THE IMPORTANCE OF MANAGERIAL SKILLS FOR MEDICAL DOCTORS

By

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Submitted in fulfillment of the requirements for the degree of Magister in Business Administration at Nelson Mandela Metropolitan University

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30 NOVEMBER 2008
DECLARATION

I, the undersigned, hereby declare that the research contained in this document is a result of my own original and independent work and investigation, except where otherwise stated. All sources are acknowledged and referenced.

This dissertation is submitted to the Nelson Mandela Metropolitan University in fulfillment of the requirements for the degree of Masters in Business Administration.

This work has not been previously accepted in substance or otherwise, for any degree and is not being concurrently submitted in candidature for any other degree.

_______________________________________
Tandiswa Ngxukumeshe
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ABSTRACT

The role played by medical doctors and the employment positions they hold in South Africa and in the world today has shifted from being clinical only to include management. They were once only responsible for patient care, now are responsible for their organization's management. Physician managers have difficult tasks for which medical school provides no preparation.

Doctors in an assortment of roles take on management responsibilities to varying degrees: these may be a single-handed private practitioner or lead a small clinical team; or a clinical or medical director or a chief executive; or hold senior management positions in National or Regional Legislature. Some are also managing and supervising colleagues in public or private hospitals and are responsible for managing budgets, allocation of resources; developing policies and making other management decisions. These roles require knowledge and competence of managerial skills in order to facilitate and lead in an effective and efficient manner.

This study revealed that medical doctors, as business owners, in Mercantile Hospital are running their businesses, the medical private practices, without any managerial skills’ training. There was a general consensus that there is a need for managerial skills in any business and the respondents confirmed that managerial skills are important and necessary for the successful achievement of goals in a medical private practice.
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CHAPTER ONE

INTRODUCTION AND OVERVIEW

1.1 Introduction

A medical private practice is regarded as a small business. Medical doctors are involved in management of some kind, yet medical schools do not provide any formal managerial skills’ training that prepares them to be good managers. Those who open their private practice use their instinctual business sense to run their practices whilst some enrol with management training institutions to acquire knowledge and competency in these management skills. Doctors’ management roles often involve responsibility for teams, people and the resources they use.

Medical schools both in South Africa and internationally do not offer any managerial skills’ training in their undergraduate medical curriculum; yet most doctors open private practices immediately after their studies and some are in management positions both in the private and public sector.

One would argue that doctors should employ consultants who will manage their medical private practice and should not involve themselves in the business aspects of the practice and should concentrate on patient care. It is generally believed that all staff members have one thing in common that they do not share with the owner of the business (the doctor), that is, they are all employees and the doctor is the owner/employer and the boss of the medical private practice business. As an entrepreneur, the doctor needs to know everything about his/her business, day-to-day operations; financial standing of the business, labour-related issues and laws governing the practice. Accountants and administrative consultants are specialties in their field, they can give advice and suggestions, but the owner of the medical practice is the ultimate person who will make all decisions that have to do with the business.
Without the necessary skills, knowledge and understanding of business management and other managerial competencies that are needed to run a business, the business will not succeed and resources will not be allocated correctly.

In order for the practitioner to be successful in managing the practice, he/she needs to be competent in the following managerial skills: financial management, human resources management, operations management, marketing management, purchasing management and public relations management.

This study will explore the use, importance and relevance of these managerial skills in the management of a medical private practice.

1.2 Research problem question and sub-problems

1.2.1 Research problem question

“What should be put in place to provide doctors with managerial skills to successfully manage their medical private practices in the Port Elizabeth region?”

1.2.2 Sub-problems

• What skills do they need to have to manage their medical private practice?

• What discrepancies are there in the medical profession with regard to managerial skills?

• How are they managing their medical private practices at the moment?

• How important and relevant are these skills in managing a medical private practice?
• How can this be addressed?

1.3 Purpose of the research study

The purposes of the study are as follows:

a. Identify managerial skills that are relevant in the medical profession;

b. Identify discrepancies that are in the medical profession with regard to managerial skills; and

c. Identify importance and relevance of managerial skills in managing private practice.

1.4 Value of the research study

The study will be valuable and beneficial to all doctors and especially those who are planning to start a business by opening their medical private practices, to understand the need to acquire all the necessary skills that will enable them to be effective managers and to run their businesses effectively and efficiently. This study is also aimed at training organizations and medical schools. It is envisaged that these training institutions will develop management training programmes that will be relevant to the medical profession and that will give the practitioners an opportunity to use these skills in their daily activities in the practice. It is also hoped that this study will stimulate further investigation in this field.

1.5 Delimitation of the research study

The study is limited only to managerial skills that are needed by doctors to be effective managers, specifically those that are relevant in managing a medical private practice, in Mercantile Hospital. The study will not cover technological skills that pertain the claiming process from the third party using medical Electronic Data Interchange (EDI) programmes like for example, Healthbridge.

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1.6 Assumptions

There are a lot of reasons why doctors close their practices. It is generally believed that most doctors who have been unsuccessful in managing their medical private practices lacked business management training and knowledge. Some are believed to have overspent due to lack of budgetary skills and experience, while some were struck off the roll because of unethical behaviour. In some cases doctors fail because they have not marketed their practices enough or lack interpersonal and communication skills or the location of the practice was not accessible to the customers.

1.7 Objectives of the research study

The objectives of the research study are as follows:

a. Recommend to medical schools the inclusion of managerial skills’ training in the undergraduate medical curriculum;

b. Recommend to training institutions to develop managerial training programmes for medical doctors; and

c. Develop doctor awareness for the need to be trained in managerial skills.

1.8 Research design and methodology

The research design is the master plan for the study and addresses the type of research needed to investigate the problem question and it determines the need for the use of primary or secondary data with the aim of ensuring that the end results of the research study are valid and reliable. The method involves the population and sample chosen for investigation and methods of data collection.
1.8.1 Research design

The researcher will use a qualitative methodology that is exploratory, descriptive and analytic in nature. Collis, J and Hussey, R. (2003:13) state that qualitative research is subjective in nature and examines and reflects on perception in order to gain understanding of social and human activities. Qualitative research is a suitable method to explore and describe the skills required for the successful management of a medical private practice business and how lack of these skills affects practice management.

The researcher will make use of both primary and secondary data. Though primary data is time-intensive and expensive, it has some advantages which include the fact that the data fits the specific needs of the researcher and has known data collection procedures and ensures privacy. The primary data will be generated to address and identify the managerial skills that are relevant to the medical profession through the use of questionnaires. The secondary data, which has advantages of being inexpensive, can be collected quickly and provide multiple perspectives, will be used to explore international perspectives of the subject. The secondary data will be collected through the use of literature.

1.8.2 Research methodology and analysis

Questionnaires, which provide the contextual framework for data collection that will be approximately five pages, will be used. Though this method has some disadvantages like for example, the questionnaire can be completed by someone else other than the intended person; it also has some advantages like for example it is less costly. This method of data collection is chosen due to the fact that doctors in private practice are generally busy and time is a scarce resource.

The questionnaires will be sent to all practitioners currently in practice in Mercantile Hospital. The questionnaires will be hand delivered and collected on a day agreed upon with the practitioner. The questionnaires will be numbered.

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and a data checklist will be used to track the collection of data from respondents and for follow-up purposes.

All doctors will be assured of confidentiality of information that they will give and anonymity of their names and occupations will be held in strictest confidence. However, those who wish to be named or would like to know the findings of the study will have to append their names, addresses and occupations in the questionnaire.

The questionnaire will have closed and open-ended questions so that physicians can give some explanations and expand on their feelings and views or opinions. A ranking method by degree of importance will also be used. It will focus on the managerial skills that doctors believe will be valuable and beneficial for the successful management of private practice and those skills that they wish they were trained on or had knowledge of or would like to have before opening their private practices.

The collected data will be analyzed by using statistical analysis to determine the average responses and responses that deviate from the average and grounded theory to develop an inductively derived theory about the subject.

1.9 Definitions of concepts

In the study, the words medical doctor, doctor, general practitioner or physician will be used interchangeably. Terms such as the practice, medical private practice or medical practice will also be used interchangeably.

1.9.1 Medical doctor/doctor/medical practitioner/physician

A medical practitioner, medical doctor, doctor, physician is a doctor who provides primary care. The doctor becomes a general practitioner after completing basic medical school curriculum and the two-year internship programme.
1.9.2 Medical specialist

Wikipedia.org describes a medical specialist as someone who specializes in a particular field of medicine. Medical specialists go through additional training, above and beyond medical school and internship in order to become very knowledgeable about a specific part of the human body or a specific type of disease. They have at least two to three years of extra training, above and beyond the basic medical school curriculum, in their specific field, and they will continually research progress in their field. In the medical profession they often function as consultants, either for private practice or employed by a hospital.

1.9.3 Intern/internship

Wikipedia.org defines a medical intern as a physician in training that has completed medical school, and is undergoing his/her first year of post-graduate training. An intern has an undergraduate medical degree, but does not have a full license to practice medicine unsupervised. The medical intern has to complete the two years of internship as an intern before he/she is regarded as a general practitioner.

1.9.4 Primary care

In medicine, primary care is a term used for a health care provider who acts as a first point of consultation for all patients. Generally, primary care physicians are based in the community (Wikipedia.org).

1.9.5 The practice/private practice/medical private practice/medical practice

This means a process of making a profit by owning a business in health care management. This may be a solo, partnership or group ownership of the business. In this study, these terms will be used interchangeably.
1.10 Outline of chapters

- Chapter 1: Introduction and overview
- Chapter 2: Medical profession in South Africa
- Chapter 3: Management of a business
- Chapter 4: Management of a medical private practice
- Chapter 5: Research methodology
- Chapter 6: Presentation, analysis and interpretation of data
- Chapter 7: Conclusion and recommendations

1.11 Conclusion

The emphasis put on this study is the need to ensure that doctors are familiar not only with the concepts of demographic, social, political and economic factors which influence clinical choices, but also with management skills which enable them to measure their effectiveness and efficiency as the ability to undertake vital operational and informed decisions in every business area of the practice, economic appraisal, budgeting, statistical and computing skills. Even if the doctor decides to hire an office manager or utilize the services of a medical business consultant, the doctor is the sole determinant, in the end, of the practice’s success.
CHAPTER TWO

MEDICAL PROFESSION IN SOUTH AFRICA

2.1 Introduction

An article on How to Become a Doctor by the British Medical Association (BMA) (2007) found on www.medical-colleges.net/doctor.htm and accessed on 09 March 2008, states that a medical career offers doctors an opportunity to serve their communities and the public at large, by diagnosing and treating illnesses, infections and diseases; and providing social support to their patients. The article (2007) further states that medicine is a rewarding yet challenging career as being a doctor involves a life-long learning, both formally and informally because of new developments in therapies that arise from increasing research activities.

According to Health Professions Council of South Africa (HPCSA) found on http://www.hpcsa.co.za/hpcsa/default.aspx and accessed on 10 March 2008, there are currently 8 medical schools in South Africa that train doctors which are in practice today, i.e. in private practice and in public health facilities. These schools are located in 5 of the 9 provinces in South Africa. They have a 5 year programme that equips doctors with all the necessary health skills to better serve the public. The British Medical Association (2007) lists in the article 'how to become a doctor', a number of skills that are considered the 'core values' of doctors and include, among others, confidentiality, compassion, integrity, caring, competence, advocacy, commitment, etc. After completion of this programme, they qualify as doctors and obtain a degree in medicine, otherwise known as MBCHB and are mandated to do community service for 2 years. The main objective of community service is to improve access to quality health care to all South Africans, more especially in previously under-served areas. This process provides these young professionals with an opportunity to develop skills, acquire
knowledge, behaviour patterns and critical thinking that will help them in their professional development.

On qualification, these medical practitioners have to register with the South African Medical and Dental Council (SAMDC) now renamed the Health Professions Council of South Africa (HPCSA). According to the HPCSA web site (2008) HPCSA is a statutory body, established in terms of the Health Professions Act no. 56 of 1974, a separate legal entity with a mandate to protect the public, all consumers of health care services, and to provide guidance on educational, professional and ethical issues to all practitioners. Membership is compulsory. According to HPCSA (2008) statistics, in 2007, there were 34 324 medical practitioners who were registered with HPCSA and the majority of these practitioners were in the Gauteng province. This number entailed 28 965 South Africans and 5 359 foreigners. Doctors who are registered with the HPCSA are either in private practice or are state employed.

Van Rensburg, HCJ, Fourie, A. and Pretorius, E. (1992:252) in explaining some of the functions of the HPCSA (SAMDC) states that the council has to protect the public from unreasonable and unethical medical conduct, disciplining and introducing disciplinary measures in cases where professional codes of conduct were breached. Hence doctors who are not registered with the council are not recognized as doctors and are not allowed to practice in South Africa. There are however, doctors who are registered with the Council but are practicing outside of the country.

There is another body that is non-statutory, the South African Medical Council (SAMA). This is according to their web site found on [http://www.samedical.org/page.asp?pageid=7](http://www.samedical.org/page.asp?pageid=7) and accessed on 10 March 2008]. The site further states that SAMA is registered as an independent, non-profit Section 21 company SAMA that acts as a trade union for its public sector members and as a champion for doctors and patients. Membership is voluntary.
According to the SAMA, as of January 2008, there were 31 731 qualified doctors in South Africa. Doctors that were doing their internship in state institutions amount to 2 879 and registrars were 1 706. There were 4 731 specialist doctors in private practice and 3 688 were state employed; and general practitioners that were in private practice amount to 9 008 and 9 719 were state employed. There was a total of 13 739 doctors that were in private practice.

2.2 Health care system in South Africa

Health care system in South Africa consists of both the public and the private sector. The public sector provides service to 80 percent of the population while the remaining 20 percent, which consists of middle to high-income earners, is catered for by private sector (Still, L. 2007:24). The state offers service through public hospitals and offers free of charge basic primary health care while the private sector offers specialised health services to a selected few who are members of medical schemes or who can afford it.

According to Still, L (2007:24) the National Treasury allocates an annual budget to the Department of Health from the finances raised through taxes and licenses and this money is used to fund the public sector facilities. These facilities are free to the unemployed and are paid for on a sliding scale according to income by other users.

Van Rensburg, HCJ, et al. (1992:332) in citing Coe, R.M., (1978:413) lists five requirements for a [health] care system, namely availability, accessibility, affordability, acceptability and accountability. The health care system in South Africa will have to improve dramatically to fulfill all the above requirements. Currently affordability and accessibility are a challenge.

The South African health care system is facing some challenges, amongst others, the shortage of personnel in public health facilities, especially in rural
areas. Spencer, I.W.F., (1980:10) explains that the reasons why doctors prefer to work in towns and cities than in rural areas is because cities and towns have better conditions to work under, better education for their children, better chances of professional advancement and contact, access to specialist and diagnostic facilities, social amenities and economic reasons.

An article found on http://www.aidschannel.org/article/view/84961/1 on Brain Drain and accessed on 13 March 2008 states that the chance to live in an economically and politically stable environment with a wider array of career opportunities and lower crime rates continues to lure professionals away from Africa. This should give international countries an opportunity to address their own personnel shortages by recruiting health professionals from the African continent. Though in South Africa there is a shortage of health professionals in rural areas, when the health professionals emigrate, they work in rural communities because they are offered better benefits like financial incentives, free stay at up-market resorts and flights for themselves and their families (http://www.aidschannel.org/article/view/84961/1 on Brain Drain and accessed on 13 March 2008).

South Africans who receive health care through the public health care system are constantly faced with this situation and have to cope with understaffing of public health facilities, which in some cases, result in death of patients. For the health care system to be effective, an adequate number of health professionals must serve the population (Spencer, I.W.F., 1980:10).

Some of the reasons for the staffing shortage include the migration of doctors and nurses to international institutions and the flat budget of the public health system (Spencer, I.W.F., 1980:10). Employment of foreign doctors and a year of compulsory community service in understaffed and underserved hospitals and clinics by newly qualified South African doctors and pharmacists are the only initiatives that are employed to combat the situation. An article on South African
Health Care by Greg Connolly (2002) in citing Dr David McCoy’s (2002) comments he said that both initiatives have been partially successful, but are insufficient to address the “brain drain” and the inadequate levels of staffing in the rural areas.

Another problem that the South African health care system is faced with is the cost escalation in the private health care services. In a speech by the Minister of Health, Ms Manto Shabalala-Msimang, found on the Department of Health media room site, the Minister in addressing the Parliament on Private Health Sector costs on 12 March 2008, stated that the per capita expenditure in the private health sector is about 8 times more than that in the public health sector. In other words, the public health sector spends about R1000 per patient per year whilst the private sector spends about R8000. The private sector spends an estimated 5.5 percent of gross domestic product. This situation does not reflect a spirit of working towards a national health system that provides reasonable and affordable access to all South Africans.

Public hospitals in South Africa are under-resourced and over-used as 80 percent of South Africans depend on public health service (Greg Connolly (2002)). This results in some people preferring to consult traditional healers instead of physicians as they will be in queues in public hospitals for days before they are seen by a health care provider and as they cannot afford private health service. There is evidence to show that early care reduces mortality and morbidity and offers the patient the best chance of survival and improved quality of life.

On the web site of the Department of Health media room found on (http://www.doh.gov.za/docs/pr-f.html) and accessed on 12 March 2008, Minister Manto Tshabalala-Msimang at the Presidential Task Team on African Traditional Medicine Policy Indaba on 23 February 2008 says that African Traditional Medicine (ATM) and the practice of consulting with traditional healers continue to
form a critical component of health care for millions of our people. She says one of the critical terms of reference for the Task Team she was addressing is to make recommendations with regard to a national policy and legal framework for the institutionalization of ATM in the country’s health care system. This was done by the Ministry of Health in an effort to protect practitioners and also the need to protect the public against those who make false claims that they are traditional health practitioners.

Private sector will continue to grow and due to inequalities in the public health service, they will have to ensure that affordable, high quality and accessible service that is perceived by the consumer as value for money, is provided.

2.3 International health care systems

2.3.1 United States health care system

Still, L. (2007:21) reports that US does not guarantee universal health coverage. The citizens receive care under private and public arrangements. There are two main government-operated health care systems and are Medicare, which provides for the elderly and disabled Americans and Medicaid, which pays doctor and hospital bills for people who qualify for public income assistance.

Most Americans receive health insurance through their employers or purchased individually. The federal law mandates public access to emergency services regardless of ability to pay.

2.3.2 United Kingdom health care system

An article date and source on the Health care in the United Kingdom (UK) found on the National Coalition on Health Care web site states that health care in UK is coordinated by the National Health Service, which was set up in 1948 “to provide health care for all citizens, based on need, not the ability to pay. They provide
free physician and hospital services to all permanent residents of the United Kingdom.

Still, L. (2007:22) states that the UK health care system is funded by general taxes. She reported that NHS pays the salaries of general practitioners and specialists in addition to providing community support services, nurses, emergency and certain types of home care. Hospital staff are salaried employees according to nationally agreed contracts, whilst primary care is largely provided by independent practices, which are paid, again via a nationally agreed contract, according to the number of patients registered with them and the range of additional services offered. Around 86 percent of prescriptions are provided free. Prescriptions are provided free to people who satisfy certain criteria such as low income or permanent disabilities. People that pay for prescriptions do not pay the full cost.

2.3.3 Canada health care system

Still, L., (2007:23) stated that Canadians, like Brittons, have a national medical care programme (Medicare) that provides free medical care to all citizens through the joint efforts of the federal and provincial governments. About 30 percent of Canadians' health care is paid for through the private sector and this goes towards services are partially covered or not covered by Medicare, like prescription drugs, dentistry and optometry. Some 65 percent of Canadians have some form of supplementary private health insurance which they mainly receive through their employers. An estimated 75 percent of Canadian health care services are delivered privately, but funded publicly.

The challenges faced by South African health care system are not unique to South Africa; they exist all over the world but in different stages. The country does not have a good health care system as in UK, but it is working towards ensuring that health care is accessible, affordable and available to all citizens of the country.
2.4 Role played by medical practitioners in the South African health care system (not only as doctors but also as managers)

An article on How to Become a Doctor by the British Medical Association (BMA) (2007) found on www.medical-colleges.net/doctor.htm and accessed on 09 March 2008, states that medical practitioners are an integral part of the health care system’s infrastructure and a key component to stopping the spread of diseases by providing both treatment and preventive measures.

Medical practitioners have a responsibility to patients, other health workers and to the community at large. Miller (1992) cited in Shortell, S.M. and Kaluzny, A.D. (2000:53) states that managers should be responsible not only for the productive performance of the organisation but also consider the additional dimension of being a citizen of the community. They said this suggests that organizations will need to refocus attention on the health of the community served, not merely on delivery of medical care. Medical practitioners play an important role in the management and effectiveness of the health care delivery of the country. They are the leaders in provided quality health care at affordable prices.

In the public sector, medical practitioners may assume the role of a department head, the superintendent, unit supervisors, Director General in the national legislature, national ministry, MECs, etc. These roles mean that they have to be managers, over and above their own professions. In other words they have to assume a new career in management.

Liebler, J.G. and McConnell, C.R. (1999:38) state that the role of manager begins to emerge as budget projections need to be made, job descriptions need to be updated and refined and staffing pattern needs to be reassessed and expanded. They said that the role of practitioners as a manager is reinforced further by the various legal, regulatory, and accrediting agencies that require chiefs of service or department heads to be qualified practitioners in their distinct disciplines.
As a manager, the professional health care practitioner has to do all the management functions of planning, organizing, coordinating, directing and controlling. Moreover, he is also responsible for staffing, decision-making, communicating, delegating, budgeting, policy making, motivating, managing conflict, and above all, leading. Timmons, J.A. and Spinelli, S. (2007:80) in quoting Ewin M. Kauffman’s powerful insight say; “People don’t want to be managed. They want to be led!”

Shortell, S.M. and Kaluzny, A.D. (2000:53) stated that health care managers will also be called upon to focus on the community and national agenda, playing a key role in developing innovative, long-term solutions for providing affordable health care to the public they serve.

In the private sector, medical practitioners develop their own private medical practices and assume a role of a manager for their business enterprises. They are managers who are not only concerned with management functions, but have to conduct business, like all entrepreneurs, in an ethical manner and within the legal and political requirements of the country. They do business in a competitive environment. Quality service, good communication skills, interpersonal skills, integrity, good doctor-patient relationship, are some of the most important sources of competitive advantage in a private practice. Another important aspect of the medical practitioner as a manager is the management of health care through education. In other words, the manager has to educate the community (patients) about how to take care of their health in order to prevent the spread of diseases.

2.5 Medical practitioners’ preparedness in fulfilling their roles as managers (the undergraduate medical curriculum)

The medical curriculum is a five year programme. It relies heavily on Problem-Based Learning (PBL), which encourages self-directed study and group work. The curriculum is outcomes-based and contains a larger component of
community health and primary health care. The main aim of the curriculum is to train a competent doctor, who is well equipped with clinical skills; who has excellent communication skills; who is a life-long learner; who can solve clinical problems and has a wide range of basic knowledge of the principles of disease and therapy.

In South Africa, the medical curriculum varies from institution to institution, especially the first two years of study. Otherwise they follow a relatively similar curriculum:

2.5.1 South African undergraduate medical degree curriculum

2.5.1.1 The Walter Sisulu University of Technology

According to Unitra (Walter Sisulu University of Technology) Faculty of Health Sciences website accessed on 19 March 2008 and found on http://www.utr.ac.za/academic/faculties/health/studentzone/mbchb5year.html, the medical curriculum’s first year of study entails Medical Physics, Medical Chemistry, Medical Biology, Communication Skills (which mainly focus on communication with patients) and Computer Literacy (Ms Word, Ms Excel, Ms PowerPoint and internet) and Human Behavioral Science and Medical Ethics.

The second year entails Physiology, Anatomy, Community-based Education (COBES) and Clinical Skills. The third year has Anatomical Pathology, Medical Microbiology, Pharmacology, COBES, Clinical Skills, Forensic Medicine and Chemical Pathology.

The fourth year includes Family Medicine, Internal Medicine, Obstetrics and Gynaecology, Psychiatry, Paediatrics and Surgery and Surgical Specialties (Ophthalmology, Otorhinolaryngology, Orthopaedics and Anesthesiology).

In the fifth year of study, the students learn Family Medicine, Internal Medicine, Obstetrics and Gynaecology, Psychiatry, Paediatrics, Surgery and electives or
special study modules which may be laboratory-based, clinical or research-focused, and will be selected by students either to strengthen their areas of weakness, or to study in depth their areas of interest.

On successful completion of this five-year intense clinical skills training, a medical student graduates and becomes a medical doctor who has to do an internship programme for two years. This internship programme is compulsory as it provides valuable opportunities for newly qualified doctors to gain experience, and determine if they have an interest in a particular career path.

2.5.1.2 University of Cape Town

University of Cape Town Faculty of Health Sciences web site found on http://www.uct.ac.za/faculties/health/departments/medicine/study, accessed on 12 March 2008, shows that the university’s medical curriculum is as follows:

1\textsuperscript{st} year

This is more of a theoretical year as it teaches students chemistry and physics, how to become a health professional, and students are introduced to the integrated health sciences.

2\textsuperscript{nd} year and 3\textsuperscript{rd} year

These two years focus mainly on professionalism and the introduction to clinical practice. Becoming a doctor is one of the modules that is taught throughout the 2\textsuperscript{nd} and 3\textsuperscript{rd} year of study together with the integrated health systems.

4\textsuperscript{th} year

Focus is on specific sections like psychiatry, obstetrics and gynaecology, public health and primary health care. Students experience clinical work as they rotate between these departments throughout the year.
5th year

Students choose electives and are exposed to special study modules like Anaesthesia, Paediatrics (including Paediatric surgery), Medical and Surgical specialties (including Dermatology, Otorhinolaryngology, Ophthalmology, Neurology, Neurosurgery, Rheumatology, and Orthopaedics), Obstetrics and Gynaecology, General surgery (including Plastic surgery and Urology), Pharmacology and Applied Therapeutics, and Trauma.

2.5.1.3 University of KwaZulu-Natal

According to the university website found on www.ukzn.ac.za, accessed on 28 March 2008, the curriculum is over a period of 5 years and is divided into themes as follows:

Theme 0: Orientation

The aim is to introduce the 1st year medical students to the process and operation of self-directed, student-centred, problem-based learning and student support courses (e.g., Isizulu for non-Zulu speakers, English for second language English speakers, Computer skills development, HIV/AIDS thread running through the year etc.).

Yr 1: Diabetes Mellitus

1.1 Nutrition
1.2 Growth & Development
1.3 Infection / Inflammation
1.4 Reproductive Health I
1.5 Trauma & Emergency Care
**Yr 2: Cardio-respiratory Disorders**

2.1 Uro-genital Disorders  
2.2 Digestion / Absorption  
2.3 “People & Bugs”  
2.4 Central Function  
2.5 Body in Motion I

**Yr 3: Body in Motion II**

3.1 Hormonal Orchestration  
3.2 Cell Dysfunction  
3.3 Fever  
3.4 Abdominal Complaints  
3.5 Reproductive Health II

**Yr 4: Sight & Sound**

4.1 Higher Mental Function  
4.2 Jaundice  
4.3 Lifestyles  
4.4 Man/ Environment/Health  
4.5 Practice Management/ Therapeutics/ Other Topics

**Yr 5: Rotation**

Students rotate through the six, 7-week clinical modules covering Family Medicine, Medicine, Obstetrics and Gynaecology, Paediatrics, Psychiatry and Surgery.
2.5.1.4 University of Pretoria

The medical curriculum of the University of Pretoria found on the web site http://web.up.ac.za/sitefiles/File/Health%20Sciences%202008.pdf and accessed on 15 March 2008, shows the following:

First year of study
First semester Module
- Chemistry
- Science and World Views
- People and their Environment
- Molecular and Cell Biology
- Medical Terminology
- General Physics
- Computer Literacy
- Academic Literacy

Second semester Module
- Molecule to Organism
- Orientation
- People and their Environment
- Introduction to Clinical Pharmacotherapy
- Academic Literacy
- Special Study Module

Second year of study
First semester Module
- People and their Environment
- Homeostasis
- Anatomy (Dissection)
- Generic Procedural Skills
- Special Study Module
Second semester Module
Pathological Conditions and Infectious Diseases
Introduction to Clinical Medicine
Basic Emergency Care
Special Study Module

Third year of study
Generic Procedural Skills
Heart and Blood Vessels
Lungs and Chest
Abdomen and Mamma
Haematological Malignancies
Special Study Modules

Second semester Module
Pregnancy and Neonatology
Special Study Module

Fourth year of study
First and second semester Modules
Disorders of Childhood
Paediatrics morning rotation
Genito-Urinary Tract Conditions
Gynaecology morning rotation
Internal Medicine morning rotation
Urology morning rotation
Head and Neck
Otorhinolaryngology morning rotation
Ophthalmology morning rotation
Nervous System
Neurology morning rotation

Medical profession in South Africa
Musculoskeletal Conditions
Orthopaedics morning rotation
Endocrinology
Ageing
Skin
Electives: Preceptorship
Special Study Module

Fifth year of study

First semester Module
Psychiatry and Social Dysfunction
Psychiatry morning rotation
Health and Healthcare
Family Medicine morning rotation
Forensic Medicine morning rotation
Traumatology
Surgery morning rotation
Pharmacotherapy
Anaesthesiology
Anaesthesiology morning rotation
Special Study Module

Second half of the fifth year of study, and the sixth year of study
Student Intern Complex (SIC) (18 months)
Surgery and related disciplines and Family Medicine Module:
(i) Surgery (7 weeks)
    - General Surgery
    - Vascular Surgery
    - Plastic Surgery
    - Paediatric Surgery
- Cardiothoracic Surgery

(ii) Surgery-related sub-disciplines (3 weeks)
- Neurosurgery (1 week)
- Urology (2 weeks)

(iii) Anaesthesiology and Family Medicine (7 weeks)
- Anaesthesiology (3½ weeks)
- Family Medicine (3½ weeks)

(iv) Orthopaedics (3 weeks)

2.5.2 Comparison with international undergraduate medical degree curriculum

Internationally, the curriculum follows more or less the same pattern with the duration ranging between four to five years of study. In some universities there is an inclusion of one more year known as the foundation year or the apprenticeship.

2.5.2.1 Wayne State University School of Medicine, US

According to the Wayne State University School of Medicine web site found on http://www.med.wayne.edu/academic_student_programs/overview.asp and accessed on 19 March 2008, the curriculum is a four-academic year curriculum of study, beginning in August of one year, and ending in May forty-five months later and is as follows:

First year required courses include Anatomy, Histology, Embryology, Biochemistry, Physiology, Clinical Nutrition, Genetics, Neurosciences and Clinical Medicine. For the second year the required courses are Immunology/Microbiology, Pathobiology, Organ-System Pathophysiology, Psychiatry, Pharmacology and Clinical Medicine.

Third year required courses include Pediatrics, Internal Medicine, Surgery, Obstetrics and Gynecology, Neurology, Psychiatry, Family Medicine and
Continuity of Care Clerkship. Fourth year required courses are Emergency Medicine, Inpatient Medicine (adult or pediatric) and Outpatient Medicine (adult or pediatric)

Traditionally, the first two years are designated as the Basic Science curriculum. A clinical medical course runs through both years, integrating many smaller courses such as Introduction to the Patient, Evidence-Based Medicine, Medical Ethics, Human Sexuality, Preventive Medicine, Public Health, Interviewing and Physical Diagnosis into a sequence of cased-based teaching modules taught in small groups. The other required courses during the Clinical Science curriculum include a minimum of six electives, typically taken as one elective in the third year and five electives in the fourth year.

2.5.2.2 University of Newcastle, UK

According to Newcastle upon Tyne University web site found on [http://www.ncl.ac.uk/undergraduate/course/A106/Medicine_and_Surgery](http://www.ncl.ac.uk/undergraduate/course/A106/Medicine_and_Surgery) and accessed on 9 March 2008, the University of Newcastle medical curriculum is a five-year course that is followed by two-year Foundation Programme of general clinical training and the course content is as follows:

The course is split into two Phases. Phase I, extends over two academic years (Stages 1 and 2) and emphasises the integrated nature of medical training. The course deals with normal and abnormal structure, function and behaviour. In Phase I the course covers eight subject areas: personal and professional development; medicine in the community; clinical sciences and investigative medicine; nutrition, metabolism and endocrinology; cardiovascular, respiratory and renal medicine; thought, senses and movement; life cycle; and a student-selected topic. People as ‘patients’ play an active role in Phase I, and students come into contact with them from the very beginning through a link with a GP.
In Stage 1 the student is attached to a family for the Family Study project, and in Stage 2 he/she undertakes an in-depth study of a patient with a chronic illness. Clinical work and patient contact are further emphasised through regular clinical skills teaching, and hospital and general practice visits. Phase II spans three years and is divided into Stages 3, 4 and 5. During Stage 3 and Stage 5 the student is allocated to, and based in, one of four regional Clinical Base Units.

During this attachment the student undertakes an initial introduction to clinical practice and a series of essential junior rotations, which provide her/him with clinical experience in a range of specialities including reproductive and child health, chronic illness, disability and rehabilitation, mental health, public health and infectious diseases. During this time the student also spends a half day each week in general practice.

Stage 4 begins with a 12-week course in clinical sciences and investigative medicine, followed by a 30-week period of student-selected components and elective study. In this period the student selects three topics, each lasting six weeks, in clinical and non-clinical areas. These student-selected components are followed by an eight-week elective period.

In the final year (Stage 5) the student is attached to hospital units and general practices associated with his/her Base Unit, for the senior rotations in primary and community care, women’s and children’s care, and mental health care as well as preparation for practice and hospital-based practice. After completing your University degree, all UK medical graduates are required to complete a two-year Foundation Programme of general clinical training.
2.5.2.3 University of Manitoba, Canada

The University of Manitoba Faculty of Medicine website found on http://umanitoba.ca/faculties/medicine/units/community_health_sciences/educational_programs/undergraduate.html, accessed on 9 March 2008, states that the Department of Community Health Sciences (CHS) participates in all four years of the medical curriculum. The teaching goals of CHS reflect the learning goals, objectives and organization of the undergraduate medical curriculum in the six major areas: Clinical care; Scientist and Scholar; Communication; Ethics and Accountability; Professional and Personal; and Social Accountability and Responsibility.

In the first year, students are taught the core concepts of community health (Population Health & Medicine course, Block 1) in the areas of epidemiology, research and statistical methods, the framework for the determinants of health, disease prevention, health promotion, occupational and environmental health, health policy, and evidence based medicine and critical appraisal. In the Human Development course (Block 2), lectures and tutorials emphasize the social determinants of health and applications of principles of community development to health promotion at various stages in the life cycle. In the systems blocks, sessions address community health objectives specific to body systems and disease.

At the beginning of the third year, Introduction to Clerkship teaching sessions focuses on the organizational aspects of medicine. Community Medicine in the clerkship years gives the student opportunities to apply the principles of community health sciences and public health to the practice of medicine. These opportunities occur in two rotations; the Family Medicine/Community Medicine rotation and the Multiple Specialty rotation. The department also has opportunities for students to complete an elective rotation in community medicine and opportunities for local elective rotations at the end of Clerkship.
The third edition of the Objectives for the Qualifying Examination of the Medical Council of Canada demonstrates the importance and relevance of a community health curriculum in the present training of medical doctors. The objectives include a large number of topics that are taught primarily by the Department of Community Health Sciences.

2.5.2.4 Comparison of other international universities

According to the information found on both the University of Zagreb Medical School in Croatia, and the University of Copenhagen Medical School in Denmark web sites found on [http://www.mef.hr/engl/curricul.htm](http://www.mef.hr/engl/curricul.htm) and on [http://healthsciences.ku.dk/education/medicine/curriculum/](http://healthsciences.ku.dk/education/medicine/curriculum/) respectively, show the following:

Table 2.1 Comparison of international universities’ medical curriculum

<table>
<thead>
<tr>
<th>Semester</th>
<th>University of Zagreb Medical School, Croatia</th>
<th>University of Copenhagen Medical School, Denmark</th>
</tr>
</thead>
</table>
| 1<sup>st</sup> | Medical Sociology  
Medical English  
Medical Physics & Biophysics  
Medical Chemistry  
Medical Statistics  
Social Medicine  
Medical Biology  
Anatomy  
Physical Education | Course introduction  
Basic human biology and medical chemistry  
Clinical skills including communication  
Integrated early general medicine, health psychology and first aid  
Pathobiology |
| 2<sup>nd</sup> | Medical Sociology  
Medical English  
Medical Biology  
Anatomy  
Histology & embryology | Integrated early general medicine, health psychology and first aid  
Cell biology and genetics |
<table>
<thead>
<tr>
<th>Year</th>
<th>Courses</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Electives</strong></td>
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<tr>
<td></td>
<td>Physical Education</td>
<td></td>
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<tr>
<td></td>
<td>Practical Training in Health Centres</td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td><strong>Sociology of Medical Practice</strong></td>
<td>Methodology</td>
</tr>
<tr>
<td></td>
<td>Medical English</td>
<td>Organ module 1: The motor apparatus and the central nervous system</td>
</tr>
<tr>
<td></td>
<td>Histology &amp; Embryology</td>
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<tr>
<td></td>
<td>Central Nervous System</td>
<td></td>
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<tr>
<td></td>
<td>Integrated course:</td>
<td></td>
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<tr>
<td></td>
<td>Anatomy</td>
<td></td>
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<tr>
<td></td>
<td>Physiology</td>
<td></td>
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<tr>
<td></td>
<td>Immunology</td>
<td></td>
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<tr>
<td></td>
<td>Physiology</td>
<td></td>
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<tr>
<td></td>
<td>Medical Biochemistry</td>
<td></td>
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<tr>
<td></td>
<td>Electives</td>
<td></td>
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<tr>
<td></td>
<td>Physical Education</td>
<td></td>
</tr>
<tr>
<td>4th</td>
<td><strong>Sociology of Medical Practice</strong></td>
<td>Early clinical training</td>
</tr>
<tr>
<td></td>
<td>Medical English</td>
<td>Organ module 2: Abdomen, intestines, liver</td>
</tr>
<tr>
<td></td>
<td>Physiology</td>
<td>Organ module 3: Heart, circulation, airways, lungs, blood</td>
</tr>
<tr>
<td></td>
<td>Medical Biochemistry</td>
<td></td>
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<tr>
<td></td>
<td>Epidemiology</td>
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<td></td>
<td>Medical Ecology</td>
<td></td>
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<tr>
<td></td>
<td>Medical Microbiology &amp; Parasitology</td>
<td></td>
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<tr>
<td></td>
<td>Electives</td>
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<tr>
<td></td>
<td>Physical Education</td>
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<td></td>
<td>Practical Training in Health Centres</td>
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<tr>
<td>5th</td>
<td><strong>Medical Microbiology &amp; Parasitology</strong></td>
<td>Organ module 4: Kidneys, urinary system</td>
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<tr>
<td></td>
<td>Medical Ecology</td>
<td>Organ module 5: Energy</td>
</tr>
</tbody>
</table>

Medical profession in South Africa
<table>
<thead>
<tr>
<th>6th Year</th>
<th>Pathology</th>
<th>Pharmacology, Medical Psychology, Pathology, Pathological Physiology, Clinical Propaedeutic – integrated course, Electives</th>
<th>exchange, muscles, Organ module 6: Endocrinology, reproduction, Organ module 7: Immune system, Mandatory Individual Assignment (OSVAL 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pathology</td>
<td>Theoretical Modules on Internal Medicine and surgery integrated with related topics</td>
<td>Theme A + B: Infectious diseases including microbiology and lung diseases, Theme C: Endocrinology, Theme D: Diseases of the Motor apparatus</td>
</tr>
<tr>
<td></td>
<td>Pathological Physiology</td>
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<td></td>
<td>Pharmacology</td>
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<td></td>
<td>Clinical Propaedeutic – integrated course: Surgery, Neurology</td>
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<td></td>
<td>Internal Medicine</td>
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<td></td>
<td>Primary Health Care Practice</td>
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<tr>
<td></td>
<td>Radiology</td>
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<td></td>
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<tr>
<td></td>
<td>Electives</td>
<td></td>
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<td></td>
<td>Practical Training in Health Centres</td>
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<tr>
<td>7th Year</td>
<td>Internal Medicine</td>
<td>Clinical module on internal medicine and surgery I, including blood type serology and clinical pathology</td>
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<tr>
<td></td>
<td>Radiology</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Infectious Diseases – Integrated course: Infectious Diseases, Clinical Microbiology &amp; Parasitology</td>
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<td></td>
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<tr>
<td></td>
<td>Neurology – integrated course: Neurology, Neuropathology, Neurosurgery</td>
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</tbody>
</table>
| 8<sup>th</sup> | Psychiatry  
Dermatoyenereology – integrated course:  
Oncology  
Electives | Theoretical integrated modules on internal medicine, surgery and related topics II:  
Theme E: Cardiovascular diseases  
Theme F: Haematology, oncology and plastic surgery  
Theme G: Gastroenterology  
Theme H: Nephrology and urology |
|---|---|---|
| 8<sup>th</sup> | Internal Medicine  
Radiology  
Infectious Diseases – integrated course:  
Infectious diseases  
Clinical Microbiology  
Parasitology  
Neurology – integrated course:  
Neurology  
Neuropathology  
Neurosurgery  
Psychiatry  
Dermatoyenereology  
Oncology  
Electives  
Practical Training in Health Centres | |
| 9<sup>th</sup> | Paediatrics  
Radiology  
Physical Medicine & General Rehabilitation  
Surgery – integrated course:  
General surgery  
Urology  
Accident surgery  
Paediatric surgery | Medical sociology and administrative medicine  
Clinical pharmacology  
Clinical social medicine  
Clinical course on internal medicine and surgery II |

Medical profession in South Africa
| Anaesthesiology & Resuscitation |  
| Otorhinolaryngology |  
| Orthopedics |  
| Maxillofacial Surgery with Stomatology |  
| Ophthalmology |  
| Forensic Medicine |  
| Electives |  

| 10th |  
| Paediatrics |  
| Radiology |  
| Physical Medicine & General Rehabilitation |  
| Surgery – integrated course: |  
| General surgery |  
| Urology |  
| Accident surgery |  
| Paediatric surgery |  
| Anaesthesiology & Resuscitation |  
| Otorhinolaryngology |  
| Orthopedics |  
| Maxillofacial Surgery with Stomatology |  
| Ophthalmology |  
| Forensic Medicine |  
| Gynaecology & Obstetrics |  
| Practical Training in Health Centres |  
| Electives |  

| Clinical module on neurology/neurosurgery and psychiatry |  
| Integrated module on internal medicine and surgery and 10th semester topics |  
| Forensic medicine |  

Medical profession in South Africa
| 11th | Ophthalmology  
Forensic Medicine  
Gynaecology & Obstetrics – integrated course:  
  Gynaecology  
  Pathology  
Organization of Health Care & Social Medicine  
Epidemiology  
Medical Informatics  
Primary Health Care – integrated course:  
  General Medicine  
  Occupational Medicine  
  School Health  
History of Medicine  
War medicine  
Medical Ethics  
electives | Clinical modules on ophthalmology, oto-rhino-laryngology and dermatovenerology  
Mandatory Individual Assignment (OSVAL II)  
Elective module and stays (VKO)  
Integrated module on internal medicine and surgery and 11th semester topics |
|-----------------|---------------------------------------------------------------|
| 12th | Clinical integrated course  
Major Elective Module | Theoretical modules on gynaecology, obstetrics and pediatrics  
Clinical courses on gynaecology, obstetrics and pediatrics  
General medicine module  
Acute patient module |
2.6 Deficiencies in the curriculum

In both national and international medical curricula, there is no management training. Some elements of management are taught in topics like professionalism or becoming a doctor. Clark, J. and Armit, K. (2008:38) reported that it is these same elements that are generally deficient for those doctors in training who are experiencing difficulties.

Medical practitioners are involved in some kind of management in one way or the other, yet their training is only clinical in nature, and their preparation to become effective and good leaders and managers is not emphasized. It is a fact that the current medical curriculum in South Africa is not preparing 21st century doctors, whose roles and contributions to the health care system of the country have changed.

2.7 Conclusion

This chapter looked at the medical profession in South Africa. It focused on the country’s and international health care systems and compared the South African universities’ medical curriculum with that of international medical universities. The next chapter is going to focus on the management of a business.
CHAPTER THREE

MANAGEMENT OF A BUSINESS

3.1 Introduction

Robbins, S.P. and De Cenzo, D.A. (2001:7) define management as the process of getting things done, effectively and efficiently, through and with other people. Eksteen, F.R.L.N. (1994:4-2) describes a business as a system operating within broader systems in the sense that all its management activities (purchasing, production, marketing, finance, administration, staff, external relations and general management) are coordinated in one economic unit to make a profit by selling goods or services. Du Plessis, P.G. (1996:189) states that management (of a business) is responsible for the performance of the activities of the business with a minimum of inputs at the lowest possible costs (efficiency) in order to achieve the stated goals (effectiveness).

It can be deduced therefore from the above that management of a business is performed through the application of the four basic management functions of planning, organizing, leading and controlling of all management activities in an effective and efficient way utilizing human and other resources at the most effective way, with the aim of making a profit.

A medical private practice can be regarded as a business and the owner (the doctor) as an entrepreneur. It can be regarded as a small business because it employs less than 300 employees, has a turnover that is less than 5 million a year and the owner is directly involved in the management function (Bowler, A and Dawood, M.S. 1996:2). Scarborough, N.M. and Zimmerer, T.W. (2003:3) define an entrepreneur as one who creates a new business in the face of risk and uncertainty and assembling the necessary resources to capitalise on those opportunities.
In this study, the main emphasis is on the management activities that the entrepreneur in a small business is directly involved in.

3.2 Small business management

Bowler, A and Dawood, M.S. (1996:2) define a small business as an independent profit-oriented business unit that is personally managed by the owner(s), with a small influence or market share in the business world. In order for the entrepreneur to be successful in managing the business, competency in these managerial skills is of utmost importance:

3.2.1 Financial management

Barrow, C. (2006:45) states that an understanding of financial reports is essential to anyone who wants to control a business, to be effective the businessman must be able to analyse and interpret the financial information. The owner(s) of any business should be conversant, competent or at least have basic skills in financial management. These skills enable the business to be managed in an efficient and effective manner for the success of the business.

An article on Basic Guide to Financial Management in For-Profits (2008) by Carter McNamara of Authenticity Consulting located on the Free Management Library found on the management help web site emphasise the importance of business leaders and managers to develop at least basic skills in financial management. He stated that basic skills in financial management start in the critical areas of cash management and bookkeeping, which should be done according to certain financial controls to ensure integrity in the bookkeeping process.

With regard to cash management, Bowler, A and Dawood, M.S. (1996:133) state that a successful entrepreneur is someone who controls the money at all times and knows how the cash flows in and out each day. By using projected cash
flow budgets, the entrepreneur can determine when and how much money will be available at some future date.

Budgeting is the most important part of financial management in small businesses. The three types of budgets that are drawn up in small business include operating budget, cash flow budget and capital expenditure budget, and these budgets are used to draw up a master budget for the business (Bowler, A and Dawood, M.S. 1996:135).

Eksteen, F.R.L.N. (1994:8-2) lists the objectives of financial management:

- To make the maximum profit;
- To increase the profitability of the business in general;
- To have sufficient cash available to meet current expenses (liquidity); and
- To maintain a favourable ratio between own capital and borrowed capital (gearing).

Marx, J., De Swardt, D and Nortjé, A. (1999:5) state that from a financial management point of view, the objective of the owner is to maximize owner’s wealth. Wealth maximization is preferred over profit maximization because of the following reasons listed by Gitman, L.J. (2006:13-14):

- Profit maximization does not take risk into consideration. A positive relationship exists between risk and profits. So both risk and profit objectives should be balanced.
- Profit maximization fails to consider the timing of returns.
- Profit maximization fails to take into account the social considerations.

An article by Pam Newman (April 10, 2006), a financial management columnist of Entrepreneur.com found on their web site in discussing Financial Fundamentals says that it is critical to the long-term success of the business that the
entrepreneur understands some of the financial fundamentals of being a business owner. She says it is important to have these key skills to measure the financial aspects of the business.

Kritzinger, A.A.C. and Fourie, C.M.W. (1996:3) list four pillars which represent the contents of financial management in the small business:

- Investment aspects
- Financing aspects
- Income division aspects
- Record-keeping aspects

They further emphasise that these four aspects must be handled by the owner of the small business enterprise in such a way that they are in keeping with the aim of the business, especially its primary goal.

3.2.1.1 Investment aspects

Du Plessis, P.G. (1996:320-321) explains the meaning of investment as the utilisation of the funds of a firm in order to acquire fixed assets such as land, buildings and machinery, and working assets such as stock and debtors. It is also concerned with when each type of asset must be provided and for how long it should be held. He further states that the success of a firm is largely determined by the manner in which investment opportunities are utilised.

Marx, J., De Swardt, D and Nortjé, A. (1999:8) states that investment decisions are made by applying capital budgeting techniques such as payback period, net present value, profitability index and internal rate of return. Gitman, L.J. (2006:376) defines capital budgeting as the process of evaluating and selecting long-term investments that are consistent with the firm’s goal of maximising owner wealth.
It is important that the entrepreneur knows which and what quantity of assets must the enterprise obtain. These assets play a vital role in the operations and in the overall management and success of a business enterprise. It is important to note that risk analysis is a critical aspect of the capital budgeting decision.

### 3.2.1.2 Financing aspects

Marx, J., De Swardt, D and Nortjé, A. (1999:220) states that the financing decision entails choosing the correct type and combination of finance at the lowest possible cost to the firm, specifically the goal of the firm which is to maximize the wealth of the owners.

An entrepreneur has to choose from two sources of finance, as listed by Kritzinger, A.A.C. and Fourie, C.M.W. (1996:78-79):

- The internal sources (also known as equity financing), which refer to the funds that are available in the enterprise. These may be funds made available by owners, funds invested in the enterprise by partners or shareholders, or reserves that are built up by the enterprise from profits with a view to re-invest them in the enterprise.

- The external sources (also known as debt financing), which refer to sources that are available outside the enterprise on the money and capital markets. These funds may be from commercial banks, suppliers who sell their products on credit, or from development corporations who are equipped to lend capital to small business enterprises.

Bowler, A and Dawood, M.S. (1996:135) highlights the factors that affect the choice of financing sources:

- Term of financing – own capital which is required in the business on a permanent basis versus borrowed capital which must be redeemed within a specific period.
• Control – original owner lose control when taking on a partner.
• Solvency – it is better to have more equity financing than debt financing
• Adaptability – owner has to leave with the burden of paying interest on borrowed funds, even if there is less profit than expected
• Nature of assets – financing is always linked to the life expectancy of the asset
• Urgency – if money is needed urgently, obtaining a loan is easier than finding a reliable partner.

An entrepreneur also has to decide which form of financing will be beneficial to the firm. Whether it is short, medium or long-term financing, the entrepreneur has to consider repayments and ensure that it does not affect the normal business operations and that the form of finance suit the type of capital need for which it will be employed. Steinhoff, D. and Burgess, J.F. (1993:188) report that many potentially successful firms have failed because of undercapitalization. In other words, they fail because of lack of sufficient funds to pay for needed assets or operating expenses.

Timmons, J.A. and Spinelli, S. (2007:91-95) highlight the importance of fit and balance between the opportunity, the resources and the team and how the potential for attracting outside funding for a venture depends on this overall fit. In other words, the entrepreneur should have a great team for a good opportunity with enough resources to attract long-term financing. This follows therefore that the entrepreneur, when looking for financing, should ensure that the investor or the financier can see value in the firm and the entrepreneur must be able to demonstrate an adequate plan for the use of the funds requested (Steinhoff, D. and Burgess, J.F. (1993:189)).
3.2.1.3 Income division aspects

This aspect involves how the net income after tax is divided. In other words what percentage of net income is ploughed back into the business and what proportion does the owner receive.

Marx, J., De Swardt, D and Nortjé, A. (1999:282) state that there are two ways to utilise net income:

- Net income can be paid out to shareholders to increase their current income, or
- It can be reinvested in profitable investment proposals to increase the future income of the firm.

Fig 3.1 The relationship between available cash flow and potential uses

Source: adapted from Marx, J., De Swardt, D. and Nortje, A. (1999:283)
As the flow chart above shows, the decision on what to do with the net income depends on whether the owners want to expand, maintain existing operations or distribute it to shareholders. In deciding what to do with the net come, it is imperative that the primary objective of maximising owner's wealth is put in mind at all times.

3.2.1.4 Record-keeping aspects

This aspect refers to why and in what manner are financial transactions and their results recorded. Marx, J., De Swardt, D and Nortjé, A. (1999:16) list various users of financial information for a variety of purposes:

- Owners need it to assess the worth of their business to them;
- Management needs it to help plan and control the activities of the firm in a way that will accomplish objectives which have been set;
- Lenders to, or creditors of the business, require it to assess the likelihood of their funds being repaid or of default;
- Labour unions need it as a basis for wage negotiations;
- Investment analysts require it when investigating the firm for investment purposes;
- The state requires it for the purpose of checking whether the amount of tax paid is correct, and also for statistical purposes;
- Credit bureaux need it to issue credit ratings.

Bowler, A and Dawood, M.S. (1996:157-8) state that every entrepreneur should keep all the incoming documents and copies of outgoing correspondence on file. They further suggested that for a successful recordkeeping system, the entrepreneur must:

- Decide which books of accounts to keep;
- Sort the documents into appropriate categories;
- Record them in chronological order;
- Ensure that all information is accurate and complete; and
- Use the information to run the business proactively.

As a general guideline, accounting documents should be kept and filed according to specific categories: receipts in one file, invoices in another, etc. Even when a computerized accounting system is used, all accounting documents must be properly filed (Bowler, A and Dawood, M.S. 1996:157).

3.2.2 Human resources management


De Beer, A.A., et al (1996:5) highlight the need for any small business owner to be able not only to manage the human resource function personally, but also manage people on a day-to-day basis, understand people and must have the ability to work with and through other people either as individuals or as groups on a continuous daily basis, in order to achieve business organisational goals.
Human resource management process involves human resources planning, recruitment, selection, training and development, compensation, performance and employee relations and these will be discussed below:

3.2.2.1 Human resources planning

Du Plessis, P.G. (1996:207) describes human resource planning as the action needed to ensure that the right number and type of employees are available at the right time and place in order to assist the enterprise to achieve its future goals.

From the business plan document, an entrepreneur should know what type of people and how many of them are needed to be able to run the business successfully (De Beer, A.A. et al 1996). A job analysis, from which a job description and job specification are compiled, should be done. A job description outlines the activities of the holder of the post, how the task should be done and under what circumstances the task should be carried out. From a job description a job specification can be developed, which indicates the requirements the holder of the post should possess in order to successful complete assigned tasks (Du Plessis, P.G. 1996:207).

Beardwell, J. and Claydon, T. (2007:172) in citing Armstrong (2005) outline the aims of human resources planning that are more appropriate to contemporary circumstances:

- to attract and retain the number of people required with the appropriate skills, expertise and competences;
- to anticipate problems of potential surpluses or deficits of people;
- to develop a well-trained and flexible workforce, thus contributing to the organisation’s ability to adapt to an uncertain and changing environment;
- to reduce dependence on external recruitment when key skills are in short supply by formulating retention and development strategies; and
• to improve the utilisation of people by introducing more flexible systems of work.

After the first part of the planning process is complete and as the entrepreneur knows what type and number of people needed for the business, he/she can start recruiting them.

a) Recruitment

Amos, T. and Ristow, A. (1999:94) describes recruitment as attracting a pool of potential candidates, from which the ideal candidate can be selected, as cost-effectively as possible. As the entrepreneur knows what types of people are needed and how many vacant posts are available from the job description and job specification, he/she will first look internally if there are any people who will be suitable for the job. This information will be found from the organization’s personnel files that contain records of employees’ skills, experience, qualifications, etc. At the same time the posts should be advertised externally using some of these sources as outlined by De Beer, A.A., et al (1996:119):

• Training institutions such as schools, universities, etc.
• Recruitment agencies
• Professional bodies such as Institute of Chartered Accountants
• Advertisements in newspapers, etc
• Head hunting
• Walk-ins

The entrepreneur should collect all the CVs and relevant information from all the applicants to conduct a selection process.
b) Selection

Nel, P.S., et al (2004:232) define selection as the process of trying to determine which individuals will best match particular jobs in the organisational context, taking into account individual differences, the requirements of the job and the organisation’s internal and external environment. Dessler, G. (2005:194) in explaining the main reasons why selecting the right employees is important states that employees with the right skills and attributes will do a better job for the company, as the business’ performance always depends in part on the subordinates.

The entrepreneur in the process of selecting the right candidate for the job must ensure that he/she considers legal requirements governing employment laws in the country like for example, Employment Equity Act and Labour Relations Act.

The entrepreneur will have to make a short-list of the applications that meet the criteria or requirements of the job and those applicants will be called for a provisional selection interview. After this interview, applicants are asked to complete an application form and then necessary tests. The type of work will determine the tests to be done. Applicants' references are then checked and then an employment interview will be arranged. It is important for an entrepreneur to ensure that he/she prepares the questions he/she would like to ask. The applicant will be asked to undergo a medical examination to ensure that the candidate is physically suitable for the job. After all this is done, a final employment decision about who to employ should be made. A letter is written making an offer to the candidate, stating starting date, salary and other benefits attached to the post (De Beer, A.A., et al 1996).
c) Employment

De Beer, A.A. (1996:123) suggested that on arrival of the employee for the first time at the agreed upon date and time to start the job, administrative matters such as unemployment insurance, medical aid form, etc. should be completed and a personal file for the new employee should be opened. The entrepreneur should then arrange a date and time to do induction.

d) Induction

Nel, P.S., et al (2004:251) state that starting a new job is considered to be one of the most stressful life experiences and a proper induction process that is sensitive to the anxieties, uncertainties and needs of a new employee is of utmost importance. Amos, T. and Ristow, A. (1999:101) state that effective orientation can help the new employee to become more productive and reduce fear and insecurity, thus creating employee satisfaction from a very early stage.

Dessler, G. (2005:268) highlights four things that successful orientation should accomplish:

- The new employee should feel welcome and at ease;
- He/she should understand the organization in a broad sense, that is its past, present, culture and vision of the future, as well as key facts such as policies and procedures;
- The employee should be clear about what is expected in terms of work and behaviour; and
- The employee should have begun the process of becoming socialized into the firm’s ways of acting and doing things.

The new employee should be introduced to other employees and to his/her supervisor.
3.2.2.2 Training and development

De Beer, A.A., et al (1996:127) define training as a systematic, planned process to change employees’ behaviour, attitude, working habits and possibly levels of job performance with the purpose of making them more effective in their current posts. They define development as a process aimed at the systematic preparation of employees with potential for certain management posts. It is a process in which managers and potential managers acquire the necessary skills and attitudes to function successfully as managers.

A small business owner is mainly involved in training and has little development to do. An entrepreneur should conduct a training needs analysis to identify training needs of each job in line with the organisation’s goals. Training can take place on the job or off the job. However, Robbins, S.P. and De Cenzo, D.A. (2001:221) warn that on-the-job training can disrupt the workplace and result in an increase in errors and that some skills training is too complex to learn on the job.

Off-the-job training includes classroom lectures, computer-based training, etc and is conducted by a training institution. It involves employees leaving the place of work for training at another venue, usually for a day or a week. All the training should be done with governing laws in mind, laws like Skills Development Act, etc. The entrepreneur should also keep developing him/herself to be successful.

3.2.2.3 Compensation

Nel, P.S., et al (2004:268) state that people must be rewarded for the services they provide for organisations and that the majority of these rewards are monetary. Though it is argued that money is not a motivator, if it is inadequate or mismatched to the needs of the employee, it results in dissatisfaction. Thus monetary rewards (pay) prevent workers from being dissatisfied.

Amos, T. and Ristow, A. (1999:128) emphasise that for a small business owner, compensation must be effectively managed as it is the largest cost item to the business and can affect not only its competitive position, but also whether or not it can maintain an effective workforce.

Carrell, M.R., Elbert, N.F. and Hatfield, R.D. (1995:500) suggest that a compensation system must attract good employees by structuring salary packages such that they tempt people to apply for the job; it must also be able to retain good workers to avoid other employers who seek their services, stealing them from the business owner; it must provide all the support needed to keep the employee motivated to perform at his/her best; and it must comply with legal requirements.

Grobler, P., et al (2006:352) maintain that while many factors may cause employees to leave an organisation, inadequate compensation is often the cause of turnover. As employees perceive that they are treated inequitably, they reduce their efforts or leave the organisation. It is of utmost importance for the entrepreneur to ensure that employees are rewarded fairly for their services and that the total compensation system fulfils both the extrinsic and intrinsic factors.

3.2.2.3 Performance management

Amos, T. and Ristow, A. (1999:130) state that effective management of individual performance is critical to achieving the goals of a small business as employees want to know how are they doing on the job. It is thus important that a small business entrepreneur continuously assess the job performance of individual employees on an informal basis and provide performance feedback to ensure
that jobs are done in the best way to achieve the goals of the small business and to stimulate employee performance.

One of the ways to stimulate employee performance is through the reward system. Compensation can be directly tied to performance. This is confirmed by Grobler, P., et al (2006:354) is stating that employees achieving the desired levels of performance expect a certain level of compensation. If employees see that hard work and superior performance are recognized and rewarded by the organisation, they set higher levels of performance expecting higher levels of compensation. The entrepreneur should safeguard this relationship between compensation and performance as it benefits both the business and the employee.

3.2.2.5 Labour relations

Swanepoel, B., Erasmus, B., Van Wyk, M. And Schenk, H. (2003:616) refer to labour relations as being concerned with the relations between the employer(s) and workers which develop from employment relationships and which are essentially concerned with balancing the various interests of, and regulating the levels of cooperation and conflict between the parties involved.

There are three parties that make up the labour relations system, namely: the employers, labour and government. The role of government as explained by Swanepoel, B., et al (2003:619) is to create and enforce the legal framework which can regulate the rights and duties of the two primary parties, which are the employer and labour.

The employers want their organisations to be successful by doing the things in the right way to ensure the achievement of organisation's objectives. Management’s role is to engage in collective bargaining and related labour relations dynamics in such a way that it ultimately serves the interests of the
employer or owner of the business (Swanepoel, B., et al 2003:619). It is management’s duty to respect and uphold the basic rights of workers.

Labour which consists of workers and their representative bodies, are the most important parties to the labour relations system. The role of workers according to Swanepoel, B., et al (2003:620) is to hire out their labour potential to perform certain work on behalf of the employer under the control of management and ultimately to further the interests of the employer or owner of the business. They further state that the primary role of trade unions and/or other bodies which represent workers is to protect and further the rights and interests of the workers and to represent them in collective bargaining.

Amos, T. and Ristow, A. (1999:169) state that a small business person not only deals with employees within the employment relationship, but may also have to deal with employees on a collective basis represented by trade unions. They further affirm that once a workplace is unionized and there are at least 10 members of a trade union at a workplace, they may elect a shop steward to represent them in their dealings with the small business. It is therefore important that a small business owner understands what is expected of him/her with regards to labour relations.

3.2.3 Operations management

Davis, M.M. and Heineke, J. (2005:4) define operations management as the management of the conversion process that transforms inputs such as raw material and components into outputs in the form of finished goods and services. Inputs may be in any four different forms and these forms are referred to as “the four ‘M’s”:

- Money
- Manpower
- Machinery
• Materials

De Beer, A.A., et al (1996:65) describe outputs as any product or service that can be sold or exchanged for money or any acceptable form of payment. The main aim of operations management is to ensure that the transformation process is running smoothly and effectively.

Operations management involves capacity planning, production systems, product design, production planning and problem-solving, and these will be briefly discussed:

3.2.3.1 Capacity planning

Steinhoff, D. and Burgess, J.F. (1993:357) state that capacity planning and design focuses on the factors and operational ingredients needed to produce the targeted number of units of product or service, which include physical capacity needed, amount of labour demanded, time projected to produce the total number of products or service, etc. They further emphasise that the critical consideration in capacity planning is the kind of facilities, equipment, labour inputs needed and at what costs, to meet targeted forecasts of production or service.

The entrepreneur should always focus on throughputs, ensuring that production or service is done at a most effective and efficient manner.

3.2.3.2 Production systems

Abha Kumar of the University of Delhi in a lesson on production planning and control found on the University web site defines production system as the framework within which the production activities of an enterprise take place. He further added that an appropriate designing of production system ensures the coordination of various production operations.
De Beer, A.A., et al (1996:69) explains three of the production systems that are normally used by small businesses: the job production system, which involves product manufacture or service according to customer’s specifications, in other words according to the needs and/or design of the customer; batch production system, which involves producing products in bulk batches of specified and standardized items; and the flow production system, which involves producing highly standardized products with a standard set of process and operation sequence.

3.2.3.3 Product design

Du Plessis, P.G. (1996:247) state that the firm must allow itself to be guided by the consumer in the choice and design of the product without neglecting its own responsibility to guide the consumer through advertising and research. It is therefore imperative that the entrepreneur investigate the consumer’s needs and adjust its production policy accordingly.

De Beer, A.A., et al (1996:72) list factors that the entrepreneur should take into account in the design of a product or service for the business:

- Use or function – design must fulfill the function for which it will be used
- Sales appearance – includes presentation and must look good in order to sell
- Design effectiveness – ensures that the product is user-friendly
- Raw materials – choice of raw material used is important
- Simplification – make use of standardized parts
- Determining of costs – ensure that the product is not too expensive to compete with others or to sell
- Patents and patent law – ensure that the product has not already been patented
• Consumer complaints – investigate complaints and change the design where necessary
• Enquiries and after-sales service – good after-sales service ensures business’ success.

3.2.3.4 Production planning

Du Plessis, P.G. (1996:264) states that production planning involves setting a target, designating guidelines and creating standards and measurements by which results can be measured, so that the control function has meaning and significance.

Eksteen, F.R.L.N. (1994:5-3) states that production planning can be a long term decision, which is concerned with the choice of and development of the product range, production process, location and layout of the factory, its size, etc; medium term decision which involves forecasting demand and sales, production plans and drafting relevant budgets; and short term decision which involves drafting and execution of the work plan, quality control and maintenance.

The entrepreneur should consider safety of the employees at all times by ensuring that the employees have protective clothing, the factory has enough ventilation, noise protection plugs, etc

3.2.3.5 Problem-solving

The entrepreneur will have to occasionally solve problems in the business with regard to resources (the four ‘M’s) and space. The most important step in problem-solving is to identify the problem and separate symptoms from problems. When solving problems that involve manpower, it is imperative that the entrepreneur deal with the problem not the person.
### 3.2.4 Marketing management


Marketing is one of the most important functions of a business as it involves the selling of a product or service for business success. This is confirmed by Steinhoff, D. and Burgess, J.F. (1993:210) in stating that business success depends upon marketing success. It is by this function that customers buy the products they like.

De Beer, A.A. (1996:46) suggested that an entrepreneur should know who the customers are, what their needs are and whether the products or service that the business is offering will fulfill their needs. To get this information the entrepreneur should do a market research to identify target market customers and their needs, desires, tastes and preferences through the use of interviews, questionnaires, focus groups, online survey etc. The entrepreneur should listen to consumers, get close to them and find out what they really want and need.

This process is in line with the concept of customer focus which according to Hoffman, K.D., et al (2005:7-8) is the one that pertains to obtaining information about customer needs and wants and then providing products (and services) that fulfill these shortages and desires. They further added that businesses that practice a customer focus obtain information pertaining to customers’ future needs and wants, as well as their current set of needs and preferences. These businesses are also involved in the practice of customer relationship management of a business.
Management (CRM), which is the process of identifying, attracting, differentiating, and retaining customers (Hoffman, K.D. et al 2005:9).

Market research also assists a business to get more information about its competitors and what they offer. This leads to an entrepreneur making his/her products and services better than those of competitors which can be referred to as differentiation. Eksteen, F.R.L.N. (1994:13-14) defines product differentiation as the attempt to create in the minds of consumers, perceptions of products that make one product seem better than or superior to others.

After conducting a market research, the entrepreneur should do market segmentation. According to Hoffman, K.D., et al (2005:16) market segmentation is the process of dividing markets into distinctive groups based on homogeneous sets of needs. This allows a firm to focus its marketing efforts on a more narrowly defined market, which is the target market.

After identifying the target market, the entrepreneur should formulate specific marketing objectives. According to Du Plessis, P.G. (1996:308) these objectives must be derived from the overall objectives of the firm and must contribute to the achievement of the firm’s ultimate objectives. De Beer, A.A., et al (1996:55) in specifying the requirements that these objectives should meet stated that the objectives should be realistic, quantifiable, and measurable and must be linked to a certain period to enable a more focused approach.

The entrepreneur should develop a marketing strategy that relates to the firm’s overall goals. Du Plessis, P.G. (1996:309) define marketing strategy as a total plan of action according to which marketing management intends competing in order to realize the predetermined objectives of marketing and the firm. Scarborough, N.M. and Zimmerer, T.W. (2003:195) state that the right marketing strategy is a key determinant of how successful a business is at achieving a competitive advantage. They can achieve a competitive advantage by focusing on the customer through the practice of CRM.
Marketing strategy sets up a management plan for developing, implementing and controlling marketing activities which involve developing a marketing mix that is adapted to meet the needs and wants of the target market. Hoffman, K.D., et al (2005:17) state that marketing strategy involves identifying target markets; tailoring marketing mixes that meet the needs and wants of each specific target market; and developing marketing mixes that reinforce the product’s positioning strategy in the marketplace. The marketing mix which comprise of the product, price, place and promotion (four Ps) play a key role in the management of the marketing process. Eksteen, F.R.L.N. (1994:13-2) describes the marketing mix as the set of controllable variables and their levels that are used to influence the target market. The entrepreneur should continuously monitor the ever-changing environmental conditions and modify the marketing mixes accordingly.

3.2.4.1 Product

Bowler, A and Dawood, M.S. (1996:82) define a product as anything that has physical or emotional utility and can satisfy the needs and preferences of consumers. Steinhoff, D. and Burgess, J.F. (1993:270) state that entrepreneurs who develop a product or service insist that quality, delivery, instructions, installation, warranties, selection and choice, brand names, packaging, accessories, ambience of the store, the display of a product, and the methods of dealing with the customer, all make up a part of the product.

Bowler, A. and Dawood, M.S. (1996:82) state that customers buy a product or service if he/she is convinced that it offers more benefits or value than a product of another business. Customers are prepared to pay a premium for the product they perceive to be better than that of competitors. It is therefore imperative that the entrepreneur is always aware of the customer’s new needs and preferences.
3.2.4.2 Price

Effective pricing strategy understands the bundle of benefits provided by the product’s value proposition and the value placed by customers on these benefits (Hoffman, K.D., et al 2005:19). An entrepreneur must set a basic price high enough to cover costs and earn a reasonable profit, but low enough to attract store traffic (customers). These are the sentiments shared by Bowler, A. and Dawood, M.S. (1996:89) on pricing for profit as the aim of a business is to earn a profit and to increase owner’s wealth.

3.2.4.3 Place

Bowler, A. and Dawood, M.S. (1996:111) explains the whole idea of distribution is to make products and services available from the producer to the final consumer in a way that is convenient, competitive, attractive, without delays, in sufficient quantities and undamaged.

The entrepreneur must make a decision on how products and services are to be distributed to the consumer, in other words he/she must decide on the distribution channels among the following channels of distribution:

- Direct channel – distribution from the entrepreneur directly to the consumer
- Single channel – one intermediary between the entrepreneur and the customer, which is the retailer
- Multiple channels – several intermediaries including the agent, the wholesaler and the retailer between the entrepreneur and the customer

Hoffman, K.D., et al (2005:352) state that distribution channel creates time, place and possession utilities for consumers and business users. These distribution channels can be simple or complex but the most simple and cost effective is the one that goes directly from producer to consumer. The small business...
entrepreneur should use the most beneficial and cost effective channel so that the customers get their products at the right place when they need them.

### 3.2.4.4 Promotion

Bowler, A. and Dawood, M.S. (1996:96) define promotion as any form of communication used by the entrepreneur to inform, persuade and remind customers about the business and to increase the sales of its products and services.

A well planned promotion is an investment in the future of the business. According to Bowler, A. and Dawood, M.S. (1996:96) a promotion mix consists of advertising, sales promotion, personal selling and publicity. They further suggested that the entrepreneur combine all these promotional methods in the promotion mix in a well planned strategy to achieve visible results.

### 3.2.5 Purchasing management

Scarborough, N.M. and Zimmer, T.W. (2003:510) state that purchasing involves the acquisition of needed materials, supplies, services, and equipment of the right quality, in the proper quantities, for reasonable prices, at the appropriate time, and from the right vendor or supplier. They added that a major objective of purchasing is to acquire enough stock to ensure smooth, uninterrupted production or sales and to see that the merchandise is delivered on time.

Purchasing management involves three functions of management which include planning, organising and control and these will be briefly discussed.

**a) Planning for purchasing**

Planning for purchasing involves formulating policy and purchasing procedures, and budgeting. A small business owner, in the process of delegating some of the
responsibilities to employees, need to have a policy that will guide employees on
the identification and selection of suppliers and the basic principles that need to
be followed; and procedures to be followed in the purchasing process (De Beer,
annual budget.

b) Organising the purchasing department

This involves a practical implementation of purchasing planning in an attempt to
reach objectives. The entrepreneur should decide whether to centralise or
decentralize the purchasing function. According to De Beer, A.A., et al
(1996:102) in a small business purchasing is naturally centralized.

c) Controlling of purchasing

Control cannot be effective without proper planning. This is confirmed by Du
Plessis, P.G. (1996:233) in stating that the purchasing management cannot
exercise control without clear planning and predetermined standards. He further
outlined four basic steps that must be followed by the purchasing department in
order to apply control:

- Development and application of standards for the control system
- Perception and assessment of actual events
- Comparison of actual events with predetermined standards in order to
determine any deviations
- Correction of unfavourable deviations

Another aspect of controlling that is very important is the quality control. The
entrepreneur has to ensure that they purchase their products from a reputable
company that offers good quality and delivery on time.

Management of a business
Purchasing function also involves activities that include determination of needs; selecting suppliers; getting quotations from suppliers; placing orders with suppliers; receiving, inspecting and distributing purchased stock; analysis of invoices; and payment of suppliers and filing of relevant documents.

In determining the needs, it is important that the entrepreneur know precisely what is needed, what quality, in what quantities and by when. This will assist the business to function smoothly as the purchaser will look for suppliers of the required stock.

After determining the needs, the entrepreneur must look for suppliers who will provide the required stock, in the required quality and quantities and at the right time. The purchaser should get quotations from all the suppliers and ensuring that he/she choose the cheapest supplier without compromising quality. Steinhoff, D. and Burgess, J.F. (1993:323) state that the object is to negotiate with suppliers for favourable prices, qualities, and deliveries while maintaining an amount of inventory that is adequate to meet demand, yet low enough to ensure efficient storage costs. A supplier that satisfies the criteria is then selected and the order is placed. If the entrepreneur acquires the goods on a repetitive basis, it is advisable that they have a written agreement.

On arrival of the order, it is important to check the order for damages, whether it is in right quantities and quality; and also check if what is written in the invoice or delivery note corresponds with what is actually delivered before the order is supplied to the section or department that ordered the goods. If all is well, then the supplier is paid and relevant documents are filed.

### 3.2.6 Public relations management

Du Plessis, P.G. (1996:354) describes public relations as the management function that entails creating and securing a general feeling of acceptance of the enterprise among its various stakeholders by means of a process of two-way communication and taking environmental factors into consideration.
De Beer, A.A., et al (1996:166) state that the main objective of public relations may be seen as a process that promotes and improves the image of the business among the public to establish a healthy relationship between the business and the public. Healthy relations make the product or service more acceptable to the public, and can contribute to the financial success of the business. Bowler, A and Dawood, M.S. (1996:104) state that publicity is important in developing and building a favourable business image and customer loyalty.

An entrepreneur should ensure that the interest groups who include employees, clientele, media, the community, Department of Labour and potential customers are well informed so that they understand the intentions of the business. He/she must treat the interest groups fairly to build up a good relationship with them.

3.3 Conclusion

This chapter dealt with the management functions that the small business entrepreneur is directly involved in. The importance of exercising planning, organising, coordinating, leading, and controlling in all the management functions cannot be over-emphasised enough.

The next chapter will deal with the management of a medical private practice, focusing on the management functions that are specific to the medical private practice and those that are common to a normal business.
CHAPTER FOUR

MANAGEMENT OF A MEDICAL PRIVATE PRACTICE

4.1 Introduction


   Everything is now thought of as a business of a sort. We are all ‘in business’ these days, be we doctor or priest, professor or charity-worker. Every organisation is, in practice, a business because it is judged by its effectiveness in turning inputs into outputs for its customers or clients, and is judged in competition against its peers. The only difference is that ‘social businesses’ do not distribute their surpluses. (p. 129)

Liebler, J.G. and McConnell, C.R. (1999:489) state that the professional who enters management is usually extremely well trained in the specialty but minimally or not at all in matters of management. The professional has to seek out sources of education and assistance to gain knowledge, assistance, understanding, skill and competence in management.

Longest, B.B. Jr, (1990:36) suggests that the work of the manager of a business, being the owner or the practitioner can be seen in three perspectives: the functions they perform; the roles they play and the skills they need.

4.1.1 Functions in the management process


   • Planning – examining future needs and developing a plan of action;
• Organising – providing human resources and capital to carry out organisational activities;
• Directing – getting the optimum from employees to the goals of the organisation;
• Coordinating – unifying and harmonising activities to facilitate successful working; and
• Control – verifying that plans are being adhered to through commands.

4.1.2 Roles played by managers

Goodwin, N., Gruen, R. and Iles, V. (2006:17) in citing Mintzberg (1989) suggest that instead of emphasising the manager as a formal decision-maker, the emphasis should be placed on the kinds of roles a manager performs and this is known as role theory. He observed that managers play interpersonal roles, informational roles and decisional roles:

• Interpersonal roles are based on the use of formal authority and three types of interpersonal roles can be identified:
  • Figurehead – involves attending ceremonies, addressing the media, etc;
  • Leader – involves hiring, training, setting an example for others to follow, etc;
  • Liaison – involves dealing with people outside the organisation.

• Informational roles are associated with fulfilling the roles of interpersonal roles:
  • Monitor – involves seeking information that may be of value;
  • Disseminator – involves knowledge transfer between staff in the workplace;
  • Spokesman – involves dealing with external clients, professionals, etc.
Decisional roles are associated with making decisions for the smooth running of the business:

- Entrepreneur – as the initiator of change, often taking risks;
- Disturbance handler – dealing with disputes and strikes;
- Resource allocator – deciding who will be allocated resources;
- Negotiator – involving negotiations on behalf of the organisation both internally or externally.

4.1.3 Skills needed in the practice of management

Goodwin, N., Gruen, R. and Iles, V. (2006:23) refer to management skills as competencies a manager holds to undertake the above roles effectively. Longest, B.B. Jr, (1990:37) in citing Katz (1955) identifies three types of skills that managers must possess:

- Technical skills are the ability of a manager to use the methods, processes and techniques of a particular field and can be acquired through training, education and work experience.

- Human skills are the ability of a manager to get along with other people, to understand them and to motivate and lead them in the workplace.

- Conceptual skills are the mental ability to visualize all the complex interrelationships that exist in a workplace among people, departments or units of an organisation and the environment in which it exists.

Though these skills as shown in Fig. 4.1 below are required in different levels of management in an organisation, in a medical private practice a practitioner, as the owner of the business, the practitioner is required to have all of them.
Fig 4.1 Management skills by levels of management (Katz 1955)

<table>
<thead>
<tr>
<th>Top level management</th>
<th>Conceptual skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle level management</td>
<td>Human skills</td>
</tr>
<tr>
<td>Lower level management</td>
<td>Technical skills</td>
</tr>
</tbody>
</table>


- To ensure the organisation serves its purpose and is efficient in the production of goods or services;
- To design and maintain the stability of the operations of the organisation;
- To take charge of strategy-making and ensure the organisation can adapt to its environment;
- To ensure the organisation meets the ends of its bosses and clients;
- To serve as the informational link between the organisation and the outside world; and
- To act as a formal authority in operating the organisation’s ‘status system’.

Management of a medical private practice
4.2 Managing a medical private practice

Forster, P (1995:43-4) state that today’s general practice requires managers who are able to:

- Manage themselves and others;
- Demonstrate a clear understanding and appreciation of human resource management;
- Demonstrate an understanding of leadership and the management of change;
- Demonstrate the use of theoretical concepts in decision making and organisational change; and
- Identify their leadership style and framework for adapting that style in general practice.

In addition, Forster, P (1995:43-4) state that they should have a range of business skills and experience, including:

- Health needs assessment;
- Financial and budgeting management;
- Business and strategic planning;
- Marketing;
- Contracting and negotiation;
- Audit and quality management; and
- Public relations.

Cheshire, M.R., Grace, S., Keaveney, B. and Moore, P. (2007) in an article on ‘Operations: Learning from the Best’ accessed on 3 May 2008 and found on http://www.physicianspractice.com/index/fuseaction/articles.details&articleID=1083.htm state that there are only two reasons why a medical practice exists: to deliver high-quality care and to drive volume and revenue. This confirms that a
medical practice, like any business, has an objective of making a profit and increasing the owner’s wealth. Over and above profit making, a medical practice’s objective is to promote health (Goodwin, N., Gruen, R. and Iles, V. 2006:19).

Still, L. (2007:24) states that private health care sector is used by people who are members of medical schemes, as well as those who pay for these facilities from their own pockets. These facilities are also used by those who choose to self-insure, as well as lower income people who cannot afford medical scheme membership and yet prefer to use private health providers. Courtney, M. and Briggs, D. (2004:43) state that independent doctors are paid by medical societies in given areas that contract with sickness funds for an aggregate payment for all services to be provided by doctors in that area. Individual doctors are paid on a fee-for-service basis, according to the volume of services rendered to consumers. This means that neither the consumer nor the individual doctor has an incentive to curtail services.

Information Technology (IT) is important in a medical practice. This is confirmed by the Foundation for Professional Development (2004) course material on Certificate in Practice Management for Ophthalmologists which states that the most important point is to computerise the whole practice, as this will ensure that the practice is geared for maximum efficiency. IT plays a vital role in the management of a practice, from record keeping of patient information to coding and billing medical aid schemes in order for a practice to receive payment for services rendered. It is therefore imperative that the practitioner invests in current technological systems and software to keep abreast with the ever changing needs of health systems requirements and medical aid schemes (CME Journal, Vol. 25, No. 1, Jan 2007 (pp 18 -23)).
As a business, management of a medical private practice is similar to the management of a small business discussed above. However, there are issues that are unique and specific to a medical private practice, and these will be briefly discussed below:

4.2.1 Financial Management

According to the Foundation for Professional Development (2004) course material on Certificate in Practice Management for Ophthalmologists, there are doctors that mainly sell consulting services, like physicians and neurologists. These doctors are selling their knowledge and skills to earn a fee. There are also those who are from a diagnostic discipline who mainly utilise expensive equipment together with their skills to provide a service to a patient, like ophthalmologists, pathologists, etc. The overhead structure for the consulting discipline differs substantially from those of the diagnostic discipline.

4.2.1.1 Billing and coding

Tainton, G., a Medical Director of Medical EDI Services in KwaZulu-Natal in his article ‘Medical Claims Submission’ found on the Continuing Medical Education (CME) Journal, Vol. 25, No. 1 (January 2007, pp 18-23), reports that 7 million people in South Africa are registered as members and beneficiaries of approximately 160 medical schemes, which operate under the supervision of the Council for Medical Schemes. Efficient claim submission to this multitude of third party funders is a vital component of practice management, as it has a considerable and direct effect on the practice cash flow.

There are basically two forms of payment used by patients: medical scheme and cash payment (which include cheque and credit card payment). In order for the practitioner to receive payment from a medical scheme, a claim to a medical scheme must be submitted.
All services rendered by the practitioner to the patient that include consultation, procedure and diagnosis, are to be coded for billing purposes, and forwarded to the medical scheme via one of the following methods of submitting claims (CME Journal, Vol. 25, No. 1, 2007, pp 18-23):

- paper claims;
- electronic data interchange (EDI) batch claims;
- real-time/online claims; or
- ‘Now or Later’ electronic claiming that offers the benefits of batch and real-time/online claiming.

An article by Selma Smith and Jean Viviers (Apr. 2008) on ‘Electronic data interface (EDI) in general practice improves debtor days’ found on South African Medical Journal (SAMJ), Vol. 98, No. 4, pp 238, reports that one of the many challenges facing medical practitioners is financial survival; essential to this end is ensuring that fees earned are received as soon as possible. On investigating whether or not the installation of EDI is beneficial to the South African medical practice they conclude that implementation of EDI in a practice significantly decrease debtor days and recommend that practitioners invest in EDI technology.

According to CME Journal, Vol. 25, No. 1, Jan 2007 (pp 18 -23), the Practice Management Application (PMA) software is required to create an invoice in electronic format for transmission to the respective medical schemes. As each medical scheme has different data requirements, the invoice data are converted into the specific medical schemes data requirement by the switching entity, and then forwarded to the medical scheme. All electronic responses from the medical scheme are treated in the same way so that the data received by the PMA are readable by that PMA.
In creating the invoice, the PMA applies codes and rules against the captured data on the diagnosis, consultations and procedures, medical scheme plans and options and medicines and materials. Coding improves the quality of data management, ensuring consistency in disease, procedural and drug descriptions, thereby enabling health care role-players to communicate efficiently (CME Journal, Vol. 25, No. 1, 2007, pp 18-23).

In a document on the ‘Investigation into a Procedural Coding System for South Africa’ prepared by the Actuarial and Insurance Solutions at Deloitte and Dr Mark Ferreira for the Board of Healthcare Funders (BHF) (Feb 2007), benefits for encoded description (provided the descriptions are sufficiently detailed) were listed:

- It allows service providers to inform funders of the services provided, and to be paid for it;
- It allows funders and regulatory bodies to analyse treatment provided to members, and to make decisions on how to allocate limited funds to various forms of treatment; and
- It allows all interested parties to evaluate the health outcomes achieved by the treatment provided to patients.

The BHF document (Feb 2007) lists the main forms of coding currently used in South Africa:

- Diagnostic coding (ICD10);
- Procedural coding (CPT4);
- Billing coding (NHRPL and UPFS);
- Medicine classification coding (NAPPI).

The following brief discussion on each of the above forms of coding is an excerpt from the BHF document (Feb 2007):
• **ICD-10**

The most widely used statistical classification in healthcare is the International Statistical Classification of Diseases and Related Health Problems (ICD), now in its 10th revision. ICD 10 is the diagnostic coding standard for South Africa as accepted by the National Department of Health and the Council for Medical Schemes. The current purpose of the ICD is to promote international comparability in the collection, classification, processing, and presentation of health statistics, including both morbidity and mortality. In practice, the ICD has become the international standard diagnostic classification for all general epidemiological and many health management purposes.

According to CME Journal, Vol. 25, No. 1, 2007 (pp 18-23) if a code is ‘valid’, then payment will follow. However, imminent new checks will ensure that the code matches the medications prescribed and the procedures done, for each line item. If the code is deemed inappropriate, that is the medical aid decides that the treatment is not appropriate to the disease or condition, then there will be no payment.

• **CPT4**

Current Procedural Terminology (CPT) is a listing of descriptive terms and codes that are used for reporting of medical services and procedures performed. CPT is used largely in the private sector for the purposes of data collection and analysis and to a lesser extent for reimbursement within contractual agreements between funders and providers of healthcare.

• **NHRPL**

According to the document commenting on the Road Accident Fund Amendment Bill, 2004 by the South African Medical Association (SAMA) found on

Management of a medical private practice
http://www.samedical.org/administration/uploads/articles/RAF%20SAMA%20Submission.pdf and accessed on 30 May 2008, National Health Reference Price List (NHRPL) is used by medical schemes as a reference to determine its benefits and by health care providers as a reference to determine their own fees. It should mainly be regarded as a coding system for the purposes of billing, rather than a coding system for descriptive purposes (BHF document (Feb 2007)).

• **UPFS**

The Uniform Patient Fee Schedule (UPFS) was developed to provide a simpler charging mechanism for public sector hospitals in South Africa. Public hospitals currently treat patients for whom external funding is available. The UPFS replaces the itemised billing approach with a grouped-fee approach.

• **NAPPI**

A National Pharmaceutical Product Interface (NAPPI) code is a unique identifier for a given product (medicine or surgical products). NAPPI coding allows the provider to identify which brand he/she is dispensing, the dispensed pack and the manufacturer. Managed Care companies are able to link GPI to each new NAPPI code that is created, thus allowing a method to group drugs for reference pricing models amongst other things.

4.2.2 **Human resource management**

Hyde, J. and Cooper, F. (2001:151) state that human resources agenda cannot be divorced from the service agenda: how staff are organised, managed and developed has a direct impact on patient care and service development. They further state that the implication of this is that human resources issues should not be professionally bounded; they need to be of central concern to all managers throughout large, medium and small health organisations and across organisational boundaries.
4.2.2.1 Recruitment and selection

Forster, P. (1995:2) reports that finding the best person to fill a vacancy depends on finding an applicant who:

- Possesses the appropriate level of skill and qualifications;
- Can identify with the objectives, values and aims of the practice; and
- Sees themselves as making a positive and effective contribution to achieving these aims.

Fottler, M.D., Hernanen dez, S.R. and Joiner, C.L. (1998:12) state that the recruitment of personnel plays an important role in helping the organisation adapt and remain competitive. In healthcare, finding employees who are proficient in medical terminology is a bonus.

Forster’s, P. (1995:49) previous experience of general practice and medical procedures is desirable when recruiting for a front office. He further states that, as far as personal qualities are concerned, person specification should include:

- A pleasant and cheerful personality;
- Ability to be able to relate to patients with empathy and understanding;
- Ability to work unsupervised with a high degree of accuracy;
- Discretion, loyalty and tact;
- Ability to cope calmly and efficiently with unexpected difficulties; and
- Good speaking voice and smart appearance.

4.2.2.2 Training and development

Fottler, M.D., et a (1998:13) state that investment in the existing human capital of a health services organisation through well-managed training and development activities offers potential for significantly enhancing the ability of the enterprise to achieve its objectives. They added that the changing environment of the health
services industry itself ensures that the training and development of current staff members will contribute to organisational performance.

According to the Foundation for Professional Development (2002) course material on Certificate in Practice Management for Ophthalmologists, the doctor and his/her skills will attract patients and referrals while staff members will either retain patients and run the practice efficiently and effectively, or not. Staff will also determine the quality of the service that patients receive and experience. It is imperative therefore that, amongst other things, staff are continuously trained in acquiring new skills to help them grow personally and professionally and they are rewarded and acknowledged through market related salaries and performance appraisal.

4.2.3 Operations Management

Operations management in a practice concerns itself with providing services within acceptable quality standards at lowest cost – the ultimate purpose of any business (SAMJ Volume 96, No. 1, January 2006, pp 26).


- Know your patients;
- Develop sound fiscal policies and stick to them;
- Create a positive office culture that focuses on patient care and financial performance; and
- Find ways to grow.
4.2.3.1 Missed appointments

An article by Maria Ines Herrera and Cecilio Mar Molinero (February 2004), on ‘Missed appointments at a NHS dental practice’, found on https://upcommons.upc.edu/e-prints/bitstream/2117/304/1/dentistenglish1.pdf and accessed on 14 May 2008 show that missed appointments create many problems in dental practices, as those patients who fail to turn up deprive other patients of an opportunity for treatment. They further state that treatment in a private practice is not subsidised and can be very expensive. By not showing up they are causing a loss of income to the practice. As patients who fail to honour appointments will, perhaps, want to be treated later, they contribute to the development of long waiting lists for dental services.

4.2.3.2 How to reduce missed appointments?

Use of technology can improve how a practice operates. This is evidenced by an article by Gail Garfinkel Weiss (March 2008) titled ‘When patients cancel appointments’ accessed on 16 May 2008 and found on http://medicaleconomics.modernmedicine.com/memag/article/articleDetail.jsp?id=494105&sk=&date=&pageIndex=3 that state that appointment reminder calls, often done via computer, are among the most useful tools in physicians' scheduling arsenal.

Another article accessed on 20 May 2008 and found on http://www.informatics-review.com/wiki/index.php/SMS,_Blogs_and_the_Patient-Provider_Relationship:_Enhancing_Co... outcomes about ‘SMS, blogs and the patient-provider relationship: enhancing communication, improving treatment outcomes’ state that two significant barriers to the development of a positive patient-provider relationship are noncompliance and patient no-shows. They further state that evidence is building that SMS may be an inexpensive and efficient way to solve both of these problems. They added that there are studies which indicate that SMS can help patients have
more productive and rewarding relationships with their healthcare providers because they will be more likely to show up for appointments, comply with therapy and have better treatment outcomes.

4.2.4 Marketing Management

According to the article found on SAMJ Volume 94, No. 8 (June 2004, pp 421-422), there are irresistible pressures within all economies causing practices to reconsider their position. The driving forces in the health care can be grouped in six headings:

- Increased patient knowledge, questioning and combative attitudes;
- Competition, both intra- and extra-professional;
- Governmental and societal pressures;
- Changing technology;
- Deregulation and liberation of practice rules; and
- Costs.

Unless medical practices develop strategies to meet emerging conditions, medicine as a discipline will be the victim rather than the beneficiary of change, and patients will be disadvantaged (SAMJ Volume 94, No. 6, June 2004, pp 421-422).

According to an article on ‘Marketing your medical practice Part II’ found on SAMJ Volume 94, No. 8, August 2004 (pp 618 – 620), effective marketing of a medical practice will benefit everyone – doctors, other health care practitioners, support staff, patients and thus society as a whole. Marketing in health care is not just a new activity, but more importantly, requires a change in attitude as seen in the table below:
Table 4.2 Change in attitude from traditional to patient-orientated

<table>
<thead>
<tr>
<th>ATTITUDES</th>
<th>Traditional</th>
<th>Patient-orientated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complacent</td>
<td>Involved</td>
<td></td>
</tr>
<tr>
<td>Narrow professional focus</td>
<td>Understanding of patients’ wider needs and problems</td>
<td></td>
</tr>
<tr>
<td>Resistance to change</td>
<td>Responsive to changing patient requirement, knowledge and expectations</td>
<td></td>
</tr>
<tr>
<td>Working as an individual</td>
<td>Part of a team</td>
<td></td>
</tr>
<tr>
<td>Professional mystique</td>
<td>A skill vital to the success of the practice</td>
<td></td>
</tr>
<tr>
<td>Conveying only information the doctor thinks the patient needs or would understand</td>
<td>Clear and comprehensible information volunteered</td>
<td></td>
</tr>
<tr>
<td>Prescribing only on clinical criteria</td>
<td>Aware of possible cost constraints on patients and medical schemes</td>
<td></td>
</tr>
<tr>
<td>Professional aspects are paramount</td>
<td>How can we improve our patients’ quality of life?</td>
<td></td>
</tr>
</tbody>
</table>

Source: SAMJ Volume 94, No. 8, August 2004, pp 618 - 620

The article (SAMJ Volume 94, No. 8, August 2004, pp 618 – 620) further states that marketing was never an issue in the health professions so long as practice rules forbade anything that might be interpreted as touting. This pejorative has itself done infinite harm to the process of making marketing acceptable to the profession. However, recommendations, directories, signs and booklets are all marketing tools and have been used mostly in a subdued and non-proactive way. For the health care profession to be able to deliver the benefits it is capable of delivering, the time is right for a proactive approach to communication (SAMJ Volume 94, No. 8, August 2004, pp 618 – 620).
According to the article on marketing your medical practice found on SAMJ Volume 94, No. 11, November 2004, pp 885 – 887, personal contact is the most effective form of marketing a medical practice. How practitioners treat their patients has a direct impact on the patient’s decision to return to the practice; as important is what they convey to potential patients. The article further advises practitioners to consider as objectively as possible whether their attitude to patients is conducive to developing confidence and loyalties.

### 4.2.5 Public relations management

An article by Geller, G. of Geller, Grace & Associates (2006) found on [http://www.gellergrace.com/PDFs/ArticleMayJune06.pdf](http://www.gellergrace.com/PDFs/ArticleMayJune06.pdf) and accessed on 20 May 2008 from Fairfield County Medical Association News Capsule titled ‘24/7 communications solutions for your medical practice’ states that healthcare public relations is a cost-effective way of explaining the practitioner’s specialty and his/her practice to patients and their families, prospective patients and referring physicians, thereby growing the practice.

She further states that the value of public relations is that the practice stays visible, deliver the message, generate new patient leads, enhance the reputation of the medical practice and build relationships.

An article by Scott Lorenz (Nov. 2006) on ‘Medical Practice Marketing: All Doctors Need PR’ accessed on 29 May 2008 and found on American Journal of Public Health and the Nation's Health from [http://www.salesvantage.com/article/1049/Medical-Practice-Marketing-All-Doctors-Need-PR](http://www.salesvantage.com/article/1049/Medical-Practice-Marketing-All-Doctors-Need-PR) believes that a well-thought out and executed public relations/marketing plan will overcome reluctance by patients to embrace medical innovations.

Foundation for Professional Development, in defining public relations in the course material of Certificate in Practice Management for Ophthalmologists point
out that it is a determined, planned and sustained effort to establish and maintain mutual understanding between an organisation and its stakeholders. The document also points out that public relations rests in the goodwill it generates; patients are more likely to return to a healthcare practice that is well known, well spoken of and recommended by those whom they respect. New patients are attracted for the same reasons.

Dowding, L. and Barr, J. (2002:4) state that within a caring profession it is important that professionals be aware of the image they portray to patients, as it is one of the major factors that encourages or detracts from the healing process.

4.2.6 Purchasing management

Purchasing management, as discussed in chapter 3 above, is one of the most important managerial skills that are required in managing a medical practice, especially by medical practices that are dispensing medication. Though this managerial skill may not be necessary to some medical practices, it is advised that medical practitioners get trained in purchasing management in case they need these skills in the future.

4.3 Conclusion

The main emphasis of this chapter has been to highlight unique and specific management issues in the management of a medical private practice. Though management of a medical private practice is similar to the management of a small business, caring for the health of the public needs more attention than making a profit. Technology has also been highlighted as the most important element of managing a medical practice. The practitioner needs to keep abreast with new trends in technology and ensure that he/she trains his/her employees for smooth operations of the practice.

The next chapter is going to deal with research methodology.
CHAPTER FIVE

RESEARCH METHODOLOGY AND DESIGN

5.1 Introduction

This chapter describes the empirical study, methods used and the theoretical basis for conducting the empirical research.

The researcher aims to address the main problem, namely what should be put in place to provide doctors with managerial skills to successfully manage their medical private practices in Mercantile Hospital. This main problem is then subdivided into the following sub-problems:

- What skills do they need to have to manage their medical private practice?

- What discrepancies are there in the medical profession with regard to managerial skills?

- How are they managing their medical private practices at the moment?

- What processes do they need to do to get these skills and their relevancy? (How important and relevant are these skills in managing a medical private practice?)

- How can this be addressed?

The literature study in chapters three and four, namely Management of a small business; and Management of a medical private practice, respectively, have addressed the first two sub-problems. An empirical study discussed in this
chapter is necessary in order to solve other sub-problems, which will ultimately solve the main problem.

5.1.1 The research process

Veal, A.J. (2005:46) suggests that the research process can be divided into eight main elements as shown in figure 5.1 below. However, the variety of approaches to research suggests that not all research projects will follow precisely the same sequence of procedure. He further explains that the first four elements rarely happen in the direct, linear way that the numbered sequence implies.

**Fig 5.1 Stages in the research process**

```
1. Select topic

2. Review literature

3. Devise conceptual framework

4. Decide research question(s)

5. List information needs and operationalise

6. Decide research strategy

7. Conduct research

8. Report findings
```

5.2 Research design

Leedy, P.D. & Ormrod, J.E., (2001:93) state that in planning the research design, it is extremely important for the researcher not only to choose a viable research problem, but also to consider the kinds of data an investigation of the problem will require and feasible means of collecting and interpreting those data.

5.2.1 Nature of research study

The research study is a qualitative study which is exploratory, descriptive and deductive in nature. Veal, A.J. (2005:125) in citing Van Maanen (1983) states that qualitative methods comprise an array of interpretative techniques which seek to describe, decode, translate and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world.

Veal, A.J. (2005:125-6) lists some advantages of qualitative research:

- Qualitative methods enable the researcher to understand and explain in detail the personal experiences of individuals;
- Qualitative research focuses on people's understanding and interpretations rather than seeking external causes or laws for behaviour;
- Qualitative methods allow the researcher to experience research issues from a participant's perspective;
- Qualitative research reports are usually presented in a narrative form rather than a statistical form, making them generally more interesting and understandable for readers not trained in statistics;
- Qualitative methods are useful in examining personal changes over time; and
- Qualitative methods tend to focus on human-interest issues that are meaningful to everyday managers.
5.2.1.1 Exploratory research

Bless, C. & Higson-Smith, C. (1995:42) state that the purpose of exploratory research is to gain insight into a situation. According to Collis, J. & Hussey, R. (2003:10) exploratory research is conducted when there are very few or no earlier studies to refer to for information about the problem or issue. Through exploration the researcher develops the concepts more clearly, establishes priorities, and in many other ways improves the final research design (Emory, C.W. & Cooper, D.R., 1991:144). In this research, an exploratory study has been conducted through a literature review found on chapters three and four where management of a small business and management of a medical private practice have been explored in detail. A literature search can provide an excellent background on the areas of interest and can supply a number of good leads into the research topic (Emory, C.W. & Cooper, D.R., 1991:145).

5.2.1.2 Descriptive research

Collis, J. & Hussey, R. (2003:11) define descriptive research as research which describes phenomena as they exist. They added that descriptive research goes further in examining a problem as it is undertaken to ascertain and describe the characteristics of the pertinent issues.

5.2.1.3 Deductive research

Emory, C.W. & Cooper, D.R. (1991:42) define deduction as a form of inference which purports to be conclusive. The process is based on prior logical reasoning: a possible explanation comes first and the data are collected later to confirm or negate the explanation (Veal, A.J., 2005:26). The conclusion must necessarily follow from the reasons given.
5.2.2 Method of data collection

Emory, C.W. & Cooper, D.R., (1991:88-9) state that data may be characterised by their:

- Abstractness;
- Verifiability;
- Elusiveness; and
- Closeness to the phenomenon.

Firstly as abstractions, data are more metaphorical than real. Secondly data are processed by our senses – often limited in comparison to other living organisms. Thirdly capturing data is complicated by the speed at which events occur and the time-bound nature of observation. Lastly data classify their verity by closeness to the phenomena.

For the purpose of this study primary data will be collected by means of a questionnaire. Primary data is sought for its proximity to the truth and control over error (Emory, C.W. & Cooper, D.R., 1991:89).

A questionnaire (Annexure 3) is selected as the data collection tool of choice because firstly, the respondents do not see the source from which the questionnaire originates. This distance allows people to respond to questions with assurance that their responses will be anonymous, and so they may be more truthful than they would be in a personal interview, particularly when they are talking about controversial issues (Leedy, P.D. & Ormrod, J.E., 2005:185). They added that questionnaires have their drawbacks which include:

- Low return rate;
- Those who return them are not necessarily representative of the originally selected sample;
• Respondents’ response reflect their reading and writing skills and, perhaps, their misinterpretation of one or more questions; and

• By specifying in advance questions that will be asked, the researcher is apt to gain only limited and possibly distorted information

Secondly due to the fact that doctors in private practice are generally busy and time is a scarce resource.

Three types of questionnaires are listed and briefly explained by Hague, P., (1993:21-2) as follows

• **Structured** - the questionnaire sets out precisely the wording of the questions and the order which they will be asked. These questions have predefined answers and there will be little latitude for a respondent to stray beyond them.

• **Semi-structured** – the questionnaire uses a mixture of questions with predefined answers as well as those where the respondent is free to say whatever is liked. It is a more flexible tool and there is likely to be more probing to find out the reasons for certain answers.

• **Unstructured** – the researcher uses a checklist of questions rather than a formal questionnaire on which the answers are written down. There is considerable latitude allowed on the part of the interviewer and different channels of questioning will be selected during the interview itself.

A structured questionnaire is used in this study.
5.2.3 Questionnaire design

Frazer, L. & Lawley, M. (2000:18-9) suggest that a questionnaire design is a five steps process:

Step 1

Determine the required information and from whom it should be sought

In order to solve the main problem, primary data will be gathered through the use of questionnaires which will be distributed by the researcher to all the doctors in the Mercantile Hospital.

Step 2

Determine the interview method and the length of the questionnaire

The method of interview chosen by the researcher is the self-administered questionnaires. Bless, C. & Higson-Smith, C. (1995:108) state that in this method of interview, the questionnaire is filled in by respondents themselves without the help of an interviewer and they can be distributed to the respondents and be collected after they have been filled out, or mailed to respondents who will then be asked to send them back. The researcher will distribute the questionnaires and will collect them when they have been filled out.

The questionnaire is five pages long and is divided into three sections: the first section is about the demographical information which is aimed at getting information on the doctors' focus of specialty; the second section is about the educational information which sought to get information on whether there are any universities that train doctors in management skills; and the third section sought to get information on managerial skills that the doctors have, use and need.
Step 3

Prepare the draft questionnaire:

- Question content
- Question wording
- Response format
- Structure and layout

a) Question content

Bless, C. & Higson-Smith, C. (1995:119) state that a question can seek either factual information or opinion/attitude. Factual questions ask for objective information about the respondents, while opinion/attitude questions ask questions only the respondent knows the true answer.

Factual questions were used in the first two sections of the questionnaire to seek demographic and educational information whereas opinion questions were used in the last section of the questionnaire.

b) Question wording

There are a number of principles the researcher should observe when wording the questions for a questionnaire (Veal, A.J., 2005:155):

- Avoid jargon;
- Simplify wherever possible;
- Avoid ambiguity;
- Avoid leading questions; and
- Ask only one question at a time.
Frazer, L. & Lawley, M. (2000:24) suggest that in order to maximise the rate of response to questions, questions should be designed such that they are easy to answer and participants are more likely to respond if they feel questions are appropriate, relevant and neutral.

In this study caution is observed to avoid any ambiguity and misunderstanding. Simple English language is used to ensure that respondents understand the questions asked and these questions are closely related to and reflect the actual problem under study.

c) Response format

The questionnaire has closed questions with a combination of multiple-choice, check list, Likert scaled and rank questions. In areas where the researcher believes the list is not exhaustive, open-ended questions at the end of each question are added where respondents are asked to add any other information they feel is necessary. This is done in order to ensure that the questions are better adapted to all situations (Bless, C. & Higson-Smith, C. 1995:121).

d) Structure and layout

The order of questions can affect the motivation of respondents to complete the questionnaire (Frazer, L. & Lawley, M., 2000:29). Veal, A.J. (2005:158) suggests that a questionnaire must be laid out and printed in such a way that the person who needs to read it – whether interviewer or respondent – can follow all the instructions easily and answer all the questions that he or she is meant to answer.

In this study simple questions are asked first and intricate questions are asked at the end of the questionnaire. The questionnaires are numbered and a data
checklist will be used to track the collection of data from respondents and for follow-up purposes.

**Step 4**

**Pre-test and revise the questionnaire**

The questionnaire will be tested for its consistency, appropriateness, relevancy, and time it takes to complete it. It will be distributed to few doctors whose medical private practices are not located in Mercantile Hospital and the questionnaires will be revised thereafter.

**Step 5**

**Assess the reliability and validity of the questionnaire**

Bless, C. & Higson-Smith, C. (1995:129) define reliability as the extent to which the observable (or empirical) measures that represent a theoretical concept are accurate and stable when used for the concept in several studies. Lancaster, G. (2005:72) adds that this assumes that there are no real changes in what is to be measured or the circumstances of such measurement. He defines validity as the extent to which the data collection method or research method describes or measures what it is supposed to describe or measure.

a) **Reliability of the research instrument**

Reliability is concerned with the findings of the research. Findings can be said to be reliable if anyone else can repeat the research and obtain the same results. Leedy, P.D. & Ormrod, J.E. (2005:93) distinguish between several forms of reliability that are frequently of interest in research studies:
• Test re-test reliability is the extent to which the same instrument yields the same result on two different occasions;

• Interrater reliability is the extent to which two or more individuals evaluating the same product or performance give identical judgments;

• Internal consistency reliability is the extent to which all the items within a single instrument yield similar results; and

• Equivalent forms reliability is the extent to which two different versions of the same instrument yield similar results.

b) Validity of the research instrument

A questionnaire is valid if it measures what it is supposed to measure and should address both internal and external validity:

• Internal validity is the degree of confidence the researcher has in the causal effects between variables; and

• External validity is the ability to generalise the findings of the research from a specific setting and sample to a much broader range of populations and settings. External validity is also subdivided into the following (Gill, J. & Johnson, P., 1997:128):

  a) Population validity is the extent to which it is possible to generalise from the sample of people involved in the research to a wider population; and
b) Ecological validity is the extent to which it is possible to generalise from the actual social context in which the researcher has taken place and data thereby gathered, to other contexts and settings.

Collis, J. & Hussey, R. (2003:59) suggest that validity of research can be assessed in a number of different ways:

- Face validity which involves ensuring that the tests or measures used by the researcher do actually measure or represent what they are supposed to measure or represent;

- Construct validity which relates to the problem that there are a number of phenomena which are not directly observable, such as motivation, satisfaction, ambition and anxiety. These are known as hypothetical constructs and the researcher must be able to demonstrate that the observations and research findings can be explained by the construct.

Leedy, P.D. & Ormrod, J.E. (2005:93) add two more ways:

- Content validity is the extent to which a measurement instrument is a representative sample of the content area being measured.

- Criterion validity is the extent to which the results of an assessment instrument correlate with another, presumably related measure.

5.3 Sample population

Bless, C & Higson-Smith, C. (1995:88) emphasise that the major issue in sampling is to determine samples that best represent a population so as to allow for an accurate generalisation of results. They further distinguish between probability or random sampling and non-probability sampling.
Probability/random sampling is one in which every member of the population has an equal chance of being selected (Lancaster, G. 2005:149); while non-probability sampling refers to the case where the probability of including each element of the population in a sample is unknown.

Probability sampling includes the following procedures:

- Simple random sampling;
- Interval or systematic sampling;
- Stratified sampling; and
- Cluster or multi-stage sampling.

Non-probability sampling includes the following procedures:

- Accident or availability sampling;
- Purposive or judgement sampling; and
- Quota sampling.

For the purpose of this research, purposive or judgement sampling is used. According to Bless, C. & Higson-Smith, C. (1995:95) purposive or judgement sampling is based on the judgement of a researcher regarding the characteristics of a representative sample. The strategy is to select units that are judged to be typical of the population under investigation.

The target population in this research study is the practicing doctors in Mercantile Hospital. Doctors who are not practicing in Mercantile Hospital will be used for the pilot study.
5.3.1 Background information on the subject (Mercantile Hospital)

This study is limited to private practitioners in Life Mercantile Hospital because of the following reasons:

- it is easily accessible and information can be easily accessed;
- There are different specialists under one roof;
- These specialists have trained in different universities, which will give me an indication of whether the universities are homogenous or there is any university that offer management skills training; and
- All private practices are managed by the practitioners.

Life Mercantile Hospital is centrally located in the corner of Kempston and Durban Roads in Port Elizabeth. According to Life Healthcare web site found on http://www.lifehealthcare.co.za/hospitals/DisplayHospital.aspx?nHospitalId=34, accessed on 20 February 2008, Mercantile Hospital was started in 1984 and was owned by the Lengro Property Holding Group. It became part of the Port Elizabeth Medical Group and was taken over by Afrox. In 2005 it was included in the Life Healthcare Group, hence the name Life Mercantile Hospital.

According to Life Healthcare web site accessed on 20 February 2008, http://www.lifehealthcare.co.za/hospitals/DisplayHospital.aspx?nHospitalId=34 Life Mercantile Centre has two facilities, a hospital and a Medical Centre. The hospital has facilities that include 177 beds and 5 theatres; 14-bed general intensive care unit, a radiology unit, a diabetes clinic, a 7-bed high care unit, a 23-bed maternity unit and a 3-bed neonatal intensive care unit.

The Medical Centre has medical and surgical facilities that have disciplines which include dentistry, anaesthesiology, ENT surgery, general surgery, gynaecology, obstetrics, ophthalmology, orthopaedic surgery, paediatrics, pathology, plastic and reconstructive surgery, radiology and urology.
Supporting facilities include an in-house pharmacy, physiotherapy, diabetics, psychology, chiropractor, orthotists and prosthesists.

The website also states that there are 51 specialists in Life Mercantile Centre from all the above disciplines who support all the hospitals in the Port Elizabeth area.

5.4 Research access and ethics
5.4.1 Research access

Lancaster, G. (2005: 32) suggests that access is a subset of ethical issues and encompasses the following aspects:

- Initial permission to enter an organisation; and
- Access to information and people as part of the research design.

When conducting a research, it is vital to ensure that all necessary access and permissions have been cleared and established in advance (Lancaster, G. 2005: 108).

Medical Centre in Mercantile Hospital is an independent entity from the hospital, in other words doctors who have practices in Mercantile Hospital Medical Centre are not part of the hospital and they are independent. Therefore there is no need to seek access permission from the Hospital Manager; the researcher can deal directly with the doctors.
5.4.2 Research ethics

Emory, C.W. & Cooper, D.R. (1991: 23) state that the goal of ethics in research is to ensure that no one is harmed or suffers adverse consequences from research activities. They added that in general, research must be designed such that a respondent does not suffer physical harm, discomfort, pain, embarrassment, or loss of privacy. To safeguard this, the researcher should follow three guidelines:

- Begin data collection by explaining to the respondent the benefits expected from the research;
- Explain to the respondent that their rights and well-being will be adequately protected and indicate how that will be done; and
- Ensure that interviewers obtain informed consent from the respondents and that the method of getting the consent is appropriate and adequate.

A covering letter (Annexure 2) explaining the above will be attached to each questionnaire. Nelson Mandela Code of Ethics for Researchers will be followed at all times and comprises the following:

5.4.2.1 Confidentiality

In the process of gathering information, the information given by participants may be confidential and participants may not freely give information in fear of disclosure of their organisations’ names or that the information given may be traced to them. Organisations or participants will be assured that all data and information collected will be treated with strictest confidence and no sensitive information will be disclosed.
5.4.2.2 Voluntary participation

If a participant refuses to participate or withdraw his/her participation due to fear of findings or results traced to his/her organisation or any other reason, his/her wishes will be respected in accordance to Nelson Mandela Metropolitan University’s (NMMU) Code of Conduct for Researchers that states that the right of individuals to refuse to participate in research or to withdraw their participation at any stage should be respected by the researcher.

5.4.2.3 Anonymity

Participants may not freely express their views in fear that their names will be mentioned in the research. Participants will remain anonymous or due consent will be sought from the participant. In addition, if the participant does not want to be named or his position stated, even though it may be important to do so, the researcher will do as the participant wishes. Manipulation of people in the name of research will be avoided under all circumstances.

5.4.2.4 Dignity

It will be unethical to ridicule or embarrass participants. It is therefore important that, in dealing with people during the research, participants are treated with dignity; their views are treated with respect. Respect for the basic rights of the individual as a human being will be practiced at all times. Some participants in the research may consider the researcher as someone with authority and may feel obliged to participate without any choice. NMMU’s Code of Conduct for Researchers states that the researcher may not misuse his/her position for personal gain and that NMMU endeavours to conduct research with due regard and dignity of the individual and basic human rights. Participants will be treated as human beings in the context of their religious, political, social and economic environments.
5.4.2.5 Integrity and honesty

Falsification of information or findings for personal gain is unethical. It is imperative that the research be conducted with utmost honesty, objectivity and integrity. By so doing the institution’s integrity will not be jeopardised and the trust put to the researcher by participants will not be prejudiced. NMMU’s Code of Conduct for Researchers states that if covert research is approved, proper feedback and debriefing methods should be included in the research design. There will be mutual understanding of the roles and interests of researchers and participants.

In addition, Leedy, P.D. & Ormrod, J.E. (2005:101) include the following ethical issue:

5.4.2.6 Protection from harm

Researchers should not expose research participants to undue physical or psychological harm. As a general rule, the risk involved in participating in a study should not be appreciably greater than the normal risks of day-to-day living.

5.5 Conclusion

This chapter outlined the research methodology and design used in this study. Questionnaire design including its reliability and validity were discussed in detail. Lastly ethical consideration and access were briefly outlined.

In the following chapter, analysis and interpretation of findings will be presented and discussed.
CHAPTER 6

PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

6.1 Introduction

This chapter presents the results, analyses and interprets the data presented by the research instrument, the questionnaire, on the empirical study conducted at Mercantile Hospital. The results are analysed using MS Excel programme. The research findings are organised and presented in a tabular form, bar and pie chart, according to the sequence contained in the questionnaire.

6.1.1 Response rate

A total of 47 questionnaires were distributed to medical private practices in Mercantile Hospital and 28 questionnaires were returned. This gives a response rate of 60 percent. Saunders, M.N.K., Lewis, P. and Thornhill, A., (2000:158) in citing Dillman (1978) and Healey (1991) suggest that a 50 percent response rate is reasonable and acceptable whilst Emory, C.W. & Cooper, D.R. (1991:333) suggest that 30 percent is an acceptable response rate for surveys.

6.1.2 Questionnaire numbering and distribution

Each questionnaire was coded with a respondent number and this was used for collection purposes. The researcher distributed the questionnaires and collected them five days later on the agreed upon date. Some questionnaires were collected seven days later. A group of radiologists returned their questionnaires uncompleted citing unavailability of time to complete questionnaires.
6.2 Analysis and interpretation of Section A: The demographic data

6.2.1 Respondents were asked to indicate the number of years in medical private practice

Table 6.1: Respondents by number of years in practice

<table>
<thead>
<tr>
<th>No. of respondents</th>
<th>Cumulative number of respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 5 years</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>20</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Fig 6.1 Number of years in practice

Fig 1 shows that 72 percent of practitioners in Mercantile Hospital have been in practice for more than ten years, whilst 21 percent have been in practice for a period between 6 and 10 years. Practitioners who have been in private practice
between 0 and 5 years yielded seven percent. This means that most private practicing doctors in the hospital have been in practice for more than ten years.

6.2.2 Respondents were asked to indicate their field of specialty.

Table 6.2: Respondents by field of specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No. of respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Gynaecology &amp; Obstetrics</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>General practitioners</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Physician</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Pathology</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Most of the specialists in Mercantile specialise in Gynaecology & Obstetrics (21 percent); followed by Paediatricians (17 percent), General Surgeons (14 percent) and General Practitioners (10 percent). The rest of the specialists fall below 10 percent, that is, there are one or two doctors specialising in each of the fields.
6.2.3 Respondents were asked whether they only work in the medical private practice or in both the hospital and the private practice

Table 6.3: Respondents by place of work

<table>
<thead>
<tr>
<th></th>
<th>No. of respondents</th>
<th>Cumulative no. of respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical practice only</td>
<td>11</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>Medical practice and hospital</td>
<td>17</td>
<td>28</td>
<td>61</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Fig 6.2 Respondents’ place of work

Fig 2 shows that 61 percent private practitioners work in both the medical private practice and the hospital, whilst 39 percent of them work only in their medical private practices. Most of the practitioners who work in both the medical practice and the hospital spend the morning session in the hospital (public hospitals) and the afternoon session in their practices, whilst others spend one or two days in the hospital and the rest of the week in their practices.
6.2.4 Respondents were asked to indicate the number of people under their supervision/employment

Table 6.4: Respondents by number of people employed

<table>
<thead>
<tr>
<th>No. of respondents</th>
<th>Cumulative no. of respondents</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 5 people</td>
<td>22</td>
<td>79</td>
</tr>
<tr>
<td>6 – 10 people</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>11 – 15 people</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>16 &amp; more</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Fig 6.3 Number of people under respondents’ supervision/employment

Fig 3 shows that 79 percent of the private practitioners have between 0 and 5 people under their supervision or employment; 14 percent have between 6 – 10 people; none of the respondents have between 11 and 15 people, whilst seven percent have more than 15 people in their supervision or employment. Most of the private practices in Mercantile Hospital have between 0 and 5 people working
in it. Private practices with more than 16 people are specialising in Pathology and in General Practice, specifically in Clinical Research.

6.3 Analysis and interpretation of Section B: The educational data

6.3.1 & 6.3.2 Respondents were asked to indicate the year, the university and the qualification they obtained in their undergraduate medical degree.

All the respondents obtained their degrees in Bachelor of Medicine and Bachelor of Science (MBChB). Out of 28 respondents, six obtained their degrees internationally between 1977 and 1990; nine obtained their degrees at the University of Natal between 1967 and 1996; eight obtained their degrees at the University of Cape Town between 1967 and 1994; two obtained their degrees at the University of Witwatersrand between 1974 and 1992; three respondents each obtained their degrees at the University of Transkei, the University of Stellenbosch and the University of Pretoria respectively between 1974 and 1992.

Respondents were asked to state the qualifications they obtained in their undergraduate medical degree in order to separate and identify practitioners who obtained MBChB from other qualifications.

6.3.3 & 6.3.4 Respondents were asked if they were trained in any of the management skills discussed in chapter 3 and in which year of study were they trained.

All but two respondents were never trained in management of any kind by their universities. One respondent who obtained his/her degree internationally was trained in human resource management in his/her sixth year of study; and another respondent who obtained his/her degree at the University of Pretoria was trained in human resources management in his/her 5th year of study.

Presentation, analysis & interpretation of data
6.3.5 Respondents were asked to indicate if they had done any management training in any other institution and to state the institution, the course and the year of training

Out of 28 respondents, two obtained a Diploma in Health Management from the University of Natal and the University of Pretoria respectively between 1992 and 1994; one obtained a Certificate in Business Management from the University of South Africa and one obtained a Diploma in Bookkeeping and Diploma in Business Management from Damelin in 1988.

This shows that these medical practitioners needed these skills in order to manage their businesses in an effective and efficient manner.

6.4 Analysis and interpretation of Section C: The managerial skills data

6.4.1 Respondents were asked if they had any management skills when they started a medical private practice

<table>
<thead>
<tr>
<th>Management skills</th>
<th>No. of respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>25</td>
<td>89</td>
</tr>
<tr>
<td>Financial management skills</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Human resources management skills</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Marketing management skills</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Operations management skills</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Public relations management skills</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Purchasing management skills</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Out of 28 respondents, 25 (80 percent) had no management skills whilst three (11 percent) said they had all or some of the management skills listed above. All
three respondents who said they had some of the management skills obtained their undergraduate medical degrees internationally. Though all but one of these respondents were not trained these skills in their universities during their medical undergraduate degree training, they acquired them through management training from other institutions before opening their medical private practices as shown in 6.3.5 above.

6.4.2 Respondents were asked what managerial skills they needed when they started their private practices

Table 6.6: Respondents by number of managerial skills needed

<table>
<thead>
<tr>
<th>Management skills</th>
<th>No. of respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial management skills</td>
<td>21</td>
<td>75</td>
</tr>
<tr>
<td>Human resources management skills</td>
<td>18</td>
<td>64</td>
</tr>
<tr>
<td>Marketing management skills</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>Operations management skills</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>Public relations management skills</td>
<td>12</td>
<td>43</td>
</tr>
<tr>
<td>Purchasing management skills</td>
<td>12</td>
<td>43</td>
</tr>
</tbody>
</table>
Financial management skills were the most needed skills (75 percent) in managing the practice. This is due to the fact that cash management and other financial management activities, including tax, are seen as the critical activities that are necessary to ensure success of any business. Human resources management yielded 64 percent; public relations and purchasing management skills each yielded 43 percent, whilst both marketing and operations management skills each yielded 39 percent.

6.4.3 Respondents were asked how they were currently managing their practices

Eleven respondents said they are learning as they go along; six respondents said they are learning as they go along while they also have computer programmes that help them; seven respondents said they have computer programmes that help them; and 3 of the respondents said they do clinical work only, whilst one respondent said he/she is learning as he/she goes along at the same time he/she only does clinical work, everything else is outsourced.
6.4.4 Respondents were asked if they had any previous career/experience where they acquired managerial skills before opening their private practices

Out of 28 respondents, 25 (89 percent) had no previous careers/experience; two (7 percent) had previous experience from either the private or the public hospitals and one (4 percent) had a management career in a pharmaceutical company. This shows that 89 percent of the practitioners had no knowledge or management skills of how to run a business, whilst only 11 percent had some management skills when they opened their private practices.

6.4.5 Respondents were asked to indicate which of the activities are outsourced and which of them are done internally

Table 6.7: Respondents by activities which are outsourced or done internally

<table>
<thead>
<tr>
<th>Activity</th>
<th>Outsourced (%)</th>
<th>Done internally (%)</th>
<th>No response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bookkeeping</td>
<td>46</td>
<td>43</td>
<td>11</td>
</tr>
<tr>
<td>Financial management</td>
<td>32</td>
<td>50</td>
<td>18</td>
</tr>
<tr>
<td>Accounting</td>
<td>64</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Recruitment &amp; selection</td>
<td>0</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Employee relations issues</td>
<td>4</td>
<td>71</td>
<td>25</td>
</tr>
<tr>
<td>Practice marketing</td>
<td>0</td>
<td>71</td>
<td>29</td>
</tr>
<tr>
<td>Operations issues</td>
<td>4</td>
<td>75</td>
<td>21</td>
</tr>
<tr>
<td>Public relations issues</td>
<td>4</td>
<td>71</td>
<td>25</td>
</tr>
<tr>
<td>Purchasing</td>
<td>0</td>
<td>79</td>
<td>21</td>
</tr>
</tbody>
</table>
Fig 6.5  Activities which are either outsourced or done internally

Fig 4 shows that 64 percent of respondents outsourced the accounting activities; 46 percent outsourced bookkeeping whilst only 32 percent outsourced financial management. Activities like recruitment and selection, employee relations issues, practice marketing, operations issues, public relations issues and purchasing are mainly done internally. Some practitioners said they sent their employees to a lot of training courses in order to do other management activities.

Footnotes to explain each activity for clarity purposes were used in this question. The researcher does not know why up to 29 percent of respondents did not respond to this question as every business have most of these activities, especially the financial aspects that can be either outsourced or done internally. The researcher also understands that those practitioners who have 0 or 1 employee will not have any human resources issues to deal with.
6.4.6 Respondents were asked to rate the importance of each of the management skills using the following guide:

1 - Of some importance
2 - Important but not essential
3 - Definitely important
4 - Of vital importance

Table 6.8: Respondents by the level of importance of managerial skills

<table>
<thead>
<tr>
<th>Rank order</th>
<th>Skill</th>
<th>Ranking position</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>No rating</th>
<th>Total</th>
<th>Composite rating %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Financial management</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>18</td>
<td>2</td>
<td>28</td>
<td>85.7</td>
</tr>
<tr>
<td>2</td>
<td>Human resource management</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>10</td>
<td>7</td>
<td>2</td>
<td>28</td>
<td>60.7</td>
</tr>
<tr>
<td>3</td>
<td>Marketing management</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>13</td>
<td>2</td>
<td>2</td>
<td>28</td>
<td>53.6</td>
</tr>
<tr>
<td>4</td>
<td>Operations management</td>
<td>3</td>
<td>2</td>
<td>7</td>
<td>13</td>
<td>4</td>
<td>2</td>
<td>28</td>
<td>60.7</td>
</tr>
<tr>
<td>5</td>
<td>Public relations management</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>3</td>
<td>28</td>
<td>53.6</td>
</tr>
<tr>
<td>6</td>
<td>Purchasing management</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>1</td>
<td>3</td>
<td>28</td>
<td>46.4</td>
</tr>
</tbody>
</table>

Before discussing this question, it is necessary to explain the method used to determine the ranking position and the composite rating.

The ranking position of each skill is determined by adding together the number of ‘of vital importance’ and ‘definitely important’ responses of each component. The sum of these responses is then expressed as a percentage of the total number of responses, which then represents the composite (combined) rating of the various skill components.
Financial management skills were rated the most at 85.7 percent. This indicates that financial management skills had 18 ‘of vital importance’ responses and six ‘definitely of importance’ responses, resulting in a combined total of 24 responses. Expressed as a percentage of the total number of responses (28), this yields 85.7 percent and is positioned at number one. Human resources and operations management skills were both rated at 60.7 percent. However, human resources management skills had seven ‘of vital importance’ responses compared to four responses of operations management skills, thus human resources management skills were positioned at number two and operations management skills at number three. The same principle applies to public relations (position 4) and marketing management skills (position 5) which are both rated at 53.6 percent.

As mentioned in chapter 4 point 2.4, marketing was never an issue in the health professions so long as practice rules forbade anything that might be interpreted as touting (SAMJ Volume 94, No. 8, August 2004, pp 618 – 620). Marketing, specifically advertising of a medical practice, is forbidden in the health profession, which explains why marketing is not seen as of vital importance in the management of a medical practice. Thus marketing of a medical private practice has to be done in an ethical subdued and non-proactive way.

Purchasing management skills are the least rated management skills at 46.4 percent. This is due to the fact that not all medical practices use this activity on a daily basis. For example, since most of the respondents are specialists, they do not dispense medication but prescribe it. Only dispensing practitioners, like general practitioners, will use this activity on a daily basis.
6.4.7 Respondents were asked to indicate the most appropriate to all that apply

Table 6.9 Analysis of Question 7

<table>
<thead>
<tr>
<th>1 Strongly disagree</th>
<th>2 Disagree</th>
<th>3 Neither agree nor disagree</th>
<th>4 Agree</th>
<th>5 Strongly agree</th>
<th>NR No response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>7.1 Most doctors open private practices on completion of a undergraduate medical degree</td>
<td>-</td>
<td>11</td>
<td>28</td>
<td>50</td>
<td>7</td>
</tr>
<tr>
<td>7.2 Most doctors open private practices without any formal training on management</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>32</td>
<td>57</td>
</tr>
<tr>
<td>7.3 Managerial skills are necessary to manage a medical practice</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>7.4 Doctors who are already out of university acquire these skills through either continuous medical education programmes, experience or MBA</td>
<td>-</td>
<td>14</td>
<td>18</td>
<td>46</td>
<td>18</td>
</tr>
<tr>
<td>7.5 Business and practice management should be part of an undergraduate medical degree curriculum</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>43</td>
<td>46</td>
</tr>
</tbody>
</table>

All the statements have a composite rating of above 50 percent, which is calculated by adding the percentages of both ‘agree’ and ‘strongly agree’ responses of each statement.

From the responses, it can be concluded that the majority view that in general:

- Most doctors open private practices on completion of a undergraduate medical degree;
- Managerial skills are necessary to manage a medical practice;
- Doctors who are already out of university acquire these skills through either continuous medical education programmes, experience or MBA. However, not all options were available for respondents to choose from, as some practitioners enroll in other institutions, like Damelin and others, to be trained in some of these skills.
The overwhelming majority view that:

- Most doctors open private practices without any formal training on management;
- Business and practice management should be part of an undergraduate medical degree curriculum.

6.4.8 Respondents were given an opportunity to add any other information or suggestions they would like to add

Twenty two respondents did not have any additional information. One respondent suggested that ethics in business should be emphasised; another respondent suggested that business and practice management should be offered to house officers, that is those in internship programme; another respondent suggested that business management including fundamentals in accounting should be taught at school level and reinforced in every course offered at tertiary level; another respondent added that no effort was made during their medical training on development of business skills yet they are essential; and another respondent suggested that doctors need to be taught time management.

6.5 Conclusion

This chapter presented and analysed the results from the empirical study. The results were documented, analysed and interpreted using charts and tables.

In the next chapter recommendations and conclusion will be given.
CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

The objective of this study was to identify what should be put in place to provide doctors with managerial skills to successfully manage their medical private practices in Mercantile Hospital. This objective was achieved through a literature study and an empirical study.

This chapter is aimed at integrating the results obtained in the empirical study with the findings of the literature survey. Recommendations will thereafter be presented.

7.2 Motivation behind the study

The motivation behind the study was that the role played by doctors and the employment positions they hold in our society today has shifted from being clinical only to involve management. Though medical doctors assume their roles as managers, medical schools do not provide preparation to make them effective and efficient managers. As a result some fail to deliver due to lack of understanding and knowledge of basic business management skills. Success of any business depends on the knowledge, understanding and competency in these managerial skills.

7.3 Conclusion

The main objective of the study was to solve the main problem, namely what should be put in place to provide doctors with managerial skills to successfully manage their medical private practices in Mercantile Hospital. In solving the main problem, the following sub-problems were to be solved:
• What skills do they need to have to manage their medical private practice?

• What discrepancies are there in the medical profession with regard to managerial skills?

• How are they managing their medical private practices at the moment?

• What processes do they need to do to get these skills and their relevancy? (How important and relevant are these skills in managing a medical private practice?)

• How can this be addressed?

7.3.1 Resolution of the problem statements

The literature study revealed that managerial skills are important and necessary for the successful and effective management of a small business, specifically a medical private practice. The empirical study has confirmed this notion as the results show that most doctors strongly agree with the fact that these skills are of utmost importance, relevant and necessary in the management of their practices.

Managerial skills’ training is not offered by any medical school in South Africa. This is confirmed both in literature and in empirical study. The literature study also revealed that this training is also not offered internationally.
7.3.1.1 Discussion of the sub-problems

7.3.1.1.1 What skills do they need to have to manage their medical private practice?

The literature study on the management of a small business and the management of a medical private practice revealed that for a business to be successful, the business owner should be have knowledge, understanding and be competent in financial management skills, human resources skills, operations management skills, marketing management skills, public relations management skills and purchasing management skills.

A medical practice, as a business, needs the same managerial skills so as to be managed in an efficient and effective manner. As confirmed by the results of the empirical study, all these managerial skills are needed by medical practitioners in different degrees of need. Some of these skills are needed more than the others depending on the field of specialty, but generally they are all important.

7.3.1.1.2 What discrepancies are there in the medical profession with regard to managerial skills?

The empirical study together with the literature study showed that the medical profession in South Africa and in the world in general, does little or nothing to assist medical professionals to acquire these skills, yet they are expected to assume their roles, as managers, with utmost competency.

7.3.1.1.3 How are they managing their medical private practices at the moment?

As much as 89 percent of doctors started their practices without any managerial skills. Yet they confirmed that they needed these skills, with financial
management skills rated as the most needed managerial skill in the management of a medical private practice, followed by human resources management skills, as all respondents confirmed that they have a number of people under their supervision.

Sixty four percent of the respondents outsourced accounting activities whilst the rest of all other managerial skills are done internally. Generally the respondents are learning as they go along (64 percent) whilst the rest have computer programmes that help them. Some doctors have left the management activities to their employees who, according to the respondents, had been sent to training courses in order to perform these activities. This shows that generally doctors are using these skills on a trial and error basis, which may impact negatively on the smooth running of the business.

As mentioned in literature study in chapter 3, even though a doctor can have people who are performing all these activities for him/her, it is imperative for the doctor, as the owner of the business, to have knowledge and understanding of these managerial skills.

7.3.1.1.4 How important and relevant are these skills in managing a medical private practice?

Financial management skills are rated as the most important skills in managing a medical private practice (86 percent). This is confirmed in literature study (chapter 3) where Barrow, C. (2006:45) states that an understanding of financial reports is essential to anyone who wants to control a business; to be effective the businessman must be able to analyse and interpret the financial information. The owner(s) of any business should be conversant, competent or at least have basic skills in financial management. This is especially true with regards to billing and coding because the financial health of all healthcare businesses requires organizational competence in this arena.

Conclusion & recommendations
Purchasing management skills are viewed as of less importance in the management of a medical practice. This is due to the fact that not all medical practices are dispensing medication where purchasing management skills are extremely important and necessary.

Marketing management of a medical practice is viewed as one of the less important skills in the management of a medical private practice. Medical practitioners fail to understand and appreciate what marketing management and public relations management can do for the private practice. They do not understand that marketing does not only entail advertising the practice on newspapers, radios, etc. Good service delivery, customer-focus and community involvement initiatives are some of the forms of marketing a medical practice. It is generally believed that 80 – 100 percent of new contacts come from referrals (Foundation for Professional Development, 2004). The majority of these referrals come from satisfied patients who recommend their relatives, friends and other contacts. The medical private practice is marketed through word-of-mouth by the satisfied customers: patients, suppliers, community, etc. This shows that there is a need for medical doctors to be trained in marketing management in order for them to make an effort in marketing their medical practices.

7.3.1.1.5 How can this be addressed

This sub-problem will be dealt with in the recommendations section.

7.4 Recommendations

In resolving the main problem, the following recommendations are presented:

a) Managerial skills in the form of business management should be part of the undergraduate medical degree curriculum and should be offered in the last year of study. This is because most doctors open medical
private practices immediately after completing their studies, be it internship programme or specialization;

b) Training in business management be a prerequisite for opening a medical private practice. This will significantly reduce the number of doctors running the practice on a trial and error basis as this not only affect the doctor concerned, but the patients and the public at large; and

c) Encourage training institutions to offer management training programmes that are specifically designed for the management of a medical private practice. In other words, offer medical doctors with management training programmes that are relevant to their specific needs where important topics like, among others, dealing with medical aids, time management for doctors, medical information technology, adherence to government laws like tax payment, etc., can be addressed in depth.

7.5 Final conclusion

Doctors use resources and play a role in setting priorities, developing policies and making other management decisions. They have an obligation therefore to work with both medical and non-medical people in a productive way for the benefit of patients and the public.

Sandberg (1986:258) points out that possessing business and management skills creates the potential for entrepreneurs to manage their businesses without the need for expensive employees to perform these functions especially when resources are limited. He further suggests that possessing these skills revolves around preventing inaccuracy rather than resolving it.

In analyzing the results of the study and the prevalence of medical doctors who open medical private practices without any managerial skill; and those who fail
due to lack of sound management skills, it was evident that the undergraduate medical degree curriculum needs revisiting. Training institutions need to be encouraged to offer management courses that are specifically designed for medical doctors and should be flexible enough to accommodate medical doctors’ busy schedules.
REFERENCE LIST


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Reference list


Dear Participant

I hereby request your assistance in completing a questionnaire aimed at getting information for a research study towards MBA dissertation at Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth.

The questionnaire is designed to study management skills that are necessary for the management of a small business, specifically a medical private practice.

The information you provide will help us better understand management skills that are relevant and important for the successful management of a medical private practice. Because you are the one who can give us a correct picture of how you are currently managing your practice, you are therefore requested to please respond to the questions frankly and honestly.

Your response will be kept strictly confidential. Only members of the research team will have access to the information you give. Your participation will remain anonymous. In order to ensure the utmost privacy, identification numbers are provided for each participant. This number will only be used for follow-up purposes. We promise to treat all participants with dignity and your views will be treated with respect.

The numbers, names or the completed questionnaires will not be made available to anyone other than the research team. A summary of the results will be made available once the research has been approved by the NMMU Business School.
Participating in this research is entirely voluntary and you have the right not to participate or to withdraw from this study at any point in time. I urge you to please answer ALL questions and not to leave any questions unanswered.

Kind regards

Tandiswa Ngxukumeshe
083 569 4921
QUESTIONNAIRE

SECTION A

DEMOGRAPHIC INFORMATION

Please tick (✓) the appropriate box

1. Number of years in medical private practice

<table>
<thead>
<tr>
<th>Years</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5 years</td>
<td></td>
</tr>
<tr>
<td>5 – 10 years</td>
<td></td>
</tr>
<tr>
<td>More than 10 years</td>
<td></td>
</tr>
</tbody>
</table>

2. Please indicate your specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentistry</td>
<td></td>
</tr>
<tr>
<td>Anaesthesiology</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td></td>
</tr>
<tr>
<td>Gynaecology &amp; Obstetrics</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>Orthopaedics</td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
</tr>
<tr>
<td>Plastic &amp; reconstructive</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
</tr>
<tr>
<td>Physicist</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td></td>
</tr>
</tbody>
</table>

Other: Please specify your specialty

________________________________________________________________

3. Please tick (✓) where appropriate

<table>
<thead>
<tr>
<th>Statement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I work in the medical private practice only</td>
<td></td>
</tr>
<tr>
<td>I work in both the medical private practice and the hospital</td>
<td></td>
</tr>
</tbody>
</table>
4. Please indicate the number of people under your supervision/employment

<table>
<thead>
<tr>
<th>0 – 5 people</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5 – 10 people</td>
<td></td>
</tr>
<tr>
<td>10 – 15 people</td>
<td></td>
</tr>
<tr>
<td>15 and more</td>
<td></td>
</tr>
</tbody>
</table>

SECTION B

EDUCATIONAL INFORMATION

1. Please state the university and the year you qualified for your undergraduate medical degree

________________________________________________________________

2. Please state the qualification you obtained

________________________________________________________________

3. Please tick (√) Yes or No in the following questions:

In the university you studied at, were you trained in any of the following when you were doing your undergraduate medical degree?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business management</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Practice management</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Financial management</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Human resources management</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Marketing management</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Operations management</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Purchasing management</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Public relations management</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

4. If you answered yes in any of the above, indicate in which year of study were you trained the above:

<table>
<thead>
<tr>
<th>1st year</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd year</td>
<td></td>
</tr>
<tr>
<td>3rd year</td>
<td></td>
</tr>
<tr>
<td>4th year</td>
<td></td>
</tr>
<tr>
<td>5th year</td>
<td></td>
</tr>
<tr>
<td>6th year</td>
<td></td>
</tr>
</tbody>
</table>

Annexure 2
SECTION C

MANAGERIAL SKILLS

Please tick (√) all that apply

1. What managerial skills did you have when you started a private medical practice?

<table>
<thead>
<tr>
<th>None</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial management skills</td>
<td></td>
</tr>
<tr>
<td>Human resources management skills</td>
<td></td>
</tr>
<tr>
<td>Marketing management skills</td>
<td></td>
</tr>
<tr>
<td>Operations management skills</td>
<td></td>
</tr>
<tr>
<td>Public relations management skills</td>
<td></td>
</tr>
<tr>
<td>Purchasing management skills</td>
<td></td>
</tr>
</tbody>
</table>

Other: Please specify

________________________________________________________________
________________________________________________________________

2. What managerial skills did you need when you started a private medical practice?

<table>
<thead>
<tr>
<th>None</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial management skills</td>
<td></td>
</tr>
<tr>
<td>Human resources management skills</td>
<td></td>
</tr>
<tr>
<td>Marketing management skills</td>
<td></td>
</tr>
<tr>
<td>Operations management skills</td>
<td></td>
</tr>
<tr>
<td>Public relations management skills</td>
<td></td>
</tr>
<tr>
<td>Purchasing management skills</td>
<td></td>
</tr>
</tbody>
</table>

Other: Please specify

________________________________________________________________
________________________________________________________________

Annexure 2
3. How are you managing your practice at the moment?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am learning as I go along</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have computer programmes that help me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do clinical work only, everything else is outsourced</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other: Please specify

____________________________________________________________________
____________________________________________________________________

4. Please indicate the most appropriate answer by ticking (√) all that apply

<table>
<thead>
<tr>
<th>Service</th>
<th>Outsourced</th>
<th>Done internally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bookkeeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial management *</td>
<td></td>
<td></td>
</tr>
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<td>Accounting</td>
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<td>Recruitment &amp; selection</td>
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<td>Employee relations issues §</td>
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<td>Practice marketing</td>
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<td>Operations issues §</td>
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<td>Public relations issues §</td>
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<td>Purchasing</td>
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Other: Please specify

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5. Please rate in order of importance the following managerial skills in managing a private medical practice using the following guide:

1 – of some importance
2 – important but not essential
3 – definitely of importance
4 – of vital importance

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<tr>
<th>Skill</th>
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<tbody>
<tr>
<td>Financial management skills</td>
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<td>Human resources management skills</td>
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<td>Purchasing management skills</td>
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Annexure 2
Financial management includes budgeting, investment, cash management, income division and record-keeping;
Accounting includes compilation, analysis and interpretation of financial statements;
Employee relations issues include conflict resolution and training and development;
Operations issues include office layout, accessibility, customer complaints, customer service;
Public relations issues include stakeholder relationship building and dealing with media.
Stakeholders include employees, patients, suppliers, government, colleagues, etc.

6. Please tick (√) where appropriate

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<tr>
<td></td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neither agree nor disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
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<td>7.1 Most doctors open private practices on completion of a undergraduate medical degree</td>
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<td>7.2 Most doctors open private practices without any formal training on management</td>
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<td>7.3 Managerial skills are necessary to manage a medical practice</td>
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<td>7.4 Doctors who are already out of university acquire these skills through either continuous medical education programmes, experience or MBA</td>
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<td>7.5 Business and practice management should be part of an undergraduate medical degree curriculum</td>
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8. Any other information or suggestions you would like to add:

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Thank you for your participation.