiently and effectively, care must be taken to minimise any potential barriers to communication that may exist within the group (Garner, 2003\textsuperscript{55}). These barriers may be physical in nature, for instance, with a team member seated a distance away from the rest of the group or behind a closed door. Barriers may also be due to perceptions that individuals hold towards others: emotional barriers such as fear, mistrust or

\textsuperscript{54} Sociology is a graphical and mathematical representation of the patterns of inter-member relations in a group (Jandt, 1976: 147). Developed by J L Moreno (1934), it emphasises the patterns of attraction and rejection among the group members and is a good reflection of the informal structure in a group.

suspicion; cultural differences; problems with comprehension as a result of differences in spoken language; barriers as a result of differences between members from different genders; and those created as a result of intra-personal problems between the group members.

4.3 GROUP PROCESS IN THE PRIVATE GENERAL MEDICAL PRACTICE

4.3.1 GROUP DEVELOPMENT
Like all groups the PGMP group will also go through a maturation process that occurs in clearly identifiable stages. However, these stages do not generally flow neatly and predictably in order, but tend to occur in a more fluid process with the group moving forwards and backwards across the stages of development. This happens as members leave and new members enter the group, and, as the group attempts to maintain a balance between the task-orientated and socioemotional needs of the members.

Bruce Tuckman’s (1977) theory of group development identifies five stages, namely forming, storming, norming, performing and adjourning [dissolving]. Having knowledge of the typical behavioural patterns during different stages of the group’s development, enables one to ably recognise or predict problems, and allow for timeous intervention.

The forming stage is a time of orientation. The members may show anxiety, and be unsure about the structure and processes characteristic of the group, and how they fit in. Mutual trust is low, and individuals will generally hold back, while they wait to see who is in charge.
During the *storming phase*, the group usually experiences conflict as roles evolve, members vie for status and the group sets its goals.

Group structure and group norms are established during the *norming* stage. Members understand their roles, and show a willingness to conform to group norms. Communication patterns are established, and members show an ability to resolve problems regarding authority and power in an unemotional and pragmatic way. The group shows signs of a common group identity that binds the different members of the group together [cohesion].

The *performing stage* is where the group concentrates on the work that needs to be done having resolved disagreements and organisational problems in the previous stages.

Lastly, in the *adjourning stage*, once the group has achieved its goal and there is no reason for the group to exist, the group will *dissolve*.

The existing PGMP group will return to the forming stage [however briefly] every time a member leaves and/or a new member enters the group. As the PGMP group needs to continue its functioning without interruption despite any changes in membership, it is important for the effective functioning of the group that it moves through the forming, storming and norming phases to the performing phase as quickly as possible.

There are a number of variables that influence the development and functioning of a group. These are discussed below:

### 4.3.2 GROUP SOCIALISATION

Group socialisation is a process of mutual adjustment resulting in changes over time in the relationship between a person and a group. Moreland and
Levine (2001:72-74) propose a theoretical model that centres on the processes of evaluation, commitment and role transition. According to the model there is constant evaluation between the group and the individual to determine the value of the relationship, producing feelings of commitment that can vary over time. This allows for the individual to occupy several roles in the group, each associated with a distinct phase. These phases are:

- **investigation**, when the individual, as a prospective member of the group, engages in reconnaissance and the group engages in recruitment;
- **socialisation**, where the group attempts to produce assimilation in the new member and the member seeks accommodation from the group;
- **maintenance**, where the individual recognises himself as a member of the group and vice versa. [During this phase, role negotiation takes place between the group and the individual regarding specific duties [e.g. leadership] in exchange for certain rewards. This phase can last indefinitely. ]
- **divergence**, when commitment starts falling on both sides and the individual becomes a marginal member of the group, leading to resocialisation;
- **resocialisation**, where the group once again attempts to produce assimilation in the member and the member seeks accommodation. [If successful, the socialisation process will re-enter the maintenance phase, with renegotiation of roles.]
- **exit** occurs when resocialisation fails and membership of the group is terminated.
- **remembrance**, when the individual reminisces about the group and the group remembers the individual as part of its tradition, and commitment on both sides stabilises at a low level.
As the PGMP group needs to function continuously and effectively, it is important that the maintenance phase be reached as soon as possible after the recruitment of a new member. Providing clear role guidelines in the form of duty sheets and an induction program will allow the individual to generate an understanding of the roles of the other group members and will assist in the reaching of this phase. Regular reviews of the job description should reduce the likelihood of divergence and assist with resocialisation where divergence occurred.

4.3.3 GROUP COHESION

Groups have a high level of cohesiveness where members positively want to be part of the group (Kakabadse et al., 1988: 173). The group with a clear identity, sound intrapersonal relations, and where most members are willing to accept the group norms and values, will have members who value being part of the group.

Kakabadse et al. (1988: 174) add that cohesion is found to be highest in smaller homogeneous groups or in groups where there is a high level of interaction and interdependence amongst group members. Groups that are geographically isolated and groups who perceive themselves as having high status also tend to show high levels of cohesion. Cohesion will be lower in larger groups where individual goals may take preference over group goals and where there are lower levels of interdependence and interaction amongst members.

While high levels of cohesion in a group are generally desirable, there are instances when it can be problematic. An example is the phenomenon of Groupthink, a term defined as a mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members’ striving
for unanimity overrides their motivation to realistically appraise alternative courses of action (Janis, 1972:9).

In the PGMP one would like to see a cohesive group that is willing to work together to place the interests of the practice’s patients and doctors foremost. Where the group accepts norms that are contrary to this vision, cohesion may become problematical.

4.3.4 SOCIAL INFLUENCE
A large measure of interpersonal interaction centres on attempts to influence others [to change behaviours and/or attitudes] to act in ways that are desirable or potentially advantageous to the person doing the influencing (Kreitner, et al., 2002: 421).

Social influence occurs when the majority of group members convince a minority to change [majority influence] or a minority manages to convert the majority of the group members to their viewpoint [minority influence] (Forsyth, 2006: 246).

Research has found that people conform for a number of reasons (Forgas & Williams, 2001: 254). Group members might conform to another’s viewpoint, because they are perceived as having relevant information, because they believe that the decision is in line with group norms, or because they are susceptible to interpersonal influencing tactics, like complaining, demanding, threatening, pleading or negotiating.

Individuals may resist influence due to the fact that they are entrenched in their behavioural patterns, have strong opposing views on the matter at hand, or are aware that influencing tactics are being used (Forgas & Williams, 2001: 41). A debtors clerk who has been making use of telephonic follow-up of
accounts may resist using advanced technology like e-mail or text messaging to reach more patients more efficiently, as he/she may be of the opinion that success as a debtors clerk relies solely on their ability to personally convince the patient to pay up.

Culture and gender have been shown to influence the rate of conformity. People who come from collectivistic societies, for instance, will tend to conform more easily to group pressure than those coming from individualistic societies and women tend to be more susceptible to influence than men.

Within groups, the level of cohesion, group size, structure and goals will also affect the level of influence majority or minority groups will have.

4.3.5 POWER

Power is defined by Kreitner et al. (2002: 423) as the ability to marshal the human, informational and material resources to get something done. Kakabadse et al. (1988: 213) stress that mere possession of such power does not guarantee success and that it needs to be utilised in a manner that is in line with organisational culture, norms and values.

Kreitner et al. (2002: 424) identify two types of power, namely socialised power that is directed at benefiting others or the group, and personalised power that is directed at helping the individual who is exerting the power achieve personal goals. When the group is functioning optimally, socialised power will be utilised maximally, while the use of personalised power will be minimised.

French and Raven (1959: 150-67) propose that power arises from five different bases, each involving a different approach to influencing others:
- *Reward power* has its basis in the control of valued resources. The individual who decides who gets access to what resources and when holds significant control of the rest of the group.

- *Coercive power* provides control over unpleasant outcomes. Threatening or bullying are tactics used by individuals using coercive power.

- *Legitimate power* is based in a person’s formal position or authority to make decisions and is usually granted by consensus. This type of power is used well when the focus is on job performance, but may be used negatively when it is used to belittle others and inflate a person’s ego.

- *Referent power [charisma]* comes into play when a person’s personal characteristics become the reason for compliance. Role models have referent power over people who identify closely with, and admire, them.

- A person who possesses valued information or skills possesses *expert or informational power* over those in need of the knowledge and/or skills.

The various bases of power as described above are not independent of one another, but usually exist in various combinations, and the presence and use of one type of power will affect the use of other types. When coercive power is used, for example, referent power will diminish as people generally do not like those who bully or threaten them.

Apart from being held by individuals, power can also be held by subunits [departments] in an organisation. This usually happens when the activities of the other subunits are dependent on them.
In the PGMP it is not desirable for one person to hold excessive power over the rest of the group, as most tasks are completed as a result of co-operation and interdependence between the different departments. The PGMP’s success is dependent on the availability of resources and information in the right place and at the right time, and the practice manager should exert their legitimate power to ensure adequate resource distribution, and, to co-ordinate and enhance the group’s performance in the most effective manner.

4.3.6 PERFORMANCE AND EFFECTIVENESS
A competent and effective group would meet its objectives and achieve its tasks. Kakabadse et al. (1988: 179) mention that an effective group that has clearly identified goals possesses its own identity and a sense of purpose. This group is cohesive and members are seen as involved and participating, while the group is able to build on previous ideas, and on feedback received. Group decisions are usually made by consensus, and members show commitment thereto, while feelings are freely expressed without fear of judgment.

Where conflict management is concerned, Kakabadse et al. (1988) continue that the effective group shows a tendency to resolve existing conflicts that are usually overt, as it generates new ways of looking at problems and alternative solutions, and is able to analyse and evaluate group task progress, process, and interactions. Where leadership is concerned, the effective group will accept the person most qualified in a particular situation to lead them. Lastly, the group members have the task at hand, and should have the technical and interpersonal expertise to achieve its objectives.
Performance depends on the members of the group having the right knowledge, skills, and abilities. While diversity tends to increase performance and creativity, thereby allowing for valuable contribution to the organisation, diversity can also result in people finding it hard to work together [reduced
cohesion] (Schultz et al., 2003: 14). It is therefore important to identify whether cohesion is essential to the group’s success, before introducing diversity. This would be the case where there is a high level of sharing of responsibilities, resulting in high intra-member dependence, as is characteristic of a small-sized practice.

4.3.7 DECISION-MAKING
The PGMP environment is tightly regulated by a number of laws and professional guidelines, often negating the necessity for advanced decision-making skills. However, it is possible that all three identified decision-making styles, namely autocratic, consultative and participative (Kakabadse et al., 1988: 197) have a place in the PGMP.

Deciding which style to use, would depend on the quality of the decision being made [i.e. will varied inputs provide information that may affect the outcome?]; the level of acceptability required amongst group members to ensure a positive outcome; and, the time available for making the decision (Schultz et al. 2003: 165). This can be explained through the next example: In case of a severe flu epidemic, the doctor(s) may make an autocratic decision to temporarily extend practice hours to accommodate the sudden influx of patients. Staff members may adjust to the decision without question, as the potential inconvenience to them is short-term, and the prospect of additional remuneration for overtime may be appealing. However, should it become clear that it is in the practice’s best interest to extend its hours more permanently, it would be advisable for the doctor or practice manager to engage in consultation with the group regarding their availability to work shifts, and possible ways of implementing the changes, without causing too much inconvenience.
When it becomes apparent that the practice requires a new computer management system, it may be advisable to adopt a participative decision-making style. Although this process may be time consuming, it will ensure that the decision is made with as much information as possible at hand. Also, a system chosen by a consensus-decision is likely to at least partially satisfy the needs of all its users. The individuals will tend to view the change positively, and be more likely to accept and deal with the problems during the transition phase, than if the system was imposed on them without their input.

4.3.8 CONFLICT
When a group member perceives that his or her ideas or interests are opposing to those of some other group members, or even, the rest of the group, conflict may arise. A PGMP may find itself in a conflict situation, as a result of one or a combination of reasons that may include: problems with group structure, including incompatible value systems and unclear or unreasonable norms; ill-defined roles; competition over resources; inadequate communication structures or ineffective communication skills; inadequate interpersonal skills; interdependent tasks where one person is not performing; unreasonable deadlines or extreme time pressures; unreasonable workload; inappropriate decision-making processes; as well as, opposing personal ideas, values, or interests. Any unresolved problems may fuel a conflict situation (Pfifferling, 2005)\(^{56}\).

Pfifferling (2005) continues that the clarification of group goals, values, norms, roles, and communication structures, together with addressing issues created by inter-group diversity, will clarify the group’s expectations of its members. This will assist to reduce competition over resources, establish

---

effective communication structures, determine reasonable deadlines and workloads, and iron out interpersonal differences. He stresses that clear, honest, and regular communication is perhaps the most important tool that the group has to prevent conflict from spiralling out of control. It is important that the group establishes appropriate decision-making processes, and creates structures that allow for positive conflict resolution. If resolved in a positive manner, conflict may lead to a decision that is equitable and fair to all parties, promoting improved interpersonal relationships and greater individual self-awareness that, in turn, will assist the individual to approach future potential conflict situations in a positive manner.

It is clear that resolving conflict can be a complex issue. Where conflict is mainly the result of one or two individuals’ behaviour, Pfifferling promotes the idea of a written policy of expectations that the group has of its members [see Table 4.1].
4.3.9 INTERACTION

Various forms of interaction may be identified in a social group. These are: exchange, cooperation, competition, conflict, and coercion.

*Exchange* is interaction between two or more group members to receive a reward or a return. For instance, a group member who has to leave work
during official working hours, will ask a fellow group member to stand in for her, and in return she will be repaid in kind at a later stage. *Cooperation* is where two or more group members act collectively to achieve an outcome, especially where one cannot do this on her own. In a PGMP members are likely to enter into spontaneous cooperation when there is a medical crisis in the practice. To sustain the services rendered by a PGMP, support staff enter into a contract with those that appoint them to their practice.

*Conflict* when two or more group members struggle towards the same goal or value, and try to prevent or eliminate each other from attaining it. While conflict can be extremely destructive, there may be procedures in place to prevent this from happening. Third party arbitration may be used to resolve conflict between members of a group.

*Coercion* is a process whereby one member of a group exerts authority over another to ‘force’ the individual to comply with the demand.

Within a PGMP, one would expect all of the mentioned interaction types, however, too great a frequency of conflict could result in group ineffectiveness.

**4.4 THE EXTERNAL ENVIRONMENT**

The environment within which the PGMP is expected to function can be divided into the *physical environment*, the *technical environment* and the *social environment* (Homans, 1965: 109-110).
4.4.1 PHYSICAL ENVIRONMENT

There is a close connection between individuals, groups and their environment. The physical workplace setting should be designed in such a way that maximum interaction, communication, task completion, and adaptation are promoted in the absence of unnecessary interference in these processes (Forsyth, 2006: 498).

Forsyth emphasises that factors such as lighting, ventilation, temperature, and noise levels all play a role in the group's ability to effectively reach its goal. In addition, as in the case with a PGMP, the layout of the practice will either promote or impede interaction and communication between the members of the group. Staff members, for example, with similar or complimentary functions should ideally be seated in close proximity to each other where they can interact and communicate without any interference. This will enhance efficiency in task completion.

In a large practice, with clearly delineated departments, care should also be taken to ensure that lines of communication between the different departments remain open. For example, the accounts department staff members need to communicate with the receptionists and nurses regarding the information required for effective debtors control, while the receptionists and nurses need to be clear on how pathology specimens should be managed and certain medical forms completed.

4.4.2 TECHNICAL ENVIRONMENT

4.4.2.1 Technology

Modern medical practices are equipped with various types of technology. Diagnostic equipment, such as those used for ECG's and lung function tests are often part of an integrated computer system, where patient information and prior test results are retrievable. Equipment for the performance of basic
laboratory tests, like haemoglobin, blood glucose levels and total cholesterol, is available in most practices, and laboratory turnaround time is continuously being reduced with the advent of electronic delivery of results. Some medical practice software systems already interface with laboratory software to post results directly onto patients’ electronic profiles (Healthfocus, 2007).57

Medical schemes prefer the paperless system of electronic claims transmission and encourage the use of e-mail and the Internet for query management and delivery of payment remissions (Sovereign Health, 2007)58.

Practice management software has already advanced to the point where a practice may opt for a paperless management system that replaces the bulky patient files (Solumed, 2007)59. Even appointment books can now be managed electronically with instant messaging systems between computer stations replacing the constant interruption of telephone calls.

Pharmaceutical wholesalers have electronic ordering systems, and electronic banking for receiving and making of payments is favoured by most individuals. Through e-filing (SARS, 2007)60 the South African Revenue Services also encourage electronic submission and payment of declarations for Personal Income Tax, Value Added Tax, Employees Tax and Unemployment Insurance Fund.

---

These developments require that most group members need to improve their computer knowledge and skills on a continuous basis, and, as systems become more technologically advanced, adapt their systems and controls to accommodate these changes.

4.4.2.2 National laws, including professional boards
As discussed in section 4.2.3.1, the PGMP is governed by laws that determine the scope of practice, and have a tremendous normative influence on the practice. Consequently, changes in these laws will influence the practice in many ways.

A good example is the recent amendments to the Medicines Control Act (no. 90 of 1997) requiring doctors and nurses wishing to dispense medicines to complete a medicine dispensing course, and obtain a dispensing license that is renewable every three years. In addition, changes in the structure of dispensing fees compelled many doctors to close or downsize their dispensaries, leading to retrenchments [affecting group membership and group size], or redeployment into other positions [affecting roles and status].

4.4.2.3 Medical Schemes and Technology
Medical schemes play a significant role in the SA private healthcare system with 3 038 919 registered main members by 30 June 2007 (Council for Medical Schemes, 2007)\(^\text{61}\). In areas where the patients are financially well-off and can afford to pay for consultations, the PGMP may elect to request that the patient pays upfront for consultations and then personally claim back from the medical schemes.

In many instances, however, the patient’s economic status dictates that he/she cannot afford to pay the doctor directly and the practice will then undertake to claim on their behalf. While this accommodates the patient’s needs, the doctor does take on a measure of risk because patients may run out of funds resulting in non-payment of services rendered. Whilst the ultimate responsibility for payment lies with the patient, it may happen that they are not in a position to cover these expenses, resulting in a loss to the PGMP.

Most South African medical schemes now offer a facility for a paperless claim transmission process. Whilst this process, conducted via electronic data interface [EDI], ensures speedy payment of claims in most instances, the PGMP that chooses direct claiming takes on the added administrative responsibility of having to ensure that all the patient details and additional information required by the medical schemes are captured correctly. Mistakes result in rejection of claims and delays in payment. EDI transmission reports need to be carefully monitored and mistakes immediately corrected to prevent non-payment.

In order to effectively deal with medical schemes each PGMP staff member needs to acknowledge that they have a role to play, be it the receptionist who initially captures the patient information, the nurse who obtains the authorisation number and correct codes for medication, or the administrative clerk whose function it is to monitor electronic claims reports. The group has to acknowledge that the whole group needs to be sensitive to changes in the medical schemes requirements and be willing to adapt to these changes.

4.4.3 ECONOMIC ENVIRONMENT
The prevailing economic climate in which the PGMP exists may impact on the practice in a number of different ways. For example, should an industry close
down in the area the doctor will lose his appointment as Industrial Medical Officer to the industry, retrenched workers will downscale on, or lose their medical insurance cover, or be compelled to relocate in search of other employment opportunities.

The inability of patients to settle high medical bills and the resultant loss of income to the practice may necessitate retrenchments, or non-replacement of key staff members leaving for other reasons and/or downscaling on equipment. Remaining staff may need to take on more responsibility without a concomitant rise in remuneration, or accept a demotion.

Industrial development, on the other hand, will result in higher income per capita and the patients' ability to afford medical insurance and expensive procedures. The medical practice may need to expand the services on offer, invest in hi-tech equipment, and, employ individuals who may be more highly trained than existing staff members.

All of the above result in changes in group numbers, sentiments, group norms and status-role patterns.

4.4.4 CULTURAL ENVIRONMENT
Culture can be defined as the learned forms of behaviour, acquired through socialisation, that represent the predominating attitudes and behaviours that characterise the functioning of a group or organisation (Houghton Mifflin Company, 2007)\(^{62}\).

Coe (1978: 167) states that the specific behaviours associated with the occurrence of disease or illness varies widely from culture to culture, and that

beliefs and behaviours associated with illnesses are generally linked to the prevailing culture of the society. Not only will the economic and social level of the patient determine to a large extent the type of medical care sought, but also their cultural background and the various traditional practices of that specific culture (Savage-Smith, 1994). Therefore, the expectations of patients regarding service delivery may vary as a result of their individual cultural backgrounds.

The role of indigenous traditional healers in the South African society serves as a relevant example of the impact of culture on these beliefs and behaviours. It is estimated that up to 60% of South Africans consult with and regard the so-called witch-doctors and herbalists as indispensable members of society (Sobiecki, 2007) and many indigenous black South Africans will visit both the traditional healer and the general practitioner who has been trained in so-called “Western Medicine”. In order to best serve their patient base, the general practitioner and his personnel should show sensitivity to, and develop at least a basic understanding of the beliefs regarding illness and medicine of the majority culture of the people whom they are serving. If, for instance, the doctor does not speak the local indigenous language it may be of benefit to employ a professional nurse who does, to assist with interpreting.

4.4.5 EXTERNAL SOCIAL ENVIRONMENT

Epidemiological studies show that certain diseases tend to be more frequently associated with socio-economic status (Coe, 1978: 61). For example, in the lower socio-economic classes tuberculosis is a major cause of death, as is gastroenteritis amongst infants, whilst coronary heart disease and type 2 diabetes are associated with the more affluent classes. It will

---

therefore make sense for the practice with an affluent patient base to run a healthy lifestyle awareness campaign promoting good diet, exercise and regular cholesterol and blood glucose monitoring, whilst the practice serving the poorer community should educate mothers about boiling water and personal hygiene.

Whilst a receptionist with no medical training can easily be trained to teach basic hygiene to mothers, the practice running the lifestyle awareness campaign will require a professional nurse to assist with the performance of ECG’s and obtaining of blood samples, and, even have a dietician and biokineticist available to guide patients.

It can thus be clearly seen that the group’s external environment has a significant impact on the how, what, where and why of the PGMP group, and can thus not be ignored when analysing the group as a social system.

4.5 SUMMARY
Diagram 4.2 provides a summarised depiction of the PGMP as a social system. From this it can be clearly seen that interaction is a decisive mechanism to the sustained life of a social system.
4.6 CONCLUSION

For a PGMP to sustain performance effectiveness, it requires group processes and structures that are firmly in place. Both medical and non-medical staff members need to align themselves with the purpose and goals of the PGMP. They should also agree on group values and norms. Apart from a sound communication network to foster goal achievement and integration, the group members also need to collaborate to ensure this. This will enhance cohesion within the group, and enable alignment with the external environment without serious effects that may render the group ineffective. While the external environment of a social system can have an adverse effect on performance effectiveness, interaction between the members of the group can counteract this. The components of the social system are in an interdependent relation with each other, and therefore
influence plays an important role in maintaining the condition of equilibrium. Through interaction, the dynamic interplay between the various functional prerequisites assures performance effectiveness. Sentiments, norms and activity specific to the social system act to strengthen the quality of interaction through which purpose is enabled.

The next chapter will provide opportunity to present data relating to the functioning of the PGMP that was selected as a case to study.
REFERENCES


CHAPTER FIVE

FINDINGS AND DEDUCTION-BRIEFINGS

5.1 INTRODUCTION
The research methodology explained in Chapter Two enabled the researcher to explore and analyse the nature of a private general medical practice as a social system with the aim to suggest recommendations for group performance effectiveness.

This chapter, therefore, presents the outcome of various data-gathering procedures and techniques that were used to obtain information about the needs of private general medical practice support staff and an analysis of a private general medical practice that served as a case study.

5.2 COMPETENCIES AND IMPORTANCE OF SOFT SKILLS
A questionnaire was submitted to, and completed by, either a general medical practitioner or a practice manager. This produced data describing the practice demographics of 17 PGMPs. In addition, a second questionnaire was directed at the support staff of the 17 practices that indicated their commitment to the research. A total of 61 questionnaires out of the possible 90 were completed. The purpose of this questionnaire was to gather information about the needs and perceptions of practice support staff specific to soft skills development and training, and the importance thereof for performance effectiveness within a PGMP.
5.2.1 PRACTICE DEMOGRAPHIC DATA

The following table [5.1] provides information pertaining to the medical and support staff who render a service within each of the practices surveyed.

### TABLE 5.1: STAFF PARTICULARS PER PRIVATE GENERAL MEDICAL PRACTICE

<table>
<thead>
<tr>
<th>Practice Number</th>
<th>Number of General Practitioners</th>
<th>Reception</th>
<th>Admin</th>
<th>Nursing</th>
<th>Total Number of Practice Support Staff</th>
<th>Total Number of Staff in Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice 1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Practice 2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Practice 3</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Practice 4</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Practice 5</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Practice 6</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Practice 7</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Practice 8</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Practice 9</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Practice 10</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Practice 11</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Practice 12</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Practice 13</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Practice 14</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Practice 15</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Practice 16</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Practice 17</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>39</td>
<td>28</td>
<td>23</td>
<td>90</td>
<td>133</td>
</tr>
</tbody>
</table>

FINDINGS

5.2.1.1 The seventeen [17] practices surveyed employ a total of 90 practice support staff.

5.2.1.2 The number of practice support staff per general medical practice ranges between one and fourteen.

5.2.1.3 Depending on the number of practice support staff per practice, a practice with

---

64 Receptionist performs all administrative duties.
65 A temporary receptionist is employed to cover times when the regular receptionist is off.
66 Functions are outsourced.
o between one to five [1-5] employed practice support staff is considered to be a **small-sized** general practice;

o a six to ten [6-10] support staff contingency is considered to be a **medium-sized** general practice; and,

o more than ten practice support staff members [>10] employed within the PGMP, is considered to be a **large-sized** general medical practice.

5.2.1.4 The ratio between medical practitioner and practice support staff is 1:2, with reception [39] and administrative practice support staff [28] totalling 67 persons - almost three times more than the number of nursing staff employed at the seventeen practices.

5.2.1.5 Ten of the practices have no nursing practice support staff, while in some smaller practices, receptionists and nurses are also expected to perform administrative duties.

5.2.1.6 In large general medical practices the functions [i.e. practice support staff job descriptions] are clearly defined, with a division between nursing and non-nursing practice support staff positions.

5.2.1.7 Four of the one-man practices that were surveyed had external appointments [i.e. industrial medicine contracts], and the medical practitioners spend a significant portion of their time in consultancy outside the surgery. This significantly reduces the number of practice support staff in such PGMPs.

**It can be deduced that**

1. practice support staff in small-sized practices, if not a qualified nurse practitioner, should be multi-skilled to deal with medical emergencies in the absence of a medical practitioner or nurse;

2. it will be required that practice support staff in small-sized practices should be multi-skilled;
3. In medium-sized, but more so in large-sized practices, there is a tendency for staff to be specialist functionaries that may result in staff group performance characterised by a lower degree of integration, which in turn will have an effect on intra-group cohesion.

5.2.2 COMPETENCIES

In addition to the demographic data [see Table 5.1], questions regarding the perceptions towards, and needs for, soft skills development and training were obtained from practice support staff members in the target group surveyed.

Sixty-one [61] (68%) respondents returned completed questionnaires. Table 5.2 offers information of practice support staff’s perception of and need for soft skills development, as well as the importance for performance effectiveness within the practice.

---

**DEFINITION OF COMPETENCIES**

For the purpose of this treatise, the following definitions will apply:

**Assertiveness:** the ability to express oneself [needs and beliefs] without taking unfair advantage of others.

**Conflict management:** the management of a situation where two or more individuals have incompatible views regarding the achievement of a goal or resolution of a problem.

**Interpersonal communication:** A two-way process involving an exchange of information between two individuals [i.e. the *sender* and the *receiver*], BUT in terms of this research refers to communication between practice staff and individuals or groups in the external environment of the social system.

**Intrapersonal relations:** Interactions between members within a group and the resultant mutual influence thereof on the interacting persons.

**Leadership:** the ability to influence and motivate others towards goal-attainment

**Stress management:** the ability to understand one’s emotions and behaviour and to take active steps in counteracting the negative effects thereof.

**Self-control:** the ability to control one’s emotions and behaviour in all social settings.

**Self-awareness:** being aware of one’s identity, strengths and limitations, and the influence that this can have on one’s self and that of others.

**Teamwork:** the ability of group members to work together to achieve their goals.

**Time management:** the ability to prioritise in order to be effective in the execution on one’s daily duties.

68 After three requests to return the questionnaire, no further requests were made. It was accepted that the respondents were either not interested in completing the questionnaire or did not value the importance of obtaining soft skills training.
### TABLE 5.2: COMPETENCY TYPE AND RATING OF ITS IMPORTANCE FOR TASK PERFORMANCE

<table>
<thead>
<tr>
<th>COMPETENCE TYPE</th>
<th>RATING</th>
<th>Priority</th>
<th>Average rating per grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>NO</td>
<td>55</td>
<td>1</td>
</tr>
<tr>
<td>communication</td>
<td>%</td>
<td>90</td>
<td>2</td>
</tr>
<tr>
<td>Time management</td>
<td>NO</td>
<td>34</td>
<td>12</td>
</tr>
<tr>
<td>%</td>
<td>56</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Leadership</td>
<td>NO</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>%</td>
<td>25</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Relationship with</td>
<td>NO</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>colleagues</td>
<td>%</td>
<td>64</td>
<td>8</td>
</tr>
<tr>
<td>Conflict management</td>
<td>NO</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>%</td>
<td>64</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>Team work</td>
<td>NO</td>
<td>44</td>
<td>10</td>
</tr>
<tr>
<td>%</td>
<td>72</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Stress management</td>
<td>NO</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>%</td>
<td>44</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Self-control</td>
<td>NO</td>
<td>34</td>
<td>12</td>
</tr>
<tr>
<td>%</td>
<td>56</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Assertiveness</td>
<td>NO</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>%</td>
<td>36</td>
<td>33</td>
<td>11</td>
</tr>
<tr>
<td>Self-awareness</td>
<td>NO</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>%</td>
<td>31</td>
<td>15</td>
<td>20</td>
</tr>
</tbody>
</table>

**FINDINGS:**

**5.2.2.1** The competencies can be broadly divided into three groups, namely those that focus on *intra-group relationships*\(^{69}\) [i.e. relationships between the members of the group and indicated against a yellow background]; those that focus on *inter-group relationships*\(^{70}\) [i.e. relationships between the members of the group and individuals or groups outside the practice, and indicated

---

\(^{69}\) Leadership, Relationship with Colleagues, Conflict Management and Team Work  
\(^{70}\) Interpersonal Communication, Time Management
against a blue background], and those that focus on the *self-relationship*\(^{71}\) [indicated against a pink background].

5.2.2.2 The respondents indicate that competencies relating to *inter-group relationships* (73%) are more important to possess than those that relate to intra-group relations (56%) and those that relate to the development of self-relations (45%) when working as a support staff member in a PGMP.

**It can be deduced that**

4. practice support staff perceive those competencies that are directly related to their work [i.e. all competencies related to practice-patient health care and administration] as more important than those that enable intra-group performance and the development of the self;

5. in spite of the fact that interpersonal and intra-personal relations depend on the quality of self-relations, practice support staff seemed to view interpersonal relations to be more important, and not linked with self-development;

6. not understanding the fact that interpersonal and intra-personal relations depend on the quality of self-relations, practice support staff seemed to view interpersonal relations to be more important, and not linked with self-development.

---

\(^{71}\) Stress Management, Self-Control, Self-Awareness and Assertiveness
TABLE 5.3: COMPETENCIES IN ORDER OF IMPORTANCE

<table>
<thead>
<tr>
<th>ORDER OF IMPORTANCE</th>
<th>COMPETENCIES</th>
<th>% RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Interpersonal communication</td>
<td>92</td>
</tr>
<tr>
<td>2</td>
<td>Team work</td>
<td>86</td>
</tr>
<tr>
<td>3</td>
<td>Conflict management</td>
<td>85</td>
</tr>
<tr>
<td>4</td>
<td>Self-control</td>
<td>76</td>
</tr>
<tr>
<td>4</td>
<td>Time management</td>
<td>76</td>
</tr>
<tr>
<td>5</td>
<td>Relationship with colleagues</td>
<td>72</td>
</tr>
<tr>
<td>6</td>
<td>Assertiveness</td>
<td>66</td>
</tr>
<tr>
<td>7</td>
<td>Stress management</td>
<td>62</td>
</tr>
<tr>
<td>8</td>
<td>Self-awareness</td>
<td>46</td>
</tr>
<tr>
<td>9</td>
<td>Leadership</td>
<td>43</td>
</tr>
</tbody>
</table>

FINDINGS:

5.2.2.3 Interpersonal communication (92%), team work (86%) and conflict management (85%) are rated as the most important competencies to possess when working within a PGMP.

5.2.2.4 Self-awareness (46%) and leadership (43%) received the lowest rating, while time management and self-control received a rating of 76%; and relationship building with colleagues a rating of 72%.

5.2.2.5 Assertiveness and stress management received a rating of 66% and 62% respectively.

5.2.2.6 Four percentage categories would guide prioritisation of competencies for development [Table 5.4]. These are those that received a rating.

- of 80% and higher [pink background] – very high importance
- between 70 and 79 percent [purple background] – high importance
- between 60 and 69 percent [orange background] – medium importance
- between 50 and 59 percent [green background] – low importance

72 Competency ratings [average] receiving a rating of 4 or 5 as expressed in % of total respondents.
- lower than 50 percent [white background] – *Of very low importance*

### TABLE 5.4: COMPETENCIES IN ORDER OF IMPORTANCE RELATING TO SIZE OF PRACTICE

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Management</td>
<td>87</td>
<td>1</td>
<td>Relationship with work group members</td>
<td>100</td>
<td>1</td>
<td>Relationship with work group members</td>
</tr>
<tr>
<td>Team work</td>
<td>82</td>
<td>2</td>
<td>Team work</td>
<td>100</td>
<td>1</td>
<td>Team work</td>
</tr>
<tr>
<td>Relationship with work group members</td>
<td>81</td>
<td>3</td>
<td>Interpersonal communication</td>
<td>100</td>
<td>1</td>
<td>Interpersonal communication</td>
</tr>
<tr>
<td>Interpersonal communication</td>
<td>76</td>
<td>4</td>
<td>Self-control</td>
<td>100</td>
<td>1</td>
<td>Assertiveness</td>
</tr>
<tr>
<td>Self-control</td>
<td>75</td>
<td>5</td>
<td>Self-awareness</td>
<td>89</td>
<td>2</td>
<td>Self-control</td>
</tr>
<tr>
<td>Self-awareness</td>
<td>69</td>
<td>6</td>
<td>Assertiveness</td>
<td>78</td>
<td>3</td>
<td>Time management</td>
</tr>
<tr>
<td>Assertiveness</td>
<td>57</td>
<td>7</td>
<td>Time Management</td>
<td>72</td>
<td>4</td>
<td>Self-awareness</td>
</tr>
<tr>
<td>Stress Management</td>
<td>50</td>
<td>8</td>
<td>Stress management</td>
<td>72</td>
<td>4</td>
<td>Stress management</td>
</tr>
<tr>
<td>Conflict Management</td>
<td>31</td>
<td>9</td>
<td>Conflict management</td>
<td>50</td>
<td>5</td>
<td>Conflict management</td>
</tr>
<tr>
<td>Leadership</td>
<td>31</td>
<td>9</td>
<td>Leadership</td>
<td>44</td>
<td>6</td>
<td>Leadership</td>
</tr>
</tbody>
</table>

**FINDINGS**

**5.2.2.7** While time management, team work and relationship with work group members are regarded as competencies of ‘very high importance’ for *small-sized practices* to possess, relationship with work group members and team work are regarded by support staff of *large-sized* PGMPs as ‘very highly important’ competencies to possess.

**5.2.2.8** On the surface it seems that small-sized practices rate competencies that are associated with ‘practice performance’ as

---

73 Competency-rating: Calculated by average of the sum of a 4 or 5 choice-rating.
the most important to possess, whereas large-sized practice support staff seem to rate competencies associated with *individual performance* to be of very high importance.

5.2.2.9 While the practice support staff members of medium-sized practices regard *self-awareness* as *of very high importance*, small-sized and large-sized practices rate these to be of *medium importance*.

5.2.2.10 *Conflict management* is regarded by both small-sized and large-sized practice staff to be of 'low importance', while *leadership* is rated to be of low importance irrespective of the size of the practice.

5.2.2.11 Team work and relationship with work group members are viewed as *very highly important* competencies to possess irrespective the size of the practice.

5.2.2.12 Competencies relating to relationship with work group members, team work, interpersonal communication, self-control and self-awareness are viewed by support staff of *medium-sized practices* to be of equal and very high importance to possess. Respondents appear to place value on the importance on both intra-group and intra-personal relationship competencies.

**It can be deduced that**

7. it may seem that all practice support staff perceive interpersonal competence as the most important [see Tables 5.2 & 5.3] to possess, however, when adding *size of practice* to the equation intra-group relations competencies are then indicated to be of greater importance by staff of medium- and large-sized practices [see Table 5.4];

8. the above mentioned deduction is an important one when considering the design of a skills training and development program for staff of medium- and large-size PGMPs.
5.3 THE PRACTICE AS A TOTAL SOCIAL SYSTEM

5.3.1 THE GREATER ENVIRONMENT OF THE SOCIAL SYSTEM

5.3.1.1 Health Care within the South African context

FINDINGS

5.3.1.1.1 The public sector is under-resourced and over-utilised, while the private sector that is run mainly on commercial lines, caters for the middle- and high-income earners who are mostly members of medical aid schemes. There are currently 124 medical schemes in South Africa with around 7.1 million beneficiaries [Chapter One: Section 1.1].

5.3.1.1.2 While the PGMP is traditionally based on a fee-for-service model, the phenomenon of managed healthcare has been making steady inroads into PGMPs since mid-1990, especially in practices serving populations with lower end incomes. [Chapter One: Section 1.2].

It can be deduced that

9. PGMPs may in future come under pressure to: make greater provision for patients of lower income groups, or be pressurised by the State to render a service to such patients on its behalf, requiring that, in order to cope with health care demands, existing PGMPs expand their practices and increase the number of support staff members, with the resultant influence on the socio-emotional dynamics of the practice support staff as a social subsystem;

10. whereas most practices cater for specific socio-economic patient groups, boundaries will become fluid, and greater emphasis will be placed on performance effectiveness to cope with cultural differences, therefore requiring improved multi-skill tasking and sub-system interdependence. This will imply emphasis on soft-skills competencies if
PGMPs are required to expand their services to include this population group.

5.3.1.2 Influence of social institutions

5.3.1.2.1 Economic Factors

FINDINGS

5.3.1.2.1.1 Industrial development and labour practices have resulted in higher income per capita and the patient’s ability to afford medical aid and expensive procedures. The medical practice may need to expand the services on offer, invest in hi-tech equipment and employ individuals who may be more highly trained than existing staff members [Chapter Four: Section 4.4.3].

It can be deduced that

11. expansion has become a reality in view of the influx of families into areas that were exclusively zoned for certain population groups during the apartheid era, necessitating the appointment of competent and specialised staff, or the training of existing staff to use the newly installed hi-tech equipment; a situation in which general practitioners have to either work longer hours to cover the running costs of a practice, or make provision for additional practitioners to help carry the costs; and prevention of on-going staff turnover in an increasingly competitive market characterised by a constant search for qualified and competent practice support staff; such conditions not only impact on the sustainability of the social system, but may result in disequilibrium of the practice support staff group as a subsystem.
5.3.1.2.2 Political Factors

FINDINGS:

5.3.1.2.2.1 Areas that were previously exclusively assigned to certain race groups have become culturally integrated since the democratic elections of 1994. This is reflected in the patient demographics of PGMPs in these areas [Chapter One: Section 1.3].

It can be deduced that

12. while some practices reflect changes in patient demographics more than others, and in some instances also in the demographics of their practice support staff, not all support staff may be competent in dealing with the effects of these changes;

13. although not indicated as a first choice of importance [see Table 5.4], practice support staff emphasise the importance of interpersonal communication as an important competence, but when adding size of practice, intra-group relations is emphasised;

14. the fact that the 17 practices that were surveyed are geographically dispersed, [and therefore collectively serve a multi-cultural patient base], seems to tie in with the need for skills development training in the area of interpersonal communication and that both economical and political factors play a direct role on the dynamics of PGMPs, and will influence performance effectiveness of the practice support staff as a subsystem on the micro-level.

5.4 DATA RELATING TO THE CASE STUDY

The PGMP consists of three general practitioners and nine female practice support staff members. The latter group is between the ages of 26 and 45. While two of the staff members have been with the practice for one and six
months respectively, the rest have all been in its employment for two years and longer, with the longest serving member having been with the practice for twelve years. One of the practice staff members is the practice manager and working towards a Management Development diploma at the NMMU Business School; three are professional nurses with a B. Cur-degree; one has a one-year secretarial diploma; and, the remaining four have matriculation certificates [Grade 12]. While all support staff members have received in-house training, they have also completed a variety of short courses presented by external service providers.

It can be deduced that

15. the practice support staff group consists of a diverse membership, in terms of formal, non-formal and informal training, age and duration of employment within the practice, which implies that skills development and training and other forms of intervention should take this into account.

5.4.1 GENERAL MEDICAL PRACTITIONERS

5.4.1.1 Group members in the employment of a PGMP are expected to subscribe to the basic values held by the Hippocratic Oath\textsuperscript{74}. These include loyalty, honesty, confidentiality, empathy, humility and respect [Chapter Four: Section 4.2.3].

5.4.1.2 HPCSA [Chapter Four: Section 4.2.3.1] and SAMA [Chapter Two: Section 2.6.1.7].

5.4.1.3 The employment contract is based on a standardised template provided by the South African Medical Association, adhering to applicable labour legislation.

It can be deduced that

16. the PGMP support staff group’s purpose is to support the general medical practitioners to attain the goal, namely that of providing a service of quality to ensure patient satisfaction. By insisting, through the wording of the employment contract, on certain general norms and values that reflect the sentiments expressed by the Hippocratic Oath, the members of the group are guided towards adaptation [see Parsons] to the GPs’ sentiments.

5.4.2 PHYSICAL LOCATION AND HUMAN RESOURCES

5.4.2.1 Geographical Location

The practice operates in an upper middle class suburb approximately 100m from two shopping centres. The practice is surrounded by a number of retirement villages, primary, secondary and tertiary educational facilities, and operates within a culturally diverse community. The practice is within easy reach of all hospitals within Port Elizabeth.

It can be deduced that

17. to render a quality health service, it is important for the practice support staff to have an understanding of the socio-cultural environment of their patient base, and more specifically, of the health and other sentiments that are held by such a diverse patient base.

5.4.2.2 Building

The building is a converted suburban house that underwent additions and renovations just prior to the time of fieldwork observations [see current outlay of practice - Diagram 5.1]. Amongst other facilities, it comprises of a waiting room for 20 patients with a reception desk and work area, a procedure room, consultation rooms, and a theatre for minor procedures requiring local
anaesthetic. The building also has a fully equipped kitchen that doubles as a staff tearoom, is air-conditioned, and is wheelchair accessible [i.e. no steps].

**It can be deduced that**

18. the practice is functionally arranged with designated physical locations for all staff members that enables work role performance and caters for patient health needs within the scope of practice;

19. to an extent space allocation supports the hierarchical pattern that exists within the practice support staff subsystem [e.g. the Practice Manager has her own office, but the Girl Friday does not];

20. space allocation, to an extent, interferes with interaction between the members of the practice support staff group, especially between the Debtors clerk and the Cashier, and most of the members of the sub-system, as these two staff members work within isolated spaces;

21. collectively viewed, the ‘open-plan’ layout, freedom of movement into each other’s spaces [excepting the Debtors clerk and Cashier areas], and the frequent use of the tearoom by most of the members of the staff at differing times, enhance opportunity for both integration and cohesion;

22. the layout of the practice also provides for the maintenance of the functional prerequisites of goal-attainment, integration and adaptation [see Parsons], and to an extent, that of pattern-maintenance and tension management. Within these spaces the practice support staff group also performs various activities related to their tasks in terms of the framework of analysis of Homans. As the space provides for interaction between most of the members of the sub-system, opportunity for them to communicate their sentiments is enhanced;

23. underlying all of this, space allocation based mostly on functionality serves to create territories and isolation for some of the members of the group, and may contribute to the sociometric status and patterns that were identified within the practice support staff sub-system.
5.4.2.3 Technology
A telephone switchboard with extensions to every room and/or office is installed, together with a wireless telephone for nurses who move between rooms. A 14-station computer network is available to all members of the practice. A 24-hour permanent Internet connection is also available for claims submission and other Internet-based business activities. Besides other office equipment and technology, the practice has a computerised Electrocardiogram and lung-function machine.

It can be deduced that
24. the practice support staff work together with the GPs within a high-tech environment that requires on-going skills training and development, as well as intra-group collaboration;
25. in terms of the Parsonian model, each department is viewed as a sub-system, and therefore, telephone and computer links enable the functions of adaptation and integration, as well as goal-attainment; notably, where the debtors clerk and cashier are concerned, physical isolation precludes face-to-face interaction with the rest of the members of the practice support staff; however, telephone and computer links, the opportunity to attend meetings and to frequent the tearoom at times allowed for this, may lessen the isolation that they are experiencing.

5.4.3 Employment and human resources-related information
The employment contract is based on a standardised template provided by the South African Medical Association, adhering to applicable labour legislation. In addition, each group member receives a duty sheet that specifies her specific duties, as well as any other duties required to ensure the smooth running of the practice, provided that they fall within the scope of the employee’s vocational ability and are within the law. Accurate records are kept of leave and sick leave particulars, and the practice has formal
disciplinary and dispute management procedures. The practice has an active 'on the job' training program and additional and specific training is provided by service providers.

It can be deduced that

26. while an employment contract informs the employee of her work description, including her rights and obligations, a detailed duty sheet provides clear guidelines for work activities assisting with the definition of expected work role behaviours;

27. while staff receive in-house training, and where required, further training at service provider locations, there is no induction program for new members to assure their integration into the practice, which may result in isolation [inadequate socialisation] of a new member with negative consequences for group integration and performance effectiveness;

28. by signing the employment contract, each practice support staff member agrees to conform to a number of ‘generic’ values and norms that [in effect] provide a common ground for expected behaviours within the practice as a social system, thereby enhancing the functions of pattern maintenance and tension management [see Parsons];

29. while some of these norms and values may be accepted within the practice support staff sub-system, this does not necessarily imply that they are internalised by all the members of the group as group norms and values, but the interdependent nature of relations between the internal and external sub-systems [i.e. practice support staff and GPs in relation to the practice] provides an important tension management function that may prevent non-conformity and conflict;

30. as the roles within the sub-system are clearly defined and are also hierarchical in nature [i.e. with the practice manager being the leader], the members of the practice support staff are more likely to respond adaptively [Parsonian model] to the demands of the external
environment, with resulting lower stress levels that in some instances, if not checked, could reach the level of conflict;

31. the fact that most of the support staff members have been working together for more than five years may also suppress conflict between the members of the group;

32. the nature of the individual roles is mostly task-related, and this has an influence on the nature of the dynamics of group interaction. Although communication patterns within the group are mostly related to task behaviours and the forming of specific intra-subgroup structures (substantiated by the outcome of an analysis of sociometric task-relations [see Section 5.4.6.1]), these may also serve to prevent conflict.
5.4.4 PRACTICE SUPPORT STAFF LOCATIONS AND MOVEMENTS

The following diagram [5.1] provides an indication of the physical layout of the practice at the time of field work observations.

5.4.4.1 Receptionists

The two receptionists have a full view of the waiting room. Two additional telephone extensions allow them to take more than one call simultaneously. Three computer stations allow for unhindered computer access and uninterrupted workflow. Exits on either side of the reception desk allow for easy movement between the reception and doctors' rooms. There is easy and frequent access for receptionists to the filing room that includes the fax
machine and photocopier. The fact that Doctor 1 is relatively far away from reception in relation to the other doctors does not seem to hamper the flow of movement.

5.4.4.2 Girl Friday
The girl Friday is an addition to the practice support staff after the renovations took place. She does not have her own office. She works at the filing room desk, where she uses the file server as her desktop computer. She also assists in reception when required, and at times stands in for the cashier during lunch hours, but always does this from the reception desk area.

5.4.4.3 Nursing staff
While there are three nursing staff members in employment, only two are on duty at any given time. While one works full day (08h00 to 17h00), one works mornings only (08h00 to 13h00), and the third afternoons only (13h00-17h00). These nursing staff members are based in the dispensary room that is also their administrative base, but move frequently between here and the ECG and procedure rooms to attend to the obtaining of pathology specimens, performing of tests for insurance medicals and immigration medicals, performing of ECG and lung function tests, and to assist the medical practitioners with in-house procedures in the procedure room. The dispensary provides easy access to the waiting room [for patients collecting medication] and reception desk areas.

5.4.4.4 Debtors clerk
The debtors clerk has her own office to the side of the waiting room area. Access can only be gained to this office by moving through the waiting room area. She can close her office door for privacy when consulting with patients regarding their accounts. The debtors clerk very rarely leaves her office for
work-related matters, and spends most of the day on the telephone to contact patients. Other members of the staff very rarely visit this office.

5.4.4.5 Cashier
The cashier has a cubicle with a payment window that faces the reception desk. Entry to this cubicle is gained through a door situated directly opposite that of the debtors clerk. She rarely leaves the cubicle for work-related matters, but assists on a rotational basis as receptionist on Saturday mornings, and occasionally during normal working hours in the absence of a receptionist.

5.4.4.6 Practice manager
The practice manager has her own office next to Doctor 1. Her door is mostly open and medical and practice support staff move freely in and out of the office. The practice manager moves freely around the practice when required.

5.4.4.7 Patients
Patients enter through the waiting room to report at the reception desk. The entrances on either side of reception desk provide free access to doctors’ rooms, dispensary, ECG room and procedure room. Patients waiting or wanting to query or settle their accounts do not need to enter further than the waiting area to do so. The toilets are conveniently located close to doctors’ rooms, allowing for privacy and preventing unnecessary traffic flow through the practice. However, the patients that visit doctors 3 and 4 will need to pass through the waiting room to access the ECG room or the procedure room.
5.4.4.8 Location of GPs and movements

Doctor 1 and Doctor 2 have unhindered access to the procedure room and ECG room, while Doctor 3 and Doctor 4 have to pass through the reception area. All doctors have toilet facilities close to their rooms. The doctors’ rooms are furnished to their individual tastes. All of them have wash basins, examination beds, curtains to provide patient privacy, scales, wall-mounted blood pressure, and ear, nose and throat apparatus, height measures, and eye charts. Each doctor holds his/her own supply of injectables, swabs and gloves in their room. Desktop computers allow for direct recording and charging of consultations, and desktop printers allow for immediate printing of documents. Furthermore, the doctors all have Internet access from their desktop, and are in immediate contact with all staff members through the internal telephone network.

It can be deduced that

33. while practice staff, including the GPs, are functionally placed, some more than others have greater opportunity to interact with each other;

34. in order to be accessible to their patient base, two members of the practice support staff are physically isolated from their group, with consequences for socio-emotional isolation [see Section 5.4.6.3 and 5.4.6.4].

5.4.5 INTRA-PERSONAL COMMUNICATION [BETWEEN PRACTICE SUPPORT STAFF MEMBERS]

5.4.5.1 Day-to-day interactions

5.4.5.1.1 While all staff members interact with each other on a daily basis, some do so more frequently than others. This is closely related to the nature of the work [see Diagram 5.2 and Table 5.5]. However, individuals may have a greater or lesser daily contact frequency.
5.4.5.1.2 The practice manager frequently utilises the telephone network to communicate with the cashier and debtors clerk regarding work-related matters.

5.4.5.1.3 The practice manager and cashier occasionally approach each other in their offices.

5.4.5.1.4 The practice manager has an open door policy, which is utilised by most staff members.

5.4.5.1.5 Although the receptionists and cashier have frequent eye contact with each other, there is very little communication between them as the cashier cubicle has a glass window [for security reasons] that prevents direct communication.

5.4.5.1.6 There is also very little or no interaction between the debtors clerk and the other members of the practice support staff. Contact is only made when issues concerning patient payments arise.

5.4.5.1.7 Staff members would frequently choose not to leave the practice for lunch, spending the time in the kitchen cum tea room. Here conversation seems relaxed with a more social content.
Diagram 5.2: Daily movements and interactions within the practice support staff group

*It can be deduced that*

35. there is a high frequency of interaction between most members of the practice support staff;

36. while the nature of their work and the requirement to complete their tasks create sub-group formations or clusters, this is also attained [i.e. cluster formation] through choice of preferred interaction based on proximity [of location] and similarity [of task-related activity];
37. intra-cluster interactions may either have a positive or negative effect on intra-group integration and inter-group interdependence, and may be the reason for the sociometric relational patterns that have emerged outside these clusters [see Section 5.4.6].

5.4.5.2 Formal Communication

5.4.5.2.1 Following the advice of a group practitioner, regular formal practice meetings were instituted four years ago. These are held every two weeks or more frequently when the need arises.

5.4.5.2.2 Meetings are run according to a formal agenda and minutes are taken and distributed to all concerned.

5.4.5.2.3 Meetings are held early morning before practice opening time to allow as many as possible practice support staff and doctors to attend.

5.4.5.2.4 Attendees are usually at least one staff member per department [reception, nursing, administration], and available doctors [usually not less than two].

5.4.5.2.5 Depending on the agenda, the meeting may require limited attendance, i.e. doctors and practice manager only for management issues, staff members without doctors [but including the practice manager] for administrative issues or a combined meeting with staff and doctors for issues that affect all. Most meetings seem to be two-fold, beginning with a full staff meeting and ending as a limited attendance meeting.

5.4.5.2.6 Staff members are provided with ample opportunity to speak their concerns freely or to participate in the discussions when they find the point on the agenda to be of relevance to them.
It can be deduced that

38. formal meetings provide opportunity for enhanced intra-group and inter-group communication [i.e. between the two sub-systems], which in turn may serve to enhance integration, cohesion, and interdependence of role performance.

5.4.6 SOCIOMETRIC ANALYSIS

All practice support members participated in a sociometric test. They were asked to provide choices to two sets of questions, and indicate their first choice with a 1, and their second choice with a 2. The sets of questions, relating to task-relations and socio-emotional relations, each had two questions. These were:

■ Questions that related to task relations\textsuperscript{75}.

  - \textit{Task Positive}: Whom of your support staff colleagues would you choose to work with on an important project?
  - \textit{Task Negative}: Whom of your support staff colleagues would you \textbf{not} choose to work with on an important project?

■ Questions that related to socio-emotional relations:

  - \textit{Socio-Emotional Positive}: Whom of your support staff colleagues would you choose to discuss a personal issue with?
  - \textit{Socio-Emotional Negative}: Whom of your support staff colleagues would you \textbf{not} choose to discuss a personal issue with?

\textsuperscript{75} Note should be taken that S4, the newly appointed staff member was only willing to list one socio-emotional attraction and no socio-emotional rejections. It is for this reason that no second choice was recorded for S4 for socio-emotional attraction and none at all for socio-emotional rejection.
5.4.6.1 Results relating to attraction based on 1<sup>st</sup> and 2<sup>nd</sup> task attraction choices<sup>76</sup>

![Diagram 5.3: 1st and 2nd task attraction choices](image)

**Findings:**

5.4.6.1.1 S8 is the star of attraction receiving a total of 6 (four 1<sup>st</sup> and two 2<sup>nd</sup>) attraction choices.

5.4.6.1.2 S5 is an emerging star of attraction receiving a total of 4 (two 1<sup>st</sup> and two 2<sup>nd</sup>) attraction choices.

5.4.6.1.3 S3 and S8 are a mutual pair of attraction [both have indicated each other as their 1<sup>st</sup> choice].

5.4.6.1.4 A number of chain attractions [only considering 1<sup>st</sup> attraction choices] exist. These are between:

- S9, S5, S2, S8 and S3
- S7, S5, S2, S8 and S3
- S4, S1, S8 and S3

---

<sup>76</sup>To maintain confidentiality, the names of the practice support staff members were replaced with numbers. Red lines indicate 1<sup>st</sup> task attraction choice, and blue dotted lines indicate 2<sup>nd</sup> task attraction choice.
- S6, S8 and S3

5.4.6.1.5 Considering the 1\textsuperscript{st} choice sociometric status of all practice support staff, a number of isolates [but not true isolates] exist. These are: S4, S6, S7 and S9.

5.4.6.1.6 Considering 1\textsuperscript{st} choice relations, a number of clusters exist. These are between:
- S3, S8 and S6
- S9, S5 and S2 [5.3.4.1.1]
- S1, S8 and S3

It can be deduced that

39. some members of the practice support group have a high task sociometric status [5.4.6.1.1 & 5.4.6.1.2], while others have a high socio-emotional sociometric status [see 5.4.6.3];

40. status claiming behaviours may emerge where some of the practice support group members are emerging stars of task attraction [even unintentionally], and this may result in intra-personal conflict, especially between these emerging stars and those that are already functioning in leadership positions by nature of their job description;

41. owing to the number of chains of task attraction that exist within the practice support group, these may either lead to sub-group formation or may enhance group-supported work activity characterised by interactivity, interdependence and collaboration;

42. some members, more than others, are inclined to become isolated when task team collaboration is required, with consequences for socio-emotional sociometric isolation.
5.4.6.2 Results relating to attraction based on 1st and 2nd task rejection choices

Diagram 5.4: 1st and 2nd task rejection choices

Findings:

5.4.6.2.1 Pertaining to 1st choice rejections, S4 received rejections from all the group members.

5.4.6.2.2 S4 is a star of rejection.

5.4.6.2.3 There is a mutual 1st choice relationship of rejection between S2 and S4.

5.4.6.2.4 There is an emerging relationship of mutual rejection between S6 and S4 when both 1st and 2nd choices of rejection is considered.

5.4.6.2.5 With reference to 2nd rejection choice, S6 received the most rejections.

5.4.6.2.6 At second choice level, S6 would be viewed as a star of rejection.

77 To maintain confidentiality, the names of the practice support staff members were replaced with numbers.
5.4.6.2.7 At second choice level, there is a mutual pair of rejection between S6 and S7, and S5 and S3.

5.4.6.2.8 Due to the direction of rejection, S6 facilitates a number of short rejection chains that may emerge into clusters of rejection linking S1, S2, S3, S4, S5, S8, and S9 with S7.

5.4.6.2.9 S8’s status as a star of attraction is confirmed in that she received no negative choices.

It can be deduced that

43. a job-specific appointment, physical placement of an appointee, and absence of an induction program tend to increase the level of exclusion of an appointee to the point of sociometric isolation during task performance, as the existing group members prefer to continue to work at tasks with those with whom they already have developed a work relationship;

44. where stars of rejection are developing, this would be an indication that the practice support staff may isolate these individuals with negative consequences for integration and group cohesion, as well as for interdependent role and sub-system functioning.
5.4.6.3 Results relating to attraction based on 1\textsuperscript{st} and 2\textsuperscript{nd} socio-emotional attraction choices

![Diagram 5.5: 1\textsuperscript{st} and 2\textsuperscript{nd} socio-emotional attraction choices](image)

**Findings:**

\textbf{5.4.6.3.1} S1, by receiving four 1\textsuperscript{st} and one 2\textsuperscript{nd} choices of attraction is the star of attraction.

\textbf{5.4.6.3.2} S7, received three 1\textsuperscript{st} choices of attraction and one 2\textsuperscript{nd} choice of attraction, and would therefore be viewed as a strongly emerging star of socio-emotional attraction.

\textbf{5.4.6.3.3} S1 and S7 form a mutual pair of attraction based on their 1\textsuperscript{st} choice.

\textbf{5.4.6.3.4} S3, S8, S1 and S7 as well as S6, S8, S1 and S7 form a strong chain of attraction based on 1\textsuperscript{st} choice indication.

\textbf{5.4.6.3.5} A number of short chains exist, thus strengthening a number of positive clusters based on 1\textsuperscript{st} choice relationships between:

- S9, S7 and S1
- S2, S7 and S1

\textsuperscript{78} \textcolor{red}{Red} lines indicate 1\textsuperscript{st} task attraction choice, and \textcolor{blue}{blue} dotted lines indicate 2\textsuperscript{nd} task attraction choice.
- S4, S1 and S7
- S5, S1 and S7

**5.4.6.3.6** S4 is the only person not to receive any 1st and 2nd choices of attraction, and can therefore be viewed as an isolate.

**It can be deduced that**

45. where stars of socio-emotional attraction are developing, and all chains are linked to this individual, both the power base and influence of such an individual within the group will be enhanced, and may in some instances lead to sub-group formation that is strong enough to sway the direction of the sentiments of the practice support group in times of emerging conflict, or even contribute to groupthink in times of decision-making;

46. having an ‘expanded’ sociometric influence across clusters may strengthen integration within the practice support group sub-system in a work environment that is characterised by high task performance and emphasises performance effectiveness and zero-defect.
5.4.6.4 Results relating to attraction based on 1st and 2nd socio-emotional rejection choices

Diagram 5.6: 1st and 2nd socio-emotional rejection choices

FINDINGS

5.4.6.4.1 Considering 1st choices, S2, S3, S7, S8 and S9 received no choices of rejection.

5.4.6.4.2 S6 [star of rejection] received three 1st choices of rejection, and S4 received two 1st choices of rejection, however, in adding second choices, both received four choices of rejection.

5.4.6.4.3 S6 and S7 form an emerging mutual pair of rejection when including the fact that S7 rejected S6 as a first choice. This is also the case with S6 and S5.

5.4.6.4.4 S9, S1, S6, S5, and S4 form a strong chain of rejection, while S2 is included in this chain forming a second strong link of rejection.

79 Red lines indicate 1st task attraction choice, and blue dotted lines indicate 2nd task attraction choice.
It can be deduced that

47. where a group member is isolated in both areas of a sociometric relationship [i.e. task and socio-emotional] this will have negative consequences for intra-group relations with a resultant negative impact on group integration and cohesion.

5.4.6.5 Sociometric patterns depicted against practice layout

Diagram 5.7\textsuperscript{80} provides an indication of the sociometric relational patterns between the practice support staff within the PGMP with reference to 1\textsuperscript{st} attraction choices relating to task and socio-emotional relations, and their physical locations within the practice.

While, Diagram 5.8 provides a depiction of the sociometric relations and daily interactions of the practice support staff, Table 5.5 indicates their daily interaction patterns.

\footnote{\textbf{This is confidential information. Please see the diagram attached.} Red lines in Diagram 5.8: 1\textsuperscript{st} attraction choices relating to task sociometric relations, and blue lines to socio-emotional sociometric relations.}
Diagram 5.8: Daily interactions and sociometric patterns [1st choices only]
### TABLE 5.5: FREQUENCY OF CLUSTER INTERACTION PER DAY

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Task attraction choice</th>
<th>Daily number of direct interactions between sociometric choice</th>
<th>Socio-emotional attraction choice</th>
<th>Daily number of direct interactions between sociometric choice</th>
<th>Daily interactions between individuals within clusters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cluster: S2, S5 and S9</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2 – S5</td>
<td>S2 chooses S8[^1] S5 chooses S2</td>
<td>5</td>
<td>S2 chooses S7</td>
<td>16</td>
<td>96 [S2 &amp; S5]</td>
</tr>
<tr>
<td></td>
<td>S2 chooses S8 S9 chooses S5</td>
<td>5</td>
<td>S2 chooses S7</td>
<td>16</td>
<td>2 [S2 &amp; S9]</td>
</tr>
<tr>
<td></td>
<td>S5 chooses S8 S9 chooses S5</td>
<td>5</td>
<td>S5 chooses S1 S9 chooses S5</td>
<td>16</td>
<td>96 [S5 – S9]</td>
</tr>
<tr>
<td>Sub-total</td>
<td></td>
<td>10 external interactions</td>
<td>10 external interactions</td>
<td>194 [Sum: S2, S5 &amp; S9]</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>10 [2.6%]</td>
<td>32 [8.6%]</td>
<td>236</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster: S3, S4, S6 and S8</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3 – S4</td>
<td>S3 chooses S8 S4 chooses S1</td>
<td>16</td>
<td>S3 chooses S8</td>
<td>16</td>
<td>16 [S3 – S4]</td>
</tr>
<tr>
<td></td>
<td>S3 chooses S8 S6 chooses S8</td>
<td>16</td>
<td>S3 chooses S8</td>
<td>16</td>
<td>2 [S3 – S6]</td>
</tr>
<tr>
<td></td>
<td>S3 – S8 Mutual choice</td>
<td>16</td>
<td>S3 chooses S8</td>
<td>16</td>
<td>16 [S3 – S8]</td>
</tr>
<tr>
<td></td>
<td>S4 chooses S1 S6 chooses S8</td>
<td>16</td>
<td>S4 chooses S1</td>
<td>16</td>
<td>16 [S4 – S6]</td>
</tr>
<tr>
<td></td>
<td>S4 chooses S1 S8 chooses S3</td>
<td>16</td>
<td>S4 chooses S1</td>
<td>16</td>
<td>16 [S4 – S8]</td>
</tr>
<tr>
<td></td>
<td>S6 chooses S8 S8 chooses S3</td>
<td>16</td>
<td>S6 chooses S8</td>
<td>16</td>
<td>16 [S6 – S8]</td>
</tr>
<tr>
<td>Sub-total</td>
<td></td>
<td>16 external interactions</td>
<td>24 external attractions</td>
<td>82 [Sum: S3,S4,S6 &amp; S8]</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>16 [4.3%]</td>
<td>24 [6.5%]</td>
<td>122</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster: S1 and S7</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S1 – S7</td>
<td>S1 chooses S8 S7 chooses S5</td>
<td>8</td>
<td>Mutual choice</td>
<td>96</td>
<td>96 [S1 – S7]</td>
</tr>
<tr>
<td>Sub-total</td>
<td></td>
<td>13 external interactions</td>
<td>0 external interactions</td>
<td>96 [Sum: S1 &amp; S7]</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>13 [3.5%]</td>
<td>0</td>
<td>109</td>
<td></td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td></td>
<td>39</td>
<td></td>
<td>467</td>
<td></td>
</tr>
</tbody>
</table>


133
FINDINGS

5.4.6.5.1 All interactions not contained in the above table, but that transpired between those externally to their cluster, as well as not contained within a sociometric relationship, provided the Sum of approximate 550 daily interactions that transpired within the practice support group as a whole [see Diagram 5.8]. (Being the only observer, more interactions could have taken place without knowledge of the researcher. Table 5.5 is the culmination of a two-week observation period. These results contain the average of all observations over this period of time).

5.4.6.5.2 Slightly more task sociometric relationships [5] took place externally to a specific cluster pertaining than those in a socio-emotional sociometric relationship [4].

5.4.6.5.3 In terms of external orientation interactions [i.e. members of a specific cluster who chose someone outside their cluster] Cluster S2, S5 and S9 had the highest percentage [8.6%] pertaining to socio-emotional relations, and Cluster S3, S4, S6 and S8 the highest percentage [4.3%] pertaining to task relations.

5.4.6.5.4 However, most interactions took place within the same cluster, irrespective of the number of external oriented attraction choices.

5.4.6.5.5 Due to the nature of her work, S6 is physically isolated from the group. She, however, has 9 contacts with Cluster A, and 9 contacts with Cluster C per day. Besides this, she has contacts with the following individual practice support staff members within her Cluster: S3 [2 contacts], S8 [16 contacts], and S4 [16 contacts]. She is attracted to S8 [her immediate superior] for both task and socio-emotional relations.

5.4.6.5.6 S4 is sociometrically isolated within the group, probably as a result of the fact that she has only been with the practice for one month.

---

82 Table 5.5 should be read in conjunction with Diagrams 5.7. and 5.8
She is socio-emotionally attracted to S1, a socio-emotional star. Furthermore, S4 belongs to a socio-emotional chain of attraction [S6, S8, S1 and S7], which will also influence her socialisation into the group.

5.4.6.5.7 S4 is oriented externally to her cluster in both her task and socio-emotional orientation. This may be due to the fact that she is in more frequent interaction with S1 and S7 than with members of her own cluster.

5.4.6.5.8 S1 and S7 have a mutual socio-emotional attraction, but are both externally oriented to another cluster for their sociometric task choice relations.

5.4.6.5.9 S3 and S8 have a mutual sociometric task-relationship. However, S3 is socio-emotionally attracted to S8, while S8 is socio-emotionally attracted to S1. S8 is therefore in an external oriented relationship with a staff member in another cluster.

5.4.6.5.10 Group members show a number of task and socio-emotional attraction relations outside of their individual clusters despite the fact that work interaction tends to be highest amongst members of the same cluster.

5.4.6.5.11 S8 [star of task attraction] communicates and interacts with the same frequency [i.e. half-hourly to hourly] with the rest of the group members.

5.4.6.5.12 Three clusters have emerged: S2, S5 and S9; S1 and S7, and S3, S4, S6 and S9. There exists a mutual socio-emotional attraction relationship between S1 and S7.

It can be deduced that

48. a high frequency of interaction would likely lead to enhanced and sustained group integration and cohesion, as well as encourage greater interdependence.
49. in the light of cluster-formation where some members choose to relate to someone outside their cluster this may give reason to believe that, because of their external orientation, their clusters are weakly integrated.

50. in the light of the above-mentioned, a weakened cluster-formation may serve the function of a ‘buffer’ to prevent total degeneration of integration and cohesion within the total social system [see Homans], and may even prevent isolation of certain members within the group as a sub-system [see Diagram 5.9].

Diagram 5.9: Cluster formations within the practice support staff sub-system

5.5 CONCLUSION
The findings point to three main conclusions: (a) that the choice of competencies to encourage soft skills development is associated with the nature and size of the practice, as well as with the nature and dynamics of the sociometric patterns characteristic of the relations within the practice support
staff subsystem; (b) that while some practice support staff have preferences for sociometric task and socio-emotional relations outside their work clusters, these serve as a buffer against clique forming and to enhance integration, cohesion and interdependence within the practice support staff sub-system, and (c) that the physical practice layout and the interaction dynamics that it creates, tends to hinder integration between the members of the practice support staff group, as a sub-system.

An analysis of (b) and (c) indicates that PGMPs that are in this situation will require the insightful and careful intervention of a Group Dynamics Practitioner.

In the next chapter, the model that was depicted in Chapter Three and the findings that were made in this chapter will be used to suggest recommendations to enhance group performance effectiveness.
REFERENCES


Rauterberg, G. W. N.D. n. d. Direct Observation. Located at: http://www.idemployee.id.tue.nl/g.w.m.rauterberg/lecturenotes/UFTdirectobservation.PDF [Retrieved 30 September 2007]


CHAPTER SIX

CONCLUDING DISCUSSION AND RECOMMENDATIONS

6.1 INTRODUCTION
This chapter should be viewed as the culmination of all research efforts, with the aim to present clear recommendations to achieve enhanced performance effectiveness of a PGMP as a social system. To ensure this, the researcher aims to present this chapter by

- giving attention to the training and skills development needs indicated by the practice support staff of private general medical practices that participated in the survey;
- suggesting recommendations to enhance performance effectiveness of the PGMP that served as a case study, derived from deductions after analysis of the findings; and,
- evaluating the outcome of this research by referring to each objective that guided her methodological approach, and to assess whether the purpose of this research was achieved.

6.2 COMPETENCIES AND SOFT SKILLS DEVELOPMENT
Two sets of recommendations are presented: those that relate to the guidelines for the design of programs and interventions, and those that relate to the content of such programs and interventions.
RECOMMENDATIONS

A1. With reference to the design of competence and skills development and training programs, as well as programs for specific intervention, the following should serve as guidelines.

i. Programs for the staff of small-sized private general medical practices should provide for multi-tasking skills [see deductions 1 and 2].

ii. The focus of programs for staff of medium-sized and large-sized practices should provide for insightful understanding of the importance of integration and cohesion to counteract a possible tendency by staff to be specialist functionaries, resulting in staff group performance characterised by a low degree of interdependence. Therefore, programs developed for such staff should provide insight into the importance of intra-group task collaboration and its consequences for group integration and cohesion [see deduction 3].

iii. Programs developed for practice support staff, irrespective of the size of the practice, and, the importance such staff place on work performance, should include a course on self-development [see deductions 4 and 5].

iv. Programs that focus on inter- and intra-relational development should emphasise the importance thereof within the external and internal social environment of the PGMP as a social system [see deductions 5 and 6].

v. The size of the PGMPs appears to influence the support staff’s perception of the nature and content of competence and skills training programs important to them. This should be taken into account when determining the training requirements [see deduction 1 – 3].

vi. Certain ‘generic programs’ may be developed irrespective of the size of the practice [e.g. self-development, and, the PGMP as a social system], while others should be developed to meet specific needs within practices of a specific size, and, with specific problems irrespective of the size of the practice [see deductions 1 – 5].
vii. All soft skills programs should make provision for the insightful understanding of the PGMP as a social system, thereby assuring that courses will emphasise competence development within the PGMP as a social system that is different in nature to other employer organisations [see deductions 1 – 6].

viii. Linked to the above, programs should also enable an understanding of the nature and characteristics of the patient base, as well as its impact on quality patient care and service, and on the challenges it has for human relations within the practice [see deductions 1 - 3].

ix. Programs should be developed bearing in mind the diverse nature of the targeted attendees, [e.g. previous training and duration thereof; the age of the trainee; the duration of employment within a PGMP] [see deduction 1 - 3].

x. Where programs are to be developed for the staff of specific PGMPs, this should be based on a thorough needs analysis to ensure that interventions will enhance performance effectiveness within the social system, and to assure both structural and processual equilibrium [see deductions relating to sociometric analysis and practice layout].

xi. Where a specific PGMP has clear intra-relational problems, interventions should provide for the attendance of all staff members. In addition, a competent Group Dynamics Practitioner, with training in a variety of group facilitation techniques [amongst others, sociodrama], will enable trainees through insight, role training, and catharsis to deal constructively with their problems [see deductions relating to sociometric analysis].
A2. Recommendations related to content of programs for competence and skills development and specific interventions, are the following:

i. It would appear, that because the support staff members of different practice-sizes vary in their choice of competencies or sets of competencies, skills development and training programs should be designed for a specific focus group [e.g. staff of small-sized practices], rather than for staff in general. Such training, while keeping in mind the nature of the practice and its characteristic inter- and intra-group relational structures and processes, should be developed to maintain a state of group equilibrium, while insight should be nurtured towards enhanced group/team performance effectiveness.

ii. The larger the practice, the greater the emphasis of skills development and training should be on enabling an understanding of intra-group relations and its effect on performance effectiveness. By so doing, this will serve to counteract individualism within large-sized practices and encourage an understanding of cohesion, integration, and team work. Staff members of small-sized practices will also be in a better position to understand and apply team work principles when attending skills development and training sessions that focus on team building and development.

iii. Medium-sized practice support staff members seem to have a greater need for intra-group dynamics than those of small-sized and large-sized practices [see Table 5.4], and therefore skills development and training should focus on how to enhance intra-group relations, allowing for individual staff member growth on the one hand, and depth of intra-group development on the other hand.
6.3 SOCIO-POLITICAL, LEGAL AND SOCIO-EMOTIONAL EXTERNAL ENVIRONMENT

For PGMPs, as social systems, to enhance and sustain performance effectiveness, consideration should be given to the impact that socio-political, legal and socio-economical changes from the external environment may have within the greater environment of the PGMP. The following changes in the external environment are likely to pose challenges for PGMPs.

6.3.1 Changes that cause expansion of practices [additional practitioners and/or longer consultation hours], and the necessity to upgrade technology to address the changing health needs of patients due to developments in the external socio-cultural environment. These developments will require appointment of suitably trained and qualified practice support staff or the training of existing staff [see deductions 9 and 11].

6.3.2 Offering different and additional options in health care and services due to a changing socio-cultural patient profile could also affect the personnel profile [see deductions 10, 12, 13, and 14].

6.3.3 Instituting measures [over and above competitive salaries] to prevent a high staff turnover in an increasingly competitive market characterised by a constant search for qualified and competent practice support staff [see deduction 11].

6.3.4 Training needs of existing and newly appointed practice support staff to deal effectively with the effects of change and its challenges, especially at the socio-emotional behavioural level [see deduction 12].

B. RECOMMENDATIONS

B1. While care should be taken to appoint suitably qualified and trained staff, emphasis should also be placed on the appointment of staff
members that are competent in dealing with change and its impact on the dynamics of self- and other relations.

**B2.** Existing practice staff members should be afforded opportunities to attend competence and skills training programs with specific focus on change management, dealing with change, understanding the impact of change on both the macro [i.e. the external practice environment and its consequences for the practice] and micro [i.e. inter- and intra-relational behaviours] levels.

**B3.** New staff should follow a structured induction programme to familiarise them amongst other things with: the mission, vision and core values of the practice; the external environment; the role and function of existing members; their task and role within the practice, as well as within the cluster to which they are assigned. They should also be given opportunities to develop both task and socio-emotional relations against the background of the phases of group or team development in a changing environment [Tuckman].

**B4.** Both existing and new staff, especially together with their cluster members, should receive the opportunity to participate in a program aimed at encouraging healthy task and socio-emotional relationships through the processes of accommodation and assimilation that will allow new members to become full members of their cluster and support staff group sub-system.

**B5.** Where the expansion of a PGMP is considered, attention should be given to the **assessment of the physical environment** of the practice to determine the following aspects.

i. Medical and non-medical staff member locations and their ease of access for both staff and patients.

ii. Placement of practice support staff members in locations that will sustain or enhance functional interaction [i.e. task and role-related activity and communication], and also prevent physical and sociometric
isolation of some persons, especially newly appointed support staff members.

iii. Intra-group interaction and its possible optimisation [whether the new member(s) will be able to interact freely with those individuals with whom they need to collaborate].

iv. Current administrative technology [such as computer and telephone networks], its applicability and adequacy for existing conditions and the accommodation for expected expansion in group numbers.

v. Clinical technology [such as ECG machines], its applicability and adequacy for the needs and special interests of existing and additional practitioners and patients. The training requirements and interventions for new and existing staff members should also be established to ensure proper utilisation of technological aids.

6.4 INTERNAL ENVIRONMENT OF THE PGMP AS A SOCIAL SYSTEM

6.4.1 PRACTICE SUPPORT STAFF SUB-SYSTEM

6.4.1.1 The practice support staff group consists of a diverse membership in terms of formal, non-formal and informal educational levels, age and duration of employment within the practice, which implies that skills development and training, and other forms of intervention should take this into account [see deduction 15].

C. RECOMMENDATIONS

C1. It is recommended that when designing a competence and skills training program for staff of a specific PGMP, or specific interventions to deal with specific problems, especially those with high emotional content, the demographic variables of the trainees should be taken into account. Not only are the practice support staff members of PGMPs
from a diverse background, they are also adults, and therefore, when training programs or interventions are to be developed, the following principles should be used as guidelines (Erasmus & Van Dyk, 2003: 128-13; Lieb\textsuperscript{83}, 1991; Vella, 1994: 6-28):

- **i.** Adults are independent and self-directed learners, and generally need to be free to direct themselves. Therefore, in the development of a training program, participants should be encouraged to take responsibility for their own learning, amongst other things by co-opting their participation in a training needs analysis, and to assist in the identification of course content and the planning of required outcomes.

- **ii.** Adults are goal-oriented, and therefore require clearly formulated learning objectives that give meaning to their training and will help them understand how the training will assist their growth.

- **iii.** Learning can be facilitated by utilising existing knowledge, skills, and life experience that participants bring with them. It shows relevance and practical application of principles and theories and gives recognition to experience already gained.

- **iv.** In order to enable participants to apply new knowledge immediately in their work environment, participative learning techniques, such as demonstration [e.g. videos, pictures] case studies, games, role-play and sociodrama, should be used.

- **v.** The facilitator should show understanding that some practice support staff members have families with the accompanying responsibilities and demands, and therefore any attempt to arrange training should be done with the least interference with these life spheres.

6.4.2 GENERAL MEDICAL PRACTITIONER SUB-SYSTEM

6.4.2.1 The PGMP support staff group’s purpose is to support general medical practitioners to provide a quality health service that ensures patient satisfaction. Through the wording of the employment contract, certain norms and values that reflect the sentiments expressed in the Hippocratic Oath will enable behaviours that will help to sustain a smooth functioning of the PGMP as a social system. This will enhance interdependence of collaboration between the sub-systems towards goal-attainment, while at the same time assuring that the needs of the patient will be met [see deductions 16 and 28].

D. RECOMMENDATIONS

D1. The GPs need to formulate and formally express the mission, vision, core values and goals of the PGMP. This, together with the guidelines contained within the employment contract and Hippocratic Oath, will form the basis from which the practice support staff group will be able to align their own values and goals with that of their employers.

D2. GPs should continue to attend formal staff meetings, as these occasions provide opportunities for expression, interaction and operationalisation of the functional prerequisites.

D3. GPs should also take the time to understand the nature and dynamics of the PGMP as a social system, including the relationship between their group as a sub-system and that of the practice support staff.

D4. Through guidance by a Group Dynamics Practitioner, GPs together with the members of the practice support staff group, should participate in an annual assessment workshop to provide an opportunity for strategic planning, assessment and enhanced collaboration towards goal-attainment.
6.5 PRACTICE LOCATION, PHYSICAL PRACTICE LAYOUT, STAFF PLACEMENT AND MOVEMENTS, AND TECHNOLOGY

6.5.1 To render a quality health service it is important for the practice support staff to have an understanding of the socio-cultural environment of their patient base, and more specifically, of the health and other sentiments that are held by a diverse patient base [see deduction 17].

6.5.2 Practice layout, staff placement, and accessibility of technological tools [such as telephone systems and computer networks] impact on the functioning of the PGMP as a social system, by inter alia

- facilitating work and role performance of all staff members [see deduction 18 and 34];
- contributing to the entrenchment of a hierarchical and relational structure that is a characteristic of the practice support staff sub-system [see deduction 19];
- facilitating interaction between some members of the practice support staff sub-system, but also hindering interaction between others, due to their physical placement within the practice, resulting in a tendency to isolate these members [see deductions 20, 21, 22, 23, 25, 33 and 34];
- facilitating inter- and intra-group task collaboration between the different sub-systems or clusters within the practice support staff sub-system, as well as between the GP sub-system and the support staff group sub-system [see deduction 25]; and,
- enabling practice support staff to work with the GPs in an intra-group collaborative situation within a high-tech environment that requires on-going skills training and development [see deduction 24].
E. RECOMMENDATIONS

E1. It is recommended that job-specific standards be created by stating the required *hard skills* for each job, and in the case of shortfalls, that these be addressed through the appropriate ‘technical’ skills training and development.

E2. Practice support staff group members should be afforded the opportunity to participate in a program that provides insight into:
   i. the importance of the individual’s performance in the processes of *integration, cohesion,* and *interdependence* within the social system;
   ii. self-development [see recommendation 6.2(iii)];
   iii. diversity in the workplace; and,
   iv. patient demographics and their health and service sentiments, and how support staff can deal with it.

E3. When designing the physical layout of a new practice, staff placement planning should consider staff movement and interaction patterns, as this will prevent both physical and sociometric isolation of certain staff members.

E4. Where staff members are already isolated, every attempt should be made to re-integrate the isolate into the group through a carefully designed intervention.

E5. It is also suggested that opportunities be created for support staff members to interact informally and on a regular basis. Arranging a lunch for practice staff at a convenient time may be beneficial, and, family outings may also enable greater integration between the members of staff.
6.6 HUMAN CAPITAL AND RESOURCES MANAGEMENT

Emphasis on human capital development, human resources management and their importance on performance effectiveness are apparent in the gist of the following deductions.

6.6.1 The standardised employment contract of the practice and individualised duty sheets serve to provide:

- clearly defined guidelines relating to expected work and role behaviours [see deduction 26]; and,
- a number of clearly defined norms and values that the employee agrees to when signing the employment contract [see deductions 16 and 28], although this does not necessarily imply that these norms and values are internalised by individual staff members [see deduction 29], or accepted as norms and values of the practice support staff sub-system.

6.6.2 The characteristic of interdependence of relations between the internal and external sub-systems [i.e. practice support staff and GPs] provides

- an important tension management function [compare Parsons] that may prevent non-conformity and conflict [see deduction 29];
- defined roles that are hierarchical in nature, resulting in an adaptive [compare Parsons] response to the demands of the external environment of the practice support staff sub-system [see deduction 30]; and,
- role development opportunities, formal and informal communication pattern networks, and sub-group formation or clusters that are mostly task-related [see deduction 32].

6.6.3 Long employment records of practice support staff [i.e. most members have been working together for five years or longer] [see deduction 31] may be explained in terms of satisfaction with their remuneration package, quality and comfort of the physical practice layout [see
finding 5.4.2.2 and deduction 18], clarity of work description [see deduction 26], opportunity for further training [see deduction 27], and positive sociometric relations [see deductions 45, 46, 47, 48 and 50] that foster integration, cohesion and interdependence.

6.6.4 While staff receive in-house training, and where required, further training at service provider locations, there is no induction for new members to assure their integration into the practice, which may result in isolation [inadequate socialisation] of a new member, with negative consequences for group integration and performance effectiveness [see deduction 27].

F. RECOMMENDATIONS
F1. Enable the group to generate their own mission, vision, norms and values.
F2. Newly appointed staff members should follow a structured induction program to
   • familiarise them with the mission, vision and core values of the practice;
   • familiarise them with the role and function of existing members, including expected role behaviours;
   • familiarise them with their own task and role, and expected work and role behaviours within the practice, as well as within the cluster to which they are assigned; and,
   • utilise opportunities to develop both task and socio-emotional relations against the background of the phases of group or team development [Tuckman] [see recommendation A3].
F3. During the design phase of the new surgery, consideration should be given to the placement of group members, not only to ensure effective work role performance, but also to maximise group member interaction [also see recommendation G2].
**F4.** Program material covering the group as a social system [see recommendation A1(iii)] should include information about the interdependence between the internal and external sub-systems and how these can assist the group with conflict management.

### 6.7 COMMUNICATION AND INTERACTIONS [BETWEEN PRACTICE SUPPORT STAFF MEMBERS]

A number of deductions are presented to depict the character of intra-personal and intra-group relations, and other forms of interaction that affect performance effectiveness within the practice support staff sub-system.

**6.7.1** There is a high frequency of interaction between most members of the practice support staff [see deduction 35].

**6.7.2** While the nature of their work and the requirement to complete their tasks create sub-group formations or clusters, this is also attained [i.e. cluster formation] through choice of preferred interaction based on proximity [of location] and similarity [of task-related activity] [see deduction 36].

**6.7.3** Intra-cluster interactions may either have a positive or negative effect on intra-group integration and inter-group interdependence, and may be the reason for the sociometric relational patterns that have emerged outside these clusters [see deduction 37].

**6.7.4** Formal meetings provide opportunity for enhanced intra-group and inter-group communication [i.e. between the two sub-systems and/or clusters], which in turn may serve to enhance integration, cohesion, and interdependence of role performance [see deduction 38].

### G. RECOMMENDATIONS

**G1.** Formal practice meetings should continue, as these provide an opportunity to enhance performance effectiveness through inter- and
intra-group interaction and communication, and the operationalisation of the functional prerequisites [Parsons] within the PGMP as a social system.

G2. Specifically, meetings create an opportunity for the members of the practice support staff to

- communicate, discuss, and decide on matters relating to behavioural issues, and where dissatisfaction exists, to deal with such matters collectively [i.e. pattern maintenance and tension management];
- set goals, to decide how and when these will be achieved, as well as to decide on measures and processes to be followed in the assessment thereof [i.e. goal-attainment];
- interact with newly appointed members, while at the same time enabling these new members to become acquainted with intra-group expectations [i.e. integration];
- interact with those members who are both physically and sociometrically isolated [i.e. integration];
- communicate, as members of a sub-system, with the members of other sub-systems [e.g. GPs] to identify their needs and expectations, and how to address these [i.e. adaptation];
- encourage a relationship of interdependence between the clusters existing within their sub-system to work collectively towards goal-attainment [i.e. a latent function of meetings]; and,
- deal with issues that encourage sustained group performance [i.e. manifest function of meetings], and also to deal with problems that are associated with group development [compare Tuckman] or to prevent this from occurring [i.e. latent function of meetings].

G3. Individual temperament style analysis and information on how the various temperament styles affect the way that people communicate/interact [included as part of self-development (see
recommendation A1(iii)) will facilitate an understanding of inter- and intra-group relations.

6.8 SOCIOMETRIC RELATIONS
This section provides deductions that relate to inter- en intra-sub-system member relations that should be taken into account when designing competence and skills training programs for this specific PGMP [i.e. target of this research], as well as when designing a specific intervention to enhance performance effectiveness. These are:

- 1\textsuperscript{st} and 2\textsuperscript{nd} sociometric task choice attractions
  6.8.1 Some members of the practice support group have a high task sociometric status [5.4.6.1.1 & 5.4.6.1.2], while others have a high socio-emotional sociometric status [see 5.4.6.3] \textbf{[see deduction 39]}.
  6.8.2 Status claiming behaviours may emerge where some of the practice support group members are emerging stars of task attraction [even unintentionally], and this may result in intra-personal conflict, especially between the emerging stars and those that are already functioning in leadership positions by nature of their job description \textbf{[see deduction 40]}.
  6.8.3 Owing to the number of chains of task attraction that exist within the practice support group, these may either lead to sub-group formation or may enhance group-supported work activity characterised by interactivity, interdependence and collaboration \textbf{[see deduction 41]}.
  6.8.4 Some members, more than others, are inclined to become isolated when task team collaboration is required, with consequences for socio-emotional sociometric isolation \textbf{[see deduction 42]}.
1st and 2nd task choice rejections

6.8.5 A job-specific appointment, physical placement of an appointee, and absence of an induction program tend to increase the level of exclusion of an appointee to the point of sociometric isolation during task performance, as the existing group members prefer to continue to work at tasks with those with whom they have already developed a work relationship [see deduction 43].

6.8.6 Where stars of rejection are developing, this would be an indication that the practice support staff may isolate these individuals with negative consequences for integration and group cohesion, as well as for interdependent role and sub-system functioning [see deduction 44].

1st and 2nd socio-emotional choice attractions

6.8.7 Where stars of socio-emotional attraction are developing, and all chains are linked to this individual, both the power base and influence of such an individual within the group will be enhanced, and may in some instances lead to sub-group formation that is strong enough to sway the direction of the sentiments of the practice support group in times of emerging conflict, or even contribute to groupthink in times of decision-making [see deduction 45].

6.8.8 Having an ‘expanded’ sociometric influence across clusters may strengthen integration within the practice support group sub-system in a work environment that is characterised by high task performance, and emphasises performance effectiveness and zero-defect [see deduction 46].

84 To maintain confidentiality, the names of the practice support staff members were replaced with numbers.
• 1st and 2nd socio-emotional choice rejections
6.8.9 Where a group member is isolated in both areas of a sociometric relationship [i.e. task and socio-emotional] this will have negative consequences for intra-group relations with a resultant negative impact on group integration and cohesion [see deduction 47].

• Sociometric patterns depicted against practice layout
6.8.10 A high frequency of interaction would likely lead to enhanced and sustained group integration and cohesion, as well as to encourage greater interdependence [see deduction 48].
6.8.11 In the light of cluster-formation where some members choose to relate to someone outside their cluster this may give reason to believe that, because of their external orientation, their clusters are weakly integrated [see deduction 49].
6.8.12 However, a weakened cluster-formation may serve the function of a ‘buffer’ to prevent total degeneration of integration and cohesion within the total social system [see Homans], and may even prevent isolation of certain members within the group as a sub-system [see Diagram 5.9] [see deduction 50].

H. RECOMMENDATIONS
To a large extent, the findings of the sociometric test served as confirmation of other observations and findings that were addressed in Chapter Five. The main conclusion from the above deductions is that, if the preceding recommendations are dealt with [see recommendations A to G], this will have a positive effect on sociometric relations between the members of the practice support staff group or sub-system. The researcher would nevertheless like to emphasise the following.
H1. Instituting an induction program as recommended [see recommendation F2] will assist new members with establishing initial relations with the members of the group, thereby aiding their socialisation and integration through the process of accommodation and assimilation.

H2. As pointed out in recommendation E3, attention should be paid to the floor plan and design of the envisaged new practice to eliminate barriers to interaction and communication. While it is understood that both S6 and S4 require work areas that are accessible to the patients, but that they also require security (S4) and privacy (S6), this need not exclude them unnecessarily from contact with the rest of the support staff group. Diagram 6.1 provides an example of how this can be achieved.

<table>
<thead>
<tr>
<th>Kitchen / Tearoom</th>
<th>W/C</th>
<th>Filing Room (S4)</th>
<th>Doctors’ rooms, Toilets, Procedure Room, ECG Room, Store</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensary (S2, S5, S9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors’ Clerk (S6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cashier (S3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reception (S1, S7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Manager (S8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting room</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diagram 6.1: Proposed new surgery outlay.**

In the proposed outlay, the debtors’ clerk and cashier offices are placed adjacent to each other with an inter-leading door [that provides access to the cashier’s office] that may remain open unless the
H3. Opportunities should be provided for the support staff group members to interact informally outside the boundaries of the practice, as such occasions will help to develop stronger socio-emotional relations, lessen the number of attraction chains by conversion into a group with greater levels of integration and cohesion [see recommendation E5].

6.9 CONCLUDING REMARKS

The recommendations do not spell out the exact content of competence and skills training and interventions, as this would necessitate further research and a needs analysis. However, each program and intervention should enable performance effectiveness of a specific PGMP as a social system.

Whether or not the research objectives were achieved [see Section 6.10], the researcher is of the opinion that the Construct that was developed [see Chapter Three] as a means to analyse the functioning of a specific PGMP does in fact enable the researcher to make a final deduction regarding performance effectiveness of the PGMP that was the unit of this study, as a social system.

If performance effectiveness of a PGMP is defined as the ability of its members to develop and sustain itself as a social group within an external environment in the most efficient manner as possible, the implication is that a PGMP as a social system needs to survive within a greater external environment through a relationship of interdependence, while also creating
and maintaining an interdependent internal and external sub-system environment [see construct depicted in Diagram 3.2], by

- effectively responding to the challenge of cause and effect created by the sentiments within the external environment in which it operates;

- defining clear norms that reflect the group’s sentiments, and that are aligned with those of the external environment;

- linking goals to the purpose of the group, and creating activities through which these goals are collectively identified, expressed and achieved, while also providing for sub-system goals as well as personal goal achievement;

- enabling the group members to feel integrated and experience that their contributions are valued, and, encouraging interaction between individual group members that is characterised by interdependent collaboration, even in the presence of sub-group or cluster formations or clusters that may develop within the group;

- enabling all members of the group to contribute to the design of assessment practices that will assure continuous collaboration, goal-attainment, integration and adaptation, through careful assessment of the purpose of the group, as well as of the interactions, activity and behaviours that are guided by sentiments and norms that ensure performance effectiveness.

Table 6.1 serves to summarise the status of performance effectiveness outcome of the PGMP that served as a unit of study.
Table 6.1: SUMMARY ASSESSMENT OF THE OUTCOMES OF PERFORMANCE EFFECTIVENESS OF THE PGMP CASE STUDY AND RECOMMENDATIONS

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>SOCIAL SYSTEM</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>effectively responding to the challenge of cause and effect created by the sentiments within the external environment in which it operates.</td>
<td>Meets the requirements</td>
<td>B1 and B2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B5(i) and (v)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D1 and D4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E1 and E2(e)</td>
</tr>
<tr>
<td>Defining clear norms that reflect the group’s sentiments, and that are aligned with those of the external environment.</td>
<td>Meets requirements, but there is no evidence of formal sub-system specific norms and values.</td>
<td>D1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F1, F2</td>
</tr>
<tr>
<td>Linking goals to the purpose of the group, and creating activities through which these goals are collectively identified, expressed and achieved, while also providing for sub-system goals as well as personal goal achievement.</td>
<td>Meets the requirements of the generic PGMP goal [quality service that satisfies patient needs], but there is no evidence of sub-system specific goals that can be linked to personal goals of individual members.</td>
<td>D1, D2, and D4</td>
</tr>
<tr>
<td>Enabling the group members to feel integrated and experience that their contributions are valued, and, encouraging interaction between individual group members that is characterised by interdependent collaboration, even in the presence of sub-group or cluster formations or clusters that may develop within the group.</td>
<td>Partially meets the requirements. Evidence points to problems in socialisation and group integration leading to sociometric isolation [task and socio-emotional] of certain members compounded by physical isolation.</td>
<td>B1, B3 B4 and B5(ii and iii)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E2(i, ii and iii), E3, E4 and E5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F1, F2, F3 and F4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G1, G2 and G3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>H1, H2 and H3</td>
</tr>
<tr>
<td>Enabling all members of the group to contribute to the design of assessment practices that will assure continuous collaboration, goal-attainment, integration and adaptation, through careful assessment of the purpose of the group, as well as of the interactions, activity and behaviours that are guided by sentiments and norms that ensure performance effectiveness.</td>
<td>Does not meet the requirements.</td>
<td>A1(i to xi)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A2(i to iii)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B2, B3, B4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C1(i-v) and D4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E1 and E2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F2 and F4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>H1</td>
</tr>
</tbody>
</table>
6.10 ASSESSMENT OF RESEARCH OBJECTIVES

TO PROVIDE AN UNDERSTANDING OF A PRIVATE GENERAL MEDICAL PRACTICE AS A SOCIAL SYSTEM

Chapter One provides an overview of the healthcare in South Africa and of the role of the PGMP therein. Providing examples of non-clinical related problems [Table 1.1], it also provides a cursory explanation of the internal and external environmental variables that create challenges for the PGMP as a social system. To set the foundation for the understanding and later, analysis of the PGMP as a social system, Chapter Three provides an exposition of various models that can be used in the analysis of social systems. This chapter concludes with a construct [see Diagram 3.2], developed from contributions of Parsons and Homans to enable an analysis of a PGMP as a social system. Chapter Four expands on this model, by describing specific variables that impact on the internal and external environments of the PGMP as a social system, and that are later detailed in Chapters Five and Six to provide findings, outcomes and recommendations.

It can be concluded that this objective was successfully achieved.

TO ANALYSE THE FUNCTIONING OF THE SUPPORT STAFF GROUP AS A SUB-SYSTEM WITHIN A PRIVATE GENERAL MEDICAL PRACTICE

Keeping in mind the contents of Chapters One, Three and Four, the researcher proceeded to collect data to

- establish the composition of staff and patient demographics of 17 of the 28 PGMPs [Table 2.1] that belong to the PEGP consortium [Table 5.1];
- test the perceptions of 61 support staff members of these PGMPs on their individual preferences for specific soft skills training and development, as
well as their perceptions of the degree of importance these soft skills have for performance effectiveness within and for a PGMP [Tables 5.2, 5.3 and 5.4].

In addition to this survey, a single PGMP was selected as a unit of analysis to serve as a case to study. By using a construct of analysis [see Chapter Three, Diagram 3.2], the researcher was able to describe and analyse the functioning of a PGMP, of which the outcome is presented in Chapter Five and Chapter Six.

While this research enabled a qualitative approach [see Chapter Two] to the understanding of the nature and functioning of a PGMP as a social system, it also enabled sub-system analysis [i.e. clusters and dyads] of the practice support staff as a sub-system within the PGMP environment. This enables a micro-sociological approach within the field of group dynamics [see Chapters Five and Six].

From the findings that were presented in Chapter Five, deductions were formulated, and used in Chapter Six to suggest recommendations.

**It can therefore be concluded that this research objective was successfully achieved.**

**TO SUGGEST RECOMMENDATIONS FOR ENHANCED AND ON-GOING PERFORMANCE EFFECTIVENESS OF A PRIVATE GENERAL MEDICAL PRACTICE AS A SOCIAL SYSTEM.**

Following the detailed analysis of the PGMP [Chapter Five], the researcher in Chapter Six outlined her recommendations. Further to this, the researcher was able to work in collaboration with architects to design a new practice for the PGMP that served as a unit of study and to design staff locations that
would enhance interaction and communication between all members of the medical and practice support staff, based on the findings and deductions of this research.

**In the opinion of the researcher, this research objective was also successfully achieved.**

**6.11 SUMMARY**

The researcher believes that, by analysing the PGMP as a social system [consisting of a number of sub-systems], a holistic understanding of the medical practice can be obtained with cognisance taken of both the internal and external variables that affect group functioning, as well as of the impact that the broader external environment has on the group.

While it is important for the Group Dynamics Practitioner to identify areas of group ineffectiveness and design interventions to counteract these occasions, it is equally important for the PGMP [support staff and general practitioners] to understand the concept of the practice as a social system and the role that each of them plays in the maintenance of the system. By creating this understanding and equipping the PGMP support staff members with the necessary soft skills, the group will be empowered to recognise potential issues and take corrective action, thereby ensuring their own group’s continued effectiveness in both their external and internal environments.
REFERENCES


BIBLIOGRAPHY


HPCSA. 2009. *Continuing Professional Development*. Located at:


Rauterberg, G. W. n. d. *Direct Observation*. Located at: http://www.idemployee.id.tue.nl/g.w.m.rauterberg/lecturenotes/UFTdirectobse rvation.PDF [Retrieved 30 September 2007].


ADDENDUM ONE: Demographic questionnaire

Please complete the questions below and return fax to:

**PLEASE NOTE:**
Should you choose not to participate in this research, please indicate this in the last question and kindly return uncompleted questionnaire by fax
CONFIDENTIALITY WILL BE MAINTAINED AT ALL TIMES

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Number of GP’s in practice</th>
<th>Suburb in which practice is located</th>
<th>Doctor Initials and Surname</th>
<th>PEGP Shareholder?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CLIENTELE MAINLY SERVED**
(approximate indications)

<table>
<thead>
<tr>
<th>Medical Aid(^{85}) (%)</th>
<th>Private(^{86}) (%)</th>
<th>Managed Care(^{87}) (%)</th>
<th>Package(^{88}) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td>86%</td>
<td>87%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Total number of staff employed by the practice:
Number of reception staff:
Number of admin staff:
Number of nursing staff:
Number of cleaning staff:

**ARE YOU WILLING TO ALLOW YOUR PRACTICE AND STAFF TO PARTICIPATE FURTHER IN THE RESEARCH PROJECT?**

YES | NO

\(^{85}\) Denotes patients on traditional “fee-for-service” medical aids.
\(^{86}\) Denotes patients who are not on medical aid.
\(^{87}\) Denotes patients on managed care options for whom the practice receives a monthly managed care fee.
\(^{88}\) Denotes “package deals” inclusive of consultation and treatment, as for indigent patients.
ADDENDUM TWO: Support Staff Questionnaire

24 March 2009

Dear Practice staff member

I am currently enrolled for a Masters degree in Sociology at the NMMU. I have chosen to research the private general medical practice with a view to enhance practice functioning. My promoter is Prof FJ Bezuidenhout and should you have any questions relating to my research, you may contact him on (041) 5042348.

Your doctors have indicated that they would like your practice to participate in the research. In order to define my area of research, it would be appreciated if you complete the questionnaire pertaining to your current duties. All information will be dealt with the strictest confidentiality.

Once completed, please fax the questionnaire to 086 672 5206 or call me on 083 327 9220 to collect.

I thank you for your assistance.

Regards,
Henriette Visser

<table>
<thead>
<tr>
<th>PRACTICE NAME:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PRACTICE TEL NO:</td>
<td></td>
</tr>
<tr>
<td>NAME AND SURNAME:</td>
<td></td>
</tr>
<tr>
<td>JOB TITLE:</td>
<td></td>
</tr>
</tbody>
</table>

**QUALIFICATIONS:**

| Highest School Grade passed. |
| Do you have any post-matric qualification? (Degree, diploma, certificate) | YES | NO |
| If yes, state qualification/s. |  |


<table>
<thead>
<tr>
<th><strong>What are you current duties?</strong> Tick where appropriate.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RECEPTION</strong></td>
</tr>
<tr>
<td>Answering telephone</td>
</tr>
<tr>
<td>Schedule appointments with doctors</td>
</tr>
<tr>
<td>Filing of specialist reports</td>
</tr>
<tr>
<td>Drawing of patient files</td>
</tr>
<tr>
<td>Capturing and Maintenance of patient records</td>
</tr>
<tr>
<td>Appointments with specialists</td>
</tr>
<tr>
<td>Receiving and receipting of payments (in receipt book)</td>
</tr>
<tr>
<td><strong>NURSING</strong></td>
</tr>
<tr>
<td>Emergency trolley</td>
</tr>
<tr>
<td>ECG</td>
</tr>
<tr>
<td>Lung function tests</td>
</tr>
<tr>
<td>Obtaining and management of samples for pathology</td>
</tr>
<tr>
<td>Assist with minor surgical procedures</td>
</tr>
<tr>
<td>Sterilisation and theater / procedure room maintenance</td>
</tr>
<tr>
<td>Completion of insurance and other medical forms</td>
</tr>
<tr>
<td>IOD Management</td>
</tr>
<tr>
<td><strong>DISPENSING</strong></td>
</tr>
<tr>
<td>Dispensing of medicines</td>
</tr>
<tr>
<td>Compounding medicines</td>
</tr>
<tr>
<td>Ordering new stock</td>
</tr>
<tr>
<td>Receiving new stock</td>
</tr>
<tr>
<td>Capturing Stock</td>
</tr>
<tr>
<td>Stock control(expired stock etc)</td>
</tr>
<tr>
<td><strong>ADMINISTRATIVE</strong></td>
</tr>
<tr>
<td>Bookkeeping</td>
</tr>
<tr>
<td>Daily, Weekly and Monthly Reports</td>
</tr>
<tr>
<td>Account printing and postage</td>
</tr>
<tr>
<td>Creditors</td>
</tr>
<tr>
<td>Debt collection (90days +)</td>
</tr>
<tr>
<td>Account follow-up Private patients 30 days+</td>
</tr>
<tr>
<td>Account follow-up Medical Aids 60 days+</td>
</tr>
<tr>
<td>Receiving (computer)</td>
</tr>
<tr>
<td>Electronic claims management</td>
</tr>
<tr>
<td>Receiving of money and receipting (receipt book)</td>
</tr>
<tr>
<td>Petty Cash</td>
</tr>
<tr>
<td>Account queries (patients)</td>
</tr>
<tr>
<td>Account queries (medical aids)</td>
</tr>
<tr>
<td>Salaries</td>
</tr>
<tr>
<td>VAT</td>
</tr>
<tr>
<td>SDL</td>
</tr>
<tr>
<td>LBS</td>
</tr>
<tr>
<td>UIF</td>
</tr>
<tr>
<td>Regional District Council Levies</td>
</tr>
<tr>
<td>Agendas and minutes for meetings</td>
</tr>
<tr>
<td>Report/Letter writing</td>
</tr>
<tr>
<td>Quotations</td>
</tr>
<tr>
<td>Management of capital equipment</td>
</tr>
<tr>
<td>Banking</td>
</tr>
<tr>
<td>Bank reconciliation</td>
</tr>
<tr>
<td>Ordering of stationery</td>
</tr>
<tr>
<td><strong>MAINTENANCE</strong></td>
</tr>
<tr>
<td>Cleaning</td>
</tr>
<tr>
<td>Refreshments</td>
</tr>
<tr>
<td><strong>OTHER DUTIES (PLEASE SPECIFY)</strong></td>
</tr>
<tr>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td>__________________________________________________________________________</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Did you receive any specific training to prepare you for your current duties?</strong></td>
</tr>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>
How did the training take place? (Tick as many as are appropriate)

<table>
<thead>
<tr>
<th>Informal in-house training</th>
<th>Formal in-house training program (including written protocols / manuals)</th>
<th>Shadowing (where you follow a co-worker during the course of their duties)</th>
<th>Half-day or full-day courses, e.g. EDI, reception, management</th>
<th>Certificated courses from accredited providers (e.g. Pastel Accounting, computer courses)</th>
</tr>
</thead>
</table>

OTHER (PLEASE SPECIFY)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

What training would you like to receive to improve your performance in the execution of your current duties?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Below is a list of skills. Please indicate, by ticking the appropriate box, how important possession of these skills are in the execution of your current duties.

<table>
<thead>
<tr>
<th>Communication skills</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Conflict management skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Time management skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Leadership skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Stress management skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Good interpersonal relationships</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Strong self-awareness (knowing what you are feeling and why you are feeling it)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Self-control</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The ability to work effectively and cooperatively in a team</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Assertiveness (the ability to insist on your rights and opinions in a positive way, without creating unnecessary conflict)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please list any other:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Would you be willing to participate further in the research?  YES  NO
ADDENDUM THREE: SOCIOMETRIC QUESTIONNAIRE

Dear Staff Member,

Thank you for your willingness to assist with my research towards a Masters Degree in Sociology. It is much appreciated.

As explained previously, my research centres around the personnel of the Private General Medical Practice (PGMP). I believe that the results will enable a group dynamics practitioner to assist the staff of the PGMP to become more effective as a group and also derive more satisfaction from their jobs.

Attached is a short questionnaire that I would like you to complete. As the information I am requesting is potentially sensitive, I want to take this opportunity to point out the following:

1. Even though I have permission from the doctors to conduct research in the practice, you, as an individual, have the right to decide whether you want to participate or not.
2. The information provided by you will be handled with total confidentiality and is purely for research purposes. It will not be revealed to anyone who is currently part of the practice, nor will it be utilised for group intervention activities.
3. The information will be processed and presented in such a way that individuals will not be identifiable.

If you have any questions or concerns, please do not hesitate to ask either myself, or my supervisor, Prof Frans Bezuidenhout (Telephone number: 041 5044083).

Once again, thank you for your time.

Regards,
Henriette Visser
NAME: ______________________________________________________________________

1. Whom of your support staff colleagues would you choose to work with on an important project? Write down the names of your first and second choices in the spaces provided.

First Choice ______________________________________________________________________

Second Choice ______________________________________________________________________

2. Whom of your support staff colleagues would you not choose to work with on an important project? Write down the names of your first and second choices in the spaces provided.

First Choice ______________________________________________________________________

Second Choice ______________________________________________________________________

3. Whom of your support staff colleagues would you choose to discuss a personal issue with? Write down the names of your first and second choices in the spaces provided.

First Choice ______________________________________________________________________

Second Choice ______________________________________________________________________

4. Whom of your support staff colleagues would you not choose to discuss a personal issue with? Write down the names of your first and second choices in the spaces provided.

First Choice ______________________________________________________________________

Second Choice ______________________________________________________________________

THANK YOU FOR YOUR PARTICIPATION
ADDENDUM FOUR – LETTER OF APPROVAL FROM NMMU ETHICS COMMITTEE

Ref: H/08/ART/SA/006
10 November 2008

Mrs H Visser
PO Box 13184
Humewood
PORT ELIZABETH
6013

Dear Mrs Visser

“AN EXPLORATION OF THE NATURE OF A PRIVATE GENERAL MEDICAL PRACTICE AS A SOCIAL SYSTEM”

Your above-entitled application for ethics clearance served at the RTI Higher Degrees sub-committee of the Faculty of Arts Research, Technology and Innovation Committee.

We take pleasure in informing you that the application was approved by the Committee.

The Ethics clearance reference number is H/08/ART/SA/006, and is valid for three years, from 5 November 2008 – 5 November 2011. Please inform the RTI-HDC, via your promoter, if any changes (particularly in the methodology) occur during this time. An annual affirmation to the effect that the protocols in use are still those for which approval was granted, will be required from you. You will be reminded timeously of this responsibility.

We wish you well with the project.

Yours sincerely

J/nxati

Ms Jannet Nxati
FACULTY OFFICER

cc: Promoter/Supervisor
HoD
School Representative: Faculty RTI

Student number: 185016340
ADDENDUM FIVE – LETTER OF CONSENT FROM PGMP USED AS CASE STUDY

20 October 2007

To Whom It May Concern:

FIELD RESEARCH: MS HENRIETTE VISSE (NMMU STUDENT NUMBER 185016340)

I hereby confirm that the above was granted permission, at a formal practice meeting, to conduct a survey of the medical practice at Bay Medical Centre for the purpose of her Masters Dissertation.

The survey is to take place at the practice’s premises situated at 6, Ninth Avenue, Summerstrand, Port Elizabeth.

Yours faithfully,

[Signature]
ADDENDUM SIX – MATRIX FOR DIRECT OBSERVATION OF INSTANCES OF INTERPERSONAL INTERACTION

DATE: ____________________
TIME: ____________________ TO ____________________

<table>
<thead>
<tr>
<th>SUBJECT NAME</th>
<th>S1</th>
<th>S2</th>
<th>S3</th>
<th>S4</th>
<th>S5</th>
<th>S6</th>
<th>S7</th>
<th>S8</th>
<th>S9</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>