

A Case study describing factors perceived to be impacting staff satisfaction amongst  
Health Care Professionals at the East London Hospital Complex

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## INTEGRATIVE EXECUTIVE SUMMARY

This thesis was born from a concern the researcher had with regard to negative reports in the media emanating from 4 babies that died at Cecilia Makiwane Hospital Paediatric ICU unit due to power supply failure. The most significant of these negative reports was in 2007 when the Daily Dispatch ran a series of articles regarding what they termed avoidable deaths over the last 14 years. The ease with which staff communicated with the media together with the high absenteeism rate and high turnover was a cause for concern.

When the researcher analysed the history of the problem, it emerged from the respondents' responses that the rationalisation process undertaken by the Eastern Cape Department of Health (ECDoH) was a significant root cause to the problem. The literature review focused on three areas viz.:

- Organisational Culture
- Organisational Change
- Foundations of Satisfaction.

This focus was used to confine the problem to a manageable project but secondly each of the aspects are interwoven. Routledge (2010) notes that culture is the reflection of the values advocated by a founder or leader by way of his/her day to day actions. This is done by the leader creating a perception or viewpoint that assists the employees to achieve the organisation's mission, vision and goals. In any organisation change is a constant and it needs to be effectively managed. With government institutions like the East London Hospital Complex (ELHC) directives come from the top and are implemented by an unprepared and untrained leadership and management cadre and clear communication of vision and objective of the desired outcomes never happens.

The aim of the research was to:

- describe the existing Organisational Culture present at ELHC (Perform an organisational diagnosis);
- describe the impact of change (rationalisation) and to
- analyze why there was such a high staff turnover,

It is clear from the results of the survey conducted that significant dissatisfaction prevailed relating to how the institution was managed. Dissatisfaction amongst the health professionals was general but also specific to the following:

- leadership and management issues,
- fairness,
- remuneration and
- lack of resources.

The recommendations therefore focused on developing management and leadership within the proposal of Dubrin's model (2001).

## ACKNOWLEDGEMENTS

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I can never forget Grandma Maggie. I was a small child when you passed on but your presence in my life has left unfading footprints.

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## SECTION 1: CASE STUDY

*“Human capital, defined as the skill, dexterity and knowledge of the population has become the critical input that determines the rate of growth of the economy and the well being of the population.”(Charlton, 1993:22)*

### **1.1. Introduction**

The starting point for this case is the rationalization process which happened in the Eastern Cape Department of Health in 2002. This process was a top down approach with no consultation with stakeholders. This resulted in a structure which was bureaucratic, with strategic units that negated the functional reporting structures. This new age movement from structure to process was not preceded by training of managers, who were still stuck in the old industrial age focusing on control and hierarchy.

In 2006 the first strategic plan was developed heralding a new age with regard to movement towards the new age with the development of a common vision and a mission by which all employees could be bound, and focusing on excellence and espousing values by which employees were encouraged to live.

Two significant events, the first being the 2006 ICU baby deaths at Cecilia Makiwane hospital and the 2007 Daily Dispatch expose into Frere baby deaths highlighted the cracks in the system. The inadequacy of management skills in the management team was a constant analytical point mentioned in the investigations conducted.

Due to the background of these striking events as well as the observation of the researcher that there was a mass exodus of health professionals from the ELHC, a study into the feelings and perceptions of the health professionals was

conducted. A questionnaire was developed and administered to 60 staff evenly across the two institutions. Furthermore, exit interviews were sampled to determine the reasons why staff left. Findings of the questionnaire as well as the exit interview are detailed in section 1.4. Recommendations are discussed that would try to address the challenges identified by the questionnaire and exit interviews.

## **1.2.      *Background to Case Study***

### **1.2.1.      Rationalisation**

The East London Hospital Complex (ELHC) is made up of two hospitals, Cecilia Makiwane and Frere, whose histories are differently influenced by an ideological planning pattern that distorted resources, structure and systems. This amalgamation was brought about by the Eastern Cape Department of Health (ECDoH) after the Government released a White Paper on the Transformation of Health Services in South Africa (ECDoH, 1997). In line with this decentralization policy, the ECDoH took a policy decision to cluster hospitals. This transformation was done to eliminate wasteful utilization of already limited resources and to eliminate the racial divide that the previous government had used to duplicate services for differing races in the same area (Qwesha, 2009).

Because the Eastern Cape wanted to correct the imbalances of the past and build efficiencies that were never present in the system, provincial health officials embarked on a Top Down approach of implementing this much needed rationalization, from January 2002. Not enough time was given to communication and consultation with all the Internal and external stakeholders in this process, resulting in the formation of Complexes (PE, EL and Mthatha) where employees were not sure or even secure about their current or future work practices (Qwesha, 2009).

This transformation (rationalization) produced the following organizational structure (within East London as well as the other two complexes):

A Chief Executive and three Directorates, these being: Clinical, Corporate Services (CSC) and Facilities Management. The Clinical Directorate managed the core services departments while CSC managed administrative issues like finance, human resources and Supply Chain Management (SCM). Facilities Management managed the maintenance and hotelier services e.g. laundry and patient food.

Staff were aligned to these functional directorates regardless of which hospital they were working in. At each hospital supervisors and assistant managers were present while managers were not specifically allocated to any particular institution and therefore had to assist in guiding the supervisors and assistant managers from both institutions. The three directors and the CEO were responsible for the strategic direction of the institutions.

With these changes, even the most basic of administration functions were centralized and middle managers did not have the capacity to engage the workers in an encouraging manner. It is also very possible that due to the rapid rationalization process thrust upon the employees of the ELHC, not enough time was given to develop the managers or leaders to fit into this new reality that was created.

### 1.2.2. Leading in Changing Times

*“Leadership is an **influence** relationship among **leaders** and **followers** who **intend** real **changes** and outcomes that reflect their **shared purposes**.”*(Rost, 1991: 6)

Because the health system is a complex organization with many different cultures, and norms, it is very important to look at what type of leadership is needed in the ELHC to deliver on the Vision and Mission and create a uniform

culture of shared values of **HEALTH** in the **ELHC**, and how the new culture can be develop from within. Due to rapid changes seen in the world and in organizations, it is critical to look at leadership within organizations and what characteristics make for an effective leader.

An effective leader is a leader who does things now for the benefit of meeting future goals for the organization. In the pre information era, the characteristics that encompassed leadership where:

Stability Management; Control; Competition; Uniformity; Self-centeredness; and being a Hero.

While in the current reality the following characteristics are true:

Change and Crisis Management; Empowerment; Collaboration; Diversity; Higher Purpose and being Humbleness (Draft 1999).

New Age Leadership therefore stems from a genuine concern for people and a passion for work, with the leader possessing more than one set of skills but a myriad of subtle personal qualities namely;

Enthusiasm

Integrity

Courage

Humility (Routledge, 2010).

The question of whether leadership can be taught is one that receives a lot of attention. Charlton (1993) argues that training is definitely the answer to the current problem with commitment to and belief in the process essential to make the difference. He notes the example of Japan sending 15 times more people for training than South African Companies, due to their knowing how to invest in human resource development.

During the industrial era, things were stable and the productivity was dependent on the inputs into a machine. Management then was about control and the focus

was on maximizing profit. The structure of industrial era companies was hierarchical with strategy coming from the top going down to the workers. People were seen as a stumbling block in this era with a move to machinery and less dependence on people, as people were viewed as being lazy and not wanting to work, needing direction and needing coercion from managers to work (Hellriegel et al., 2004) or as Bartlett and Ghoshal (1994) put it, “the objectives of the strategy-structure-systems framework was to minimize the idiosyncrasies of human behaviour.”

The next step is to look at processes rather than structure. As noted earlier, corporate structures had become large after the Second World War when there was high economic growth. With the above structure not delivering economic results by the late 1970's and early 1980's, General Motor's Sloan and Pierre S. du Pont of Du Pont pioneered the understanding of creating divisional structures. “The key here was not only diversifying their products and market but also institutionalized diversification as a method of growth (Bartlett and Ghoshal, 1995(a)).”

This shift from structure to processes, brought with it the realization that the old way of vertical communication did not work and a new horizontal way of working was essential. Managers started re-engineering companies to integrate functionally separate tasks into unified horizontal processes. They also saw the organization in a different light, from a hierarchy of static roles to a portfolio of dynamic processes (Bartlett and Ghoshal, 1995(a)). Through the shift from structure to processes, this change allowed for the core competencies to be developed by reducing the red tape and allowing for innovation and knowledge sharing.

Bartlett and Ghoshal (1995(b)) eloquently describe the conundrum of a systems' driven approach as that of ensuring control and conformity but inhibiting creativity and innovation. Because people were stripped of their individuality, people would

engage in the very behavior that the system tried to control, with antagonism and subversion being the worst observed of resultant behaviors.

In this post industrial age, competitive advantage no longer resides in technology, competitive advantage lies in the ability of a leader to harness his peoples' creativity and the collective competencies of the group being lead. Because this era is defined by constant change a different approach needs to be taken. Firstly, the strategy does not come from the top. The leader needs to foster within the employees a sense of purpose. The next shift that needs to occur is that of moving away from structure to processes.

The building blocks for an effective leader are dealt with earlier with shifts from strategy to purpose, structure to processes and systems to people. These shifts allow for people to be central, with a leader's characteristics and traits as well as behavior and style important in the interaction of group members and individuals within an organization. This constant interaction and awareness of one's self and his/her surroundings is the precursor of what is termed as Emotional Intelligence. It is defined as "the ability to manage ourselves and our relationships effectively and consists of four fundamental capabilities: self-awareness, self-management, social awareness and social skill" (Goleman, 2000:5).

Daft (1999) best describes what is happening at the ELHC by stating that many leaders are caught in midair between practices and principles that define the industrial era and the emerging principles of the post modern world. Team work, empowerment and diversity in our organizations have failed because leaders' and workers' beliefs and thought processes are still stuck in the old paradigm. The questions then stands, how do we get this transformational leadership going in our organization and what type of other types of leaderships should we look out for and develop? Being in the service industry, servant leadership and level 5 leadership are very critical where humility and personal and professional will are

key. In the African context, African Leadership should be something that we strive for.

The leadership and management within the ELHC has not moved from the old paradigm of Hierarchy and Control. It is clear that a transformational leader needs to emerge who will assist the ELHC move its managers and employees towards the developed Vision and Mission. The answer to the problems of new reality using old order tools is therefore leadership development.

### **1.2.3. Development of ELHC Strategic Plan**

Due to the previously mentioned fragmented planning and unequal resources distribution challenges, it was identified that there needed to be an inclusive planning process that would address the planning distortion and these challenges. This need therefore gave birth to the strategic planning conference held at Mpekweni in February 2006. This planning session ushered in the first strategic plan for the complex since its formation in 2002. The chairpersons of both hospital boards commended the inclusive nature of the process in developing a Vision and Mission statement and felt that these would “carry the complex forward for many years. “The foundation for sound Corporate Governance, as evidenced in the inclusive participatory build up and actual strategic planning session makes us proud as community representatives and shines a ‘Star of Hope’ of the future that is all embrative and caring. ” (EcDoH 2006:5)

The Vision of the ELHC is to be “a health centre of **excellence** that renders **quality care to all levels** of the community” while its Mission is to “provide a comprehensive integrated health service” and also “ensure optimal utilization of all available resources.” This is being done through the “support of competent, committed health workers and a responsive and friendly environment” as well as provision of “modern equipment and facilities” (EcDoH, 2006:10). This meant that the CEO and his directors were responsible for steering these two different



institutions into one functional organization with friendly people producing a conducive healing environment for the patients.

The acronym **HEALTH** in the **ELHC** spoke to the core values binding the staff. It contains the ethical/ moral and business practice values that the ELHC hoped its employees will live by, while simultaneously putting forth its core ideology. Within the acronym lie the core behavior standards like honesty, trustworthiness, humility and empathy. These behavioral standards form the integral part of ensuring that staff create a responsive and friendly environment for health.

With the merger of these two distinct hospitals with a comparable but different history, it was envisaged that this single formed unit, albeit geographically apart, would take from its individual strengths and consolidate into a tertiary level service that eliminated the duplication in services brought about by separate development policies of the past (EcDoH, 2006). This therefore led to the formation of the four “core areas of competence” viz.: Clinical Services; Quality Assurance; Facilities Management and infrastructure; and Corporate Services.

Looking at the Coca Cola Sabco Competency and Capabilities Model (Staude 2008:5) and adapting it to the ELHC, it is clear that of the four core areas according to the strategic plan, only one area fulfills the criteria of being a core competency. This is the Clinical Service delivery which is of a specialist nature, rendering level 2 and 3 patient care predominantly. The three other areas are more capabilities which assist in the delivery of health care. Take for example one of the Quality Assurances' functions of conducting clinical audits. Without such indicators it would be difficult to ascertain the quality of clinical service being rendered. Therefore Quality Assurance as a capability is able to assist Clinical service delivery through clinical audits. The same goes for Facilities and Infrastructure Management as well as Corporate Services.

When looking at the organization through a value chain perspective it is clear that the primary activity of the organization is clinical service delivery. This is done through any one of the nineteen clinical domains. There a customer receives service in relation to their need at the time. The customer (patient) either undergoes further investigations through the clinical support team or receives treatment to take back home. If there is a need for hospitalization and further treatment either through medication being administered in a controlled environment or surgical intervention, when it is warranted, this is undertaken. The primary activity in ELHC's value chain is clinical service delivery. This primary activity is augmented by clinical support services through diagnostic testing and or treatment. A good example is pharmaceuticals where most patients get some sort of medication prescribed. Others include physiotherapy and occupational therapy. Supportive activities come from the three other areas, namely Quality Assurance, Facilities and Infrastructure Management as well as Corporate Services.

“The public sector remains the main service provider of health services to the population with lesser financial and human resources. The rising cost and declining benefits offered by the private sector and the geographical maldistribution of health services remains the main obstacles to equity, quality and access to health services” (Rispel et al., 2007:12).

Considering the previous point, ELHC's strength is that it is the only public institution in the central region of the Eastern Cape that houses specialist level services. There is ongoing training of specialisms occurring at the institution. An outreach programme is conducted by most of the differing clinical domains to some of the 25 district and one regional hospital in this region.

The fact that there is no district hospital within the Buffalo City Area has the effect of “diluting” these specialized services due to a resultant influx of primary level of care patients. The quality of care in the district hospital as well as a poor referral

system is a major weakness. The lack of formal clinical research could assist in understanding the impact of disease better as well as to help monitor effectiveness of interventions undertaken (Evidence based medicine).

#### **1.2.4. Media**

On the 20<sup>th</sup> May 2006, 4 babies died at the Cecilia Makiwane hospital neonatal intensive care unit due to a power failure caused by the failure of the back-up generator and the lack of an uninterrupted power supply source. The deaths were officially attributed to this failure. The incident attracted local as well as national media coverage. From the 12<sup>th</sup> July 2007, the Daily Dispatch ran a series of articles entitled “Frere Baby Deaths Investigation”. This expose had a lead article claiming “Why Frere babies die”. The report detailed interviews with medical staff, a review of internal documents as well as interviews with heart-broken mothers. (Makhubu et al, July 2007 (a)).

These reports detailed accounts of a shortage of staff, shortage of resources and equipment as well as space. In her interview with a nurse that had worked over 5 years in the post natal sections, Makhubu (2007) highlighted how staff had left in droves and not been replaced. This situation had led to those that remained being disgruntled and de-motivated due to the working conditions. The nurse was quoted saying that she would arrive at work with corridors full of patients in all stages of labour and that she would fight the urge of turning back and running from the hospital (Makhubu, 2007).. “The problem began at admission where ideally four or five nurses should be present, but there was never more than two” reported Makhubu (2007).

The subsequent articles within the series relate to how the problem had started long before the symptoms became evident in 2007 with the then Head of the Obstetrics and Gynaecology Unit, Dr Max Bennum, getting political pressure in 1998 from the then MEC of health, Dr Bevan Goqwana, to make black appointments at a time when the candidates were not available (Horner, 2007).

Dr Bennum resigned in 2000 when by then his team had been reduced from 14 to 7 doctors, and inclusive in the resignations were 3 of the 4 consultants. Dr Bennum is quoted by Horner (2007) as saying that he was working with an administration that was “not thinking like him”.

The staffing troubles did not affect doctors only. Makhubu et al. (2007:2 (b)) relates in the article how the nursing staff were in turmoil due to a controversial figure, the assistant director nursing and quality assurance, who was appointed in 2003. “At least 20 nursing and former nursing staff members surfaced during the investigation detailing that the dissatisfaction with this particular manager went as far back as 2003, with a petition signed by 29 supervisors and assistant directors”

The expose put the spotlight on Frere hospital with national coverage and visits from as high up as the then Minister of Health Dr Manto Tshabalala-Msimang. For over a month, debate raged as to whether or not the Daily Dispatch had sensationalized its reporting on the Frere Baby deaths. This led to a lot of political mud-slinging, with the then Deputy Minister Nozizwe Madlala-Routledge visiting Frere and claiming a “national emergency” while her boss, Dr Tshabalala-Msimang was reporting that there was no crisis. The then President of the country Mr Thabo Mbeki indicated that what had happened at Frere was within the norms (Cullinan, 2007). Within this whole fiasco, the unions within the province were calling for the MEC of Health’s (who was now Ms Nomsa Jajula) head, as well as that of Head of Department, Lawrence Boya. The unions indicated that they were being misled by the administration and the political head by virtue of their secret plan, the Strategic Turnaround Plan’s (STP) existence, which was denied by both. This plan was to see most hospitals being downgraded to Community Health Centres (CHC’s). At the centre of the row was the apparent downgrading of Cecilia Makiwane Hospital from a Secondary and Tertiary training facility to a District Hospital.

During research of newspaper articles to do with Frere and Cecilia Makiwane Hospital, it was interesting to note that during the period of interest 2005 till date, there had been huge coverage during 2007 with over 100 articles relating to the expose from July to December. For 2005 no articles were found, with 2006 presenting one article related to the resignation of a nurse, who had served for over 30 years, due to the treatment she got from the then assistant director nursing and quality assurance, who has been mentioned previously (Makapela, 2006). In 2008 there were 44 articles with 22 in 2009, 13 in 2010 and 13 in 2011. It's clear that 2007 was a significant year with a huge spotlight cast on the ELHC.

### **1.2.5. Politics and Health**

Bradshaw (2008) asserts that the determinants of health lie outside the direct influence of health and social care. Krieger (2008) writes that the societal disease pattern is made up of three main contributors namely: political, economic and socialization. Legal factors play more of a secondary role (an adjunctive to the political will) in relation to accessing health care via a private or public institution, as well as the protection of the population through the regulation of this industry (Rispel et al, 2007)

The World Health Organization Commission on Social Determinants argues that there are 3 principles that governments need to take action on, viz.: improving daily living conditions of people; reducing health inequalities; and strengthening the ability to monitor population health (Bradshaw, 2008). This comes about due to the fact that even though South Africa has a well established economy with sound fiscal and monetary policies, there remains a largely uneven distribution of resources, indicated by the high Gini coefficient that still remains at 0.68 post apartheid (Bradshaw, 2008).

“Not only is poor health strongly associated with low socio-economic position, but there is growing evidence that inequalities play a role in poor health outcomes” (Doolan et al. 2007:8). This point is very important at this time where in our

country a lot has happened post the Polokwane 2007 political conference. With the change in political leadership within the ruling party, Gray et al (2008) asked the question whether there would be a disjuncture between plans and policy managed by the Executive. If so, then it is clear that the political climate will affect both the social and economic wellbeing of the country resulting in a growing divide with resultant negative impact on the health status of the population as a whole. But from resolutions taken from the Polokwane conference, it is clear that the new leadership has continued with the current policies with the fast tracking of issues that are still to the fore in terms of policy e.g. National Health Insurance System (ANC, 52 National Conference 2007).

A good example of politics (legal) influencing health care is the issue of National Health Insurance proposals. The debate has raged on for years on how to finance health care and conventional wisdom has in the 21<sup>st</sup> century accepted the fact that pre-paying for health through tax and or health insurance contributions are the ideal way and offer greater financial protection for a household. This is being seriously looked at in South Africa with the development of the social security system. A social security system makes more sense when one is able to predict, based on epidemiological and actuarial data, a group's health care needs and cost; hence the importance of pooling funds (McIntyre et al. 2007).

It is clear that we have 3 possibilities with regard to the future of the population's health. Firstly, continuing with the same political policies will render the health status unchanged, or more realistically worsened, due to the increased burden of disease caused by the HIV/Aids and TB epidemics. Secondly, and more favorably, an introduction of a social security system with better distribution of resources and improved daily living conditions will result in an improved health status and resultant longer life expectancy. A very different and extreme alternative would be that there would be a global ecological catastrophe with a resultant wiping out of mankind as we know it. This could be in the form of war,

3<sup>rd</sup> world war or an accelerated shift in the climate e.g. global warming, tsunami etc.

Gray and Jack (2008:15) articulate this point clearly when they assert that “the General Elections, combined with the constitutionally mandated change of President, promise to make 2009 a milestone year in the history of South Africa. The opportunity exists to outline in far greater detail, how health care will evolve into the future.”

Looking at the context of East London and more broadly the Eastern Cape Department of Health, it is clear that not all is well. With the Departure of MEC Dr Bevan Goqwana in April 2006, Ms. Nomsa Jajula became the MEC until 2008 when Ms. Pemmy Majodina took over. In 2009 Phumolo Masualle became the MEC of Health and was subsequently replaced by Sicelo Gqobana, who took over the reins in late 2010 and is still the current serving MEC. The Head of Department post has not had not been filled, with the previous incumbent, Mr. Lawrence Boya leaving in August 2009. In 2010, Dr Siva Pillay was appointed the new Superintendent General. There has been a mass exodus of senior and executive managers at the head office. One such critical post which remains unfilled, is that of Deputy Director Clinical Services.

With this constant change of political as well as administrative heads, the concerns raised by Gray and Jack (2008) are very valid.

### **1.3. Procedure**

The researcher, having joined the ELHC in 2005, noted a sharp increase in negative reporting by the local paper, the Daily Dispatch, specifically with the 2007 expose. What was interesting and significant in the reports was the ease with which the reporters gained access to the premises, as well as how freely the staff co-operated with the reporter sharing sensitive information and voicing their frustration with their willingness to be interviewed. This lead the researcher to

believe that there was a lot of dissatisfaction in the staff and the current management, from the top down, in the unplanned rationalization process and how they are being handled as well as other general issues relating to the working environment.

The researcher aimed to test this hypothesis through a survey which included 40 questions aimed at eliciting positive or negative feelings around 11 predetermined themes, which were:

- Workplace resources and safety
- Communication
- Organizational change
- Employee engagement
- Compensation
- Coworker relations
- Fairness and diversity
- Individual Employee's immediate Manager
- Management
- Job satisfaction
- Employee Benefits (Connolly and Connolly, 2005).

40 questions were selected from pretested questions in above mentioned themes. 60 questionnaires were distributed, 30 at each site (Frere and Cecilia Makiwane Hospital) to the following areas:

- Accident and Emergency
- ICU
- Medical
- Surgical
- Paediatrics
- Obstetrics and Gynaecology



These areas were identified due to the relatively busy work load in each of them. Doctors, nurses and pharmacists were the identified participants. The researcher approached most of the participants individually to explain the purpose of the research as well as reassure them of anonymity when participating. Each questionnaire was accompanied by a prepaid self addressed envelope which ensured further anonymity. The cover page of the questionnaire was marked from 1 to 30 per site with the initials FR or CMH for the respective institutions. Each department was allocated 5 questionnaires. This was in an effort to trace only the departments and not the individual so as to be able to take the analysis to department level.

#### **1.4. Findings**

Of the 60 questionnaires distributed, there were 36 respondents. 15 CMH, 14 Frere and 7 undetermined (cover page returned removed). Of the respondents 21 were female respondents, 14 male respondents and 1 undefined respondent. Within the female respondents, 19 were black, 1 white and 1 other. Of the males, 7 were black, 5 white, 1 indian and 1 other.

When looking at years of service, for the female group, 11 had more than 15 years, 1 had between 11 and 15 years, 4 between 6 and 10, 4 between 1 and 5 with 1 having less than 1 year of service. Within the male group, 8 had more than 15 years of service, 2 were in the 11 to 15 years category, 2 in the 6 to 10 years, category 2 in the 1 to 5 years category and none in the less than 1 year category. The one undefined participant had between 11 and 15 years service.

The 11 themes identified previously were consolidated into 6 groups. These being:

- Resources
- Organizational Change
- Communication

- Compensation
- Relations (Coworkers and Manager)
- General management.

#### **1.4.1. Questionnaire**

The questions are on a Likert scale, 1 being strongly disagree to 5 being strongly agree, phrased in a positive manager (Annexure 4.1). The results were collected and entered into a spreadsheet. The raw data was formatted in the following way:

1. The number of respondents per question and the total for each of the 5 numbers on the scale was represented in Table 4 (Annexure 4.4). Non responses to questions were also included.
2. After totaling per number scale this was converted to a percentage represented by Table 5 (Annexure 4.5).

From Table 5, the data was collated into three categories namely:

- Unfavourable Items 1 and 2 of the Likert scale were added,
- Neutral
- Favourable being 4 and 5 added.

This gave rise to Table 6 (Annexure 4.6) which was the unsorted Unfavourable-Neutral-Favourable raw data. When this table was sorted out, it gave rise to Table 1 Most Favourable Questions below. From the table it is evident that there were only three questions that scored 50% or above. These were questions 21, 13 and 9.

*Question 21: "I would feel comfortable going to my manager with a concern."*

*Question 13: "I would feel comfortable communicating openly with senior management if the need arose."*

Question 9: *“My job offers me the opportunity to gain work experience in challenging new areas.”*

QUESTION NUMBER	UNFAVOURABLE	NEUTRAL	FAVOURABLE
21	19.4	16.7	63.9
13	22.2	16.7	61.1
9	33.3	16.7	50.0
29	41.7	19.4	38.9
33	33.3	27.8	38.9
1	41.7	19.4	36.1
3	41.7	22.2	36.1
18	52.8	11.1	36.1
5	47.2	19.4	33.3
31	61.1	5.6	33.3
32	41.7	25.0	33.3
37	44.4	22.2	33.3
4	41.7	22.2	33.3
22	44.4	22.2	33.3

34	55.6	11.1	33.3
2	50.0	19.4	30.6
10	50.0	16.7	30.6
20	47.2	22.2	30.6
6	33.3	38.9	27.8
7	63.9	8.3	27.8
35	41.7	30.6	27.8
16	63.9	11.1	25.0
30	58.3	19.4	22.2
14	66.7	13.9	19.4
23	50.0	30.6	19.4
26	55.6	22.2	19.4
36	52.8	25.0	19.4
17	47.2	36.1	16.7
19	55.6	27.8	16.7
40	47.2	33.3	16.7
24	50.0	33.3	16.7
15	63.9	22.2	13.9
25	52.8	30.6	13.9
8	44.4	13.9	13.9
38	61.1	27.8	11.1
39	44.4	44.4	11.1
11	75.0	19.4	5.6
12	69.4	25.0	5.6
28	69.4	25.0	5.6
27	80.6	16.7	2.8

**Table 1. Most Favourable Questions**

Question 21 topped the favourable questions list and only scored 64%, indicates that there was not a single strong satisfaction indicator. A score of 67% and

above would have been a strong indicator of satisfaction with 75% or more showing outright strength (Connolly and Connolly, 2005:132).

QUESTION NUMBER	UNFAVOURABLE	NEUTRAL	FAVOURABLE
27	80.6	16.7	2.8
11	75.0	19.4	5.6
28	69.4	25.0	5.6
12	69.4	25.0	5.6
14	66.7	13.9	19.4
16	63.9	11.1	25.0
7	63.9	8.3	27.8
15	63.9	22.2	13.9
38	61.1	27.8	11.1
31	61.1	5.6	33.3
30	58.3	19.4	22.2
19	55.6	27.8	16.7
26	55.6	22.2	19.4
34	55.6	11.1	33.3
18	52.8	11.1	36.1
36	52.8	25.0	19.4
25	52.8	30.6	13.9
10	50.0	16.7	30.6
23	50.0	30.6	19.4
24	50.0	33.3	16.7
2	50.0	19.4	30.6
20	47.2	22.2	30.6
40	47.2	33.3	16.7

5	47.2	19.4	33.3
17	47.2	36.1	16.7
8	44.4	13.9	13.9
22	44.4	22.2	33.3
37	44.4	22.2	33.3
39	44.4	44.4	11.1
1	41.7	19.4	36.1
29	41.7	19.4	38.9
35	41.7	30.6	27.8
3	41.7	22.2	36.1
32	41.7	25.0	33.3
4	41.7	22.2	33.3
6	33.3	38.9	27.8
33	33.3	27.8	38.9
9	33.3	16.7	50.0
13	22.2	16.7	61.1
21	19.4	16.7	63.9

**Table 2. Least Favourable Questions**

Table 2 above arranged the questions from the least favourable to most favourable (reverse of Table 1). Connolly and Connolly (2005) state that an unfavourable percentage of 35% or above is a critical indicator of dissatisfaction with 20 to 34 % being a dangerous indicator. 39 of the 40 questions are above this threshold.

Question 27 topped the list at 81%, with 21 questions above the 50% mark.

*“There is a strong drive toward satisfying the needs of all employees in this organization.”*

This result is significant as it is a clear indicator that the employees are dissatisfied. The reasons for the dissatisfaction can be seen with the top 5 least favourable questions.

*Question 11: "This organization is well managed."*

*Question 28: "Resources are allocated fairly."*

*Question 12 : "Management acts consistently; they do as they say."*

*Question 14 : "Top management is fair in dealing with people."*

There is a strong indication that the staff do not trust the management and feel as indicated in question 11 and 28 respectively. Comparing these feelings towards management and the most favourable questions 21 and 13 it is clear that contradictions are at play. It is possible to have a good relationship with ones' direct supervisor or manager and have an open communication channel with top management and for management to ignore this communication and do as they please.

QUESTION NUMBER	UNFAVOURABLE	NEUTRAL	FAVOURABLE
39	44.4	44.4	11.1
6	33.3	38.9	27.8
17	47.2	36.1	16.7
24	50.0	33.3	16.7
40	47.2	33.3	16.7
23	50.0	30.6	19.4
25	52.8	30.6	13.9
35	41.7	30.6	27.8
19	55.6	27.8	16.7

33	33.3	27.8	38.9
38	61.1	27.8	11.1
12	69.4	25.0	5.6
28	69.4	25.0	5.6
32	41.7	25.0	33.3
36	52.8	25.0	19.4
3	41.7	22.2	36.1
4	41.7	22.2	33.3
15	63.9	22.2	13.9
20	47.2	22.2	30.6
22	44.4	22.2	33.3
26	55.6	22.2	19.4
37	44.4	22.2	33.3
1	41.7	19.4	36.1
2	50.0	19.4	30.6
5	47.2	19.4	33.3
11	75.0	19.4	5.6
29	41.7	19.4	38.9
30	58.3	19.4	22.2
9	33.3	16.7	50.0
10	50.0	16.7	30.6
13	22.2	16.7	61.1
21	19.4	16.7	63.9
27	80.6	16.7	2.8
8	44.4	13.9	13.9
14	66.7	13.9	19.4
16	63.9	11.1	25.0
18	52.8	11.1	36.1
34	55.6	11.1	33.3
7	63.9	8.3	27.8



31	61.1	5.6	33.3
----	------	-----	------

**Table 3. Neutral Responses**

Table 3 represents the neutral responses or the undecided. These questions were difficult to analyse as they might indicate an unimportant item or an item which is not an issue at the moment. It could also mean that the respondents were undecided and were between the negative and positive of this spectrum. Topping the list in this category was question 39 which dealt with past change initiatives.

*Question 39: "Past change initiatives have had positive results."*

When looking at the question in its context, there is an equal percentage of responses towards a negative and neutral response. This places significance in the neutral response in that it's possible that this has been an ongoing negative issue and has stopped becoming an issue because the respondents feel that there is nothing further that can be done to change the situation. Analysing the top 5 neutral responses, it is interesting to note that these questions have to do with perception of the organization.

*Question 6: "I am proud to be part of this organization."*

*Question 17: "Management provides a clear picture of the long-term goals and direction of your organization."*

*Question 24: "This organization encourages a climate where diverse perspectives are valued."*

*Question 40: "The climate for change is very positive and supportive in my organization."*

#### **1.4.2. Exit Interviews**

Initially the researcher planned to conduct 3 semi structured interviews with former employees to ascertain the reasons for leaving. Due to time constraints, it was suggested that the researcher review exit interviews within the personal files of employees who left. The Human Resources manager as well as the Director of Corporate Services directorate were emailed with a request for access to 10 exit interviews done, 5 for each institution i.e Frere and Cecilia Makiwane Hospital (CMH). The first major challenge experienced was that exit interviews were not being done and were apparently done by the last HR manager in 2007. The exit interviews were currently only being done by the nursing division and only Cecilia Makiwane Nursing had a template and were doing regular exit interviews. The researcher was also able to get an exit interview template from Clinical Support services at CMH but none that had been done for exiting staff (Annexure 4.3).

The researcher was able to gain access to 10 interviews done at CMH and one from Frere hospital. Of the 11 interviews received, two were 65 years old and were retiring, 5 had personal or family problems and these were noted not to be work related environmental issues. Two (2) were financial problems and not work related, with one resigning due to ill health. This was due to a back injury sustained at work and the nurse was hoping for early medical boarding but that decision was taking a long time. The last one was seriously unhappy with the institution as they indicated that they were resigning due to shortage of staff and resources. They emphatically wrote that they would never come back even if they were offered an opportunity in the near future.

In responding to question 4 of the exit interview (Annexure 4.2) asking for suggestions on ways to prevent resignations:

- 8 indicated the need to improve staffing,

- 1 indicated that an improvement of salary scales would be useful,
- 1 did not respond,
- 1 was not structured (Frère interview) and nothing elicited.

Question 5 regarding rejoining the complex:

- 8 said they would most definitely come back
- 1 said “no” due to health related issues
- 1 unknown due to the Frere interviewee not having a template
- 1 definitely said “no”.

Suggestions to improve template: Question 1 must have a list of common reasons for resignation where interviewees would choose three of them.

## **1.5.      *Recommendations***

It is clear that ELHC has on the surface made the theoretical shift from the industrial era to the new age reality with strategic plans that talk to shared values and create a conducive healing environment with friendly people. What has not happened is that the managers and leadership have not shifted paradigms from the strategy, structure and systems priorities to those of purpose, processes and people. This is evident with the negative publicity that ELHC has received since 2007.

Dubrin (2001) offers a useful model which could be used for the development of leadership in the ELHC. He argues that developing leadership skills is more complex than developing a structured skill. He proposes a learning model that will be useful for the East London Hospital Complex. The model has the following elements:

1. Conceptual Knowledge and behavior guidelines

2. Conceptual information demonstration by examples and brief description of leaders in action
3. Experiential exercises
4. Feedback on skill utilization or performance from others.
5. Practice in natural setting.

The above model talks to the need to train, train and continue to train all staff in developing their Emotional Intelligence. Through understanding one's behavior and identifying in others certain behavioral traits, one is able to make use of differing styles to influence and motivate thereby creating a sense of shared purpose which is better to leverage change. The result is a long-term relationship or partnership with group members. Constantly reviewing what you know and don't know and making sure you develop people in areas that are lacking will make anyone move from unconsciously incompetent to unconsciously competent as a leader.

It is therefore essential for the ELHC leadership to evaluate the training that has happened in the last 5 years and realign training to the strategy. Once a month during operational meetings, managers must develop and present case examples through which managers can share how to best approach a similar type of situation. By getting people involved, one can get managers owning up to their personal development as well as development of people that they manage.

The leadership constantly needs to rearrange and stretch their mind-sets by challenging the status quo and looking for better ways of solving problems. The best example of this is illustrated by Gregersen et al. (1998) with the tall American in a Japanese restaurant. He hit his head twice on the wood beam over the entry before finally on his third trip he remembered to duck when entering.

Team work is very essential in getting people with differing experiences and viewpoints thinking towards emotional connectivity and emotional intelligence.

Integrity becomes key at a personal level and during group interaction as those being lead always look out for inconsistencies in one's management or leadership style. When fairness and integrity are not innate to the person's character, the person can never influence or motivate because trust has not been built into the relationship.

### **1.6. Conclusion**

From the findings, it is clear that there has been significant impact made by the rationalization process. There is a general dissatisfaction but specifically it is related at how the organization is being managed. With challenges facing the department as a whole with a lot of political musical chairs and senior management posts not being filled, the researcher hopes that the recommendations for building management and leadership capacity will be both accepted and practiced at the ELHC and a similar study could be expanded to identify the challenges faced at head office so as to bring stability to the organization as a whole.

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## **1.8. Annexures**

### **1.8.1. Questionnaire**

RHODES UNIVERSITY BUSINESS SCHOOL  
MASTERS RESEARCH

April 2011

Dear Colleague

Rhodes University and I would greatly appreciate it if you could complete the attached questionnaire – to be used for research purposes only. This questionnaire is part of research exploring the factors that impact on staff satisfaction of the Health Care Professionals at the East London Hospital Complex. This research is aimed to contribute to the scientific knowledge in the organizational behaviour and management fields by describing the current organizational culture as well as the impact rationalisation (Complexing) had. The anonymity/confidentiality of respondents is guaranteed. All completed questionnaires will be coded and names of respondents will be erased. If you have any questions, please do not hesitate to contact me. Once completed please place the completed questionnaire in the envelope provided. Seal the envelope and post it at your nearest mail box or leave it with my secretary. Please note that postage has been prepaid. Please answer all the items in the questionnaire.

Thank you for giving up your valuable time to assist in the research.

Sincerely,

Luntu Galo

Manager Medical Services, Cecilia Makiwane Hospital, ELHC

## INSTRUCTIONS

(Takes Just 20

minutes)

This survey is designed to get feedback from you regarding your opinion about things that might impact on your satisfaction at the East London Hospital Complex. Your responses will be completely anonymous. Survey results will form part of the analysis and recommendations for my dissertation and will not identify individuals.

Please mark the number on the right that best represents your opinion, based on the scale below. Your feedback is greatly appreciated. Thank you for your time.

### Demographic Information

Gender	M <input type="checkbox"/>	F <input type="checkbox"/>			
Age	18-24 <input type="checkbox"/>	25-30 <input type="checkbox"/>	31-40 <input type="checkbox"/>	41-60 <input type="checkbox"/>	61+ <input type="checkbox"/>
Race	Black <input type="checkbox"/>	White <input type="checkbox"/>	Indian <input type="checkbox"/>	Coloured <input type="checkbox"/>	Other <input type="checkbox"/>
Number of Years at ELHC	Less than 1 year <input type="checkbox"/>	1- 5 years <input type="checkbox"/>	6 -10years <input type="checkbox"/>	11 – 15 years <input type="checkbox"/>	+15 years <input type="checkbox"/>

Please be sure to use the following scale to define your response:

Strongly Disagree Agree	Disagree	Neutral	Agree	Strongly
1	2	3	4	5

1 I am satisfied with my opportunity for growth and development.  
1 2 3

1	2	3	4	5
---	---	---	---	---

2 I believe my career aspirations can be achieved at this organization.  
1 2 3

1	2	3	4	5
---	---	---	---	---

3 I am satisfied with the level of balance between my work and personal life.  
1 2 3

1	2	3	4	5
---	---	---	---	---

4 I am involved with decisions that affect my work.  
1 2 3

1	2	3	4	5
---	---	---	---	---

- 5 I see myself working for this organization three years from now.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 6 I am proud to be part of this organization.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 7 My work environment enables me to be as productive as I can be.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 8 I have the resources I need to do my job.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 9 My job offers me the opportunity to gain work experience in challenging new areas.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 10 I am given opportunities to improve my skills in this organization.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 11 This organization is well managed.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 12 Management acts consistently; they do as they say.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 13 I would feel comfortable communicating openly with senior management if the need arose.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 14 Top management is fair in dealing with people.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 15 I have trust and confidence in the leadership of this organization.  
1 2 3 

1	2	3	4	5
---	---	---	---	---
- 16 There is genuine management concern for the problems employees face.  
1 2 3 

1	2	3	4	5
---	---	---	---	---

- 17 Management provides a clear picture of the long-term goals and direction of your organization.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 18 My manager involves me in decisions that affect my work.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 19 My manager provides the resources I need to do my job.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 20 My manager effectively coordinates the work flow in our department.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 21 I would feel comfortable going to my manager with a concern.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 22 My manager takes a supportive role in my professional growth and development.  
2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 23 My manager ensures that people who do a good job are recognized and appreciated.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 24 This organization encourages a climate where diverse perspectives are valued.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 25 Senior management demonstrates its support for diversity by its actions.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 26 Our organization treats employees fairly without regard to employment level.  
2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 27 There is a strong drive toward satisfying the needs of all employees in this organization.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- 28 Resources are allocated fairly.  
1 2 3
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
- |   |   |   |   |   |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

29 I work in an environment where I feel comfortable being myself.

1 2 3

30 Compensation practices at this organization are fair and reasonable.

1 2 3

1	2	3	4	5
---	---	---	---	---

31 This organization pays me fairly for the work I do.

1 2 3

1	2	3	4	5
---	---	---	---	---

32 I understand how my compensation is determined.

1 2 3

1	2	3	4	5
---	---	---	---	---

33 Information about our organization's policies, practices, and procedures is easily available.

1 2 3

1	2	3	4	5
---	---	---	---	---

34 We are kept informed about important developments in different departments.

1 2 3

1	2	3	4	5
---	---	---	---	---

35 This organization has adequate procedures for sharing information.

1 2 3

1	2	3	4	5
---	---	---	---	---

36 People communicate comfortably with one another in this organization regardless of position or level.

1 2 3

1	2	3	4	5
---	---	---	---	---

37 Considering everything, I am satisfied working for this organization at the present time.

1 2 3

1	2	3	4	5
---	---	---	---	---

38 Adequate communication to employees takes place prior to implementing new programs and/or systems.

1 2 3

1	2	3	4	5
---	---	---	---	---

39 Past change initiatives have had positive results.

1 2 3

1	2	3	4	5
---	---	---	---	---

40 The climate for change is very positive and supportive in my organization.

1 2 3

1	2	3	4	5
---	---	---	---	---

## 1.8.2. Exit Interview CMH Nursing Template

### Questions for exit interviews

Name and Initials .....

Designation .....

Institution .....

Department .....

1. Why do you terminate services?

.....  
.....  
.....  
.....

2. Would you say the working environment has contributed to you taking the decision, and Why?

.....  
.....  
.....  
.....

3. If there was a problem in relation to ques. 2, did you bring it up, and what transpired after that?

.....  
.....  
.....

4. What do you suggest should be done to prevent more resignations/early retirements?

.....  
.....  
.....

5. If an opportunity arises in future within the Complex, would you be interested to join the ELHC

.....  
.....

### 1.8.3. Exit Interview Clinical Support Template



Province of the  
**EASTERN CAPE**  
HEALTH

Clinical Support Services • Room 4.12 • 4<sup>th</sup> Floor • Frere Hospital • Amalinda Drive • East London • Eastern Cape  
Private Bag X9047 • East London • 5200 • REPUBLIC OF SOUTH AFRICA  
Tel.: +27 (0)43 709 2312 • Fax: +27 (0)43 709 2418 • Website: [www.ecdoh.gov.za](http://www.ecdoh.gov.za)

#### **EAST LONDON HOSPITAL COMPLEX EXIT INTERVIEW**

**NAME:** .....

**DESIGNATION:** .....

1. Would you consider coming back to ELHC?

.....  
.....  
.....  
.....

2. In your opinion, were you paid an adequate salary for the work you did?

.....  
.....  
.....  
.....

3. Under what conditions would you have stayed?

.....  
.....  
.....  
.....

4. If you were to change something in the ELHC, what would you have changed?

.....  
.....  
.....  
.....

5. Do you believe management in the ELHC adequately recognized your contributions?



-----  
-----  
-----

6. Did you understand the various departmental policies and the reasons for them?

-----  
-----  
-----  
-----

7. Do you feel your training was adequate?

-----  
-----  
-----  
-----

8. Were you satisfied with your working conditions?

-----  
-----  
-----  
-----

9. Do you have any suggestions for improving employee morale?

-----  
-----  
-----  
-----

10. What did you like

- Most about your position?

-----  
-----  
-----  
-----

- Least about your position?

.....

.....

.....

.....

11. Could anything have been done to prevent you from leaving?

.....

.....

.....

.....

12. Did you find that the goals and targets of your role were clear during your employment?

.....

.....

.....

.....

13. Could your qualifications and skills have been used to better advantages?

.....

.....

.....

.....

Interviewed by:

NAME: .....

DESIGNATION: .....

DATE: .....

#### 1.8.4. Raw data Table 4: Number of Respondents

**N=60**

QUESTION NUMBER	NUMBER RESPONDENTS	QUESTIONS NOT ANSWERED	1	2	3	4	5
1	36	1	5	10	7	11	2
2	36	0	6	12	7	9	2
3	36	0	6	9	8	11	2
4	36	1	3	12	8	9	3
5	36	0	6	11	7	5	7
6	36	0	7	5	14	5	5
7	36	0	10	13	3	7	3
8	36	0	5	11	5	3	2
9	36	0	3	9	6	15	3
10	36	1	8	10	6	7	4
11	36	0	17	10	7	1	1
12	36	0	13	12	9	2	0
13	36	0	2	6	6	12	10
14	36	0	10	14	5	7	0
15	36	0	12	11	8	5	0
16	36	0	8	15	4	6	3
17	36	0	5	12	13	5	1
18	36	0	4	15	4	11	2
19	36	0	5	15	10	5	1
20	36	0	3	14	8	10	1
21	36	0	2	5	6	16	7
22	36	0	4	12	8	8	4
23	36	0	7	11	11	7	0
24	36	0	8	10	12	6	0
25	36	1	7	12	11	5	0
26	36	1	6	14	8	7	0
27	36	0	13	16	6	1	0
28	36	0	14	11	9	1	1
29	36	0	4	11	7	10	4
30	36	0	8	13	7	7	1
31	36	0	10	12	2	10	2
32	36	0	6	9	9	11	1
33	36	0	5	7	10	10	4
34	36	0	5	15	4	8	4
35	36	0	4	11	11	7	3
36	36	1	9	10	9	5	2
37	36	0	9	7	8	10	2

38	36	0	7	15	10	3	1
39	36	0	9	7	16	4	0
40	36	1	7	10	12	5	1

**Table 4. Number of Respondents**

### 1.8.5. Raw data Table 5: Percentage Respondents

QUESTION NUMBER	1	2	3	4	5	AVG
1	13.9	27.8	19.4	30.6	5.6	5.8
2	16.7	33.3	19.4	25.0	5.6	6.0
3	16.7	25.0	22.2	30.6	5.6	6.0
4	8.3	33.3	22.2	25.0	8.3	5.8
5	16.7	30.6	19.4	13.9	19.4	6.0
6	19.4	13.9	38.9	13.9	13.9	6.0
7	27.8	36.1	8.3	19.4	8.3	6.0
8	13.9	30.6	13.9	8.3	5.6	4.3
9	8.3	25.0	16.7	41.7	8.3	6.0
10	22.2	27.8	16.7	19.4	11.1	5.8
11	47.2	27.8	19.4	2.8	2.8	6.0
12	36.1	33.3	25.0	5.6	0.0	6.0
13	5.6	16.7	16.7	33.3	27.8	6.0
14	27.8	38.9	13.9	19.4	0.0	6.0
15	33.3	30.6	22.2	13.9	0.0	6.0
16	22.2	41.7	11.1	16.7	8.3	6.0
17	13.9	33.3	36.1	13.9	2.8	6.0
18	11.1	41.7	11.1	30.6	5.6	6.0
19	13.9	41.7	27.8	13.9	2.8	6.0
20	8.3	38.9	22.2	27.8	2.8	6.0
21	5.6	13.9	16.7	44.4	19.4	6.0
22	11.1	33.3	22.2	22.2	11.1	6.0
23	19.4	30.6	30.6	19.4	0.0	6.0
24	22.2	27.8	33.3	16.7	0.0	6.0
25	19.4	33.3	30.6	13.9	0.0	5.8
26	16.7	38.9	22.2	19.4	0.0	5.8
27	36.1	44.4	16.7	2.8	0.0	6.0
28	38.9	30.6	25.0	2.8	2.8	6.0
29	11.1	30.6	19.4	27.8	11.1	6.0
30	22.2	36.1	19.4	19.4	2.8	6.0
31	27.8	33.3	5.6	27.8	5.6	6.0
32	16.7	25.0	25.0	30.6	2.8	6.0

33	13.9	19.4	27.8	27.8	11.1	6.0
34	13.9	41.7	11.1	22.2	11.1	6.0
35	11.1	30.6	30.6	19.4	8.3	6.0
36	25.0	27.8	25.0	13.9	5.6	5.8
37	25.0	19.4	22.2	27.8	5.6	6.0
38	19.4	41.7	27.8	8.3	2.8	6.0
39	25.0	19.4	44.4	11.1	0.0	6.0
40	19.4	27.8	33.3	13.9	2.8	5.8

**Table 5. Percentage of Respondents**

#### **1.8.6. Raw data Table 6: Unfavourable-Neutral-Favourable**

QUESTION NUMBER	UNFAVOURABLE	NEUTRAL	FAVOURABLE
1	41.7	19.4	36.1
2	50.0	19.4	30.6
3	41.7	22.2	36.1
4	41.7	22.2	33.3
5	47.2	19.4	33.3
6	33.3	38.9	27.8
7	63.9	8.3	27.8
8	44.4	13.9	13.9
9	33.3	16.7	50.0
10	50.0	16.7	30.6
11	75.0	19.4	5.6
12	69.4	25.0	5.6
13	22.2	16.7	61.1
14	66.7	13.9	19.4
15	63.9	22.2	13.9
16	63.9	11.1	25.0
17	47.2	36.1	16.7
18	52.8	11.1	36.1
19	55.6	27.8	16.7
20	47.2	22.2	30.6
21	19.4	16.7	63.9
22	44.4	22.2	33.3
23	50.0	30.6	19.4

24	50.0	33.3	16.7
25	52.8	30.6	13.9
26	55.6	22.2	19.4
27	80.6	16.7	2.8
28	69.4	25.0	5.6
29	41.7	19.4	38.9
30	58.3	19.4	22.2
31	61.1	5.6	33.3
32	41.7	25.0	33.3
33	33.3	27.8	38.9
34	55.6	11.1	33.3
35	41.7	30.6	27.8
36	52.8	25.0	19.4
37	44.4	22.2	33.3
38	61.1	27.8	11.1
39	44.4	44.4	11.1
40	47.2	33.3	16.7

**Table 6. Unfavourable-Neutral-Favourable**

## **SECTION 2: LITERATURE REVIEW**

### ***2.1. Introduction***

The literature review will cover three main areas of theory namely:

- Organisational Culture
- Organisational Change and
- Foundations of Satisfaction

Within each section an in-depth discussion is entered with reference to seminal works as well as current researched literature. Organisational change is dealt with extensively and the various concepts are unpacked.

### ***2.2. Organisational Culture***

The notion that organisational culture can affect health care performance rests upon certain assumptions: that health care organisations, units or work groups have identifiable cultures; that culture is related to performance; that a culture can be altered to impact on performance; that the intervention will provide a worthwhile return on investment; and that it will outweigh any dysfunctional consequences (Deal and Kennedy, 1982:4; Hellriegel et al, 2004:357; Rowe, et al, 1994: 472; Schein, 1992:52; Smith, 2002: 249).

What distinguishes one culture from another is the vast pool of tacit knowledge, which natives understand, but are not conscious of knowing. Culture, therefore, is not merely the observable in social life; it is also the shared cognitive and symbolic context within which a society can be understood (Nazir, 2005: 40-41; Rowe et al, 1994: 472; Schein, 1992: 12).

### 2.2.1. Definition of Culture

Routledge (2010) defines culture as a set of key values, assumptions, understandings and norms that are shared by members of an organization and taught to new members as correct. It is the “personality” of an organization, how it looks and “feels” when you enter it.

According to French and Bell (1995) culture is based on deeper, relatively permanent and often unconscious values, norms and assumptions.

“It is a collective assessment of an organization based on the pattern of shared basic assumptions that the group has learned as it has solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems” (Schein, 1992:12).

Culture can be understood from three different levels, where levels refer to the degree to which the cultural phenomenon is visible to the observer:

- First Level: *artefacts* is the most visible level, although the most difficult to make sense of. It represents what one would see, hear and feel when encountering an organization such as the architecture of the physical environment, language used, technology, products, clothes, myths, rituals, ceremonies, stories and publications.
- Second Level: *espoused beliefs and values* represent what ought to be, as distinct from what is. These values influence how to deal with new tasks, problems or situations, and if the solutions work, the value can become a belief.
- Third Level: *assumption* is least visible and represents those assumptions that guide behaviour. (Schein, 1992:16)



Culture gives employees a sense of organizational identity and generates a commitment to particular values and ways of doing things. Culture also serves two important functions in organizations:

- It integrates members so that they know how to relate to one another ,
- It helps the organization adapt to the external environment (Routledge 2010: 33)

### **2.2.2. Shaping Culture**

Routledge (2010) raises an important point of culture being the reflection of the values advocated by a founder or leader by his/her day to day actions. This is done by the leaders to create a perception or viewpoint that assists the employees achieve the organisation's mission, vision and goals. The leader makes use of organizational rites and ceremonies, stories, symbols and specialised language to enact cultural values. Importantly, emphasis is placed on careful selection and socialisation of new employees to keep cultures strong (Routledge, 2010).

Routledge (2010:32) says that, "Once a healthy culture is established, leaders use a variety of techniques to maintain a strong culture that provides both smooth internal integration and external adaptation."

### **2.2.3. Organisational Values**

"Organizational values are the enduring beliefs that have worth, merit and importance for the organization. In considering what values are important for the organization, leaders consider the external environment and the company's vision and strategy." (Routledge, 2010:34)

Daft (2005) identifies four cultural sub-types:

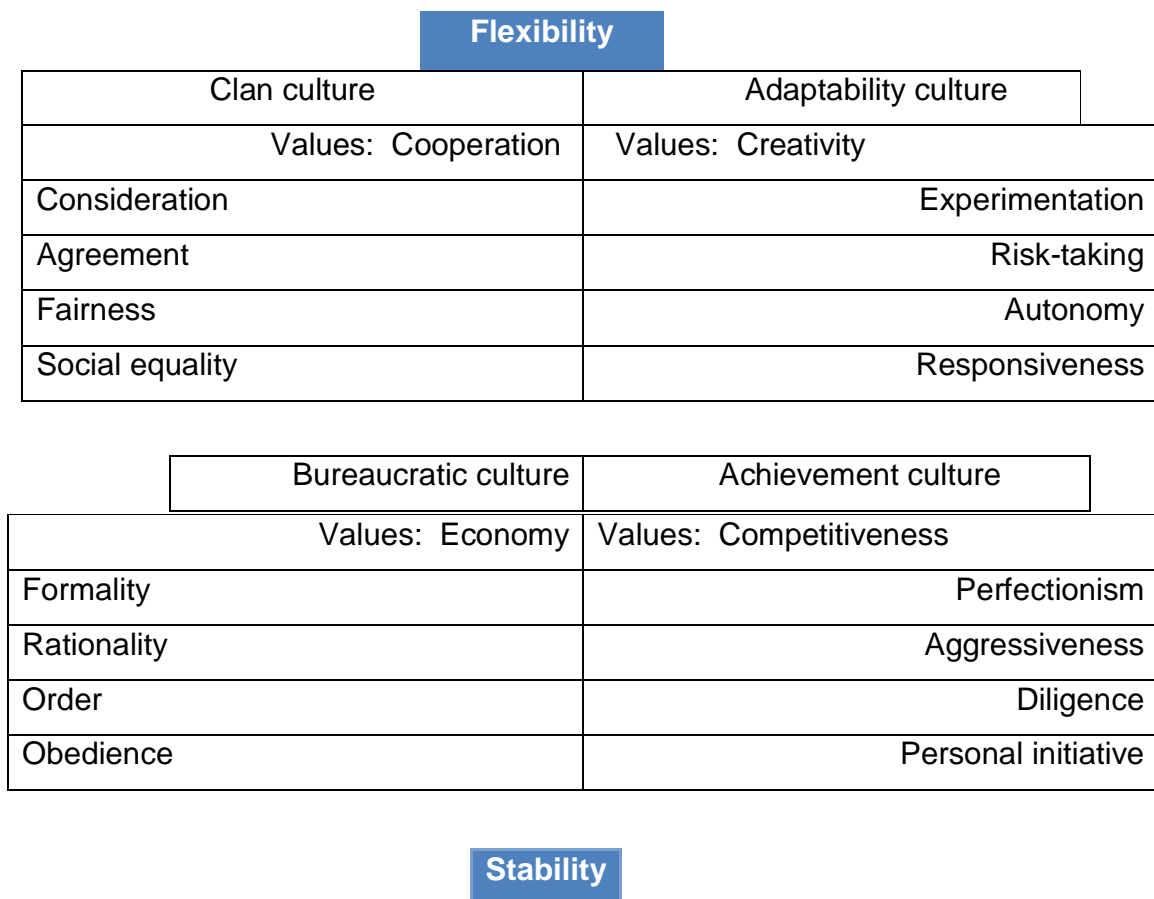
- Adaptability Culture

- Achievement Culture
- Clan Culture
- Bureaucratic Culture

And chooses to focus on two specific dimensions of organizational culture namely:

- The extent to which the competitive environment requires flexibility or stability.
- The extent to which the organization's strategic focus and strength is internal or external.

In the development of his model:



Relative emphasis on various cultural values depends on the organization's strategic focus and on the needs of the external environment with each of the four cultures able to yield successful results (Routledge, 2010). He further states that "Leaders might have preferences for the values associated with one type of culture, but they learn to adjust the values they emulate and encourage, depending on the needs of the organization" (Routledge 2010:36).

## **2.3. ORGANIZATIONAL CHANGE**

There is no single accepted definition of organisational change. This is perhaps not surprising given the wide diversity of change experienced by organisations and individuals.

Change is becoming a constant feature of organisational life (Hayes, 2002; Iles and Sutherland, 2001). In the change management literature there is considerable disagreement regarding the most appropriate approach to changing organisations. These doubts are substantiated by the critical management literature that contains many accounts of change projects that regularly go wrong, such as those given by Burnes (2004).

From the literature there would appear to be two main approaches to change management:

1. Planned
2. Emergent.

### **2.3.1. Planned Change**

Based principally upon the work of Kurt Lewin, this approach views organisational change as a process that moves from one 'fixed state' to another through a series of pre-planned steps, and can therefore be analysed by Lewin's (1951) 'Action Research' model. Another planned approach to organizational change is Lewin's (2003) 'Three-step model' which describes the three learning

stages of freezing—clinging to what one knows, unfreezing—exploring ideas, issues and approaches, and refreezing—identifying, utilising and integrating values, attitudes and skills with those previously held and currently desired. This approach recognises that, before any new behaviour can be adopted successfully, the old one has to be discarded. Only then can the new behaviour be fully accepted.

Building on the work of Lewin many writers have adopted similar approaches. Cummings and Huse (1989) developed an eight-phase model, and Bullock and Batten (1985) developed a four-phase model of planned change based on a review of over 30 models of change. Whilst planned change has many followers it also has a number of critics. Garvin (1994) argues that change cannot occur from one stable state to another with the turbulent business environment that exists today. Hayes (2002) highlights that there are situations where an organisation may need to change initially for environmental reasons but it may not be obvious what to do. In such circumstances it may not be possible or desirable to define an end state for the change process.

Bamford and Forrester (2003) suggest the planned approach is based upon an assumption that everyone within an organisation agrees to work in one direction with no disagreement is not always being the case. Within any group of individuals differences of opinion on important matters will always exist.

### **2.3.2. Emergent Change**

The 'emergent' approach as a concept that lacks the formal history that planned change has. Burnes (2004) argues that its supporters appear more united in their stance against planned change than their agreement upon a specific alternative. Dawson (1994) and Wilson (1992) both challenge the appropriateness of 'planned change' within business environments that are increasingly uncertain. Wilson (1992) believes that the planned approach, in laying down timetables,

objectives and methods in advance, is too heavily reliant upon the role of the manager. On the other hand, Dawson (1994) adopts a processual approach to change that is less prescriptive and more analytical in nature. This approach is, in theory, better able to achieve a broader understanding of the problems of managing change within complex environments.

Organizational change is seen to be less dependent upon detailed plans and projections than on reaching an actual understanding of the complexity of the issues involved and identifying the range of possible options. Dawson (1994) claims that change must be linked to developments in markets, work organization, systems of management control and the shifting nature of organisational boundaries and relationships. He emphasises that, in today's business environment, one-dimensional change interventions are likely to generate only short-term results and heighten instability rather than reduce it.

Implicit in the emergent change argument is the assumption that if organizations operated in more stable and predictable environments, the need for change would be less and it might be possible to conceive of it as a process of moving from one relatively stable state to another. Consequently, for the proponents of emergent change, it is the uncertainty of the environment that makes planned change inappropriate and emergent change more pertinent (Bramford and Daniels, 2005). This point is emphasised by Strickland (1998), who draws on systems theory to emphasise the way that organisations are separate from but connected to their environment. Strickland (1998: 76) raises a question which many of those studying organisational change appear not to acknowledge: 'to what extent does the environment drive changes?' This is a question worth asking about the East London Hospital Complex and to what extent is the ELHC in control of its own within the change processes?' Obviously the environment, in organisation terms, includes both internal and external influences.

A major development of emergent change is an emphasis on 'bottom-up' action rather than 'top-down' control in commencing and implementing organizational change. The rationale behind this is that the pace of change is so rapid and complex, once it occurs, that it is impossible for senior management to identify, plan and implement every action required. The responsibility for change is, therefore, more devolved and, as a result, requires great changes in the roles played by senior management. They change from being a controller to a facilitator (Bramford and Daniels, 2005). Pettigrew and Whipp (1993) believe there are no universal rules with regard to leading change. It involves linking action by people at all levels of the business. As can be seen, the advocates of emergent change come from a wide variety of backgrounds and each offers their own distinct view on how organizations should and should not manage change. In an effort to come to grips with the organization as a holistic entity and organisational change as a phenomenon that affects the entire organization, some researchers have put together more complete models of understanding change. Hinings and Greenwood's (1988) model of change dynamics, Kanter et al. (1992) 'Big Three' model of organizational change, Pettigrew's (1985) process/content/context model, and Burnes (2004) change management framework are all in this category. Another area for consideration is the notion of so-called 'psychological contracts': unwritten expectations to do with implicit matters of dignity and worth (Burnes, 2004).

### **2.3.3. Impact of Change on the Psychological Contract**

The literature on change management consistently points to the potentially negative impact of organizational change on the psychological contract. Worrall, Cooper and Campbell-Jamison (2000a,b) observe the negative impact of change in the public sector resulting in a breakdown of the psychological contract as a consequence of reduced job security, loyalty, morale and motivation and the threat to the careers of managers. Guest and Conway (2000, 2001), in a general review of the psychological contract in the public sector, make similar

observations. Worrall et al. (2000a,b), looking at change in a wider context, consider the particularly damaging effect of redundancy programmes that can result in 'survivor syndrome' being observed. This again challenges the stability of the psychological contract, as does the frequency of change, as observed by Pate et al. (2000).

#### **2.3.4. Types of Change**

Organizations evolve and need to adapt to their environment and this inevitably requires change within the organization. The effective initiation and management of change can determine whether or not the change initiative will be successful (Amos, 2006). The aim of this change is often to make fundamental changes in how business is conducted in order to help cope with a new, more challenging market environment (Kotter, 1995:59).

Before any change happens, it should be understood what type of change it is and how will it affect the organization and its employees. Armstrong (2009:167) differentiates between different types of changes that could occur as being:

- Incremental,
- Transformational,
- Strategic,
- Organizational,
- Systems and processes,
- Cultural and behavioural changes.

#### **2.3.4.1. Incremental Change**

This is gradual change as it takes place in small steps. This type of change takes at the operational as distinct from the strategic level. Continuous improvement is not about making sudden quantum leaps; it is about adopting a steady, step-by-step approach to improving ways in which the organization does things (Caldwell, 2004).

#### **2.3.4.2. Transformational Change**

This is the process of ensuring that an organization can develop and implement major change programmes so as to respond strategically to new demands and continue to function effectively in the dynamic environment in which it operates. A distinction can be made between first-order and second-order transformational development. First-order development is concerned with changes to the ways in which particular parts of the organization function and second-order change aims to make an impact on the whole organization (Pascale, 1990).

Transformational change of organizations has been defined as radical and wide ranging changes made to an organisations' mission, culture and structure in order to meet changing environmental conditions (Dunphy and Stace, 1990). Two types of transformational change have been identified — modular and corporate, according to the scale and depth of change. 'Modular' change alters some structures while 'corporate' change tackles all structures including making changes to power and status of individuals within the organisation (Dunphy and Stace, 1990).

#### **2.3.4.3. Strategic Change**

This change is concerned with broad, long term and organization wide issues. It is about moving to a future state that has been defined generally in terms of strategic vision and scope. It covers the purpose and mission of the organization, its corporate philosophy and such matters as growth, quality, innovation and values (Pettigrew and Whipp, 1991).



#### **2.3.4.4. Organizational Change**

This change deals with how organizations are structured and how they function. It deals with addressing issues of centralization and decentralization, how management tasks should be divided into separate activities, how these activities should be allocated to different parts of the organization and they should be directed, controlled, coordinated and integrated (Johnson and Scholes, 1997).

#### **2.3.4.5. Systems and processes**

Changes to systems and processes affect operations and impact on working arrangements in the whole or part of an organization. These changes may be concerned with various aspects of administration such as financial and management accounting, materials requirements planning, scheduling, procurement and order processing (Ulrich, 1998).

#### **2.3.4.6. Cultural Change**

This change aims to change the existing culture of an organization. It involves developing a more appropriate set of the values that influence behaviour and ensuring that people 'live the values'. This change may be in support of a newly adapted strategy that requires a paradigm shift from the employees in order to be executed successfully (Miller et al, 2001).

#### **2.3.4.7. Behavioural Change**

Involves taking steps to encourage people to be more effective by shaping or modifying the ways in which they carry out their work. Behavioural change can be achieved by getting people involved in setting objectives, giving them more responsibility to manage their own teams and providing rewards (Hop- Hailey, 1998).

### **2.3.5. Kotter's eight steps**

It is not sufficient for leaders to identify and define the kind of change that they are seeking to introduce to the organization, but they also need to be able manage the change process. The observation of the change efforts of more than 100 organizations led to Kotter (1995) identifying eight fundamental steps in managing change as:

- Establishing a sense of urgency – examining market and competitive realities and identifying potential crises and/or major opportunities.
- Forming a powerful guiding coalition – assembling a group with enough power to lead the change effort and encouraging the group to work together as a team.
- Creating a vision – creating a vision to help direct the change effort and developing strategies for achieving that vision.
- Communicating the vision – using every vehicle possible to communicate the new vision and strategies and teaching new behaviours by the example of the guiding coalition.
- Empowering others to act on the vision – getting rid of obstacles to change. Changing systems that seriously undermine the vision and encouraging risk taking and non-traditional ideas, activities and actions.
- Planning for and creating short term wins – planning for visible performance improvements and recognizing employees involved in the improvements..
- Consolidating improvements and producing still more change – using increased credibility to change systems, structures and policies that don't fit the vision. Hiring, promoting and developing employees who can implement the vision.

- Institutionalising new approaches – articulating the connections between the new behaviours and corporate success and developing the means to ensure leadership development and succession..

Even successful change efforts are messy and full of surprises, but just as a relatively simple vision is needed to guide people through a major change, so a vision of the change process can be the difference between success and failure (Kotter, 1995:67).

Unfortunately, many people come through the process of change feeling bruised, disenchanted and de-motivated. As a consequence the laudable aims of the change programme are all too often lost in the ‘noise’ of the process (Freeth, 2003).

### **2.3.6. History of Change within Health Sector**

Bramford and Daniels, 2005 suggest that successful change is much more difficult for the public sector for a number of reasons, including the fact that such organisations have to answer to a range of stakeholders, not just shareholders. The rationale for change is also more difficult to articulate in a sector where demand for services usually exceeds the resources available (Becker et al., 1998). Also, the political context into which such changes are introduced has a significant impact. While areas such as health care are key targets for reform (Southon 1996), changes proposed are often vulnerable to shifts in the political context (Becker 1998) and they rarely deliver all that is promised by those who promote them (Ferlie 1997). Lastly, the arrival of new leaders into the public sector, often as the result of electoral cycles, frequently results in organisational changes. These changes are introduced as a means of establishing a new leader’s managerial style, often at the expense of repudiating previous organisational directions (Becker et. al,1998). Continuous changes of this kind

can lead to high anxiety and low morale among non-managerial staff (Southon, 1996).

In an article examining the failed attempt at health system reform in the USA in the mid-1990s, Mechanic (1996) found that the lack of a simple, understandable vision of change that utilised existing structures and demonstrated clear, incremental gains, led to the downfall of this reform effort. A shift in the political context also meant momentum for change was lost.

Ashton (2001) stated that the lessons learned from this process included the need for: clear goals and strategies; to achieve them means early and frequent consultation with stakeholders; establishing trust with stakeholders and using opinion leaders to help promote change; and that substantial reform takes time and structures should be evaluated for their effectiveness before they are reformed or replaced. Klein (1998) stated that another problem is that research and evaluation rarely take place concurrently with changes in policy and this makes the development of an evidence base for health policy decisions very difficult. Moreover, there is little systematic evaluation and analysis of agency level organisational change efforts either internationally or in Australian health care systems (Pollitt 1997).

## **2.4. FOUNDATIONS OF JOB SATISFACTION**

Employment represents an exchange relationship between the employer and the employee (Young, 1997). Justice constitutes a basic requirement for the effective functioning of organizations and the overall level of satisfaction people derive from their employment (Greenberg, 1990). Organizational justice reflects individual employees' perceptions of fairness and one's evaluation as to the appropriateness of a given outcome. People tend to be less satisfied or dissatisfied with outcomes they perceive to be unfair (Cropanzano and Greenberg, 1997). Hence, organizational justice, as it pertains to the level of

compensation as an outcome received in exchange for the job inputs can be evaluated in terms of the satisfaction with pay.

## **2.4.1. Theories of Job Satisfaction**

### **2.4.1.1. Fulfillment Theory**

Vroom (1964) sees job satisfaction in terms of the degree to which a job provides the person in the job with positively valued outcomes.

### **2.4.1.2. Discrepancy Theory**

Satisfaction is determined by the differences between the actual outcomes a person receives and some other outcome level

### **2.4.1.3. Equity Theory**

This theory postulates that people evaluate fairness by comparing their job inputs and outcomes, using some referent source for making this comparison. For instance, people may compare their own inputs and outcomes to those of others, and assess the differences in their wages within that context. A state of equity is thought to exist if the perceived ratio of outcomes to inputs favourably compares to the outcome-input ratio of relevant others (Robbins, 1998).

## **2.4.2. Consequences of Dissatisfaction**

Routledge (2010) says that people who are dissatisfied with their job will tend to do only that which they must contractually do, what rebounds directly to their self-

interests; but contribute only grudgingly, if at all, in other ways. These effects on Organizational Citizenship Behaviour, rather than in-role performance or productivity, as traditionally defined, are the casualty of dissatisfaction.

The initial belief was that job satisfaction influenced job performance. But through research it has been noted that the prevailing understanding has swung to the view that satisfaction influences absenteeism and staff turnover (which affects the organizational effectiveness), but not job performance

#### **2.4.3. Satisfaction and Organizational Citizenship Behaviour (OCB)**

Organizational Citizenship Behaviours are a special type of work behaviour that are defined as individual behaviours that are beneficial to the organization and are discretionary, not directly or explicitly recognized by the formal reward system (Organ, 1988). These behaviours are primarily a matter of personal choice.

Smith, Kendall and Hulim (1983) conceptualized OCB with two dimensions:

- altruism (behaviour targeted specifically at helping individuals) and
- generalized compliance (behaviour reflecting compliance with general rules, norms and expectations).

Later Organ (1988) identified five OCB dimensions namely:

- *Altruism* consists of voluntary actions that help another person with a work problem – how to use new equipment, helping another to catch up on backlogs, etc.
- *Courtesy* For example, helps someone prevent a problem, provides advance notice of impending changes in work schedules, etc.
- *Sportsmanship* is a posture of toleration. It means not whining about small, unexpected emergencies.
- *Conscientiousness* is a pattern going beyond minimally required levels of attendance, punctuality, housekeeping, and conserving resources,

- *Civic virtue* is responsible, constructive involvement in the political processes of the organization, including expressing opinions, reading mail and keeping abreast of larger issues in the organization. To these forms can be added *Peacemaking* – actions that help to prevent, resolve, or mitigate unconstructive interpersonal conflict.
- And *Cheerleading* – the words and gestures of encouragement and reinforcement of accomplishments and professional development.

Organ (1988) further elaborated that OCB can maximize the efficiency and productivity of both the employees and the organization which will ultimately contribute to the effective functioning of the organization.

Based on Organ's (1988) five-dimension taxonomy, Williams and Anderson (1991) proposed a two-dimensional conceptualization of OCB:

- OCB-I (behaviour directed towards individuals; comprising altruism and courtesy) and
- OCB-II (behaviour directed towards organization, comprising the remaining three dimensions i.e. conscientiousness, sportsmanship and civic virtue in Organ's (1988) conceptualization.

Organizational citizenship behaviour has been recognized as a key factor in organizational performance. In general, it has been argued that organization's with a higher degree of OCB experience reduced absenteeism, reduced turnover, employee satisfaction and employee loyalty, which subsequently leads to improved organizational performance (Chughtai and Zafar, 2006).

## **2.5. Conclusion**

Having gone into detail about what makes up culture, it is important to remember that these perceptions, assumptions and belief and value systems are formed by a leader in an effort to shape vision and goal of an organization. Without the

understanding of the basis of change management from Lewin's work, it is difficult to appreciate the two main theories of change management.

Kotter simplifies the formula to change initiative success to 8 steps.

A perspective of an international change initiative within the health care sector is able to bring what seems to be corporate theory home towards a familiar environment of a public organization versus the business environment oriented research that is done.

Satisfaction theory and especially looking at the concept of organizational citizenship behavior (OCB) explains why the effort is no longer on happy employees being more productive, but the results of dissatisfaction being staff turnover and absenteeism. These behaviours in turn contribute to the inefficiency of the organization.



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## **SECTION 3: DESCRIPTION OF RESEARCH METHODOLOGY**

### **3.1.      *Introduction***

This section defines the problem statement and describes the objectives of the study. The methodological approach selected, namely the case study method, is explained as well as such intrinsic design issues as the paradigm and the approach. The data collecting techniques were restricted to sampling by use of a questionnaire or survey as well as sampling of archived documents namely the exit interviews.

Permission was granted by ELHC to conduct the study and the participants were reminded of anonymity when they participate.

### **3.2.      *Research aim and objectives***

The aim of this research was to investigate and analyse the feelings, perceptions and attitudes of Health Care Professionals at the East London Hospital Complex (ELHC).

The resultant objectives of the research were to:

1. Describe the existing Organisational Culture present at ELHC (Perform an organisational diagnosis).
2. Describe the impact of change (rationalisation).
3. Analyze why there is such a huge staff turnover.
4. Make recommendations on how to improve organisational culture.

The writer intends to present the findings of this research to senior management of the ELHC together with recommendations in the hope that senior management

will be able to share the salient features and develop strategies to improve the working environment and therefore staff attitudes and perception.

### **3.3.      *Research Paradigm***

A Paradigm according to Babbie (2001:42), “is the fundamental model or frame of reference we use to organise our observations and reasoning”, while Guba and Lincoln (1994:1) describes it as “a set of basic beliefs (or metaphysics) that deals with ultimates or first principles”.

The research adopts a constructivist paradigm with a relativist ontology. The relativist view posits that realities are captured in the form of multiple constructions which are experientially and socially based and dependent on the individual or groups holding the constructions. As a result of the above paradigm being adopted, the epistemology will be subjectivist, because the researcher and the researched are assumed to be interactively linked so that the findings are created as the investigation proceeds (Guba and Lincoln, 1994).

### **3.4.      *Research method: case study design***

As the main aim of this study is to evaluate feelings and perceptions amongst the staff at the ELHC as well as describe the current organizational culture, a case study methodology is therefore appropriate as it allows for a detailed understanding, and interpretation of phenomena, within a single bounded system, that system being the organisation, ELHC (Welman and Kruger, 2001).

Gray (2004:123) says that “case studies explore subjects and issues where relationships may be ambiguous or uncertain”. He further asserts that “case studies are trying to attribute causal relationships and not just describe them.” While Yin, (1994:13) describes case study methods as “an empirical enquiry that



investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” He further states that case study is an intensive investigation of a single unit. The unit of analysis could include an individual, a group a section of an organization or an organization (Babbie and Mouton, 2006)

The focus was on a specific section of the organization, that section being the Health Care Practitioners i.e. Nurses, Doctors Pharmacists, and other Allied Health workers (professionals) at the East London Hospital Complex (Frere and Cecilia Makiwane Hospital). This study was important for the management of the ELHC to understand the impact of organizational culture as well as unplanned change on productivity and staff turnover. With the presentation of these challenges faced by employees to management, it is hoped that strategies and plans can be put into place to create a positive organizational culture.

The output will therefore be a single case study discussing in a holistic approach what a subsection of the organization is feeling and thinking and using that information to generalize on the attitudes and perceptions of the whole staff population at the ELHC.

### **3.5.      *Data collection techniques***

Yin (1994) suggests six main sources of data for utilisation in a case study, each with their own strength and weaknesses. It is noted that the sources are not mutually exclusive and multiple sources are used to produce a good case study.

The primary data collected was from information gathered using a structured questionnaire or survey (questions selected from Connolly and Connolly, 2005) that aimed to elicit the dominant factors affecting staff satisfaction as well as demographic details, mainly of interest being the years of service. A cross-section of the professional staff (30 from each site) i.e. Nurses, Doctors and other

Allied Health Professionals (Pharmacists, Radiographers, Physiotherapists etc) from the busiest units such as Accident and Emergency (Casualty), ICU, Labour Ward, Medical, Surgical and Paediatric wards in both Hospitals that make up the East London Hospital Complex (Frere and Cecilia Makiwane) were sampled. This sampling was opportunistic in the sense that the researcher approached members of staff with whom he had a good rapport. Another reassuring issue that was impressed on the participants was that the questionnaire was accompanied by a prepaid paid envelope with the researchers postal address already completed. This further ensured anonymity as the only thing they were encouraged to do was to drop the completed questionnaire into the envelope and post it at the nearest post box at no cost to them.

The intention of the survey was explained, together with the emphasis that it was anonymous with no personal information being recorded. Due to the fact the researcher forms part of the senior management team, it was further explained that the findings of the survey would only be presented to management in the form a bound copy of the completed research with particular recommendations for implementation. Secondly the researcher offered to present the findings of his research to the general staff population after getting approval from management.

The next data source involved sampling exit interview questionnaires conducted for exiting employees for the nursing section at Cecilia Makiwane Hospital. Of concern was that there was no formal standardised exit interview questionnaire for the ELHC and the only available records were from Cecilia Makiwane Hospital nursing division and nothing was available on file for other categories from Frere or Cecilia. The Clinical Support Directorate (Allied Health Professionals i.e. Radiographers, Physiotherapist etc. at Cecilia Makiwane had developed their own exit interview template which had not yet been implemented.

### **3.6.      *Data analysis***

Yin (1994:102) notes that data analysis consists of three parts namely: examining, categorising, or otherwise recombining the evidence to address the initial propositions of the study. Boyatzis (1998) talks about thematic analysis and that this involves three distinct stages:

- Stage I: deciding on sampling and design issues
- Stage II: developing themes and coding with three techniques namely: theory driven, prior data or prior research driven and inductive (from raw data) or data driven
- Stage III: validating and using the code.

The researcher used a hybrid of research driven and inductive data analysis for the questionnaires.

### **3.7      Questionnaires**

The questions for the questionnaire were taken from Connelly and Connelly (2005) and are tested instruments and have been repeatedly used and applied in various organizations of varying sizes since 1987. Two or three questions were taken from 11 differing themes, these being (to make up 40 questions):

Employee Benefits, Organizational Change, Employee Engagement, Communication, Compensation, Co-worker Relations, Fairness and Diversity, Employee relations with Supervisor/Manager, Job satisfaction, Workplace Resources and Safety and General Management.

Due to the large number of themes, it was important to group some themes from the above list to make it more manageable. The two extremes of strongly agree and strongly disagree were picked up from the responses. The last response that the researcher looked at was where the respondent disagreed with the question. Major themes that emerged from the data when using the aforementioned filters showed that there was a lot of dissatisfaction with

communication, a feeling that resources were not fairly distributed and the supervisor/manager relationship was not positive. Other dominating themes were the lack of faith in management and the negative impact past change effects had on the organization as well as the current environment being not ready for any change initiative. There was a lack of clarity in remunerative issues, with people feeling they were not fairly compensated and some not understanding the remunerative structure was elicited.

### **3.7.1. Exit Interviews**

A total of 11 exit interviews (surveys) were sampled. The one done at Frere Hospital did not have a specific format, it was written as a report from the Area Manager to the Nursing service manager. It only stated that the nurse resigned due to personal reasons which were not elaborated and of concern was that the nurse had not completed training to become a professional nurse when she finally effected her resignation.

Of the 10 remaining interviews, all of which were done at CMH using the exit interview template for nurses (annexure 1.7.2), 2 had reached retirement age, 1 resigned for personal problems undefined, two due to shortage of staff and lack of resources, two due to remuneration issues, one due to family issues and the need to be closer to home and one due to back ache, injury on duty. A significant number, 8 of the 10 who had the ability to work noted shortage of staff as a major issue leading to adverse working conditions - a contributory factor in people leaving.

When asked about joining the ELHC again one was a definite no, while four said yes with the two retirees willing to come back to work as well.

### **3.7.      *Quality issues in case study research***

Winter (2000) claims that quantitative researchers attempt to disassociate themselves as much as possible from the research process while qualitative researchers have come to embrace their involvement and role within the research. While the credibility in quantitative research depends on instrument construction, in qualitative research, "the researcher is the instrument" (Patton, 2001:14). Thus, it seems when quantitative researchers speak of research validity and reliability, they are usually referring to a research that is credible while the credibility of a qualitative research depends on the ability and effort of the researcher. Although reliability and validity are treated separately in quantitative studies, these terms are not viewed separately in qualitative research. Instead, terminology that encompasses both, such as credibility, transferability, and trustworthiness is used.

Reige (2003) says that meaningful interpretations of accumulated data can only be constructed and presented if the research conforms to the following "quality" indicators, namely: "reliability" and "validity" To understand the meaning of reliability and validity, it is necessary to present the various definitions of reliability and validity given by many qualitative researchers from different perspectives.

Babbie and Mouton (2006:119) define "reliability" as "a matter of whether a particular technique, applied repeatedly to the same object, would yield the same result each time". However, "reliability" does not ensure accuracy. Babbie and Mouton (2006) also caution that "reliability" is always a concern whenever single observers are the sources of data. This is as a result of the impact of the degree of the subjectivity of the observer.

"Validity" implies "the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration (Babbie and Mouton, 2006:122). Consequently, the research process in this case study ensured that

there was a corroboration of the evidence by no fewer than two sources of information, namely: survey and archival records in the form of exit survey interviews.

Reige (2003:81) defines four design tests to mitigate against the risks of invalidity and unreliability, we will look at the relevant three (as Transferability cannot be considered as generalization is not possible in a case study):

“*Confirmability* is analogous to neutrality, and the design test assesses whether the interpretation of data is drawn in a logical and unprejudiced manner”.

“*Credibility* is the parallel construct to internal validity, and it involves the approval of research findings by either interviewees or peers”.

“*Dependability* is analogous to reliability, and its purpose is to show indications of stability and consistency in the process of inquiry, particularly to determine whether the techniques and (or) procedures used in the process of study, are consistent”.

### **3.8.      *Ethical considerations***

Denzin and Lincoln (2000) details four primary guidelines for ensuring ethical conduct during the research process, namely: informed consent, deception, privacy and confidentiality, and accuracy.

Permission was granted by the management of East London Hospital complex to conduct the research. Since the researcher forms part of the Management Team at the East London Hospital Complex, it was important to remind the participants at all times of the anonymity of their responses and that their identity would at all times remain anonymous. Complete trust between the researcher and the respondents was possible due to the opportunistic nature of sampling. All

communication and interaction with the participants was conducted with honesty and integrity, thereby negating any concerns of deception from either party.

The researcher is aware of the fact that certain confidential information was made available to him through the exit interviews sampled and the participants approached. While permission has been granted by the management for the research to be conducted, due care and integrity has been exercised to protect the individual participants as well as where the information and insights may be emanating from.

### **3.9.      *Conclusion***

It is clear that deficiencies in communication as well as type and style of management have contributed to the current dissatisfaction elicited in the questionnaire. There is the issue of previous change efforts which have never been resolved that are coming out as well.

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