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TOWARDS A VALUES-BASED MODEL TO MANAGE JOINT ACADEMIC APPOINTMENTS IN THE HEALTH SECTOR IN SOUTH AFRICA

by

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Submitted in fulfilment of the requirements for the degree
MCOM INDUSTRIAL PSYCHOLOGY

in the

FACULTY OF ECONOMIC AND MANAGEMENT SCIENCES

at the

UNIVERSITY OF PRETORIA

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Date of submission:
30 June 2011

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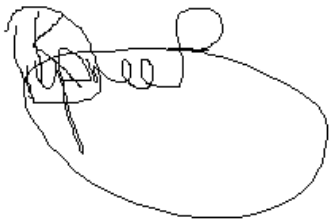
Declaration of original authorship

I, Karen Kay du Preez, declare that **TOWARDS A VALUES-BASED MODEL TO MANAGE JOINT ACADEMIC APPOINTMENTS IN THE HEALTH SECTOR IN SOUTH AFRICA** is my own work. All the resources I used for this study are cited and referred to in the reference list by means of a comprehensive referencing system. I declare that the contents of this dissertation have never before been used for any qualification at any tertiary institute.



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30 June 2011
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FACULTY OF ECONOMIC AND MANAGEMENT SCIENCES

Acknowledgements

I would like to warmly acknowledge the following persons:

- A big thank you to my study promoter, for great ideas, helpful input, support and encouragement,
- Colleagues at the University of Pretoria and Steve Biko Academic Hospital for their willingness to participate. A special mention to Emmie, Connie and Nicolien for your help and encouragement,
- To my family, for all their support and understanding and for always believing in me,
- To my husband Johan and daughter Melissa for giving me the time to follow my dream and for all their encouragement, love, support and patience and
- To my heavenly Father who is my foundation.

Towards a values-based model to manage joint appointments in the health sector in South Africa

Abstract

Joint appointments in the health sector in South Africa are made to serve both service and academic functions in one post. Typically the employing organisations are unequal, as one of them is the paying organisation while the other is the academic employer. This practice has been in existence for decades, and is ruled by expediency rather than being based on values. Joint employees experience role confusion, job confusion, dual loyalty confusion and being managed according to the rules of two organisations. This suboptimal situation leads to lower-than-expected performance in the eyes of both employing organisations.

In this study the knowledge and problem areas of joint appointments were explored. The first part of the study consisted of a questionnaire analysis of the knowledge and view of problems as expressed by joint staff as well as by human resources (HR) practitioners. Group discussions, as well as the major part of the study, namely, interviews with senior management staff of both organisations were then conducted. In order to complete the study, an analysis was made of values that might inform on the problem.

Joint staff members were found to have limited knowledge of the work requirements of a joint employee, and expressed concern about loyalty and role confusion. When the values were discussed with senior management staff, some values were identified as informing on possible solutions such as joint establishment of vision, joint objectives, respect for all components of the job, as well as generic values, including honesty, transparency, fairness, diversity and others.

A framework is suggested commenting on the potential place for a values-based approach. From this a model is proposed by means of which a values-based process can be initiated by a top-level agreement meeting (“meeting of the minds”) of both employers that may lead to a single joint vision and set of objectives. From this agreement a policy-making joint body can establish the rules, while application and implementation are monitored by local joint management committees.

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CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

The Constitution of South Africa states that access to health care is a basic human right of our population. The implications from this statement include that health care must be provided, and that health-care professionals must be trained and utilised. Furthermore, the state is planning a National Health Insurance system to further enforce the availability of medical care to all.

It is understandable that the health, health expenditure and health-care provision of a nation are of massive importance to the population of a country, and it is allocated a significant budget slice every year. It is similarly of interest to the rest of the world as this is one of the measures of developmental status of a country. Availability of health-care providers is central to this issue. Training of future health-care providers has become a key discussion in most countries in the world as budgets, research, staff retention and creation of institutions all compete for centre stage attention. Over centuries health-care training has been transformed from mainly experiential learning to a highly scientific profession.

Training students in the different health-care professions in South Africa takes place at various training sites, namely, health-care institutions that are managed by the responsible state department. The training is offered at universities through their Faculties of Health Sciences (Memorandum of Agreement, 2008). Universities are offered access to the training sites in order to conduct clinical training, and to allow for experiential learning by the students. At such training sites the health workers have a dual responsibility, namely, to provide clinical service (state responsibility) and to train (university responsibility) (Hemis, 2006; Memorandum of Agreement, 2008;Salvoni, 2001). Therefore, joint appointments are made at those training complexes (Draft Position Document, 2009; Memorandum of Agreement, 2008). Medical students are trained in Schools of Medicine where the majority of the staff members are joint appointees.

1.2 BACKGROUND TO THE RESEARCH

The management of joint appointments still leaves a knowledge gap with numerous unanswered questions. Pertinent aspects of jointness, showing problem areas where two employers are involved, can be classified as shown in Table 1. This list is by no means exhaustive. The distilled description is that role confusion occurs, and that human resources management, as well as organisational psychology aspects, is very complicated for this group of employees.

Table 1: Pertinent aspects of jointness with potential areas of conflict

DESCRIPTION	ITEM
Conditions of service	- Hours of duty - Time allocation (per employer) - Remuneration - Benefits - Appointment levels - Academic absences from service provision (e.g. external examination) - Performance management - Sabbatical leave and remunerative work outside the public sector
Conflict resolution and appeals mechanisms	- Who should discipline; the province or the university or both?
Career advancement	- Initiation and timing of the process are different for these institutions. - Career advancement for both the clinical and teaching parts of the appointment is not synchronised.
Belonging	- Loyalty - Conflicting responsibilities - Work ethic and ethics models, including postmodernism - Academic values versus service values
Appointment selection committees	- Procedural differences and technical aspects

In this study the different aspects of jointness, as described above, will be studied in detail, identifying the problems associated with each aspect. By using literature review, as well as qualitative research, values will be identified to support the concept of jointness, and to address management of such employees.

1.3 RESEARCH PROBLEM

The problem statement for this study can therefore be summarised as follows: Joint appointments by two unequal employing organisations seem to be an effective strategy to get the work done, but leads to an enormous amount of role confusion for the individual and to industrial-psychology problems for both employing organisations. This may often be at the cost of the employee who may be pressurised by both employers to achieve unrelated outcomes, leaving the role-confused employee in the middle.

This problem statement implies that the status quo is not acceptable, and a better model must be developed. The research question is whether a values-based model can be developed with the potential of being better than the status quo.

The purpose statement is to develop a values-based model for the management of joint appointments.

In order to achieve this, the research objectives for the study are the following:

- Developing a clear description of the complexity and problems surrounding the identified aspects of joint academic appointments
- Analysing the academic joint appointment process for medical doctors at the School of Medicine, University of Pretoria together with the Steve Biko Academic Hospital, (SBAH) as a template for the study
- Analysing the impact on service provision and on training for each of the listed aspects of joint appointments
- Identifying values that should govern joint academic appointments
- Developing a framework where the values can be used to inform on the problems identified
- Extending the framework to suggest a model for human resource management of joint appointments in the specified sector

1.4 DEFINITION OF KEY TERMS

Throughout this document, and in the entire study, many key terms will be used. The glossary shown in Table 2 below will be beneficial.

Table 2: Glossary

Key term or abbreviation	Section where first encountered	Definition
Academic activities	2.4	The classic description of teaching, research, community engagement used in a university context
Academic promotions	Appendix A	Awarding academic ranks of lecturer, senior lecturer, adjunct professor, associate professor or professor at universities
ASC (Appointment selection committee)	Appendix A	A interview committee of a prescribed format with all relevant partners present, where appointments and promotions are discussed and external assessors offer opinions. Recommendations are made.
CEO (Chief Executive Officer)	36	The Chief Executive Officer of Steve Biko Academic Hospital
Chief specialist	2.5	Highest rank for a medical specialist appointed by the provincial health department, often a head of department
Community service	Appendix A	In this work referred to as serving on statutory, academic or related bodies such as the College of Medicine, the Medical and Dental Professions Board, professional societies and others
Congress leave	Appendix A	Special leave awarded to attend scientific congresses. Is not deducted from annual leave.
EE (Employment Equity)	2.5	Government policy and university regulations pertaining to preferential appointment of designated persons
Faculty of health sciences	2.3	Faculty at the University of Pretoria consisting of 4 schools one of which is the School of Medicine

Key term or abbreviation	Section where first encountered	Definition
GHD (Gauteng Health Department)	1.1	Provincial department tasked with health care for the patients in the public sector; key partner in joint appointments
GSSC (Gauteng Shared Services Centre)	Appendix A	Body installed by the Gauteng Provincial Government to be responsible for centralised functions including appointments, purchases and deliveries to hospitals
Hatfield	Appendix A	In this work referred to as the site for the main operations of the University of Pretoria
Health worker	Introduction	Person of various ranks and designations working to better the health of the population
HPCSA (Health Professions Council of South Africa)	2.5	A statutory body under the Health Act mandated with registration of health workers and with accreditation of training these workers
Joint appointment	Introduction	In this work referred to appointment of a health worker, and more specifically a medical doctor by two employing institutions. This person has to fulfil more than one role.
MDPB (Medical and Dental Professions Board)	2.5	The statutory professional body governing the practice of medicine and dentistry in South Africa
Jointness	Introduction	The result of a joint appointment
NHLS (National Health Laboratory Service)	Introduction	A statutory body tasked with providing laboratory services in Health to the public sector; a key partner in joint appointments. This is recognised as such, but is not included in the study sample.
Overtime	Appendix A	Paid work after completion of normal working hours. This is how patient care is sustained at night, etc.
PM (Performance management)	Appendix A	Human resources process of real-time monitoring of the performance of an employee

Key term or abbreviation	Section where first encountered	Definition
Principal specialist	2.5	Second-highest rank of employment of a medical doctor in the provincial health service, part of the management team
Professionalism	Appendix A	A difficult-to-define code of conduct and type of behaviour described by the regulations of professional bodies to indicate the expected behaviour of a person belonging to a specific profession
Private-sector health care	2.1	Health care provided by independent practitioners for which accounts are rendered. In South Africa this comprises less than 20% of the patient population and more than 80% of the doctors.
Public-sector health care	4.1	Health care provided by the state to the population. In South Africa this comprises more than 80% of the patients and contains less than 20% of the medical doctors
Registrar	2.5	A medical doctor appointed in a specific position in order to train to become a specialist in a specific field. This person is both a postgraduate student of the university and a key workforce element of the service employer.
RWOPS (Remunerative Work Outside the Public Sector)	2.4	A statutory inscription in the Public Service Code where persons may, outside of working hours, do remuneration-generating work with explicit permission from the employer.
Sabbatical leave	Table 1	Paid leave for academic purposes. It is peculiar to academic institutions and is governed by regulations. Typically one month of sabbatical leave is “earned” per year, and may usually be taken in stretches of 6 months.
Senior specialist	2.5	A medical specialist in a senior position as appointed by the provincial health department
Specialist	2.5	A medical doctor who has trained and qualified as a specialist in one of the listed categories of medical specialities in accordance with the Health Act of South Africa. In this work this is also regarded as the entry-rank specialist appointment by the provincial health department.

Key term or abbreviation	Section where first encountered	Definition
SBAH (Steve Biko Academic Hospital)	3	The level 3+ hospital linked to the University of Pretoria
UP (University of Pretoria)	1.1	Host institution for this study
UP leave calendar	Appendix A	University dispensation where certain periods are designated as paid leave periods for all staff (e.g. the period between Christmas and New Year) except for joint appointments who have to either take holiday leave or work on those days.
Values	Title	Desirable concepts that persons and groups want to embrace
Values-based practice	2.8	Business practice based on values as a primary driver, and not only on expediency

1.5 JUSTIFICATION OF THE RESEARCH

Joint appointments in the health sciences occur in most provinces in South Africa, and there is a desire to expand this to all the provinces for the sake of uniformity. The only colloquial rules in place are the “fact of jointness” with an erroneous assumption of a 70:30 share of time in favour of the service component, and the tasking of the service department to carry the larger portion or all of the remuneration.

On a practical level, and as far as industrial psychology, and in particular its human resources management component is concerned, the field is under-investigated, and there are no standardised answers to deal with the many problems that occur on a daily basis. The need for research into a values-based model is important, hence this study.

1.6 DELIMITATIONS

The study has national importance, but will be limited to the Gauteng Health Department and the University of Pretoria's agreement and cooperation as far as appointments in the School of Medicine are concerned. This implies, furthermore, that, other than medical doctors, health-care workers will not be included in this study.

1.7 ASSUMPTIONS

As with all other studies, assumptions have to be made mainly within the paradigm of the qualitative research methods that are used in this study.

Firstly, in this study it is assumed that the participants at all levels will have an opinion on the issues of jointness as described elsewhere in this document. They will be able to explain those opinions, and will also be willing to participate at a level beyond questionnaires, namely semi-structured interviews and discussions, as required.

Secondly, the assumption is made that the modern context of values-based practice will be applicable to the outcomes of the study. This will allow the creation of a values-based model with impact on the human resources management domain as is envisaged by the study. Based on UP practice and literature guidance Lefkowitz (2003), a set of values was selected as not all values in existence can be included in the study.

1.8 METHODOLOGY

In this study, which is mainly qualitative, various research tools were used to investigate the many facets of the study problem. The initial basis was aimed at breadth (Mouton& Marais, 1988) where questionnaires were used. These included open-ended questions which enabled the researcher to collect opinions and data in order to describe joint appointments extensively. Existing documentation was also used to describe the situation (phenomenon). This led to the major part of the research that was aimed at depth where group discussions and interviews with informed persons were conducted with the goal of

better understanding the phenomenon. Conclusions were drawn, and recommendations were formulated by means of data analysis, discussion, reflection and interpretation.

1.9 OUTLINE OF THE REPORT

Following this introductory chapter the relevant literature was reviewed. Key concepts were highlighted. The importance of values was introduced. A comprehensive description of the study methodology follows. The results are subsequently discussed, and the dissertation culminates in a discussion and explanation of recommendations.

CHAPTER 2: LITERATURE REVIEW

2.1 CONTEXTUALISATION

The provision of health care to the population of South Africa is enshrined in the Constitution of South Africa – in particular section 27c (Constitution, Act 108 of 1996), and is governed by the National Health Act (National Health Act, 2003). In the same Act the responsibility for training of health-care providers is detailed, and the implementation allocated to several academic health complexes. In South Africa there are eight universities with medical schools, namely (in alphabetical order) the Universities of Cape Town, Free State, KwaZulu-Natal, Limpopo, Pretoria, Stellenbosch, Walter Sisulu and Witwatersrand. Other categories of health-care workers are trained in the above institutions, as well as in several others.

In practical terms, in South Africa health care is provided to the public sector by several categories and tiers of health workers. The responsibility for provision of medical care to the public sector has been delegated to the provincial health departments (hospital care) as well as local government (clinics and community health centres) (Hunter, 2008; McIntosh, 2006; Memorandum of Agreement, 2008). Those service departments have the responsibility of appointing health workers, and, in this particular case, doctors, to fulfil the mission of providing health care to the population of the country. Health-care facilities are classified into primary care (a diverse group of facilities comprising clinics staffed by

nursing personnel, to so-called Level 1 hospitals where generalist doctors work), secondary care (secondary or Level 2 hospitals who have medical specialists on their staff) and tertiary care facilities (predominantly staffed by medical specialists and sub-specialists, of course, in addition to nursing and other health-care staff) while some quaternary facilities or quaternary functions exist in tertiary hospitals (examples may include subspecialist care, or unique features such as the heart-transplant facility in Cape Town or the gender reassignment programme in Pretoria) (Hunter, 2008). The provision of laboratory services to public-sector patients has been centralised in the National Health Laboratory Service (NHLS). Therefore the partner organisations with the universities are the provincial health departments as well as the NHLS. Private health care is an autonomous entity, but private practitioners may be involved in health-care training in a salaried or non-salaried fashion.

The academic complexes as referred to in the National Health Act have designated training sites to fulfil their missions of training future health-care providers, and draw on the resources of the whole classification of sites as explained in the preceding paragraph (Memorandum of Agreement, 2008). For health-care providers who are working at such sites the responsibility to train now becomes part of the duty. What is happening in South Africa, to some extent, is similar to what is happening in other countries: a system of joint appointments has been developed to allow for this dual function of teaching or training, and providing a service (Fowler, 2008;Rundio, 1992). South Africa is one of a number of countries where this system is in place, other examples include Australia, some areas in the United Kingdom, certain countries in Europe and North America and in neighbouring countries of South Africa (Tamlyn, 1995). In South Africa the main employer is the state department (typically the provincial Department of Health) that is responsible for service provision, and the minor employer is the university (tasked with teaching and research). It is a system that to some extent has evolved independently rather than having been planned or researched.

2.2 APPOINTMENT OF TEACHERS OR TRAINERS IN HEALTH SCIENCES

A traditional model for the appointment of teachers and trainers in health sciences would commence with state-employed practitioners who adopt an honorary teaching role. When

a proposal would be made to approve a medical school, implementation would be required from the government, and a designated university would then be tasked to appoint professors to subsequently develop academic departments (Mieny, 1993). Most of these teachers would then become full-time government doctors, or alternatively doctors from the private sector who would spend some time in training medical students.

In South Africa some universities still appoint top-echelon academic doctors on their own staff complement (draft position statement, 2009), but this has been proven to be very costly, and hard to sustain. In the recent past, many of those universities have been forced to reduce the number of self-carried professorial positions, often in favour of provincial, rather than joint appointments as the latter system is not yet universally used in this country. In these cases service-level agreements are in place to ensure that the two legs on which the work stands, namely service and academic duties, are maintained.

In a totally expected parallel development medical training has become a much specialised field with its own science, research, scientific journals and growth. Specific attributes are striven for including the teaching of clinical skills (Morton, 2006), and the adherence to the concept of continuous learning (Knight, 2007; Barley, 2001) to use only two examples. To use these attributes in a most excellent way could be regarded as a value and the position of the medical teacher or trainer has thus become an important and uniquely identifiable position. Soon research responsibilities were added as the universities expected research and research outputs from all their academic staff.

There is no medical school in South Africa that can appoint teaching staff from university budgets only. The search for the most appropriate way of appointing teachers led to the creation of a joint appointee category of state-paid doctors who, in some way, were aligned to the universities to allow the teaching and research function to take place.

2.3 JOINT APPOINTMENTS IN HEALTH SCIENCES

Since the 1980s (Royle, 1985), literature addressing the concept of joint appointments could be found, and has mostly been published in discipline specific journals, although

some more recent papers have been taken up in human resource management type journals.

The largest experience that is based on joint appointments is found within the nursing profession. The driver of joint appointments is consistently stated to bring together teaching skills and service needs (Beitz, 2000; Brasell-Brian, 2002; Fairbrother, 1998, Fowler, 2007; Hutelmayer, 1996, McKenna, 1999; Patton, 1994, Salvoni, 2001). The literature is consistent in identifying a gap if teachers operate in a "sterile" or ivory-tower environment that, in terms of its service needs, is removed from the realities of the world. Joint appointments have been visualised as the "gap junction" to bring reality into the teaching, but also to allow the teachers, often experts in their fields, to provide service. After its conception this idea was widely introduced, and immediately had positive-effects, but it also revealed several problem areas, most importantly role confusion, loyalty issues and non-standardised handling of employees.

In several reports the need for structure, care and standardisation is emphasised (Acorn, 1991; Elliott, 1997; Gappa, 2007; Ogilvie, 2004; Rowe, 2008; Twedell, 2008). If care is not taken by both employers to support the joint appointees, the levels of role confusion will rise to a degree that will prohibit optimal functioning of the employee. This will be detrimental to both employers, as outcomes will not often be met.

In medicine and health-care sciences joint appointments have been reported to a lesser degree than in nursing (Williams, 1989). Success with a service or teaching programme through joint appointments was reported from the USA where private and public appointments allowed surgeons to continue working in their dual roles (Gupta, 2008). From an eminent medical faculty at Vanderbilt University came a report (O'Neill, 2001) confirming that a programme similar to joint appointments made training affordable and beneficial, and in actual fact contributed to the survival of the training programmes. The positive influence of jointness between academic and service in public-health medicine was also recognised and supported (Loos, 1997).

It is of interest that during the literature review the published works on joint appointments were not found to report on failure of this system or inadequacies to reach the dual

objectives. It seems that either there were only success stories or that failed projects did not reach the press. This is a common bias as positive research findings are much more likely to be published than neutral or negative findings. The papers advising structure and care might, however, be regarded as the cautionary component of the literature.

2.4 JOINT APPOINTMENTS IN SOUTH AFRICA

Such appointments have been in place from as long back as the 1960s. Documents in the archives of the University of Pretoria confirm that for the existence of the Medical School (formerly Medical Faculty) at UP joint appointments have been utilised as academic staff since 1954 (Mieny, 1993). The jointness focused on function, namely, service as well as teaching. The salaries were paid by the provincial health department (of the Transvaal in those days) while UP afforded lecturer status and certain benefits (mainly library access). The central issue of remuneration, and how that related to the service that was provided was therefore present right from the onset.

In a recent position statement to the Committee of Medical Deans in South Africa (Draft position statement, 2009) most of the attention was still paid to financial matters. This is not surprising as funding of medical training is a crucial matter in all countries. The related question of who the primary employer was, also came pertinently to the fore. This is a highly-important matter as the primary employer has a moral right to dictate the working conditions.

The financial importance is quite clear: the State provides funds for tertiary medical education through a number of grants. The State also provides funding for the activities of Universities through separate funding channels. Because spending mechanisms and staff models vary widely in South Africa there is no predictability, transparency and consistency in utilising the funding. Universities are as involved in complicating the matter as are the provincial health departments. Most South African universities with medical schools seem to consistently attempt to shelve the larger portion of the costs of medical training on the provincial health departments. This seems to be evident in chronic budget cuts to medical schools. While increased output is expected (education, research and other university objectives) the investment seems to shrink continuously. The unhappy consequence of

this spending attitude by universities contributed to the fact that the provincial health departments automatically become the primary employers. Not only does this result in prioritisation towards service objectives and downscaling of academic activities, but it also allows the provincial health departments to unilaterally make important human resource decisions, the most important of which are the freezing of posts and an unyielding post structure with very limited opportunity for a career academic medical doctor to experience promotion and career growth. Dealing with such a situation is not easy. Fortunately, over decades goodwill has always been present, and the concept of jointness has grown; although it is still very friable. Further implications, such as difficulty in performance management, revision of staff complements and establishments, disciplinary matters, uneven salary allocations and the problem of managing RWOPS place great strain on the concept of jointness.

Subsequently, pressure is applied by the Provincial Departments of Health to ensure that all academic medical doctors be appointed on provincial conditions of service. The real concern is that the primary employer will then downscale academic responsibilities even further to the level of abandonment. This concern is expressed by the Committee of Medical Deans and many academic doctors (Draft Position Statement, 2009, Kirsch, 2009).

Even to the casual observer it must be clear that a “winner-takes-all” attitude will be enormously detrimental to academic medicine in totality. The only conceivable solution must lie in a system where jointness, contracts, wedges and balances are valued and employed.

In the recent Memorandum of Agreement (2008), entered into by the Gauteng Health Department and the three universities with medical schools in the province, it was recognised that academic medical centres would be managed by joint management committees. This co-governance is supported in an authoritative publication by the past president of the Colleges of Medicine of South Africa (Kirsch, 2009), although the latter model is more intricate and probably represents a swing of the pendulum to the far side. Gauteng leads the country in these agreements, and the Joint Management Committee has only become operational in July 2009. Some of the major reasons for this dilemma

are that there is no model to work from, no data and no structure, and each party is still suspicious of the other. Once again the concept of jointness is the only apparent saviour. Both employers must buy into the concept of jointness to make the process successful.

The NHLS is another partner of the University in the joint appointment system in the School of Medicine. Once again the rules are dissimilar to that of the GHD, and this has already led to industrial action by NHLS employees. This partner should be included in further studies on jointness. Signed agreements between the NHLS and the universities are in existence.

It should be noted that the academic doctor has a major commitment towards patient care, and that there is no attempt to shelve service duties. This was recently again emphasised in the aftermath of the 2009 “doctors strike” (Kenoshi, 2009) where, although the “strike” was called to further salary claims, the resolution included concern about lack of facilities and means of providing proper patient care. To assume that all academic doctors want to perform academic activities may be as presumptuous as assuming that nobody wants to undertake academic activities. There is no data available to advise on these concerns. So this is another gap this study aims to fill. In this regard it should be emphasised that stratification according to post level and experience must be a component of the “level” of jointness. Ascertaining the amount of time that everyone spends on performing tasks, is a major burning issue, and this knowledge will advise on a number of policy issues, including funding and staff complements. Providing answers is hugely complicated by the jointness in the nature of the work performed (Hemis, 2006). As an example: there is no separation between teaching and service provision when a clinical teacher consults with, or operates on, a patient with students present.

2.5 STRUCTURE OF APPOINTMENTS ON THE THREE EMPLOYING SIDES

A complicating structural matter is the post level that is used by the three different employing bodies, UP, GHD and NHLS. At junior level some correlation can be drawn but at senior level the correlation disappears. This happens because of different sets of minimum criteria used by the different bodies, and in particular by the universities when appointments are made. In terms of academic status the universities insist on retaining

some correlation between its different campuses and faculties (Rt 115/04, 2004), who do not have to deal with the post levels of any partnering organisation. For the partner organisations factors other than academic merit play an overwhelming role. Employment equity, the capability of service provision and organisational skills are often sufficient for making a senior appointment. For the universities, academic output is of high importance. These include doctoral degrees, research outputs and teaching accolades. Almost the only constants in appointment plans are registration status as a specialist with the HPCSA through its MDPB, and some undefined years of experience in the field. A further complicating factor is that both partner employers employ the majority of their staff outside the confines of training sites. Those bodies equally have the insistence that the post levels across all their sites remain comparable. The first consequence of this difficult situation is that at university level, senior positions may be filled by persons of low academic status, while in other-than-training sites senior posts will be filled by provincial employees who have no training or research responsibility at all.

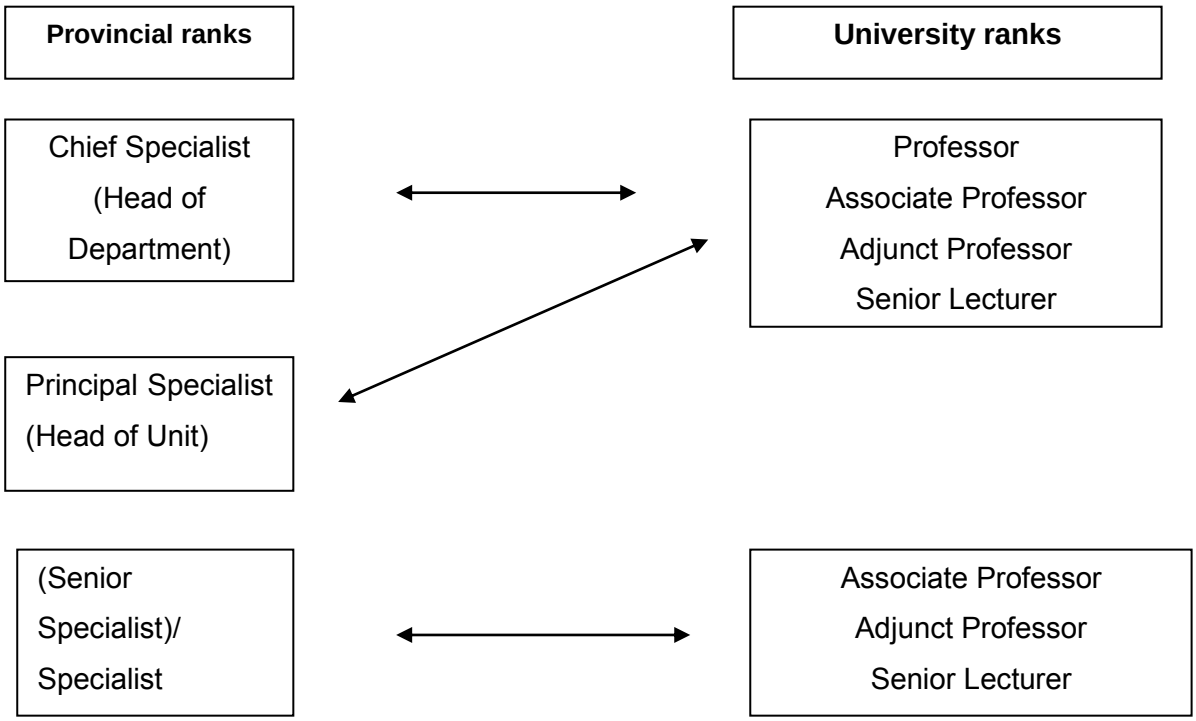
In Table 3 an overview is given of the different post ranks as seen by the separate employing bodies applicable at the time of employment. This refers to the specialist echelons.

Table 3: Post ranks in health-sciences appointments (RT 115/04)

University post ranks	Provincial post ranks	NHLS post ranks
Professor	Chief specialist	E1, E2
Associate professor	Principal specialist (Head of Unit)	D4
Adjunct professor	Specialist	D3
Senior lecturer	Specialist	D2
Lecturer	Specialist	
Registrar	Registrar	Registrar

In Figure I, a schematic presentation is given of how the ranks correspond. It should be noted that the rank of Registrar is constant, as this is a training position. In all cases these persons are appointed in joint posts, but as they are postgraduate students they occupy the same post rank.

Figure 1: Correspondence between different post ranks at the time of appointment at different institutions



Previous surveys done at the University of Pretoria (Hemis, 2006) clearly indicated a varying pattern of time consumption according to post rank. This is to be expected as, for example, the administrative component rises while the clinical component may decrease gradually with increasing seniority. In provincial terms, principal and chief specialist posts are regarded as management positions.

There is a junior rank in existence, namely, a medical officer in provincial terms that can be appointed as a junior lecturer in university terms.

2.6 CURRENT JOINT APPOINTMENT PRACTICE IN THE GAUTENG PROVINCE

According to the Memorandum of Agreement, that was recently signed between GHD and the three universities with medical schools in Gauteng, joint appointments are to be continued. The governance structure has been defined as the Joint Management Committee, a high-level committee that obtains information from several subcommittees,

namely: Partnership, Finance, Human Resources, Research and Teaching and Bilateral Facility Committees (Memorandum of Agreement, 2008). At the time of writing none of the subcommittees have been constituted, and therefore have not commenced functioning. The principles contained in the Memorandum of Agreement simply state the following:

- Joint appointments are to be made by joint appointment selection committees.
- The number of posts per facility cannot unilaterally be frozen or decreased by the GHD.
- GHD is the funder for these posts but the universities will carry the funding load for specifically designated posts.
- A person in a joint post will be contracted to only one employer.
- The duties of joint staff will include: health-service provision, teaching and training, research, management and administration, and community engagement.

There is thus no existing detailed assignment of tasks within the job description.

The function of the subcommittees will be to find out whether the clauses in the Memorandum of Agreement are workable over a period of one year (Ngcobo, 2009). It is therefore possible that even the most basic points of agreement may change. Possible reasons for that, among other things, may be that this agreement is new and untested, that one or more of the signature parties may have secondary concerns, or that gaps that need to be bridged may exist between regulation and practice.

From this discussion of the Agreement it is clear that it (the Agreement) consists of mechanistic rules and statements, and that there is a lack of values-based arguments or provisions for joint appointees (see 2.8).

2.7 CONCERNS REGARDING JOINT APPOINTMENTS

The administrative and fiscal responsibilities of the employing departments clearly have to address both sides of the joint appointments (Draft position statement, 2009, Memorandum of Agreement, 2008). This has grown through evolution, and has not been

subjected to research or stratification, in other words one rule is applied to all workers regardless of the circumstances. This is not regarded as a perfect model for management. It is purely a set of rules to act as a parameter for management (Hemis, 2006).

The most evident cause for concern on both sides of the agreement is the actions that the joint appointees will actually take. Clarity on what academic duties entail is not only limited on the side of GHD, but even on the side of the universities there also remains some role confusion. The very nature of the work performed by joint appointees does not match the standard university model of what an employee should accomplish. For this reason an audit was performed and released in 2006 (Hemis, 2006) where a fit was created between the university model and the medical school work activities. An example is presented in Figure 2. This refers to the rank Senior Lecturer corresponding with Senior Specialist. Similar examples are available for the other post levels. As it is extremely difficult to accurately calculate the hours per year, the week is used as a working unit.

In the most recent development the National Department of Health has indicated that the rank of Senior Specialist will be abolished in favour of an encompassing rank of Specialist, with a career ladder included in this rank. This development was the result of the occupational-specific dispensation (OSD), the tool that was developed to increase the remuneration of several categories of health workers (PHSDSBC Resolution, 2009). In provincial ranking terms the categories Clinical Managers (Chief and Principal Specialists) and Medical Specialists (previously Senior Specialists and Specialists) are retained. Medical Specialists are subclassified into 1-3 on the basis of experience and qualifications. Remuneration is calculated according to a guiding formula. The implication is that a person can remain in the GHD category Medical Specialist for years, achieving no rank promotion, but achieving increased remuneration over time.

Figure 2: Academic activities required from joint appointees in the Medical School, UP (Hemis 2006)

UNIVERSITY OF PRETORIA

UTILISATION OF HUMAN RESOURCES PER PERSON (in hours)

NB: Form A6/06 must be completed for every person

Department ……

A. Incumbent	Personnel no	Rank	Post no*	No of* incumbents
		Snr Lecturer/Snr Specialist		

B. Activity

		Programme no	Hours …….
1.	University Activities		
1.1	Formal teaching:	0011	14
1.2	Teaching/Patient Care (Ward rounds)	0019	33
1.3	Research	0020	3
1.4	Academic Administration: (Including school-committee work)	0046	4
1.5	Development of New Courses and Curricula	0047	1
1.6	Academic Personnel Development	0048	1
1.7	Top Management	0061	0
	Subtotal: University Activities:		56
2.	University and Hospital Activities (including Joint Appointments)		
2.1	Community Teaching (not formal programme)	0012	
2.2	Hospital Service Provision (no student involvement)	0109	5
	Subtotal: University and Hospital Activities		5
3.	Non-University Activities		
3.1	External Research/Contract Research	0031	
3.2	External Work, Consultations, RWOPS	0032	
3.3	Other Community Services	0033	5
	Subtotal Non-university Activities		5
	Grand Total All Hours		66

At the same time, another first, the HEMIS document (Hemis, 2006) reported on the assumed differences between the various post levels and the time spent on various

activities. This is reflected in Table 4. In 2008 the Department of Education (another role player) appointed a task team to identify and solve crises and limitations in clinical training. During that process the Hemis document referred to was adopted as the most accurate reflection on how time was divided between activities that was available at the time. This contributed to a separate training grant made to medical schools by the Minister of Education.

These examples address endeavours that have been done to try to do justice more accurately to the work performed by a joint appointee. In practice several more issues arise in each and every case (Acorn, 1991). There is no local or national solution to these issues at this time. A model for managing joint appointments is not in existence in South Africa. This reflects on insufficient or absent studies on this subject. Apart from the practical problems there is no clear ethical and values-based approach to manage the careers of these employees. To attempt to pursue this road towards jointness without study, research and data will lead to dictatorial policy impositions where the universities and academic medicine will undoubtedly become the losers. To address these major concerns will entail that from the sides of both employers joint values be identified, described and implemented. This will require a clever model.

Table 4: Variations in work division for joint appointees

Work activities during a week					
40 h plus 16 h plus 12 h	HOD/Chief specialist	Principal Specialist (Head of Unit)	Snr Specialist	Specialist	Registrar
1. Subsidised activities					
1.1 Formal activities					
A. Lectures	2	2	2	2	0
B. Small groups	6	8	8	8	6
C. Seminars	2	2	2	1	1
D. Practical's (in laboratory depts) **or** Bedside/clinic/ward teaching (in clinical depts)	6	8	8	8	10
E. Unique postgraduate teaching not included in the above	4	2	2	1	0
1.2 Research -contract -academic merit	5	3	3	0	3
1.3 Supplementary support					
1.4 Academic administration	19	14	4	4	5
1.5 Curriculum development	1	1	1	1	0
1.6 Academic personnel development	1	1	1	0	0
1.7 Top management (deans etc.)					
1.8 Training and service in clinical context (80% of training)	15	20	25	30	35
2. Non-subsidised activities					
2.1 Community teaching					
2.2 Hospital service rendering (no students)	0	0	5	5	10
3. Non-university activities					
3.1 External work					
3.2 RWOPS (remuneration outside of working hours)					
3.3 Community Service	5	5	5	5	0

2.8 VALUES, VALUES-BASED PRACTICE AND VALUES-BASED MANAGEMENT

Values are defined as qualities that render something desirable or the beliefs of a person or a group into which they have made an emotional investment ("Values", 2009a; "Values", 2009b). A value is an ethical assumption upon which implementation can be extrapolated. This leads to the concept that a values system is a set of consistent measures and to the concept that a principle value is the foundation upon which other values and measures of integrity can be based ("Values", 2009). In the business world, values are likewise regarded as important and enduring beliefs or ideals shared by the members of a culture (or a group) about what is good and desirable and what is not ("Value Based Management", 2009). Therefore values are seen as exerting major impact and influence on how situations over a broad spectrum can be managed.

Values have been described as the rules by which decisions on right or wrong are made. This takes place within the moral context of the person or group: morals are the motivators based on the ideas of the person or group of what is good or wrong. Ethics is the broadest concept as it represents a system of moral values or standards of conduct ("Values, Morals and Ethics", 2009) Therefore a straight line can be drawn from ethical practice and beliefs, leading to moral concepts stating what is right or wrong, leading to definition of values as guiding rules.

This concept of good and desirable practice has been termed "Value-based Management" ("History of Value Based Management", 2009) where the core philosophy is that management in a corporation or organisation is consistently run on values. While this has been practiced for years, and even centuries, it was at a low-keyed level until the 20th century when the importance of communication, standardisation, risk management, honesty, and strategic positioning and employee evaluation became recognised. Values-based management became much more prominent, however, after the Enron crisis in 2001. This was followed by similar scandals, where ignoring the values led to corruption and major losses ("History of Value Based Management", 2009). Since then this concept has been redeveloped to include good governance, strict financial management and

accounting, increased attention paid to ethics and social responsibility and a long-term view towards value creation. This is regarded as values-based practice.

In the context of joint appointments it may be of value to reflect on the Performance Prism from Canfield University ("Performance Prism", 2009) that states that organisations striving to be successful in the long run must have an exceptionally clear picture of who their key stakeholders are, and what they want. Management should understand the following:

- Stakeholder satisfaction: who are the key stakeholders, and what do they want?
- Strategies: what must be put in place to achieve the needs of the stakeholders?
- Processes: what processes must be written to execute the strategies?
- Capabilities: what is needed to achieve this?
- Stakeholder contribution: what must stakeholders contribute in order to ensure maintaining and developing these capabilities?

Translated into the process of joint appointments this would require the following:

- Identification of the needs of the two employers
- Creation of strategies supported by specific processes and defined capabilities to allow the requirements of both employers to be met
- Definition of specifics from both employers to ensure sustainability

It has been proposed that this can best be accomplished by using a values-based approach. It is recognised that there is a lack of consistency in the literature (for example, Morton (2006), 1988; Knight (2007); Barley (2001) did not regard their findings as Values, but as attributes. For the purposes of this study the broader approach was utilised as supported by Lefkowitz (2003).

According to Lefkowitz (2003), the values to be searched for in the context of managing joint appointments in the health sector would include the following:

- Transparency and honesty
- Respect for all the aspects of the job

- Justification of divisions of the job
- Loyalty
- Equity and equality in working benefits
- Joint decision-making
- Joint establishment of vision

The interpretation of this concept by the researcher is that there are general values that should guide all processes (honesty, transparency, respect, loyalty, equity and equality) but then specific values should be identified guiding the process of jointness: here joint establishment of a vision, joint decision-making and respect for all aspects of the job are prime examples.

2.9 INDUSTRIAL PSYCHOLOGY ISSUES AND JOINT APPOINTMENTS

The industrial psychologist is faced with the situation of making the system work. There are two very clear outcomes: On the one side the best results for the employers, on the other hand the best results for the employee.

While both employers have diverging expectations and desired outcomes (as discussed), the problems will persist: Examples include:

- Advertising practice where both employers must feature
- Appointment selection-committee practice
- Communication between two separate offices regarding a shared employee
- Performance management
- Management of benefits
- Idealistic factors such as selection, diversity management, succession management
- Disciplinary practice, grievance and appeals

In a recent commentary, Paskoff (2010) suggested that inability to clear administrative and functional matters as listed above would serve as an obstruction to the concept of creating a values-based workplace.

2.10 EVIDENCE THAT A VALUES-BASED SYSTEM IMPROVES OUTCOMES

It is clear that, seen from the perspective of the two employers dealing with joint appointments, also between Industrial Psychologists and employees, even the expected outcomes will differ.

Rick, Patterson, Lekka and Ilott (2008) stated that the desired outcomes of the appointment for the employee could be listed as follows:

- Competence
- Autonomy
- Individualised patient care
- Role clarity
- Job satisfaction
- Anxiety-contentment
- Depression-enthusiasm

For this to be achieved participants will be required to become involved in the process, and acquire ideological fit, flexibility, transparency, goal congruency, an employee voice and decentralisation of power.

According to Rick et al., (2008) there was to be a statistically significant impact on the improved outcomes if the process allowed for the values mentioned to drive it.

Lyons (1971) stated that perceived role clarity led to lesser voluntary turnover, job tension and special leave requests, and impacted positively on job satisfaction. These impacts were much more often present in job categories with specific requirements, and less so in the case of general workers.

It thus follows that for the employee job clarity leads to improved performance. Job clarity is improved if the appointment process and clarity in the expected outcomes from both employers are present. Such clarity follows on agreement of values.

CHAPTER 3: METHOD OF INVESTIGATION

3.1 RESEARCH PARADIGM OR PHILOSOPHY

This study focuses mainly on qualitative methods that are operating in reality. Data collection will also include certain quantitative techniques. It can therefore be stated that this study utilises mixed-method research with emphasis on qualitative research.

For the small quantitative component of the research the study may approach a **positivist** paradigm. This approach, also termed the scientific approach, requires data to be collected through empirical observation, and then analysed to arrive at the truth (Creswell, 2009). Through data collection the phenomenon will be examined and described, and opinions will be quantified. The purpose of this component is to achieve such a good understanding of the scope of the phenomenon that the next component, the in-depth study, can be performed with the expectation that error (due to poor understanding of the phenomenon) will be minimised as much as possible.

As far as the main stream of the research is concerned, the important qualitative paradigm of interpretivism (Cohen & Crabtree, 2008) will be followed. This approach relies on naturalistic methods of interviewing, observation and analysis. The researcher accepts the theoretical belief that reality is fluid, not rigid and predictable, and is socially constructed, and therefore limited by positivist approaches. The objective data from the questionnaires cannot reflect total reality of the phenomenon.

The **dimensions** can be explained as follows:

Sociological: This is a self-initiated individual project with a supervisor. My own background comes from human resources management, and I have partaken in both qualitative and quantitative research before. I deal with the problems regarding joint appointments on a daily basis.

Ontological: The study will utilise groups of participants in various stratifications with written, verbal and group interaction.

Teleological: This study is aimed at describing problems in the context of the problem statement (see earlier), and attempts to offer an alternative, namely, a values-based model.

Epistemological: For the quantitative component stringent validity and reliability measures will be employed to ensure maximal accuracy. In this case the questionnaires (the tool used for data collection) will be repeatedly discussed with knowledgeable persons.

For the qualitative component the emphasis will be on the trustworthiness and transferability of the data.

Methodological: As explained, this is mixed-type research, but the main stream is qualitative.

3.2 DESCRIPTION OF INQUIRY STRATEGY AND BROAD RESEARCH DESIGN

This is an interpretivist study. The initial basis, aiming at breadth (Mouton& Marais, 1988), utilised questionnaires that included open-ended questions to enable the researcher to describe joint appointments extensively. Existing documentation was also used to describe the phenomenon. The major part of the research was aimed at depth by using discussions, interviews with informed persons and pragmatic expansion of the research.

A hypothesis for the study remained undeclared and instead the research question was stated (see 1.3). The research question will be addressed by means of the following various research objectives and research procedures:

- Identifying values that should govern joint appointments
- Developing a clear description of the complexity and problems surrounding the identified aspects of joint appointments
- Issuing questionnaires to both joint employees (see Appendix A1) and human resource operatives (see Appendix A2), followed by focus-group discussions and interviews with informed persons

- Using the academic joint appointment process for medical doctors at the School of Medicine, University of Pretoria as a template for study, and thereby demarcating the study population
- Analysing the impact of joint appointments on service provision and training for each of the listed aspects of joint academic appointments
- Not issuing questionnaires to institutional managers of both employing organisations as in-depth interviews with these informed persons were to be held (the interview guide is attached (see Appendix A3))
- Developing a framework where the values can be used to advise on the problems identified. This will be presented in this dissertation following analysis of all the data.
- Extending the framework to suggest a model for human resource management of joint appointments in the specified sector
- Using the framework to propose a values-based model as the ultimate purpose of the study

The two questionnaires are attached as Appendices A1 and A2.

In the interviews the focus will be on the “lived” experience of the participants. The researcher used an interview guide to semi-structure the process (see Appendix A3). The interviews were recorded, and the researcher made notes and annotations.

3.3 SAMPLING

Sampling is used to observe a segment of a population so that predictions can be made in terms of a larger or a total population (De Villiers, 2009).

In order to sufficiently explore the breadth of the study, the questionnaires were distributed to all medical doctor joint appointees as indicated below to obtain as wide an opinion pool as possible on experiences and understandings of the process.

The purpose of the first questionnaire was to provide insight into experience of joint appointees. By making use of the known staff establishment of SBAH and UP (Appendix A1), the following ranks of joint appointees were recruited to complete the questionnaire:

- Chief Specialists (Heads of Departments)
- Principal Specialists (Heads of Units)
- Specialists
- Registrars

The staff working in the HR divisions of the Faculty of Health Sciences, UP, as well as in the SBAH, were recruited to complete Questionnaire A2. This instrument was created to assess questions of policy and management, as these persons were not joint appointees themselves.

Informed persons, who were regarded as people with vast experience in joint appointments but who were not included in any of the above groups, were interviewed. Informed persons are senior managers with knowledge and exposure to joint appointments from both organisations. Interviews were preferred as depth could be obtained through discussion.

Comment on the focus groups: While protocol made provision for the construction of focus groups when, on analysis of the questionnaires, divergent opinions were found, the analysis and interpretation of the questionnaire data showed so high a degree of coherence that several groups were ultimately discarded (not formed). There was also a reluctance of respondents to be identifiable even in coded format.

3.4 DATA COLLECTION

Initial data collection was done by using questionnaires as described above. By nature this contained quantitative elements, and data analysis allowed the research process to proceed. As the questionnaires needed to be answered by participants who were “blind” and anonymous to the researcher, the following scheme was presented:

- The staff complement was identified on a print-out.
- The questionnaires were duplicated to accommodate the various groups and strata by using colour coding.
- All questionnaires were numbered.
- A research assistant distributed the correct number of questionnaires to the different departments and sections.
- Participants were requested to use their own “PIN-numbers” on the forms which would allow self-identification only.
- The questionnaires were collected after two weeks and opened by the research assistant.
- The data was analysed (as described in 3.5) by the researcher.

In the research sequence it became clear that the formation of focus groups in the academic staff respondents group would not be possible. This was not only for reasons of concerns about individual exposure of opinion, but also because of the results of the data analysis. This will be demonstrated in the following section. Semi-structured interviews were held with human resources staff and key informed persons. The discussion guide for the semi-structured interviews is attached as Appendix A3.

Normal consent practice was followed (see appendices A1 and A2). The entire study was submitted for approval to the Research Ethics Committee of the relevant faculty, namely, Health Sciences. This approval was obtained, and is attached as Appendix B.

3.5 DATA ANALYSIS

The quantitative data-analysis plan included the following essential steps:

Validity and reliability were achieved by exposing the questionnaire to several knowledgeable persons, and repeated discussion with faculty management and research advisors in the Faculty of Health Sciences. Anonymity of participants who completed the questionnaire was regarded as the best method to obtain trustworthiness.

Data was recorded from the questionnaire papers, and stored electronically. Data summaries were constructed at each interim stage of the research, and coded into themes.

Data from the qualitative component of the study was stored at the Faculty of Health Sciences.

Data analysis of the interview meetings followed the Six Steps of Analysis (Kvale, 1996:1-190) namely:

- Participants describe their opinions during the interview.
- Participants discover and see new meanings and relationships during the interview.
- The researcher condenses and interprets the meanings coming from the participants.
- At first the transcripts will be reviewed by the researcher alone, and then again together with other individuals. The material will then be structured, clarified, and all non-essential elements removed. This is done to develop the contents of the interviews to highlight the meanings of the participants, and to add perspectives from the researcher. Data coding and classification will follow. Data will continuously be compared, re-examined and updated. Data will be stored and analysed.
- Future interviews will be done if required.
- Action will follow by making the data available and presentable, first graphically, and also by means of the text.

Taking another leaf from Kvale (1996), the process of data analysis follows the logical path of condensation, categorisation, structuring and interpretation.

3.5 ASSESSING AND DEMONSTRATING THE QUALITY AND RIGOUR OF THE RESEARCH DESIGN

The broad concept of the research is in line with the Van Leent concept of multidimensional research as explained by Mouton & Marais (1998), where two dimensions of the scientific space, namely, breadth and depth, will be addressed. The use of questionnaires to initiate data can be operationally justified as description is the

essential starting point. The risk that findings based on responses to questionnaires with a small sample size and a low response rate may be questionable, is acknowledged. The following measures were taken to support validity:

1 Each questionnaire has been subjected to internal control measures, in particular test-and-retest analysis on a small sample.

2 For the "depth" dimension, the norms of qualitative research were followed, with involvement of the researcher in the processes, contextualising the data and the results from discussions and descriptions of sensitising concepts after analysis, discussion, reflection and formulation.

Some comments on trustworthiness of the interviews are required. For this purpose personal notes were kept, together with the recordings to note divergence from the initial expectations. Independent checks were performed by persons other than the researcher. Member or participant checks were made to ensure accuracy. Transferability of the interviews was achieved by multiple listening and transcriptions of the interview recordings. Also an interview guide was utilised in all cases (Annexure A3).

3.6 RESEARCH ETHICS

In performing qualitative research that is related to health-care sciences, the following four major areas of ethics concerns are identified (Du Toit, 2007):

1 Prevention of harm occurring to participants

2 Informed consent from participants

3 Protection of privacy of participants

4 Prevention of deception (also termed misrepresentation (Richards, 2002)

While this is most prominent when doing research where the patient is the participant, it is no less true when the health-care worker is the participant.

Informed consent was obtained by the study structure. No possibility of exploitation was perceived in this study. Indeed, the title of the study refers to values. The researcher had no hold authority over any participant in this study.

In this study a great deal of attention was paid to protecting the participant by maintaining confidentiality of the responses, and by allowing voluntary withdrawal. There was no perceived physical or psychological risk to participants nor opportunities for anxiety or distress as the discussions were about the “facts-of-the-day” regarding their employment status. Personal matters such as own remuneration were not included in the questionnaires.

All efforts at avoiding misrepresentation were maintained in this study. This was done by prior validity and reliability assessment of the tools, as well as the use of group discussions after data had been collected.

The researcher has worked in HR management for many years, and has been exposed to the problems and difficulties of the status quo. The experience of the researcher merely led to the research questions being asked, and the study protocol being constructed. The answers were lacking, and the data was used to construct information.

Finally, as the researcher held no power over the participants, it is believed that the theoretical, epistemological and teleological dimensions of this qualitative research came to the fore at a high level.

3.7 RESEARCH SEQUENCE

The research took place in the following sequence:

- Initial interviews to identify possible values to be included for the later interviews
- Distribution and recovery of questionnaires
- Data analysis from questionnaires
- Discussion groups and interviews with knowledgeable persons from both employing organisations
- Analysis of data from all interviews and groups
- Integration of the concepts identified in the data analysis with the values having been identified before
- Creation of a values-based framework, and then a proposal for a model

CHAPTER 4: RESULTS

4.1 CONCEPTUALISATION

This study was undertaken with the purpose of exploring ways to improve the appointment experience of joint staff in the School of Medicine. In hr management such improvements must be researched and a framework be devised. The key element of values-based management was selected as the research topic. As stated in the introduction, certain observations, leading to the identification of this research opportunity, were made prior to the onset of the study.

It was thought essential that these observations be tested to exclude bias, and to inform on the areas to be addressed in the second, larger, part of the study. For this reason a questionnaire component of the study was created. This allowed exploration of knowledge, as well as identification of problems as seen from the perspective of the HR staff as well as the joint appointees.

However, the study revolved around the qualitative part, and those results will be presented in fine detail.

4.2 QUESTIONNAIRE RESULTS

4.2.1 HR questionnaires

A total of eight questionnaires were distributed, five to HR staff of UP and three to HR staff of the SBAH. Despite numerous promises and reminders, including instruction from the CEO, none of the questionnaires were returned from the SBAH HR staff. This is a telling observation. On reflection this strengthened the opinion that jointness and its associated challenges seemed not to be a high priority for this group of respondents.

The results are tabled in Table 5. Throughout (owing to the small sample numbers), Options 1 and 2 were grouped together for analysis, and the same was done with Options 4 and 5.

Table 5: Frequencies of Reponses to HR questionnaires

5	**Conditions of service**	**1 and 2** Don't agree	**3** ?	**4 and 5** Agree
5.1	The Gauteng Health Dept. requires joint employees to work for 40hours per Week			3
5.2	UP requires the joint appointee to spend an undisclosed amount of time on university activities	3		
5.3	Joint employees in medicine are remunerated by GHD as well as by UP	3		
5.4	A joint employee does not follow the UP calendar for leave			3
5.5	Their children can obtain study support from UP			3
5.6	A joint employee is Performance Managed by Gauteng Health Dept.			3
5.7	All joint appointees qualify for sabbatical leave	3		
5.8	The rules regarding sabbatical leave are clear to me		1	2
5.9	Joint appointees fall under the disciplinary rules of GHD			3
6	**Conflicting responsibilities**			
6.1	Advertisements should show logos of both employers			3
6.2	Setting up ASC should be the responsibility of both employers			3
6.3	Continuously changing staff complements threaten the process			3
6.4	Lack of institutional knowledge of persons coming into HR from dissimilar organisations threaten the process			3

5	**Conditions of service**	**1 and 2** Don't agree	**3** ?	**4 and 5** Agree
6.5	Communication between the two employers is good enough			3
6.6	Conflict resolution in ASC follows a prescribed protocol			3
7	**Systems**			
7.1	UP HR should perform all administrative work for joint appointments as preferred provider		1	2
7.2	There is good approachability between UP HR and hospital HR		3	
7.3	There is adequate understanding on the part of UP HR as well as hospital HR about their roles in the process of joint appointments	2	1	
7.4	It is important to have both HR parties present at the interview level			3
7.5	Senior ASC should be managed by UP HR			3
7.6	Information on appointments and resignations are shared between hospital HR and UP HR	3		
7.7	The sequence to be followed is clear to all parties	1	1	1
7.8	There is proper understanding in hospital HR that the UP appointment process must be completed before any announcements are made	3		
7.9	New developments (such as OSD) are shared between the two HR parties		1	2

In order to test bias, the researcher compiled a "most-likely answer", or expected response based on own knowledge and experience. The comparison of the "most-likely answer" with the real answers is shown in Table 6.

Table 6: Comparison of most-likely answer with real answer of HR staff

Question	Expected response	Majority response
5.1	5	5
5.2	5	1 *
5.3	1	1
5.4	5	5
5.5	5	5
5.6	5	5
5.7	1	1
5.8	5	5
5.9	5	5
6.1	5	5
6.2	5	5
6.3	5	5
6.4	5	5
6.5	1	3 *
6.6	1	3 *
7.1	3	5 *
7.2	5	3 *
7.3	1	1
7.4	5	5
7.5	5	5
7.6	1	1
7.7	5	1,3,5 *
7.8	3	1 *
7.9	5	5

The following questions were singled out as diverging from the expected responses:

5.2: UP requires the joint appointee to spend an undisclosed amount of time on university activities

6.5: Communications between the two employers is good enough

6.6: Conflict resolutions in appointment selection committees follow a prescribed protocol

7.1: As the preferred provider, UP HR should perform all administrative work for joint appointments

7.2: There is good approachability between UP HR and SBAH HR

7.7: The sequence from advertisement to appointment is clear to all parties in HR

7.8: There is proper understanding in SBAH HR that the UP appointment process must be completed prior to any announcements being made to the successful candidate

Discussion on divergent responses

In Question 5.2, the common understanding is that the time to be spent on the activities of the two employers is uncertain and undisclosed. All UP HR respondents did not agree with this, and thought the time problem did not exist. The researcher does not agree with this, as in the literature review reference was made to Hemis's proposals for time allocation. However, that has not been accepted as part of GHD regulations.

In Question 6.5, all respondents indicated neutrality regarding communication between UP and SBAH. The expected response was that the level of communication was poor. As will, surprisingly, be seen in the following section, poor communication was singled out as the most prominent issue by the UP HR respondents in the open-ended questions.

Once again in Question 6.6, there was neutrality on conflict resolution. The researcher is of the opinion that UP HR division may not have been aware of the regulations governing conflict resolution and management that were included in the Memorandum of Agreement between UP and GHD.

In Question 7.1, the researcher expected neutrality on whether all administration work for joint appointments should be done by UP HR staff. All respondents agreed with this concept. This may be regarded as an indication of frustration with current practice and poor level of communication.

In Question 7.7, there was no majority answer from the respondents.

In Question 7.8, the researcher expected neutrality on the understanding from SBAH HR regarding the UP appointment processes. The respondents unanimously agreed that this understanding was absent. This again indicated the poor level of communication.

Open-ended questions were included, and in all cases of the questionnaires returned, it was clear that IMPROVED COMMUNICATION was the single item listed as the most wanted improvement for the current situation.

4.2.1.1 Reflection

The data obtained from HR questionnaires indicated the following:

- The communication between UP HR and SBAH HR is indeed lacking
- UP HR is knowledgeable about the conditions of service and appointment process for joint appointees.
- SBAH HR by not responding sent a telling message to the researcher about their level of sincerity and commitment, despite the fact that other senior SBAH staff members were taking part in the study.
- This led to the reflective thought that lower echelons would only buy into values-based systems if ordered to do so by policy. Policy is created by the top echelons, and that must be the starting point for all change (Top down).

  The data collected, and the reflections made, informed on discussion, and also on later focus-group interviews. The interview was required owing to the limited data that was available from the questionnaires in these groups.

4.2.2 Questionnaires to joint appointees

A total number of 130 questionnaires were distributed to medical doctors in the various departments of the SBAH. Of these 35 were returned, 20 from consultant staff and 15 from registrars. This represented a 27% return. The results are given in two tables: one for the

consultant staff and one for registrars. The reason for this is that registrars are “contract” joint appointees but will form the future backbone of the consultant staff once they have qualified as specialists. The results are tabled in Tables 7 and 8. Throughout (owing to small sample numbers) Options 1 and 2 were grouped together for analysis and the same was done with Options 4 and 5. The response rate was not unexpectedly low, as during conversations, many people expressed their unwillingness to expose themselves to questioning by their employers.

Table 7: Consultant staff

	Working conditions: Options	**1 and 2** Don’t agree	**3** ?	**4 and 5** Agree
5.1	**Working hours**			
5.1.1	My duty hours resemble those of a GHD employee more than those of a UP employee	2	3	15
5.1.2	UP expects me to spend an undisclosed amount of time on academic activities, namely, lecturing and research	2	1	14
5.1.3	Clinical work has an academic component as well			19
5.1.4	UP time can be separated from GHD time in my position	15	2	2
5.1.5	I experience no conflict about whether I perform UP or GHD duties at any time	9	4	6
5.1.6	I am remunerated by both employers	13	1	4
5.2	**Benefits**			
5.2.1	A joint appointee does not follow the UP calendar for leave	1		18
5.2.2	A joint appointee can receive UP child study support		4	15

	Working conditions: Options	1 and 2 Don't agree	3 ?	4 and 5 Agree
5.3	**Appointment levels**			
5.3.1	A UP rank is added to my GHD appointment but without remunerative benefits			18
5.3.2	The criteria for UP rank appointments are well-known to me	8	6	5
5.4	**Academic absences from service**			
5.4.1	I am allowed time on-duty but off-site for specific situations e.g. external examination	2	2	15
5.4.2	As a joint appointee I can request congress leave	2	1	16
5.4.3	Joint appointees may request sabbatical leave		3	16
5.4.4	Joint appointees request to do RWOPs for more reasons than extra remuneration	4	3	12
5.4.5	RWOPs must be approved by both employers	3	6	10
5.4.6	RWOPs is a threat to teaching and research	12	1	5
6.	**Performance management (PM)**			
6.1	As a joint appointee my PM is done only by my GHD manager	3	1	15
6.2	A joint appointee is PM on teaching and research	7	5	5
6.3	All my activities should be subject to PM		1	18
7.	**Conflict resolution**			
7.1	I work under the disciplinary rules of GHD		2	17

	Working conditions: Options	1 and 2 Don't agree	3 ?	4 and 5 Agree
8.	**Career advancement**			
8.1	My career is planned out by both employers	11	5	3
8.2	Joint appointees find it difficult to achieve academic promotion	2	5	13
8.3	If I obtain additional qualifications my post level may not change at all		3	17
8.4	There is limited interest from UP in my clinical skills	1	2	16
8.5	There is limited interest from GHD in my teaching and research capabilities		1	17
9.	**Belonging and loyalty**			
9.1	My primary loyalty is towards the employer paying my salary	2	3	14
9.2	I am loyal to UP and my academic responsibilities	1	2	16
9.3	It is possible to be loyal to both employers	1	2	16
9.4	It will improve matters if there is clear guidance on division of time and responsibilities by both employers		2	17
9.5	I do not want to be put in conflict when having to choose between service and academic responsibilities	1	2	16
9.6	When UP requires my presence at UP activities (Faculty Day, Academic Opening, Graduation Ceremonies) I need to be able to attend without conflict from GHD			19
10.	**Appointment selection committees (ASC)**			
10.1	My initial interview was by a GHD committee	6	1	11
10.2	If I apply for a senior position I am interviewed by a joint UP-GHD Committee	2	3	15

	Working conditions: Options	**1 and 2** Don't agree	**3** ?	**4 and 5** Agree
10.3	Hospital HR's management of my appointment was good	9	5	5
10.4	UP HR's management of my appointment was good	7	4	8
10.5	The GHD and UP Employment Equity needs should not compromise academic needs and standards		1	18

Table 8: Registrars

	Working conditions: Options	**1 and 2** Don't agree	**3** ?	**4 and 5** Agree
5.1	**Working hours**			
5.1.1	My duty hours resemble a GHD employee more than a UP employee	1		14
5.1.2	UP expects me to spend an undisclosed amount of time on academic activities namely lecturing and research	1	5	10
5.1.3	Clinical work has an academic component as well	1	1	13
5.1.4	UP time can be separated from GHD time in my position	13	1	1
5.1.5	I experience no conflict about whether I perform UP or GHD duties at any time	6	5	4
5.1.6	I am remunerated by both employers	14		
5.2	**Benefits**			
5.2.1	A joint appointee does not follow the UP leave calendar	1	4	9
5.2.2	A joint appointee can receive UP child study support	5	6	1
5.3	**Appointment levels**			
5.3.1	A UP rank is added to my GHD appointment but without remunerative benefits	2	3	9
5.3.2	The criteria for UP rank appointments are well known to me	14	1	1
5.4	**Academic absences from service**			
5.4.1	I am allowed time on-duty but off-site for specific situations e.g. external examination	7	1	7
5.4.2	As a joint appointee I can request congress leave	6	3	6
5.4.3	Joint appointees may request sabbatical leave	5	6	3

	Working conditions: Options	**1 and 2** Don't agree	**3** ?	**4 and 5** Agree
5.4.4	Joint appointees request to do RWOPS for more reasons than extra remuneration	2	8	4
5.4.5	RWOPS must be approved by both employers	2	8	2
6.	**Performance management (PM)**			
6.1	As a joint appointee my PM is done only by my GHD manager	1	4	9
6.2	A joint appointee is PM on teaching and research	3	7	5
6.3	All my activities should be subject to PM	2	5	8
7.	**Conflict resolution**			
7.1	I work under the disciplinary rules of GHD	1	2	12
7.2	Both employers should be involved in any disciplinary process	1	5	9
8.	**Career advancement**			
8.1	My career is planned out by both employers	9	1	5
8.2	Joint appointees find it difficult to achieve academic promotion		10	5
8.3	If I obtain additional qualifications my post level may not change at all	4	7	5
8.4	There is limited interest from UP in my clinical skills	4	3	4
8.5	There is limited interest from GHD in my teaching and research capabilities	2	6	8
9.	**Belonging and loyalty**			
9.1	My primary loyalty is towards the employer paying my salary	3	4	9
9.2	I am loyal to UP and my academic responsibilities	1	5	10

	Working conditions: Options	**1 and 2** Don't agree	**3** ?	**4 and 5** Agree
9.3	It is possible to be loyal to both employers	3	3	10
9.4	It will improve matters if there is clear guidance on division of time and responsibilities by both employers		1	13
9.5	I do not want to be put in conflict when having to choose between service and academic responsibilities		1	15
9.6	When UP requires my presence at UP activities (Faculty Day, Academic Opening, Graduation Ceremonies) I need to be able to attend without conflict from GHD			16
10.	**Appointment selection committees (ASC)**			
10.1	My initial interview was by a GHD committee	4		12
10.2	If I apply for a senior position I am interviewed by a joint UP-GHD Committee	3	3	9
10.3	Hospital HR's management of my appointment was good	8	4	4
10.4	UP HR's management of my appointment was good	3	6	5
10.5	The GHD and UP Employment Equity needs should not compromise academic needs and standards	2	2	11

In order to test bias and knowledge the researcher compiled a "most-likely answer", or expected response based on own knowledge and experience. The comparison of the "most-likely answer" to the real answers is shown in Tables 9 and 10.

Table 9: Consultant Staff: Comparison between most-likely answer and real answer

Question	Expected response	Real majority answer
5.1.1	5	5
5.1.2	5	5
5.1.3	5	5
5.1.4	1	1
5.1.5	1	1
5.1.6	1	1
5.2.1	5	5
5.2.2	5	5
5.3.1	5	5
5.3.2	5	1 *
5.4.1	5	5
5.4.2	5	5
5.4.4	5	5
5.4.5	5	5
5.4.6	5	3 *
5.4.7	1	1
6.1	5	5
6.2	5	1 *
6.3	5	5
7.1	5	5
7.2	5	5
8.1	3	1 *
8.2	5	5
8.3	5	5
8.4	5	5
8.5	5	5
9.1	5	5
9.2	5	5
9.3	5	5
9.4	5	5

9.5	5	5
9.6	5	5
10.1	various	5
10.2	5	5
10.3	3	1 *
10.4	5	5
10.5	5	5

Table 10: Registrars: Comparison between most-likely answer and real answer

Question	Expected majority answer	Real majority answer
5.1.1	5	5
5.1.2	5	5
5.1.3	5	5
5.1.4	1	1
5.1.5	1	1
5.1.6	1	1
5.2.1	5	5
5.2.2	5	3 *
5.3.1	5	5
5.3.2	1	1
5.4.1	3	1,5 *
5.4.2	3	1,5 *
5.4.4	3	3
5.4.5	3	3
5.4.6	3	3
5.4.7	1	5 *
6.1	3	5 *
6.2	3	3
6.3	5	5
7.1	5	5
7.2	5	5

8.1	1	1
8.2	5	3 *
8.3	3	3
8.4	1	1,5 *
8.5	1	5 *
9.1	5	5
9.2	5	5
9.3	5	5
9.4	5	5
9.5	5	5
9.6	5	5
10.1	Various	5
10.2	5	5
10.3	5	1 *
10.4	5	3 *
10.5	5	5

The following questions were singled out as diverging from the expected answers:

Consultant staff

5.3.2: The criteria for UP rank promotions are well-known to me

5.4.6: RWOPS must be approved by both employers

6.2: A joint appointee is performance managed on teaching and research

8.1: My career is planned out by both employers

10.3: SBAH HR's management of my appointment was good

Discussion on divergent responses

In Question 5.3.2, the assumption was that joint appointees are knowledgeable about the regulations for UP rank appointments. However, 14 out of 19 (73%) were either neutral or in disagreement. This should be seen together with Question 8.1 where 16 out of 19 (84%) had no clarity on career-planning from both employers. On the other hand, 13 out of 19 (68%) agreed that it was difficult to achieve academic promotions for a joint

appointee. The questionnaire informed on the following events of role confusion in several aspects:

- In Question 5.1.4, disagreement that UP time can be separated from GHD time, 13 out of 19 (68%) experienced some conflict about performing UP or SBAH duties.
- In Question 9.4, 17 out of 19 (89%) believed that clarity on time allocation would improve their quality of life. In addition 16 out of 19 (84%) expressed the desire not to be put in a conflict situation on time allocation.
- In Question 5.4.6, the assumption was that knowledge existed that both employing parties were involved in approving RWOPS. This was the way that it was practiced at SBAH. It was not, however, contained in the regulations of GHD. This served as an example of goodwill arrangements in managing joint academic appointments.
- It is of interest to note (Question 5.4.7) that 13 out of 19 (68%) of the respondents held the opinion that RWOPS was not a threat to teaching and research.
- In Question 6.2, there was no clarity on what should be included in performance management of a joint appointee. The overwhelming opinion, 18 out of 19 (95%), was that all activities of a joint appointment should be subject to performance appraisal. This should be read together with Question 8.4, where 16 out of 19 (84%) stated that there was a limited interested from UP in their clinical skills and 17 out of 18 (94%) held that there was a limited interest from SBAH in teaching and research (Question 8.5).
- A further related finding was that 17 out of 19 (89%) stated that they worked under disciplinary rules of GHD (Question 7.1) but 19 out of 19 (100%) felt that both employers should be involved in any disciplinary process (Question 7.2). This section can be regarded as a very strong opinion from the consultant staff that the differences should be sorted out by the two employers to present the joint appointee with a set of values, regulations and practices as if there were only one employing organisation. The researcher was struck by the unfairness of saddling an appointee with these matters of role confusion.
- It was noted in Questions 9.1 and 9.2 that the majority of consultant staff, 73% and 74%, expressed loyalty to GHD and UP respectively. The most important statement was that 16 out of 19 (84%) stated that it was possible to be loyal to both employers. The interpretation of the researcher is that the setting of organisational

values should be such that dual loyalty disappears, and that loyalty be channelled into common vision, mission and values propositions.

Registrars

5.2.2: A joint appointee can receive UP child-study support
5.4.1: I am allowed time on-duty but off-site for specific situations e.g. external examination
5.4.2: As a joint appointee I can request congress leave
5.4.7: RWOPS is a threat to teaching and research
6.1: As joint appointee my performance management is done only by my GHD manager
8.2: Joint appointees find it difficult to achieve academic promotion
8.4: There is limited interest from UP in my clinical skills
8.5: There is limited interest from GHD in my teaching and research capabilities
10.3: SBAH HR's management of my appointment was good
10.4: UP HR's management of my appointment was good

Discussion on divergent responses

As a group, the registrars showed limited knowledge and understanding of joint appointments. Many questions were expected to have neutrality, and subsequently showed neutrality in the real answers. Examples of limited knowledge are found in Questions 5.2.2, 5.4.1 and 5.4.2. An interesting phenomenon was that the registrars felt that UP had limited interest in their clinical skills, and that GHD had limited interest in their research and teaching capabilities. The researcher was struck by this as registrars are in training, and have to demonstrate an understanding of high-level clinical skills and research capabilities in order to complete their studies. Completion of the registrars' studies is of paramount interest to both employing organisations. An inference can also be made at another level of role conflict namely the registrar as a front line health-care worker, as well as a postgraduate student at the university. Registrars as a group felt that their appointments have not been managed well by both HR departments.

Open-ended questions

The responses drew attention to the following factors:

- Communication issues
- A comment that academic medicine be furthered by the involvement of both employers, but that currently there is limited understanding of service versus academic needs by both employers
- Significant discussion is required between the two employers to eliminate role confusion
- Time allocation has been highlighted
- A joint appointment combines academic pursuits with service delivery, and that is an ideal humanitarian venture
- UP has to offer rewards that include remuneration for academic delivery
- The experiences with both HR divisions were negative, and there was a delay in sending confirmatory letters of employment.

4.2.2.1 Reflection

The data obtained from the questionnaires completed by joint appointees revealed the following:

- The knowledge of the appointment process and conditions of services was incomplete.
- A common theme existed that the two employing organisations started off with two different sets of expectations and requirements, but that the joint appointee wanted this to become united in a single vision and set of outcomes.
- The respondents supported significant discussion between the two employing organisations.
- Respondents expected the university to offer some reward which could be varying in nature. In the opinion of the researcher this could be support for study leave, sabbatical leave, research efforts or rebate on tuition fees, or even direct remuneration for certain aspects of the job.

The data captured and the reflections made, led to the very important next component of the study namely discussions and interviews.

4.3 GROUP DISCUSSIONS

As described in section 3.4 of the methods chapter, a focus-group discussion consisting of HR practitioners was planned and put together. Only the practitioners from the UP arrived to take part in this meeting. The strongest point from the focus group was a lack of communication and erratic coordination between the two HR departments; those of the UP and SBAH. Other points discussed included whether all joint appointment administration should be administered by UP HR staff, and this was felt to be contradictory to the spirit of jointness, and was not supported. What came out strongly in the focus group was the need for personal liaison and contact between the two HR offices. The conclusion of the focus-group discussion was that the HR Department could provide the technical improvement of the joint appointment process, but the most important aspect was the establishment of a joint vision and values, and the sharing of all joint information leading to a unified management system.

4.4 INTERVIEWS WITH INFORMED PERSONS

As described in section 3.4 of the methods chapter, a series of interviews were conducted with people who were identified as experienced and senior in rank on the side of both employers. As part of informed consent confidentiality was guaranteed. The transcripts are, however, available for reference with the remainder of the research data. All interviews were conducted in a standardised format with written consent, and all with the same introduction that was read from a printed document. This contained an explanation of the study and the objectives of the interview. The questions were put to the respondents in accordance with protocol. The interview sheet is attached as Annexure A3. The questions were informed by the findings of the questionnaires. This was done to ensure that the issues that were identified would be the most relevant for discussion. The most important findings were confusion about the job, loyalty and employer expectations. The results of the interviews are presented in a narrative format below:

Interviewee A: MEETING OF THE MINDS

Paraphrasing: A striking sense of fairness and a wish for the improvement of career opportunities for all employees were evident during this interview.

The university is considering support measures for joint appointees to enable them to take sabbatical leave, and further their academic careers. He suggestion that joint programmes where the objectives of both employers could be furthered. Regular meetings at the highest level were suggested to ensure that the objectives of both organisations were reached. He stated that the current joint appointment agreement is based on functionality more than on values, and in order to improve this a values-based framework should be set up.

He noted that all aspects of the job should be respected and included in performance management. Key performance areas and responsibilities of an academic as well as the performance areas in terms of service outcomes are required.

He suggested a “Meeting of the Minds” that must lead to a memorandum of understanding with commitment towards development of joint strategies and outcomes which could be diverse and at different levels.

A mechanism should be developed against the value framework to discuss, design and develop a joint strategy to support the outcomes. He suggested that key role players would include faculty management and senior members of GHD. The protocol and mandate of such a committee should be a high-level strategic discussion, and operational discussions should follow at another forum. He also commented that better career planning is needed for joint appointments. UP remains uneasy about research outputs and PhDs as this is their core business. This interviewee was not in favour of expanding the joint appointments to senior hospital management.

In his opinion, it must be part of the university’s strategy to have service delivery as a key performance area. As far as values are concerned he classified those into the following two categories:

- Basic and common values that are found in society which form an inherent part of an environment. Transparency, honesty, openness and fairness are examples of these values.

- Values supporting jointness. These values should be well-aligned with the vision and mission of the university. There must be focus on joint appointments as academic responsibility but with flexibility; thus requiring a review of the job descriptions. He stated that key performance indicators for joint appointments should be reassessed to deal with the peculiarities of the situation – another dimension of the flexibility in terms of the visible agreements that are reached between the two major players against the backdrop of the values framework.

Interviewee B

Paraphrasing: This interviewee expressed initial doubts about whether a values-based framework would work, but after an explanation of what a values-based framework is, she immediately supported the concept of specific values to be used in formulating joint vision and strategy. All aspects contributed by both employers should in her opinion be valued, and there was agreement to top-level meetings as an arena for formulating strategy.

Interviewee C

Paraphrasing: This interviewee expressed the need for a common vision to ensure fairness and effectiveness. She made a point in favour of extending joint appointments to hospital executive. The academic activities of joint appointments should be valued by GHD as they also reflect positively on GHD. She suggested that performance management and disciplinary action should be a joint process as is currently the practice. In her opinion this an example of goodwill. She confirmed that the current agreement and high level of co-operation was a result of goodwill.

Interpretation: This interviewee was not aware of the huge communication problems between the different HR divisions, however, she is well aware of the efforts of the academic Heads of Departments to work with hospital management and vice versa.

Interviewee D

Paraphrasing: While expressing a belief in jointness this interviewee stated that jointness was more than goodwill; it was a small part of the understanding that both sides needed one another.

He expressed the belief that values like honesty and quality were already present, but interestingly enough not loyalty. He thought these values were in play but values to define joint outcomes were lacking. He said that the high number of publications produced by the faculty was of no significance to the SBAH, whereas they should have been important. Academic output should be a joint responsibility, and conversely failure to achieve greatness should be the responsibility of both employing organisations.

Interpretation: The interviewee was a firm supporter of a joint management process in the work area, including joint performance management and disciplinary measures acted on by both employers. Understanding was expressed that different ranks would have different widths of responsibility. The interviewee appeared to be in favour of making SBAH executive joint appointments.

Interviewee E

Paraphrasing: Prior to being appointed at management level the interviewee claimed not to have had an understanding of jointness as a benefit. The only benefit he could think of was access to the library facility. Experiences on the unfavourable side were thought to be the status quo. These included the lingering role confusion, and the total ignorance of the two employers on either side.

He then had a long discussion on the general values of the workforce crystallised into the key values that were required for jointness being described as joint decision-making, joint establishment of a vision and joint respect for all aspects of the job.

He suggested that there had to be a meeting between key role players where vision and policy were established, and managerial meetings at a lower level to ensure maintenance of the process. He believed that this had to lead to shared objectives by both employers, and subsequently to improved communication.

Interviewee F

Paraphrasing: The interviewee clearly stated his understanding of joint appointments, namely that as clinicians who were in government service, and who were looking after government patients they should be GHD employees, while at the same time being either teachers or students, and thus having been appointed by the University as well. He felt that this concept of joint appointments should be clearly explained to the teachers, trainers and students at the time of appointment. A pitfall of joint appointments was that the previous statement could lead to the concept of two masters; and hence role confusion. The ultimate aim of the efforts of both employers was to provide good health care to South Africa. He believes this was an example of a possible shared value. A further pitfall that was identified by him was the possibility that senior members of both employing parties did not fully understand the process of jointness. This might have led to contradictory policy creation that was not beneficial to shared values. An example would have been the unilateral freezing of Registrar posts by GHD. He conceded that this might have had budgetary benefits on the short term, but could disrupt the essential continuity of training and service. If policies were similar, the strategies might still have differed, and this might similarly have led to confusion.

A further difficulty according to him was the time allocation by joint appointees that was a key feature of role confusion. The time allocation would differ with differing ranks of seniority.

He stated that the interviewee stated that the mission statement and objectives should be identified and written down in the belief that goodwill was not enough to carry the joint process forward, as goodwill was dependent on interaction of a set of people, and staff changes might have changed the perspectives.

Interpretation: To eliminate the “us-and-them” scenario in this interview, it became clear that it would have been hugely beneficial to have had senior management of SBAH as joint appointees as a gesture to cement the goodwill, and support the joint values as a matter of course.

As a measure of improving the joint appointment process it was clear that all aspects should be jointly managed from recruitment and selection to final appointment. This would assist in minimising the role confusion experienced by current joint appointment.

4.4.1 Reflection on interviews

Interviews with informed persons from both employing organisations elicited agreement that joint appointments were extremely valuable in the context of this training site as both service delivery and academic activities could be supported in this way.

The problem of role confusion and loyalty has been confirmed by all interview respondents (Question 2). All respondents accepted the need for values to drive the process. It was clear from the responses that more was at stake than generic values (Question 1).

The following values to inform were singled out (Question 4):

- Respect for all aspects of the job
- Diversity and transformation
- Joint decision-making
- Quality and equality
- Having a joint vision (this was the most commonly stated value)

On reflection diversity and transformation, as well as quality and equality should be possibly regarded as common values for all appointment scenarios. The remaining three values indicate the way towards jointness.

All respondents indicated that the generic values of quality, relevance, fairness, purpose, transparency and sustainability were important, but that they would refer to any work situation, and were not specific to joint appointments (Question 3).

Communication was highlighted as one of the key problem areas as well as one of the important values to be added to the system (Question 5).

The interview question on improving joint appointments therefore elicited the following two main answers:

a. Joint establishment of vision
b. Improved communication

The next question (Question 6), related to open-ended questions, and informed on the pertinent question of whether the traditional academic functions should be seen as a value by GHD, and conversely whether the university should value service competence and excellence. This was put to all respondents. In all cases, with varying degrees of certainty, the answer was in the affirmative.

When asked about how a values-based process could be instituted, the most forceful response was that everything started with a “meeting of the minds”

CHAPTER 5: DISCUSSION

The questionnaire data informed on the existence of problems. The following observations could be made:

- Role confusion is a reality, and is borne out in problematic time management, and issues in terms of conflict and loyalty.
- There is limited communication between HR divisions, as well as between both HR divisions and the joint appointee.
- There is limited knowledge about conditions of service on the part of joint appointees.
- The non-participation of SBAH HR led to the perception of an uneasy relationship.

The focus-group discussion and the discussions with informed persons were the aspects of the study that informed most on the problems, as well as on possible solutions. The following key issues were identified:

- Absence of a values-based system that could lead to coherence and true jointness
- A desire to move from the current situation to a situation of shared values and shared objectives
- The necessity to have buy-in from top echelons, and others further down the organisations
- The necessity of improved communication
- Establishment of a structure that will execute policy to ensure an improved outcome at the level of the workplace
- An increased role of the UP in the total process as seen by sharing its values and mission, various forms of support for joint appointments, and extension of joint appointments to senior management staff at SBAH

It is clear to the researcher that –

- in this facility, joint appointments were started half a century ago in order to use less staff to achieve two objectives, namely, service provision as well as teaching and training;
- the process has become embedded in practice, and has not been changed much since the beginning;
- the literature illustrates all the pitfalls experienced in other areas of the world where similar procedures were followed (this was reviewed in Chapter 2);
- role confusion has become more prominent as both employing parties have extended their expectations of the actions of the joint appointee (universities want research and training as well as community engagement, GHD wants service but is also interested in research, and training is accepted by GHD as part of the process);
- joint appointees have limited knowledge of the process of their appointments – more so registrars than consultants;
- while employees are loyal to both employers, the practicality of the situation creates conflict;
- while technical adjustments can be suggested to make the processes better, the first step must be a consensus opinion on the values to be followed by both parties (this must start at the top echelons in the organisations, and will require “meetings of the minds”, and the greater good is therefore to use identified shared values to inform on the process in the hope that these shared values will go a long way to solve issues of loyalty and role confusion);
- reflecting on the literature and referring to strong value statements (Lefkowitz, 2003), values should underlie all practice as this is a more recent foundation of practice compared to the older views of the “bottom-line” or unchanged practice rules. A values based approach allows a new beginning for co-operation and other enterprises;
- the values-based approach can be suggested in a framework (Chapter 6); and
- a model is proposed in Chapter 7.

CHAPTER 6: FRAMEWORK

Two employing organisations are involved in a process of joint appointments. Each organisation has its own vision, mission and strategic direction.

The paying employer is GHD, and the academic employer is UP. Together these employers are concerned with the joint appointment process that is examined in this study. According to the perception of the researcher the following statements are made:

The benefits for the individual to work for GHD are:

- Salary and benefits
- Good working environment
- Helping sick people
- Community engagement
- Possibility to undertake subspecialisation
- Possibility to perform RWOPS

The following are benefits for the individual to work for the University of Pretoria are:

- Access to teaching, research facilities and programmes
- Academic status
- Study benefits for the individuals and their families
- Congress and sabbatical leave

These lists are not exhaustive but are commonly held to be accurate by responding staff members. The challenge will be not to persist with two separate sets of benefits but to have one set of benefits, values and rules.

In a process of joint appointments where individuals work for both employers, there has to be a buy-in into the values of both organisations. The top values for GHD are excellence in patient care and service delivery. The top values for UP are excellence in teaching and learning, research and community engagement.

In this context working for GHD has the following disadvantages, and they are all related to jointness are:

- Role confusion
- Time regulation and insufficient time planning
- Belonging
- Career advancement issues
- Conflict resolution

Similarly, for a joint appointee to work for UP has the following disadvantages are:

- Role confusion
- Time regulation and insufficient time planning
- Conflict resolution
- Rigid GHD career ladder

The disadvantages are now very similar from the perspective of both organisations. Following on this thought process, there can be no doubt that the values of both organisations should meet.

Seen from GHD the advantages of jointness are as follows:

- UP quality doctors on their staff establishment
- Relevance in training and patient care
- Experiential learning offered
- Access to UP infrastructure, staff and equipment

From the UP perspective the benefits of joint appointments are as follows:

- Relevance (clinical service is the most extreme form of community engagement)
- Relevant research in the context of patient care
- Experiential learning for students
- Lecturers being paid by GHD

Disadvantages for medical doctors working for GHD include the regulation and planning of time. Disadvantages from a UP perspective are that the appointment of staff is managed by GHD.

The following can be described as threats to jointness from a GHD perspective:

- Political preferences
- Budget constraints
- Patient overload leading to excessive service demands
- Gauteng Shared Services Centre inefficiency

Threats to jointness from UP perspective:

- Lack of understanding of state budget process and preference
- Red tape and excessive processing
- The strong government transformation drive that leads to mentorship being required even for senior staff members
- Failure to communicate with UP on HR process matters by GHD

As was discussed in 2.3, the advantages of jointness were clearly noted and discussed in the literature.

The individual employee is a health-care professional. The professional behaviour (professionalism) that dictates the function and work of the individual must assist the joint appointee in coping with the various demands. Professionalism can be defined as a set of values that describe a group of people in a job category. It therefore follows that the disadvantages of jointness and individual work that have been described must be transformed to advantages for the system to optimally support the joint appointee.

The following can thus be regarded as original work stemming from the research.

6.1 THE FRAMEWORK THEREFORE CAN BE SEEN AS FOLLOWS:

All the findings from the interview data suggested the following:

A. The values must be identified by the top echelons of both employers in combined meetings. This is referred to as the "meeting of the minds". What follows are the key values identified in this study:

- Joint establishment of vision
- Joint decision-making
- Respect for all the aspects of the job
- Communication

The inclusion of generic values (honesty, transparency, quality, relevance, even-handedness, fairness, diversity and openness) must be accepted by all as a given. Loyalty deserves a special mention, as this study revealed that the majority of staff members responded positively to the statement that loyalty to both employing organisations was possible. In the opinion of the researcher this is more than possible it is essential.

B. The next step in the framework is proper description of joint vision and other values in a uniform policy document. This policy must be implemented by high ranking committees with membership from both employers in order to set the flow of structure, regulation and process.

C. At institutional level, the senior managers representing both employers should be joint appointees, or should become joint appointees. This will be a visible indication that the shared vision is translated into common practice.

The joint committees mandated by the existing Memorandum of Agreement between UP and GHD, will then have a common objective.

In this sense it must be as important for the academic employer as it is for the paying employer that excellence in service delivery and clinical care is reached. Likewise excellence in research and teaching and learning must be as important to the GHD as it is for the UP. This has serious implications on performance management processes.

Once these values have been put in place it will be easy, and a technical matter, to solve issues relating to time and other process challenges. In terms of this, reference is made to existing Hemis documents (referred to in this study) where pro-formas have been designed.

All the findings of the study indicated that for jointness to be optimised, and indeed to survive as an appointment model, all the processes, from values to execution must be pure, transparent and sustainable. In the next chapter a model is proposed that depicts this thought pattern.

CHAPTER 7: MODEL

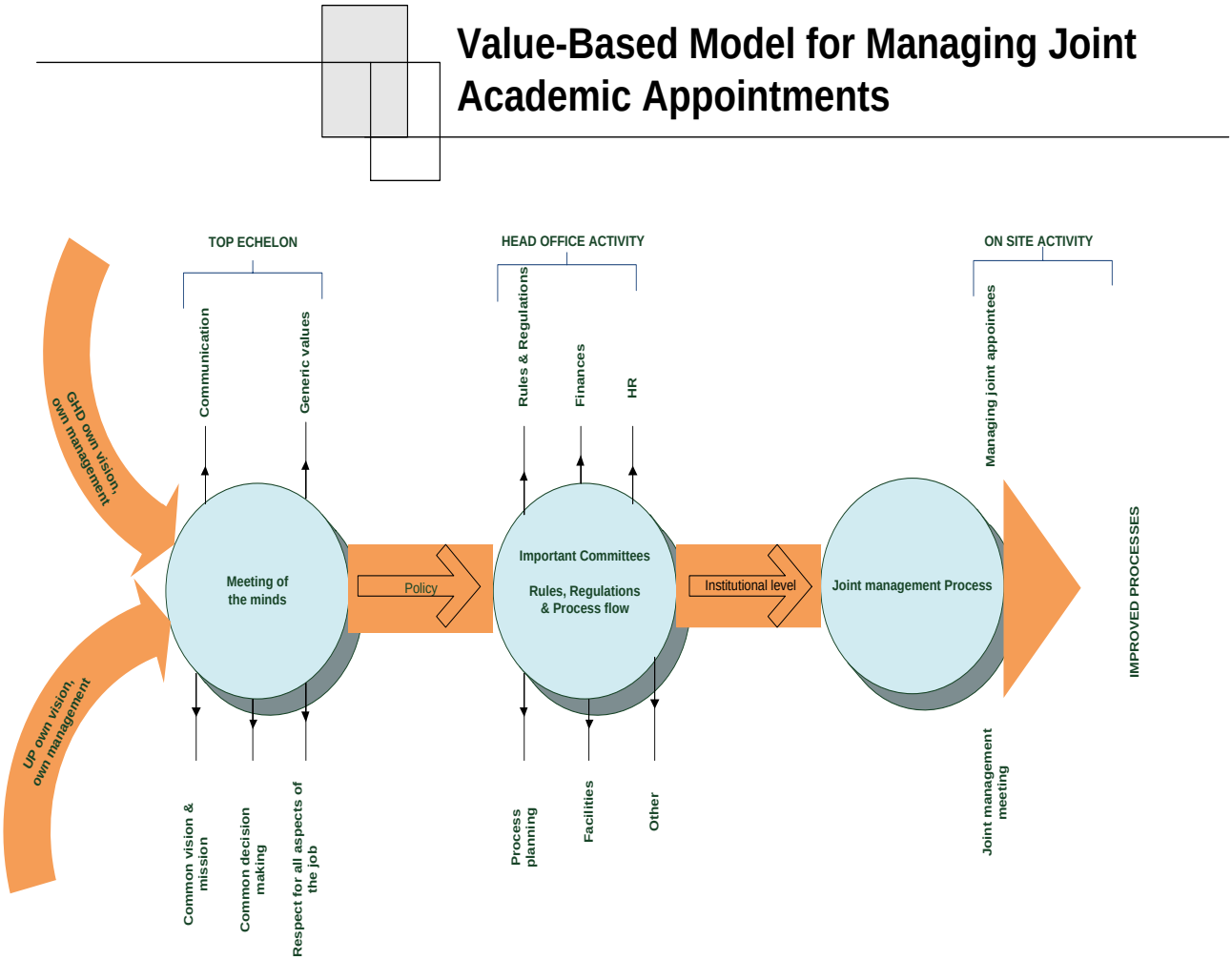
The final outcome of the study is a proposed values-based model to better manage joint academic appointments as shown in Figure 3. It is the firm belief and finding of this researcher that unless the first step is executed by the top echelons of both organisations, the programme will not be successful. This is therefore the most critical finding of the study.

The model suggested by the study can be interpreted as a top-down approach. Top-down approaches are commonly used in organisations (Van Tonder, (2006) when rapid change is desired. A bottoms-up approach may be effective if chronic change is desired over a long period but it is highly debatable that employees in such a big organisation as state organs can effect change on their own.

In the opinion of the researcher, the research question has been answered**:** A model has been suggested that, following the findings, if tested, may lead to a better outcome for practice.

All the components of the model below follow the descriptions of the framework.

Figure 3: Value-Based Model for Managing Joint Academic Appointments



CHAPTER 8: LIST OF REFERENCES

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APPENDICES

APPENDIX A

Data-collection Instruments

APPENDIX B

Ethics Approval

APPENDIX A1: QUESTIONNAIRE – JOINT EMPLOYEES

UNIVERSITY OF PRETORIA

FACULTY OF HEALTH SCIENCES

QUESTIONNAIRE ON JOINT APPOINTMENTS: Joint employees

The aim of the questionnaire is to assess your knowledge and feelings on joint appointments and their various facets. The survey forms part of a post-graduate study, and is performed with the consent of the University of Pretoria, the Steve Biko Academic Hospital and the NHLS. Participation is encouraged but is voluntary. There are no benefits for respondents and no penalties for non-respondents

The questionnaire also contains some open-ended questions where you can state your opinions. If these opinions require further discussion, an interview may be requested or a discussion group may be formed. Although your identity may then become known the discussion will remain confidential. When this part of the survey is activated the researcher will request the departments to seek participation of specific responders by number. Therefore, please remember the following number that has been allocated to you:

Number of questionnaire/respondent |_ | _| __|

Personal PIN number |_ | _| _|_ | _|__|

Demographics: Please mark the boxes that are applicable to *you*

							OFFICE USE KANTOORG EBR.
	Rank						
1.	Chief specialist	1	Principal specialist	2	Specialist / Senior specialist	3	R01_____
2.	Registrar	4					R02_____
3.	Female	1	Male	2			R03_____
4.	Please indicate your department:						R04_____

Survey

For each of the questions that follow encircle ONE number that reflects your view most accurately. (If, in your opinion, the question is not relevant to this particular topic, encircle N/A6. However, please use that option sparingly.)

1 = Disagree entirely/very bad or poor
2 = Disagree/bad or poor
3 = Neutral opinion
4 = Agree/good
5 = Agree entirely/very good

5.	**Working conditions**								
5.1	**Working hours**								
5.1.1	My duty hours resemble those of a GHD employee more than a UP employee	1	2	3	4	5	N/A6		R05_____
5.1.2	UP expects me to spend an undisclosed amount of time on academic activities, namely lecturing and research	1	2	3	4	5	N/A6		R06_____
5.1.3	Clinical work has an academic component as well	1	2	3	4	5	N/A6		R07_____
5.1.4	UP time can be separated from GHD time in my position	1	2	3	4	5	N/A6		R08_____
5.1.5	I experience no conflict about whether I perform UP or GHD duties at any time	1	2	3	4	5	N/A6		R09____
5.1.6	I am remunerated by both employers	1	2	3	4	5	N/A6		R10____
	5.2 Benefits								
5.2.1	A joint appointee does not follow the UP leave calendar	1	2	3	4	5	N/A6		R11____
5.2.2	A joint appointee can receive UP child study support	1	2	3	4	5	N/A6		R12____
5.3	**Appointment levels**								
5.3.1	A UP rank is added to my GHD appointment but without remunerative benefits	1	2	3	4	5	N/A6		R13____

1 = Disagree entirely/very bad or poor
2 = Disagree/bad or poor
3 = Neutral opinion
4 = Agree/good
5 = Agree entirely/very good

5.3.2	The criteria for UP rank appointments are well known to me	1	2	3	4	5	N/A6		R14____
5.4	**Academic absences from service**								
5.4.1	I am allowed time on-duty but off-site for specific situations e.g. external examination	1	2	3	4	5	N/A6		R15____
5.4.2	As a joint appointee I can request congress Leave	1	2	3	4	5	N/A6		R16____
5.4.4	Joint appointees may request sabbatical leave	1	2	3	4	5	N/A6		R17____
5.4.5	Joint appointees request to do RWOPs for reasons other than extra remuneration	1	2	3	4	5	N/A6		R18____
5.4.6	RWOPs must be approved by both employers	1	2	3	4	5	N/A6		R19____
5.4.7	RWOPs are a threat to teaching and research	1	2	3	4	5	N/A6		R20____
6.	**Performance management (PM)**								
6.1	As a joint appointee my PM is done only by my GHD manager	1	2	3	4	5	N/A6		R21____
6.2	A joint appointee is PM on teaching and research	1	2	3	4	5	N/A6		R22____
6.3	All my activities should be subject to PM	1	2	3	4	5	N/A6		R23____
7.	**Conflict resolution**								
7.1	I work under the disciplinary rules of GHD	1	2	3	4	5	N/A6		R24____
7.2	Both employers should be involved in any	1	2	3	4	5	N/A6		R25____

1 = Disagree entirely/very bad or poor
2 = Disagree/bad or poor
3 = Neutral opinion
4 = Agree/good
5 = Agree entirely/very good

	disciplinary process								
8.	**Career advancement**								
8.1	My career is planned out by both employers	1	2	3	4	5	N/A6		R26____
8.2	Joint appointees find it difficult to achieve academic promotion	1	2	3	4	5	N/A6		R27____
8.3	If I obtain additional qualifications my post level may not change at all	1	2	3	4	5	N/A6		R28____
8.4	There is limited interest from UP in my clinical skills	1	2	3	4	5	N/A6		R29____
8.5	There is limited interest from GHD in my teaching and research capabilities	1	2	3	4	5	N/A6		R30____
9.	**Belonging and loyalty**								
9.1	My primary loyalty is towards the employer paying my salary	1	2	3	4	5	N/A6		R31____
9.2	I am loyal to UP and my academic responsibilities	1	2	3	4	5	N/A6		R32____
9.3	It is possible to be loyal to both employers	1	2	3	4	5	N/A6		R33____
9.4	It will improve matters if there is clear guidance on division of time and responsibilities by both employers	1	2	3	4	5	N/A6		R34____
9.5	I do not want to be put in conflict when having to choose between service and academic responsibilities	1	2	3	4	5	N/A6		R35____
9.6	When UP requires my presence at UP activities (Faculty Day, Academic Opening, Graduation Ceremonies) I need to be able to attend without	1	2	3	4	5	N/A6		R36____

1 = Disagree entirely/very bad or poor 2 = Disagree/bad or poor 3 = Neutral opinion 4 = Agree/good 5 = Agree entirely/very good									
	conflict from GHD								
10.	**10. Appointment selection committees (ASC)**								
10.1	My initial interview was by a GHD committee	1	2	3	4	5	N/A6		R37____
10.2	If I apply for a senior position I am interviewed by a joint UP-GHD committee	1	2	3	4	5	N/A6		R38____
10.3	Hospital HR's management of my appointment was good	1	2	3	4	5	N/A6		R39____
10.4	UP HR's management of my appointment was good	1	2	3	4	5	N/A6		R40____
10.5	The GHD and UP Employment Equity needs should not compromise academic needs and standards	1	2	3	4	5	N/A6		R41____

11. In your view, what are the merits of joint appointments?

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12. In your view, what are the irritations that you have experienced as a joint appointee?

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13. If values are to drive the process of joint appointments what values would you like to be emphasised?

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14 What values do you currently perceive to be present in the system of joint appointments?

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15. In your view, how can the system be improved?

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THANK YOU FOR YOUR PARTICIPATION

APPENDIX A2: QUESTIONNAIRE – HUMAN RESOURCES PRACTITIONERS / INDUSTRIAL PSYCHOLOGISTS

UNIVERSITY OF PRETORIA

FACULTY OF HEALTH SCIENCES

QUESTIONNAIRE ON JOINT APPOINTMENTS: HUMAN RESOURCES OPERATIVES

The aim of the questionnaire is to assess your knowledge and feelings on joint appointments and their various facets. The survey forms part of a post-graduate study, and is performed with the consent of the University of Pretoria, the Steve Biko Academic Hospital and the NHLS. Participation is encouraged but is voluntary. There are no benefits for respondents and no penalties for non-respondents

The questionnaire also contains some open-ended questions where you can state your opinions. If these opinions require further discussion, an interview may be requested or a discussion group may be formed. Although your identity may then become known the discussion will remain confidential. When this part of the survey is activated the researcher will request the departments to seek participation of specific responders by number. Therefore, please remember the following number that has been allocated to you:

Number of questionnaire/respondent |_ | _| __|

Personal PIN number |_ | _| _|_ | _|__|

Demographics: Please mark the boxes that are applicable to you.

							OFFICE USE KANTOORGEBR.
1.	HR UP	1	HR GHD	2	IO psychologist? Yes?	3	R01_____
2.	<5years service at institution	4	5+ year's service at institution	5			R02_____
3.	Female	1	Male	2			R03_____
4.	Special field of interest at work:						R04_____

Survey

For each of the questions that follow encircle ONE number that reflects your view most accurately. (If, in your opinion, the question is not relevant to this particular topic, encircle N/A6. However, please use that option sparingly.)

1 = Disagree entirely/very bad or poor 2 = Disagree/bad or poor 3 = Neutral opinion 4 = Agree/good 5 = Agree entirely/very good									
5.	**Conditions of service**								
5.1	Gauteng Health Dept requires joint employees to work for 40 hours a week	1	2	3	4	5	N/A6		R05_____
5.2	UP requires the joint appointee to spend an undisclosed amount of time on university activities	1	2	3	4	5	N/A6		R06_____
5.3	Joint employees in Medicine are remunerated by GHD as well as by UP	1	2	3	4	5	N/A6		R07_____
5.4	A joint employee does not follow the UP leave Calendar	1	2	3	4	5	N/A6		R08_____
5.5	Their children can obtain study support from UP	1	2	3	4	5	N/A6		R09____
5.6	A joint employee is PM by Gauteng Health Dept	1	2	3	4	5	N/A6		R10____
5.7	All joint appointees qualify for sabbatical leave	1	2	3	4	5	N/A6		R11____
5.8	The rules regarding sabbatical leave are clear to me	1	2	3	4	5	N/A6		R12____

1 = Disagree entirely/very bad or poor 2 = Disagree/bad or poor 3 = Neutral opinion 4 = Agree/good 5 = Agree entirely/very good									
5.9	Joint appointees fall under the disciplinary rules of GHD	1	2	3	4	5	N/A6		R13____
6.	**Conflicting responsibilities**								
6.1	Advertisements should show logos of both employers	1	2	3	4	5	N/A6		R14____
6.2	Setting up ASC should be the responsibility of both employers	1	2	3	4	5	N/A6		R15____
6.3	Continuously changing staff complements threaten the process	1	2	3	4	5	N/A6		R16____
6.4	Lack of institutional knowledge of persons coming into HR from dissimilar organisations threaten the process	1	2	3	4	5	N/A6		R17____
6.5	Communication between the two employers is good enough	1	2	3	4	5	N/A6		R18____
6.6	Conflict resolution in ASC follows a prescribed protocol	1	2	3	4	5	N/A6		R19____
7.	**Systems**								
7.1	UP HR should perform all administrative work for joint appointments as preferred provider	1	2	3	4	5	N/A6		R20____
7.2	There is good approachability between UP HR and hospital HR	1	2	3	4	5	N/A6		R21____
7.3	There is adequate understanding on the part of UP HR as well as hospital HR about their roles in the process of joint appointments	1	2	3	4	5	N/A6		R22____

1 = Disagree entirely/very bad or poor 2 = Disagree/bad or poor 3 = Neutral opinion 4 = Agree/good 5 = Agree entirely/very good									
7.4	It is important to have both HR parties present at the interview level	1	2	3	4	5	N/A6		R23____
7.5	Senior ASC should be managed by UP HR	1	2	3	4	5	N/A6		R24____
7.6	Information on appointments and resignations are shared between hospital HR and UP HR	1	2	3	4	5	N/A6		R25____
7.7	The sequence to be followed is clear to all parties	1	2	3	4	5	N/A6		R26____
7.8	There is proper understanding in hospital HR that the UP appointment process must be completed prior to any announcements are made	1	2	3	4	5	N/A6		R27____
7.9	New developments (such as OSD) are shared between the two HR parties	1	2	3	4	5	N/A6		R28____

8. Describe the merits of joint appointments

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9. Describe irritations that you have experienced during the joint appointee appointment/promotion process

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10. What is your experience of cooperation between the partners when joint appointments have been made?

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11. If values are described as desirable objectives what values do you want to see in a system of joint appointments?

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12. At present, what values are apparent in the system of joint appointments?

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13. How can the system be improved?

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THANK YOU FOR YOUR PARTICIPATION

APPENDIX A3: GUIDE FOR INTERVIEWS (ADAPTED FROM KVALE 1996)

- Explanation of the process, including all ethics issues
- General guiding questions
- Types and meanings: joint appointments
    - What does this mean to you?
    - What are the contexts that give this meaning to you?
    - Tell about your experiences that make you feel this way
- Follow-up questions about specific issues raised from the questionnaires (not yet known but to be included in this guide)
- Probing questions where needed, also specifying questions if required
- “Most-important” questions
    - What is the most important factor?
    - Can you explain that?
- Concluding questions
    - From all that you said, …

Structure of the first interview

Need for the interview
On an interview basis, discussing the concept of values, and identifying the values that are preferred to be used as basis for a model for joint appointments.

Targets
Senior members of both employing organisations
UP: Dean, representative(s) of top management, senior HR practitioner, other senior and knowledgeable persons
GHD: CEO of SBAH, representative(s) of top management, senior HR practitioner, GHD senior HR practitioner, other senior and knowledgeable persons

Structure

1. Introduction: the study in brief, need for the study, sequence, the values-based approach

2. A semi-structured interview with the following items:
   How do you understand the principles and the process of joint appointments?
   What do you see as the pitfalls of the process?
   In you opinion, what are the most important values in the workplace?
   What values would you prefer to build on in joint appointments?
   What is your vision for improving joint appointments?

3. Open-ended questions

Facilitating list

From the literature review the following list of workplace values will be offered to the participants to work from:

Loyalty	Equity and equality in working benefits
Honesty	Fairness
Transparency	Joint decision-making
Quality	Purpose
Relevance	Joint establishment of vision
Respect for all the aspects of the job	Openness
Even-handedness	Reproducibility of actions
Divisions of the job that can be justified	Communication
Diversity, transformation	Sustainability

APPENDIX B: ETHICAL APPROVAL

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

* FWA 00002567. Approved dd 22 May 2002 and Expires 13 Jan 2012.
* IRB 0000 2235 IORG0001762 Approved dd Jan 2006 and Expires 13 Aug 2011.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee
Fakulteit Gesondheidswetenskappe Navorsingsetiekkomitee

DATE: 26/08/2010

PROTOCOL NO.	**165/2010**
PROTOCOL TITLE	Towards a values based model to manage for joint academic appointments in the Health Sector in South Africa
INVESTIGATOR	**Principal Investigator:** Mrs K K du Preez
SUBINVESTIGATOR	Prof B G Lindeque
SUPERVISOR	Prof B G Lindeque
DEPARTMENT	**Dept:** Faculty of Health Sciences **E-Mail:** karen.dupreez@up.ac.za **Cell:** 0829071658
STUDY DEGREE	MCom Industrial Psychology
SPONSOR	None
MEETING DATE	**25/08/2010**

The Protocol and Informed Consent Document were approved on 25/08/2010 by a properly constituted meeting of the Ethics Committee subject to the following conditions:

1. The approval is valid for 1 year period [till the end of December 2011], and
2. The approval is conditional on the receipt of 6 monthly written Progress Reports, and
3. The approval is conditional on the research being conducted as stipulated by the details of the documents submitted to and approved by the Committee. In the event that a need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Members of the Research Ethics Committee:

Prof M J Bester	(female)BSc (Chemistry and Biochemistry); BSc (Hons)(Biochemistry); MSc(Biochemistry); PhD (Medical Biochemistry)
Prof R Delport	(female)BA et Scien, B Curationis (Hons) (Intensive care Nursing), M Sc (Physiology), PhD (Medicine), M Ed Computer Assisted Education
Prof VOL Karusseit	MBChB; MFG P(SA); MMed(Chir); FCS(SA) - Surgeon
Prof JA Ker	MBChB; MMed(Int); MD – Vice-Dean (ex officio)
Dr NK Likibi	MBBCh – Representing Gauteng Department of Health)
Prof TS Marcus	(female) BSc(LSE), PhD (University of Lodz, Poland) – Social scientist
Dr MP Mathebula	(female)Deputy CEO: Steve Biko Academic Hospital
Prof A Nienaber	(female) BA(Hons)(Wits), LLB; LLM(UP); PhD; Dipl.Datametrics (UNISA) – Legal advisor
Mrs MC Nzeku	(female) BSc(NUL); MSc(Biochem)(UCL, UK) – Community representative
Prof L M Ntlhe	MBChB(Natal); FCS(SA)
Snr Sr J Phatoli	(female) BCur(Eet.A); BTec(Oncology Nursing Science) – Nursing representative
Dr R Reynders	MBChB (Prét), FCPaed (CMSA) MRCPCH (Lon) Cert Med. Onc (CMSA)
Dr T Rossouw	(female) M.B,.Ch.B. (cum laude); M.Phil (Applied Ethics) (cum laude), MPH (Biostatistics and Epidemiology (cum laude), D.Phil
Dr L Schoeman	(female) B.Pharm, BA(Hons)(Psych), PhD – Chairperson: Subcommittee for students' research
Mr Y Sikweyiya	MPH; SARETI Fellowship in Research Ethics; SARETI ERCTP; BSc(Health Promotion) Postgraduate Dip (Health Promotion) – Community representative

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Dr R Sommers (female) MBChB, MMed(Int), MPharmMed – Deputy Chairperson
Prof [illegible] BChD, MSc (Orlando), MChD (Oral Path), PGCHE – School of Dentistry representative
Prof [illegible] MRCPsych), MD, FCPsych), PTCL), DPLM – Chairperson

Dr K Schoeman BPharm, BA(Hons)(Psych), MMed(Int), MPharmMed
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria