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This thesis is presented for examination for the degree of Doctor of Philosophy. I, Pat Bowerbank, declare this research to be my own unaided work, both in concept and execution. All references to other works are fully acknowledged at the end of the thesis.

University of Cape Town

Pat Bowerbank

## **ACKNOWLEDGEMENTS**

I wish to thank all the following people who have assisted and supported me during the five years I have been working on this research:

Professor Frank Horwitz, my supervisor from the Graduate School of Business, University of Cape Town

All the physiotherapists who gave me their time, answered my questionnaires and lent me documents and journals, most especially Pat Swilling, Sheena Irwin-Carruthers, Margaret Beattie, Gubela Mji, Zodwa Ngxolo, Margaret Farquharson and Anita Erens.

Tshlidzi Nmutandani a final year student who worked as a research assistant in his holidays and typed the questionnaire.

Lindsay Hooper who read and edited the first draft.

My colleagues and friends who showed so much interest and encouragement.

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**This work is dedicated to the hundreds of physiotherapists I have met, from all over the world, over the last forty years. We were privileged to experience a great profession together.**

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## **GLOSSARY OF ABBREVIATIONS**

African National Congress	ANC
Health Professionals Council of South Africa	HPCSA
Health Sciences Working Group	HSWG
Medical Association of South Africa	MASA
National Council for the Care of Cripples	NCCC
National Hospital Group	NHG
Orthopaedic Manual Therapy Group	OMT Group
Primary Health Care	PHC
Private Practitioners Association	PPA
South African Medical and Dental Council	SAMDC
South African Society of Physiotherapy	SASP
South African Sports Medicine Association	SASMA
Truth and Reconciliation Commission of South Africa	TRC
World Confederation of Physical Therapy	WCPT

## CHAPTER 1 RESEARCH OVERVIEW

### 1.1 INTRODUCTION

This research focuses specifically on the South African physiotherapy profession, that societal institution which is primarily concerned with health, illness and the physical elements of movement in the human body. Together with South African society as a whole this institution has experienced monumental changes over the last 30 years.

**The objective of this research is to describe and critically evaluate the nature, direction and depth of those changes for the South African physiotherapy profession.**

To this end the research attempts to identify some of the broad political and societal trends in the macroenvironment, and to contextualise these within the healthcare environment and the physiotherapy profession.

The main argument is that social circumstances determine not only the health of the population, but also the health care services and how health care professionals function in society (Benatar, 1997). Health care services and how health care professional's function in society are socially constructed phenomena and therefore there are marked differences in the way health care is delivered from country to country and one political system to another. Over the past decade, management research has increasingly paid attention to the manner in which organisations work to influence and shape their environments (Lawrence, 1999). A central issue has become the manner in which organisational environments are constituted, reproduced and transformed through organisational action and relationships.

### 1.2 RESEARCH QUESTION

**How does a relatively small professional organisation manage its key survival factors in order to maintain a dynamic and viable position in a changing health care environment?**

### 1.3 CASE STUDY APPROACH

The research will attempt to answer the question by conducting a socio-historical analysis of the cycles of change and growth of the physiotherapy profession in South Africa from 1971 to 2000. A case study approach is utilised and will

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explore the contexts, content and processes of change together with their interconnections in this particular professional organisation through a 30 year period. The focus is on the process of change in the context of the all-pervasive socio-political situation in South Africa that manifest themselves in the health care arena. The overall research challenge is to understand the complex and sometimes paradoxical ways change emerges over time, and to construct a model for physiotherapy which is sensitive to the conflicting objectives, goals and rationalities of that profession.

The period under investigation (1971 – 2000) has been chosen for three reasons. Firstly, this was a time when physiotherapy world wide was experiencing considerable change, particularly in relation to its position from a semi-profession up to the 1970s (Goode, 1969) to its position as an independent, autonomous profession thereafter (Mintzberg, 1979). Secondly, the period under research saw major technological advances within health care in general. South Africa experienced considerable political and societal upheavals during this period resulting in wide reaching policy changes including those regarding health care. Thirdly, as it was a period when the researcher practiced as a physiotherapist, the intimate knowledge gained of the history and norms of the profession provides an interpretive framework within which to decipher the actions of the members of the profession

#### **1.4. THE PURPOSE**

**The research revolves round two main purposes. Firstly the intention is to present a paradigm or model for the physiotherapy profession in South Africa; secondly the research will demonstrate in detail the challenges involved in integrating a longitudinal study with theory building qualitative approaches to enhance the study of organisational change**

##### **1.4.1 A PARADIGM FOR PHYSIOTHERAPY**

Paradigm proliferation in organisational studies has provided a wealth of perspectives from which to view organisations and organisational change. These include population ecology (Aldrich and Pfeffer, 1976; Hannah and Freeman, 1989); resource dependency theory (Pfeffer and Salancik, 1978) and institutional theory (Scott, 1987; DiMaggio and Powell, 1983). Kuhn (1970) uses the term paradigm to express the unique thinking, acting and methods of problem-solving

of a particular group of people. Applied to the physiotherapy profession, the notion of a paradigm has the potential to help clarify, express and evaluate fundamental beliefs, which underpin the physiotherapy organisation (Richardson, 1993). Furthermore a number of management theorists (Mintzberg, 1979; Goode, 1969; Scott, 1992; Botha and Orkin, 1993; Wallace, 1995; Lawrence, 1999) have contributed to the literature concerning professionals and strategies adopted by them for sustainable development and leadership.

A physiotherapy paradigm requires the members of the profession think of themselves in terms of what they do, how they do it and how they identify themselves in terms of professional values. This process of critical self-reflection and self-identification helps to determine what is given attention, what interpretations are made and what behaviors are elicited. The greater part of physiotherapy scientific inquiry has focused on a logical positivist paradigm underpinning the "medical model" – stressing the importance of experimental research and quantitative methods. Whilst this is likely to continue as the dominant culture of research especially in the light of the importance of evidence-based practice which integrates the best evidence with clinical expertise and patient values (Miller et al 2003), the recent radical changes in health care policy and philosophy throughout the world encourage the profession to define its position and role using a more interpretive approach (Rothstein, 2001).

## **1.5 RESEARCH PROBLEM**

Firstly, no formal theory has been developed that contains a physiotherapy paradigm for understanding and managing the health care environment. A number of authors (Paartero, 1982; Tyni-Lenne, 1991; Richardson, 1993; Grant, 1995) have challenged physiotherapy organisations world-wide to question their profession and its role in health care. They have suggested that a paradigm, as a theoretical concept, could frame the questions, which would help to establish an organisational identity and definition for the profession. In this instance a paradigm may be defined as a general perspective of thinking that reflects fundamental beliefs and assumptions about the nature of an organisation (Gioia & Petrie, 1990).

Secondly, there is a paucity of organisational research dedicated to longitudinal case studies using theory building, qualitative approaches (Hitt et al., 1998). Ecological and institutional theorists have contributed to empirical generalisations but most studies have focused on basic demographic outcomes. More attention needs to be paid to the evolution of organisational forms and the content of organisational processes (Aldrich, 1999). Since organisations are fundamental structures within societies it is important that studies be made of why and how they change over time.

Finally, the experience of the physiotherapy profession in South Africa over the past 30 years is unique in the context of the international physiotherapy community. It encompasses a period of severe political oppression and a subsequent period of democratic freedom. The unfolding experience of transformation in this profession provides rich opportunities for learning about organisational change during two contrasting periods. Very little research has examined this phenomenon in any of the health care professions. Without formal records or written research, the passage of time and fading personal memories result in fading institutional memory. Whilst accepting that other organisations in South Africa and possibly organisations in other countries with oppressive/democratic regimes have similar experiences, this research focuses explicitly on the physiotherapy profession in South Africa.

## **1.6 IMPORTANCE OF THE RESEARCH**

This research is a case study of a small health care profession and explores the interconnections of the contexts, content and processes of change in the profession through a 30-year period. The focus is on change and in studying the long-term processes in their contexts. The overall research challenge is to understand the complex and sometimes paradoxical way that change emerges over time. The research will show how the profession moved from the protected environment of the medical profession to the protected environment of legal control in a very well defined market niche and thence to a very competitive modern environment with a far broader market niche occupied by a greater number of contenders.

The research contributes to the development of broader management and professional organisational theory in two ways. Firstly, a paradigm or theoretical model will be constructed which is sensitive to the conflicting objectives, goals, and values of the physiotherapy profession and outlines the way in which the profession directs its patterns of actions that are concerned with managing the institutional structures within which it competes for resources.

In so doing the research will highlight i) how the high degree of specialisation and division of labour in the modern economy have elevated the importance of professional service organisations and ii) the conflict between self preservation and self interest of the professions and the altruistic calling to serve the public as described in agency theory (Sharma, 1997)

Secondly, the research will demonstrate those features of a professional organisation that endure over long periods of time and over contrasting eras of social systems, and about which some generalisations can be made. At the same time it will highlight those features of the organisation that changed and suggest reasons why the changes took place. Thus the research documents

the history of events, decisions, strategies, structures, network associations, policies, beliefs and perceptions of the profession, while presenting a somewhat unique picture of a contemporary organisation. The research will show the impact of organisational identification, identity and image on the behaviour of the South African physiotherapy profession. Very few empirical studies have been published that examine these effects (Dukerich, 2002)

## **1. 7 THE HEALTH CARE ENVIRONMENT**

As a start it is appropriate to give a very brief overview of the two contrasting approaches to health care which the physiotherapy profession embraced during the research period. South African health care has, for the most part, been a reflection on the political economy of the time. Due to the history of racial and political discrimination in the broader societal context, inequalities and fragmentation of health care became very marked in the apartheid era. Van Rensburg and Fourie (1994) attributed the following characteristics to health care in this era:

- 1 The absence of a binding health policy, that resulted in a highly divided health care structure, fragmented along criteria of race, function and geography;
- 2 The prominent role of the free market, entrepreneurialism and profit taking in the private sector which gave rise to laissez-faire patterns of provision of healthcare personnel and facilities;
- 3 Apartheid and white dominance led to the creation of structural inequalities from which originated undemocratic, discriminatory measures and practices based on inequality and racial difference;
- 4 The dominance of the established medical profession encouraged specific practices with heavy emphasis on curative, high technological care, at the expense of alternative health care practices some of which might have been more appropriate.

There is little doubt that the peaceful transition in 1994 from the repressive apartheid regime to a new democracy is one of the most remarkable political processes of the late twentieth century. Within the new democratisation process a more equitable dispensation was made possible for the people of South Africa resulting in fundamental reform of the health care sector. Thus process of national transformation reorientated the role of the health sector placing its practice within the larger social context. In this context, the following issues are the current driving forces for health care (Hanekom et al., 1996:1247):

**Health Reform:** an emphasis on equity and social upliftment, the goal of universal access to health care, the drive towards primary health care and the strengthening of the public sector

Managed health care: concerted programmes to manage cost, and access to all who can afford payment and quality care

Technology: rapid advances in technology which requires continual upgrading of medical knowledge

Inclusivity: In the context of South Africa, the challenge of inclusivity and valuing diversity will be vital to maintain leadership in the health care environment

## **1.8 THE PROFESSIONAL ASSOCIATION**

The physiotherapy profession in South Africa is represented solely by its professional association, the South African Society of Physiotherapy (SASP). This is a non-statutory body - that relies on voluntary membership from the student and qualified physiotherapists in the country. The professional association plays an important role in the development of the profession itself (Bowerbank, 2000; Richardson, 1999). In order to maintain enduring membership it has to balance the diverse needs and goals expressed by the different coalition groups amongst its membership. These include exerting influence on state regulators; promoting the collective good of the members; obtaining economic advantage; and enhancing the image of the profession. As the principal and only decision making body representing the physiotherapy profession in South Africa, the SASP presents as the ideal subject for the purpose of this research.

Professional status for physiotherapists in South Africa (and many physiotherapists in other countries of the developed world) has been a long-held ambition and, since 1972, there has been considerable recognition of a structured body of knowledge, a regulating body with code of practice, and recognition of autonomy of practice. Since the early 1970s the South African physiotherapy profession has striven to develop a strong coherent professional image of expertise and service whilst being sensitive to the processes of change and reform in health care.

## **1.9 PROPOSITION GENERATION**

The aim of the research was to construct an explanatory framework or paradigm which would explain how the South African physiotherapy profession managed its external environment in order to survive.

The existing literature dealing with organisation-environmental relationships was consulted and an initial set of hypotheses, based on management theory presented in current literature, was developed for the research proposal (Appendix 1). Once the research was under way the researcher decided to discard the hypotheses in favour of the development of propositions. The research methodology uses qualitative methods and descriptive data and does not engage in statistical significance testing. The distinctive characteristics of

propositions in qualitative research is that they are generally formulated after the researcher has begun the study; they are grounded in the data and are developed and tested in interaction with it, rather than being prior ideas that are tested against the data ( Maxwell, 1996).

Central to the conceptualisation of propositions was the idea that while the physiotherapy organisation has an institutional perspective from which external pressures are seen to impose limitations and yet simultaneously require the organization to be responsive to external demands and expectations for survival, in practice the essential elements of a health care profession led to characteristics such as monopoly of the market place for services rendered, protection of knowledge and skills, and competition for economic and social rewards. In so-doing, the physiotherapy organisation focused on strategies that were based on self-interest, and which derive from a resource based perspective. These contrasting theoretical puzzles can be viewed as core issues about institutional change and survival. The successful theoretical explanation and empirical support must address what triggers change in an established institutional field and how a practice, once introduced, becomes standard for all members. Four key factors were identified as vital for continued survival in the modern health care environment – resource management, legitimacy within the institutional environment, domain/niche occupancy, and inter-organisation dependencies.

The data collected from the tracking of historical records (chapter 4, point 4.7.1) and the analysis of the results of the pilot study (chapter 4, point 4.4) provided rich information that gave a new perspective to the research and especially to the role of the propositions. With this in mind the original hypotheses were discarded and reformed as four propositions, these were modified, reworked and eventually the data from the historical tracking methods and cause mapping led support to the four propositions listed below:

**PROPOSITION 1**

**The greater the environment changes over time with its differing demands on the organisation, the greater the likelihood of variable strategic responses affecting professional goals, activities and boundaries.**

**PROPOSITION 2**

**The greater the degree of professional autonomy and opportunity perceived to be obtained from the institutional environment, the greater the incentive for transformation of the professional form and practice**

**PROPOSITION 3**

**As institutional pressures increase, the effort by the organisation to improve inter-organisational linkages, which are viewed as legitimate by the wider institutional environment, becomes greater.**

**PROPOSITION 4**

**The ability of the profession to affect standards of practice in the organisational field is positively associated with its technical, political and marketing expertise and the degree to which it is perceived as the legitimate organisation in the field.**

## 1. 10 RESEARCH METHODOLOGY

The research takes a multi-method approach to enable validation of data by triangulation including unobtrusive historical content analysis; cause mapping and a survey questionnaire. Triangulation is the act of bringing more than one source of data to bear on a single point. Data from different sources, or using differing research methods, can be used to corroborate, elaborate or illuminate the research in question (Marshall and Rossmann, 1995). The research focuses on the institutional and structural transformations of the health care industry and specifically, on the physiotherapy organisation. The aim is to develop a paradigm which contains a series of connected propositions that specify a number of components and relations between them and is supported by the conclusions from the research data and theoretical explanations. A summary of the research process is shown in a flow diagram (Appendix 22)

### 1.10.1 HISTORICAL CONTENT ANALYSIS - Tracking strategies and processes

Strategies do not change on schedule, they may remain stable for several years and when they do change the process may be complex. An organisation's line of development results from the interplay of its actions with environmental resources and constraints. Although members might intend a certain course, interaction with the environment might result in a different route (Aldrich, 1999). Strategies may therefore be intended or emergent strategy, described as a "pattern in a stream of decisions" (Mintzberg and Waters, 1982:466). The research becomes a search for consistencies in decision-making behaviour and the investigation of their appearance and disappearance.

This study takes the form of historically grounded context analysis in which chronologies of the decisions and actions that shaped the physiotherapy profession's history as well as trends and events in the external environment are developed. A qualitative software package NUD\*IST NVIVO is used to collate data (described in chapter 4).

#### OBJECTIVES

- A. To track the chronologies of structured change that took place in the SASP during the period 1971 – 2000 and which affected the profession's performance
- B. To record systematically institutional change and transformation in the organisational field, that shaped the physiotherapy profession in South Africa, and the reasons for this change and transformation,
- C. To establish the reasons and conditions under which, the SASP established linkages or exchanges with other organisations in the interorganisational field

### 1.10.2 REVEALED CAUSAL MAPS

The question of when and how organisations change their strategy has received much interest in organisational research (Ginsberg, 1988). Previous research, linking cognition to strategy, suggests that organisational action is based on the beliefs decision makers hold regarding how the organisation can best succeed in the current environment (Daft and Weick, 1984). This belief system is based over time on past activities and results and as such provides a useful "map" for directing effective organisational action. The environment in which the South African physiotherapists have operated over the last 30 years tends to be very complex, constantly changing and confronting the profession with unfamiliar events and choices (Botha and Orkin, 1993). Effective responses require that decision makers update their understanding and belief systems in order to align themselves and their strategies with the demands of the external and internal environments. Causal maps have been used by researchers (Huff, 1990) to demonstrate the causal relationships among cognitive elements, for example how the current situation can be explained in terms of previous events. The strength of causal mapping methods lies in the fact that it can be analysed for change in beliefs over long periods of time, about the industry environment, strategic behaviours and performance of the organisation.

This research will make use of "revealed causal mapping" as one of the research tools.

#### OBJECTIVES

- A. To extract relevant data in order to construct the revealed causal maps (RCM)**
- B. To track the pattern of interpretation development that occurs as decision makers confront events in the institutional environment**
- C. To portray the information as time series pictorial graphs**
- D. To analyse the way in which the SASP adapts its key strategic activities in response to events in the environment**

### 1.10.3. SURVEY QUESTIONNAIRE

Professional organisations may be viewed as a coalition of interests and a network of activities whose membership, composition, and goals are constantly changing and in which projects rather than position are central (Kanter et al., 1992). Change is thus always occurring although it may not necessarily be consistent with the purpose of the principal stakeholders or be guided by organisational leaders. The organisational leaders concerned with controlling events or guiding change must be aware of the nature of these coalitions and networks in order to maintain the organisation in an overall direction. Since organisations are made up of different coalition groups with varying interests and values, members are likely to show contrasting frames of reference and perceptions about what is the "right" route for the professional organisation to take.

The purpose of the survey is to analyse the perceptions of the members of the South African physiotherapy profession about how they believe their profession is coping with change and the effectiveness of the profession to survive. The questionnaire has to be robust enough to be able to describe group experiences and also has to take into account a cohort affect whereby historical events have a differing impact on younger versus older members of the profession (Aldrich, 1999). This research makes use of the 100-item instrument – the group dynamics q-sort (GDQ) as described by Peterson et al (1999). The GDQ in this research is modified to 50-items. Each item has two polar opposite statements, raters are asked to identify the extent to which one or other of the extreme statements characterises the physiotherapy profession. A software package, SphinxSurvey – an integrated package for the design, administration and analysis of data, is utilised to manage the data.

In order to understand and make the data more tangible a sense-making framework is developed based on the Competing Values Model (CVM) described by Quinn (1988). The model is based on four contrasting perspectives of organisation. Scores developed from the GDQ are plotted on the CVM allowing the researcher to use the model as a diagnostic tool.

#### **OBJECTIVES**

- 1. To develop a research tool in the form of a questionnaire which measures the group decision- making process made by the SASP**
- 2. To administer the questionnaire to a stratified sample of registered physiotherapists in South Africa**
- 3. To develop a model framework for measuring the perceptions of South African physiotherapists about the decision making process and management of organisational change in their profession**

### 1.11 THE RESEARCHER

The researcher is a qualified physiotherapist who has practised in South Africa since 1968. During the period under investigation the researcher served on the Executive Committee of the SASP for a total of eight years over different periods of time, was a member of the Professional Board for eight years and represented the SASP at the Council meetings of the World Confederation of Physical Therapists from 1978 to 1983. In 1993 she was asked to join an *ad hoc* committee of the SASP that was given the mandate by the members to restructure the SASP. The greater part of her career has been spent in the public sector, and only the last fifteen years has she taken on a more academic role.

Clearly some personal bias reflects on the "trustworthiness" of the research report. Lincoln and Guba (1985) argue that establishing the trustworthiness of a research report lies at the heart of issues conventionally discussed as validity and reliability, but also propose their own criteria – a concern for credibility, transferability, dependability, trustworthiness and authenticity. The researcher attempts to present the facts as they seemed evident in the physiotherapy organisation, but neutrality depends on a separation of values from inquiry and due to the nature of the research which includes inductive methods, this is not possible. Guba and Lincoln (1994) say authenticity is demonstrated if researchers can show that they have represented a range of different realities. In this way the research should help readers develop "more sophisticated" understandings of the phenomena being studied, be shown to have helped readers appreciate the viewpoints of people other than themselves, to have stimulated some form of action, and to have empowered readers to act.

It is the aim of the researcher to produce high quality research embedded in the above characteristics which offers insights into the organisation of physiotherapy in South Africa. The research methodology makes use of triangulation, in which several methods are used at once revealing multiple constructed realities. These do not necessarily guarantee validity but offer deeper understanding of different aspects of the research subject, thus reducing the risk that the conclusions will reflect only the biases or limitations of a single method, leading to a greater credibility and authenticity than one limited to one method.

## **CHAPTER 2**

### **THE SOCIO-HISTORICAL PERSPECTIVE**

In order to contemplate any significant changes taking place in the physiotherapy profession it is necessary to try to grasp some of the origins of the multidimensional problems of inequality in South African society and health care, brought about by the all-pervasive discriminatory political systems that dominated all socio-economic conditions in South Africa for more than three centuries; although the actual formal discriminatory system and its policies are considered to have come only in 1948. More recently, following the change in 1994 to an ANC- lead government, fundamental change has taken place in the broader societal context, and this has brought about some structural changes to the health care system.

This chapter focuses specifically on the broader political conditions and changes which impacted on the South African health care system and ultimately the physiotherapy profession. The aim is to estimate the nature and direction of change and to identify the broad trends in South African health care over the long term, and to contextualise these in relation to the development of physiotherapy in South Africa. The approach takes the form of a historical overview making use of sources from the literature.

#### **2.1 THE HEALTH CARE ENVIRONMENT**

##### **2.1.1 EARLY TWENTIETH CENTURY**

This section focuses on changes and trends in the health care system in South Africa from the time of Union in 1910 up to the research period ending in 2000. Van Rensberg (1991) argues that in reality there were, despite much dynamics and slight changes, no fundamental changes at all up to the end of the apartheid regime. The political and social distinctions that were established early in the colonial period impacted on the later health care system in terms of separation of treatment on colour lines, apartheid medicine, and the dominant position of whites in the professions. The South African Medical and Dental Council (SAMDC) was established by Act in 1928, the prime function was to serve as an instrument to protect the public from unprofessional conduct by the medical profession. The SAMDC was vested with a wide range of powers including setting of medical examinations, the approval of training schools, the recognition of local and foreign medical qualifications and the exercise of disciplinary power over persons registered in terms of the Act. Following an inquiry, the SAMDC

could impose various penalties ranging from a caution to removal of a practitioner's name from the register.

Between 1910 and 1939 the successive Union governments established a 'comprehensive system for segregation. In 1923 the Smuts government laid down the basic framework for administering the lives of urban Africans. This was based on the understanding that Africans were only required in the urban industrial areas to administer to the needs of the Whites and had to depart when they had finished doing so. The Native Urban Areas Act of 1923 amended in 1932 forced Africans in towns to live in dormitory towns or locations. This was to have a very divisive effect on the way health care was delivered, and by the time the second world war took place the South African health care system reflected the following features (Van Rensburg, 1991):

- 1 A split structure with a dominant Western scientific component and a number of non-official, traditional and alternative variants of health care
- 2 A physician and hospital-centred care system with strong emphasis on curative care, in the midst of which other types of health care personnel were given secondary emphasis
- 3 A racially or colour differentiated structure in health care delivery
- 4 A fragmented structure that showed little coordination in either control or function, and which was heavily concentrated in urban areas
- 5 A mixed structure in which both public and private provision and financing alternated, which lead to a pluristic supply structure

By 1945 the end of World War II and a considerable rise in the gold price generated an economic boom, and sent thousands of rural Africans to the cities in search of work and better wages. Meanwhile the ANC, encouraged by the hope of a better life in post-war years, issued a Bill of Rights in 1943 demanding the "freedom of African people from all discriminatory bills whatsoever", which was turned down by the government as unrealistic.

### **2.1.2 GLUCKMAN COMMISSION**

A shift in emphasis towards a more primary health care approach was recommended by the Gluckman Commission in 1944, together with a strong plea for a non-racial national health service for South Africa. This recommendation was 50 years ahead of its time and was ignored. The Nationalist government did not encourage preventative health care until the late 1980s when it became obvious that curative health care was becoming too expensive (SA Race Relations Survey 1989/90). Eleven years later in 1955 the ANC was to produce its Freedom Charter, described by Coovadia (1985) as "... It is essentially a people's statement of the minimum conditions for social arrangements, economic order and political institutions. The Charter therefore meets a necessary

condition to achieve health and that it is the expression of the people or at a different level, community involvement in health matters". In 1956 when the ANC sought to adopt the Charter, the State brought charges of high treason against 156 leading members of the Congress party. At the same time, the Group Areas Act provided different residential areas for every section of the population, and stations, hospitals, schools, lifts and public transportation all held apartheid signs.

### **2.1.3 HEALTH CARE SEGREGATION**

The following period saw the gradual upgrading of South African health care in terms of a marked increase in staff, facilities, and diversification of care and care institutions, and in the numerous adaptations and amendments in health policy and legislation. This brought about a gradual improvement in the health standard of the population (Van Rensburg, 1991). However Van Rensburg goes on to argue that no fundamental change took place, and that the health care system continued to function with the same basic inequality in provision for Whites and Blacks, between urban and rural areas and with greater exclusion of access and discrimination towards Blacks. The government did continue to build clinics and hospitals for Africans but these were either in their dormitory towns (the locations), or in the homelands. Only Whites could enter a 'white' hospital and Africans were denied access to health care in white areas. All mission hospitals, which had not previously been segregated were taken over by the state in 1973 and declared hospitals for Black patients.

In 1967 the Medical Schemes Act was promulgated allowing those who could afford to, to join a medical aid scheme whereby private health care providers would be paid a fee for services delivered. This further divided the country into those who were employed and could afford private health care and those who were not employed or could not afford to join, and were consequently reliant on the state health system.

Legislation, policies and practices in the health care sector were determined by ideological agendas rather than the by the needs of those requiring care (Baldwin-Ragaven et al., 1999). In the late 1960s and 1970s the state went on a great building spree. New academic teaching hospitals were built in all the towns supporting "White" medical schools, but many new hospitals were also built in Black townships.

### **2.1.4 HOMELAND HEALTH SERVICES**

The ideological agenda was further emphasised in 1976 when the government decided to "grant the full freedom of option in respect of future health services to the major identity groups as represented by Black homelands" (De Beer

1976). This disastrous policy was to see, by 1983 when Own Affairs departments were introduced for Whites, Indians and Coloureds, fourteen different Ministries of Health all with their own separate budgets. This led to almost indescribable confusion with a very expensive system of fiscal control and a complete fragmentation of services and staff.

Despite ostensible commitments from the homeland governments to primary health care, the lack of financial resources was crippling. In 1982 the entire budget for KwaZulu with a population of approximately seven million, was equivalent to the budget of one Johannesburg hospital (De Beer, 1984). The rural hospitals and clinics had great difficulty retaining staff, many clinics were run solely by nursing staff, and the equipment was in a very poor state. Medical care was often given by young, newly qualified doctors completing their military service.

#### **2.1.5 THE STEVE BIKO AFFAIR**

In 1963 the famous Rivonia trial took place when Nelson Mandela and seven others were sentenced to life imprisonment for treason against the State. This was followed by a very violent period when many acts of sabotage were carried out and resulted in the passing of the Terrorism Act of 1967 that allowed for indefinite detention without trial for political prisoners. In the years following many detainees suffered serious assault, and many died at the hands of security police. By far the most far reaching and notorious was the death in 1977 of Steve Biko. In 1977 Steve Biko, leader of the Black Consciousness Movement and a former medical student, was detained by security police in the Eastern Cape. Held under legislation that provided for his indefinite detention, Biko died 23 days later in Pretoria prison after being transported there from the Eastern Cape naked and suffering traumatic head injuries sustained during his detention. The subsequent legal procedures are well covered by Van Heerden (1996). In 1980 the two doctors, one a District Surgeon, who had attended Biko in prison in the Eastern Cape, filled in false medical certificates and authorised his removal to Pretoria in spite of his suffering serious head injuries, appeared before a disciplinary hearing of the SAMDC. SAMDC found no reason to take further action against the doctors. The Boards of the Medical Schools of the Universities of Cape Town and the Witwatersrand disassociated themselves from the decision of the SAMDC. Early in 1982 five doctors appealed to the SAMDC to hold a full and open enquiry into the ethical conduct of the two doctors, but the committee of the SAMDC found no reason to re-open the case. The five doctors then appealed to the Supreme Court to set aside the SAMDC's decision. The Supreme Court found that the SAMDC "had not applied its mind" and ordered a full

investigation. In 1983 a full council of SAMDC found the two doctors attending Biko guilty, and cautioned the one and struck the other off the register.

In another case, in 1982 medical doctor and political activist Dr Neil Aggett, allegedly hanged himself while in detention, two days after the Minister for Law and Order had assured parliament that every measure was being taken to ensure that detainees could not commit suicide. The Medical Association of South Africa (MASA) found itself under considerable domestic and international pressure, and in 1982 announced it would establish an ad hoc committee to inquire into the medical and ethical care of prisoners and detainees. The committee consulted widely and presented a report to government, who took 18 months to reply. All the recommendations of the report were turned down except for the recommendation for the formation of a panel of doctors to which detainees would have access. This however never became functional. The reputation of SAMDC and of MASA was gravely damaged (Benatar, 1990) and it was some while before they were able to restore it.

The editor of the South African Medical Journal (SAMJ), Professor D Ncayiyana wrote (1997:719), " a perusal of the records available at the SAMJ leaves little doubt that there was a concerted effort on the part of the top officers of the MASA to suppress correspondence submitted for SAMJ that was critical of the MASA handling of the Steve Biko affair", and proceeded to publish the letters 17 years after they were written. The Biko affair was to have profound effect on the health care professions as whole, with critics of MASA feeling it had not done enough, and breaking away to form opposition organisations. The health care professions came under increasing pressure from their international colleagues and associations, with serious threats of expulsion.

### **2.1.6 PRIVATISATION**

In 1986 the upward spiral in the cost of health care generally, the unfavourable exchange rate, the increased demand in both quality and quantity of health care and the social and political uncertainties, lead the government to turn to the private sector to share the burden for health care delivery. Privatisation was encouraged to the extent that it practically became government policy. A free enterprise system was promoted and effective competition was encouraged in the health care market. Some form of provision was also considered for the formation of health care teams (previously disallowed in the private sector). This commitment to privatisation by the government lead to a scramble to put up private hospitals and clinics and for health care professionals to turn to the private sector for their income. Calls by prominent academics for a National Health Service were rejected by the government (Benatar, 1985; Klopper, 1986; Coovadia et al, 1986).

In 1987 South Africa spent 5.8% of its gross national product on health care. Of this 44% was spent in the private sector that cared for perhaps 20% of the population. The remaining 56% was spent on the care of that 80% of the population dependent on the public sector (De Beer and Broomberg, 1990). These inequalities are summed up by Van Rensberg and Fourie (1994) "the inequality in South African health care encompasses a myriad related dimensions (i) in disproportionate distribution and thence also to over concentration and under concentration of personnel, services and facilities (ii) it refers to unequal provision and availability of services and facilities (iii) it is expressed in differential or unequal accessibility of services or facilities together with the phenomena of in/exclusion from services, as well as obstructive and discriminatory measures which limit/bar access to services...(vi) it also surfaces in the differential quality of services in the sense that some receive more and better services while others receive less and poorer".

### **2.1.7 SOCIO-POLITICAL REFORM**

In 1990, the State President, FW de Klerk opened Parliament with a speech which took the country by surprise. This included the laying down of guidelines for political and constitutional reform and for the redress of socio-economic problems, the unbanning of outlawed political parties and freeing of political prisoners. The Minister of Health announced that "all 44 white owned hospitals would be open to all races" (SA Race Relations Survey (1990/91). Health care would now revolve round five principles: the accessibility of health services, their affordability, the effectiveness of health care programmes, equity in the provision of health services and the acceptability of services to all people. Priority was to be given to primary health care 56 years after it was recommended in the Gluckman report. Schlemmer (1991) described this government turnabout as "The acceptance of a policy of common political citizenship and the elimination of social segregation in South Africa is substantially more than a reform initiative or a civil rights programme. It amounts to a transformation of a social order".

This change of heart by the government brought about a flurry of workshops, discussion groups and policy documents, as community groups, health care providers, professional associations and institutions realised that the political changes likely to take place would produce demands from the previously disenfranchised communities for a health care system more in keeping with the principles of social justice (De Beer and Broomberg, 1990a; 1990b). These authors called on government and the private sector to begin to do more than pay lip service to community needs, and pointed out that there was a need to embark on ambitious policy-orientated research programmes, a need for a serious appraisal of the health care system in South Africa and the need for a

process of negotiation to be put in place to ensure that the legitimate needs of all parties be met.

Many suggestions and recommendations were made for new health care systems varying from national health insurance and managed health care (Broomberg, DeBeer and Price, 1990; Fourie and Marx, 1993) to district health systems (Tollmann et al, 1993; Frankish, 1993; Barron and Fisher, 1993). De Beer and Broomberg (1990a; 1990b) argued that fundamental to the attainment of social justice in health care, is the principle that access to care should not be contingent on such factors as wealth, geographical location and race. Attempts to fund health care from private sources (as pursued by the government) was likely to contravene this principle. The authors urged the implementation of a statutory national health scheme, arguing that private sources pay for health care for the individuals who contribute only, that administrators of private medical insurance have an interest in excluding high-risk patients from membership, that private sources pay mainly for curative health care, and finally that the existence of multiple insurance agents is an additional form of fragmentation.

#### **2.1.8. PRIMARY HEALTH CARE**

By 1993 it was becoming obvious that the government's health care policy was going to revolve round primary health care (PHC). The development of primary health care depended on the success of the district health system (DHS), a concept untried in South Africa. The World Health Organisation (WHO) has described the DHS as crucial to the success of PHC because it provides a framework for local resource allocation and for rational planning to meet priority needs. In an editorial in *SAMJ* Zwarenstein et al (1993) called for the implementation of the DHS immediately, citing following reasons (i) it is the right level for engaging regular community participation in decision making (ii) it is the most sensitive level for the evaluation of health impact (iii) it is at this level that real collaboration with other sectors takes place (iv) it is the level at which communication with non governmental organisations (NGOs) and the private medical care providers can take place.

Unfortunately, at the time, these new approaches were very difficult to realise in the midst of the old established structures. Many meetings were held, and disagreements were made known, many people felt their jobs and positions were threatened, and some health care workers went on strike.

By 1993 South Africa had 239 medical schemes and most of them were in a state of financial crisis as the system was clearly unsustainable (Fourie and Marx, 1993). During that year the government continued with restructuring the health sector and passed legislation that deregulated medical aid schemes, and

abolished the three Own Affairs health departments. According to the Centre for Health Policy at the University of Witwatersrand, the Medical Aid Schemes Act would also facilitate the development of health maintenance organisations (HMOs). The HMOs comprising GPs, nurses, specialists, physiotherapists and other health care professionals would be able to provide health care to patients at a fixed cost, which would remove the incentive to over-supply services (Broomberg et al, 1990).

### **2.1.9 1994 – POLITICAL CHANGE**

In April 1994, the African National Congress came into power with Nelson Mandela as the new State President. The building of a united nation from a deeply divided South Africa called for the simultaneous pursuit of democratisation and socio-economic change, as well as reconciliation and consensus based on the commitment to peaceful coexistence. New priorities were laid down with special attention being paid to health care, in particular primary health care.

The ANC released its National Health Plan at the beginning of 1994 and the new Minister of Health made her maiden speech to the National Assembly. A firm commitment was made to the provision of primary health care, with the district health system as the cornerstone. The state was to be the key planner and promoter of public health. The fragmented health services were to be unified at all levels into an integrated national health system. New health care graduates would be directed to communities where staff shortages were experienced in under-served communities. Children under 5 would receive free health care. Legislation was also passed which provided for the establishment of an Interim National Medical and Dental Council. On account of budgetary constraints, a weak Rand and the need to upgrade community facilities, the Department of Health was forced to cut back on the budgets of larger hospitals and most especially the academic teaching hospitals which had previously received the lion's share of the health budget. In 1995/6 a number of posts were cut at these hospitals leading to considerable dissatisfaction, young graduates expressed anger regarding the compulsory community service and 1200 health care personnel left the country an increase of 454% over the previous two years (SA Race Relations Survey 1995/6).

### **2.1.10 TRUTH & RECONCILIATION COMMISSION**

In 1994 legislation was introduced to establish a Truth and Reconciliation Commission (TRC) chaired by Archbishop Desmond Tutu. The TRC was required to investigate the context in which gross violations of human rights had occurred

since 1960, and was given power to grant amnesty after full hearings. The amnesty legislation prescribed that only individuals could apply for amnesty and this had to be linked to specific acts for which they accepted responsibility. Statements by organisations accepting responsibility for gross human rights violations could only be made to the Human Rights Violations Committee. The TRC required spokespersons of professions to declare their roles as promoters or opponents of apartheid. Evidence from early TRC hearings pointed significantly to the complicity of health professionals in human rights abuses during the apartheid era. Health professionals, themselves, were also trying to come to terms with the past abrogation of professional ethics (Baldwin-Ragaven et al 1999). As a result of these debates the TRC decided to hold a special hearing on the health sector to establish a complete picture of the context in which human rights violations had taken place. The hearings were historic for it was the first time anywhere in the world that a truth commission held a hearing dedicated specifically to an examination of the nation's health sector (Hayner, 1994).

Health Sector Hearings were held in Cape Town in June 1997. Twenty four submissions out of the fifty received were heard. The hearings were aimed at describing the role of the health care sector in "colluding with, perpetrating and resisting human rights abuses during the period March 1960 – May 1994, and the intention is to examine the context of such violations in order to make recommendations to prevent them in the future" (TRC Commissioner for Health, Dr Wendy Orr, opening the proceedings). The Invisible thread of Steve Biko ran through all the proceedings (Spencer-Jones, 1997). Dr Bernard Mandell, chairman of MASA, offered his "unreserved apology" on behalf of the Association for "insensitive and indifferent actions" in the past. Organisations such as SAMDC and MASA had paid dearly, in terms of membership, political clout and credibility for what was perceived as their apathetic silence. Reporting on the hearings, the TRC made a number of recommendations for the health sector, that training in human rights be a fundamental and integral aspect of all curricula for health professionals.

### **2.1.11 TRANSFORMATION IN EDUCATION AND TRAINING**

There was wide agreement on the need for substantial reform of the education and training of health professionals in South Africa, in line with the changes in health care delivery planned to address the inequalities in the earlier system (Shear et al, 1997). The Health Sciences Working Group (HSWG) was appointed by the National Commission for Higher Education (NCHE) to advise on what the organisational and financial model for the training of health sciences personal should be. Amongst many recommendations regarding structure, organisation and financing of education, the working group made the following recommendations: (i) wherever possible a consortium of health sciences should be established within which there would be core shared educational programmes

(ii) an individual consortium should establish a interdisciplinary curriculum review facilitating body to develop guidelines on how to restructure the curriculum to focus on the health needs of South Africa and that these should be orientated towards comprehensive primary health care-. (iii) access for groups disadvantaged in the past because of race, gender, locality or finance had to be improved. This meant that there was to be much sharing of generic courses between the various health care professionals. This was far removed from the system used in most health science faculties where the various professions constructed their own courses independently. The recommendations lead health sciences faculties to review and make considerable changes to their courses and curricula.

### **2.1.12 TRANSFORMATION IN HEALTH CARE SYSTEMS**

A White Paper on the Transformation of the Health System in South Africa published in 1997 set out a broad strategy to provide health care for all. The paper made provision for change in some key aspects of existing health policy by passing three Health Acts.

The Medical, Dental and Supplementary Health Services Professional Amendment Act of 1997 provided for the establishment of a Health Professions Council of South Africa (HPCSA) to replace the Interim council. The council required a smaller number of professional boards thus obliging the various individual boards to make coalitions with each other. The Act also made provision for registration of chiropractitioners, homeopaths, aromatherapists, massage therapists and acupuncturist with the Allied Health Professionals Council.

In 1998 the Parliament passed the Medical Schemes Act which compelled all schemes to cover the cost of at least a minimum set of essential hospital benefits, and to ensure that access to basic medical schemes is not limited by age or ill health provided the applicant can pay the premium.

The Continuing Professional Development (CPD) Act of 1999, requires all doctors (and other health professionals at a later date), irrespective of earlier qualifications to obtain a specified number of points in order to retain their registration by attending continuing professional development courses. Newly qualified interns are required to do remunerated compulsory community service at State hospitals for one year. Only after completing this are they allowed to register with HPCSA.

By 1999 the ANC government had firmly committed itself to providing basic health care as a fundamental right and had managed to achieve a unitary health system. Forty-two health regions and 162 districts had been demarcated nationally. The health districts were realigned with the newly demarcated municipalities (South Africa Year Book 2001/2).

## **2.2 PHYSIOTHERAPY IN SOUTH AFRICA**

This section gives a very broad historical overview of some of the major processes that have taken place in the physiotherapy profession as a result of the institutional pressures from the macro socio-political environment of the country as well as the international health care environment.

### **2.2.1 ORIGINS OF PHYSIOTHERAPY IN SOUTH AFRICA**

Physiotherapy has its origins in folk medicine, a traditional healing therapy using massage and simple physical agents was further developed in health spas utilising the healing properties of spring waters. Eventually this form of hydrotherapy progressed to physical education – the knowledge of the structure and function of the body as well as the effect of exercise used in situations of both health and illness. As these healers developed their skills and knowledge and adapted them for the rehabilitation of the disabled and handicapped, they were admitted within the formal structures of health care (Paartero, 1982). Severe injuries from war battles, polio epidemics, congenital disabilities, the increase in transport and industrial accidents and the ability to relieve pain from arthritis and other disabling disorders justified the existence of physiotherapy to complement nursing and medical care, institutionalising their position within the health care environment.

The first pioneer physiotherapists, or masseurs as they were then known, came to South Africa at the beginning of the twentieth century (Irwin-Carruthers 1988). However the end of the First World War provided the impetus for the development of the profession when a number of physiotherapists arrived in the country looking for work in the "colonies" (McFarlane, 1985). In 1921 the Durban branch of the London-based Chartered Society of Massage and Medical Gymnasts was formed, and at the same time the small group of masseurs in Cape Town banded together to form the Certified Masseurs Association, primarily to fight for inclusion in the provisions of the forthcoming Medical, Dental and Pharmacy Act of 1928 (Irwin-Carruthers, 1988). This was a very important move by these intrepid pioneers the great majority of whom were women. It took 50 years before their vision, to be included in the Act, could be realised. In 1924 masseurs throughout the major centres joined together to form the South African Society of Massage and Medical Gymnastics (SASMMG), and in 1938 the first training for physiotherapy in South Africa was established at the University of the Witwatersrand, thus adding legitimacy to the profession.

Improved medical care and the use of antibiotics aided the survival of people severely injured and disabled during the Second World War, but this created need for these survivors for physiotherapy rehabilitation services and the development of rehabilitation skills by the practitioners. In response to this

demand the 1950/60s saw a proliferation of physiotherapy services and training schools throughout the Western world and British Commonwealth countries. A further four schools were established in South Africa, in Pretoria, Cape Town, Stellenbosch and Durban, all initially offering a 3-year diploma course.

After the Second World War, the SASMMG changed its name to the South African Society of Physiotherapy (SASP) and by 1954 the membership had swelled. This allowed the society to expand to 10 branches throughout the country (Appendix 2). About the same time South Africa, along with five other countries, became founder members of the World Confederation of Physiotherapy (WCPT), and from 1963-1970 was represented on the Executive Committee.

Rising living standards; increases in social equality; global communications; professional sport; technological advances in medicine and the concept of quality of life have placed considerable demands for physiotherapy services. From the 1970s, with far greater resources and opportunities at its disposal, physiotherapy services developed to the very sophisticated level which is available at present time; far removed from the folk practices on which it was originally based (Richardson, 1993). It is interesting to note that the physiotherapy organisation in Canada (Higgs K, 2002), Australia (Turner, 2001) and England (Richardson, 1993) all followed similar patterns as in South African.

### **2.2.2 PHYSIOTHERAPY AS A PROFESSIONAL ORGANISATION**

All professions came into being to fulfill specific social functions, and they are found in the division of labour which prevails at a particular time (Etzioni, 1964) Organisations are built up of roles which stand in relation to each other and it is the quality and strength of these roles which give the organisation its character. The public has expectations or requirements of these roles that can be specifically defined or described. Physiotherapy developed into its unique role within the health care sector at the turn of the twentieth century when doctors began to realise the importance of exercise and movement, i.e rehabilitation, following surgery, illness or disability. Society accepted masseurs and then physiotherapists when doctors referred them for treatment for their pain, immobility or disability, which was then helped or relieved by the skills of the physiotherapist. When the physiotherapists organised themselves into a professional organisation with rules and regulations this was accepted by society

In the 1970s physiotherapists occupied two main employment roles. The first role, in which the greater proportion of physiotherapists were employed at the time, was of state employee in large bureaucratic institutions such as state hospitals or clinics where they made their skills available to the public. The classic perspective on bureaucracy was proposed by Weber (1947) and had, as its main characteristics, a hierarchy structure and employment based on length

of service and merit, employees were expected to be loyal to the ideals of the institution rather than their profession. This posed many problems to the aspirations and development of physiotherapists and the profession, which believed it should have more autonomy and discretion in scheduling work tasks. The second role, in which only a few physiotherapists were then engaged, was of private practitioner who contracted their skill directly to individual patients.

In 1967 the Medical Schemes Act was passed which allowed for the formation of Medical Aid Schemes with scheduled tariffs. Initially physiotherapists had no separate tariffs for their services and their fees were linked to those published in the Medical tariff Book for specialists in Physical medicine (Pilkington, 1980). In 1969 the physiotherapists in private practice believed that the SASP was not aware of their special needs and that they were not sufficiently understood or protected, so, they decided to form a private practitioners association (PPA) under the umbrella of the SASP. Their main goal was to receive authorisation from the SASP to be able to negotiate with National Association of Medical Aid Schemes (NAMAS) regarding fees to be paid for physiotherapy services. Their first attempt at a meeting with NAMAS the PPA was refused.

Physiotherapists have traditionally looked to the medical profession for guidance (Kinston and Ovretveit, 1981). In 1970 physiotherapists could only receive patients following a doctor's referral and prescription, physiotherapists did not control their own work, neither did they have control over their own member violations – they fell under the South African Medical and Dental Council. Physiotherapists at this time could not make independent decisions concerning appropriate procedures for work tasks and activities. They had little autonomy and discretion over work procedures and therefore had little freedom and legitimacy. Very few had university degrees and even fewer took post graduate degrees. Goode (1969) states "...many aspiring occupations and semi professions will *never* become professionals in the usual sense; they will never reach the levels of knowledge and dedication and dedication to service that society considers necessary for a profession". He goes on to say that even if they do reach professional level they will always be less professional (than medical doctors, attorneys eg) in such traits as cohesion, commitment to norms of service and control over professional violations.

Registration of physiotherapy qualifications was established gradually during the 1960s. In 1971 provision was made for the establishment of separate professional boards within the SAMDC and in 1972 the physiotherapy profession elected its first professional board, a statutory body falling within the SA Medical and Dental Council. This event was to have a profound effect on the growth and development of the physiotherapy profession. Since 1974 the registration of recognised physiotherapy qualifications has been a prerequisite for practice. The

structure of the SASP and its relationship to the Professional Board for Physiotherapy is shown in Appendix 3.

The SASP is a voluntary association and in 1971 had a rather simple structure with few committees and no special groups. It is established for the benefit of its members whereas the Board is there for the benefit of the public. The two organisations enjoy a very close relationship and much correspondence flows between them. In terms of the research problems in this study, the Board is seen within the institutional environment as it performs a statutory function. In 1994 the Boards were terminated and Interim Boards were formed. These had similar functions to the Board but had to have members of the public elected to the Board. In 1997 the Health Professions Council of South Africa was formed and the physiotherapist joined with podiatrists and medical biokineticists to form a Board.

### **2.2.3 EDUCATION**

Six universities offered physiotherapy training as a course in 1972, four were degree courses and two were diploma courses. Perusal of the advertisements placed in the South African Physiotherapy Journal show the racial slant of these degrees - University of Cape Town, under Length of Training states "Both white and black" presumably referring to the racial status of the applicants; King Edward VIII hospital School states: 'Race All Non-White' (Appendix 4) In the 1970s a physiotherapy school was opened at the Medical University of South Africa (MEDUNSA) which was only for Black students, and in the 1980s a school was opened at the University of Western Cape ostensibly for Coloured students although Black students were also admitted. The Universities were autonomous institutions in terms of the curricula they presented. They were completely separate from the SASP and only had to concur with the Professional Board in as much as the Board and SAMDC had, in principle, to approve the curriculum. End of year examinations were inspected from time to time by Board members. (The researcher was a member of the Board for several years but never heard of a course being condemned). However all universities appointed external examiners from other universities to validate final examinations and in this way a relatively equal standard is maintained between the training programmes (Beenhakker, 1977). By the mid 1980s all universities offered 4 year degree programmes and all universities were offering post graduate degrees as well.

### **2.2.4 INTERNATIONAL PRESSURE**

The early 1980s saw considerable pressure being exerted on the professional association from member countries in the World Confederation of Physical Therapists regarding South Africa's apartheid policies and the bad publicity following the Medical Association's handling of the Biko affair. The SASP was able to plead its case and was not expelled from the world body (Irwin-Carruthers, 1987). In 1988 the SASP published and made public a Policy Statement (Appendix 5) in which it reaffirmed that "It does not and will not discriminate on the grounds of race, colour, creed national origins, social status, or sex in the practice of physiotherapy or in the administration of its organisation". The following year (1989) guidelines were developed for SASP members when treating prisoners, political detainees or victims of unrest (Appendix 6)

### **2.2.5 RESTRUCTURING OF THE ASSOCIATION**

In 1993 the SASP decided to appoint an ad hoc committee to investigate the possibility of restructuring the Association. In part this was due to some serious conflict within the membership and also because it was necessary to re-admit all the members residing in the "independent states" or homelands, who were now eligible for membership of the SASP. The nomenclature of the SASP changed: Chairman became President, National Council became National Assembly, a Chief Executive Officer was appointed to manage the affairs of the Association. By this stage the structure of the Association was far more complex than in the early 1970s – the development is described and discussed in subsequent chapters.

### **2.2.6 PRIMARY HEALTH CARE**

The changes proposed in health care in the early 1990s, led many health care professions to meet together with civic and community organisations to discuss the implications of primary health care. Comprehensive health care formed the foundation to the PHC approach, an unfamiliar concept for physiotherapists at that time (Bowerbank, 1994). The trend towards PHC also influenced the curricula of undergraduate students which focused on the development of manual skills and strong institutionally based education. Furthermore physiotherapy students displayed a number of perceived inhibitors towards practicing in a rural setting (Mitchell, 1997).

### **2.2.7 TRUTH & RECONCILIATION COMMISSION**

The TRC invited professional organisations to make a submission in 1996. Van Speyk (1997) makes an argument for a submission by the physiotherapy profession. The SASP made a submission to the TRC and then subsequently drew up a plan of action in order to prevent a repetition of past failings and to

promote reconciliation within the profession (Appendix 7 & 20). The World Confederation of Physical Therapy (WCPT) made a financial grant towards the production, printing and postage of the document. Copies were sent to all registered physiotherapists in South Africa, the Minister of Health, the Director General of Health and in addition copies were sent to all the member countries of WCPT, approximately 50 countries.

## **2.2.8 THE PRIVATE SECTOR**

The Private Practitioners Association of the SASP changed its name to PhysioFocus in 1998 and represents about 1500 members. The PhysioFocus instituted a national network of physiotherapists (PhysioNet-works) who were willing to meet certain criteria and be contracted to managed health companies. The PhysioFocus portfolio was responsible for preparing motivational material for negotiations with the medical aid schemes and managed health companies for increased tariffs or relational values.

### **2.2.10 TRANSFORMATION IN HEALTH CARE SYSTEMS**

In line with developments that have taken place in the medical profession physiotherapists are also expected to transform their systems. The transformation in the education system for health professionals has required considerable effort and negotiation. Calls have been made for a greater emphasis to be placed on teaching human rights, caring for victims of torture Faure (1995), restructuring of curricula and more relevant clinical practice.

Although beyond the scope of this research the SASP received notice that all physiotherapy students graduating at the end of 2002 will have to complete one year of community service in 2003. Continuing professional development (CPD) will become compulsory for all physiotherapists registered in South Africa from 2003. The term CPD is used to describe the ongoing learning that professionals need to undertake throughout their career in order to maintain, enhance and broaden their professional competence (Bardin, 1998).

This chapter has presented the historical background of the external environment including the health care sector and physiotherapy profession over the last century. This research sets out to investigate how the physiotherapy profession deals effectively with its changing external environment, how it interprets its environment and attempts to make appropriate decisions and responses.

## **CHAPTER 3**

### **LITERATURE REVIEW**

#### **3.1 INTRODUCTION**

This chapter focuses on the theoretical concepts introduced in this research and explains their relevance to the research question. This research is about the organisation of physiotherapists in South Africa since the 1970s, and the manner in which this phenomenon has survived and sustained itself within the turbulent health care environment in South Africa over the last 30 years.

Organisations dominate contemporary life and profoundly affect most aspects of individual life, 'organisations are viewed as the primary vehicle by which, systematically, the areas of our lives are rationalised – planned, articulated, made more efficient and orderly, and managed by experts' (Scott,1992:5). Organisations must be viewed as actors in their own right: they are born, make decisions, take actions, utilise resources, enter into contracts, own property. Some will continue to grow and some will demise. People construct organisations to accomplish things they cannot do on their own. Their achievements depend on the knowledge and resources available to them which vary over time and in differing environmental contexts. Knowledge and resources are culturally embedded and historically specific, their availability reflects societal conditions at a particular historical juncture (Aldrich, 1999).

#### **3.2 EARLY ORGANISATIONAL THEORY**

##### **3.2.1 ORGANISATIONS AS A BUREAUCRACY**

The first era of organisational studies was characterised by the dominance of closed-systems models, which emphasised internal factors as the prime causal agents in accounting for the structure and behavior of organisations. Weber is considered to be one of the earliest analysts of organisations, whose concepts helped to shape and understand how and why organisations arose, and how their operation affects the wider social structure (Scott 1992). Weber(1947 trans.) was the first researcher to identify and use the term bureaucracy. He defined bureaucracy as the increasing sub division of the function of an enterprise. In this view, bureaucracy consists of those positions and activities whose function is to serve and maintain the organisation itself. The early bureaucracies, as described by Weber, were characterised by a fixed division of

labour among participants, a hierarchy of offices, a set of general rules that governed performance, a selection of personnel on the basis of technical qualifications, and employment viewed as a career by participants. Weber focused primarily on organisations as systems of power or domination in which the leader exercises control over and through a hierarchy of officials who both receive and give orders. Weber believed bureaucracy to be completely indispensable for the needs of mass administration found in modern organisations, and saw it offering a stable, strict, intensive and calculable administration. He emphasised organisations as rational systems and saw the spread and development of bureaucratic administration as one of the most crucial phenomenon of the western world (Pugh, 1990).

The characteristics of bureaucracies tended to produce competing loyalties for professionals as was shown in the following studies: Goode (1969) had assumed that the solo practitioner best exemplified the ideal situation of the professional at work, and that professionals employed in organisations experienced bureaucratic demands that conflicted with professional ideals. Wallace's (1995) study of the legal profession examines how the different structural arrangements of bureaucratic organisations relate to lawyers' organisational and professional commitment. The results of his study show that loyalty to the employing organisation appears to be highly dependent on professionals' opportunities for career advancement and the criteria used in the distribution of rewards such as pay and promotions within that organization.

Selznick (1957) presented a different approach which concentrated on critical decisions made by organisations which, when made, changed the structure of the organisation. The pattern of critical decisions viewed over time results in the development of a distinctive character structure for each organisation. Selznick refers to the process by which an organisation develops a distinctive character structure as *institutionalisation*. Institutional commitments develop over time as the organisation confronts external constraints, Selznick observed the process by which organisations develop distinctive structures, capacities and liabilities. This approach can be seen as a natural history of an organisation – a description of the processes developing over time.

In contemporary societies these elements of rationalised formal structures are deeply ingrained in widespread understandings of social reality. Many professional services and programmes, such as physiotherapy, are shaped by public opinion, by important constituencies, by knowledge legitimised through the tertiary education system, by social prestige and by legislation .

### **3.2.2 ENVIRONMENT IN ORGANISATION THEORY**

The second era of organisational research is related to the growing acceptance of the open systems theory of organisations, which portrayed them as socio-technical mechanisms drawing resources from the environment at one end and exporting services and products into the environment at the other. Through the 1950s and 1960s a series of models were developed showing linkages between environment, technology, structure and process. Most of these models were very static and failed to deal with the problem of change in the environment and how this affected organisational decision making. The literature on the environment of an organisation and its direct and indirect impact upon organisational processes and outcomes has passed through a number of formative stages.

Dill's (1958) pioneering work both defined the task environment and suggested a causal relationship in which this task environment affected management autonomy. Dill made the distinction between general and task environments, the latter being composed of customers, suppliers, competitors and regulatory groups (such as government or unions); the task environment was seen as that portion of the total setting that is relevant for goal setting and attainment. The work of Burns and Stalker (1961), Emery and Trist (1965) and Lawrence and Lorsch (1967) has indicated that as the task environment becomes more dynamic, the organisation must become more receptive to change and alter its internal structure and operations to maintain its survival possibilities. Early researchers also tended to focus on two characteristics of an organisation's task environment; firstly ; its complexity, which referred to the number and diversity of external factors facing the organisation, and secondly its turbulence or dynamism, or the degree of change exhibited in these factors (Dill, 1958; Duncan, 1972; Terreberry, 1968). Environmental dependency is viewed an important component of environmental complexity (Osborne and Hunt, 1974) and is the degree to which a system relies upon specific elements in the environment for growth and survival and the extent to which these important environmental elements affect each other. Emery and Trist (1965) and Terreberry (1968) suggested that the combined impact of increased risk and dependency is negative whereas taken alone, environmental dependency has a positive impact on organisational outcomes.

These early models tended to stress the technical interdependence of organisations and their environments and although limited, they helped to create and legitimate modern thought on organizations. The modern era, beginning in the mid 1970s, focused more on the social and cultural interdependence of organisations and environments. From this perspective organisations are seen to participate in larger systems of inter-organisational relations including larger cultural systems, and involving the exchange of such normative elements as legitimacy and meaning (Scott, 1992).

### **3.3 ORGANISATIONS AND ENVIRONMENTS – current theories**

Institutional thinking and research developed very rapidly from the mid 1970s and much attention was given to the factors that produce and maintain the structure and life chances of organizations (Zucker, 1988; Powell and DiMaggio, 1991). Contemporary theoretical perspectives focus firstly on organisational structures that are created to deal with environmental pressures, and on the variability of these pressures in different environments. The forces of the environment can account for the number and variety of existing organisations as well as for the emergence and stability of relationships between organisations.

Secondly, contemporary theories hold that environments are more than stocks of resources, and that they are cultural systems, which define and legitimate organisational structures and thus aid in their creation and maintenance (Meyer and Scott, 1992). Kanter et al (1992: 10) suggest that a contemporary organisation is "any organisation is defined in its operations by the presence of a set of characteristics associated with enduring patterns of behaviour, both of the organisation as an entity and of people involved in it." The fundamental value of any organisation lies in its capacity to accumulate momentum and to exhibit reasonable consistency both over time and with respect to the behaviour of its members. The consistency of an organisation over time leads to its legitimisation which is essential to its survival. Stability in an organisation relates to the lack of conflict and serious challenges facing it from the environment. This occurs when resources are abundant and easily obtained, competitors are few and competition is confined by protected markets, technologies are standard and understood, commitments are clear and acceptable to stakeholders, and interests are aligned. This is similar to the "placid environment" described earlier by Emery and Trist (1965).

Most health care professions, including physiotherapy, experienced this type of stability" in the late 1970s and early 1980s. However the opposite situation faces most organisations in today's environment, especially in South African health care organisations. The environment is unstable, and resources are scarcer and more difficult to obtain, competitors are many and are no longer restrained by legal barriers, financial crises are common and are not easily solved, commitments by customers, employees, or other stakeholders are short-lived because of numerous choices; and interests and change frequently. The environment can be described as a turbulent.

A proliferation of contemporary organisational studies has provided a number of approaches in an attempt to put into perspective these varying aspects of the environment which impact on organisations. Population ecology theory, institutional theory and resource dependency theory are three distinct

contemporary theories, that are concerned with inter-organisational relations and organisational-environment relations, and provide models from which to view organisations and organisational change and survival. These theories are reviewed to provide insights into the development of the framework for the present research. Recent literature that provides a synthesis of these theories and offers valuable research approaches for understanding organisational characteristics which effect an organisation's chances of survival, are reviewed.

### **3.3.1 POPULATION ECOLOGY THEORY**

The population ecology or natural selection model of organisations originated with the work of Darwin. It draws an analogy with the biological evolution of species in exploring how populations of organisations are transformed by environmental change (Aldrich, 1999; Hannan and Freeman, 1989). This approach differs from others in that it applies to populations of organisations rather than individual companies or practices. Applied to this research, the Population Ecology model refers to the whole population of physiotherapists in South Africa. It also seeks to explain why certain forms of organisations survive and multiply whereas other types languish or die. Population ecology theory suggests that organisational survival is the result of environmental pressures that differentially select adaptive forms for retention in an organisational population (Hannan and Freeman, 1977). Among the environmental selection criteria that population ecologists have elaborated are external pressures for legitimacy, the forces of competition, and institutionalisation in organisational populations (Hannan and Freeman, 1977; 1989). Populations are dependent upon distinct combinations of resources known as *niches* that support them. A niche is defined as consisting of 'of the social, economic, and political conditions that can sustain the functioning of organisations that embody a particular form' (Hannan and Carroll 1995:34). Because they compete for resources within the same environment, organisations in a population are in a state of competitive interdependence. Competition pushes organisations toward adopting similar forms, resulting in greater homogeneity of forms within different niches. Competitive and cooperative interdependencies jointly affect organisational survival and prosperity (Aldrich, 1999; Hannan and Freeman, 1989).

Hannan and Freeman (1984, 1989) have proposed that selection pressures favour organisations that are able to demonstrate their reliability defined as the capacity to produce services of a given quality repeatably; and, accountability, defined as the appearance of compliance with institutional norms of rational and acceptable behaviour. As competition increases and environmental resources become increasingly scarce, the enhanced ability of institutionally linked organisations to mobilise resources and social support is expected to provide these organisations with better survival advantage.

Astley (1985) investigated how populations of organisations transformed from within by the differential success of their constituent members. Some practices fail and are selected out while others survive. At the same time new practices are created and enter the population, and as these replace the failed predecessors, the population as a whole gradually changes composition. Populations retain their distinctive character over time because dominant competencies are not easily learned or transmitted across population boundaries. Haveman (1992) found that organisational change may prove beneficial if it occurs in particular circumstances, such as in response to dramatic environmental shifts that threaten the organisation with extinction, and if it builds on established routines and competencies. The premise that organisational change is difficult and that organisations are subject to strong inertial forces is central to population ecology theory. When an organisation undertakes change it must learn new patterns of communication to facilitate the flow of different information, it must integrate new members and learn new routines in order to fulfill new functions (Singh, House and Tucker, 1986).

The conception is firmly based on an open system model and the importance of the environment is strongly underlined in the population ecology framework. The bottom line is survival (Scott, 1992).

Ecologists have focused their research analysis on the founding and disbanding of companies and practices in populations. Because they ordinarily study entire populations they are particularly well placed to study the conditions under which transformation occurs. With longitudinal data on organisations that did change, and those that did not, ecologists are able to identify the preconditions of transformation (Aldrich, 1999). However the ecological analyses of transformations have not included the social processes involved in organisational change and transformation.

Since the analysis of social processes is an essential part of this research on the physiotherapy profession, the research methodology will include elements from both population ecology theory and institutional theory (described below).

### **3.3.2 RESOURCE DEPENDENCY THEORY**

Whereas the population ecology approach stresses selection, the resource dependency model stresses adaptation. It is assumed that individual organisations can act to improve their chances of survival. Resource dependency theory emphasises that most organisations confront numerous and frequently incompatible demands from a variety of external sources (Pfeffer and Salancik 1978). As in population theory and institutional theory, resource dependency theory assumes that organisations attempt to obtain stability and legitimacy for the purpose of demonstrating social worthiness and mobilising resources.

However, in contrast to the other two theories discussed in this section, resource dependency theory argues that stability is achieved through the exercise of power, control, or the negotiation of interdependencies for the purposes of achieving a predictable or stable flow of vital resources, and thus reducing environmental unpredictability. Organisations must exercise some degree of control or influence over the resource environment for the purpose of stability. Resource characteristics include whether a resource is scarce, unique, inimitable, non-tradable, and durable (Oliver, 1997). External influences to key resource selection or acquisition will depend on such factors as barriers to acquisition, imitation and substitution. These can inhibit competitors' abilities to obtain the critical resources and lead to differences amongst members or organisations.

The resource dependency perspective is strongly rooted in an open system framework. It emphasises that no organisation is self sufficient, and that all must engage in exchanges with the environment as a condition of their survival. The importance and scarcity of resources determines the nature of organisational dependency. This perspective is seen to be much more active than the population ecology perspective in determining the fate of the organisation and one of the major contributions of the perspective is to discern and describe the strategies in response to the institutional processes that affect them (Oliver, 1991). Therefore, from a resource-based perspective, sustainability of an organisation is the outcome of, firstly discretionary choices; secondly selective resource accumulation; and thirdly deployment and strategic industry factors. By employing a longitudinal study methodology this research will investigate how the physiotherapy organisation in South Africa managed these three factors over the research period.

### **3.3.3 INSTITUTIONAL THEORY**

The institutional theory approach looks at social and political forces surrounding organisations, maintaining that organisations must comply with social expectations and values. If they do not, they are less likely to survive than if they do, regardless of their efficiency. This is in contrast to resource-based view which sees successful organisations as those acquiring and maintaining valuable resources for sustainable competitive advantage.

Meyer and Rowan (1977: 24-25) offer a key insight to institutional theory

"...formal structures are not only creatures of their relational networks in the social organisation. In modern societies the elements of rationalised structures are ingrained in, and reflect, widespread understandings of social reality. Many of the positions, policies, programmes, and procedures of modern organisations are enforced by public opinion, by views of

important constituents, by knowledge, by social prestige and by laws. In modern societies the myths generating formal organisational structure must be taken for granted as legitimate, apart from their evaluations of their impact on work outcomes."

Institutional theory therefore proposed that an organisation is likely to survive if it obtains legitimacy, social support and approbation from external constituents of its institutional environment (Meyer and Rowan, 1977; DiMaggio and Powell, 1988;). The institutional environment is defined as including the rules and belief systems as well as relational networks that arise in the broader societal context (Scott 1992: 14). This corresponds to the task environment described by Dill (1958). External legitimacy elevates the organisation's status in the community, facilitates resource acquisition, and deflects questions about an organisation's rights and competence to provide specific services (Oliver, 1990; Baum and Oliver, 1991). New organisations, services or programmes are formed or come about as institutionalised myths that define new domains of rationalised activity, and as the rationalising myths arise in existing domains of activity, organisations expand their formal structures so as to become isomorphic with these new myths. Meyer and Rowan (1977) argue that isomorphism with environmental institutions legitimises the organisation, and in so doing promotes the success and survival of the organisation. Institutionalised activities, therefore, are those actions that tend to be enduring, socially acceptable, resistant to change and not directly reliant on rewards or monitoring for their persistence (Oliver, 1992). Many of these activities are so taken for granted or so strongly endorsed by the organisation's prevailing culture or power structure that decision-makers can no longer question the appropriateness of these activities.

Establishing collaborative linkages to legitimated community and public institutions in the inter-organisational field is an important means by which organisations achieve reliability and accountability, and increases their survival prospects. The inter-organisational field is defined as the historically specific practices and transactions produced by network of cultural and historical actors and their actions (Leblebici et al 1991). It can be seen as a set of interacting groups or organisations orientated round a common substantive interest, such as health care in this study. Struggles within the organisational field occur over non-material as well as material resources, and the most intense struggles develop over control of the power to shape rules and norms. The resource and social support an organisation obtains from the establishment of institutional linkages may be the result of either legitimacy by association with organisations that already possess high legitimacy, or the conferral of more specific resources (Meyer and Rowan, 1977; Scott and Meyer 1983; Oliver, 1990). Population Ecology theory similarly premises that legitimating linkages to well established societal institutions reduce the likelihood of organisational failure.

The basic premise of institutional theory is that organisations with tendencies toward conformity with predominant norms, traditions and social influences in their internal and external environments, are those that gain support and legitimacy by conforming to social pressures. Institutional theory does not clearly define how transformation within an organisation takes place. The implied assumption is that organisations only change when external contingencies change. Leblebici et al (1991) explore how institutional practices change over time in an inter-organisational field in the historical context of the USA radio broadcasting industry. Through an historical analysis, the study documents the cycles of institutional change. The approach describes how the original structure and goals of this government agency were transformed over time by the commitments of its participants to the means of action, to particular ways of work, and more importantly to the survival of the organisation itself. The latter commitment had the unintended consequence of allowing powerful external constituents, in return for their support, to influence and compromise organisational goals.

This research, using a methodology similar to that of Leblebici et al (1991), will investigate whether a professional organisation does, in fact, conform to such institutional pressures and whether the physiotherapy profession does take on an isomorphic form, or whether professional health care organisations represent a different situation, especially in terms of self interest, autonomy and of achieving sustainability.

### **3.3.4 COMBINING THE PERSPECTIVES**

Over the past decade, management research has increasingly paid attention to the manner in which organisations work to influence and shape their environment. The divergent approaches described above are beginning to converge over a central issue relating to the manner in which organisational environments are constituted, reproduced and transformed through organisational action and relationships. When an organisation develops ties to well-established societal institutions, it signals its adherence to institutional prescriptions of appropriate behaviour and obtains a variety of rewards that are predicted to contribute to its likelihood of survival (Baum and Oliver, 1991). Oliver (1990) defines organisational relationships as "those enduring transactions, flows, and linkages that occur among or between an organisation and one or more organisations in its environment". Oliver (1990) integrates the literature on inter-organisational relationships into generalisable predictors of relationship formation in order to distinguish between what causes such relationships, and the conditions under which such relationships occur. She proposes six critical contingencies of relationship formation, necessity, asymmetry, reciprocity, efficiency, stability and legitimacy, that explain the

reasons why organisations choose to enter into relationships with one another. These determinants are then applied to six types of relationships. What Oliver does not explain is under what conditions the critical contingencies will be more likely to enter into a type of relationship. This research will make use of the critical contingencies described by Oliver and by applying them across longitudinal data relating to the physiotherapy organisation in South Africa will attempt to answer this question.

Baum and Oliver (1991) attempt to establish common ground or consistency between of population ecology and institutional theory for predicting failure and failure rates in organisations. Competition occupies a central role in ecology theory. The differential ability of organisations to obtain scarce resources under competitive conditions is argued to determine which organisations survive (Hannan and Freeman 1977, 1984, 1989). As competition increases and environmental resources become increasingly scarce the ability of the institutionally-linked organisation to mobilise resources and social support is expected to provide these organisations with an increasing survival advantage over unlinked competitors. According to institutional theory, an organisation's life chances are significantly improved by when the organisation demonstrates conformity to the norms and expectations of the institutional environment. The insights from these two approaches were integrated to study the conditions under which child day care centres in Toronto, Canada, survived or failed. The results suggest that institutional relationships play a significant role in reducing the likelihood of organisational mortality.

The convergent insights of institutional and resource dependency theory to the prediction of strategic responses to institutional processes (Oliver, 1991) are offered to describe the ways in which an organisation acts as a result of the institutional pressures towards conformity. The convergent insights of the two theories demonstrate how organisational behaviour may vary from passive conformity to active resistance in response to institutional pressure. Institutional theory tends to focus more specifically on the pressures and constraints of the institutional environment whereas resource dependency tends to emphasise the task environment. Differences in emphasis on the institutional versus task environment suggest different positions of external power and different linkage processes between organisations and environment (those that shape and enforce institutional rules, beliefs and isomorphism versus those that control scarce resources) (Scott 1987). These differences lead, in turn, to different conclusions about appropriate responses to the environment. Institutional theorists have emphasised the survival value of conformity with the institutional environment (DiMaggio and Powell, 1983; Meyer and Rowan, 1977). Resource dependency theorists stress the necessity of adapting to environmental uncertainty and actively controlling resource flows (Pfeffer and Salancik, 1978). The comparisons between the two theories suggests that they are capable of addressing a broad

range of strategic responses to the institutional environment if they assume potential for variation in the resistance, awareness, proactiveness, influence and self-interest that organisations exhibit in response to institutional pressures. Five types of strategic responses are proposed which vary from passivity to increasing active resistance: acquiescence, compromise, avoidance, defiance and manipulation (Oliver, 1991).

### **3.3.5 EVOLUTIONARY APPROACH**

The evolutionary approach serves as an overarching framework within which the value of other approaches can be recognised and appreciated (Aldrich, 1999). The approach provides a generic framework for understanding the genesis of organisations and populations and their social change in modern industrial societies, and defines four generic processes that drive evolution and generate critical events that occur in the life histories of organisational entities. These events are variation, selection, retention and diffusion. The approach is particularly useful for understanding organisational transformation and organisations and social change. Aldrich (1999:165) defines transformation as “. a major change in an organisation involving a break with existing routines and a shift to new kinds of competencies that challenge organisational knowledge”. Major changes occur along three possible dimensions: changes in goals, boundaries, and activities. Transformation, as currently conceptualised, only takes on meaning if the assumption is made that relative inertia (the daily reproduction of routines and competencies that perpetuate the organisational form) constitutes the normal state of organisations. Transformation’s potential harmful consequences were explicitly addressed by the Hannan and Freeman (1984) model of structural inertia. They suggested that transformations are disruptive in the short term but may improve an organisation’s chances for survival in the long run. Ashburner et al (1996) examined the British government-sponsored attempts at organisational transformation in the NHS, and found that, at early analysis, limited change took place but subsequently, on analysis of key variables, there was some administrative reform and that an unexpected and unintended element of a new “hybrid” form of management emerged. The results of this study supported Hannan and Freeman’s (1984) model.

Transformation is significant for organisational evolution for three reasons. Firstly, an organisation that cannot change in fundamental ways will constantly be at risk if its environment is evolving and it cannot keep pace. Second, if most organisations in a population are restrained by structural inertia, from undergoing significant transformation then that population will persist in evolving environments only through the founding of new organisations that are better suited to the changing context. Thirdly, if a substantial fraction of the organisations in a population are unable to make the transformations necessary

to evolve in tandem with their environments, and new organisations do not replace them, the population itself is likely to be doomed.

Max Weber explicitly framed his writings on organisations and bureaucracy in historical terms and many authors since then have called for an historical approach to organisational analysis (Zald, 1990). Historical influences may be classified into three types of effects. A cohort effect occurs when historical events have a different impact on younger members versus older members; age effect describes the secular process of aging – a process inherently associated with the duration of existence, eg when an aging member's enthusiasm dwindles; period effect represents changes produced by historical events and forces which have a similar effect on all members, regardless of age (Aldrich, 1999).

From an evolutionary perspective, organisational aging means not only duration but also the accumulation of organisational memory in the form of organisational knowledge (Walsh, 1995). The routines and competencies that are retained from an earlier period have special intensity, because they are associated with the emotions surrounding those formative years. Organisational knowledge therefore stands available as a set of selection criteria against which possible new routines, technologies and competencies are judged, and therefore helps to shape the future.

A period effect is a historical discontinuity caused by an observed break in the continuity of social, political, economic and normative trends in a society. Periods become important for researchers carrying out longitudinal studies on populations because, with hindsight, they are able to create labels for such periods. Period effects give direction to a narrative analysis of organisational evolution, ordering events by their chronology (Aminzade, 1992). Identifying periods gives researchers a way of conceptualising one-time events, while emphasising the common features of all organisations in a population. However, choosing which years constitute a "period" reveals a potential problem with historical analysis, because narrative analysis not only relies on events occurring serially, in chronology, but also depends on unique events (DiMaggio, 1994). Different observers view the same events from diverse perspectives on their significance. In practice, researchers create period labels on the basis of their research objectives and working hypotheses (Aldrich, 1999). Four classes of period effects have been investigated:

- (1) political events and changes in regimes;
- (2) legal and regulatory policy changes;
- (3) shifts in societal norms and values;
- (4) changes in resource availability.

Political, legal and societal events may affect an organisation's ability to survive within a particular time period. Period effects thus reflect variations in environments to which organisations must adapt if they are to remain fit. Some environmental variations are favourable, whereas others are hostile (Aldrich, 1999; Amburgey et al, 1993).

Aldrich (1999:345) remarks that "Ecological and institutional researchers have been most active in building data sets that span great sweeps of history. Roaming over decades and inserting period effects, ecologists and institutional theorists have compiled empirical generalisations. Many studies, however focus on the basic demographic outcomes – foundlings and disbandings – because of data limitations. More attention should be paid to the evolution of organisational forms or the content of organisational processes".

### **3.4 THE PROFESSIONAL ORGANISATION**

Sociologists view the professions as social phenomena comprising a set of role characteristics. These are the possession of specialised knowledge and training that enable professionals to know what to do in particular circumstances, the ability to provide a rational explanation for their actions, and to undertake the action safely; dedication to public service; and socially approved self-governance (MacDonald, 1995). Professionals differ from other classes of employees not only in the relative amount of power they exercise but in what aspects of work they control. The health care professional occupations have sought to exercise power not only over the conditions of work, such as reimbursement and employment benefits, but also over the definition of the work itself. Professionals therefore attempt to use their power to shape the institutional frameworks supporting their activities in the broadest possible terms. In this way they seek cognitive control, insisting they are uniquely qualified to determine the definition of problems, and how these are to be processed. Physiotherapists possess a code of practice and scope of practice drawn up by themselves, which they firmly protect. They also seek normative control, determining who has the right to exercise authority over what decisions and members in what situation; and, they seek regulative control determining what actions are to be prohibited and permitted (Scott, 1995).

Mintzberg (1979) defines a professional as "someone in whom the capacity to carry out some complex, specialised work has been internalised through extensive training". He consequently describes the functions and structure of the professional organisation as:

1. Relying for co-ordination of function on the standardisation of skills and its associated training;

2. Having considerable control over its own work but working closely with the clients served, and having a social system within the profession that is collegial;
3. Maintaining standards by the self governing professional association, which sets its own occupational and ethical guidelines;
4. Setting universal standards which emphasise the power of expertise and licensing systems;
5. Establishing the structure of the professional organisation that is at the same time both functional and market based, and where the activity is connected to some value the community considers important.

### **3.4.1 COMPETITION AMONGST THE PROFESSIONS**

All modern societies are made up of systems in which there is some form of competition among individuals and groups. People make demands on money, power, or prestige markets. Resource dependency theory sees economic supply and demand as shaped by such factors as monopoly, entrance restrictions, and shifts in taste which will determine how high the financial support will be. However, supply and demand operate in the markets of power and prestige as well (Goode, 1969). A profession can command more prestige only if society, functioning in the institutional environment and applying its evaluative criteria, perceives the performance of a particular profession to be better than before or higher than those of similar occupation. Occupations that seek recognition and legitimacy as professions engage in transactions within all three markets – prestige, power and income. In order to be accepted by the institutional environment as a profession, an occupation must make special transactions in the prestige market as, should they be successful, they are likely to obtain more power and financial gain. Thus institutionalised professional organisations achieve societal support – legitimacy and resources - by virtue of having good connections with their environment. Such connections in the prestige market include, in the case of the physiotherapy profession, licensing and accreditation procedures, raising the competence of student entrants, imposing quality controls over members' work, establishing centres for developing post-graduate qualifications and improved techniques.

The outcomes of the exchanges between the professions and society result in a profession expending some of its collective resources in maintaining its position in society; a position that is constantly under threat. Thus the physiotherapy profession in the 1970/80s put up considerable barriers to protect its scope of practice and established high ethical controls over its members. The total effort by a profession toward maintenance of its position and the struggle for additional rewards, is a large part of the total allocation of energies and resources in the institutional environment (Goode, 1969). In terms of the physiotherapy profession these efforts included the changes in graduate education; legislation

to protect the profession from new threats or to consolidate new gains; on-going bargaining for financial rewards; marketing activities to impart information to public; establishing and maintaining links with other organisations; and promoting the profession itself.

These external, somewhat self-seeking and self-serving aspects of professionalism in search of power, wealth and status, would seem to be at odds to the more internal aspects of the health care profession such as public service, caring for others and commitment to excellence. However the sociological concept of a profession has as its starting point a social context in which classes, status groups and other social entities compete for economic, social and political rewards. The overall objective is to acquire a monopoly in the market place for services rendered and to enjoy social status. Achieving these involves working with the state, other professionals, educational institutions and the public to acquire control over work practices and access to professional privileges (Benatar, 1997).

#### **3.4.4 PROFESSIONAL KNOWLEDGE AND GROUP MEMBERSHIP**

Much of the literature on professionals (Boreham, 1983; Friedson, 1986; Tolbert and Stern, 1991) relates to their authority and autonomy in performing work tasks. The exclusive right of professionals to evaluate the competence of colleagues in executing professional tasks and activities, is reflected in the amount of authority that professionals have to participate in decision making and evaluating colleagues in their employing organisation. Individual members also have the right to make independent decisions concerning the appropriate procedures for work tasks and activities (Wallace, 1995). Critical to professional authority is the right to make decisions involving the evaluation of professional work according to professional standards (Tolbert and Stern, 1991). Although the South African physiotherapy profession currently enjoys these rights, this has not always been the case, and part of this research describes the struggles the profession experienced in order to acquire autonomy and discretion in performing work.

DiMaggio and Powell (1983:152) argue that normative pressures stem primarily from the phenomena of professionalisation, that is, dealing with issues of power implicit in group membership of a professional organisation such as physiotherapy. The strategies of power include those of membership, " and those relating to issues of legitimacy, knowledge, association and responsibility. Membership strategies involve the definition of rules that delineate the space within which members can operate. It may serve professionals to restrict the membership of their association if legitimacy is somehow related to the exclusivity of an elite. On the other hand it may pay members of the professional group to expand the space within which their expertise is considered

legitimate. In conjunction with the erection of barriers, professions make attempts to define the meaning of membership, that is, the authority, responsibility and especially expertise with which their membership is attributed (Lawrence, 1999). The importance of expertise and a perception of leadership in the knowledge field, are associated with a number of membership strategies that attempt to reform standards of practice and improve professionalism. These include the formation of special interest groups in which members work together to establish communication networks, education and accreditation processes.

Standardisation strategies involve the institutionalisation of practices and services through the assignment of value beyond their technical value (Selznick, 1957) through social mechanisms. They are concerned with technical and legal standards that define what is normal for a practice or service through regulation. Standardisation strategies often involve the development of coercive or mimetic pressures (DiMaggio and Powell, 1983) that compel members to comply with institutional standards. Thus in the physiotherapy profession, members entering the private sector in the 1980s were forced to comply with very rigid rules concerning the establishment of a practice. Standardisation strategies are distinctly not about organisations adopting practices which are already normatively sanctioned, in order to legitimate their own existence. They are about the movement of practices from the realm of technical rationality to that of substantive, or institutional rationality. (Selznick, 1957). Professions will find it in their best interests to effect standards in the broader institutional arena that privilege their own strategic position either because these standards demand practices at which the profession excels or because they necessitate resources for which the profession has preferential access (Lawrence, 1999). In South Africa during the 1970/80s very strict legislation was laid down regarding shared accommodation and partnerships in the private health care sector. A physiotherapist could only be in a partnership with another physiotherapist and could not share physical accommodation with another profession. In the 1990-2000s the reverse is common – multi-disciplinary partnerships flourish and much accommodation is shared. The key issue here is the degree to which the legal definition of “good practice” and take-for-granted rules are contested or supported by intractable social mechanisms that reward conformity and sanction deviance. Successful standardisation strategies involve the establishment and legitimation of new normal practices for some institutional sectors (Lawrence, 1999).

Benatar (1997) is concerned that this broad concept of professionalism is challenged by social critics and by the public who view the motives of the health care professionals with mistrust. These include the ways in which major advances have been made and applied in health care; the cost associated with their use, often for individual gain; the growing gap between knowledge and power of the health care professional and that of society; high and often

unrealistic expectations from society regarding what they should receive from professionals; the need for rationalisation of health services because of rising costs; erosion of professionals' commitment to the internal purpose of their role; and the expansion of bureaucracy with commodification of health care in a world in which economic considerations have become extreme. Relmen (1991) has described these tendencies as a 'medical industrial complex', indicating the extent to which medicine has become more like an industry and less like a profession.

The history of physiotherapy in South Africa has allowed its practitioners to establish standards of practice that are highly institutionalised. The development of these practice standards reflects the complex institutional context in which the profession has evolved over the past thirty years. This research will track the processes involved and the strategies undertaken during the evolution of the profession over the research period.

### **3.5 COGNITIVE THEORY AND CAUSE MAPPING TECHNIQUES**

#### **3.5.1 COGNITIVE THEORY**

Simon (1957) was one of the first theorists to link the limits of individual cognitive capacity with the nature of organisational structure. He described how organisational structures work to simplify and support decision making of individuals in organisations. In accepting organisational membership, individuals are expected to adopt organisational values, rules, procedures as a guide to their decision making. These greatly reduce the discretion of most participants so that they both make fewer choices and are more circumscribed in the choices they do make (Scott, 1995). The programmes individuals use to select and process information are variously labeled schemas, frames, or inferential sets. These refer broadly to cognitive structures, ranging from world views to specific filing systems for classifying and ordering data. Extensive research by psychologists has shown that these cognitive frames enter into the full range of information-processing activities, from determining what information will receive attention, how it will be encoded, and how it will be interpreted, thus affecting evaluations, judgments, predictions and inferences. Cognitive psychologists recognise that individuals participate actively in perceiving, interpreting and making sense of their world.

Research linking cognition to strategy suggests that organisational action is based on beliefs decision makers hold regarding how the organisation can best succeed in its current competitive or institutional environment (Daft and Weick, 1984). These beliefs consist of interpretations of both the competitive and institutional environment themselves, and the organisational action required to be sustainable in those environments (Barr, 1998). This belief system is developed over time based on past activities and results and as long as it reflects

a reasonable (if not entirely correct) representation of the environment, it provides a useful "map" for directing effective organisation action (Weick, 1995). Huff and Schwenk (1990) describe how environmental changes in interpretive schemes or cognitive models of the world that may lead to organisational restructuring. Decision maker's mental models both facilitate and limit attention to encoding salient information about changes in organisational environments. Mental models help individuals cope with an abundance of available stimuli (Kiesler and Sproull, 1982) but strongly held mental models may lead decision makers to overlook important environmental changes so that appropriate action within the organisation is not taken. Organisational transformation requires decision makers to change their mental models in response to environmental changes, and delays in this adjustment process will be associated with decline (Barr et al, 1991). To make sense of their world, decision-makers rely on simplified representations or mental models consisting of concepts and relationships to understand various situations or environments. They serve as maps allowing individuals to perceive environments on a larger scale, beyond the range of immediate perception (Huff, 1990; Weick, 1995). A feature of mental models of particular interest to management researchers involves cause-effect understandings about the environment (Narayanan and Fahey 1990; Barr et al 1992). This kind of map provides understanding about how individuals link events occurring at a particular time to other events occurring at other times. The relational links that these maps convey capture judgments about the link between actions and outcomes (Fiol and Huff, 1992). These kinds of maps provide information about potential linkages among entities of importance to the organisation through time.

#### **3.5.4 COGNITIVE MAPS**

Cognitive mapping is a tool developed in the study of managerial and organisational cognition which makes conceptual entities visible (Huff and Jenkins, 2002). Huff and Jenkins define a map as a visual representation that establishes a landscape, or domain, that names the most important entities within that domain, and simultaneously places them within two or more relationships. The most distinctive attribute of a map is that it establishes relationships. Thus cognitive maps are the representation of an individual's personal knowledge, of a person's own experience and views of reality (Weick and Bougon, 1986). They are graphic representations that locate people in relation to their information environments. They provide a frame of reference for what is known and believed; they simultaneously highlight some information and fail to include other information either because it is deemed unnecessary or is unknown. They exhibit the reasoning behind purposeful actions (Fiol and Huff, 1992)

Causal maps are of interest to this research because they are a means of displaying graphically the physiotherapy profession's strategic position within a historical perspective. Each map will allow the researcher to assess, at a particular time, the position of the profession at that time, the organisational relationships and linkages, major events that occurred, and the basis on which the profession acted or failed to act. The cognitive maps are also of interest to the research, as they are representative of the thought process that can be related to decision making in the profession. Cognitive mapping is a technique which has been used widely by management researchers in a variety of different contexts: operations of a sports club (Hall, 2000); high growth firms (Porac et al, 2000); organisational renewal in USA railroads (Barr et al 1992); TV industry (Narayanan and Fahey, 1990). Cognitive maps provide a holistic picture of an individual or a group's overall perspective without any loss of detail, and thus enable the researcher to move beyond the assumption of internal consistency, to the detailed assessment of specific concepts within the map (Jenkins and Clarke, 1997; Clarke, 2001). They also allow the researcher to undertake inductive analysis to distil and clarify emergent issues (Clarke, 2001). The technique is inherently interpretive and involves the judgment of the researcher to develop themes from the data. The technique also allows for differences in decision maker's views suggesting that individuals interpret data differently and present contrasting perceptions of problems.

Causal mapping is a form of content analysis which isolates the key assertions within a document that deal with causality, existence or categorisation - all basic elements for strategic decision making. The methodology of cause analysis was initially developed by Axelrod (1976) and elaborated by Huff et al (1990). However the methods used for coding maps vary between researchers in relation to purpose (Eden et al 1992). The theoretical basis for causal mapping which allows an interpretation of analysis of those maps, is rarely made explicit, so the link between a theory of cognition and the coding method is usually difficult to detect. There are few well-developed methods for the elicitation of causal maps, but for representation purposes a causal map is usually drawn as short pieces of text linked by unidirectional arrows. A statement at the tail of an arrow is taken to cause the statement at the arrow head. If a map is to be of any sort of reflection of individual's cognition then it must be distinctly different from the map of any other individual's cognition; and, if the two individual maps are to be compared for emerging properties of convergence then some over-arching framework will have to be developed. Eden et al (1992:314) suggest that there is always a need to discover appropriate methods of analysis for the emerging structural properties, and then to use these emerging properties as a means of comparison between individual maps. Reductionism in the initial construction of maps is necessary if emergent properties are to be analytically discovered.

Barr et al (1991) conducted a study of two USA railroad firms using cause mapping. Their interest lay in whether two similar companies in similar situations differ in their ability to recognise changes in their environment. The source of data for constructing causal maps in the study is the 50 letters to shareholders published by the two companies over a 25-year period. After the documents were coded into a series of maps these were then analysed according to constructs, concepts, linkages and the occurrences of generalisations. The methodology presented an innovative way for examining organisational responses to a declining environment.

Narayanan and Fahey (1990) demonstrate the use of revealed causal maps for tracking decline in a company competing in the TV industry. Their data source, like Barr et al (1991), was the company annual reports and statements made by top management in Television Digest over a 14 year period. All statements in the form of concepts and cause-effect relationships were captured in the language of the decision-makers. In order to translate the maps into a language that served the theoretical ends, the reductionist method was used – an explicit conceptual scheme shaped by the specific theory, and made up of theoretical concepts, was developed for organising the causal assertions. The causal links were then sorted into one of the categories. The conceptual maps could then be aggregated into eras, which in turn could be compared and analysed.

Using a similar methodology Barr (1998) investigated the pharmaceutical industry.

Methodologically, causal mapping offers a sophisticated method of tracing changes in organisations over time making use of statements available to the public and archival documents. This research will make use of the methodology to trace the South African Society of Physiotherapy chairman's interpretations and the council members' decisions over time as they grapple with environmental events.

### **3.6 SUMMARY**

This chapter presented a brief overview of early theories of environment-organisation relations. A more detailed account is given of three contemporary approaches which offer differing theories about the relationships between organisations and their environments. Institutional theory focuses on conformity and isomorphism whereas resource dependency theory is concerned with the active management and control of resources to the extent that the importance of internal and external politics and self-interest in professional organisations is ignored by both theories. Population ecology theory emphasises the selection of accountable, reliable organisations over competitors as an indicator for survival. Research has been confined to longitudinal studies of population density, and founding and disbanding of organisations but does not discuss the social

processes which take place in order to survive. The section on professional association has indicated that strong forces exist in these organisations directed at protecting boundaries, expertise, skills, knowledge and membership strategies. The degree to which the changing South African political environment has impacted on these resources of the South African physiotherapy profession will be investigated in this research. This research will contribute to the broader organisational-environment theory by examining the little researched context of institutional processes and structures from the perspective of a professional health care association concerned with developing and surviving in a very competitive environment over a thirty year period.

## **CHAPTER 4 RESEARCH METHODOLOGY**

### **4.1 OVERALL STRATEGY**

#### **4.1.1 CASE STUDY APPROACH**

The research makes use of a case study approach as the overall research strategy, focusing on the physiotherapy profession in South Africa. The strength of this approach lies in its capacity to explore social processes as they unfold in organisations, while also allowing for a processual, contextual and longitudinal analysis of the various actions which take place and which are constructed within organisations, and their meanings (Hartley 1997). A case study is not a method as such but a research strategy (Yin, 1981) because the context is deliberately part of the design, there will be too many "variables" for the number of observations made; consequently the application of standard experimental and survey designs and criteria are not appropriate.

The case in this instance is the South African Society of Physiotherapy – the strategic decisions that were made by its members, observations that were by the chairmen, actions that were taken (or not taken) by the SASP and its members as a result of environment pressure, and the perceived image and identification of physiotherapists to their professional organisation. A boundary was established that included only concepts related to the development of the profession, thus the internal financial transactions were excluded. Educational institutions, health care institutions and the SAMDC were placed beyond the boundary as part of the external environment.

#### **4.1.2 TRIANGULATION**

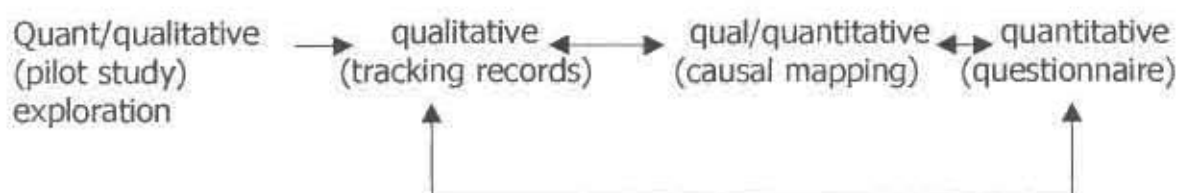
The triangulation of data by multi-method approaches is essential to answer many of the most important questions in organisational research. The aim of triangulated methodology is to gather different types of data which can be used as cross checks, and drawing on the particular and different strengths of various data collection methods and sources, to present different observations and angles of view, thereby overcoming bias and improving validity. While the triangulation made possible by multiple data collection methods provides stronger substantiation of constructs and propositions (Eisenhardt 1983), it can happen that the different sources are inconsistent leading to what Miles and Huberman (1994) describe as "initiating a whole new line of thinking".

Rossmann and Wilson (1984) suggest three broad reasons for linking qualitative and quantitative methods within the same research design: i) to enable confirmation or corroboration of each other through triangulation; ii) to elaborate

or develop analysis, providing richer detail; and iii) to initiate new lines of thinking. Firestone (1987) suggests that on the one hand, quantitative studies "persuade" the reader through de-emphasising individual judgement and stressing the use of established procedures, leading to more generalisable results. On the other hand, qualitative research persuades through rich depiction thereby overcoming the 'abstraction' inherent in quantitative studies. Currall et al.(1999) utilise qualitative and quantitative methods to accomplish both 'discovery' and 'justification' in the same study. They quote McCall and Bobko (1990:382) defining discovery as "anything related to the creation of new theories or interpretive applications, including anything related to adopting novel approaches to measurement, inventing or uncovering new constructs or original theoretical perspectives from which to view organisational phenomenon". Justification is defined as "the empirical evaluation and confirmation of theory" (Currall et al., 1999:6).

In the present study, discovery is achieved by using qualitative data from historical documents to develop theoretical ideas about the subtleties of change within the physiotherapy organisation, special interest advocacy amongst the members and linkages in the interorganisational field. To justify the theoretical propositions causal mapping techniques are applied firstly to the chairmen's reports and then secondly to the decisions made by council members. The data is then quantified and analysed thus adding more detail to the qualitative data. Justification is further applied by a questionnaire survey of members' perceptions of the characteristics of the physiotherapy producing quantifiable data which seeks to corroborate and elaborate the findings of the first two methods.

Within this broad strategy four different research methods are used – interviews, tracking of historical data, causal mapping, and a questionnaire. Data collected by these methods will produce both qualitative and quantitative evidence shown in the diagram below:



### 4.1.3 TEMPORAL NATURE OF THE RESEARCH PERIOD

In this research change can be seen as a process, as the development over time of regulative, normative and cognitive systems capable to varying degrees of providing meaning and stability to the social behaviour of the physiotherapy profession. The research therefore makes use of process theory, in which time is of the essence, to deal with series of occurrences of events. This approach assumes that "history matters", and that how things occur influences what things happen (Scott, 1995:65).

The research process is longitudinal in nature emphasising the importance of temporal interconnectedness – that is to say locating change in the past, present and future. Thus "history is not just an event in the past but is alive in the present and may shape the future" (Pettigrew, 1990). History is therefore not just a collection of events and chronologies but has deeper, underlying processes related to understanding, learning and making decisions, which help shape future change processes. The temporal nature of the research is captured through a combination of retrospective and contemporary analysis. Any adequate research into change has to be capable of revealing temporal patterns, causes and movements from continuity to change, and vice versa (Pettigrew, 1990).

A critical issue for the researcher was that of time and perspective. A pragmatic judgement had to be made as to when to start and conclude the research period. Consequently, this research starts in 1970 and finishes in year 2000 for reasons set out in chapter 1. This period marked a time of considerable social and political change in South Africa, and the assumption has to be made that it will provide an opportunity to gain an in-depth understanding of the growth, evolution, transformation and dramas over time of a previously little researched social system.

## 4.2 RESEARCH QUESTION

**How does a relatively small professional organisation manage its key survival factors in order to maintain a dynamic and viable position in the changing health care environment?**

## 4.3 POPULATION UNDER STUDY

The physiotherapy profession in South Africa is the population under study. The professional association is the South African Society of Physiotherapy (SASP), a

non-statutory, voluntary organisation. Not all physiotherapists practicing in South Africa belong to SASP but a reasonable assumption can be made that 75% of the profession are members. Unfortunately no accurate census is available with information regarding the number of physiotherapists practicing in the country as, on graduation, many students register with the Professional Board and then leave the country while maintaining their registration. The SASP is the recognised decision making body in the country and as such is the organisation that is the ideal subject for this research.

#### **4.4 PILOT STUDY**

In 1996 a pilot study in the form of an interview/questionnaire with open-ended questions was conducted amongst a sample of senior physiotherapists in South Africa. The aim of the pilot study was not to test a research instrument but was more in the nature of information gathering that would help to generate propositions and develop the main research process.

##### **4.4.1 OBJECTIVES FOR PILOT STUDY**

1. To investigate the perceptions of respondents regarding strategies for professional survival and growth
2. To assess the general understanding of respondents towards concepts of professional change and transformation
3. To collect information that would inform and help develop a) the initial hypotheses for research b) a research framework

##### **4.4.2 SAMPLE FOR PILOT STUDY**

Thirty physiotherapists who had 20 years of professional experience were asked to take part in the study. A purposeful sample was taken which included physiotherapists from all the major race groups in South Africa; who worked in the public, private health care sector and tertiary education sector; and could conveniently be interviewed by the researcher. Respondents came from the major cities in South Africa and were well known to the researcher; they were specifically chosen for their first hand experience of the profession, their knowledge, cultural diversity and preparedness to speak openly.

### 4.3.3 DATA COLLECTION FOR PILOT STUDY

The research literature dealing with organisational change was consulted. Concepts from three models of change - resource dependency theory, institutional theory and population ecology, were incorporated into the questionnaire.(Appendix 9)

#### STEPS TAKEN

1. Of the original 30 contacts 26 could be interviewed. A letter explaining the interview was sent to each respondent (Appendix 8)
2. Appointments and venues were established and these included offices, private homes, clinics, and hotels in various towns in South Africa.
3. A topical interview method was used (Rubin and Rubin, 1995) to search out explanations & descriptions of processes. The researcher played an active role in directing the questioning & keeping the conversation on a specific topic
4. All interviews were recorded using a standard tape recorder and lasted one hour. The researcher made notes on the individual questionnaires.

### 4.4.4 PILOT STUDY DATA ANALYSIS

- a) Transcriptions of each interview were made onto a Word Processing package and imported to a qualitative software program NUD\*IST NVIVO (NUD\*IST NVIVO is a computer package designed to aid users in handling Non-numerical and Unstructured Data in qualitative analysis, by supporting processes of coding data in an Index System, Searching text or searching patterns of coding and Theorising about the data). The data was coded into themes, concepts and ideas by the researcher. The aim was to establish the themes that described the culture and organisation of the physiotherapy profession, and the concepts that reflected the underlying ideas and perceptions with which respondents labeled their understanding of their professional world.
- b) Notes made on the individual questionnaires were recorded on SpinxSurvey software and analysed using lexical analysis

### 4.4.5 RESULTS OF PILOT STUDY

Five broad themes emerged: (1) professional skills are the most important and critical resource, and are gained from training courses; (2) patients and other health care professionals have become better educated in terms of their understanding of physiotherapy practice and are important for conferring external legitimacy; (3) state laws positively affected the profession when first line practitioner status was conferred on the profession, while the apartheid laws had a negative effect; (4) good quality care, high standards of practice and professional image are important elements for sustainability; (5) dependencies

1970

TIME

2000

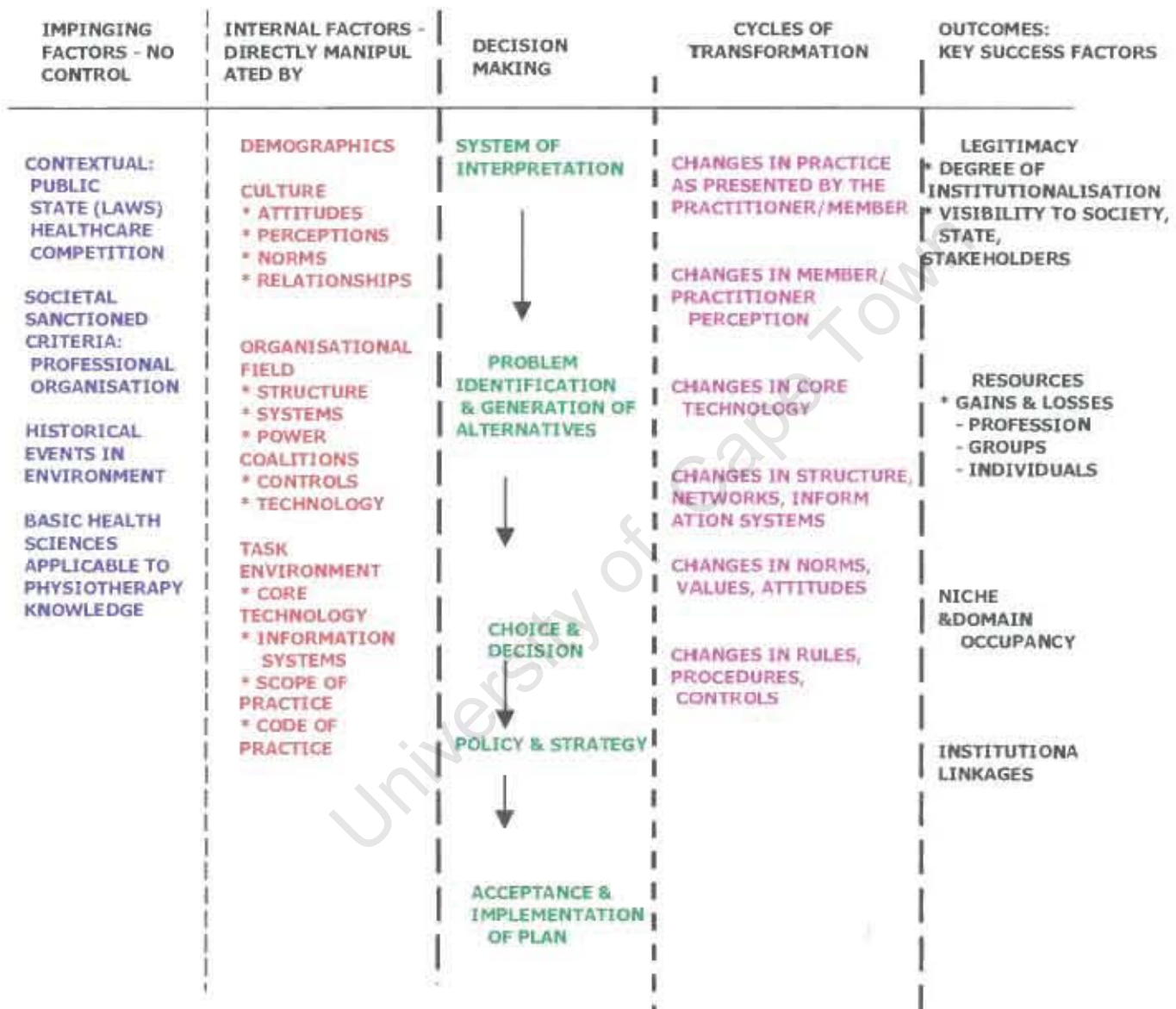


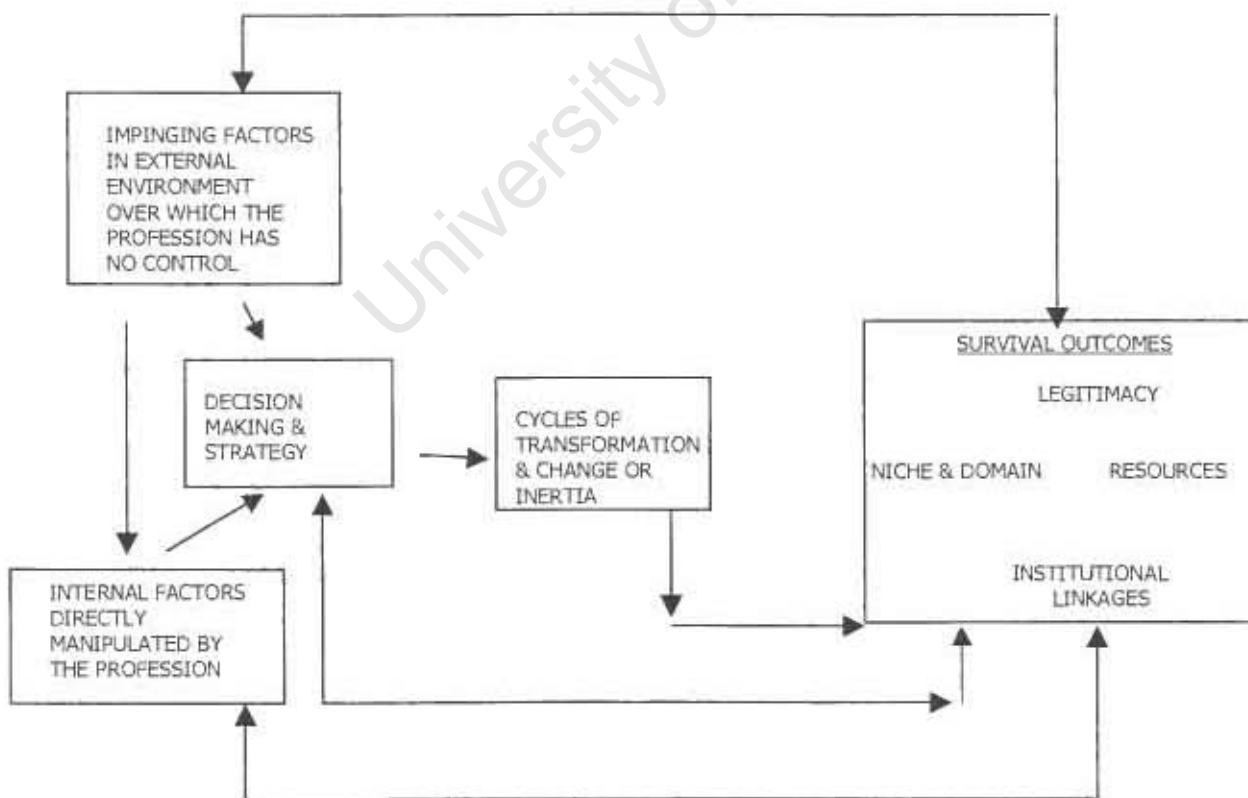
FIGURE 1 A CONCEPTUAL FRAME WORK FOR UNDERSTANDING THE RESEARCH PROCESS

are made with other health care professionals, medical aid schemes, self help and care groups.

#### 4.5 BUILDING A CONCEPTUAL FRAMEWORK

Prior to starting the research process a conceptual framework was constructed (Figure 1.) that explains graphically the scope of the research process, that is, the key factors, constructs, and variables and the presumed relationships between them. The framework has a bounding and focusing function, allowing only some relationships and some kinds of constructs in the form of outcomes to be measured. It also has to take into consideration that change is multi faceted, involving political, cultural, structural and incremental dimensions. The first column constitutes the external, institutional environment over which the physiotherapy profession has no control but must respond if it is to remain a dynamic organisation

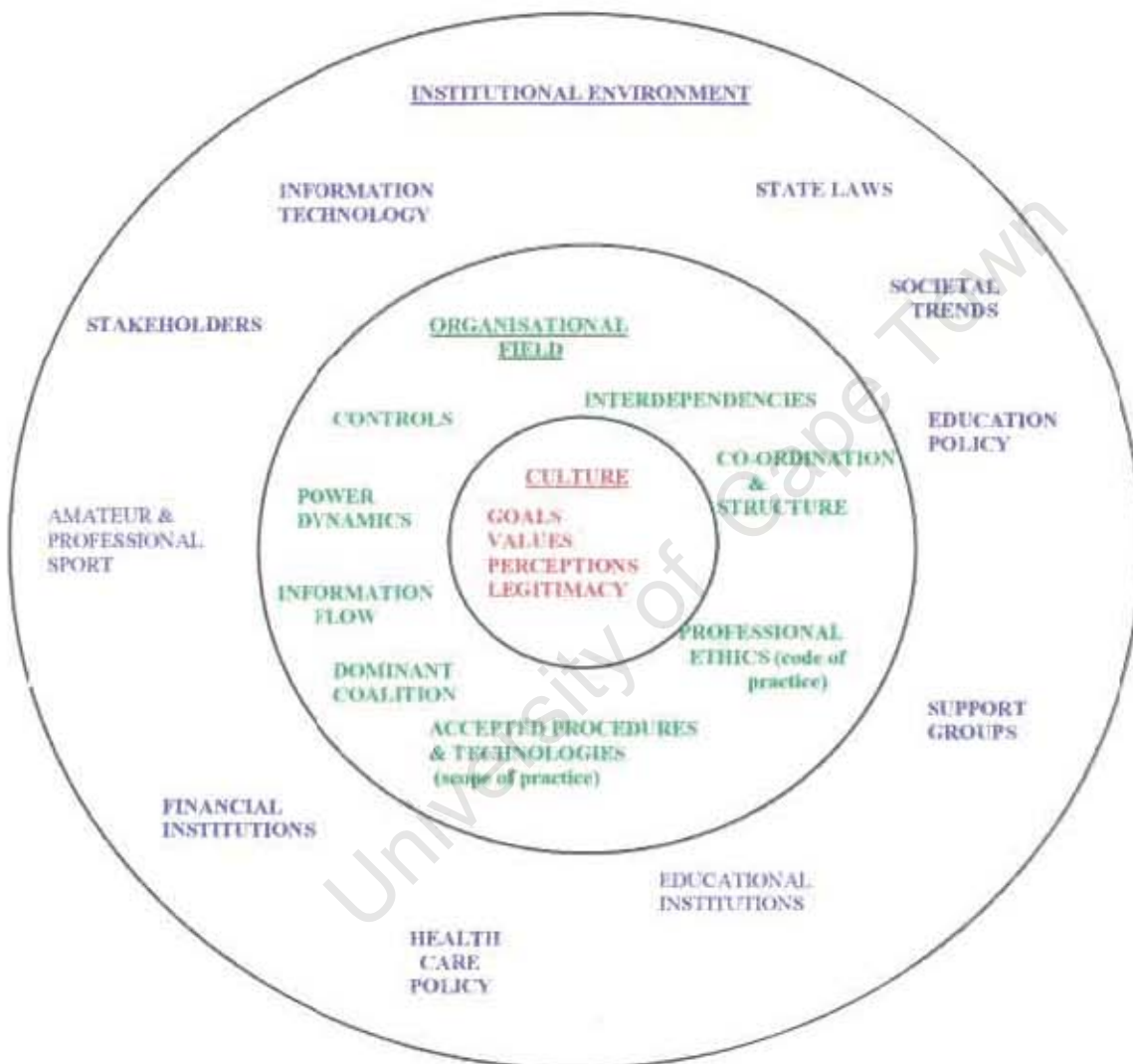
**Figure 2 The relationship of the elements shown in the conceptual framework**



The second column shows the internal factors that can be manipulated by the profession in response to pressures or opportunities from the external environment. Columns three and four – decision making and transformation – show the mechanisms available to the profession to bring about successful resolutions, shown in the last column, to the pressures or opportunities from the external environment. Figure 1 shows a linear flow of processes, but Figure 2 shows the relationship between the various elements in the conceptual framework and the feedback which takes place between the elements.

Figure 3 differentiates amongst the three organisational levels of environment, and shows the concepts and variables which make up the organisational field, the institutional environment and the organisational culture. The outer context includes the institutional environment and corresponds to Duncan's (1972) external field and Dill's (1958) task environment. It refers to political policies and laws, socio/cultural trends and the health care environment. The middle context refers to the organisational field corresponding to Duncan's (1972) internal environment. Lebledici (1991:338) defines it as "historically specific practices and transactions produced by network, cultural and historical actors and their actions, it also includes the normative systems defining their rights within them." The inner context locates not only the shared cultural and belief system of the physiotherapy profession but also forms the image of what the profession represents, both to itself and to outsiders.

Some researchers (Gioia and Petrie 1990) have objected to a formal a priori selection of constructs believing that emerging data might be biased or contaminated from existing theories. However Miles and Huberman (1994) have argued for a priori conceptual framework in situations where something is known about the phenomena to be studied but not enough to develop a theory. In other words, not to use the researcher's background knowledge and conceptual strengths can be self-defeating. Also, a priori specification of constructs can be valuable because it helps the researcher measure constructs more accurately. Should these constructs show importance as the research progresses then there is firmer ground for emergent theory.



**Figure 3** The relationship of the three levels of organisational environment

The framework is an initial guide and is likely to shift and undergo subsequent revisions and modifications as the research proceeds – no construct is guaranteed a place in the resultant theory, no matter how well it is measured (Eisenhardt 1983). In the present research, the constructs, in the form of outcomes, were developed from the contemporary literature dealing with organisational-environment relations (cf. previous chapter). The four constructs, namely, degree of legitimacy, resource acquisition and delivery, niche/domain occupancy and institutional linkages, are described by all three theories (institutional theory, resource dependency theory and population ecology theory), but not necessarily in the same way, as being important for survival in modern environments. All four outcomes are dependent on each other for the survival of the physiotherapy organisation

#### **4.6. RESEARCH PROPOSITIONS**

The purpose of the research task is to present a paradigm which links the context and process of change and transformation in the South African physiotherapy profession over a period of 30 years, with the insights that institutional theory, resource dependency theory and population ecology theories of organisations have contributed to the research.

It is the intention of the research methodology to make four propositions which make assertions about the physiotherapy profession and its capability to manage its institutional environment. These assertions will be supported or dismissed by the conclusions drawn from the research data.

Institutional theorists have proposed that an organisation is more likely to survive if it obtains legitimacy, social support and approval from the external constituents of its institutional environment. Organisations survive by conforming to institutional norms (Meyer and Rowan, 1977; DiMaggio and Powell, 1983; Baum and Oliver, 1991). Resource dependency theorists focus on a wide range of active behaviours that organisations can exercise to manipulate external dependencies or exert over the allocation of resources (Pfeffer and Salanik, 1978; Oliver, 1991). Both perspectives assume that organisations maybe self-interest driven and that organisations attempt to obtain stability and legitimacy (DiMaggio and Powell, 1983; Meyer and Rowan, 1983; Pfeffer and Salanik, 1978; Oliver, 1991). Population ecology theory suggests that organisation survival is based on the selection of adaptive forms that can survive environmental pressures for legitimacy, the forces of competition and institutionalisation (Hannan and Freeman, 1977; Baum and Oliver, 1991).

With these three theoretical approaches and the conceptual research framework in mind and, taking onto consideration the results of the pilot study, the following four propositions are made:

**PROPOSITION 1.**

The greater the environment change over time with its differing demands on the organisation, the greater the likelihood of variable strategic responses affecting organisational goals, activities and boundaries.

**PROPOSITION 2.**

The greater the degree of professional autonomy and opportunity perceived to be obtained from the institutional environment, the greater the incentive for transformation of the professional form and practice.

**PROPOSITION 3**

As institutional pressures increase, the effort by the organisation to improve inter-organisational linkages which are viewed as legitimate by the wider institutional environment becomes greater

**PROPOSITION 4**

The ability of an organisation to affect standards of practice in the organisational field is positively associated with its technical, political and marketing expertise and the degree to which it is perceived as the legitimate organisation in the field

**4.7 DATA COLLECTION METHODS**

Three data collection methods are used: (i) tracking historical records (ii) causal mapping (iii) questionnaire/survey. Each of these will be described in their relevant section.

**4.7.1 TRACKING HISTORICAL RECORDS**

Data collection methods were based on those described by researchers in the management literature. These authors all presented historically grounded descriptive material that requires a longitudinal approach. In the case of Mintzberg's (1982, 1985) two longitudinal studies, decisions and strategies were tracked back over several years by studying archival material and searching for traces of decisions and actions taken by the organisation under study, as well as traces in the external trends and events in the environment and indicators of performance. Leblebici et al (1991), through a historical analysis, documented the cycles of change in the USA commercial radio by identifying three critical phases in broadcasting. For each period the transitions were described that

moved the field from where it started to where it ended. Baum and Oliver (1991) examined, over a sixteen year- period, the impact of institutional linkages on the survival or failure of childcare service organisations in Toronto.

#### **4.7.1.1 OBJECTIVES FOR TRACKING PROCESS**

Three objectives are developed:

1. To record systematically i) institutional change and transformation in the organisational field, ii) the reasons for this change, iii) the transitions that took place in the physiotherapy profession in South Africa
2. To track the chronologies of structured change that took place in the SASP during the period 1971 – 1999, and which affected the performance of the profession
3. To establish the reasons, and under what conditions, the SASP established linkages or exchanges with other organisations in the inter-organisational field

#### **4.7.1.2 SAMPLE FOR TRACKING PROCESS**

The South Africa Society of Physiotherapy is the sample. Data was collected from the following archival documents belonging to that organisation:

- Minutes of the SASP Council from 1971 – 1996
- Policy statements from 1971 – 2000
- Correspondence 1971 - 2000
- South African Journal of Physiotherapy 1971-2000
- Forum magazine 1987- 2000
- Minutes of the National Council of Representatives 1976- 1988
- Minutes of the National Assembly 1997 – 1999

#### **4.7.1.3 STEPS TAKEN DURING TRACKING PROCESS**

All the archival material was gathered together from a number of sources including the researcher's personal collection, the SASP head office in Johannesburg, the personal collections of members of various committees, and the SASP Western Cape branch office. Documents were easily located.

- I. All the documents were perused and relevant data selected and exactly transcribed onto a word processing document (Appendix 10). The following criteria for inclusion was applied:

The data had to show the following:

- I. Processual – relating to decisions, actions of individuals & groups, events, development of structures taking place in the organisational field as a result of pressures in the institutional environment
- II. Historical – the evolution of ideas and actions for change, patterns of continuity and change
- III. Contextual – reciprocal relationships between the two fields, versions of reality and competition as described by members

- II. Each document was imported to the software programme NUD\*IST NVIVO. This programme allows the researcher to organise the great volume of data, by coding and retrieve method, into an analyzable state.
- III. The data from the minutes of meetings, policy statements and correspondence was coded according to the research framework. Five master nodes were created according to the category headings on the framework – external factors, internal factors, decision making, cycles of transformation and key success factors. Factors flowing from these main nodes were added as the coding progressed (Appendix 11) This area tends to focus on the inter-organisational and organisational field.
- IV. The data from the Forum magazine was coded according to pattern codes by discerning themes and patterns, and then dividing the data in the following categories – perception of situation, understanding of situation, processes, activities, events, strategies, relationships. This area tends to focus on the cultural and organisational field.

#### **4.7.1.4 ANALYSIS OF DATA**

The analysis focuses on the institutional and structural changes leading to transformation of the profession and specifically i) the existence of multiple and interrelated changes across the profession ii) the creation of new organisational forms at a collective level iii) the reconfiguration of power relations within the profession and inter organisational field iv) the impact of institutional linkages on the success of the organisation

**OBJECTIVE 1**

***To record systematically institutional change and transformation in the organisational field, the reasons for this change, and the transitions that took place in the physiotherapy profession in South Africa***

Chronologies were developed of the decisions and actions that shaped the organisation's history as well as the trends and events taking place in the institutional environment. Historical periods are specifically identified, recognising these through abrupt breaks in the continuity of the normative trend in the profession. Specific period effects are described by Aldrich (1999:206) as a historical discontinuity that has similar impact on all units in a population, without regard to their ages. Aldrich classifies four classes of period: i) political events and change in regimes ii) legal and regulatory policy change iii) shifts in social norms and values iv) changes in resources. These events had to receive mention in the chairman's report as being important or having a major impact on the organisation before being identified. Changes in strategies following these events were identified so that major eras or periods in the history of the organisation could be inferred and labelled.

**OBJECTIVE 2**

***To track the chronologies of structured change that took place in the SASP during the period 1971 –2000 and which affected the profession's performance***

The data was sorted chronologically into the structured change that took place within the organisation. This took two main themes: founding, enduring and closing of special interest groups and committees within the SASP and the effect these had on the development of the profession over the period of the study. Information was collated onto a database (Microsoft Access). (Appendix 9)

**OBJECTIVE 3**

***To establish the reasons, and under what conditions, the SASP established linkages or exchanges with other organisations in the inter-organisational field.***

An inter-organisational linkage is defined here 'as direct and regularised relationship between the organisation and an institution in the organisation's environment' (Baum and Oliver 1991:187). They are the relatively enduring transactions, flows and linkages that occur among or between an organisation and one or more organisations in its environment. Oliver (1990) describes six

types of relationships and six critical contingencies of relationship formation. The assumption is made that organisations are presumed to make conscious, intentional decisions to establish inter-organisational relationships for explicit formulated purposes and the contingencies explain, from the organisation's point of view, why organisations enter into relationships.

Based on Oliver's (1990) research paper, four critical contingencies of relationship formation are proposed as generalisable determinants of interorganisational relationships across the physiotherapy organisation's settings and linkages: necessity, asymmetry, reciprocity and legitimacy. These contingencies explain the reasons why the organisation chose to enter into relationships with another organisation or institution.

## **4.7.2 REVEALED CAUSAL MAPS**

Cause mapping is a form of content analysis that provides detailed, rigorous collected information that isolates the key assertions that deal with causality, existence or categories in a document (Barr et al 1992).

### **4.7.2.1 SAMPLE FOR CAUSE MAPPING**

The South Africa Society of Physiotherapy is the sample. Data was collected from the following archival documents belonging to that organisation:

- Agendas and minutes of Council meetings held 1971-1996
- Agendas and minutes of National Assembly meetings held 1997-1999

### **4.7.2.2 OBJECTIVES FOR CAUSE MAPPING**

- 1. To extract relevant data in order to construct the revealed causal maps (RCM)**
- 2. To track the pattern of interpretation development that occurs as decision makers confront events in the institutional environment**
- 3. To portray the information as time series pictorial graphs**
- 4. To analyse the way in which the SASP adapted its key strategic activities in response to events in the environment**

#### 4.7.2.2 SOURCE OF DATA FOR CAUSE MAPPING

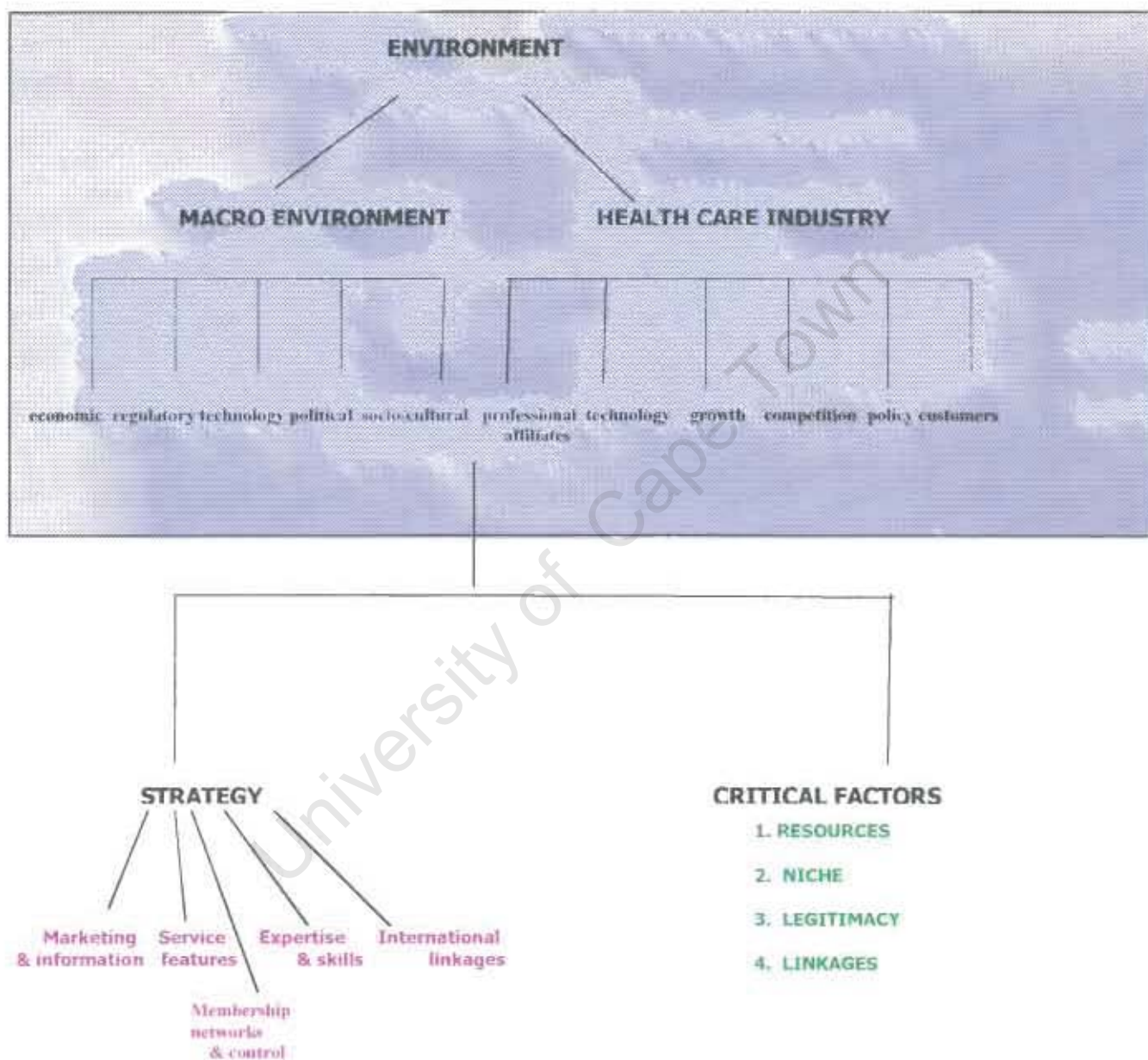
A focus on revealed maps directs the researcher's attention to data sources in which an organisation, through its key spokespersons, discusses the action plans and their rationale. The source of data for constructing cause maps in this research was guided by two a priori decision rules that guided this choice of data source. Firstly, since the research is interested in the evolution of the physiotherapy profession, it was assumed that over the thirty years research period significant changes would take place in the institutional environment and the profession, and these would be noted by the chairpersons of the Council or National Assembly of SASP in their biennial reports. Secondly, another separate data source, potentially orientated towards different constituencies in the form of resolutions put forward at council meetings and passed by the various coalition groups representing members of the profession, also offered information regarding strategies and objectives for the profession over the period under research.

These data sources have the critical value of being written in the time period of interest and also provide insight into the changing understanding, perceptions and methods of senior members of the profession over time.

#### 4.7.2.4 STEPS TAKEN IN CAUSE MAPPING PROCESS

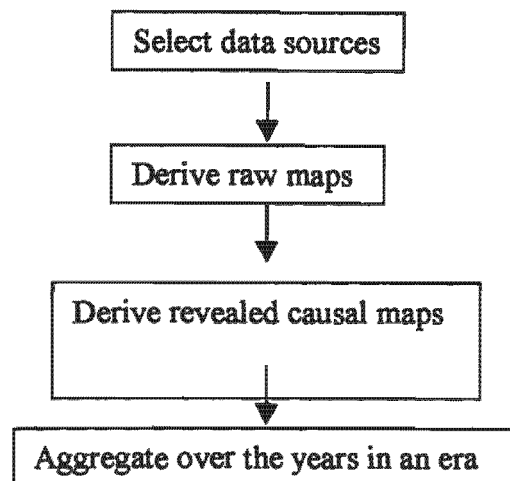
##### CHAIRMANS REPORTS

1. The causal maps embedded in public reports to members are stated in the Chairman's own words. Since the chairmen use different words and ways of expressing concepts, their assertions are not easily compared. Consequently it was necessary to "translate" these assertions into a language that serves theoretical ends. An explicit conceptual scheme shaped by specific theory is necessary for such translation.
2. This conceptual scheme of this research for organising causal assertions is based on that presented by Narayana and Fahey (1990), and is tied to organisation/environment literature (as previously discussed) as well as strategic management literature (Porter, 1990; Hofer and Schendel, 1978). The conceptual scheme is built up of three blocks (Figure 4) the institutional environment made up of the macro environment and health care/industry environment; the strategies adopted by the profession that relate to the well-being, status, recognition and quality of the profession and the four factors which are critical to the profession for survival. Each block is separated into constituent elements or nodes. This scheme does not prefix the causal linkages in the maps. The causal linkages, their directions and intensity, constitute the data that need to be elicited from the causal assertions.



**Figure 4.** Conceptual scheme for reading Revealed Causal Maps

A four step process took place for studying revealed causal maps:



3. Deriving "raw" RCMs in which all statements in the form of concepts and cause-effect relationships were captured in the language of the chairman. The method suggested by Axelrod (1976:5), 'the concept a person uses are represented as points, and the causal links between these concepts are represented as arrows between these points'. This gives a pictorial representation of the causal assertions of a person as a graph of points and arrows' and adapted by Narayanan and Fahey, (1990) was adopted for deriving "raw" RCMs.
4. Deriving RCMs – the "raw" maps were translated into RCMs using the scheme presented in Figure 4. The concepts (elements) underlying the raw maps were sorted into one of the theoretical categories. The network charts were redrawn in the embraced language, this activity did not require any judgement since the theoretical scheme did not set a priori specifications for the nature of the causal relationships. (Appendix 12)
5. Aggregating the maps over the eras. The theoretical RCMs were aggregated over the eras (described in objective 2, point 7.1.4) When the same causal link was present in more than one report it was represented by the number of mentions in the maps.

## DECISIONS

1. The same process for deriving RCMs from Chairmen's reports was used for decision making. All passed or accepted resolutions, with their motivations, were captured in the language of the decision-maker. In some instance this was problematic as the motivations were long and rhetorical and had to be summarized into "raw" RCMs (Appendix 13).

2. Deriving RCMs, as with chairman's reports these were translated using the theoretical scheme Figure 4. In this instance the effect is shown as a critical factor, that is the resolution described a strategy and what it hoped to achieve; if no objective was given, this was inductively assumed by the researcher.
3. Aggregating maps over eras. Maps were aggregated over the eras as described above

#### **4.7.2.5 DATA ANALYSIS IN CAUSE MAPPING**

The figures for the data aggregated over the periods for, firstly, the Chairman's reports, and secondly, for the Council decisions, were placed on Microsoft EXCEL. Data is represented as a histogram and is analysed across periods for changes in the patterns of interpretation that occurs as a result of changes in the institutional environment. The two charts were then collated and analysed across the four periods focusing on the strategies the organisation chooses and the critical factors that are affected across the research period.

#### **4.7.4 SURVEY QUESTIONNAIRE**

This final part of the methodology studies the group process and dynamics of the physiotherapy profession through the perceptions of the individual members of the physiotherapy profession. The final step in the research is to propose an additional way of studying the dynamic processes in the physiotherapy profession that can blend some of the richness and time sensitivity of the more qualitative approach with the rigor of the empirical approach – an adaption of the q-sort. The questionnaire sorts both perceptual and attitudinal responses

##### **4.7.4.1 OBJECTIVES FOR QUESTIONNAIRE SURVEY**

1. To develop a research tool in the form of a questionnaire which measures the group decision- making process of the SASP
2. To administer the questionnaire to a stratified sample of registered physiotherapists in South Africa
3. To develop a model framework for measuring the perceptions of SA physiotherapists about the decision- making process and management of organisational change in their profession

The questionnaire is based on the Group Dynamics Q-sort (GDQ) described by Peterson et al (1999). The GDQ embraces many of the strengths of the case study approach by providing an extensive array of questions assessing in detail

the interaction of group members, group boundaries and the context in which the group is located (Peterson et al 1999). The original GDQ is a 100 item instrument which requires the respondent to place each item on a 1 to 9 Likert-type scale, each item having two polar opposite statements. Raters are asked to identify the extent to which one or the other of the extreme statements characterises the group in question.

#### **4.7.4.2 ADJUSTING THE QUESTIONNAIRE**

1. Some of the items of the questionnaire by Peterson et al. (1999) were clearly not related to the research question and were eliminated. Seventy-five items remained.
2. In order to test the suitability and user-friendliness of the 75-item questionnaire, it was sent to five physiotherapists who had very good knowledge of the SASP and who lived in the same town as the researcher. The respondents were requested to complete the questionnaire and add any comments.
3. These respondents complained that the questionnaire was too long, difficult and time consuming. Some items were not relevant and the 9-scale Likert scale was too fussy.
4. The researcher met with the five respondents and by consensus the questionnaire was reduced to 46 items. Four new items (No 8, 10, 12, 26) were added, the Likert scale was reduced to 7 choices (Appendix 14).
5. The nature of this research process did not lend itself exactly to the method for rating items as described by Peterson et al (1999). The researcher adapted a simpler method described below Section 4.7.4.4.

#### **4.7.4.3 SAMPLE FOR THE QUESTIONNAIRE**

Purposeful sampling was used (Patton, 1990) this is a strategy in which particular persons are deliberately selected to gather information from specific situations and who provide a representative, sample of the various features of the physiotherapy profession in South Africa and who will provide information in order to answer the research question. Probability sampling was therefore not the choice method.

The questionnaire was distributed in January 2000, when 3800 physiotherapists were registered with the Professional Board, and 2300 were members of the SASP. However the 3800 registered physiotherapists were not all working or living in South Africa, as many registered after graduation and then left the country.

Physiotherapists were selected from the following lists and their addresses and dates of registration were noted:

- Membership of the SASP

- Directory of Private Physiotherapy Association in South Africa (which necessitated membership of PPA & SASP)
- Registered physiotherapists with SAMDC (compulsory for working in South Africa)

The date of registration was important as it allowed the researcher to group the respondents into cohorts with similar lengths of experience of the physiotherapy profession. Physiotherapists registering after 1996 were not considered as it was assumed their experience of the physiotherapy profession was too limited for the purposes of this study.

#### **The sample of 750 physiotherapists was selected in the following way:**

- All physiotherapists who had attended a Council or National Assembly meeting (236)
- At least one physiotherapist from every suburb listed in the Directory for PPA (462)
- All Heads of Departments of University training centres (8)
- All Heads of Departments of major provincial hospitals and schools for disabled scholars(30)
- Physiotherapists who were appointed to national sports teams (6)
- Physiotherapists who were working in community health centres or in NGOs dealing with health care (8)

This sampling plan made the assumption that it would result in a satisfactory stratification or distribution of respondents, in terms of geography, work experience, length of professional experience, professional associations and specialisation, age, race and gender.

#### **4.7. 4. 4 STEPS TAKEN FOR QUESTIONNAIRE SURVEY**

##### **PHASE 1 THE QUESTIONNAIRE**

1. All the selected physiotherapists were sent a copy of the 50-item questionnaire together with a letter explaining the objectives and instructions for completion
2. All the names, addresses and date of registration for the selected physiotherapists were entered onto an Excel Microsoft spread sheet
3. Each questionnaire was allocated a number according to its ID on the Excel spreadsheet. This was not to identify the physiotherapist but to be able to record the cohort group and geographical information.
4. As questionnaires were returned, the data was entered onto an Excel spread sheet
5. After 6 weeks non- respondents were identified and sent a reminder.
6. The data was exported into SphinxSurvey software programme

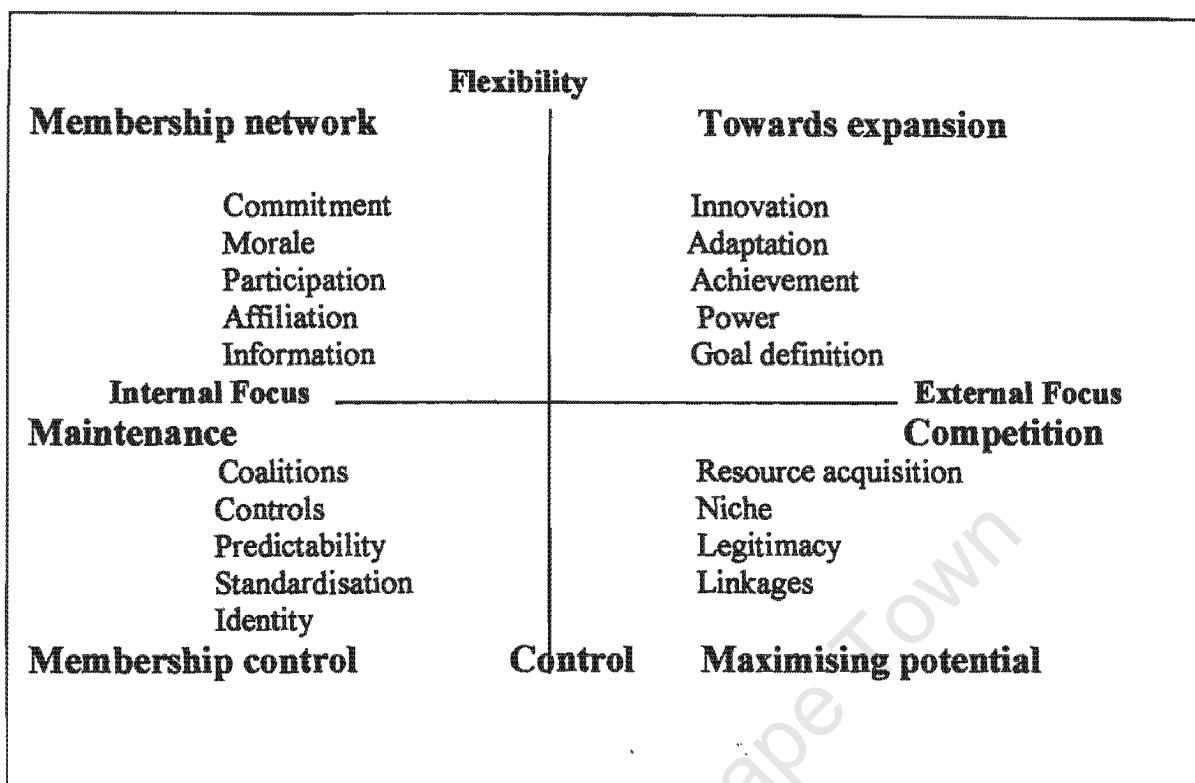
## **PHASE 2 THE COMPETING VALUES MODEL**

In order to make sense of the data presented by the questionnaire that asked respondents to choose between polar opposite statements, a framework was developed based on the work of Quinn (1988) and Human and Horwitz (1992). This well-tested instrument measures organisational effectiveness, and is based on the premise that organisational life is intrinsically contradictory and therefore consists of competing values. The effective organisation will manage all the competing values equally well. Quinn's model is based on two axes: The vertical ranges from flexibility to control, and the horizontal axis from an internal to external focus. The model has been adapted for this research, each quadrant of the framework (Figure 5) representing concepts from organisational change theory and theory of professional organisations discussed in chapter 3.

The competing values model (CVM) was utilised in the following way:

**Utilising Delphi technique:**

1. The researcher and two colleagues individually allocated each item from the questionnaire to one of the four quadrants of the CVM – judging it to be a “best fit”
2. All the results were discussed and a immediate consensus was reached on 46 items (91% agreement)
3. Following further discussion complete consensus was reached on all 50 items (Appendix 14)



**Figure 5 Competing values model (adapted) Quinn RE, 1988. Beyond Rational management.**

#### 4.7.4.5 DATA ANALYSIS FOR QUESTIONNAIRE SURVEY

The questionnaire elicited an even spread of responses from different geographical areas and different types of respondents, thus giving the survey data a high level of validity.

Data was analysed using four different methods:

- a) Data from the questionnaire was analysed using descriptive statistics from the analysis tool on Excel spreadsheet. The mode was calculated for each item indicating the mid-point in respondents' rating. Stem and leaf plots were drawn for each item indicating the range of ratings.
- b) Data exported to SphinxSurvey was analysed using Cross tabulation, factor analysis and principal components analysis.
- c) The Competing Values Model was divided into seven concentric circles, valued 1-7 from inside out. Using the mode (calculated in

- (a)) as a measurement, each item was placed in its allocated quadrant according to its strength (1-7).
- d) Making use of the information on Excel spreadsheet, respondents were clustered according to their date of registration into cohort groups corresponding to the four eras identified in chapter 5.1. The aim was to measure whether the perceptions of the different cohort groups varied in their rating about the effectiveness of the physiotherapy organisation.

## **4.8 OVERALL DATA ANALYSIS**

The overall research process and data analysis required an inductive approach which at times appears to be complicated, but which nonetheless ensured that the research problem became more focused and susceptible to explanation and theory generation. The case study analysis has allowed the tracking of change over time and eras, as a response both to historical forces, contextual pressures and the dynamics of various stakeholders, coalition and power groups in proposing or opposing change. The results of the questionnaire/survey allow the researcher to add another insight to the analysis, by means of triangulating the data. By comparing the evidence produced by the longitudinal tracking and mapping techniques to that of the time fixed evidence of the questionnaire, it is possible to assess whether the three analyses confirm and strengthen each other. Simply put, it allows the question of whether the perceptions of the members of SASP support the historical findings and developing theory of the research.

**A flow Diagram which pulls together all aspects of the data analysis is shown in Appendix 23**

## **4.9 RELIABILITY AND VALIDITY**

### **4.9.1 RELIABILITY/DEPENDABILITY**

The underlying issue is whether the process of the study is consistent and reasonably stable over time and across research methods. The research study attempts to explain how the South African Physiotherapy profession managed itself over a 30-year period, and the ways in which it was or was not successful in this. The main focus is on the matters raised at the biennial Council meetings although some events taking place and mentioned in the Forum magazine are referred to. The research makes no attempt to analyse the development of physiotherapy scope of practice.

The researcher is a physiotherapist very familiar with the period under consideration. At the same time the researcher is in a privileged position – that of making judgements about outcome evaluations in a change process. Judgements such as these are sensitive to the quirks of shifting internal and external contexts, time point of observation and subjective observations. Research such as this has to accept that different versions of reality must exist where different researchers approach the subject with a variety of interests and perceptions. This researcher has made every effort to remain within the constraints of the research question but at the same time has used inductive methods, which by definition must contain an element of bias.

Most facts are quoted verbatim from reports and all the data relevant to the study has been included. The raw data must therefore be considered trustworthy and authentic. The data is analysed across well-tested and documented research methods. In several instances colleagues were used to verify the instruments used in the research. By using a triangulated approach the researcher has attempted to corroborate the research findings. The study is somewhat unique, in that very few similar studies having been documented, and it is therefore difficult to compare the evidence and findings of this study to those of others. The development of a physiotherapy paradigm has to be judged on its own merits and against the background described in chapter 2.

#### **4.10 ETHICAL CONSIDERATIONS**

This research concerns the physiotherapy profession in South Africa. Prior to starting the research a copy of the proposal was sent to the Research and Ethics committee of the SASP. The Committee approved the research and donated a research grant. The higher degrees committee of the Faculty of Commerce of University of Cape Town also passed the proposal. The Doctoral Boards Committee approved the proposal and the research was awarded a Doctoral scholarship.

In the study all the names of the participants are obscured.

Much of the research quotes verbatim from the minutes of the Council meetings of the SASP, which are not strictly confidential documents and are to a certain extent in a narrow public domain. Any judgements made on the actions of the physiotherapy profession are the responsibility of the researcher and are made in the spirit of the research methodology.

## CHAPTER 5 PRESENTATION OF THE DATA

This chapter presents the research data, divided into three sections corresponding to the three data collecting methods described in the previous chapter, and reflecting the steps of the research – tracking historical records, causal mapping and questionnaire survey. Chapter six will discuss the findings in relation to the four propositions, an interpretation and analysis will then be offered of the historical periods focusing on explaining the transition from one period to the next and delineating the conditions that foster the development of institutional strategy.

### 5.1 TRACKING HISTORICAL RECORDS

This section focuses on the institutional changes caused the physiotherapy profession to evolve as an independent professional organisation. The events and conventions that triggered these changes are also described. The historical narrative traces the origin of these events and conventions, their impact on institutional change and their consequences for institutional strategy. Four critical periods were identified using criteria described in the previous chapter and dividing the research into four phases: 1971 - 1975, 1976 – 1985, 1986 – 1993, 1994 – 2000. This research follows the evolutionary approach taken by Aldrich (1999), which asserts that organisational transformations occur within historical and geographical contexts and that transformation often follows an external event which takes place in the external environment.

#### 5.1.1 1971 – 1975 The period of standards and controls

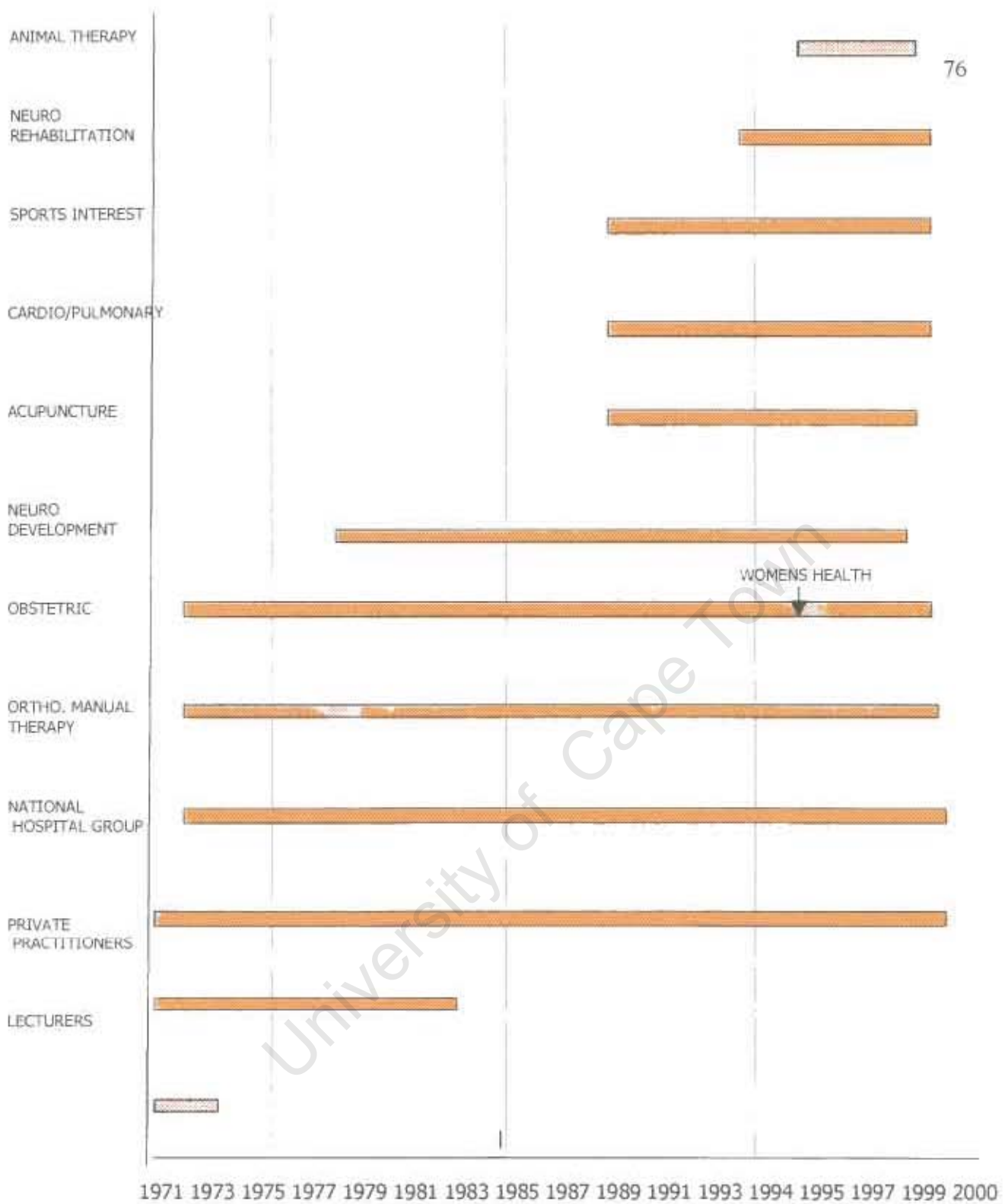
At the beginning of this period physiotherapists were regarded as having a semi-professional status, with very little independence, as they were completely reliant on the medical profession for patient referrals and treatment prescription. Many departments in the larger hospitals were under the direction of physical medicine specialists (a speciality which was to die out a few years later). Doctors were largely responsible for the early development and training of physiotherapists. Only one university conferred a degree on completion of the physiotherapy course, with the result that almost no physiotherapists undertook post-graduate research. Physiotherapy fell directly under the jurisdiction of the medical profession of the South African Medical & Dental Council. The close involvement of doctors with the profession was to continue until 1971 when the passing of the Medical, Dental and Pharmacy Act allowed physiotherapists to form their own professional board.

EXTERNAL EVENTS	STRATEGIC RESPONSES
Medical schemes Act 1967	Formation Private Practitioners Association
Formation NAMAS	Negotiations for physiotherapy fee
Medical, Dental & Pharmacy Act 1971	Election Physiotherapy Professional Board Development scope of practice Introduction of limited registration
Development of manipulative therapy in Western countries	Visit by Australian expert – Geoff Maitland Formation Orthopaedic Manipulative Therapy Group (OMT)
New salary scale for state employees - lack of parity for Non White salaries	Memo written & meeting with authorities Formation National Hospital Group (NHG)
Two diploma courses up-graded to degree	Change in nomenclature – teachers group to Lecturers group Setting of minimum standards for diploma
National athletics meeting	Physiotherapy service provided round the clock

**Table 1 The major external events during 1971 – 1975 and strategic actions taken by the physiotherapy profession**

The above Table 1 summarises the main events taking place in the institutional environment and the strategic responses from the SASP. Figures 6 and 7 show the founding, enduring and disbanding of physiotherapy special interest groups and physiotherapy council committees during the period 1971 - 2000.

The major events affecting this period, were the passing of the Medical Schemes Act 1967, which regulated the private sector and allowed for the introduction of medical aid schemes, and which in turn led to the formation of National Association of Medical Aid schemes (NAMAS). Although just out of the period of research this event was to give impetus to the evolution of physiotherapists from employment mainly in the public sector working for state organisations, to the employment of the majority of physiotherapists in the private sector. For the physiotherapy profession these events were to profoundly effect the future organization and practice of the profession. The shift in health care perspective which provided for a regulated private health sector motivated the physiotherapists working in that area to pursue new goals and challenges. These challenges stimulated major changes, firstly in resource availability in the form of a fee for service structure and secondly, causing a shift away from public health towards subsidized private health care. Although available to only a small



**FIGURE 6 : The founding, enduring and closing of special interest groups of the South African Society of Physiotherapy**

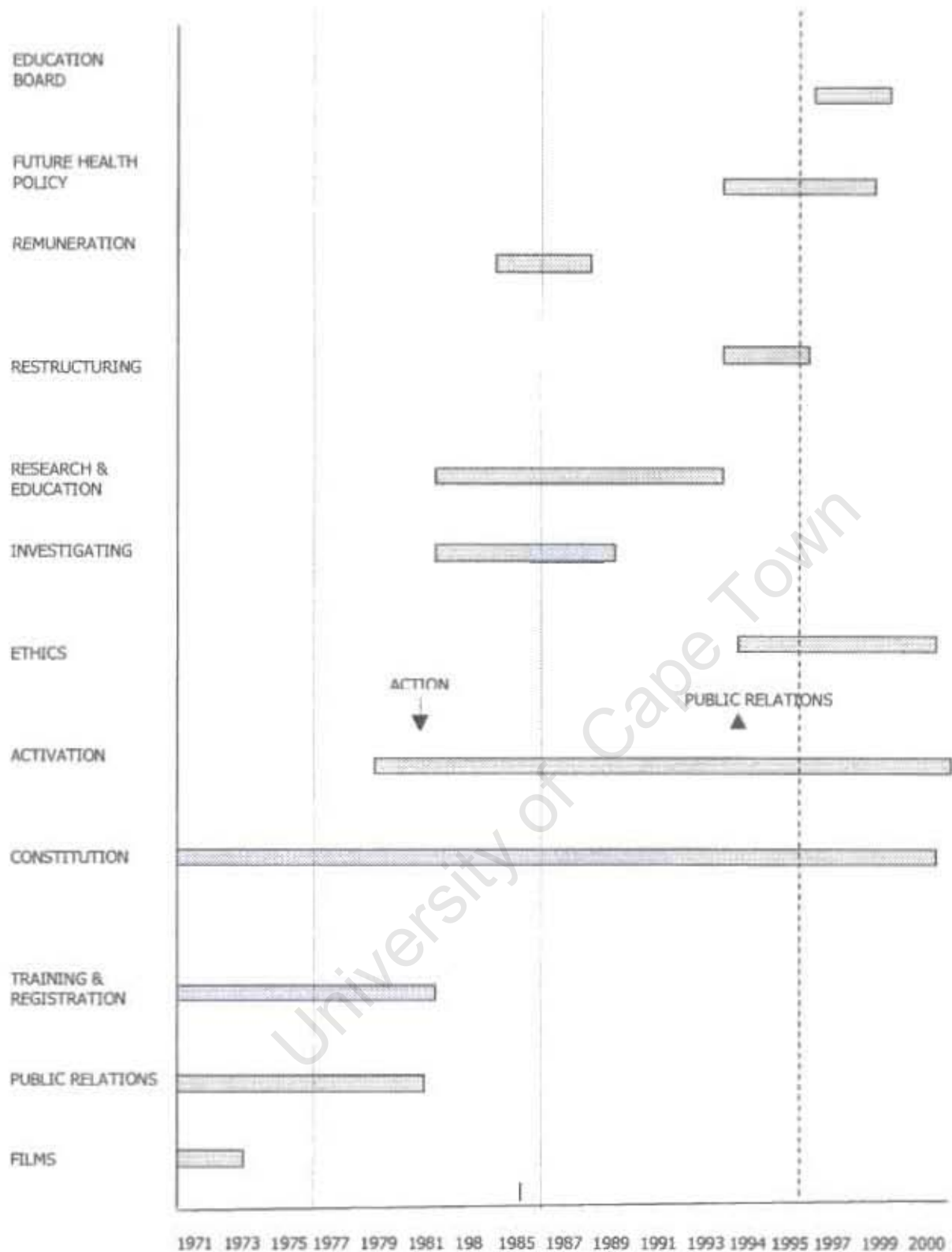
percentage of the population, this shift was to make an impact on the health care delivery system in South Africa.

The private practitioners formed the Private Practitioners Association (PPA) (Figure 6), which became a special interest group within the SASP in 1971. Initially this group only had 145 members who felt that the SASP was not aware of the needs of private physiotherapists and that their special interests were not sufficiently understood or protected (Pilkington, 1970). The main aim of the group was to represent its members' needs especially in relation to the negotiation of fees, the publication of the Private Practitioners Directory, and to gain some control of unregistered personnel who performed physiotherapy. In 1971 the PPA attempted to negotiate fees with NAMAS but they were refused a meeting. They then decided to charge a fee structure utilising the fee structure of physical medicine specialists, refusing to accept the lower fee structure offered by NAMAS. Eventually an agreement was reached with NAMAS who accepted the recommendations of private physiotherapists. This initial brush with the medical aid schemes was to become a characteristic of the PPA who became very skilled at negotiating and motivating for remuneration.

In 1971 the Medical, Dental and Pharmacy Act was passed, granting the Supplementary Health Professions the right to form their own Professional Boards. The first physiotherapy professional board was elected in 1973 and described by the then chairman of the SASP as *'the most exciting point of our society's history'*<sup>1</sup>(Chairman's report, 1973). The label 'profession' is used by occupational groups to signify a highly trained, competent, specialised and dedicated group that is effectively and efficiently serving the public trust (Richardson, 1999). The formation of the Professional Board allowed the physiotherapy profession to pursue, in a more independent manner free from the restraints of the medical profession, the characteristics of a profession: an exclusive knowledge base, occupational control of rewards, a commitment to the task and a means to maintain standards. The SASP was now able, through the Professional Board, to protect its profession. It did this through its registration committee and constitution committees (Figure 7), setting out to establish the barriers and controls which would (1) protect and standardise its knowledge base through the scope of practice *'taking long and tedious hours to draw up'*, (2) maintain high standards of practice by establishing a register of registerable qualifications and the concept of limited registration *'the many foreign trainings a most vexing problem – standards vary so much'* and (3) ensure ethical practice. The rules governing ethical practice were to change in a somewhat iterative manner over the study period but in the early period they were rather inflexible and confining:

Referral status - *Not to undertake the treatment of any patient, except when referred by a registered medical or dental practitioner;*

<sup>1</sup> Quotes in italics indicate data extracted verbatim from Council minutes or Forum magazine. The author of the quotes is usually unknown. The quotes are used as data to support the point being made in the text.



**FIGURE 7** The founding, enduring and closing of committees of the South African Society of Physiotherapy

Partnership - *A member may only enter into partnership with a registered physiotherapist ;*

Employment - *a member can only be employed by registered physiotherapist, physical medicine specialist, government, provincial, municipal, mines benefit or approved institution (SASP Ethical rules, 1971).*

As the profession developed these ethical rules were to change to allow more flexibility.

The state-employed physiotherapists, like those in the private sector, decided to form a group, the National Hospital Group (NHG) (Figure 6), which would look after their interests. However, unlike the private physiotherapists who were able to negotiate their fee structures, the state-employed physiotherapists had no negotiating forum and were reliant on memoranda sent to Department of Health officials and Provincial health authorities. Amid competing claims from other professionals for dwindling health resources, and the fact that most of these physiotherapists worked in large acute hospitals dominated by medical doctors and bureaucratic administrators, their task of improving the lot of hospital employed physiotherapists was a daunting one. The other concern was that of the salary for black physiotherapists which was much lower than that of the white physiotherapists in spite of receiving the same training. Black physiotherapists could also only work in hospitals or wards dedicated to black patients. Black and white colleagues were therefor officially segregated although in practice many white physiotherapists worked in black hospitals. Efforts by the SASP to attain parity of salaries for all races of physiotherapists went on unabated and were strongly motivated for in all memoranda

During this early period the concept of specialisation in the physiotherapy profession was just beginning to be considered, and in 1971 a world expert in the field of joint mobilisation and manipulation, Geoff Maitland, an Australian physiotherapist, was invited to South Africa to conduct a course of the techniques bearing his name. The course was described as '*an unparalleled success*' by the SASP chairman. These techniques were little known in South Africa and were not taught in the undergraduate course, neither was it in the physiotherapy scope of practice as orthopaedic specialists considered it to be within their field of practice. The course participants formed the Orthopaedic Manipulative Therapists (OMT) group (Figure 6). The first of the special interest groups to form, it was, over time, to become the largest and most influential group in the physiotherapy profession. The patient evaluation, problem identification and relevant treatment strategies developed by Maitland were to change the image and scope of physiotherapy world-wide. In 1975 the International Federation of Manipulative Therapists was formed but South Africa could not join as it did not have an approved standard of courses and examinations.

In 1975 two universities up-graded their three year physiotherapy diploma course to a four year degree course. The Medical University of South Africa (MEDUNSA), a university specifically for black students, started a diploma course for training black physiotherapists. Within SASP, the Teachers Group changed its name to Lecturers Group, perceiving this to have a better image and status. Also in 1975 this group established the minimum requirements for a diploma in physiotherapy, thus setting the minimum level that was acceptable for registration with the SAMDC.

In summary the major critical evolution during this first period was the beginning of independence and the institutionalisation of scope of practice and standard of practice for physiotherapy. The second critical development was the founding of special interest groups whose main objectives were to promote and protect their sphere of interest. These new structures were to shift the balance of power, previously maintained by the doctors, towards the physiotherapy profession in terms of professional knowledge, identity and status.

#### **5.1.2 1976 – 1985 The period of consolidation**

The event marking the beginning of the period was the announcement in 1976 by the Minister of Health prescribing the magisterial areas requiring compulsory registration by physiotherapists with the SAMDC, thus allowing only those to practice whose standards reached the level established by the Professional Board. Described by the Chairman as *'this most important event is the fulfillment of a long awaited dream and culmination of many years of dogged determination on part of the Society to gain its rightful status in, and the respect of, the community.'* The passing of this law gave physiotherapists the opportunity and responsibility to take forward the purpose of their profession and most importantly it would control the information and expertise with which the members were attributed.

Because of the compulsory registration, a physiotherapist could now only practice the skills he/she had been taught and those that appeared on the scope of practice. Meanwhile, a number of new techniques requiring new skills were being introduced onto the scope of practice. This resulted in a flurry of physiotherapists, who found it both necessary and desirable to upgrade their knowledge and expertise, enrolling in a variety of post-graduate courses being offered by the special interest groups and universities. Not only was training in specialised professional skills becoming so important, the physiotherapists working in the public sector realised to become effective in the very competitive environment in which they worked, they had to expand their knowledge to include management and marketing concepts.

<b>External event</b>	<b>Action by SASP</b>
Magisterial districts are prescribed	Only registered physio may practice. Minimum standard 3 year training established
Marketing as an image making technology	Activations/Action committee established
Remuneration committee to be established at request medical aids	SASP through PPA to apply for Tariffs commission for determination of fees
SAMDC agrees to 4 year degree for all physiotherapy under graduate training	Minimum standards for degree established - modern knowledge & skills to replace the old syllabus
First line practitioner status for Australian physiotherapists – no referral required	Recommendation to SAMDC for change to SA ethical rule
Australia presents concept of specialisation	Post basic courses proliferate
Black homeland policy – 14 MOH Serious shortage physiotherapists in black hospitals	Physiotherapy assistant training instituted
Steve Biko affair, serious political unrest. SASP 'under fire' from certain member countries at WCPT	Attempts to convince WCPT that SASP does not subscribe to the apartheid policy
Poor economic climate	Memorandum & meeting with Minister

**Table 2 The main events in the external environment and the actions taken by the physiotherapy profession 1976 - 1985**

The special interest groups, envisaging an opportunity to boost their status and legitimacy, produced a plethora of courses to satisfy this demand. However, the membership strategies of the SASP involved the definition of rules requiring a physiotherapist to belong to the SASP in order to attend a course given by a special interest group. This led to a sudden rise in SASP membership as new members joined who wished to register for courses.

The Lecturer's Group, recognising the need for a major revision of the undergraduate syllabus, submitted a memo to the SASP in 1978 giving, in detail, the requirements for the minimum standard of a 4-year degree course in physiotherapy. The memo motivated strongly for this to be the minimum standard for training in South Africa, and urged the SAMDC to recognise the 4-year degree course. This was accepted in 1983. Having successfully won the fight for a 4-year degree the Lecturers Group suddenly, in 1984, decided that SASP must '*consider very seriously*' the possibility of internship for newly qualified physiotherapists. It is not clear from the motivation whether this was an attempt to further upgrade the physiotherapy students to medical student level or whether they genuinely felt that their students were incapable of practicing. However the concept was not agreed to at that time, but was raised again on many subsequent occasions. It is to become reality, in a different guise, in January 2003 when the students will, by law, have to complete one year of community service.

In 1979, at the World Confederation of Physiotherapy (WCPT) Council meeting, the most important issues raised by the Australian association were the question of medical referral and how this affected member organisations and, the recognition for the need for specialisation within the physiotherapy profession. The ethical principles of the world body were binding on the member countries and these emphatically stated that .... '*members should treat only patients who are referred to them by a registered medical practitioner*'. At this stage many member countries found it difficult to envisage first line practitioner status for their profession. The issue was the competence of physiotherapists who at that time were not trained to diagnose problems without the aid of a medical practitioner. Later a modified ethical principle was agreed upon by the world body: *that physiotherapists carry out with loyalty and skill any physiotherapy treatment in responsible consultation with the medical or dental practitioner* (WCPT council minutes, 1979). In South Africa, however, physiotherapists had no difficulty envisaging first line practitioner status, and embraced the concept with much enthusiasm. In order to persuade the South African medical profession that the physiotherapists were capable of practicing independently, discussion within the physiotherapy profession centred around finding the most effective strategy to convince the medical profession, either incremental change of the rule, or the possibility of radical change and the conditions to bring that about. Either way these changes would require changes to some core skills in the training of physiotherapists and to the administrative systems recording patient care. Resistance was anticipated from the medical profession who would view these developments as a further erosion of their power. In the end the ethical rule pertaining to patient referral was to change slowly, over eight years, and in 1985 the SAMDC recognised the wording which required a physiotherapist to work '*in close collaboration with a medical practitioner*'. This, in effect, allowed

physiotherapists, especially those in private practice, to practice independently and had *'far-reaching implications and result in a major shift in professional status, responsibility and accountability'* (Chairman's report, 1983).

In 1975 the Medical Schemes Amendment Act was passed, phasing out NAMAS and phasing in Representative Association of Medical Aid Schemes (RAMS), who requested a Remuneration Committee to review a new format for fees. The PPA, acting in a pro-active manner, requested permission from the Minister of Health to form their own Tariff Committee that would negotiate with the Remuneration Committee. After many delays this was approved in 1980. In 1984 the Tariff committees were abolished and interested parties negotiated directly with RAMS. The physiotherapy profession, along with optometrists and psychologists, were the only Supplementary Health Care professions who were granted gazetted fees during this period. The advantages of this were considerable as physiotherapists were able to charge patients a fee for service that was claimed from the medical aid schemes

The National Hospital group spent most of its energies on two pressing commitments: firstly the ongoing struggle for recognition as a genuine profession with commensurate remuneration and secondly, the development of the category of assistant physiotherapist. During this period the physiotherapists kept up a barrage of memoranda with written evidence of the changing role and status of the physiotherapy profession to the Commission for Administration, who at that time were responsible for salaries for public service staff. The struggle for a reasonable salary was variously described over the eight years *'salaries continue to be a bone of contention... and the structure for our non-white colleagues continues to disturb us', '... the battle is long, tedious and uphill and our ultimate goal is far from sight', 'the struggle is not over .. we have not arrived yet'*. Following a Commission of Enquiry into health services in 1981, salaries for physiotherapists working in state hospitals improved considerably and by 1985 all salaries were equalised. The training for physiotherapy assistants became a difficult issue, and although a scope of practice and salary scale were compiled, the administration and supervision of these workers was problematic. Institutions could apply to the professional board to be allowed to run a course and usually were allowed to do so, but the Department of Health was slow to recognise the category of physiotherapy assistant with a formal salary structure. The result was that, although formally recognised as physiotherapy assistants by the physiotherapy board, in practice these workers were frequently appointed to any available post such as a porter or cleaner.

By the end of the period the number of physiotherapists entering the profession had rapidly increased. This was mainly due to the fact that eight universities were by now offering a 4-year degree course. In the early 1970s all the physiotherapy schools were attached to provincial administrations who paid

many of the students a small bursary, expecting them to stay on and staff their hospitals, but only a limited number of students could be admitted to the courses due to provincial budget restrictions. When the universities took over the training students had to pay fees, it was therefore beneficial to the universities to admit as many students as possible to garner as much income as possible from the fees. Large numbers of students were admitted to the courses and eventually these large number of students with a four year degree passed into the system as graduate physiotherapists, adding to the prestige and status of the profession.

In 1977 the SASP, recognising the need to protect the standards of physiotherapy and at the same time wishing to establish the new image of the profession that was being created, appointed a standing committee of the council known as the Activations committee (Figure 7), later named Action committee. Initially the aim was to establish an understanding and appreciation of the profession by the medical profession, the public and its own members. Subsequently in 1984, following a request from members, the committee developed long term aims and objectives for the profession, which had to clarify such interesting questions as: How can physiotherapy be defined against the South African setting? What is the role of the SASP in relation to i) the special interest groups, ii) the Professional Board and its association with SAMDC and the Biko fiasco? What role is the profession going to play in developing primary health care? How is the profession going to take up the challenge regarding first line practitioner status and doctor's referral and how will it establish accountability? What advocacy role is the profession going to play within communities?

An indication of all the changes taking place in the professional organisation can be seen through the Constitution committee which announced in 1983 that *'due to all the changes taking place in the SASP and physiotherapy practice it is necessary to completely revise the Constitution with all its amendments and by-laws'*.

By 1985 the bad publicity elicited by the Steve Biko case and the country's apartheid policies were reflected onto the physiotherapy profession. Member countries of the WCPT objected to South African participation and *'unfortunately, there is increased politically inspired pressure against South Africa in WCPT'* (Chairman's report, 1985).

In summary, the major development of this period was the phasing out of the legal requirement of a doctor's referral and prescription for patient treatment. Other critical points in the management of this transformation, were the roles of the private practitioners group and the orthopaedic manipulative therapists group. Another critical evolution was the promotion of all physiotherapy undergraduate training to a 4-year degree, opening the way for post-graduate

degrees and doctoral research, and thus greatly increasing the legitimacy and status of the profession. Strenuous efforts were made by the special interest groups to advance professional development by providing opportunities for increasing knowledge and skills. In addition much effort went into consolidating all the new gains achieved over fourteen years by requesting legislation which would protect the profession and its legitimacy.

### **5.1.2 1986 – 1993 The period of competition and political turmoil**

As the 1980s wore on, two features dominated the period - the continuing political violence and turmoil and the decision by government, in 1986, to encourage privatisation of health care. The early 1990s were marked by political changes that turned the focus towards primary health care.

In spite of strong criticism of the fragmented structure for health care from academic leaders, professional associations and activists in healthcare, and the call for a more equitable and unitary health care system, and in the face of the professional health care associations being expelled from their world bodies, little or no impact was made on the dominant culture and working arrangements of the South African government health departments until the late 1980s.

The SASP, facing a very serious threat of **expulsion** from the WCPT following the boycott by member countries of a world meeting in Australia in 1986, took an unprecedented step by defying the South African government and issuing a statement condemning the apartheid policy (Appendix 5). The SASP was concerned that should it be expelled from the world body, all communication with member countries would cease and the profession would be completely isolated, with no further visits from overseas experts to give advanced skills courses. Physiotherapists from South Africa would not be welcome in member countries. Following an equally unprecedented step, the WCPT held a hearing of South Africa's case and decided not to expel the SASP. *The SASP has been informed that the Danish Physiotherapy Association has written to all member-associations informing them of their intention to boycott the 10 International WCPT meeting because the Executive committee has declined to expel the SASP* (Council minutes, 1987).

External events	Strategic actions by SASP
Major technological advances & specialisation in tertiary health care	Increase in post graduate courses College of physiotherapy proposed Quality Assurance programmes introduced Education committee formed
Political pressure from WCPT to expel S Africa	SASP publically rejects apartheid policy & presents policy document to WCPT
Government promotes privatisation in health care, private hospitals proliferate	Private practice becomes dominate from of service delivery in physiotherapy profession
Increase in professional marketing & Information technology	Back week implemented Forum magazine published
State health care fragmented & in chaos	SASP advocates for unitary health system
Nelson Mandela released from prison, new Political dispensation including introduction PHC principles	Policy documents compiled on future health care, position statements & education. meetings & workshops ++ with other health care workers
SA readmitted to international sport, Professionalisation of national sports teams	MSc in sports medicine, physio appointed to national sports teams Special interest group: sport physiotherapy

**Table 3** The main events taking place in external environment and the strategic actions adopted by the SASP 1985 - 1993

The SASP subsequently went on to document, in detail, all the objections it had regarding the outcomes of apartheid policy and in 1989, presented its members with a policy document outlining the recommended treatment of political prisoners and victims of torture. This was a substantial shift by the physiotherapy organisation away from the normative pressures to conform to the apartheid policy and is in contrast to its position of conformity ten years earlier towards institutional demands. This not to say that all members agreed with the stance of the SASP but there is no available evidence to show that anyone objected to it.

In the mid-1980s the Action committee introduced two initiatives which would become synonymous with South African physiotherapy - that of Back Week and Forum magazine. Both these initiatives resulted from the need to market

physiotherapy to the public by means of Back Week, and to the physiotherapy profession through Forum. Back Week evolved into a very powerful strategy and marketing tool and has been used by the majority of physiotherapists to promote their particular area of interest. Each year a different aspect of back care is targeted and thousands of very professional posters are displayed throughout the country, thousands of flyers handed out and displays, open days, radio, TV and newspapers are utilised to communicate physiotherapists' role in the care and prevention of back problems. As the years progressed the Action committee became skilled at managing the flow of information regarding Back Week through the mass media. These efforts have been favourably received by the public, industry and health care professionals, transforming the old image of a physiotherapist as a masseur to that of a skilled professional concerned with managing a serious and chronic problem which presents to a wide proportion of the population.

The economic crisis in the public sector lead the Government to further promote privatisation as a means of unburdening itself of its responsibilities and thus placing an even greater strain on the public sector physiotherapists. Whereas in previous years newly graduating physiotherapy students would be expected to take a job in a state hospital where most likely there were large departments and staff, now the state, under serious economic strain, cut back or froze posts leaving departments with ever-diminishing staff structures. This resulted in new graduates, unable to get jobs in the state sector, entering the private sector and by 1990 over one thousand physiotherapists were employed full time in this area, more than double that in the state sector. Senior members of the PPA, alarmed at this influx of young new members, made strenuous efforts to define the meaning of membership of the PPA in order to preserve the institutional standards and rules pertaining to the private sector. As a strategy, members of the PPA began publishing short articles in Forum discussing such issues as *professional image, professional ethics, professional communication and relationships*. Strategic planning workshops were given and requests went to the universities to run courses in management for final year physiotherapy students.

By 1993 the ethical rule pertaining to doctor's referral had passed through two more revisions and SAMDC approved '*changes to regulations which remove reference to referral and collaboration. It is the physiotherapists right to diagnose and treat in areas in which they are trained*' (letter from SAMDC to PPA, 1994). This announcement secured the autonomous position of the physiotherapy profession in terms of control and discretion over the performance of their work tasks.

One of the distinguishing features of this very eventful period is that of the evolution of post-graduate education. The Lecturers Group, which was formed as a support group, closed down in 1987, and the Education and Research

committee (Figure 7) was formed as a standing committee of council. Its functions were to develop an optimal curricula for under-graduate training, to formulate recommendations for post-graduate study and research and to maintain high standards of continuing education. This committee established competencies for under-graduate training but failed as a committee to make an impression on the many initiatives that were going on within the professional organisation. The university departments functioned independently of the SASP and had closer ties to their faculties than the Education Committee and were running their own post-graduate courses. The special interest groups, such as OMT and Obstetric groups, were far stronger coalition groups and had little allegiance to the Education committee. This resulted in the SASP having to rethink its strategies in terms of co-ordination of education within the professional organisation. The OMT group, having successfully gained admission to the International Federation for OMT in 1985, offered a number of post-graduate courses throughout the country for which *'the demand is undiminished'* *'there is an overwhelming demand for the 75 hour course'*. By 1993 they had over seven hundred members.

Two new initiatives were introduced during the period: Quality Assurance (QA) programmes and a College of Physiotherapy, both aimed at improving the quality and standard of physiotherapy practice. The aim of the College was to offer a Fellowship in Physiotherapy practice through advanced study. This vision was attractive to the special interest groups who saw it as another route to increasing their power and status. Ultimately the introduction of College concept, although valid in principle but difficult to sustain in practice, proved impractical and the College was closed in 2000. Countries, such as Holland, were introducing QA programmes and, in a sense, these were the forerunner of evidence based practice, a mandatory concept with Managed Health care. Although some interest was shown in QA programmes these did not get off the ground and evidence based practice became the relevant programme in the next period. At that time these initiatives were very advanced strategies, similar to activities taking place in other countries that were world leaders in physiotherapy.

Three new special interest groups were formed, reflecting the growing diversity of interest amongst physiotherapists: sports physiotherapy group, acupuncture therapy group and cardiopulmonary group (Figure 6). The sports interest group was formed out of necessity to co-ordinate all the physiotherapists who were working as physiotherapy volunteers at the very many sports events being held round the country. Added to this was the fact that South Africa was slowly being admitted back into the international sports arena where many major sports were becoming professionalised and physiotherapists were an essential part of the medical team. Opening up a new niche, the MSc degree in sports physiotherapy was offered at two universities, and a number of physiotherapists took this degree envisaging a successful career working with sports teams.

Holistic health and alternative therapies became very popular and fashionable with certain communities. This led to some modalities such as acupuncture and reflexology, which previously were banned by the medical fraternity, to slowly creep into the treatment rooms of a few health care professionals. Acupuncture, combined with other more traditional physiotherapy techniques, opened up yet another new niche and became an acceptable form of treatment by physiotherapists who had to spend much time learning the techniques. Although acupuncture was admitted to the scope of practice for physiotherapy, not all physiotherapists were in agreement – asking *'are we going to reach back again into the ancient mysticism of the East?'* (Forum March, 1990:10). Vociferous complaints were received from the chiropractic association and the society of acupuncturists objecting to the physiotherapists trespassing in their field of practice, accusing them of not having sufficient training. The physiotherapists strongly refuted this claim, pointing out that the modalities were on their scope of practice - *the Chairman of the Chiropractors Association stated that only chiropractors are qualified by the nature of their training to do spinal manipulation therapy, and that no medical person, including physiotherapists, has this training.....we wish to point out that manipulation both vertebral and peripheral is included in physiotherapy scope of practice* (Forum, September 1991:12). At this time the SAMDC continued to oppose any co-operation with alternative medicine as it considered their methods unacceptable and unscientific, but six years later this attitude had to change. In 1993 Government passed the Associated Health Service Professions Bill recognising and providing for the registration of chiropractors and homeopaths.

The obstetric group also had on-going battles with the midwives concerning pre and post natal exercises and whose responsibility it was to give these exercises *..that there is a hazard to physiotherapy cannot be disputed, as obstetric physiotherapists we are only too aware of the encroachment midwives have been making into not only our antenatal but also out post natal physiotherapy classes* (Forum, May 1988:3).

By 1990 it was becoming clear that very major political changes were about to take place in South Africa. The SASP, wishing to align its future plans with those of the government, secured a meeting in 1991 with the Minister of Health requesting information about the Future Health Policy. In a complete turn about from all previous health strategies, the Minister stressed the following:

1. The health care system would be restructured to form a comprehensive, rationalised service based on primary health care
2. The system had to be accessible, equitable, affordable, effective and acceptable
3. Both state and private sector must be involved in health care delivery.

The SAMDC also put out a policy statement sharing the view that health care should be affordable, accessible and equitable. Up until 1991 the rules of SAMDC prevented the establishment of managed health care delivery systems (MHCDS), but following the financial crisis in the medical aid schemes, the SAMDC was prepared to review the rules to allow MHCDS.

The SASP responded to these declarations by forming an ad hoc committee – Future Health Care Committee (Figure 7), with the aims of monitoring health care policies and being active in health planning. The committee compiled a new mission statement for the SASP and issued four position papers: The role of physiotherapy profession in future health care delivery systems, the role of physiotherapy in rehabilitation, the role of physiotherapy in primary health care, the role of mid-level and grassroots-level workers in the provision of physiotherapy services.

Towards the end of this period physiotherapists became concerned about the centralisation of decisions in the SASP, the lack of communication with members, the relevance of their training and the lack of consultation over such matters as policy statements regarding the role of physiotherapy in future health care. Many members corresponded with Forum expressing their disquiet:

*'come on SA physiotherapists there is no balance in our services, I get so tired of seeing the word professionalism as being a constant striving for academic excellence, perfectionalism and competition at the exclusion of addressing the needs of our population at large.'* Forum January 1992:2-3

*'In an analysis of health care personnel the supplementary health service personnel were omitted altogether – suddenly in the process of rationalisation we have been deprived of our identity and refused an opportunity to discuss the matter.'* Forum June 1993:3

*'our undergraduate degree is hopelessly inadequate how can we be expected to be regarded as peers when we have so little to offer. At present almost every individual is a jack of all trades and master of none, we must begin to realise our profession is under threat.'* Forum Dec 1992:6

*'physiotherapy is at its turning point in that it offers some excellent treatments, it links traditional Western medicine with alternative therapies and it addresses itself to appropriate care. Our profession attracts persons of sound good sense, intelligence and energy – all this can be directed towards the creativity and imagination the profession so badly needs. Let us be proud of our profession and not allow physiotherapy to die.'* Forum March 1991:5

At the SASP council meeting in 1993 serious concern was expressed by the members at the concentration of power in the Society Head of office in Johannesburg and lack of communication and consultation. Several resolutions were passed calling for a restructuring of the profession.

To summarise the period 1986 to 1993: A considerable amount of energy was spent improving the level of professionalism, and raising the standards of practice for physiotherapy. The profession arrived at a high degree of maturity in the late 1980s, challenging the government over its health care, homeland and apartheid policies; negotiating directly with the medical aid schemes over tariffs; achieving the major triumph – independent practice; producing post graduate courses and degrees. The private sector offered many opportunities for developing physiotherapy practice, the number of private physiotherapists more than doubled during the period. However, towards the end of the period medical aid schemes started to collapse financially, causing considerable uncertainty in the private sector. In conceptual terms, this period began by making innovative, challenging and proactive strategies, but towards the end things fell apart somewhat as strategies became disjointed and reactive. The physiotherapists working in the state sector struggled to achieve any realistic gains as the government was locked into a state of inertia and political crisis.

Many factors contributed to the switch in government health policy from an emphasis on tertiary curative care to that of primary health care. This switch caused much uncertainty in the state sector. With the release of Nelson Mandela, other political prisoners and exiles, and the build up to democratic elections, the social, political and economic sectors were all under extreme pressure. This was reflected in all organisations and individuals in South Africa. The conflict in the SASP, the frustration and anxiety experienced and expressed by members in the early 1990s was, in a sense, a reflection of what was happening throughout South African society at that time.

### **5.1.3 1994 – 2000 The period of transition and more equitable dispensation**

The final period covered in this research saw a radical shift in the environment with the end of the apartheid era and the democratic election of a new government, led by the African National Congress. For health care, and more specifically physiotherapy, three major pressures were strengthened by this transformation: the need for an equitable health care delivery system; the need for transformation in the health care education system; and comprehensive and holistic care based on multidisciplinary and interdisciplinary teamwork.

External events	Actions taken by SASP
Change in government & health care policy with emphasis on PHC	Restructuring of SASP in line with government structures for provinces & districts
Establishment of TRC	SASP makes a submission to TRC
Managed health care in private sector	PPA changes to PhysioFocus & introduces PhysioNetWorks Establishment of ethics committee Accreditation of practices
Recognition of different levels of worker	Investigations for 3-tier training & efforts to establish CBR programme
Rationalisation of state health services	Establishment of National Physiotherapy Forum Meeting with Minister of Health
Statutory committee investigates health education	Formation of Education Board with full time Director
Termination of SAMDC and start of Health Professions Council of South Africa	Physiotherapists lobby with Association Biokineticians and Chiropractors to form a Professional Board

**Table 4 The main events taking place in the external environment and the strategic actions adopted by the SASP 1995-2000**

At the SASP council meeting two weeks after the ANC had been elected to power, the Chairman noted:

*The fact that we are meeting here this week amidst the uncertainties is an act of faith in the future, it demonstrates our willingness and courage to meet circumstances and to adapt to them. Never before has council met at such an auspicious time, we hope to start anew the business of practicing our profession to the benefit of our patients and ourselves.*

Chairman's report, 1994

The correspondence quoted at the end of the section on the previous period suggests there may have been a crisis of confidence in the profession. Coupled, with the anxiety over the uncertainty around the institutional environment, this lack of confidence placed considerable pressure on the SASP. The ad hoc committee restructuring the SASP and the Future health care committee in late 1994, spent time developing different possible future health care scenarios but *'what we do not know is the place of physiotherapy in the different scenarios'*. The dilemma between the self-interest of the profession and the interests of the country produced a tension making it difficult for the profession to unilaterally define its role without being favourable to itself. The Restructuring committee's main recommendations included, firstly, that the SASP be reconstituted along the same geographical boundaries as the new provinces, with nine branches that could be subdivided into sub-branches. This new structure would lead to the incorporation into the SASP of physiotherapists who had previously been employed in the independent homelands. The second recommendation was that some of the nomenclature used by the SASP be changed. Thirdly, an Education Board be constituted with strong representation from all special interest groups and universities, and which would be run by a full-time salaried Director. However the real change lay in the fact that the SASP was now decentralised in terms of real power within the society. Branches, groups and special interest groups could make wide ranging decisions without getting permission from the council. The all-powerful national executive committee and over-cumbersome council were dismantled and replaced by a small management committee and smaller National Assembly with just one representative from each branch, group, special interest group and standing committees. These recommendations were all accepted in 1995 and implemented in 1996.

Three issues characterised 1995 for the physiotherapy profession : intense debates round the role of the State in the health care sector, unification of the fragmented health service into an integrated national health system and the implementation of primary health care; managed health care in the private sector; and legislation that made provision for the establishment of interim councils for nurses, chiropractors, homeopaths, allied health professionals and doctors and dentists that replaced the old councils of the SAMDC. The future success of the SASP lay in understanding these driving forces in the health care environment. The aim was now on equity and social upliftment, interdisciplinary teamwork, with the need to appreciate the distinct qualities of the various professions, and on the establishment of a health service that was cost effective and market responsive. In addition, health care professionals were expected to be accountable for the outcomes of their practice and of their use of resources.

As a start, the Public Relations Division of the SASP (previously known as Activations, Action committee) held a weekend workshop to plan a strategy for

the SASP which would be aimed internally at members and externally at the general public and the government. The critical issues revolved round *'the members working together and acknowledging themselves and one another as critical components of a strong unified whole and secondly to gain government and public support by proactively becoming visibly involved in community projects rather than their own self interest'* (Forum January, 1995:4-5). The proposed strategy involved three events that were already on the physiotherapy calendar, namely Back week, the Comrades and Two Oceans marathons. The marathons are being highly visible and much publicised international events. These three events involved very many physiotherapists including students, and engaged the public in a very tangible and effective way. They provided an opportunity to maintain an unambiguous public profile that presented the unique purpose and value of the physiotherapy profession (Richardson, 1999). The strategy was to exploit these opportunities with a concentration of resources directed at improving the marketing and promotion of physiotherapy as a highly professional service dedicated to promoting good health to the public. This strategic plan has been highly successful for the profession, and many other similarly successful ventures have flowed from it.

The trend amongst physiotherapists to work independently supplying a highly skilled specialised service product, made it very difficult for these members of the profession to understand how primary health care and comprehensive care was going to work (Bowerbank, 1994). Furthermore this trend strongly influenced the curricular development for undergraduate training, which tended to concentrate on a preponderance of manual skills training and strong subject based education.

*'it is my belief we have largely fulfilled all the criteria for full acceptance as a professional but that in order to qualify as an essential relevant service in providing in the new South Africa a service for all that is accessible, affordable and affective we must provide a service that is intrinsically valuable to society. In doing so the heavy emphasis on cure will change to that of care and support, education, teaching self help to patients and teaching care givers will have to be fostered'*. (Forum, June 1994)

The university departments, through their undergraduate and masters programmes, started to implement community based rehabilitation service in the early 1990s. In the course of this period these accelerated until a considerable amount of training was conducted in community settings. By the end of the century newly graduating physiotherapists were far more able to implement primary health care programmes than their more senior colleagues who had never moved away from acute curative treatments *'..physiotherapists show an inability to render services within a context of Community-based Rehabilitation. Community posts have been created but very few physiotherapists have applied*

*because they do not feel confident doing community work'* (Chairman's report, 1998). The newly formed Education Board of SASP made strenuous efforts to bring the university departments together to reach consensus on a new more relevant curriculum, but by 1997/8 this proved impossible. This was due, in part, to the autonomous nature of the universities and the fact that the lecturers felt greater allegiance to their faculties than to the greater good of the profession. The Co-ordinator of the Education Board delivered a scathing response *'we cannot avoid the issues of access, redress of inequalities and transformation of physiotherapy education. We need to deconstruct old prejudices, attitudes and systems in the existing structures and physiotherapy education. The model of transformation should not be the one that attempts to preserve its own stakes and attempts to preserve its own interests'* (Forum, December 1997:14-15). This situation was unfortunate as the universities have considerable resources in terms of skills, space, knowledge and research skills, and furthermore they bestow the fundamental skills, norms, beliefs and ethical behaviour expected by the physiotherapy profession to its under graduate students. It was only after the TRC hearings and the publication of its report, that tertiary education made real attempts at transformation.

Following the encouragement in 1997 from Van Speyk, (a physiotherapist working for the Trauma Centre for Survivors of Political Violence and Torture) for the SASP to make a written submission to the TRC, a group from the SASP met to take the process forward. Their aims were: *To be part of an historical process which is occurring in our country; to claim our place within the health sector; to stand back and critically review what we do, what we did not do, and what we should be doing in terms of health care rights, human rights, and violations or abuses; to be proactive and market our profession* (Forum, August 1997:12). A very thorough and comprehensive report on physiotherapy's sins of omission and commission, and the times when the profession acted well or even nobly, was prepared and submitted to the TRC in 1998 (Appendix 21).

*'There is some discrimination against the profession because it is predominantly female, also the male administrative officials at the Professional Board imposed their ideas on the Board and were not prepared to submit to differences of opinion – this needs to be referred to the gender commission. The TRC believed the profession should be trying to bridge the gap between white and black physiotherapists, it was felt the profession was still very divided. The majority of older black physiotherapists still do not ever intend to join the SASP. They still hold a grudge. What would heal the wounds of these physiotherapists? Most black physiotherapists would like to study further and they need support to be able to do this.'* (Chairman's report, 1998)

Copies of the TRC physiotherapy report were sent to all registered physiotherapists in South Africa, to the Minister of Health, all universities with

Health Care faculties, and to all members of the World Confederation of Physiotherapy (WCPT). The WCPT made a substantial grant towards the financing of this venture. The report included a process of actions to ensure that the profession never found itself in a situation like this again (Appendix 7).

The recommendations of the Health Sciences Working Group (HSWG)(discussed in chapter2) and the TRC regarding changes in the curriculum for health professionals, forced major changes regarding what was taught and how it was taught in all the health sciences faculties.. The Education Board held a series of workshops in 1999 including *'a mixed bunch of interested parties to address issues relating to physiotherapy education. The need to redesign the undergraduate curriculum is imperative to ensure that physiotherapy address the issues of equity and redress but also adapt to new government directives and strategies.'* (Forum, September 1999). As a result of these discussions the Education Board recommended that a framework be developed which allowed for multiple entry and exit levels of practice, essentially in accordance with the HSWG's guidelines.

Meanwhile the private sector had to re-organise itself round the fact that managed health care was slowly replacing the fee for service, medical aid schemes. In 1998 the PPA changed its name to PhysioFocus as it was felt that the name of the association should contain some reference to the profession, and that this would be helpful to the public. In a move which had far reaching implications for private physiotherapy a new body was formed to guarantee the security and autonomy of physiotherapy in private practice. PhysioFocus instituted a national network of physiotherapists who were willing to negotiate and form agreements with different stake-holders in the South African health care environment. The network, which is known as PhysioNet-Works, provides a useful database for the managed health companies and is the business arm of the PPA (Appendix 20). Once PhysioNet-Works was established, negotiations with insurance companies were undertaken and it was agreed to standardise treatments . PhysioFocus established a practice accreditation process, based on that of the Australian Physiotherapy Association, including clinical guidelines for practice and standards of practice. The ethics committee, established in 1996 as a standing committee of the SASP National Assembly, is concerned with the ethos of standards of practice. The initial role was to be responsible for investigating problems of standards of practice, ethical behaviour, and inappropriate tariffs billed to patients. In 1999 the committee changed to a peer review committee *'where one is judged competent or not by one's equals – it involves frank discussion between peers without fear of criticism of the quality of care provided or ethical behaviour displayed as judged against agreed standards'* (Forum, September1999:10-12)

The PPA had been concerned about professional ethics and behaviour for a number of years, and once the right to independent practice became law, this

became a serious issue: Professional ethics concerns our relationship towards our patients, colleagues, and community and relates to our rights and responsibilities as citizens. As we move towards independent practice we need to accept even greater responsibility for maintaining the highest standard of professional competence and ensuring personal integrity of all our members. ( PPA report to Council, 1989)

Forum published two lengthy articles (September, 1999, 2000) to ensure that all its members were well acquainted with the Ethical principles of the SASP and the guidelines for making professional services known as laid down by the Professional Board for Physiotherapy. Following the directive from the TRC, all health professionals must receive a course on health ethics and patient rights in order to prevent any future violation of human rights in health care. Molatoli (1999) made recommendations for implementing such a course for physiotherapists.

Ironically, the shift in health care perspective away from tertiary, curative care towards community and primary health care, seriously affected the physiotherapists working in the public sector during this period. With severe financial cuts to hospital services and most particularly to the teaching hospitals, the number of posts available to physiotherapists working in this sector was greatly reduced. The employees in the state sector, used to a traditional bureaucratic environment, struggled to come to terms with the new backdrop of a fluid, ever-changing health care environment. Constantly beset by pressures to implement community rehabilitation, the vacillation of the Department of Health regarding a decision on whether it would or would not recognise physiotherapy assistants and community based rehabilitation, the lack of recognition of physiotherapy services and the problems related to the Health department's definition of disability, resulted in the statement that *'the morale amongst staff is at a very low ebb'* (Forum, June 2000:11).

The greatly reduced number of posts posed a crisis for the large group of new graduates who had a taken-for-granted attitude that they would be entering the labour market through the large teaching hospitals. This led the president of the SASP to comment *'we are entering a competitive era, students must be proactive and not wait for jobs to fall into their laps. They must source, discuss and plan their professional careers'* (Forum, July 1999L:3-4).

Three members of the profession requested and received an invitation to meet with the Minister of Health to discuss the crisis (Forum, July 1998), and subsequently had another meeting with the Department of Health. Both meetings were described as *'fairly productive'*, but *'one got the feeling that the Department was not very interested in the issues raised'* (Forum, January 1999:9).

This group of physiotherapists, bogged down in their state of isomorphism, struggled to come to terms with new environment, always resorting to the old

tried and tested strategies of writing a memorandum and going to talk to the powers that control their resources - with little success. In an effort to support the physiotherapists in public service the SASP initiated, in 1999, an annual gathering known as the National Physiotherapy Forum with the aim of allowing physiotherapists to network with each other in order to develop strategies for survival in the public sector, and to take responsibility for their own identity and future.

One of the major factors that has contributed to the legitimacy of the SASP has been the way in which it has managed its international relationships. Three significant occurrences have contributed to this. Firstly, the regionalisation of WCPT in 1991 resulted in Africa becoming an autonomous regional committee. The intention was to facilitate opportunities for more frequent contact among members in close geographical areas with similar cultural, economic and social outlooks. South Africa has held the position of Chairperson for two terms of office, and in 1998 hosted the WCPT Africa Regional Congress. South Africa has been able to provide a considerable amount of scientific knowledge to WCPT Africa but at the same time has been able to learn much from other African countries especially in the field of health promotion. Secondly, in 1997 the SASP, under the Western Province branch, held an International congress in Cape Town that was followed by a meeting of the International Private Physiotherapists Association also in Cape Town. Thirdly, the greatest achievement of all was to win the bid to host the very prestigious International Federation of Manipulative Therapists congress in Cape Town in 2004.

In 1999 legislation was passed for the establishment of a single health council – the Health Professions Council of South Africa (HPCSA) - made up of a smaller number of Boards than its predecessor, the SAMDC. The Boards consisted of several professions working together, and after some lobbying the Physiotherapists were joined by the Podiatrists and Biokineticians. Another interesting development was the passing of the rule allowing collaboration and referral between practitioners registered with the HPCSA and those registered with the Council for Chiropractic, Homeopathy and Associated Professionals. Previously forbidden, this also allowed practitioners to hold dual registration with both Boards. Of necessity, physiotherapists are now making partnerships with professionals they previously considered their competitors.

In contrast to its disapproving relationship with the SASP in the 1980s, the Danish Physiotherapy Association made funds available in 1999 to enable three of their members to use their expertise to facilitate a workshop for the SASP on strategies and objectives. Participants were nominated by their provinces and were not necessarily members of the SASP. During the workshop, several issues of concern were described by the participants and tasks teams were nominated to seek ways to address these. From the work of these task teams evolved the

'realities' facing the physiotherapy profession at the time (Forum, September 2000). These were listed in a random fashion, some realities existing in the external environment as opportunities or threats and others related to possible strategies or solutions. Whilst addressing the SASP at the start of an Assembly meeting in 2000, the researcher presented the realities into Threats/Opportunities and Strategies/Solutions shown in the table below (Table 5).

The threats/opportunities, grouped into supplier, competition and consumer, are not areas of the institutional environment that the SASP has traditionally targeted with strategies, neither are the strategies/solutions familiar actions taken by the profession. The end of the research period appears to see the physiotherapy profession in a quandary and uncertain state. The issues relating to evidence-based practice where treatment procedures must be supported by sustainable and convincing rationale, highlights the paucity of hard research evidence for many commonly used physiotherapy approaches.

THREATS/OPPORTUNITIES		STRATEGIES/SOLUTIONS
Reorientation of the Public sector resources and funding to PHC	supplier	Re-orientation of rehabilitation services to communities & inter disciplinary groups
Increased public/private co-operation		
Integration of health services	competition	Multi-disciplinary co-operation
Alternative health care professionals in health care arena		
Increased competition from other allied health professions		
Changing patient profiles & referral patterns	consumer	Contracts between physiotherapists & provider groups and funders
Increase in consumerism		
Increased litigation		
Increased challenge to ethical parameters		
		Alliances and joint ventures
		Clinical guidelines & evidence based data
		Licensing & accreditation of practices
		Technology for data capture & information

**Table 5 The realities facing the SASP in 2000. (Bowerbank, 2001:8)**

The need to work in multidisciplinary and interdisciplinary teams is a very different form of practice from that experienced by the majority of physiotherapists who currently enjoy a high degree of autonomy and

independence. The realities will test the physiotherapy profession's ability to seek out opportunities and raise the profile of their practice in new ways.

The far-reaching organisational changes apparent in this last period were ambitious in scale and politically-led. As far as health care restructuring is concerned, all health care is organisationally unified under the Department of Health, the central controlling body that has the mandate to formulate, execute and control a binding health policy at national level. Health care is recognised as a basic human right and much of the change affecting the public sector is based on models of primary health care. However, to date, a pluralistic system still applies to health care in South Africa – a public sector and a private sector remain, even though they operate differently from in previous periods. The critical evolution taking place in the physiotherapy profession during the period 1994 - 2000 saw members once more attempting to consolidate the position of their profession. The institutional environment imposed critical demands on health care organisations, requiring them to reassess both their external legitimacy and their historically unique positions in their domain. Physiotherapists were pressurised into: (1) contemplating their position during the apartheid era, thereby acknowledging their wrongs and becoming more sensitive to ethical issues; (2) accepting the radical transformation of the education system from an elitist perspective to a more encompassing position; (3) working through complex problems and finding solutions in order to survive in the private sector; (4) utilizing marketing processes to advertise some of the unique qualities of physiotherapy; (5) accepting loss of ground in terms of both resources and status in the public sector due to restructuring.

## **5.2 ESTABLISHING LINKAGES WITH OTHER ORGANISATIONS**

The purpose of this section is to trace the physiotherapy profession's linkages to the government and legitimated community, professional and public institutions and to establish the reasons and under what condition these linkages were made. An institutional linkage is defined here as a direct and regularised relationship between an organisation and an institution in the organisation's environment (Baum and Oliver, 1991). Institutions are defined as government, professional or community constituents in the organisation's task environment possessing either community or uncontested social acceptance or legislative and administrative authority in the physiotherapy organisation's domain. Hannan and Freeman (1984) contend that selection forces in contemporary populations favour reliable, accountable organisations and establishing collaborative linkages to legitimate community and public institutions may be an important means by which organisations achieve reliability and accountability and improve their survival prospects.

Based on Oliver's (1990) research paper, four critical contingencies of relationship formation are proposed as generalisable determinants of interorganisational relationships across the physiotherapy organisation's settings and linkages: necessity, asymmetry, reciprocity and legitimacy. These contingencies explain the reasons why the organisation chose to enter into relationships with another organisation or Institution.

**Necessity:**

The organisation establishes linkages with other organisations in order to meet legal or regulatory requirements. Mandates from higher authorities may provide the impetus that otherwise might not have been felt. This might be mandated or voluntary (the organisation makes the decision).

**Asymmetry:**

This contingency suggests a power approach is the motivating factor, one organisation exercising control or influence over the other as resource scarcity prompts the relationship. Loss of decision making, latitude, autonomy and discretion can follow.

**Reciprocity:**

Motives of reciprocity emphasise co-operation, collaboration and co-ordination amongst organisations for the purpose of pursuing common or mutually beneficial goals or interests. Scarce resources may induce co-operation rather than competition.

**Legitimacy:**

Legitimacy is one of the most significant motives for the organisation to interconnect. Institutional theory suggests that the institutional environment impose pressures on organisations to justify their activities in order to improve their reputation, image, prestige or achieve congruence with prevailing norms.

Many relationships are based on a combination of contingencies in order to fulfil organisations expectations and requirements e.g. power and legitimacy.

The research is divided into the four periods described earlier in this chapter and each organisational relationship is investigated against the above contingencies. Only relationships sanctioned by the SASP Council or Assembly and listed in the Council or Assembly minutes are investigated.

### **5.2.1 RESULTS**

The results are shown in Tables 6,7, 8, 9.

1971-1975	Type of	Necessity	Asymmetry	Reciprocal	Legitimacy
National Council Care of Cripples	community	X	Influence sources of knowledge	project collaboration	demonstrate norms of co-operation
SA Paraplegic games Assn	community	x	facilitate exchange expertise	collaboration & support	demonstrate norms of co-operation
Sa National Council for Aged	community	X	facilitate exchange of expertise	collaboration & network	demonstrate norms of co-operation
SAMDC	government	mandatory legal requirement	lobby state regulators	obtain professional advantage	enhance image of profession
WCPT	professional affiliation	voluntary requirement	influence sources of power	facilitate exchange & information	increase professions acceptance & status
Dept of Health	government	voluntary requirement	influence source of funds	co-operation service provision	enhance professional image and status
Provincial Directors of health	government	voluntary requirement	influence source of funds and service provision	co-operation service provision	enhance professional image and status
Public Service commission	government	voluntary requirement	influence source of funds and personnel	information	status
National council of Women	community	X	increase market power	promote collective good & network	community visibility
SA Federation of professional & Business women	community	X	increase market power	promote collective good & network	community visibility
Professional Board for Physiotherapy	government	mandatory legal requirement	increase market power & entry barriers	obtain synergies on knowledge & technology	enhance image & status
Depts Bantu, Coloured & Indian Affairs	government	voluntary requirement	government policies	information	project professional beliefs & values
SA Medical Assn	professional affiliation	X	augment power relative state regulators	facilitate exchange clients & knowledge	increase professions acceptance & prestige
SA National Council for health Education	community	X	increase market power	information and technology	community visibility
Co-ordinating council for medical Aid Schemes	financial	voluntary requirement	exert control over access to finance	share knowledge & information	project image of financial viability

**Table 6 The linkages and critical contingencies of relationship formation by the SASP 1971 to 1975**

1976 - 1985	Type of linkage	Necessity	Asymmetry	Reciprocity	Legitimacy
National Council care of Cripples	community	x	influence source of knowledge & research funds	project collaboration	demonstrate norms of co-operation
National Council for Women in SA	community	x	increase market power	information & network	community visibility
SA Fed of Business & professional women	community	x	increase market power	information & network	community visibility
SA National Council for Aged	community	x	facilitate exchange of expertise	collaboration & support	demonstrate norms of co-operation
SA sports Assn for physically disabled	community	x	facilitate exchange of expertise	collaboration & support	community visibility
SAMDC	government	mandatory requirement	legal lobby state regulators	obtain professional advantage	enhance image of profession
Professional Board for Physiotherapy	government	mandatory requirement	legal increase market power & entry barriers	obtain synergies on knowledge & technology	enhance professional image of profession
Universities	community/ prof alliance	voluntary requirement	influence technical, knowledge and research base	exchange knowledge, share risks entering new programmes	demonstrate norms of co-operation
Dept of Health	government	voluntary requirement	influence source of national policy	co-operation provision	service enhance professional image and status
Provincial Health	government	voluntary requirement	influence source of funds and service provision	co-operation provision	service enhance professional image and status
Public Service Commission	government	voluntary requirement	influence source of funds and personnel	information	status
Remuneration Commission	financial/ government	mandatory	exert control over access to financial resources	balance bargaining position	project image of financial viability
RAMS	financial	voluntary requirement	co-opt financial constituents	information	project image of financial viability
SA Neuro Development Assn	professional alliance	x	increase market power	coordinate network affiliates	increase members community visibility
SA Nursing Council	professional alliance	x	exert control over access to resources	reduce cost of service delivery	demonstrate norms of co-operation
SA Gerontological Assn	professional alliance	x	x	share knowledge and information	collegial
WCPT	professional alliance	voluntary requirement	exert influence over policy	share knowledge and information	increase professions acceptance and status

**Table 7 The linkages and critical contingencies of relationship formation made by the SASP 1976 to 1985**

1986 - 1994	Type of linkage	Necessity	Asymmetry	Reciprocity	Legitimacy
WCPT	professional affiliation	voluntary requirement	reduce political uncertainty	facilitate exchange of information and knowledge	increase professions acceptance and status
National Council physically disabled in SA	community	x	influence source of knowledge & research funds	project collaboration	demonstrate norms of co-operation
National Council for women in SA	community	x	increase market power & influence	information & network	community visibility
SA Council for Aged	community	x	facilitate exchange of expertise	collaboration and support	demonstrate norms of co-operation
SA Gerontological Assn	professional affiliation	x	x	share knowledge and information	collegial
SA National Council for Health Education	community	x	increase market power and influence	share knowledge and information	community visibility, status
SAMDC	government	mandatory legal requirement	exert control over access to regulatory processes	obtain professional advantage	enhance image of profession
Professional Board for Physiotherapy	government	mandatory legal requirement	increase market power and entry barriers	obtain synergy on knowledge & technology	enhance professional image and status
Universities	Community/pro alliance	voluntary requirement	influence professional knowledge, research base	exchange knowledge, share research base	demonstrate norms of co-operation
Dept of Health	government	voluntary requirement	influence source of national policy	co-operation professional policy	demonstrate norms of co-operation
Provincial Health Authorities	government	voluntary requirement	influence source of funds and service delivery	co-operation service delivery	enhance professional image and status
Commission for Administration	government	voluntary requirement	influence source of funding for personnel	information	status
RAMS	financial	voluntary requirement	exert control over access to financial resources	balance bargaining position	project image of financial
SA Sports Assn for Physically Disabled	community	x	facilitate exchange of expertise	collaboration and support	community visibility
SA Gym Owners Federation	community	x	increase market power	obtain synergies in technology and	community visibility
CHASA	community/prof affiliation	x	increase collective power in policy making	collaboration & support	demonstrate norms of co-operation & community visi
SA Sports Medicine Assn	professional affiliation	x	influence source of knowledge and research funds	project collaboration	demonstrate norms of co-operation
Veterinary Council	professional affiliation	x	influence access to resources	collaboration	project image of profession status

**Table 8 The linkages and critical contingencies of relationship formed by the SASP 1986 - 1994**

1995-2000	Type of linkage	Necessity	Asymmetry	Reciprocity	Legitimacy
National Council for physically disabled	community	x	influence source of knowledge & policy making	project collaboration	demonstrate norms of co-operation
SA National Council for the Aged	community	x	facilitate exchange of expertise & policy making	information and project collaboration	demonstrate norms of co-operation
National Council for women in SA	community	x	increase influence and market power	information & network	community visibility/ professional values
SA Gerontological Assn	professional affiliation	x	lobby for support	share knowledge & information	collegial
SA National Council for Health Education	community	x	increase market share and influence	share knowledge and information	community visibility and status
SA Neuro Development Assn	professional affiliation	x	increase market share	share knowledge and information	collegial
SA sports Assn for physically disabled	community	x	facilitate exchange of expertise and policy making	collaboration and support	community visibility
WCPT	professional affiliation	voluntary requirement	Augment collective power	obtain synergies in knowledge and technology	enhance profile of profession internationally
WCPT-Africa	professional affiliation	voluntary requirement	Augment collective power	share knowledge and information	community visibility
SAMDC - IMDC - SAHPC	government	mandatory requirement	legal exert influence over control of resources	share risks in mounting new programmes	enhance profile in industry
Prof Board for Physio., Podiatry & Biokinetics	government	mandatory requirement	legal increase collective power	co-ordinate network	increase members visibility
SASMA	professional affiliation	x	influence source of knowledge and research funds	project collaboration	demonstrate norms of co-operation
Department of Health	government	voluntary requirement	influence source of national policy	co-operation professional policy	promote image of co-operation
Universities	community prof affiliation	voluntary requirement	facilitate transformation of education	co-operation and support	enhance profile in education
Liaison Forum for Health Professionals	government	voluntary requirement	increase collective power for resources	reduce costs of service	increase acceptance and co-operation
Truth & Reconciliation Commission	government	x	x	share in national history making	increase acceptance
Health Insurance Companies	financial	voluntary requirement	exert control over sources of funding	share risks of new programmes	enhance profile in industry

**Table 9** The linkages and critical contingencies of relationship formation by the SASP 1995 to 2000

Two institutional linkages, with the potential to confer legitimacy and resource benefits on the physiotherapy profession, are those of the National Council for Care of Cripples (NCCC) (for the Physically Disabled) and the South African Sports Medicine Association (SASMA). Both these associations are multidisciplinary but in reality were, in their early days, dominated by powerful and charismatic medical doctors. Both have altruistic aims, the NCCC is run by orthopaedic surgeons with an interest in disability especially amongst children, whilst SASMA is interested in research related to elite sports-persons. In the 1970s and early 1980s the NCCC was a very powerful organisation with strong community ties especially in terms of fund raising. In more recent times their popularity appears to have waned. Although well represented on NCCC the physiotherapy organisation did not fare very well with this relationship. During the 1970s the orthopaedic fraternity opposed physiotherapists becoming skilled in Maitland mobilising and manipulative techniques and, in the early 1980s formally objected to the concept of first line practitioner status for physiotherapists. Physiotherapists preferred to place their energies elsewhere, constructing their own autonomous structures such as the Orthopaedic manual Therapy group (OMT group) rather than struggle in what appeared to be an autocratic and paternalistic organisation. However sharing did take place especially amongst some of the physiotherapists and orthopaedic surgeons with an interest in children suffering from cerebral palsy.

Initially the relationship with SASMA, which began in 1990, was also difficult due to the dominance of the medical profession but perseverance from the physiotherapy and biokinetic professions allowed firm relationships to be formed. This relationship led to the very strong presence of physiotherapists with sports teams at national and local levels. Physiotherapists later went on to form their own sports physiotherapy group, in part to be able to make recommendations to national sports teams and Olympic selection committees about the suitability of candidates to tour with international teams. Maintaining relationships with this association has conferred considerable legitimacy on the profession, and has made accessible the very valuable resource high quality research. Physiotherapists have collaborated with members of SASMA on major research projects, including masters and PhD studies and presentations at international research congresses, generating a strong profile of expertise.

The SASP's relationship with WCPT has been somewhat ambiguous. On the one hand it was a founder member of WCPT in 1952, and sat on the Executive committee for several years, a position it held at the beginning of this research. On the other hand, towards the end of the 1970s, the interorganisational relationship between the SASP and the South African government, and the SASP and the SAMDC were evaluated by members of WCPT and perceived not to conform to WCPT's expectation of societal and professional norms. So with the threat of expulsion, the initial positive, reciprocal relationship of the SASP with

WCPT, was to change rapidly to one of defence and justification - a very asymmetric position to be in. Following the change in government in 1994 and SASP's submission to the TRC, the relationship was to change again, and an SASP member was admitted back onto the WCPT executive committee as a representative for WCPT-Africa. The linkage is essential, physiotherapy could not survive internationally as an acceptable profession without membership of WCPT.

The ability of an institutional linkage to improve an organisation's life chances will depend significantly on whether the linkage is perceived as legitimate or consistent with the normative expectations of the organisation's social environment (Baum and Oliver, 1990). The SASP consistently maintained a relationship with the various government health departments or agencies throughout the research period. Attempting to firstly, advance a profile of physiotherapy practice that was more than consistent with those required by the Department of Health, and secondly, to press the need for adequate resources to maintain such activities. Although the legitimacy of the profession was unquestioned, the quest for improved salary and personnel was not always so successful.

The success of the private practitioners group in requesting for a Tariffs commission in 1980, subsequently negotiating their own tariff of fees and establishing the Physio-Net-Works, enhanced their image and status with the medical aid schemes and insurance companies over the whole period of study. Presumably the public too, perceived them as a legitimate societal institution, since the number of private practitioners doubled from 1983 to 1993 indicating the public's support for their services.

Over the study period the SASP maintained a number of relationships with national professional organisations, with the aim to remain within a network of socially acceptable professional groups and to be visible to the broader community. Many of the relationships included collaboration and support between the two organisations or some form of exchange of expertise as was established with the National Council for the Aged and the South African Paraplegic Association.

A symbiotic relationship exists with the Professional Board for Physiotherapy. The SASP is reliant on the Professional Board to give legal support to its code of practice and scope of practice, while the SASP has to abide by the rules of Professional Board. The growth and development of the profession depends on maintaining this status, knowledge base and scope of practice which together ensure a credibility of competence in professional practice. The relationship between these two organisations is an extremely important one for the SASP.

Finally the linkages with the universities departments of physiotherapy contain elements of all the linkages - essential, government funded, professionally affiliated and community based. Due to the complexity of these linkages the SASP has not always managed to influence the universities in ways that it would wish. The universities are not reliant on the SASP for resources; as autonomous bodies they are able to negotiate with individual physiotherapists, communities, financial organisations and government bodies for resources without the assistance of the SASP. However the universities are reliant on the community, government and physiotherapy profession to bestow legitimacy on the departments so in a sense the relationship is one of reciprocity although this may vary from university to university.

When the National Assembly was formed in 1996 no records were kept of formal linkages with the National Councils and it is unclear whether these were maintained. Once the new structure of the SASP was in place, allowing for a far more open structure, the majority of linkages were made through local branches, special interest groups, academic institutions, NGOs and individuals. Forum magazine records numerous linkages through the local branches and special interest groups, who maintain wide networks with community organisations – sports clubs, old age homes, support groups, schools, fund raising functions and through back week. The Universities maintain very strong relationships with very many community organisations to provide their students with suitable clinical training. Furthermore university departments make joint ventures with foreign aid funders, such as the Kellogg foundation to provide community services and to carry out research into community needs. These community linkages give legitimacy and status to the physiotherapy profession and at the same time provide a new niche with resources which can be reciprocally shared (Futter, 1996; Taukobong, 1999; Struthers, 2001; Wallner and Stewart, 1994).

### **5.3 CAUSAL MAPS**

Sixteen Council and Assembly meetings were held during the research period and eight different physiotherapists held the position of chairman.

The research interest lies in the way in which the chairpersons and members of council of SASP changed their mental models in response to environmental changes. The research investigates the link between changes in mental models and changes in organisational action by analysing the causal assertions made by leaders of the SASP over the 30-year period 1971 to 2000. Defined by Barr et al., (1992:16) as 'an aggregate of interrelated information' mental models consist of concepts and relationships an organisation or individual uses to understand various situations or environments. Thus mental models allow individuals and organisations to make sense of their environment and act within it. However the problem is that mental models can be inaccurate and this may increase as the

environments change. This may appear in two important ways: firstly mental models determine what will be given attention, individuals recall the elements which are most prominent in their mind and give attention to environmental changes which support their mental models. Secondly mental maps direct action, just as mental maps selectively limit information attended to and slant how this information is interpreted, existing mental maps will also limit the range of alternative solutions to the issues that have been identified.

Because of the way the leaders of the SASP direct attention of the membership, they offer an explanation for how the physiotherapy profession deals effectively with a changing environment, how it identifies appropriate responses and thus maintain its position in the South African health care sector. The conceptual scheme shown in figure 4 and discussed in chapter four provides a framework for understanding the chairmen's reports and the decisions made by members at the council and assembly meetings of the SASP:

**Chairmen's reports:** Concepts to be considered are connected by arrows indicating causal and definitional relationships. Statements containing these concepts are analysed by identifying the influence relationships from one of the eleven nodes in the category - external environment and one of the five nodes in the category - the intended strategy. The number of links to each node in a category are totalled. Maps from each period are aggregated and the total links to a node are expressed as a percentage of the total for the category( Appendix 18).

**Decisions or actions to be taken:** The resolutions for action are similarly analysed, however deciding on the relationship between strategy and critical factor is more difficult since this has to be inferred from the motivation accompanying the resolution. The influencing relationship comes from one of the five strategies which is directed towards one of the four critical factors. Links to nodes in each category are aggregated as for chairmen's reports (Appendix 19).

### 5.3.1 RESULTS

Sixteen maps were elicited for each of the chairmen's reports and decisions made. These were combined and collated into the appropriate periods described at the beginning of the chapter. Table 10 contains the combined results of the thirty two maps with connections between the elements expressed as percentages. The complexity of the maps and of the changes that occurred over time cannot be fully reflected in a table format. Important changes have been explained in detail in section 5.1 (tracking the records) however, data relevant to this section is described below.

**Table 10 Summary of the environmental elements, strategies and factors expressed as percentage of each category and characterising the areas of attention at SASP Council meetings 1971-2000**

	1971-1975	1976-1985	1986-1994	1995-2000
<b>CHAIRMAN'S REPORT</b>				
<b>MACRO ENVIRONMENT</b>				
economic	0.12	0.2	0.2	0.15
regulatory	0.22	0.23	0.1	0.15
technologic	0	0	0	0
political	0.1	0.02	0.01	0.28
socio/cultural	0.04	0.02	0.1	0.1
<b>HEALTH CARE INDUSTRY</b>				
technology	0.16	0.04	0	0
growth	0.12	0.02	0.01	0.1
competition	0.04	0.1	0.1	0.2
policy	0	0.1	0.2	0.1
customers	0.22	0.2	0.3	0.29
professional affiliates	0.1	0.15	0.01	0.2
<b>STRATEGY</b>				
marketing & information	0.1	0.1	0.2	0.2
service features	0.4	0.4	0.4	0.2
members network & control	0.2	0.3	0.2	0.4
education/skills/expertise	0.2	0.2	0.25	0.2
international linkages	0.1	0.1	0.01	0.04
<b>DECISIONS</b>				
<b>STRATEGY</b>				
marketing & information	0	0.2	0.12	0.16
service features	0.5	0.4	0.5	0.43
members network & control	0.2	0.2	0.08	0.16
education/skills/expertise	0.2	0.1	0.3	0.25
international linkages	0	0	0	0
<b>CRITICAL FACTORS</b>				
resources	0.1	0.2	0.3	0.16
niche/domain	0.2	0.3	0.3	0.4
legitimacy	0.2	0.5	0.25	0.16
institutional linkages	0.1	0.01	0.15	0.25

Notable results are highlighted in red, they reflect a proportion greater than break-even for the category.

Reading across the chairmen's reports Table 10:

During the first two early periods influences from the external environment were rather evenly spread with the exception of regulatory pressures which made up over 20% of the total for both periods. In the last two periods, regulatory pressures were low. During two early periods the chairmen of the SASP all held prominent positions on the Professional Board and the possibility exists that this directed their attention towards the Board. Whereas, later chairmen did not hold such positions, and the position of the Boards was far less influential and somewhat unstable in the 1990s due to the breakup of the SAMDC in 1995, the formation of the Interim Medical Council in 1996 and the formation of the HPCSA in 1999. What is of importance to note is the lack of attention to the political influences, most particularly in the second period 1976 to 1985 when major political decisions regarding health care were being made. The only mention is the lack of parity of salary scales but no mention is made of the political turmoil that faced the country at this time nor the chaotic situation that was emerging in

the health services. No mention is made to the Biko fiasco. However, in the third period 1986 to 1994 the political situation became the driving force behind the strategies and actions taken effecting service delivery, undergraduate training and the SASP's position within WCPT. The chairman in 1989, made very forceful statements regarding the government's position and the position the SASP intended taking.

In the last period the political situation becomes an overwhelming element and influence on the profession. The situation changed from the previous period, now a new government is in power and the profession has to change its stance to fall in line with the new policies. In contrast to the chairman in 1989 who challenges and defies the old government making strong strategic recommendations, the chairman in 1994 gives the impression of anxiety and uncertainty about the role of the profession and how the needs of the customers will be met. The healthcare environment received little attention except for customers who featured strongly throughout the research period, most particularly in the final period, when the philosophy of primary health care delivery focused more on needs of communities and 'at risk groups'.

Service features dominated the need for strategic action throughout the research time. In the early period the formation of the professional board and the various ethical rules were to influence service features, most particularly affecting those members in private practice (how the service must be delivered) and members control (governing professional behaviour). In the later two periods the strategic focus turned towards the ways and means for the implementation of primary health care and the changes made by the private practitioners towards managed health care.

Education received attention only in the third period and even then the indication is not particularly strong. This is a most significant finding considering the importance of education and the need for research and post graduate training. It might be an indication why the SASP experienced problems maintaining a standing committee for education. The results indicate that chairmen gave the elements of service features and membership control and network more attention throughout the research period than education. Only one educationist held the position of chairman during the research period and that was during the third period when education received some attention.

In the second period, 1976 to 1985, membership network and control also became an important strategy as a result of the special interest groups making a claim for power and attention by producing a range of post graduate courses. The last period, 1994 to 2000 membership network and control strategies, featured strongly following the need to produce the TRC document; and, the policies for ethical principles and practice accreditation required by managed health care companies.

Table 10 shows that the members of council focused their attention on decisions for action that involved service features throughout the research period. In the last two periods education and marketing were also strategies that were strongly enacted. Of interest are the critical factors resulting from these strategies: In the first period **resources acquisition**, in the form of improved salary structure for state employees and a tariff of fees for the private physiotherapists was of considerable significance. In the second period the development of a service structure aimed at **legitimacy** (scope of practice, registerable qualifications and boundaries round the profession). The special interest groups passed a number of resolutions and decisions aimed at occupying a **niche** which would allow them to practice their expertise. The third period saw a further action towards **niche** development, as customers became more knowledgeable about health care promotion and alternative therapies, physiotherapists had to acquire these new skills and expertise to enlarge their niche to accommodate these customer needs. The College for Physiotherapy was a considerable **resource acquisition** in the third period as it was developed to promote specialisation and fellowships in physiotherapy. The final period, in the face of major changes in health care delivery, saw a shift in strategic thinking in the SASP meetings. Strategic decisions revolved round the need to investigate the role of physiotherapy in the two new scenarios of primary health care and managed health care and to plan carefully how this role would be enacted. These roles included undergraduate education, the training of community health care workers and assistant physiotherapy staff, and the necessary linkages that had to be made with other health care workers to support these positions. These strategies were firmly directed towards defining the **new niche** for the profession. Table 11 summarises the most important features of the above discussion

Chairmans report	1971 -1975	1976- 1985	1986-1993	1994-1999
Macro environment	Regulatory	Regulatory	Political	Political
Health care environment	Customers		Customers	Customers
Strategy	Service features	Service features Membership network & control	Service features Education & skills	Membership network & control
<b>Decisions</b>				
Strategy	Service features	Service features	Service features Education & skills	Service features Education & skills
<b>Critical Factor</b>	<b>Resources</b>	<b>Niche Legitimacy</b>	<b>Resources Niche Legitimacy</b>	<b>Niche Institutional linkages</b>

**Table 11 Summary of the most important features of chairman's reports and decisions made by SASP council**

## 5.4 QUESTIONNAIRE SURVEY

Seven hundred and fifty questionnaires (Appendix 14) were sent to a stratified sample of the members of the South African Society of Physiotherapy, representing a 30% sample. Two hundred and forty seven replies were received of which, seven questionnaires were incorrectly filled in and were discarded. Physiotherapists from each of the provinces in South Africa were represented (Table 12 and cohorts graduating during the periods under study were also well represented (Table 13). Two hundred and forty questionnaires were analysed representing a 30% response rate, this was considered to be satisfactory. The structure of the questionnaire forced respondents to think carefully about each item, they had to make a decision about which items are more descriptive than others. This prevented respondents making extreme or fence-sitting choices.

<u>PERIOD</u>	<u>SENT</u>	<u>REPLIES</u>	<u>% RESPONSE</u>
Pre 1974	192	65	0.34
1975 – 1985	244	79	0.32
1986 – 1993	200	53	0.27
1994 - 2000	114	43	0.38

**Table 12 Distribution of cohorts and response rates**

<u>Sent</u>	<u>PROVINCE</u>	<u>Received</u>	<u>% RESPONSE</u>
1	Botswana	1	1.0
244	Gauteng	95	0.39
118	Kwazulu-Natal	30	0.25
31	Mpumalanga	12	0.39
6	Northern Cape	2	0.33
15	Limpopo	6	0.40
18	NW Province	5	0.28
35	Orange Free State	12	0.34
230	Western Cape	74	0.32
52	Eastern Cape	10	0.19
750	<b>TOTAL</b>	247	

**Table 13 Geographical distribution of respondents to the questionnaire survey**

### 5.4.1 RESULTS

Data from each pair of statements was recorded onto Epi info version 5 spreadsheet and Excell spread sheet. The median, stem and leaf plots and frequency is calculated for each statement (Appendix 16). A summary of the most interesting and notable results is shown in Table 14. Statement 31 is *highly characteristic* of the physiotherapy profession. Statements 1,4,13,30,and 43 fall between *quite and highly characteristic* of the profession.

	Statement	Median	Mode
31	The profession is always careful to act within the law	1	1
4	The profession is aware of & believes it should be responsive to community needs	2	1
13	The profession places enormous importance to public relations	2	1
1	There is a widely shared belief that members require technical or scientific knowledge unique to that industry	2	1
30	Members are convinced that the profession possesses skills that are critical for achieving professional goals	6	7
43	The profession realises it is own its own – even if it fails it will not be bailed out by powerful protectors.	6	7

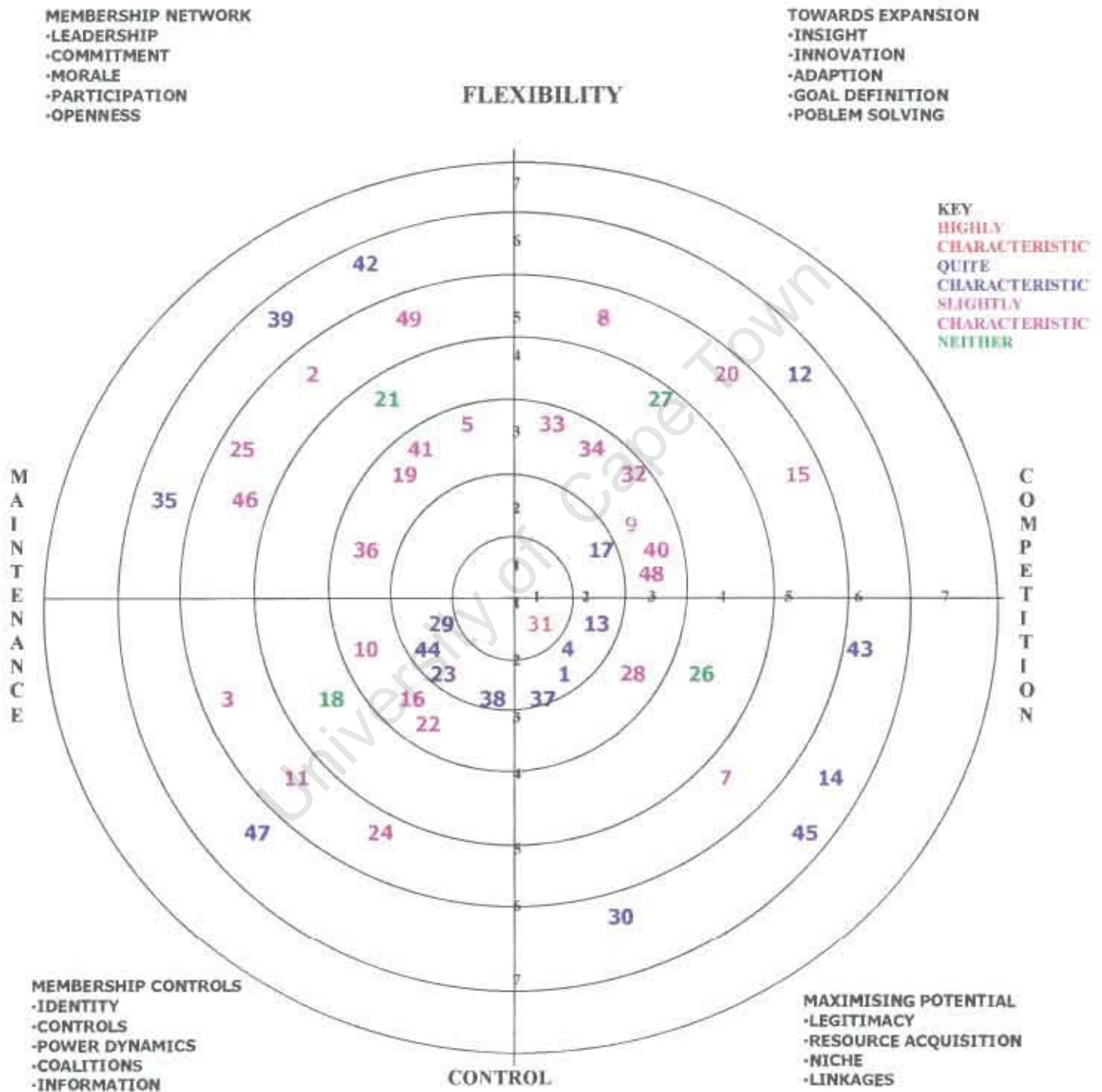
**Table 14** The most interesting and notable results from the questionnaire

All the median values for all the statements were plotted onto the Competing Values model according to their allocated quadrant Figure 8 . Of considerable noteworthiness is the fact that all six of the above statements fall into the quadrant **Maximising Potential**, indicating that respondents consider this is the most important and characteristic area for the SASP. The Maximising Potential quadrant contains the four critical success factors identified by this research to be the most important factors for organisational survival. 50% of respondents believed that the upper statement for question 1, shown in Table 5.14, is highly characteristic of the profession, indicating the importance of knowledge and skills as a resource for the profession.

#### 5.4.1.1 Summary of the results of the questionnaire

The aim of the questionnaire was to measure the respondents perceptions of the South African Society of Physiotherapy and how the Society went about making decisions. The Competing Values model allows the researcher to measure these perceptions.

Figure 8 The results of the Questionnaire as a Competing Values Model



The upper right hand quadrant emphasises flexibility and external focus – expanding the horizon of the profession, the opposite quadrant control and internal focus – setting standards and membership identity. The upper left hand quadrant on internal and flexible focus – establishing membership networks and its opposite, control and external management -maximising potential, the things the profession must achieve. On perusal of the model it can be seen from the top half of the model, results cluster in the 3 and 5 pink bands indicating that these characteristics are only slightly shared by the profession - showing the profession has only a slight commitment towards openness, sharing, participation and innovation. In spite of perceiving the environment to be threatening to its continuing existence the profession has a risk aversion and prefers to adopt a more cautious approach acting in a somewhat passive/reactive way to growth and development. This interesting but not surprising result supports Mintzberg's theory (1979) that work of professional such as physiotherapists is not intended to be creative or innovative, it applies carefully learnt skills to be specific health care problems. They look for confirmation of their reputation through their skills. This is clearly indicted in the lower half of the model showing the results clustered in the 1,2,6, red and blue bands indicating characteristics to be most descriptive of the profession. These describe the profession's particular focus on members needs, and most especially those of the special interest groups (membership control quadrant), this is to be expected since one of the prime objectives of a professional organisation is to support the various coalition groups of its membership. More importantly, are the items shown in the Maximising Potential quadrant, these, according to the respondents most strongly describe the profession (Table 14), including the profession's legitimacy. The items in this quadrant are a combination of characteristics denoting community and social responsibility and professional self interest

These results suggest that the physiotherapy organisation takes a very narrow focus when developing strategies, this has served them well over the research period but it may not be a very effective approach in the future. The profession has been well protected by legislation and regulation with very few competitors encroaching onto the physiotherapy field of practice. This is not the current situation, the environment is far more open and society is more informed and tolerant of a wide selection of holistic health care modalities. If the physiotherapy profession is continue to be successful and compete in the health care environment it may have to change its profile and acquire some of the characteristics show in the top two quadrants.

#### **5.4.2 Comparison between two variables**

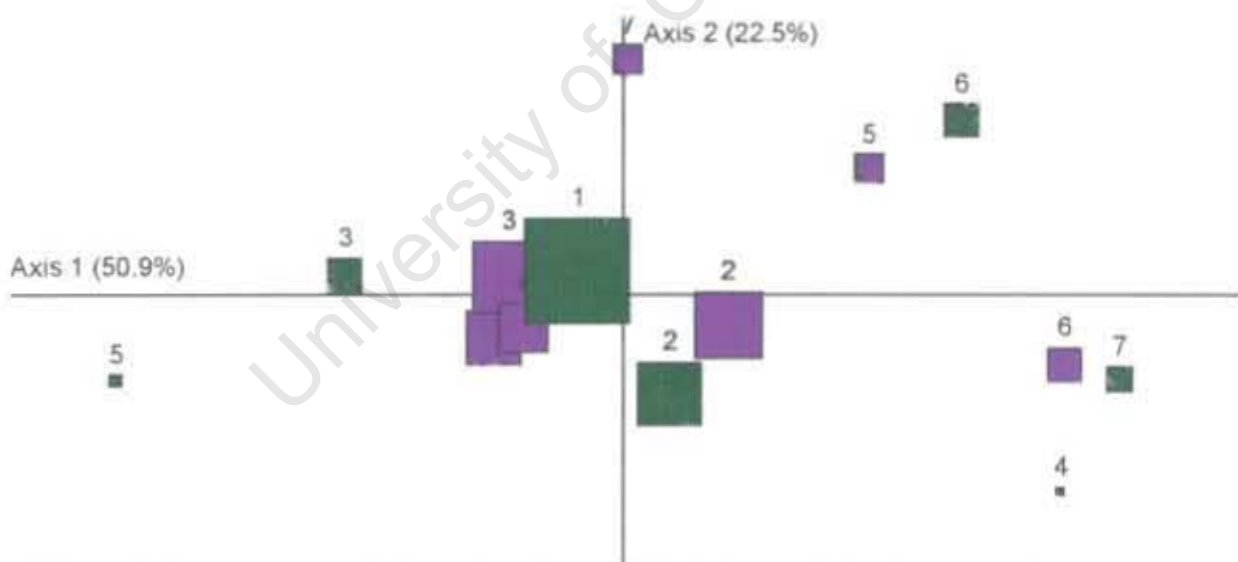
In order to obtain a clearer understanding from the Competing Values model cross tabulations are performed using Sphinx Survey software programme to compare two variables (in this research two

pairs of statements), the results are shown as a factor analysis table, and a factor map.

#### 5.4.2.1 Comparison 1: Legal requirements (Q 28 and Q31)

Question to be asked: The profession is highly institutionalised from both a societal point of view and as a health care professional, do physiotherapists feel restricted by the very strict legal regulations they have to adhere to?

lawful regulation	1	2	3	4	5	6	7	TOTAL
1	23	9	3	0	1	1	1	38
2	33	14	3	1	0	4	3	58
3	40	12	7	0	1	3	2	65
4	24	10	2	0	0	1	0	37
5	9	2	0	0	0	2	1	14
6	6	5	0	0	0	2	2	15
7	9	1	1	0	0	2	0	13
TOTAL	144	53	16	1	2	15	9	240



**Table 15** Factor analysis and factor map of paired statements No 28 and 31

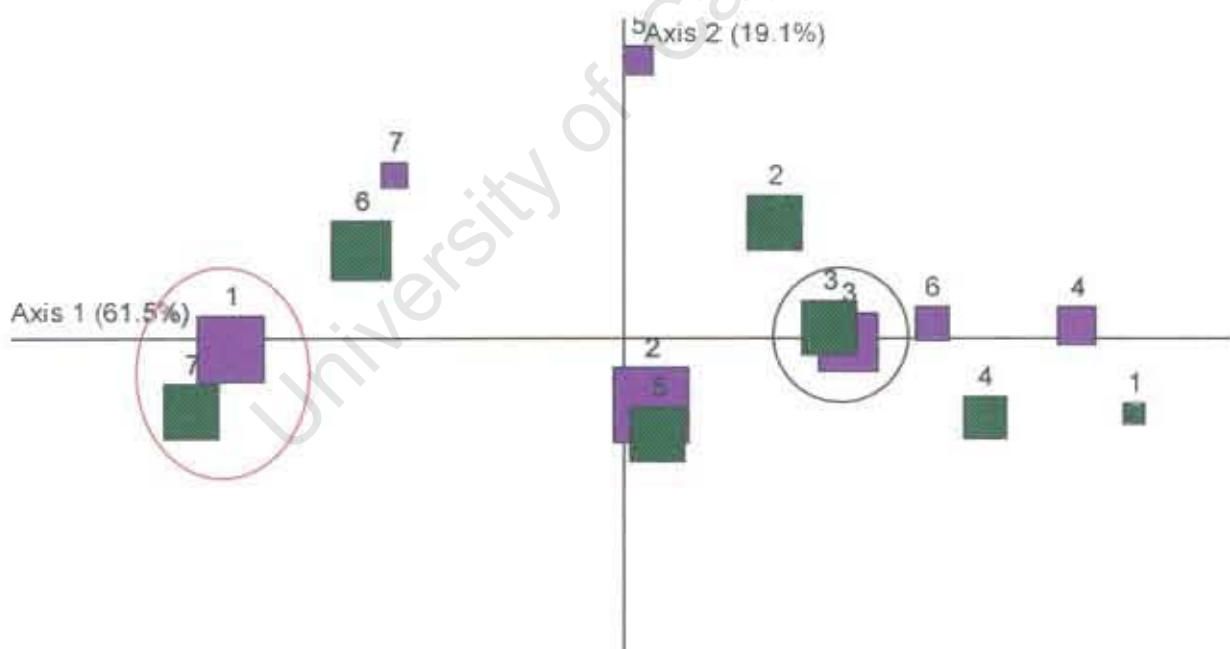
Table 15 shows the position of the two large green squares 1 and 2 reflecting that although physiotherapists are indeed careful to keep to the law the close proximity of purple blocks 1,2,3,4, indicate the profession has limited resource option because of the strong regulatory pressure. In other words, physiotherapists are highly institutionalised, they must stay within the limits of their scope of practice, they must abide by the rules of practice management and

their strategies have to comply to government ruling in terms of resource procurement.

#### 5.4.2.2 Comparison 2: Coping with the environment (Q17 & Q20)

Question: Results from the questionnaire show that respondents perceives a serious threat to its continued existence as being quite characteristic of the profession, but is the profession under stress or can it cope?

coping environment	1	2	3	4	5	6	7	TOTAL
1	0	6	4	3	10	19	19	61
2	2	11	17	7	15	7	15	74
3	3	8	10	5	10	7	2	45
4	1	5	4	6	2	2	0	20
5	0	5	4	0	0	4	1	14
6	1	4	3	2	4	2	0	16
7	0	3	1	0	1	3	2	10
<b>TOTAL</b>	<b>7</b>	<b>42</b>	<b>43</b>	<b>23</b>	<b>42</b>	<b>44</b>	<b>39</b>	<b>240</b>



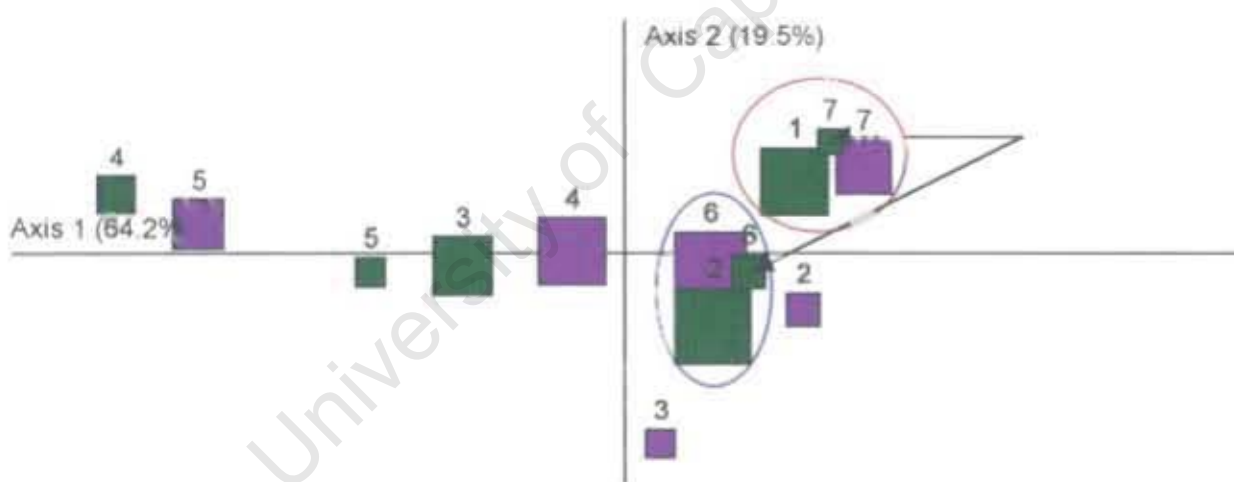
**Table 16 Factor analysis and factor map of Statements 17 and 20**

Factor analysis Table 16 shows an interesting result, although many view the environment as very threatening towards the profession and many are under considerable stress because of this (columns 1/6,7, red circle), there are some who think the threat is only slightly characteristic and that the profession may cope (3/3, black circle).

### 5.4.2.3 Comparison 3 Strategic Approach (Q15 and Q17)

Highly institutionalised professions perceiving the environment to be threatening and under stress are likely to be cautious whilst developing strategies and action plans (Kanter et al.,1992). Are physiotherapists prepared to take risks or do they take a more cautious approach?

environment strategy	1	2	3	4	5	6	7	TO TA
1	2	2	1	0	1	1	0	7
2	3	6	1	0	1	3	1	15
3	1	9	3	0	1	0	0	14
4	16	19	11	8	3	4	1	62
5	3	5	12	10	5	1	1	37
6	17	22	13	2	2	5	3	64
7	19	11	4	0	1	2	4	41
TOTAL	61	74	45	20	14	16	10	240



**Table 17 Factor analysis and factor map for statements 15 and 17**

The factor map Table 17. The environment is perceived to be very threatening and a very cautious approach is being taken (red circle and blue circle). Interesting a small group of respondents who perceive the environment to be placid also believe a cautious approach is being under taken (green 7/6 indicated by arrow).

#### 5.4.2.4 Comparison4: Response to community needs (Q4 & Q27)

Table 17 Respondents affirm very positively that the profession believes it should be responsive to community needs Statement 4. This assumption is supported by the fact that a number of resolutions in the 1990s were directed at investigating how the profession could shift its focus from curative treatments to more community orientated projects. However, as the SASP president noted in 1999 physiotherapists would not take up community posts as they felt insecure working in the community.

Question: How attuned are members to their communities and the major changes taking place which involve developing community health projects?

changes community	1	2	3	4	5	6	7	TO TA
1	13	31	14	5	5	10	5	83
2	4	21	11	5	17	11	6	75
3	1	5	5	3	2	8	6	30
4	0	0	2	3	2	1	2	10
5	0	2	3	0	6	4	1	16
6	2	3	1	1	1	7	3	18
7	0	0	0	0	1	1	6	8
TOTAL	20	62	36	17	34	42	29	240

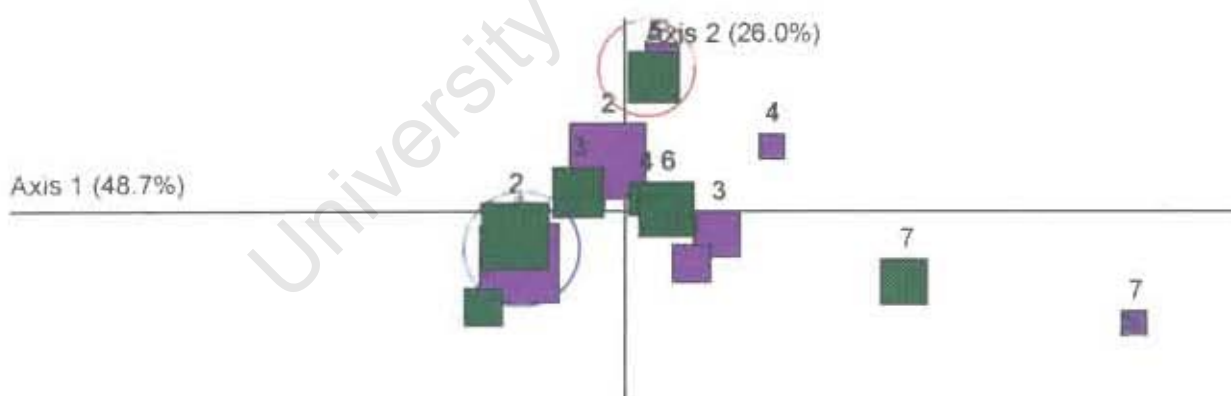


Table 18 Factor analysis and factor map Statements 4 and 27

Table 18 shows that it is clear that the majority of respondents perceive the profession to be responsive to community needs (Blue circle), however a small group (circled in red) perceive the profession to be reacting slowly to community needs and in fact community needs are ignored. 19% of respondents answered negatively to Statement 4. This is an interesting finding and will be further discussed in chapter 6.

### 5.4.2.5 Comparison 5: Ownership and choices (Q33 & Q 43)

Over the thirty years under study physiotherapists fought hard to achieve professional status and independence, relying on its own efforts to maintain status and legitimacy.

Question: In the context of success or failure, could the profession rely on others or was on its own; and does it recognise that painful decisions might have to be made or does it believe that it can achieve everything on its wish list

ownership choice	1	2	3	4	5	6	7	TO TA
1	0	1	0	2	0	7	18	28
2	1	3	2	0	7	23	35	71
3	1	1	3	2	11	22	28	68
4	1	2	1	3	5	9	14	35
5	1	2	0	2	3	11	2	21
6	1	2	1	0	1	3	3	11
7	0	1	0	1	2	1	1	6
TOTAL	5	12	7	10	29	76	101	240

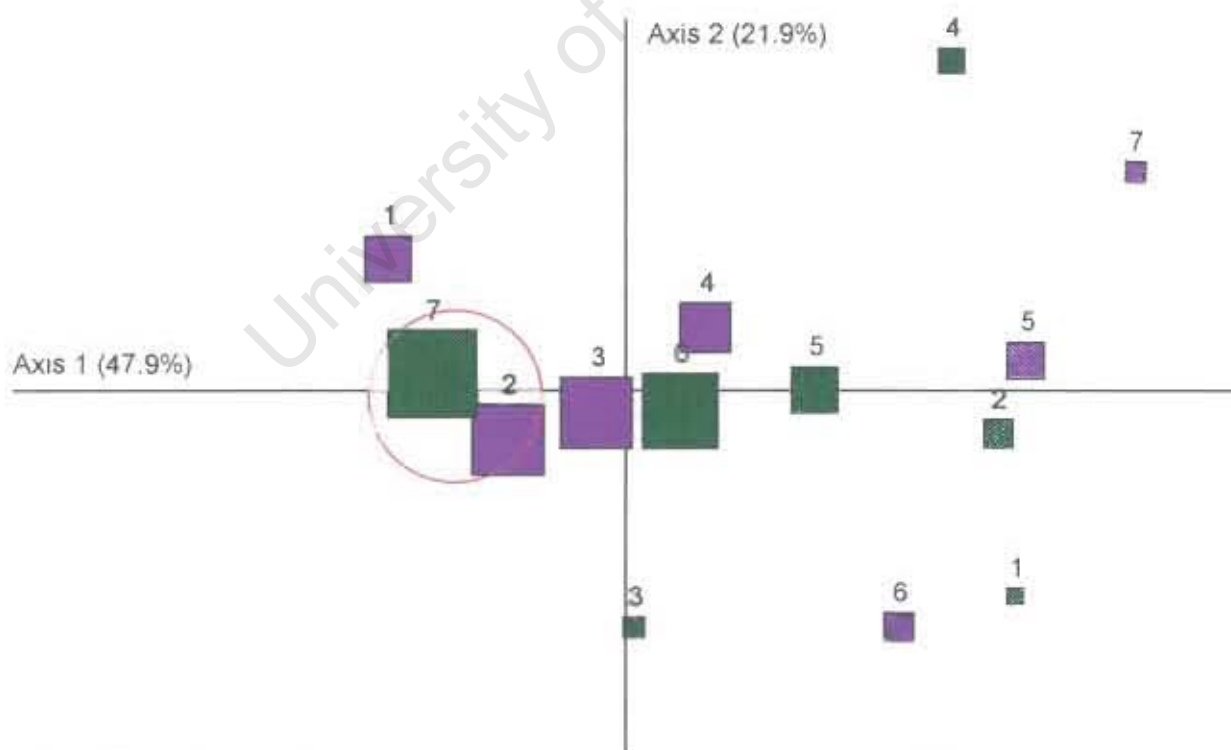


Table 19 Factor analysis and factor map for statements 33 and 43

Table 19 shows very clearly that respondents believe the profession is on its own (column 7/2, red circle), this is supported by Statement 39 that profession has to be responsible for its woes, but at the same time some painful and divisive choices might have to be made. Unfortunately this research does not ask the respondents what those choices might be but it is likely that the current regulation requiring compulsory continuing education, accreditation of practices and the struggle for posts in the state sector will prove to be unpopular.

## 5.5 SUMMARY OF RESULTS

The classic problem with case study approach, from a research point of view, is the lack of generalisability. This problem stems from the fact that each researcher gives a unique insight and emphasis to the research data, different researchers are likely to emphasize different aspects of the dynamics of organisation. The advantage of the case study approach is its descriptive richness and sensitivity to changes over time, what Peterson et al (1999:108) call ' "thick" descriptions of group processes providing a more thorough understanding of dynamic processes in organisations over time as well as the context in which each organisation is imbedded'. The questionnaire also embraces many of the strengths of the case study approach by providing an extensive array of questions assessing the detail of interaction of organisational members, organisational boundaries and the context in which the organisation is located. This research makes use of three different research methods in order to provide triangulation to the research question. Through the historical narrative, analysis of professional linkages, analysis of the chairmen's reports and council decisions the results make evident the sequence of events, processes and behaviours which took place over the period 1971 to 2000.

The findings suggest that the physiotherapy profession, bound by the institutionalised rules and standards as guides to acceptable and legitimate behaviour within its niche, concerns its strategy towards managing those structures in order to establish a strategically favourable set of conditions. The membership strategies associated with professionalisation are undertaken mainly through the formation of special interest groups in which members establish communication networks, education and accreditation processes. The profession does not concern itself with gaining competitive advantage, unless it has to protect its unique skills and expertise. The questionnaire, which was completed at the end of the research period by a stratified sample of physiotherapists working in South Africa, confirms the findings of the historical analysis and case mapping: the power of the regulatory system over the profession; the profession's disinclination to take strategic risks; its skill in managing public

relations; the importance of special interest groups; and the presence of professional self interest.

The following chapter will discuss these findings in relation to the four propositions.

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## CHAPTER 6

### **DISCUSSION: CONSIDERING THE RESEARCH PROPOSALS AND FINDINGS**

#### **6.1 INTRODUCTION**

The South African physiotherapy profession, together with other health care professionals and society as a whole has experienced major changes over the last thirty years. Chapter 1 poses the research question:

**How does a relatively small professional organisation manage its key survival factors in order to maintain a dynamic and viable position in a changing health care environment?**

This research set out to answer this question by describing the nature, direction and depth of the changes which took place in the South African Physiotherapy profession over the period 1971 to 2000. It makes the assumption that for organisational sustainability to take place the physiotherapy profession and the environment must relate to one another over long periods of time.

After making a study of the contemporary literature of organisation-environment relationships and professional organisations, two conceptual frameworks were constructed (Figures 1 and 3). These aimed at making an early theoretical statement about the physiotherapy organisation and its Institutional environment and some of the concepts to be studied in the research process. Four outcome factors were identified from the literature as being critical to organisation's success: acquisition of resources, external legitimacy, occupation of niche or domain, Institutional linkages. During the research process a network of four propositions were generated, containing connected statements which reflected the physiotherapy organisation and its ability to manage the four critical success factors. The degree of support for these propositions will be discussed in this chapter.

The research takes a longitudinal approach by conducting a socio-historical analysis of the cycles of change of the physiotherapy profession. Using Aldrich's (1999:207) definition of classes of period effects (1) political events and change in regime; (2) legal and regulatory policy changes; (3) shifts in societal norms and values; (4) changes in resource availability not otherwise due to any other previous three changes, four historical periods were explicitly identified over the research time frame: 1971 to 1975; 1976 to 1985; 1986 to 1994; 1995 to 2000.

These four periods were distinguished by the changes taking place in the external environment affecting the physiotherapy profession.

## 6.2 PROPOSITION 1

A resource based perspective argues that growth and direction of organisations are determined by a complex interaction between available resources, capabilities and the mental modes of decision makers (Barr,1998). These mental modes or dominant agendas, provide subjective constraints to organisational action by limiting the amounts and types of activities and opportunities an organisation will consider (Porac et al.,2002). By carrying out this qualitative research, analysing narrative statements about developing potential for the professional organisation, and growth and control of the organisation, it has been possible to discern the trend in strategies used by the profession to defend and adapt its position in the environment. This leads to the first proposition:

### PROPOSITION 1

**The greater the environmental changes over time with its differing demands on the organisation, the greater the likelihood of variable strategic responses affecting professional goals, activities and boundaries**

The proposition suggests that as the environment becomes more complex, the physiotherapy organisation must adjust its internal structure and processes to maintain or improve its effectiveness and success rate. However, in order to succeed in the changing environment the physiotherapy profession had firstly to stay abreast of fundamental changes taking place in the health care arena. Secondly, they had to challenge pre-existing assumptions and beliefs by the medical profession and the general public in order to generate a new conceptualisation of the physiotherapy organisation in terms of the status and legitimacy and their existing knowledge and resources. Thirdly, they had to reduce any ambiguity which might have existed about their capabilities for their stakeholders – the medical profession and the public, thereby gaining credibility and legitimacy. On the other hand institutional theory states that organisations are driven to incorporate strategies, practices and procedures defined by the prevailing rationalised concepts of the organisation's work and institutionalisation in society. Organisations do so to increase their legitimacy and their survival prospects (Meyer and Rowan, 1977).

This research incorporated a process of causal mapping of chairmen's reports and the decisions made by members of council. The research data is reflected in

Table 10 representing a hierarchical network that maps the strategic intent of the physiotherapy profession over the 30-year period 1971 to 2000. This strategy map contains the aggregation of thinking of many people, including different slants on the same issues and different perspectives on similar views. The top half of the strategic map records the mental modes of the eight chairmen in office over this research period. Considering this covered a 30-year period the mental modes of the chairmen are remarkably consistent and stable showing regulatory elements and customers as the main source of their attention. This consistency is supported by Mintzberg (1989:188) who describes professional organisations as tending to show a considerable degree of stability of strategic planning, with key areas concerning services offered to the public. However, further scrutiny of Figure 5, focusing on the decisions made by council members reflecting intended strategies and the outcomes likely to bring success to the physiotherapy organisation, show that these changed over the time period.

During the first period, 1971 to 1975 strategies of service feature contained a strong focus towards resource acquisition, firstly in the form of obtaining external funds for private practitioners and improved salaries for public servants and secondly, regulatory protection for the resources unique to the profession – its skills and expertise. The regulatory effect of the promulgation of the Medical, Dental and Pharmacy Act 1971, and the earlier Medical Schemes Act 1967 allowed the physiotherapy profession, on the one hand, to establish very high boundaries to protect the resources of the profession and, on the other hand widen the boundaries to allow for the development of private physiotherapy. The formation of the Private Practitioners Association was a strategy to give the private physiotherapists the power and mandate to negotiate for the very scarce resources – a structured tariff of fees. Encompassed within the boundaries protecting the profession were a number of regulations relating to ethical practice, restricted the employment of physiotherapists either to another physiotherapist, to public institutions or to medical practitioners. Although the private physiotherapists were proactive in their strategies, taking the opportunity as soon as it became available and looking to their own self-interest, at the same time their choice was very limited, the institutional environment constrained their activities, most particularly in the way they could practice. The visit by Geoff Maitland to South Africa in 1971, bringing a most valuable resource - the mobilising and manipulative techniques bearing his name, was initiated by physiotherapists working in the physiotherapy educational institutions. This was important, because educationalists were the first South African physiotherapists to learn the techniques, They had the teaching skills and capacity to impart their new skills to many physiotherapists from all over the country. Orthopaedic doctors believed that the field of mobilisation and manipulation belonged to them and it was unlikely that they would willingly give this up. However they received very little training in the techniques and the course offered to physiotherapists was far more detailed and required far greater skills than those used by the

doctors. Many physiotherapists had to be well trained in the techniques before they could legitimately approach the medical profession to sanction their activities and obtain acknowledgment for the techniques by the Medical Aids Tariff committee. Thus, the sheer numbers of physiotherapists who became skilled in the techniques eventually lead to its legitimisation, considerably broadening the scope of practice for physiotherapists. This strategy, of spreading a resource in order to gain legitimacy, is described by Oliver (1991) as influence tactics, directed toward institutional values and criteria of accepted practice. The practice had to be accepted by the physiotherapists themselves, the medical profession and the public. This process of legitimisation is discussed further in chapter 7.

In the second period 1976 to 1985 strategies continued to favour service features but also include strategies containing actions promoting professional development and growth but, at the same time, standardising and controlling members' practice. These strategies were focused on maintaining and strengthening the new, widened niche and obtaining legitimacy for the new developments in the professional organisation. The opportunities prevailing in the external environment during the second period resulted in the physiotherapy profession, who up to this time did not warrant the status of a full professional, to develop strategies that would lead them to full professional status. Firstly, the regulatory requirements making registration compulsory for all physiotherapists led to a number of membership strategies involving the definition of scope of practice delineating the space within which members could practice, restricting the acceptable level of expertise for registration (thus disallowing many foreign trained physiotherapists from practicing in South Africa) and establishing a four year degree as the acceptable level for under graduate training in South Africa. At that time, very few countries in the world had established a four-year degree as the basic registrable qualification, although now it is accepted as the basic qualification by the World Confederation for Physiotherapy. In this strategy South Africa was a world leader, along with Australia and the USA and it greatly increased the legitimacy of the profession. Secondly, the efforts by Australia to introduce the concepts of first line practitioner status in physiotherapy practice into the World Confederation in 1978 met with mixed reception from many members. The South African physiotherapists reacted positively to the concept, realising it would advance their cause for professional status and independence. However, the SASP and most especially the Private Practitioners Association decided it would need to attempt a slow bargaining strategy with the SAMDC and the Medical Association of South Africa to accept first line practitioner status for South African physiotherapists. Resource dependency theorists describe this negotiated environment 'as exacting some concessions from an external constituent' (Pfeffer and Salancik, 1978: 143-187), assuming that organisational

relations with the environment are open to negotiation and the exchange of concessions.

During the third period, 1986 to 1994, the external environment was marked by increasing political turmoil in South Africa, international boycotts, financial crisis in the public sector of the South African economy, rapid growth in private health care and a change in health care policy towards primary health care.

The goals of the physiotherapy profession at the start of this period revolved around growth, especially in expertise and knowledge; preservation of standards of practice and consolidating the profession's position in its niche. The fact that the health care environment encouraged the development of curative, high tech, individual treatments and the public sector supported the tertiary care teaching hospitals at the exclusion of community care, encouraged the SASP to adopt a number of strategies that would support its members in these environments. Building onto the initiative made by Australian Physiotherapy Association whereby its members could specialise in different aspects of physiotherapy, efforts were made by the South African physiotherapists to increase their expertise and legitimacy by introducing a similar specialisation process for South African physiotherapists. These strategies of membership specialisation, included the inauguration of The College of Physiotherapy, development of Quality Assurance programmes and the provision of registrable post graduate programmes. Although these strategies were in line with the societal norms and values of that time, aimed at providing a curative service to a very small section of the population, they did not necessarily equip the physiotherapist with the skills to work with the larger section of the population, most of whom had no means of attracting the skills and expert knowledge of physiotherapy (Bowerbank, 1994).

Following the threat of expulsion in 1986 from the World Confederation of Physiotherapy which would have resulted in very serious repercussions for South African physiotherapists, the SASP adopted a strategy of defiance (Oliver, 1991), challenging the institutional pressures for compliance with the South African government policy of apartheid (Appendix 5). It is not clear whether this challenge was made as a means of expressing the member's convictions and integrity or, by going on the offensive against institutional pressures the SASP may have been making a statement about what it believed was rational and acceptable. Either way, at that time, it was a remarkable and courageous strategy and as a long term outcome gave credibility to the organisation. It is also interesting that an organisation with strong institutional ties was prepared to defy its own government in order to retain its integrity and self-interest with its world body.

The end of the period marks the dramatic turn around in government politics and health care policy. In an environment of extreme uncertainty, the SASP complies

with the external pressures, writing policy documents which mimic other institutional models, such as Primary Health Care, using concepts and vocabulary virtually unknown to physiotherapists and advocating different ways of practicing. Meyer and Scott (1983) describe this type of strategy as reducing the organisation's vulnerability to negative assessment of its services, enhancing the organisation's legitimacy and sustaining society's confidence in its activities. This period was a very active time for the SASP, taking some bold and ambitious strategies aimed at maintaining access to resources and niche position.

Not surprisingly political elements formed a major focus during the last period. Although the institutional environment changed dramatically during the last period 1996 to 2000, the SASP made very few documented strategic decisions that directly involved itself and the external environment. By this stage the SASP had just restructured and many of the council decisions related to the restructuring process and rewriting a new constitution. The decision to make a statement to the Truth and Reconciliation committee was made by members of the SASP and those of the Professional Board for Physiotherapy. Whereas the medical profession had clearly made 'Acts of Omission' the position of the physiotherapy profession was not so clear. The resultant contributions made by physiotherapists were revealing and, for some, unexpected. From the point of view of the profession the strategy was perhaps manipulative, what Oliver (1990:157) describes as 'a purposeful and opportunistic attempt to influence the institutional pressures and evaluation of the profession.' However from an individual physiotherapists point of view the strategy was more personal and, possibly, made a considerable contribution to the reconciliation of the various racial groups within the profession. Strategies implemented during this period relate to developing communication, partnerships and teamwork with other actors in the institutional environment. Decisions were made particularly in the area of education and the restructuring and development of the private sector. Kanter et al (1992) make the point that after considerable strategic activity organisations need to consolidate and turn their attention to internal activities. It would appear that this is what happened to the SASP.

**Summary:** The physiotherapy profession in South Africa changed its identity during the period under study: from being a semi-professional under the direction of the medical profession and practicing largely in bureaucratic state hospitals, to an independent profession functioning mainly in the private sector in a niche that contained a far greater range of services from that of 1971. Health care professions are bound by such strong institutional ties, particularly by the legal and regulatory environment, strategies involving competitive advantage which include market expansion, service development, capital intensity and diversification are constrained, almost non-existent, leaving the physiotherapy profession to operate from a position of low strategic choice. These findings are supported by results from the questionnaire (Table 14) which shows the

strongest characteristic of the profession to be the importance of legal requirements and the constraints imposed by the regulations. Perusal of the competing values model (Figure 8) shows that the upper quarter - towards Expansion, reflecting strategies of competitive advantage, is uncharacteristic of the physiotherapy profession. The profession's values lying in the importance of scientific knowledge, expertise, membership control and social responsibility (Table 14). Whilst a certain degree of focus leads to the development of distinctive competencies, too much focus leads to a skill set that is not capable of keeping up with the variation in environmental demands (Porac et al., 2002) and may leave the physiotherapy profession unable to meet the demands of the environment.

The study confirms that the physiotherapy organisation interacted with the demands from its environment making methodical and cautious responses and that members believed it had the skills to remain strategically effective (Figure 8)

### 6.3 PROPOSITION 2

#### **PROPOSITION 2**

**The greater the degree of professional autonomy and opportunity perceived to be obtained from the institutional environment, the greater the incentive for transformation of the professional form and practice**

According to both institutional and resource dependency perspectives organisational choice is limited by a variety of external pressures and organisations must be responsive to external demands and expectations in order to survive (Meyer and Rowan, 1977; Pfeffer and Salancik, 1978). The above section has indicated that the physiotherapy profession is very constrained by the regulatory element of the institutional environment and that opportunities and professional autonomy has to be accepted within the limitations of socially accepted norms and practices. The windows of opportunity offering autonomy to health care professionals are therefore likely to be small consisting in changes in client's needs, regulations governing practice, techniques and financial acquisitions. An examination of the narratives suggests four such windows of opportunity presented to the physiotherapy profession during the research period. Firstly, in the 1970s the opportunity to develop private practice and to acquire new skills and expertise; secondly, in the mid 1980s the opportunity to gain first line practitioner status; thirdly, in the early 1990s the relaxation of the very restrictive ethical rules regulating scope of practice, standards of practice and employment of physiotherapists allowed for more flexible possibilities for physiotherapy practice and fourthly, the move towards primary health care in the

mid 1990s encouraged new forms of practice and the provision for multidisciplinary teamwork amongst health professionals.

The characteristics of a professional are an autonomy of practice, an exclusive knowledge base, an occupational control of rewards and a means of maintaining standards (Richardson, 1999). In order to responsibly accept the above opportunities the SASP had to develop structures and activities that would conform to institutional rules and expectations of physiotherapy practice but would, at the same time allow for the development of the professional characteristics. Thus the opportunities of the 1970s led members of the profession to form special interest groups made up of national networks of members whose goals were explicit and included issues of expertise, financial remuneration, responsibility and public relations. The Private Practitioners Association, National Hospital Group, Orthopaedic Manual Therapy Group and Obstetric Association (Figure 6) were all formed at this time in response to the demands of the institutional and health care environment which offered to support a more professional physiotherapist. To legitimise these new structures the SASP had to work through the Constitution and Registration committee (Figure 7) to define the rules which delineated membership and scope of practice within which the members could operate. In order to protect and maintain the resources gained from the opportunities these committees had to establish barriers to imitation from possible competitors and to legitimise these through the Professional Board. These new structures, which were self-serving by supporting members needs, led to a considerable transformation of the profession, bring about increased prestige, legitimacy, internal commitment and increased access to rewards. At the same time the regulatory effects limited more innovative and perhaps, from societal point of view, effective and efficient ways of delivering health care, this had to wait for the 1990s.

The socio/political changes in the 1990s brought about a number of opportunities for the physiotherapy profession: the relaxation of the rules governing standards of practice; the re-entry of South African sports teams into professional sport; society's interest in holistic health care; and, the emphasis on quality of health and prevention of injury. These new phenomena led to a number of structural innovations within the profession: just as SASP members made special interest groups in the 1970s, so new interest groups were formed in the 1990s – Acupuncture, Sports Interest, Cardio-pulmonary, Animal therapy and Neuro rehabilitation groups (Figure 6) representing a very diverse network of unique skills. The relaxation of the rules governing standards of practice relating to employment possibilities for physiotherapists allowed them to work for organisations not dedicated to health care delivery such as sports teams, industry, insurance companies and NGOs. The growth and development of any profession depends upon maintaining a status, knowledge base and scope of practice which together ensures a credibility of competence in professional

practice (Richardson, 1999). The changes in practice settings, modes of health care delivery and ethos of health care, placed physiotherapy practice within a wider perspective and domain than that of the 1970s, reflecting the complexity of societal demands but at the same time making strong demands on the profession to maintain its integrity. In order to do this the SASP established an ethics committee in 1994 (Figure 7) whose function was to monitor ethical practice and to deal with minor infringements of unprofessional conduct.

The radical shift in political ideology toward primary health care in 1994 suggests that an opportunity might have been available, but in reality it posed a number of problems for the physiotherapy profession. The downsizing of the large teaching hospitals and secondary hospitals resulted in the available positions for physiotherapists in state health to be cut by over one third. This so reduced the strength of these physiotherapists they became what Kanter et al.(1992) describe as the 'anorexic' organisation, the pressures of the activities they are committed to drives out the ability to think about opportunity. Through the lack of institutional support for any efforts to develop community structures the state employed physiotherapists resorted to a state of inertia. Table 16 shows physiotherapists perceive a serious threat to their existence and are stressed by this situation, but still believe the profession will cope. Table 18 shows that although physiotherapists believe they are committed to community health in reality the profession has been slow to take up the challenge. It is not clear why this is so, it is possible that the dominant cohort group, the private practitioners, have little interest in community work envisaging very little remuneration, and the remainder of the members lack the leadership to initiate feasible strategies that would move the profession towards a greater transformation and commitment to community based work.<sup>2</sup>

Summary: The findings of the research suggest that opportunity and autonomy does indeed produce transformation of professional practice and form in the physiotherapy profession but the incentive must also include professional status, legitimacy and self interest.

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<sup>2</sup> All physiotherapy students graduating at the end of 2002 and subsequently, have to complete one year of community service in a South African state institution before registering with Health Professions Council of South Africa. Posts had to be created in these state hospitals and the physiotherapy profession established a 'buddy' system to support these students. This is likely to result in some structural changes in the physiotherapy profession working in the state sector giving impetus to their transformation .

#### 6.4 PROPOSITION 3

**As institutional pressures increase, the effort by the organisation to improve the inter-organisational linkages, which are viewed as legitimate by the wider institutional environment, becomes greater.**

The proposition suggests that establishing collaborative linkages to government and legitimated community and public institutions may be an important means by which organisations achieve reliability and accountability and increase their survival chances, Tables 6, 7, 8, 9. show the linkages made by the SASP during the research period. According to institutional theory, an institution's life chances are significantly improved by conformity to the norms and social expectations to the institutional environment (Meyer and Rowan, 1977; Scott and Meyer, 1983). When an organisation develops ties to well-established societal institutions it signals its adherence to institutional prescriptions of appropriate conduct and obtains a variety of rewards (Baum and Oliver, 1991; Meyer and Scott, 1983). During the early 1970s the SASP maintained strong relationships with the Council for the Aged, National Council for Care of Cripples and the National Paraplegic Association. These three organisations were established by charismatic leaders who gathered together a group of like-minded people who identified with the values and ideology of the organisation. During that time, physiotherapists identified strongly with the interests and culture of these organisations and many worked professionally with the doctors involved, many of whom held prestigious positions in medical schools or practices. These Councils not only acted in an advocacy role for people who were suffering from disease and disability but also generated funds for research, published research articles and held congresses. From the point of view of the SASP, initially it gained a considerable amount of support including legitimacy by association with national organisations that already possessed high legitimacy. During the 1970s these associations were important for the physiotherapy profession as it was building its reputation as a professional organisation and the legitimacy that was conferred helped its cause. As time passed, the leadership and culture of the Councils changed and physiotherapist's interests and affiliation moved on to other areas and the linkage became very weak and tentative.

The power of asymmetry refers to interorganisational relationships when one organisation potentially has the power to exercise control over the other. In this instance the Professional Board for Physiotherapy, which fell within the South African Medical and Dental Council (SAMDC) (later to become the Health Professions Council of South Africa), is a statutory body and has the power to

control physiotherapists. Resource dependency theory proposes that resource scarcity prompts organisations to cooperate with one another and that organisations will attempt to exert influence over the other organisation that possesses the required scarce resource. The SASP is dependent on the Professional Board to legalise the definitions for scope of practice, ethical practice, standards of practice and registration norms for physiotherapists. These concepts define the membership of the physiotherapy profession: its authority, responsibility and especially its expertise. The relationship continued throughout the duration of the research time and was particularly intense during the first two periods when the SASP was establishing the boundaries for membership and required the somewhat scarce resource of status and power which the Professional Board through the Medical Council could bestow. No mention is made in the records of the SASP of the behaviour of the SAMDC during the Biko fiasco, it would appear that the taken-for-granted nature of institutional rules which require compliance towards government policy and an uncritical attitude towards influential colleagues applied. No references of linkages to the Professional board are made in the last period, possibly because of the disruptions following the closure of the SAMDC and the confusion round the structure of the new Boards.

A fundamental premise of institutional theory is that an organisation is a target of external assessment of its legitimacy and rationality ( Baum and Oliver,1991) Society and the public evaluate the degree to which an organisation's structural and procedural characteristics are aligned with the prevailing institutional values and beliefs. In order to improve the economic position of its members the SASP had to maintain an on-going linkage with the relevant authorities charged with the authority to improve or disprove salaries and working conditions of physiotherapists. The Private Practitioners Association (PPA) strenuously negotiated with the various medical aid schemes throughout the research period for appropriate fee structures for its services. At the same time the SASP through the National Hospital Group attempted to influence the Department of Health of its worth and service to the public, motivating for improved salary structures and conditions of service for its members. The proposal suggests that the ability of an organisation to improve its survival chances will depend on whether the linkage is perceived as legitimate or consistent with the normative expectations of the organisation's social environment. The initial efforts of the PPA to collaborate with the medical aid schemes clearly enhanced their prestige and status. More recently the considerable pressures brought about by the collapse of medical aid schemes and the passing of the Medical Schemes Act 1998 resulted in a new set of relationships for the PPA when they formed PhysioNetWorks and entered into partnerships with managed health care organisations. Although physiotherapists working within the public service are perceived as legitimate, the general rationalisation of health care over the last decade has seriously curtailed many activities. The attitude held by

physiotherapists that they must "go it alone" (Table 14) does not agree with the proposition, especially in the context of primary health care which requires multi-disciplinary team work. This finding suggests that physiotherapists lack the skills and socialisation processes necessary to form linkages in a team approach setting. The finding is supported by the competing values model (Figure 8) which highlights the weakness of the Membership Network sector with few strong characteristics such as commitment, team participation and leadership.

The enhancement of organisational legitimacy has been cited as a most significant motive in the decision for organisations to connect (DiMaggio and Powell, 1983; Meyer and Rowan, 1977). Institutional theory suggests that institutional environments impose pressures on organisations to justify their activities. These pressures motivate organisations to increase their legitimacy in order to appear in agreement with the prevailing norms, rules and expectations of external constituents. The South African apartheid policies led the World Confederation of Physiotherapy (WCPT) to place considerable pressure on the SASP in the early 1980s, threatening to expel it from the world body. The SASP took the radical step of denouncing the policies of the government of South Africa in order to retrieve its legitimacy and reciprocity with WCPT. The SASP's need for a positive professional linkage with its world body, in this instance, had a greater critical value than that of a positive linkage with the politics of South Africa.

Recent research has shown that interorganisational linkages also affect the ability of the organisation to accomplish fundamental transformation (Baum and Oliver 1991; Lawrence, 1999). Traditional adaptationist perspectives in organisational theory suggest that most intended organisational change should improve organisational survival chances (Pfeffer and Salancik, 1978). The report from the TRC accompanying the SASP's submission recommended the SASP to transform from its elitist perspective to be more open and community orientated. A community orientated perspective suggests a more bottom up approach and the physiotherapy profession was encouraged to establish a network of relationships at a more local level between the local branches, practices, training institutions, special interest groups and community organisations. The restructuring process of the SASP undertaken in 1996, fortuitously, enabled the 'bottom up' approach to be embraced by the local branches. The external legitimacy provided by institutional relationships helped increase the physiotherapy profession's ability to acquire social support for the rationality of undertaking the change by allowing the organisation to demonstrate its continued conformity to social expectations. Programmes adopted during back week, physiotherapy services provided to sportsmen and women at local sports events and various community projects such as advice to the elderly and physically and mentally challenged people improved physiotherapy linkages at a local level.

This new organisation of health care, with its emphasis on preventative and promotive health programmes with a community participation approach involving a variety of interested parties required that the educational processes for training physiotherapy students adopt a different paradigm from the traditional medical model it had always practiced. The narrow focus of the medical model placed students in tertiary and secondary hospitals working under experienced, specialised physiotherapists delivering curative health care. During the first two periods and part of the third period of this research this mode of physiotherapy education was the accepted method for training. The university departments had to maintain strong linkages with special interest groups of the SASP in order to remain up-to-date with their curricula. The current undergraduate educational programmes have to ensure that physiotherapists are prepared to respond to the new challenges of primary health care. The educational programmes in the 1990s set about curriculum reviews which required a completely new approach to health care, collaborating with diverse community settings bringing about new linkages and working in multi-disciplinary teams. These new approaches to training undergraduate physiotherapists are aimed at overcoming the inadequacies of the older more traditional education processes. Articles appearing in Forum magazine suggest this strategy appears to be successful, encouraging the local SASP branches and special interest groups to also adopt a more community orientated approach especially in terms of Back Week and support towards care givers groups.

**Summary:** The SASP established few formal linkages over the thirty year research period. In the early period formal relations were established between the executive members of the SASP and other National Councils, few community links were established. Apart from the SASP's linkage with the World Confederation of Physiotherapy, international linkages, were made almost exclusively through the universities, special interest groups or individuals. Mintzberg (1989) supports this finding, noting that professional organisations can be distinguished by the fact that the determination of contacts (or linkages) is made by independent professionals working with the clients they serve and that professionals work independent of colleagues. This is not surprising as the ethical rules concerning professional practice in the 1970s and 1980s were very confining, disallowing contracts between other professionals and laying down very restrictive employment possibilities. The relaxation of these rules in the early 1990s saw a proliferation of community linkages and newly established partnerships. However the old traditional way of thinking still prevails within the members, results to the questionnaire Table 19 shows that members of the profession believe that 'the profession realises it is on its own – even if it fails it will not be bailed out' to be characteristic of the physiotherapy profession, Richardson (1999:468) supports this finding stating that 'for physiotherapists, collaboration in a socially-based, client centred model of health care is a radical change from the hierarchial, medical model of health care...of previous times'.

This suggests again, that the legitimising linkages are made through individuals and groups of physiotherapists who through their skill and knowledge develop collegiate relationships (Mintzberg, 1989), the strength of the relationship and the ability to attract resources depends on the social validity of the physiotherapist.

## 6.5 PROPOSITION 4

The professional organisation is unique among the different configurations of organisations (Mintzberg, 1989:189), it is democratic, disseminating power directly to its members, and provides the members with extensive autonomy even freeing them from having to coordinate closely with colleagues. Whilst the physiotherapist is therefor attached to an organisation, the SASP and the Professional Board, yet is free to serve clients in his or her own way, constrained only by the established standards of the profession. The problem for professional organisations lies in the difficulty of effectively coordinating work of its members who on the whole work independently and who come together only to draw on common resources and support services. Various factors confound the difficulties of coordination: firstly the issues round censuring irresponsible behaviour and secondly the intrinsic difficulties of measuring the outputs of professional physiotherapy work. Proposition 4 stems from these comments:

### PROPOSITION 4

The ability of the profession to affect standards of practice in the organisational field is positively associated with its technical, political and marketing expertise and the degree to which it is perceived as the legitimate organisation in the field.

Standardisation strategies involve the institutionalisation of practices and services through the assignment of value through social and cultural mechanisms. They are concerned with the establishment of technical and legal standards that define what is normal for a practice and service through regulation. A professional organisation's needs for certainty and predictability in their engagements lead them to adopt the technical and legal answers implicitly or explicitly prescribed by leading members of the profession (DiMaggio and Powell, 1983). The history of this research is filled with examples of the physiotherapy profession involved in standardisation strategies. In 1971 the status of the physiotherapy profession within the health system was low, members had not achieved professional status and the majority were employed in bureaucratic organisations. The formation of the Professional Board for Physiotherapy in 1973 enabled the members to effect a professional standard that would unequivocally change this situation and privileged their own competencies and resources. Boundaries were erected that

would restrict the membership to those who had achieved the established registration norm, expertise was limited to those who had registered and controls were established assigning authority and responsibility to members. Members who transgressed these rules were liable for disciplinary action through the Professional Board. The implementation and success of these standards fell to the SASP and the Universities who had to ensure that they became institutionalised as normal. This led to the establishment of continuing education programmes, with a particular emphasis on specialisation of skills and instruction by internationally recognised lecturers; explicit standards of practice; postgraduate coursework and examination; internationally recognised, professionally legitimated rewards (post graduate degrees and diplomas) and an enhanced professional recognition and increased legitimacy. The special interest groups that formed in the SASP vied for the establishment and legitimation of their own specific expertise as 'normal' practice within the institutional sector and with the international groups. For physiotherapists to successfully establish themselves as professionals, able to diagnose problems and make a decision for treatment, the relevant medical practitioners and society must be willing to accept this new membership definition. This required that the taken-for-granted concept of the doctor as the sole legitimate practitioner, making a diagnosis and prescription, be understood as problematic (Lawrence, 1999) and more crucially that the regulatory framework that support this exclusivity capacity be opened for reconsideration. In 1985 the physiotherapy profession, through its Professional Board, was able to convince the South African Medical and Dental Council that its under graduate training, now a 4-year degree, adequately equipped a physiotherapist to take autonomy over their work and by the year 2000 all reference to doctors referral was removed from the ethical rules of practice for physiotherapists. Critical to this new found independence has been the skill by the SASP in managing the flow of information regarding physiotherapy practice through the mass media. The marketing strategies of Back Week, sports events, schools open days, and affiliation with local care-giver groups have all brought the concept of physiotherapy to a wider community.

The early standards of practice primarily concern legal practice that regulate the relationship between the physiotherapist and client and the specific techniques and treatments utilised by physiotherapists. Current standardisation strategies revolve round challenging the efficacy of certain techniques and treatments, the accreditation of practices and continuing professional education. These changes have come about in recognition that health funding is limited, concern for client rights, the need to establish a health service that is cost effective and market-responsive and the fact that health care professionals are expected to be accountable for the outcomes of their practice and their use of resources (Richardson, 1999). This is a shift away from the traditional interventionist model wherein the physiotherapist provides services to a patient to effect recovery with a well and tried but, unproven treatment, towards treatment based

on outcomes measurement. Jette (1995:7) describes this 'as having profound implications for the development and testing of theory and ultimately could contribute to the body of knowledge guiding physiotherapy practice. Today outcomes research is being used to justify policy regulating practice (in the USA) and practice protocols.' In 2000, the effect of this policy on physiotherapy in South Africa was unclear, however Managed Health Care organisations are demanding its implementation. The accreditation of practices was established by PhysioFocus in 2000. The aim of this programme was to provide funders with a bench mark for quality practices which were clinically and administratively well organised. Accredited practices are expected to undertake continuing quality management projects with a view to improving the practice performance and thus the legitimacy of the practice. Continuing Education became mandatory in 2001 as a prerequisite for registration by practicing physiotherapists. Physiotherapists must attend a certain number of courses in order to obtain the requisite points for registration.

Summary: Standardisation strategies that affect scope of practice, code of practice and that focus on formal levels of acceptable practice have to be formulated through established formal institutional processes. However, the initial recommendation and subsequent execution of these strategies takes place through the membership structures of the SASP, and the educational institutions who have to constitute formal structures through which the strategies can be implemented, and which may require changes to the Constitution of the SASP. The success in marketing standardisation strategies depends on the perceived privileges and outcomes for the members, who have to establish their own interpretation and application of the rules. The advantages will tend to favour those members who motivated for and instituted the rules and conditions. These standards of practice have shifted away from the earlier norms which decided what a physiotherapist would practice towards a more descriptive mode of 'how' they will practice. This has led Benatar (1997) to state 'in the modern era, economic and bureaucratic considerations are increasingly intruding on decision-making in medicine. There is more concern today about health service budgets and about laws and regulations pertaining to health and the health care professions. The nature of professional autonomy and the extent to which professionals have control over what they do are shifting because of changing ideas about what is valued in health care'.

## CHAPTER 7 CONCLUSIONS

This research presents a socio-historical analysis of the cycles of change and growth of the physiotherapy profession in South African from 1971 to 2000. At the beginning of the research period, 1971, the physiotherapy profession was about to enter into the comparatively new and unexplored context of professional autonomy, specialisation and private health care. The end of the research period, 2000, finds the physiotherapy profession once again, entering into a new arena of health care with a greater emphasis on health promotion, multi disciplinary team work and clinical practice based on evidence based research.

The intention or purpose of the research, discussed in chapter 1, is to present a paradigm or model which will describe the unique thinking, acting and methods of solving problems by the physiotherapy profession enabling it to be a legitimate and viable organisation within the health care environment. The notion of a paradigm has the potential to help clarify, express and evaluate fundamental beliefs and values which underpin physiotherapy activities in order to sustain professional development and growth. A paradigm, as sets of basic beliefs, are not open to proof in the conventional sense, any given paradigm represents simply the most informed and sophisticated view that its proponents have been able to devise (Guba and Lincoln, 1990). The same can be said of analysis or propositions which cannot present incontestable logic or indisputable truth, nonetheless strong paradigm-developing research should result in insights which are logically coherent and convincingly grounded in the evidence (Eisenhardt, 1989).

This research makes use of an interpretive approach based on the view that members of the physiotherapy profession can be socially and symbolically constructed and sustain their own organisational realities. The goal of the research is to generate descriptions, insights and explanations of the events so that the system of interpretations and meaning, and the structuring and organisational processes of the physiotherapy profession are revealed (Gioia and Pitrie, 1990). Structures are viewed as socially constructed, ongoing processes of accomplishment serving to both influence and constrain the activities of members.

Based on the findings of this research and theoretical insights from organisation/environment and professional organisation perspectives, three theoretical principles are presented that underlie the central insight of survival of a small professional health care organisation in South Africa, A fourth principle,

a specific finding of this research, is added as a contribution to the body of knowledge regarding health care professionals:

1. Existing theories of institutionalisation, resource dependency and population ecology all share the first principle that organisations must relate to their environment to survive and that what decision makers do, depends on how they selectively focus their attention on certain elements of the organisation and environment and ignore others;
2. The second principle describes health care organisations as demonstrating strong institutionalised connections which externally impose, rigid requirements on the organisation;
3. The third principle states that health care organisations possess a strong technical foundation of highly protected skills which are also subject to technological imperatives.
4. This research extends these principles by adding a fourth principle: conformity to institutional pressures and requirements take place provided the perceived outcomes are unlikely to compromise the professional status and self-interest of the organisation.

A careful reading of Oliver (1992:145) alludes to the fact that "The institutional perspective has been increasingly criticised for its lack of attention to the role of organisational self-interest and active agency in organisational responses to institutional pressures and expectations." This research updates this observation and includes the fourth principle with the first three principles to reflect contemporary theoretical understanding about modern health care organisations.

This chapter builds upon the four theoretical principles of a health care organisation and develops a process paradigm representing the cycles of change to which the physiotherapy profession must adapt if it is to survive (Figure 9). It assumes that at any stage of the evolution of the interorganisational field various options are open for organising the fundamental interdependence amongst its participants. Any particular choice defines, not only the relationship between the organisations, but what resources are critical, the occupation of domain and what defines success.

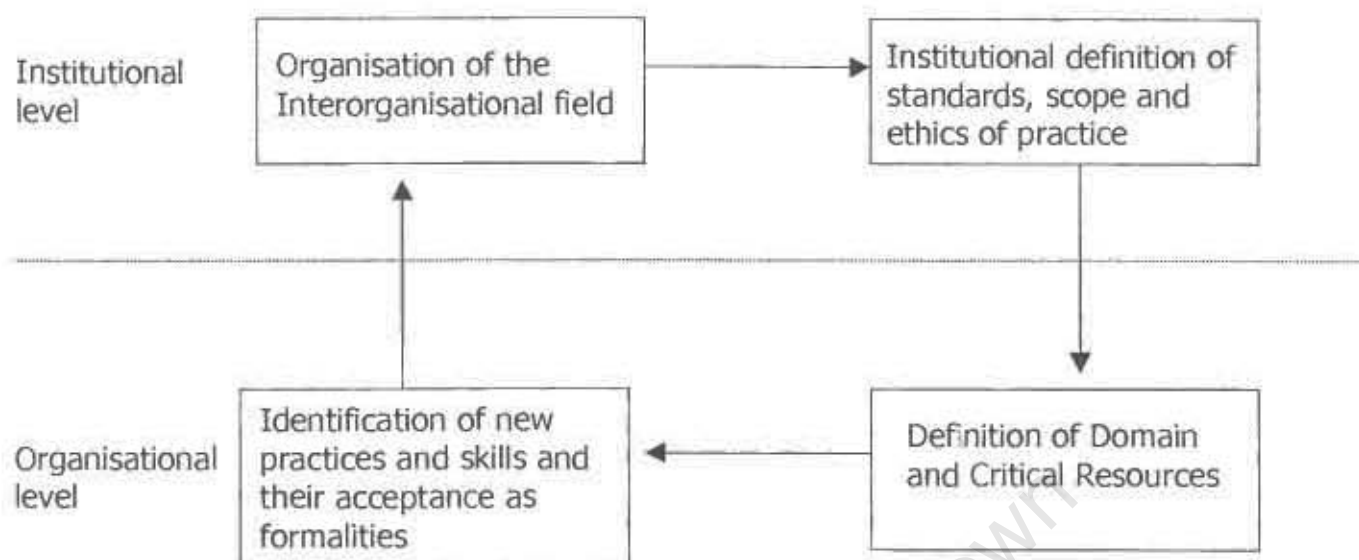


Figure 9 Adapted from Leblebici (1991:357) Paradigm 1: Cycles of change in Professional Organisations

The cycles of change also encompass the four critical factors – resource acquisition, legitimacy, domain occupation and institutional linkages that were identified in the research process as essential to the sustainability of the physiotherapy organisation. Acknowledging that the driving forces for strategic planning in the physiotherapy organisation contain the need for i) the acquisition and perfecting of skills and scientific knowledge, ii) the significance of professional status and reputation and iii) over-arching external legitimacy through regulation, a further paradigm is proposed (Figure 10).

This second paradigm describes the actions taken by the South African Society of Physiotherapy as it implements strategy, it typifies the strategy/ structure pattern of organisations but highlights the unique processes required by professional organisations to perfect and embed skills within the organisation, to legitimise these processes through regulation before delivering the practices to the public. As the institutional strategies are developed the organisational forms and practices become increasingly isomorphic, particularly as the attempts at professionalisation are successful. The degree to which standards of practice are formalised act as a resource for strategies aimed at professionalisation. The restrictive regulation results in very low strategic choice and the profession is unable to exploit innovative opportunities that might come its way. The research concludes that the strategy of the physiotherapy profession in South Africa tends to be reactive taking a 'analyser' strategy described by Miles and Snow (1986). A

few individuals or a special interest group adopt a new practice or skill once it has been developed elsewhere, this gets refined and perfected for the South African situation whence it becomes common practice.

Level of analysis	Cognitive Strategies		Institutional Strategies	
	Learning	Internal legitimacy	External legitimacy	Regulatory legitimacy
<b>Organisational</b>	Create knowledge base through research, investigation and continuing education	Link new practice to the past via symbolic language and behaviour	Build on local networks of trust especially through the Department of Health & private health care schemes	Develop early communication with Prof. Board and ascertain the viability & legality of the new venture
<b>Within-organisation</b>	Deepen a knowledge base by encouraging convergence around a new skill or practice	Collaborate by forming special interest groups to create standard setting and accreditation bodies	Foster perceptions of reliability and expertise by mobilising to take collective action and negotiation with D of H, private health & Medical Association	Present a united front to the Professional Board and Medical Council & co-opt as allies against competing organisations
<b>Community</b>	Solidify a knowledge base by creating linkages with established educational curricula and continuing education groups	Develop a reputation of a new activity as reality in scientific journals, newsletters and meetings	Embed legitimacy by organising collective marketing and lobbying efforts	Legalise the activity and develop barriers to imitation.

Figure 10. Paradigm 2: Strategies adopted by the physiotherapy profession in South Africa to facilitate sustainability and growth.

## THE IMPORTANCE OF THE RESEARCH

The research focuses on the evolution of the physiotherapy profession through different life cycles phases. Using triangulated research methods including documentation analysis, questionnaire surveys and personal interviews a rich

picture of variables affecting the development of the profession from 1971-2000 is identified. This includes an analysis during apartheid and post-apartheid periods of why and how the profession has changed and the determinants of specific changes. The study describes and evaluates the direction and depth of those changes for the South African physiotherapy profession.

The research is original research in the South African context – in fact in the international physiotherapy context. Very few studies have been published which investigate the effect of the changing health care culture on the experiences of physiotherapists (Blau and Jette, 2002) or evaluate the physiotherapy profession relative to the changing health care arena (Turner and Whitfield, 1999). There is clearly a paucity of literature specifically focused on the evolution of professional organisations; this in spite of a considerable literature on organisational theory. The research shows the difficulties a highly regulated and successful profession experiences when it is made to make radical changes in the face of a new socio-political environment. However, in many respects this has placed the South African physiotherapy profession ahead of its more illustrious western colleagues eg physiotherapists in the United Kingdom have still to come to terms with Compulsory Professional Development in relation to registration. Not all states in the United States of America allow physiotherapists to practice independently.

The research advances our understanding of professional organisations and its relationship with the institutional environment in three ways: firstly to appreciate the power of the regulatory system to control a group of highly trained professionals to practice within the legal requirements; secondly to understand that professionals will use the regulatory system to defend their gains and exclusivity over a specific knowledge domain even if they themselves are restricted by such rules and thirdly, professionals will defy institutional values and expectations if these go against the profession's self-interest. The autonomy and self-interest of health professions has come under considerable scrutiny under the new political regime with suggestions that health professionals cannot unilaterally determine their roles in the current health care system. Hence a tension develops between self preservation and the need to monitor the actual performance of the physiotherapist as measured by the outcome relative to expectations. Further research could be conducted to establish the role of agency theory and the practice of physiotherapy in South Africa.

The research also highlights the importance of special interest groups and the role of structure in professional organisations. The professional chairmen had little influence on strategic development of the physiotherapy organisation, whereas individuals and special interest groups and even some committees were very influential and held considerable power within the organisation. Previous literature has given very sparse attention to this point (Dukerich, 2002) and

further research needs to be carried out into the role of specialists and cohort groups and the effect they have on strategic development in professions. The research draws attention to the importance of the perceptions of members towards organisational identification, image and identity and the role this plays in the profession's ability to develop new strategies involving competitive advantage and market expansion. Further research should investigate the relationship of the physiotherapists' assessments of the attractiveness of the health system's perceived identity and their cooperative behaviour.

Finally, the research makes a special contribution to organisational research and illustrates the advantages of using multi-method research to develop a rich description of the values, perceptions, decisions and activities of a small professional group over three decades. The complexity of this research with its multiple levels of analysis has attempted to draw together a wide variety of theoretical elaboration and constructs employed.

### **LIMITATIONS**

The findings and future work must be considered in the context of this study's limitations. The limitations of the research lie in the fact that only printed material was used to develop data and clearly that does not reflect all aspects of the research subject. The printed material itself could be construed as being anecdotal and biased – not necessarily reflecting what actually happened but what the recorder believed to have happened. Research which includes interviews with members of the profession making use of contemporary methods described by Ambrosini and Bowman (2002) and Johnson and Johnson (2002), would greatly add to the understanding of the profession.

The theoretical framework made use of three contemporary theories concerned with inter-organisation and organisation-environment relationships, the study therefore focuses on environmental determinism, this is an accepted form of academic research however other approaches such as agency theory would also make a further contribution to the body of knowledge of professional organisations.

The results reflect the unique situation of the physiotherapy profession in South Africa and caution must be exercised towards assuming similar results for other countries of the world.

### **SUMMARY**

The expectations of the contemporary world towards health care professionals is far removed from that of 1971. Today the client expects to be told, before any treatment is delivered, what the cost will be. Clients search for the 'best value' and expect to be part of the decision making process about their health. Many

aspects of the professionalisation processes have been socialised and society has created very high and sometimes unrealistic expectations of what health care can deliver. The majority of physiotherapists have moved away from bureaucratic forms of employment to self employment carrying a heavy load of professional responsibility. The professional values and respect for human rights are expressed in ethical codes but these present moral dilemmas in the face of the modern era of economics and accreditation regulations that drive practice. Physiotherapists, who have fought so hard for professional autonomy, find their autonomy being eroded in the face of evidence based practice, managed health care and enforced continuing education. Those working for the state have to move away from traditional ways of organising themselves in large hospital environments to a more community orientated environment where the central role of primary health care requires new approaches to prevention of disability and promotion of good health.

Modern physiotherapists find themselves in the midst of considerable change and uncertainty in the health care environment and this presents major challenges to the profession as a whole, placing its sustainability under stress. This research would appear to suggest that strategically, they need to focus less on the areas of control and perfectionism and expand into more innovative forms of practice. The four principles which underpin the strategic development of the physiotherapy profession in South Africa and the two paradigms describing this process of strategic development provide the profession with a blue print on which to work. The focus must change and be directed at developing and creating knowledge and a more flexible and innovative form of practice.

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University of Cape Town

**APPENDIX 1  
PROPOSAL**

University of Cape Town

**TITLE: The Growth, Development And Survival Of A Health Care Organisation: A Longitudinal Study Of The South Africa Physiotherapy Profession from 1970 - 1999.**

**RESEARCH QUESTION: How Does A Relatively Small Professional Organisation Manage Its Key Survival Factors In Order To Maintain A Dynamic And Viable Position In The Changing Health Care Industry?**

## **PURPOSE**

The purpose of this research is to construct a theory or paradigm which will describe, explain and predict how the physiotherapy profession manages itself through its different organisational structures and develops a strategic decision making process in order to maintain an active position in the changing health care industry.

The research will investigate the significance of the broad developments and changes which have taken place, and continue to take place, in the health care industry from 1970 - 1999, and the demands these place on the South Africa physiotherapy profession.

The research will also investigate i) how the South African physiotherapy profession seeks to take advantage of the new opportunities, or responds to counter threats and constraints in its external environment ii) the significance of these demands for organisational practice and management within the South African physiotherapy profession over 30 years; iii) and the implications and challenges which arise in terms of ongoing decision making and organisational strategy for that profession.

The main methodological focus will take the form of a triangulated, multi-method qualitative research study, utilising unobtrusive historical content analysis, a survey questionnaire which will include some quantitative data, and semi structured interviews allowing for in-depth examination of phenomena.

Reference will be made to contemporary theories of organisational change, in particular i) population theory, institutional theory and resource dependency theory, in order to present historically grounded descriptive material which explains and offers key factors for organisational survival in the changing contemporary world and ii) strategic decision making theory which offers conjectures for understanding the strategic and tactical responses made by the South African physiotherapy profession to its environmental demands.

The purpose of the research is an attempt to provide some answers to the main research question. In so doing it will:

- i) develop a theoretical framework utilising contemporary models of organisational change for understanding the development, growth, and survival of the South African physiotherapy profession
- ii) describe the South African physiotherapy profession in terms of a profession-specific paradigm and place this within a dynamic historical context
- iii) identify and categorise the complexity of demands in the environment, as perceived by members of the profession, and to analyse the process of interpretation adopted by the profession as it attempts to understand and respond to these demands
- iv) track and categorise, in chronological order, the strategic decision making process used by the organisation, in order to draw inferences and patterns in strategic responses.
- v) analyse the changes in technology, structure and core business in relation to the key survival factors

### **PROBLEM**

No formal theory has been developed which contains a physiotherapy paradigm for understanding and managing the health care environment. A number of recent authors (Paartero, 1982; Tynne-Lenne, 1991; Richardson, 1993; Grant, 1995;) have challenged physiotherapy organisations world-wide to question their profession and its place and role in health care. They have suggested that the use of a paradigm as a theoretical concept could frame the questions which would help to establish an organisational identity and definition for the profession and develop a substantial theory.

The majority of physiotherapy scientific inquiry has focused on a logical positivist paradigm underpinning "the medical model" stressing the importance of experimental research and quantitative methods (Parry, 1997). Whilst this is likely to continue as the dominant culture of research, the radical changes in health care policies and philosophy throughout the world, encourages the professions to define their positions and roles using a more interpretive approach. A physiotherapy paradigm requires the profession think of themselves in terms of what they do, how they do it and how they identify themselves in terms of professional values. This process of critical self reflection and self identification helps to determine what is given attention, what interpretations are made and what behaviours are elicited.

Kuhn (1970) used the term paradigm to express unique thinking, acting and methods of solving problems of a particular group of people. The notion of a paradigm has the potential to help clarify, express and evaluate fundamental beliefs which underpin physiotherapy organisation (Richardson, 1993). In the absence of such a notion this research will attempt to construct a conceptual framework from which it will be possible to develop a unique physiotherapy paradigm for sustaining itself in the health care environment and also contribute to a theoretical body of knowledge about professional organisations.

## **THE HEALTH CARE ENVIRONMENT**

Like most industrial and organisational environments the Health Care environment experiences ongoing constant change. The 1970 and early 1980s were characterised by expansion and few real controls on costs. Major investments were made in developing personnel capacity in the form of specialist medical training, new nursing and allied health schools (including physiotherapy), and the training of additional specialised health care personnel; major investment in research and medical technology; the construction of sophisticated facilities especially in the private sector and state tertiary care hospitals.

Historically hospitals, clinics and other health care organisations delivered health care services according to their own interests and perceived needs (Brown, 1986). Public hospitals could, within reason, justify any range of service as appropriate for meeting needs of patients. Relatively few budgetary controls existed and overdrawn budgets were either rolled over from year to year or paid off by central funds (Kirsch, 1991).

The impact of this expansion in South African can be measured in two ways - a serious escalation of costs to both the state and the consumer, and an emphasis on curative tertiary care medicine at the expense of primary health care. The development of a Western curative model of health care met the needs of the most advantaged section of the population but failed to be creative in meeting the needs of the most disadvantaged and oppressed sections of the population (Benatar, 1990).

With the change in government in 1994 a new state health philosophy, based on principles of primary health care, was formulated and imposed on the health care environment. A dramatic shift has taken place in terms of funding and priorities in health care. The public sector health care budget has been restricted with considerably reduced funding for secondary and tertiary state hospitals whilst greater priority has been established towards the development of primary level clinics and services. Thus the dominance of spending on curative medicine during apartheid era is replaced by a greater emphasis towards preventative, promotive health care and community services (Owen, 1996).

Private medical care, which is expensive and can generally only be afforded by persons with medical insurance, has seen considerable growth since medical aid schemes were introduced in the late 1960s. There has not been a notable change in government policy towards promoting health service privatisation and this is likely to remain for the foreseeable future, albeit, with differing structural and funding policies.

## **THE HEALTH CARE ENVIRONMENT & PHYSIOTHERAPY**

This research will investigate the role of the South African physiotherapy organisation during the period 1970 - 1999. Documentary evidence exists in the South African Society for Physiotherapy archives such as agendas and minutes of council meetings, records of the decisions which have been made by the organisation, and much information

is available in various scientific journals, articles, congress proceedings and public newspapers and magazines.

Physiotherapy has its origins in folk medicine (Paatero, 1982), an old traditional healing therapy using massage and simple physical agents; this traditional care was further developed in health spas utilising the healing properties of spring waters. Eventually this form of hydrotherapy progressed to physical education - the knowledge of the structure and function of the body as well as the effect of exercise which was used in situations of both health and illness. As these healers developed their skills and knowledge and adapted it for the rehabilitation of the disabled and the handicapped they were admitted within the formal health care structures. Severe injuries from war battles; polio epidemics; congenital disabilities; the increase in industrial and road transport accidents and the ability to relieve pain from arthritis and other disabling conditions justified the existence of the physiotherapy fraternity to complement nursing and medical care. Thus, at the beginning of the twentieth century (McFarlane, 1985) the first modern physiotherapy training and professional associations came into existence.

Rising living standards; increases in social equality; global communication; socialisation; professional sport; technologic advances in medicine and the concept of quality of life through improved health care have placed considerable demands for physiotherapy services. From the 1970s physiotherapy service developed to the very sophisticated level which is available at the present time, far removed from the disciplines on which it was based (Richardson 1993).

The South African Society for Physiotherapy was formed in 1926 but compulsory registration for physiotherapists was only enforced in 1972. The establishment of the Professional Board for Physiotherapy was promulgated in 1974 bringing about control of physiotherapy practice under a regulatory body. The ethical rule(21)1 allowing physiotherapists to practice only under medical referral was relaxed in 1985, allowing physiotherapists to practice as first contact practitioners ; and, in 1984, the draft amendment bill re. gazetting of medical aid fees, gave physiotherapists considerable professional autonomy to manage their own affairs and develop their scope of practice "to a point where it appears difficult to express an all encompassing concept of the uniqueness of physiotherapy care, to explain where it all fits in to health care, and to describe the direction of its development" (Richardson, 1993). Thus physiotherapy grew from a strong institutionalised bureaucratic state structure in 1970 to a private context where the individual's autonomy was particularly high and currently at least 80% of all physiotherapy services are in the private sector.

Since the late 1980s economic pressures and philosophical ideologies have led to a reassessment of health care and in particular the role and position of rehabilitation, preventative and promotive care. Medical models of curative care are being replaced by holistic models of health care which suggest a very different view from that held previously. Added to this is the fact that health care is being determined, not so much by social needs and demands, but by economic reality.

The health care environment of the 1990s and future is profoundly different from that previously experienced with a change in demand for service, greater accountability for service given, and decreased budgets for resources (Grant, 1997). The question to be addressed is how this change is managed by the physiotherapy organisation. The major catalyst for change has been brought about by the current government's demand for a primary health care approach, a change in the allocation of funding and, in the private sector, an alteration in the reimbursement system from a cost based system to a pre-determined outcomes based system - thus limiting the nature and length of services offered.

Whereas in earlier years patients were treated for their good, because it was believed patients needed the treatment, all services now, in the public and private sector have to be justified on the basis of the contribution they make to the patient outcome. Needed services in both areas of health care provision will only be retained because they are the most effective investment in funding. Further more the primary health care approach embraces comprehensive care, a concept most physiotherapists would applaud and certainly one which the organisation has accepted, but nonetheless a structure which is unfamiliar to most physiotherapists whose practice is firmly rooted in curative and rehabilitative care (Loveday, 1995).

These new developments are very difficult issues for the physiotherapy organisation to address because they run counter to the development and structure of the profession and in fact might challenge the very existence of the profession as it is currently defined (Brown, 1986).

## **PHYSIOTHERAPY AS A PROFESSIONAL ORGANISATION**

Every profession came into being to fulfil a specific social function and they are found in the division of labour which prevails with the times. In health care, professions delineated their own sphere of activities into specialist areas as they sought to define their fields into specific occupations and to emphasise their own status. In 1970 a greater proportion of physiotherapists were employed by the state in bureaucratic institutions, either hospitals or clinics, which were perceived at that time to be the main employing bodies. The classic perspective on bureaucracy was proposed by Weber (1947) and had, as one of its main characteristics, a hierarchial structure and employment based on length of service and merit. This posed many problems to the aspirations and development of physiotherapists and to the profession itself. Goode (1969) states " .... many aspiring occupations and semi professionals will *never* become professionals in the usual sense; they will never reach the levels of knowledge and dedication to service that society considers necessary for a profession." He goes on to say that even if they do reach professional level they will always be less professional ( than medical doctors) in such traits as cohesion, commitments to norms of service and control over professional violations. Organisations that seek recognition must change themselves and be able to engage in transactions which include power, prestige and income.

Mintzberg (1979) defines a professional as “someone in whom the capacity to carry out some complex, specialised work has been internalised through extensive training.” and describes the function and structure of professional organisations as follows:

1. relying for co-ordination of function on the standardisation of skills and its associated training and indoctrination
2. having considerable control over their own work but works closely with the clients served, the social system within the profession is collegial
3. standards are maintained by the self governing professional associations which sets its own occupational and ethical guidelines
4. professional associations set universal standards which emphasis the power of expertise and licensing system
5. the structure of the professional organisation becomes at the same time both functional and market-based
6. and (also) the activity is connected to some value the community considers important

In a sense professionalism can be seen as an ideology with certain crucial characteristics associated with it (Paarato, 1981), and the position and location of physiotherapy is along a continuum of professionalisation - shifting as conditions change.

The profession has, over the period under review, spent considerable time and effort engaging itself in activities which involve the above features; and the research will investigate where, on the continuum, it places itself.

Paarato (1982) comments in the closing address at the IX World Confederation of Physiotherapy congress held in Stockholm, that it is interesting that physiotherapy being a relatively small organisation within the greater health care industry holds a high status of professionalisation. She contributes this to the strong tradition for private practice where ethical rules are important and health and disease are being cared for in a direct client relationship with no direct supervision from the institutions or authorities; and where professional bodies play an important role as consolidators of the status of physiotherapy and maintainer of internal control.

An organisation is “a social structure deliberately created and maintained to get work done” (Etzioni, 1964). Physiotherapists, as part of such a social structure, occupy three main employment roles in South Africa, the role of state employee which involves making physiotherapy skills available to the public sector; the role of educator involving the training and education of under graduate and, more recently, post graduate students; and thirdly the role of private practitioner which includes contracting an individual’s skills directly to individual patients. The most immediate difference in the nature of the three roles is the degree to which the holder may define the role. Private practitioner may decide on who they may treat, how, where and when they will treat the person, and the colleagues they may associate with. More significantly there is no ceiling on earnings. The role of those in state employment is that of a professional bureaucrat where the needs

of patients have to be balanced with the needs and demands of other health care workers, the needs of the profession and needs of the individual therapist. Salary structures and terms of employment are laid down by the government and were, until recently, virtually non-negotiable.

The educators are contracted to the universities providing physiotherapy training, their contracts and terms of employment vary, and departments fall under different faculties depending on the university. Universities are autonomous bodies and set their own curriculum, examination procedures, and selection procedures for both students and staff. However all university departments undergo regular peer review under the aegis of the Professional Board for Physiotherapy. Physiotherapy students have to meet very specific competencies laid down by the Board.

The professional association has to balance the diverse needs expressed by the different coalition groups amongst its membership in order to maintain a legitimate presence both internally and to the outside community of stakeholders.

### **THE PROFESSIONAL ASSOCIATION**

Michaels (1975) describes an association as “ a collection of people who agree to come together and govern themselves by certain rules in order to accomplish things which as isolated individuals they could not accomplish.” The South African Society of Physiotherapy (SASP) in the form of a voluntary association came into being in 1926, it has gone through several stages of restructuring and has a current membership of approximately 3000 members.

Professional associations must be orientated towards the needs of its members by pursuing objectives which enhance the well-being, status, recognition and quality of the profession (Benveniste, 1987); through these broad objectives the association represents, controls and sets policy for the entire profession, ensuring the knowledge base is relevant to its task and thus legitimising the profession.

The professional association plays a central role in defining and defending its boundaries and maintaining its relationship with the external environment, influencing and informing stakeholders and preventing encroachment from other professionals.

The scope of practice for physiotherapy, which is prescribed and changes from time to time in line with acquired technologies and patient needs, lays down specific goals and unambiguous criteria for understanding the activity of physiotherapy; as such it legalises and legitimises the activity (Scott, 1992).

The South African Society for Physiotherapy frequently works as an intermediary for members and the Professional Board for Physiotherapy (a statutory body which functions as a regulatory body). The SASP plays a very important role within the organisation maintaining a visible presence both nationally and internationally. The relationship between the Professional Board and SASP is show in diagram (Addendum ).

This research assumes that it serves not only the scientific research community by developing a model which will contribute to a theoretical body of knowledge about

professional organisations but ultimately it serves the South African Physiotherapy profession.

By exploring the way in which the South African Physiotherapy profession, over a 30 year period, defends a strong and coherent professional image of expertise and service whilst maintaining its position within the on-going change and reforms of health care, the research helps practitioners understand and challenge their profession in a way that will impact and contribute to their practice.

The research also assumes that the physiotherapy practitioners have more than a superficial understanding and knowledge about their profession and in this sense they become co-partners in the research as they provide insight and information about events that have taken place.

### **ORGANISATIONS AS A SYSTEM**

The research will use systems theory to underpin the study methodology i.e. understanding that the physiotherapy organisation is only a component of a much larger socio-political system and depends on that system's support for its continued existence. An open system perspective views organisations as a comprehensive structure of coalition of interests and networks of interdependent activities, dependent on resources, information and technology from the outside environment which shapes the structure and supports the organisation.

The existence of the organisation is maintained by a boundary, separating it from its environment, and distinguishing it from other organisations or systems. This research which utilises an open system and a natural model perspective as described by Scott (1992), assumes that the boundary includes all physiotherapists registered in South Africa and their collective activities; the SASP and its activities; and the part played by physiotherapists in the Professional Board for Physiotherapy. The open natural systems models place great importance of the environment in determining the structure, behaviour and survival chances of organisations

Diagram (Addendum ) shows the organisational field pertaining to the physiotherapy organisation surrounded by a boundary beyond which the institutional or task environment make up the physiotherapy domain. Surrounding the domain is the external environment of specific social, political, technological and cultural factors to which the organisation must adapt or respond in order to grow and survive. In this study the term "organisation" refers to the function and operational boundaries, thus focusing on vital activities and relationships of physiotherapists in South Africa.

### **CONCEPTS OF ENVIRONMENT & THEORIES OF ORGANISATIONAL CHANGE**

Organisations in an open-system framework interact with their environment; environment in this context maybe defined as being composed of those institutions or forces that affect the performance of the organisation but over which the organisation has little or no direct control (Robbins, 1987). In order to develop, organisations have to be capable of

detecting trends, events, competitors, markets and technological developments in the external environment which are relevant to their survival and to which they have to adapt (Daft & Weick, 1994). In order to study how the physiotherapy profession adapts to the environmental demands this research will focus on the decision making process which results in cycles of transformation. Miles, Snow & Pfeffer, (1974) describe four processes organisations make regarding decisions over its the environment:

- i) selecting a portion of the domain or a niche in which to practice its activity and choosing a strategy for managing that domain
- ii) choosing and establishing an appropriate technology for implementing the activity
- iii) creating structures, roles and relationships to control and coordinate technology and strategy
- iv) sustainability - the capacity to survive, develop and grow.

Terreberry (1968), building on the work of Emery & Trist (1965), discusses different typologies of change and especially that of turbulence; the sheer rapidity of change as well as increasing complexity and uncertainty, precludes long term planning and environments can only be seen as being in various stages of turbulence. Mintzberg (1993), writing twenty five years later, argues that "the world of planning has always been turbulent" and therefore turbulence should be seen as normal, the difficulty lay in the uncertainty surrounding planning.

Contemporary theories have been developed to describe firstly the way in which the environment pressurises organisations to change and secondly the interdependencies between the external environment and organisations. This study will focus on three theories from the ecological perspective which all suggest that organisations attempt to obtain stability and legitimacy in order to survive; however the explanatory processes underlying motives of stability and legitimacy differ between these three perspectives and these are shown below:

- i) population ecology focuses on the task environment and selection processes (Aldrich & Pfeffer, 1976; Hannan & Freeman 1977, 1989; Baum 1996). The organisational form which can acquire resources and best fit the environment will survive until a new change cycle is set in motion and new resources are required. Organisational change is hampered by strong inertia pressures and is less frequent than environmental change (Haverman, 1992).
- ii) resource dependency theory assumes that organisations which survive are those which are best at bargaining for scarce resources. The theory focuses on the organisations ability to adapt and exercise control and influence over its task environment, the effectiveness of the organisation is its ability to create acceptable outcomes and actions utilising the resources it has acquired (Pfeffer & Salancik, 1978)
- iii) institutional theory looks at organisational structures and practices and raises fundamental questions about the governance and control within the organisation as measured against the current moral and political interest and values at that time. Organisations maintain legitimacy by conforming to societal expectations and values.

There is pressure to adopt structural similarity or isomorphism (Scott 1987; DiMaggio & Powell, 1983; Aldrich & Fiol 1994) .

## **DECISION MAKING & STRATEGY FORMULATION**

March (1987) relates decision making to theories of choice, that choices are made intentionally for collective purpose on the basis of expectations about future consequences. A choice is made between possible alternatives, in order to make the best possible choice information has to be gathered and weighed up and the legitimacy and consequences of the choice considered. Theorists of decision making agree that it can be portrayed as intentional, consequential and optimising, that is, it is assumed that decisions are based on preferences - wants, needs, values, goals and interests and that the best possible alternative is chosen (March 1988).

Decision making may be influenced by power groups or by the value system of the organisation. It can also be undermined by confusion, complexity and disorder and the problem solving and decision making process in organisations include elements of politics (Pettigrew 1973), incrementalism (Quinn 1980), satisficing (March & Simon 1958) and garbage can (March & Olsen 1976) rather than rational, foresighted and goal directed activity.

An important determinant in the decision making and strategy formulation and implementation is the organisation's life cycle. This metaphor refers to the predictable responses an organisation is likely to make to events occurring in the external environment depending on the stage of its life cycle.

Mintzberg (1991) describes strategy in conceptual terms - as a position - locating an organisation in an environment. In ecological terms the strategy becomes a niche, in management terms it becomes a domain; the place in the environment where the resources may be found. He discusses the different formations of strategy ranging from intended purposeful strategy through deliberate to realised strategy and emergent strategy. Mintzberg (1993) advocates a flexible approach to strategy allowing for vision and learning - the broad perspective may be deliberate, the specific position emergent and change is more easily accommodated.

Strategy assumes prior existence of a set of consistent goals and purpose for the profession, and strategic planning relates action to the purpose which is consistent with the goals. However, assuming that there are a number of coalition groups and individuals in the physiotherapy profession who use their own resources, including control over information as a leverage for pursuing their own interests and needs, this research has to take into consideration the possible power bases that exist within the profession which influence the decision making and planning process.

Drawing on the work of Daft & Weick (1984) this study will analyse the way in which the profession interprets its environment and then formulates strategic responses. Institutional, resource dependency and population ecology theories display both convergent and divergent emphases to the strategic responses made to environmental pressures. Their combined characteristics allow this research to draw on the work of Oliver (1991) to study the potential for variation in the degree of choice, awareness, proactiveness, influence and self interest the physiotherapy organisation exhibits in making decisions and forming strategy.

## **PROPOSED RESEARCH**

Arising from the main research question are several important sub questions which must be answered:

1. What are the main trends or cycles of transformation which have taken place in the organisation over 30 years
2. How do physiotherapists perceive their organisation over the past 30 years and how do they perceive the concept of change in the current situation
3. How does the organisation interpret its relationship with the external environment
4. What are the main contributing factors influencing the process of decision making, strategy formulation and change in the physiotherapy organisation
5. How has the professional association contributed to the growth, development and survival of the profession
6. What is the relationship between the transformation processes and key survival factors

## **RESEARCH METHOD**

The research will primarily focus on the physiotherapists and their professional association giving an account of how they think of themselves in terms of professional growth and survival. In particular the research will delve into both the past and the contemporary situation and present an account of the organisation talking about itself; about its evolution, about its development, and its performance.

The research will therefore be a longitudinal study over a 30 year period utilising triangulation methods and qualitative data analysis.

A framework has been developed figure (Addendum ) for understanding the relationship of the concepts applied to the research process; a more simplified model is shown in figure (Addendum ).

## **DATA COLLECTION**

The following steps will take place:

1. A pilot study interview pro forma was drawn up in 1995 including research questions designed to give the researcher as much information as possible in 30

minutes of interview. The questions were based on those presented as research questions in this proposal and related to how the individual physiotherapists viewed the external environment. The questionnaire was tested on 26 respondents chosen by the researcher from across the country. The aim was to establish the type and range of responses individuals were prepared to make.

2. An wide ranging literature review of both organisation management literature and that which pertains to changes in the broad health care industry and in particular literature related to change management in the physiotherapy profession.
3. This initial review will be used to construct a framework on which to base the next step, which is to consult all the Journal of South African Physiotherapy from 1970 to the most current issue and all the Physiotherapy Forum (a newsletter) from its first edition in 1985 to the most current issue. Only information which pertains to the research question i.e. only data which reflects decisions and actions, professional attitudes, trends and events will be used. These multi- faceted perspectives will be placed into the constructs which have been designed into the framework order to reflect patterns and periods. The aim is to make a systematic and chronological record of the organisations history.
4. An investigation into each construct will be conducted utilising minutes and agendas from the association's council minutes, information from other physiotherapy journals, and medical journals, newspapers and government policy and any other form information which can throw a deeper understanding on the constructs. Of interest will be the events which shaped what was going on at the time. A preliminary attempt will be made to analyse the way in which the organisation engages with the external environment will be made.
5. A general set of interview questions will be drawn up into a questionnaire reflecting the individual physiotherapists perspective of the organisational culture, the task environment and the current change processes taking place in the health care environment. This questionnaire will be distributed to a sampled group of physiotherapists. The results will be analysed using qualitative and quantitative methods.
6. In depth interviews will be conducted with selected physiotherapists who have special knowledge of the physiotherapy organisation and who will be able to give further information or clarify issues.
7. Building theory and a physiotherapy paradigm. This stage will focus on the main conceptual issues which have formed during the research e.g. patterns in change in decision making and strategies; the relationship between changes in the environment and organisational strategy and core business; the place of inertia, proactiveness, choice, niche occupancy, influence and self interest and the process of strategic positioning.

## **DATA ANALYSIS**

### **VALIDITY & RELIABILITY**

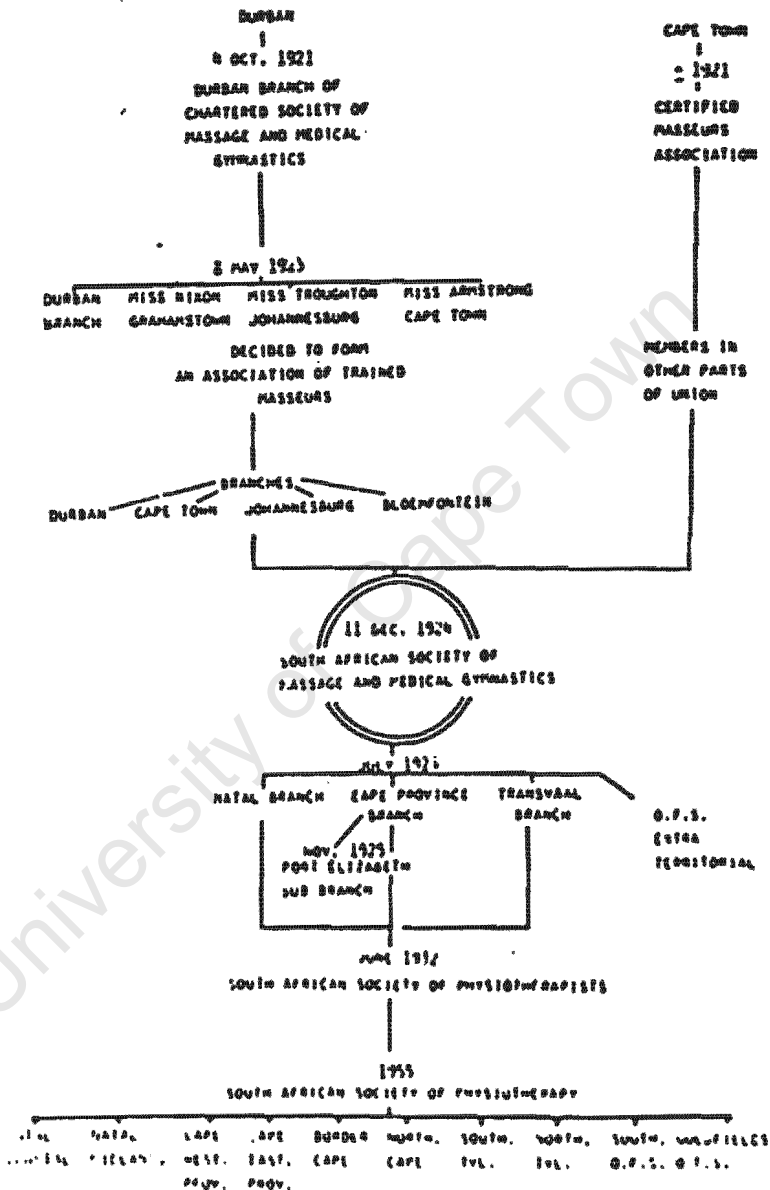
### **IMPORTANCE**

### **REFERENCES**

**APPENDIX 2**  
**STRUCTURE OF THE SOUTH AFRICAN SOCIETY PHYSIOTHERAPY**

University of Cape Town

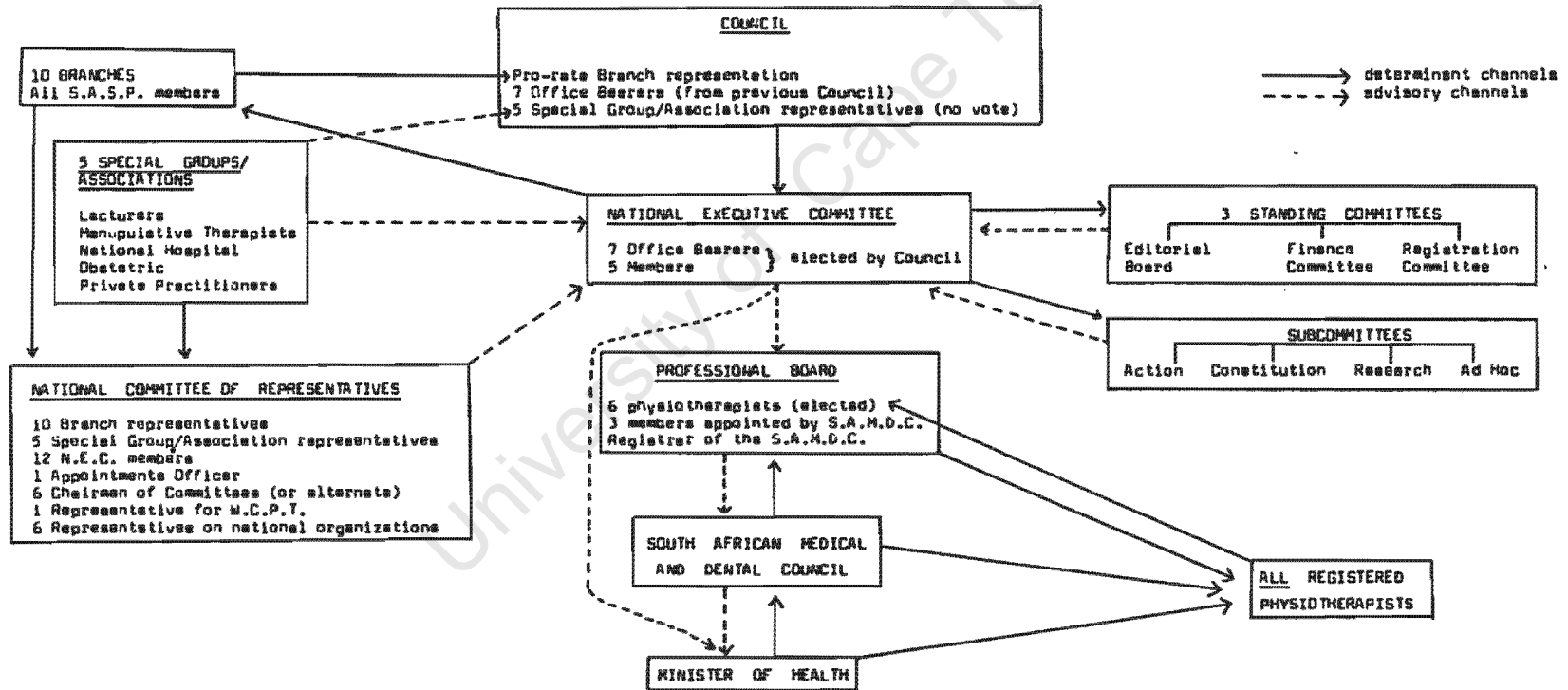
**THE FORMATION AND DEVELOPMENT OF THE SOUTH AFRICAN SOCIETY OF PHYSIOTHERAPY**



**APPENDIX 3  
RELATIONSHIP BETWEEN THE SASP  
&  
THE PROFESSIONAL BOARD**

University of Cape Town

STRUCTURE OF THE SOUTH AFRICAN SOCIETY OF PHYSIOTHERAPY AND ITS RELATIONSHIP TO THE PROFESSIONAL BOARD FOR PHYSIOTHERAPY



**APPENDIX 4**  
**RACIAL OVERTONES AT THE TRAINING INSTITUTIONS**

University of Cape Town

## Training Schools in the Republic of South Africa

### UNIVERSITY OF THE WITWATERSRAND

Acting Head of Department: Miss J. Blair, M.C.S.P., Teachers' Certificates.

Pre-entry requirements: University "A" Stream Matriculation.

Mathematics essential.

Length of Training: Four Years.

Degree: B.Sc. Physiotherapy.

English Medium.

Particulars obtainable from Assistant Registrar, Medical School, Johannesburg, or Miss J. Blair, Sub-department Physiotherapy, Medical School, Johannesburg.

### PRETORIA COLLEGE OF PHYSIOTHERAPY

P.O. BOX 437, PRETORIA.

Corner of Dr. Savage and Soutpansberg Road.

Acting Principal: Miss A. Hendry.

Full-time 3-year course of training for the National Diploma in Physiotherapy.

Educational Requirement:

Matriculation exemption with pass in Mathematics. Physical Science and Biology are also recommended subjects.

Teacher's Diploma in Physiotherapy:

The course extends over 1½ academic years at the University of Pretoria.

Requirements:

Minimum of two years' experience in approved hospitals.

### UNIVERSITY OF CAPE TOWN

#### DEPARTMENT OF PHYSIOTHERAPY

Pre-entry Requirements:

Matriculation exemption with pass in Mathematics.

Course at University of Cape Town; all facilities available for students.

1972 Degree Course.

Length of Training:

Degree Course B.Sc.—4 years.

English Medium.

Both white and non-white.

Lecturer in Charge: Miss Margaret R. White, M.C.S.P. Dip., T.P.

Department of Physiotherapy, 8 Clee Road, Observatory, Cape, S.A.

Particulars from Registrar, University of Cape Town or Department of Physiotherapy.

### UNIVERSITEIT VAN DIE ORANJE VRYSTAAT

#### DEPARTEMENT FISIOTERAPIE

Toelatingsvereistes: Universiteitsvrystelling met Wiskunde.

Graad: B.Sc. in Fisioterapie.

Tydsduur: Vier jaar.

Senior Lektor: Mnr. R. R. Rogers, M.C.S.P., Dip. Ed. Physiother. (P.T.A.).

Inligting verkrybaar van:

Die Registrateur,

U.O.V.S.,

Posbus 339,

Bloemfontein.

### PHYSIOTHERAPY SCHOOL

#### KING EDWARD VIII HOSPITAL, DURBAN

Pre-entry Requirements: Matriculation or Senior Certificate with exemption, either with 6 subjects.

Facilities: Anatomy Department—University of Natal.

Physiology Department—Durban University College.

Library—Medical School, University of Natal.

Clinical—King Edward VIII Hospital, General, Clairwood Hospital, General; Wentworth Hospital, Cardiac Thoracic Surgery; Point Hospital, General.

Courses: National Diploma in Physiotherapy—3 year training. Teachers Training can be arranged when required.

Language: English.

Races: All Non-White.

Principal: Mr. C. A. Liggins, M.C.S.P., H.T., Dip. T.P.

Further Particulars address Staff Office, King Edward VIII Hospital, Durban.

### UNIVERSITEIT VAN STELLENBOSCH

Senior Lektrise: Mej. M. J. Runnalls, Dip. Physio., C.T.P. (U.C.T.).

Toelatingvereistes: Universiteitsvrystelling met Wiskunde.

Tydsduur van opleiding: 4 jaar.

Graad: B.Sc. in Fisioterapie.

Inligting verkrygbaar van:

Die Registrateur,

Universiteitskantoor,

Universiteit van Stellenbosch,

Stellenbosch K.P.

**APPENDIX 5  
POLICY STATEMENT**

University of Cape Town

# The South African Society of Physiotherapy

## Policy Statement



The Society has the dual objectives of ensuring the highest possible standards of physiotherapy services to all peoples throughout South Africa, and of ensuring the welfare and advancement of all its member physiotherapists.

The South African Society of Physiotherapy wishes it to be known that it stands by its published Statement of Intent, made to the 11th General Meeting of the World Confederation of Physical Therapy held in Sydney, Australia, in May 1987, viz:

The South African Society of Physiotherapy reaffirms that:

1. It does not and will not discriminate on the grounds of race, colour, creed, national origins, social status or sex in the practice of physiotherapy or in the administration of its organisation.
2. Together with the Professional Board for Physiotherapy, it will continue to ensure the quality of physiotherapy services to all peoples throughout South Africa.
3. It will continue to safeguard the welfare of its members and, as it has done in the past, will make representations against discrimination against any of its members.
4. Recognising problems which have been occasioned by the division of health service administrations, it supports unequivocally the provision of a unitary health service, at the same time supporting and encouraging the progress which already has been made in the integration of health services.

On the 21st May 1987 the South African Society of Physiotherapy was one of 26 delegations to sign a Statement on the position of physical therapists working in countries where the government régime may attempt to limit or regulate their activities. This Statement reads as follows:

The 27 delegates representing member-organisations present in Sydney gathered informally because a sufficient number to permit a quorum of the W.C.P.T. were not present (some because they supported a boycott, other because their government policies prevented free association and others because financial constraints were not overcome). 26 of the delegates adopt the following position.

The Xth Congress of the World Confederation for Physical Therapy held in Sydney, Australia, May, 17 - 22, 1987, has demonstrated the positive benefits which emanate from the sharing of research and experience in a spirit of friendship and professional accord. 2311 delegates from 49 countries heard 238 papers, examined 41 poster presentations and viewed 47 film productions, all demonstrating the vitality of the physiotherapy profession around the world.

The 45 member-organisations of the World Confederation for Physical Therapy are bound by the Articles of Association and the Code of Ethics lawfully approved by previous general meetings of the Confederation. Despite the criteria for membership and these ideals of the Confederation it has proved impossible to prevent the intrusion of particular political matters originating in the governments and cultures of a number of countries.

As we know, many physiotherapists practise their profession under difficult circumstances, particularly in countries where the political system may limit, influence or prevent physiotherapists functioning professionally or personally. However, we hereby express our deepest disdain for laws and political systems that prohibit physiotherapists from practicing according to the Code of Ethics of the World Confederation for Physical Therapy.

### FOOTNOTE

It was obvious at the Sydney meeting that the W.C.P.T. had reached a crossroads. The Articles of Association have now been revised by the Executive Committee under the guidance of Miss Ruth Wood of the American Physical Therapy Association. The S.A.S.P. was one of the very few Member Organisations which submitted suggestions for the revised draft.

Of interest to South Africa is a much more explicit procedure for dealing with complaints against Member Organisations. A new and interesting concept is that of a smaller Executive Committee but the creation of a new body — a Council consisting of the Office Bearers together with six regional representatives, from Member Organisations in Africa, Europe, Asia, North America, South and Central America, and the western Pacific. This new structure would, however, only be implemented at the next General Meeting.

Arrangements are going ahead for the Special Meeting of the W.C.P.T. to be held in London at the beginning of July this year. It will be remembered that the Meeting in Sydney was inquorate, and a special postal vote has been taken since then, reducing the quorum for the Special Meeting in order that essential business can be conducted. The most important items on the agenda are the adoption of the revised Articles of Association and the election of a new Executive Committee.

It is very much hoped that the revised Articles will be adopted in toto by the Special Meeting in July, so that the Executive Committee can be given the go-ahead to plan for the future.

**APPENDIX 6**  
**GUIDELINES FOR THE TREATMENT OF POLITICAL VICTIMS**

University of Cape Town

## ***Guidelines for Members of the South African Society of Physiotherapy When Treating Prisoners, Political Detainees and/or Victims of Unrest***



A survey conducted recently by Marion Butler on behalf of S.A.S.P. established that prisoners of all types generally had adequate access to physiotherapy services. It appeared, however, that physiotherapists were not always sure how to handle the practical situations which arose. The National Executive Committee therefore decided to publish guidelines for members.

These guidelines should be read in conjunction with the Society's Mission Statement and Ethical Rules, as well as the Rules of the Professional Board for Physiotherapy.

1. The patient's dignity should be observed at all times.
2. The patient at all times retains his rights as a patient, including
  - the right to receive information necessary to give informed consent to treatment
  - the right to be afforded privacy during treatment
  - the right to expect all communications and records concerning his treatment to be kept confidential
  - the right to receive the best possible care
  - the right to refuse to participate in research projects
  - the right to refuse treatment
  - the right to request a second opinion.
3. The physiotherapist should
  - ensure the patient's privacy by requesting any guards to wait outside. (If this is impracticable, screens should be provided.)

- request the guard to remove any restraints for the duration of the treatment
  - ensure that no guard or other law enforcement officer interferes with the patient's treatment
  - Keep meticulous records of her evaluation and treatment of the patient and not release or disclose these to any law enforcement officer except when required to by a valid search warrant or subpoena or in a court of law
  - report any evidence of mal-treatment of the patient to the responsible District Surgeon immediately.
4. When the physiotherapist's rights are affected by a search warrant, he/she is entitled to demand a copy of the warrant. The warrant must be specific — i.e. it must state exactly what premises may be searched and what property may be confiscated if found. Although a police officer may search and seize without warrant should the person give permission, the physiotherapist should refuse such permission if the search is likely to breach the ethical rule of confidentiality regarding patient records. (Note that in terms of the Emergency Regulations a search may in some instances be made without a warrant. The officer concerned should be requested to quote the relevant regulation.)
  5. Notwithstanding anything written in 3 or 4, if the physiotherapist is employed in a public sector hospital, no records may be divulged without consulting the Medical Superintendent of the hospital

**APPENDIX 7  
PLAN OF ACTION FOR THE TRUTH AND RECONCILIATION  
COMMISSION**

University of Cape Town

# TIME TO ACT

*The group which collated the Truth and Reconciliation Submission have put together a draft of an action plan. They'd like your input by 28 February 1998, so do read this carefully, and let them know if you have any objections or additions. Input can be sent to: Clare Cresswell (011) 880-7112*

## **SUBMISSION BY THE PHYSIOTHERAPY PROFESSION TO THE TRUTH AND RECONCILIATION COMMISSION**

### **SUGGESTED ACTION PLAN**

The submission will have been of little worth if it is only destined for the archives. A commitment needs to be made to action to prevent a repetition of the past and promote reconciliation, and where possible redress wrongs permitted or committed.

The action plan is incomplete. Further suggestions/comments will be welcomed.

Prevent a repetition of the past and promote reconciliation within the profession.

<b>ISSUE</b>	<b>ACTION</b>	<b>RESPONSIBLE PARTY/IES</b>	<b>TIME</b>
<ul style="list-style-type: none"> <li>• All Physiotherapists should know and understand what happened in our past.</li> </ul>	<p>The TRC Submission must be taught at University (incorporated in ethics courses). Professionals to hold "Healing of Memories" Workshop.</p>	<p>Tertiary Institutions/Education Board. Professional Bodies to approach Human Rights - type NGOs to facilitate the process.</p>	<p>1998  1998/1999</p>
<ul style="list-style-type: none"> <li>• Position of Physiotherapy related to gender composition</li> </ul>	<p>Task Team to examine gender issues within and around the physiotherapy profession</p>	<p>Board to facilitate setting up of team. ? Involve Gender Commission</p>	<p>Early 1999</p>
<ul style="list-style-type: none"> <li>• Inadequacy of existing professional rules and regulations.</li> </ul>	<p>Set up a task team to change the existing "professional" rules and regulations to a moral, rights-based set of ethical guidelines to protect practitioner and patient/ clients.</p>	<p>Professional Board to set up a task team.</p>	<p>1998</p>
<ul style="list-style-type: none"> <li>• Knowledge of Rights/ lack of understanding of Civil Society</li> </ul>	<p>Workshops (? at next Congress) on: - Bill of Rights &amp; Constitution, - Declaration against Torture - and (adapted) Patients Rights Charter. Develop a protocol/ guidelines for dealing with victims of violence, abuse/ torture.</p>	<p>? Congress Committee ? Board/SASP (use NGO facilitation again e.g. Trauma Centre for Victims of Violence and Torture).</p>	<p>1998/1999</p>
<ul style="list-style-type: none"> <li>• Lack of support for a physiotherapist wishing to report unethical treatment of a patient/client.</li> </ul>	<p>Establish a subcommittee of the Board to provide such support. (should include non-professional members.)</p>	<p>Professional Board</p>	<p>1998</p>

**Read all about it** *The SASP Head Office has a copy of the TRC Submission, so if you want to read what's been said, phone (011) 485-1467 or pop in to collect your copy.*

ISSUE	ACTION	RESPONSIBLE PARTY/IES	TIME
<ul style="list-style-type: none"> <li>• Public's lack of knowledge about physiotherapy and their rights within the physiotherapeutic relationship.</li> <li>• Demographic Representivity of the Board.</li> <li>• Demographic make-up of the profession and SASOs.</li> <li>• Relationship between professionals and SASOs.</li> <li>• Ratios of private to public sector practitioners.</li> <li>• Demographic make-up of SASP.</li> <li>• Equity between historically black and white institutions and rural and urban areas in terms of:  <ul style="list-style-type: none"> <li>staff/patient ratios</li> <li>staff/scholar ratios</li> <li>staff/student ratios</li> <li>space</li> <li>equipment</li> <li>skills</li> <li>finance</li> </ul> </li> <li>• Access to Physiotherapy Training</li> <li>• Contents of training courses</li> <li>• Implementation of training.</li> </ul>	<p>Adapt Patient's/Client's Rights Charter. Media Campaign e.g. Soul City, Press releases, TV Talk Show.</p> <p>To monitor progress in the issues listed, set targets, take action where progress is unsatisfactory.</p>	<p>SASP/Board</p> <p>Board</p> <p>Board</p> <p>National PT Forum</p> <p>Board</p> <p>SASP?</p> <p>?</p> <p>?</p> <p>?</p> <p>Education Board</p> <p>?</p> <p>?</p> <p>?</p> <p>?</p> <p>Education Board</p> <p>Education Board</p> <p>Education Board</p>	<p>July/ Aug 1998 Aug/Dec 1998</p> <p>Before new Board is elected</p> <p>Every 2 years</p>
<b>Redress</b>			
<ul style="list-style-type: none"> <li>• Discrimination suffered by physiotherapists.</li> </ul>	<p>Apology by the profession to colleagues. Translation of document into relevant languages. Wide circulation of document. Request Public Service Administration to provide redress for lost benefits.</p>	<p>Provincial Physiotherapists</p> <p>Provincial Physiotherapist &amp; Professional Bodies TRC</p>	<p>TRC document End of Feb 1998 March 1998 March 1998</p>

**APPENDIX 8/9**  
**LETTER TO RESPONDENTS OF PILOT STUDY**  
**& QUESTIONNAIRE FOR PILOT STUDY**

University of Cape Town

Pat Bowerbank  
Department of Physiotherapy  
Medical School  
Anzio Road  
Observatory 7925  
tel w 021-4066402 h 0216856314

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TO

Dear

Thank you very much for agreeing to take part in my research. I am sure you are aware that I am very interested in organisations and change processes and my research will revolve around these areas. Very little research has taken place which studies physiotherapy as an organisation and factors which shape the management of our service delivery.

My research starts with the premise that organisations survive to the extent that they are effective; and physiotherapy effectiveness derives from the way in which it acquires and manages resources.

The research will examine the external forces which are changing and transforming physiotherapy practice: what different technologies, economic conditions, politico-legal factors and socio-cultural issues are necessitating a different organisational pattern within physiotherapy practice in the acquisition of resources.

The research will also seek to develop and describe models of practice which have evolved to deal with the need to acquire resources from the external environment.

I am asking the question: what accounts for the long term change in individual physiotherapy practice and in the population of physiotherapy practice within the health care industry, as it seeks to acquire resources in order to survive and remain effective.

The first part of my research requires a historical view of the fate of physiotherapy over the past 20 years 1974-1994 pre-election. I am asking you to take part in this review in order to generate a rich and perhaps broad range of factors which have influenced physiotherapy practice as outlined above. Initially I hope to interview 40 physiotherapists and from the data will draw up a questionnaire which will be validated by yourselves and a control group. The second part will look at the external forces which act on the profession for 4 years post-election.

Before I interview you I would be pleased if you could review your life experience of physiotherapy over the last 20 years and list the major resources you and your organisation (private and/or public sector) have had to acquire in order to be effective, which sector of the external environment was involved in this acquisition? Think of the critical resources and their availability. What other organisations did you have to relate to either within the profession or beyond, in order to acquire resources.

Consider major changes that have taken place in the health care arena over the last 20 years to which you have had to respond.

Think also about the effect the acquisition of resources had on your organisation, the structure, method of practice and your relationship with other organisations. How did it change your organisation?

Thank you very much for your assistance in this research I very much appreciate your co-operation

# QUESTIONNAIRE

NAME

DATE

1. As a place to start , on what basis does a client evaluate, choose or is recommended to the various suppliers of physiotherapy service
2. Over the 20 years what are the major resources physiotherapists have had to acquire to be effective as you have described above
3. From where have those resources come
4. Which have been the most difficult to acquire why is this so
5. Which have been the most critical to your organisation
6. How has the availability of resources changed over the last 20 years

7. How has your organisation adapted or restructured itself in order to ensure that you have access to resources assuming you require a variety of different resources from different sectors of the environment
8. How have you gone about ensuring that you have some influence on the availability of resources
9. Do physiotherapists have core resources which they protect
10. Are there any resources over which you have no control
11. Has your influence over this changed over 20 years
12. Have there been any significant changes in the health care arena over the last 20 years to which you have had to respond. which have been the most important to your organisation
13. If we focus on the technological changes over the last 20 years which have made the greatest impact on your organisation

14. How has your organisation gone about acquiring those technologies

15. Would you say that your organisation has responded to community needs over the last 20 years

16. How have client needs changed over the 20 years

17. How have you responded to these changes if any

18. In what ways has your organisation had to differentiate (specialise) in order to compete in the external environment for resources.

19. How have you managed to sustain this differentiation and what effect has it had on your organisation

20. What has been the effect of legislation ( in your experience) on physiotherapy practice
21. How well has physiotherapy managed its professionalisation and self regulation and how does it affect you in your organisation
22. How much control do you have have over policy and decision making in terms of your effectiveness to gain resources
23. In what way would you say that you maintain legitimacy
24. Who confers that legitimacy
25. What coalitions have you made in order to be effective
26. How dependent are you on these coalitions inorder to gain resources and to retain your legitimacy

How much degree of cooperation is there between your organisation and other organisations in the profession and outside the profession in order to gain

**APPENDIX 10  
NUD\*IST DOCUMENTS**

University of Cape Town

## DOCUMENT LISTING

### Documents

**in Set:** All Documents

**Created:** 99/05/31 - 09:23:09

**Modified:** 99/05/31 - 09:23:09

**Number of Documents:** 112

- 1 agm 1996
- 2 council 1971
- 3 council 1973
- 4 council 1975
- 5 council 1977
- 6 council 1979
- 7 council 1981
- 8 council 1983
- 9 council 1985
- 10 council 1987
- 11 COUNCIL 1989
- 12 council 1991
- 13 council 1993
- 14 council 1994
- 15 council 1995
- 16 forum april 1988
- 17 forum april 1990
- 18 forum april 1991
- 19 forum april 1992
- 20 forum april 1993
- 21 forum april 1996
- 22 forum april 1997
- 23 forum april 1998
- 24 forum april 1999
- 25 forum august 1987
- 26 forum august 1988
- 27 forum august 1989
- 28 forum august 1997
- 29 forum dec 1991
- 30 forum dec 1992
- 31 forum dec 1994
- 32 forum dec 1995
- 33 forum dec 1996
- 34 forum dec 1997
- 35 forum dec 1998
- 36 forum jan 1988
- 37 forum jan 1991
- 38 forum jan 1992

39 forum jan 1993  
40 forum jan 1994  
41 forum jan 1995  
42 forum jan 1996  
43 forum jan 1997  
44 forum jan 1998  
45 forum jan 1999  
46 forum july 1987  
47 forum july 1988  
48 forum july 1991  
49 forum july 1992  
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51 forum july 1994  
52 forum july 1996  
53 forum july 1997  
54 forum july 1998  
55 forum june 1988  
56 forum june 1990  
57 forum june 1991  
58 FORUM JUNE 1992  
59 forum june 1993  
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62 forum june 1996  
63 forum june 1997  
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65 forum march 1991  
66 forum march 1992  
67 forum march 1993  
68 forum march 1994  
69 forum march 1996  
70 forum march 1997  
71 forum march 1998  
72 forum march 1999  
73 forum may 1988  
74 forum nov 1987  
75 forum oct 1990  
76 forum oct 1992  
77 forum oct 1993  
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80 forum oct 1996  
81 forum oct 1997  
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83 forum sept 1987  
84 forum sept 1989  
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86 forum sept 1991  
87 forum sept 1992  
88 forum sept 1993  
89 forum sept 1994

- 90 forum sept 1995
- 91 forum sept 1996
- 92 forum sept 1997
- 93 forum sept 1998
- 94 FORUMA3
- 95 Memo for - council 1975
- 96 Memo for - policy & strategy
- 97 national assembly 1997
- 98 national assembly march 1998
- 99 national assembly march 1999
- 100 national assembly sept 1997
- 101 national assembly sept 1998
- 102 ncr 1976 jan
- 103 ncr 1976 nov
- 104 ncr 1977 Oct
- 105 NCR 1980 MAY
- 106 NCR 1980 NOV
- 107 NCR 1981 SEPT
- 108 NCR 1982 March
- 109 NCR 1984 March
- 110 NCR 1984 SEPT
- 111 NCR 1986 MAY
- 112 NCR 1988 JUNE

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**APPENDIX 11  
CODING OF NUD\*IST DOCUMENTS**

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## NODE LISTING

### Nodes in Set: All Tree Nodes

Created: 99/05/31 - 09:23:09

Modified: 99/05/31 - 09:23:09

Number of Nodes: 195

- 1 (10000) /Working Nodes!
- 2 (10000 1) /Working Nodes/Document Annotations
- 3 (10000 2) /Working Nodes/Free Nodes
- 4 (10000 4) /Working Nodes/ISS Nodes
- 5 (10000 3) /Working Nodes/Text Search Nodes
- 6 (10000 3 1) /Working Nodes/Text Search Nodes/TextSearch
- 7 (10000 3 2) /Working Nodes/Text Search Nodes/TextSearch194
- 8 (10000 5) /Working Nodes/TextSearch194
- 9 (4) /cycles of transformation
- 10 (4 1) /cycles of transformation/changes in practice
- 11 (4 1 2) /cycles of transformation/changes in practice/5 3 3
- 12 (4 1 1) /cycles of transformation/changes in practice/OAG
- 13 (4 3) /cycles of transformation/core technology
- 14 (4 3 3) /cycles of transformation/core technology/OMT
- 15 (4 3 1) /cycles of transformation/core technology/under grad
- 16 (4 2) /cycles of transformation/member perception
- 17 (4 2 1) /cycles of transformation/member perception/PTA
- 18 (4 5) /cycles of transformation/norms, values, attitudes
- 19 (4 6) /cycles of transformation/rules, procedures
- 20 (4 6 2) /cycles of transformation/rules, procedures/ethical rule
- 21 (4 6 1) /cycles of transformation/rules, procedures/salaries
- 22 (4 4) /cycles of transformation/rules, procedures,controls
- 23 (4 4 1) /cycles of transformation/rules, procedures,controls/action committee
- 24 (4 4 6) /cycles of transformation/rules, procedures,controls/code of practice
- 25 (4 4 6 1) /cycles of transformation/rules, procedures,controls/code of practice/PPA
- 26 (4 4 2) /cycles of transformation/rules, procedures,controls/MEMBERS
- 27 (4 4 2 1) /cycles of transformation/rules, procedures,controls/MEMBERS
- 28 (4 4 2 2) /cycles of transformation/rules, procedures,controls/MEMBERS
- 29 (3) /decision making
- 30 (3 5) /decision making/accept plan & implement
- 31 (3 5 2) /decision making/accept plan & implement/activations committee
- 32 (3 5 3) /decision making/accept plan & implement/restructuring
- 33 (3 5 1) /decision making/accept plan & implement/salaries
- 34 (3 6) /decision making/institution
- 35 (3 6 1) /decision making/institution/legitimacy

- 36 (3 6 2) /decision making/institution/norms & values
- 37 (3 6 7) /decision making/institution/value laden
- 38 (3 1) /decision making/interpretation
- 39 (3 11) /decision making/norms & values
- 40 (3 3) /decision making/policy & strategy
- 41 (3 3 6) /decision making/policy & strategy/CBR
- 42 (3 3 7) /decision making/policy & strategy/future PT
- 43 (3 3 1) /decision making/policy & strategy/PHYSIO ASSISTANTS
- 44 (3 3 5) /decision making/policy & strategy/professional advisors
- 45 (3 3 4) /decision making/policy & strategy/public relations
- 46 (3 3 4 1) /decision making/policy & strategy/public relations/non white training
- 47 (3 3 2) /decision making/policy & strategy/structure
- 48 (3 3 8) /decision making/policy & strategy/TRC
- 49 (3 3 3) /decision making/policy & strategy/undergrad edu
- 50 (3 2) /decision making/problem identification
- 51 (3 2 3) /decision making/problem identification/PPA practice
- 52 (3 2 1) /decision making/problem identification/salaries
- 53 (3 2 2) /decision making/problem identification/under grad training
- 54 (3 4) /decision making/resource depend
- 55 (3 4 6) /decision making/resource depend/goal driven
- 56 (3 4 1) /decision making/resource depend/unique~ efficiency
- 57 (3 4 2) /decision making/resource depend/value maximise
- 58 (1) /external factors
- 59 (1 1) /external factors/contextual
- 60 (1 1 5) /external factors/contextual/competition
- 61 (1 1 4) /external factors/contextual/Healthcare
- 62 (1 1 3) /external factors/contextual/state laws
- 63 (1 1 3 2) /external factors/contextual/state laws/ethical practice
- 64 (1 1 3 1) /external factors/contextual/state laws/ethical referral
- 65 (1 1 3 6) /external factors/contextual/state laws/labour act
- 66 (1 1 3 4) /external factors/contextual/state laws/registration
- 67 (1 1 3 3) /external factors/contextual/state laws/salaries
- 68 (1 3) /external factors/historical events
- 69 (1 2) /external factors/society saction
- 70 (1 2 1) /external factors/society saction/professional board
- 71 (10) /forum
- 72 (10 3) /forum/attitude
- 73 (10 8) /forum/back week
- 74 (10 7) /forum/competitors
- 75 (10 7 1) /forum/competitors/attack
- 76 (10 1) /forum/do
- 77 (10 1 2) /forum/do/control
- 78 (10 1 1) /forum/do/faction
- 79 (10 1 3) /forum/do/pessimism
- 80 (10 1 4) /forum/do/stability
- 81 (10 9) /forum/institutional
- 82 (10 9 3) /forum/institutional/compliance

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96 (10 6 1) /forum/rd/control  
97 (10 6 2) /forum/rd/share  
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112 (2 3 3 2) /internal factors/organisational field/power coalition/OAG  
113 (2 3 3 1) /internal factors/organisational field/power coalition/PPA  
114 (2 3 3 5) /internal factors/organisational field/power coalition/SASP  
115 (2 3 3 7) /internal factors/organisational field/power coalition/sports interest  
116 (2 3 3 6) /internal factors/organisational field/power coalition/unionisation  
117 (2 3 1) /internal factors/organisational field/structure  
118 (2 3 1 7) /internal factors/organisational field/structure/college  
119 (2 3 1 6) /internal factors/organisational field/structure/education committee  
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121 (2 3 1 3) /internal factors/organisational field/structure/NHG  
122 (2 3 1 2) /internal factors/organisational field/structure/obstetric group  
123 (2 3 1 5) /internal factors/organisational field/structure/PPA  
124 (2 3 1 8) /internal factors/organisational field/structure/SANDT  
125 (2 3 1 1) /internal factors/organisational field/structure/under graduate training  
126 (2 3 2) /internal factors/organisational field/system  
127 (2 3 2 3) /internal factors/organisational field/system/community practice  
128 (2 3 2 2) /internal factors/organisational field/system/salary structure  
129 (2 3 2 1) /internal factors/organisational field/system/tariffs committee

130 (2 3 5) /internal factors/organisational field/technology  
131 (2 4) /internal factors/task environment  
132 (2 4 4) /internal factors/task environment/code of practice  
133 (2 4 1) /internal factors/task environment/core technology  
134 (2 4 1 4) /internal factors/task environment/core technology/post reg course  
135 (2 4 1 1) /internal factors/task environment/core technology/quality assurance  
136 (2 4 1 3) /internal factors/task environment/core technology/specialisation  
137 (2 4 1 2) /internal factors/task environment/core technology/training  
138 (2 4 2) /internal factors/task environment/information systems

139 (2 4 2 1) /internal factors/task environment/information systems/marketing  
140 (2 4 3) /internal factors/task environment/scope of practice  
141 (5) /KSF  
142 (5 1) /KSF/legitimacy  
143 (5 1 3) /KSF/legitimacy/back week  
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146 (5 1 4) /KSF/legitimacy/under grad ed  
147 (5 1 2) /KSF/legitimacy/visibility to state  
148 (5 4) /KSF/life cycle  
149 (5 4 1) /KSF/life cycle/black empowerment  
150 (5 3) /KSF/niche  
151 (5 3 3) /KSF/niche/managed health care  
152 (5 3 1) /KSF/niche/PTA  
153 (5 3 2) /KSF/niche/unionisation  
154 (5 2) /KSF/resources  
155 (5 2 2) /KSF/resources/group  
156 (5 2 2 3) /KSF/resources/group/MTG  
157 (5 2 2 1) /KSF/resources/group/salaries  
158 (5 2 3) /KSF/resources/individuals  
159 (5 2 1) /KSF/resources/profession  
160 (6) /political manipulation  
161 (6 3) /political manipulation/Bill of rights  
162 (6 6) /political manipulation/black PT  
163 (6 6 1) /political manipulation/black PT/salaries  
164 (6 7) /political manipulation/TRC  
165 (6 2) /political manipulation/WCPT  
166 (12) /Search Results  
167 (8) /STRUGGLES  
168 (8 5) /STRUGGLES/action committee  
169 (8 5 6) /STRUGGLES/action committee/internal SASP  
170 (8 6) /STRUGGLES/internal  
171 (8 8) /STRUGGLES/membership transformation  
172 (8 7) /STRUGGLES/OAG  
173 (8 3) /STRUGGLES/PPA  
174 (8 3 1) /STRUGGLES/PPA/managed health care  
175 (8 1) /STRUGGLES/PTA  
176 (8 2) /STRUGGLES/SALARIES

177 (8 4) /STRUGGLES/undergrad training  
178 (11) /sustainability  
179 (11 1) /sustainability/institution  
180 (11 1 2) /sustainability/institution/contextual  
181 (11 1 1) /sustainability/institution/effective mgmt  
182 (11 1 3) /sustainability/institution/regulatory  
183 (11 12) /sustainability/resource dependent  
184 (11 12 3) /sustainability/resource dependent/competency blue print  
185 (11 12 2) /sustainability/resource dependent/protect unique  
186 (11 12 1) /sustainability/resource dependent/value enhancing  
187 (7) /SWOT  
188 (7 3) /SWOT/opportunity  
189 (7 1) /SWOT/strength

190 (7 1 1) /SWOT/strength/action committee  
191 (7 4) /SWOT/threat  
192 (7 2) /SWOT/weakness  
193 (9) /UNCERTAINTY  
194 (9 1) /UNCERTAINTY/community practice  
195 (9 2) /UNCERTAINTY/internal

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**APPENDIX 12  
CAUSAL MAPS CHAIRPERSONS REPORTS**

University of Cape Town

As we continue to grow with particular needs and problems	G	MN	Special groups will be formed such as the PPA
WCPT held a council meeting to vote for a new committee	PA	IL	SA was not elected back onto The committee
The 6 international congress of WCPT was held in Amsterdam	PA	IL	3 papers were read by our members which were well received- good publicity
The passing of the medical, dental & pharmacy act was passed in June 1971	R	MI	A great deal of publicity was obtained by whatever means
The salaries of non-white physios remain a worry	PL	SF	We met with the director of provincial hospitals to discuss salaries & service structure
The Maitland course on mobilising techniques took place this year	T	EX	It was an unparalleled success
The branches have held several follow up courses	EX	SD	The practice is very much on the increase
The profession is growing more interesting & exciting	G	MN	We are entering a new phase of history of physio – we must push forward our profession

Chairman's report  
1971

In april 1973 the election took place for the first professional board for physiotherapy	R	C	our profession had at last attained proper protection for its members and its standards
The function of the Boards	R	C SF MC	1)protect the public 2)to maintain high standards of physiotherapy and training and 3)to deal with the registration of physiotherapists.
We have continued in our efforts in public service	E	SF	to obtain salary structure
non-white physios we have not made much progress	SF	P	we have written to the depts health Bantu, Indian, Coloured affairs
Regarding nonwhite salaries	SF	S	We also wrote to SAMA
The ethical rule was passed at the last SAMDC council meeting	R	SF	re employment of physios by a medical or dental has caused much friction amongst physios
physios being employed by medical practitioners.	SF	S	A referendum was held amongst physios a small majority were not in favour of
Maitland course techniques	TEC	ES	The physiotherapists have given lectures and courses to the branches
following the national games	C	SF	There has been much interest in sports injuries where physios supplied round the clock services for the athletes.
post-grad courses to a recognisable standard	ES	MC	Special meeting of the Training and Registration committee to discuss
New school opened at Garankuwa	S	ED	Training of non-white physios
Need for physio training in paediatric physio	TEC	IL	Looking for foreign physio to help
physiotherapy practice	SF	MC	Required to be defined
other professionals encroaching on our fields of work	C	MC	ensure that your profession does not retrogress and become second class

Chairman's report 1975

necessity to organise post registration courses of a worthwhile length	ES	IL	SASP brought out an experienced physiotherapist in the field of paediatrics.
sports injuries is an area where physio is playing an increasingly important role	Tec	IL	SASP brought out experienced physiotherapy
there is a need to place physios in community service	C	ES	the introduction of special post graduate course
an increasing need for co operation with members of other disciplines	SF	ES	Investigations are being made into holding of multi disciplinary courses at post registration level
This is an era of specialisation	Tec	ES	necessary to maintain the standards of treatment of the patient and to develop new skills and research
senior level of physio are to be enticed to remain in state services	SF	E	press for a more realistic salary structure
Salary structure for non-white colleagues is still disturbing	SF	E	No opportunity goes by without us pressing for a realistic salary
Physios with unregistrable qualifications	R	MC	Open examinations have been held
source of great worry where qualifications are recognised for unlimited registration			tasks for the professional board was to revise the list of registrations make provision for limited registration.
the ethical rules of conduct for physios - employment of physios on a salary basis by medical practitioners	R	MC	a deputation of physios met with exco SAMDC agreed that this rule be altered and will conform with our own ethical rules.
public & members of the medical professions whose knowledge of physio is on the whole pathetically meagre	C	MI	physiotherapists must find ways and means of educating them & publicising physiotherapy

Chairman's report 1975

the announcement in the GG no5349 dec 1976 that certain magisterial areas to be prescribed	R	MC	Any person practicing physiotherapy who is not registered as a physio is liable to prosecution.
in respect of the community. the profession to gain its rightful status	C	MC	some qualifications formerly accepted will now not be registrable.
so as to fall into line with world wide trend of accepting individual qualifications	SC	MC	The list of registrable qualifications is being completely revised
For some persons not automatically registerable	R	MC	the introduction of limited registration will permit people on an approved list to work under supervision for a period before undergoing a practical exam.
to assess comparable standards of all training centres	R	MC	The professional Board has instituted an inspection of the final year exam over a period of two years
The economic climate of the country is against salary increases	E	SF	Make commission recognise & acknowledge our standard of training. Salaries of non-white very distressing
The professional board has persuaded the SAMDC to agree in principle to the establishment of degree courses for all physio trainings	R	ES	look at the training and the syllabus- new concepts must replace old as modern knowledge and skills are drawn from the sciences basic to medicine.
policy of continuing education including multi disciplinary courses.	T	ES	several training centres have commenced further degrees and post registration courses
In order to gain necessary support from provincial authorities	E	SF	in service training of physiotherapy assistants has been vigorously tackled by the activations committee
Medical aid scheme request MOH for remuneration committee	E	SF	PPA to request tariff committee
We are under fire at WCPT regarding the acceptable policies in this country.	P	MI	We will have to convince the international body that we not necessarily subscribe to these views.

Chairman's report 1977

make a wider circle more aware of our profession its capabilities function and value	C MI	As we expand & spread our tentacles
SA did not retain its seat on the Exco of WCPT	PA IL	this is an effective way of making ourselves known presenting a good image for SA and our profession internationally and of countering any challenges that may be made against us.
discussion centred round the change made in the Australian Associations ethics	PA R	the removal of the clause which requires all patients to be referred by a registered medical or dental practitioner
An amazing number of member organisations and individual members were totally against this.	PA MC	amendment to the rules places the onus on member organisations to decide for themselves.
The list of unacceptable qualifications registered with the Professional Board has been completely revised.	R MC	The withdrawal of several qualifications previously registered was recommended to the Professional Board.
The concept of limited registration has been established	R SD	enables persons to practise as physios if in the opinion of the Professional Board they hold a satisfactory standard of professional education.
Criteria for the registration of additional qualifications have now been established	R ES	are designed to cover those qualifications of at least one academic year where physios have moved into the field of research.
public service commission has indicated that they may introduce a credit system for such qualifications with regard to salary structure.	E ES	professions responsibility to develop the level of professional courses at pre-basic, basic and post-basic levels.
Hundreds of masseurs will be open to prosecution	C MC	amend our scope to include only medical massage for pathological conditions –
witness the encroachment of the Phys Ed into the physio field of cardiac rehab.	C MI	We must be vigilant of the abuse in the remedial field

salary structure linked to a three year diploma course	E MC	denigration the total image of physio.
the value and ever increasing necessity for a multi-disciplinary approach to medicine particularly in the community	CU CO	Care of patient our concern must oust the unskilled untrained persons who often usurp our field.
adverse remuneration effects	E SD	resulting in an often unsatisfactory service

Chairman's report 1979

University of Cape Town

There is a general agreement on the need for the introduction of department assistants as well as a proposed training and conditions of service	G MC	The measure of control which assistants will be subject to is of the utmost importance
Need to distribute rehab services throughout the hospital and community services.	C SD	ensuring high standards of physiotherapy practice.
The future structure must include the facility for entry into the professions at several levels.	P SD	Physiotherapists will need to learn how to utilise such workers without detriment to themselves.
Change in policy regarding ethical rule 21 a comprehensive memo has been sent to SAMDC.	R MC	Acceptance would have far reaching implications, major shift in professional status, responsibility and accountability.
Intense negotiations took place between CfA – a process of differentiation of disciplines is underway with the opportunity to up-date job descriptions	E SD	The importance of this cannot be over emphasised questionnaires are to be distributed to ensure all physios are contacted personally we must use this opportunity with insight and imagination.

Chairman's report 1981

This has subsequently been turned down by MASA who want to have further clarification on what this actually means.	PA R	The ethical rule regarding patient referral has been accepted by the SAMDC but has not been promulgated.
SAMDC has agreed to an annual review of tariffs	R SD	Establishment of the tariffs committee
Physiotherapy assistant training has been approved by samdc	R SD	Posts must now be created for the category PA
Here is an urgent need for physios to expand into the field of psychiatry and ergonomics	CU ES	However very few posts are available in the dept health and physios feel their knowledge is inadequate.
In response to the need for further post registration training	P ES	A number of post registration courses have been held – industrial , exercise re-training, adult hemi plegia, basic NDT
Career and salary structure – implementation of the proposed professional differentiation has some very serious limitations	E MN	the image of physio that has been reflected was disturbing to say the least.
growth preventative and rehabilitative areas in industry, and normal schools.	CU PA	physiotherapists are being overtaken by other disciplines
We are not moving into wider spheres of community and social involvement with other organisations as much as we should be doing.	CU MC	While we are much more involved in extending certain existing fields of activity we are not yet evaluating what we are doing.

Chairman's report 1983

In order to improve community services the profession found that there are 10 posts in the whole country	CU SD	No further action is planned although it is acknowledged that physios must initiate involvement in community programmes – shortage of manpower.
The scope of physiotherapy in ergonomics, industrial and occupational physio has been investigated and clarified.	CU SD	The lack of manpower precludes expansion into this area
economic situation in the country caused some courses to be cancelled.	E ED	Post-grad and specialisation courses are regularly planned
The society was requested to examine its role in the health care system of SA and delineate its objectives for the future.	P MC	This resulted in memo being drawn up and includes research, autonomy and professional status, management skills, work satisfaction, public relations, standards of practice community needs, education needs both under, post and continuing education.
newly qualified physiotherapists are going into solus PP.	SD MC	Internship for is being considered.
there is unfortunately increasing political inspired pressure against SA in WCPT.	P IL	The next international WCPT congress will be held in Australia it was moved from India
Increasing demands are being made for physiotherapy services.	CU SD	The provision of adequate physiotherapy physio services for the whole community will be the major responsibility of the future.
but the present economic crisis precludes creation of such posts	E SD	16 PAs are registered with SAMDC and centres are applying for permission to train them,
Physiotherapists working in Ciskei are faced with maintaining standards & rendering a services during a time of proliferating demands Ina situation where they are not in control and where plans are	SD P	Profession has approached Dept Health & Co-op & Development.

being made to set up a physiotherapy training centre		
consider the introduction of a new/different level of course at technicon or university –	T ED	The need for an alternative training programme for physio is under discussion.

Chairman's report 1985

University of Cape Town

A needs survey was carried out regarding the availability of physiotherapy services and the perceived needs of the communities.	CU SD	It was found that physio must play a greater role in preventative services particularly in schools, industry, sports clubs. Greater emphasis needs to be placed on the education of families and other care givers in the management of the terminally ill or severely disabled.
in order to plan for improved health care.	CU SD	It was found that a high level of consultative and educational services are required in the rural areas
as centres for mentally handicapped persons are increasingly making use of physiotherapy assistants	CU SD	There is still a great need for physiotherapy services in these centres
Home visits are not economically rewarding in the private sector	E SD	problem of community care needs urgently to be addressed
This has culminated in a new PAS being implemented with parity of salaries being a reality.	E SD	Continued and exerted efforts have been made regarding salary and career structures. Meetings have been held with the MOH and DG for dept of health and DG of Cf A.
The improved salaries will hopefully	E SD	stop the drain of physiotherapists from hospital service.
A census was carried out to this showed that the needs of the rural areas are not being meet	CU SD	physiotherapists are not interested in this important facet of physiotherapy. More physiotherapists are entering private practice which is compounding the problem.
We were asked by MOH to investigate ways and means of setting up a three tier plan of training	R ED	is being investigated by the Education committee. It was decided to start on a competency profile for the graduate physiotherapist.

Chairman's report 1987

<p>policy statement drawn up by Chairman expresses concern at the apparent lack of involvement by members in the issues of the day which affect the lives of our colleagues And the health of all the people of our country.</p>	<p>P</p>	<p>Based on this a Priorities for Action has been drawn up.</p>
	<p>SD</p> <p>ED</p> <p>MI</p> <p>MN</p> <p>P</p> <p>SD</p>	<ul style="list-style-type: none"> <li>• The fragmentation of the Health Services has made the availability of health care to all people even more difficult. A unitary service under one administration to deal with all aspects of health is advocated by the profession</li> <li>• More physiotherapists need to be trained especially black and coloured to offer an approved service. Universities have been approached regarding selection procedures and bridging courses.</li> <li>• Physiotherapy as a career must be marketed at black schools</li> <li>• Means of providing bursaries for black students must be found</li> <li>• Attempts to tackle discrimination both on racial grounds as well as on the basis of gender. We advocate the abolition of the group areas act which makes professional activities very difficult. We liaise with a number of womens organisations to alleviate discrimination against women.</li> <li>• Guidelines for the treatment of detainees, prisoners and victims of unrest have been</li> </ul>

		<p>published in the journal  Counteract the adverse affects of  the academic boycott on the  development of physiotherapy  services  The profession affirms its fight  against all forms of  discrimination in the practice of  physiotherapy and the  administration of the profession</p>
A survey reviewing quality assurance was conducted over an 18 month period	SD MC	Clinical competence, efficient administration, measurement of treatment outcome, communication were adjudged as some of the key areas needing evaluation.
The review is essentially a peer auditing procedure	MC SD	provide objective information regarding patient care. It assesses practice not practitioners.
A proposed specialisation process involves the setting up of a college of physiotherapy. This will function as an independent entity.	G ES	Speciality boards consisting of members of the various special interest groups
The World Health Organisation recommended that in view of the evidence so far submitted SA relations with WCPT should be maintained.	P IL	WCPT has regionalised and SA has been allocated to the Africa division with Kenya, Nigeria, Zambia, and Zimbabwe
The feasibility of independent practice without mandatory referral to a medical practitioner is being investigated.	R SD	It is assumed that physiotherapists are now adequately professional to cope with practice outside the medical umbrella.

Chairman's report 1989

strategic planning exercise had been completed to groom members	MN	MI ED	participate in development and participation in society activities, public relations and post graduate education
Meetings held with MOH and various health departments becomes clear	P	SD	physios will have to find a niche in preventative and promotive health in order to survive.
Need for national policy for physiotherapy in community	P	MI	Memorandum relating to physios position in these areas has been drawn up
The collective bargaining position for physios is steadily deteriorating	E	SF	and the formation of a professional union will strengthen the impact of applications for improved salaries and conditions of service.

Chairman's report 1991

University of Cape Town

The scope of the biokineticians was investigated and a committee was later set between members of the SA Assn for biokineticins and SASP	PA MN	Memorandum relating to physios position in these areas has been drawn up to discuss common problems and to work towards a better understanding between our two professions.
Policy required to state role of physio in future health services	P SD	We will prepare position papers on the role of physiotherapy in rehab, primary health care and the role of mid level and grass roots workers in relation to physiotherapy services
A steering committee of the interdisciplinary health forum was formed by several allied medical health professionals to look into unionisation	PA MN	This then became a body Professional Health Organisation (PHOSA).
We were very concerned at the lack of physiotherapists in the SA team to the Olympics	CU MI	this matter has been taken up with the Olympic committee as have other issues concerning physiotherapists involved in various overseas sports tours.
Now that VAT has risen to 14%	E SD	we have been battling to get a VAT zero rating on physiotherapy services
Physiotherapists have motivated to work as veterinarian physiotherapists	CU ED	it is clear that in order to do so they will have to complete a course which includes animal anatomy and physiology.
alternative physiotherapy training seems to have given rise to all sorts of speculation and adverse criticism.	ED CO	The Natal technicon seems to be he best facility to start a course and is very keen and willing to do so.
If physios do not want to get involved the technicon might still go ahead without us.	CO ED	A clear policy is urgently needed on this educational issue.
People do not know about physiotherapy	CU MI	The possibilty of advertising our profession has been thoroughly investigated
The College has inaugurated and is a fully constituted autonomous body	ED ES	it is possible to register as a student in any one of 3 specialities.

the on-going campaign against smoking	P MI	we sent a document to the MOH setting out our suggestions for limiting smoking and banning smoking in certain areas.
Chapmar Industries produce and market a video and pamphlet on correct lifting for workers and	CU MI	they asked us to endorse the product we decided to do so and receive 2% royalty.

Chairman's report 1993

University of Cape Town

The fact that we are meeting here this week amidst the uncertainties that we are in is an act of faith in the future,	PL MN	We hope to start anew the business of practicing our profession to the benefit of our patients and ourselves.
What we do not know is the place of physiotherapy in the different scenarios	SC MN	We certainly have expounded on the role of physiotherapy in the new south africa.
Perceptions of how the desired health care of the future is to be achieved vary greatly.	PL SF	What we have done is an enormous amount of preparation for participating in any of several scenarios.
An analysis of Health care Personnel omitted altogether the Supplementary Health Services Professionals. A disquieting omission.	E SF	The abolition of the names of the different Supplementary Health Service Professionals with the replacement by the generic term health Therapist.
Nearly 20 years of close collaboration with the various health administrations all deleted without any consultation.	PL MN	Suddenly in the name of Rationalisation we have been deprived of our identity.
More than ever before will we have to educate inform and disseminate information to the public	CU MI	For the past decade we have been intent on projecting a positive image to related professions and the public
We must be seen to deliver quality, affordable, appropriate care, especially where it is needed in the community.	CU MI	Our future image will depend on each and everyone
We are aware of the critical situation of the physios in public service	SD E	have pressed for a full investigation into the post structure and salaries for physios.
Newly qualified physios are entering solus practice immediately after qualifying	SD MC	recommended to professional Board that all newly qualified PTs receive only limited registration during their first year of work.
We had a meeting with MASA to discuss the issue relating to physiotherapists referring patients to specialists	PA SD	they want PTs to refer first to GP only in exceptional cases can a PT refer directly.

Chairman's report 1994

April we were able to entertain four members of the WCPT Exco committee to lunch in our offices.	PA IL	We were able to discuss matters of relevance to both WCPT and SASP. SASP is hoping to make a bid to host WCPT world congress in 2003.
the unfair recognition by the WCA of chiropracs as first line practitioners	CO R	The SASP has been working very hard trying to get the law changed so that we too may be recognised as such. We will employ someone on our behalf as legal representative at parliament
We have also been concerned with primary and secondary levels of physiotherapy training at the technicons	CU ED	We consulted as many physiotherapists in this field as was possible before completing our reply – support multi level entry
The DOH asked: How does our profession view the roles of CBR & CRF and their inclusion in the formal health system?”	P SF	our recent input to the Health department concerning CBR workers and CRF has been well received.
We are also sending delegates to various workshops National workshop on the co-ordination of disability research; National Consultative Health forum.	PA MI	in order to keep a high profile
We also met with the Presidents of the Speech & hearing and OT Assn	PA MI	to discuss matters of common interest to deal with relevant issues.
We will now fall under a Board which incorporates the biokineticians and podiatrists so we will no longer have our own board.	R MC	The whole restructuring of the SAMDC and the Professional Boards has been of great concern to us
The whole question of whether we are liable for VAT or not has been of great concern	E SF	and we are making an application to the dept of finance for exemption

Chairman's report 1996

The parliamentary hearing on medical and dental and supplementary health professions bill and the medicines control councils bill.	PL SF	We gave an oral presentation to the Parliamentary committee on health
The PPA attended a negotiating forum with Sanlam Health on Managed Health Care the current minefield in privatised health	E MI	The physiotherapists on the tariffs committee were congratulated by the RAMS committee on their presentation they said that the physios are streets ahead of other health professionals vis a vis costing and presentation of figures.
With regard to the professional board	R PA	we now share the board with the biokinetician and podiatrist
The WCPT Africa congress is to take place in Pretoria	IL MI	Please put the message across and create an awareness of this important event that SA is hosting.
In April this year the Truth & Reconciliation Commission requested the medical, nursing and psychiatry professions to make submissions	PL MI	The physiotherapy profession elected to do likewise and we made representation around the country for input to this document.
keep pace with the changing face of health care in the private sector. Their biggest headache is managed health care	SC MN	The PPA continues to make enormous efforts they are constantly calling for directives from our members.
This year we received great coverage for back week	MI CU	The help line was inundated with calls and was very successful.
The children will tell their parents this alone creates an awareness	CU MI	With regard to PR to promote physiotherapy we need to target outlying primary schools in disadvantaged areas
The children will return to their homes and share their experiences.	CU ED	In the long term we need to have black students in training who come from these areas
There are huge issues facing the profession in the face of the health situation in SA today eg admission criteria for student representing the demographic makeup of the country	CU ED	not least the curriculum changes to under graduate education The profession needs to make a stand on this issue.

government has decreed that there are to be multiple entry and exit points during training to facilitate training for people who are unable to spend years on the trot training	P ED	community skills would be taught that would be multi disciplinary of nature and would cover physiotherapy, OT and speech therapy
These CBRW would then be registered with the board of PT, Bio, Pod	R MC	Thus ensuring they would be supervised which would protect our professional integrity
at present our scope consists of a shopping list of things we can do	MC MC	it was felt that we need to change this formation order to cover ourselves more fully.
WCPT has published a description of Physiotherapy	PA MC	which will be scrutinised and perhaps included in the scope.
The TRC document has been sent to all physios The discriminations of the past need to be addressed	G MC	We have drawn up a list of actions that must be taken, to prevent this ever happening again
The matter of private hospitals employing physiotherapists is a matter of concern	CO MC	this infringes on our ethical rules.
In order to accommodate the assistants who want to upgrade as well as keeping pace with developments in our profession.	SF ED	We must appraise the curriculum of our physiotherapy education to include multiple exit and entry levels
PT graduates should work for one year in public service before being eligible for private practice	SF ED	thus releasing 450 graduates per year for community service.
in order to register and ultimately practice	R ED	Guidelines will be given about Continuing Professional Education concerning a prescribed amount of continuing education lectures people must attend
The need has arisen for accreditation for quality control, specialisation, accreditation for CPD	R ED	The college of physiotherapy is now in place with three-fold functions

Because a number of complaints have arisen against PTs.	CU MC	An ethics committee will act as a peer review group a form of professional self regulation
A patients rights charter is being drawn up	CU MC	it will be mandatory to display it in places where PT services are being delivered.
The PPA has changed its name to PhysioFocus	MN MI	it is felt that its name should reflect the profession

Chairman's report 1999

University of Cape Town

**APPENDIX 13**  
**CAUSAL MAPS OF DECISIONS MADE AT COUNCIL MEETINGS**

University of Cape Town

## 1971 DECISIONS

that the society continue its efforts to obtain realistic salaries revision of the salary structure and eliminate salary differences

SF

RES

not to under take the treatment of any patient except when referred by a registered medical or dental practitioner

SF

NICHE

that a member PT may only be employed by another registered OT, a registered specialist, medical practitioner, government, provincial or municipal authority or institution approved by national council

SF

NICHE

that in view of the fact that hospitals in the non white homelands are now the responsibility of the central government the DOH be requested to sponsor training of non-white PTs for hospitals in all areas but with specific reference to the Transkei and Ciskei areas

ED

RES

that members working in hospitals form a group to be known as the hospital group on the SASP

MN

LEGIT

that council approves the formation of a manipulative therapists group

MN

LEGIT

that a PT may enter into partnership only with a registered PT

SF

NICHE

## DECISIONS 1973

That the society continue to investigate and endeavour to improve the salary scales of the non-white physio

SF

RES

That the SASP be requested to continue negotiations with the central health services co-ordinating committee in order to have the salary scales of physios calculated according to their actual years of service

SF

RES

## DECISIONS 1975

That the council endeavour to obtain improved salary scales for non white physios & grading systems in provincial hospitals with a view to equality

SF

RES

That the DOH be approached with a comprehensive memo relating to salaries & conditions of service of all members with a view to the positive action to their improvement

SF

RES

That a sub committee be formed to be called the Activations committee for the purpose of considering constructive suggestions for improving the marketing of physiotherapy

MN

LEG

That the society approve the principle of post registration multi-disciplinary courses

EX

LINK

That the SASP approaches all health authorities with an offer of assistance in the investigation into the need for physiotherapy assistants and the possibility of formal in-service training and recognition

SD

NICHE

That the society draws the attention of the SAMDC to the fact that physical educationalists, in some parts of the country, are treating patients for orthopaedic and medical conditions

SD

LEG

**DECISIONS 1977**

That this council recommends to the professional board that application for registration of post grad qualification be considered on merit with due recognition of the recommendation of this council in each case

ED

LEG

That in spite of the present economic climate the NEC should continue to press for a more realistic salary structure & conditions of service for PTs of all races in Prov employ

SF

RES

That with due cognisance of the functions of the PRO as laid down in the bye laws this council give consideration to the requirements of the society with regard to PR & publicity

MKT

LEGIT

That the activations committee investigate the possibility of a purely practical training for PT assistants

ED

NICHE

That this council reconsiders the advisability of an internship period of one year following qualification prior to full registration with SAMDC

SD

LEGIT

That this council again inform the dept of labour & immigration of the exact nature of PT & the regulation regarding registration & employment as a PT in this country

MKT

NICHE

That this council recommends to the Prof Board that its policy with regard to the registration of post grad courses as additional qualification be laid down

EX

LEGIT

That the society approaches the DOH & motivates them to limit payment for PT services under the medical schemes act to registered PTs

SD

RES

That in view of the prssure being brought to bear upon certain training institutions for the creation of a 3 year degree course in PT this council request the NEC to approach the Prof Board to appoint a delegation to wait on the President of SAMDC & the rectors of UP & MEDUNSA toimpress upon them the necessity of the 4 year BSc course as the basic PT training.

ED

LEGIT

That the society should apply for the establishment of a Tariffs committee

SF

RES/LEGI

University of Cape Town

DECISIONS 1979

That a sub committee be elected to make a study of the PT career structure, conditions of service & criteria for recognition for registration of post basic qualifications which do not fulfill present requirements as laid down by the Prof Board for registration of post basic qualifications

MN

LEGIT

That all race groups should have parity of salaries & conditions of service

SD

LEGIT

Rather than insisting on first contact PT which in this country would mean changing the law of the land .....

Not to undertake treatment of any patient except when referred by a registered medical practitioner or dentist except in an emergency or for some other exceptional reason or unless s/he has direct access to the patient's doctor

SF

LEGIT

That in the interest of the public image of PT members are reminded of its policy that PTs who are interviewed by the media must request the permission of the NEC & that committee exert careful discretion when such applications are received

MKT

LEGIT

That the society asks the Prof Board to consider amending the Medical, dental & Suppl Professions Act in such a way that other professions are excluded from carrying out such acts as may be specified & which are the scope of PT

MN

LEGIT

That the possible means whereby a multi disciplinary team of therapists in private practice may be permitted to work together for the benefit of the patient

SD

LINK

That the council endeavours to get the medical aid societies to recognise that prophylactic PT and exercise classes are accepted forms of PT and should be included if the schedule of fees as paid by medical aid societies

SD

RES

University of Cape Town

DECISIONS 1981

That the functions of the Activations/PR committee be reviewed & that such a committee be solely responsible for promoting the profession & its interests

MKT

LEGIT

Not to undertake the treatment of any patient unless that patient has been referred by registered medical practitioner or a registered dentist or in close co-operation with such registered practitioner except in an emergency

SF

NICHE

That an action committee representative of all areas of physiotherapy be appointed to:

1. Assess the role that PT should play in fulfilling future community health needs
2. Formulate a plan of action in which all PT in training or qualified will be adequately equipped to fulfil these needs
3. Devise means of educating the general public as to what PT can offer with emphasis on preventative PT
4. Consider the appt of a PRO

MKT

NICHE

University of Cape Town

**DECISIONS 1983**

**That the society should delineate its objectives for the next 10 years with a view to long term planning**

**MN**

**NICHE**

**That the society requests the Professional Board to consider inspecting hospitals & other clinical facilities**

**SF**

**LEGIT**

**That the basic requirements for admission for training as PT assistant should be reconsidered**

**MN**

**NICHE**

**That the ratio of Pt to PTA be reconsidered**

**MN**

**NICHE**

University of Cape Town

**DECISIONS 1985**

that the society consider various ways of investing in property for the society

MN

RES

a member PT may only enter into partnership with another registered PT or with another registered member of a supplementary health services Profession as approved by the Prof Board for PT

SF

LEGIT

that the long term objectives and the short term goals of the society be adopted as a working basis & acted upon as recommended

MN

NICHE

That the NEC strongly re-motivate for parity in salaries

SF

RES

That the council expresses its view on the need for multi purpose therapists

SD

LINK

The treatment of any patient unless that patient has been referred... or in consultation with a colleague or another member of the health team

SD

NICHE

That the SASP recommend to the Professional Board to recommend to SAMDC the PT & rehab be included in the undergrad medical students syllabus

MKT

LEGIT

A physiotherapy promotion week will be established known as Back week and will involve all PTs in SA

MKT

LEGIT

**DECISIONS 1987**

**not to undertake the treatment of any patient except in an emergency or in close collaboration with a registered...**

**SF**

**NICHE**

**a member may enter into association with a registered member of another supplementary health services professional with the approval of the Prof Board**

**SF**

**LINK**

**that the SASP write to the universities to stress the need for higher degrees for registration in manipulative therapy**

**ED**

**RES**

**that NEC request the Professional Board to investigate means of ensuring that physios are not allowed to open solus practice without one years clinical practice in an approved institution**

**SF**

**LEGIT**

University of Cape Town

## DECISIONS 1989

A country wide quality assurance programme is essential a survey must be set up to investigate the extent to which individuals & institutions were already involved in QA and identify which individuals would be willing to help design and implement such a programme

That this council authorises the incoming NEC to initiate & implement a QA programme

ED

LEGIT

That the council approves the draft specialisation programme

ED

NICHE

That this council appoints an interim college council to draft the memo and articles of assn for the proposed College of Physio of SA

MN

RES

That this council authorises the incoming NEC to appt interim speciality boards for the purpose of formulating criteria & syllabi for each speciality area

ED

NICHE

That the society accepts the community health Assn of SA CHASA as a national body on which it may be represented

MKT

LINK

That the NEC investigate the possibility of advertising through the media in order to educate the public as to the skills & uses of PT

MKT

LINK

That the Society approach the CFA & request that the specific professional disposition for PT in state institutions be expedited

SF

RES

That this council discuss the implementation of the category of CRW & its relation to the category of PA

SF

NICHE

**That this council endorses the steps taken in initiating action against discrimination & enjoins sasp is opposed to the policy of apartheid & to all discriminatory practices .....**

**SF**

**LEGIT**

**That the SASP condemns any act of violence, torture or humiliation perpetrated by any individual or group**

**MKT**

**LEGIT**

**That this council instructs the NEC to request the Professional Board to investigate the feasibility of amending the rules of conduct to enable registered PT in SA to become independent practitioners**

**SF**

**NICHE**

**That the society accepts the SASMA as a national body on which it may represent**

**MKT**

**LINK**

University of Cape Town

## DECISIONS 1991

That the society makes urgent representation to the MOF to seriously consider giving PT a zero rating as far as VAT is concerned

SD

RES

That the SASP associates itself with the needs and aspirations of the people of SA & with all those institutions & individuals who are working towards peaceful change, in particular we support the principle of Bill of Rights, the Convention on the rights of the child, the final abolition of apartheid, universal franchise & the provision of unitary health and education systems.

MKT

LEGIT

The NEC should forward the policy statement on community physiotherapy to interested bodies such as PHOSA, CHASA & relevant authorities for discussion, recommendation & implementation

MKT

LINK

That this council agrees to the setting up of a task force to investigate & make recommendations regarding alternative PT training ( technikon level)

ED

NICHE

That the incoming NEC be requested to identify & implement the best option for unionisation of SA physios

MN

RES

That the NEC continue investigating proposals to modify the advertising regulations to make them more realistic & to encourage legislation through the Prof Board as soon as possible

MKT

RES

That the NEC investigate the possibilities & cost of marketing the Profession through the various forms of media & plan & carryout advertising the profession

MKT

LEGIT

That the NEC investigate the possibilities & cost of marketing the Profession through the various forms of media & plan & carryout advertising the profession

MKT

LEGIT

That NEC formulate a plan for the role of PT in future health services & motivate & encourage the implementation

SF

NICHE

That NEC nominate a member to carry a portfolio to monitor future health policies to be negotiated for SA

MN

NICHE

That NEC negotiate for the recognition of the need for and subsequently the granting of full legality to PTs working in the veterinary field

SF

LEGIT

That the NEC approach the CFA & ask them to consider immediately revising the present salary scale for state employed PT

SF

RES

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## DECISIONS 1993

That the SASP convene a committee which will put forward a policy statement relating to undergraduate PT training which will take into account the realistic needs of the future SA

ED

NICHE

That discussions on a third tier of training be continued & thoroughly investigated including the relationship to post structure & the better utilisation of the already available manpower & resources

ED

RES

That the SASP recommends to the Prof Board that all newly qualified PT receive only limited registration during their first year of work. Full registration to be granted only after a years practical experience at an approved institution or private practice.

SF

LEGIT

That a national continuing education programme, planned & co-ordinated by the NEC – in consultation with branches be instituted as soon as possible to provide in the educational needs of members & groups nation wide & ensure optimal use of this valuable & academic resource

ED

RES

That the SASP urge the CFA to upgrade the posts of the PT representative at provincial head offices of the various health authorities to those of at least a deputy director

SF

RES

That the society establish a peer review committee to review standards & ethics in the profession

MN

LEGIT

That the NEC take cognisance of the critical situation in physiotherapy in the public sector & press for a full investigation by the CFA into the post structure, salaries & conditions of service

SF

NICHE

That MASA be asked to discuss with the SASP the position regarding referral between PT & specialists

SF

LINK

**DECISIONS 1994**

**That the NEC motivate to establish an acceptable course in pharmacology to qualify PTs to prescribe PT related drugs**

**SF**

**NICHE**

**That the SASP ensures that the SASP is actively involved in negotiation and decision making with all its key players involved with health policy making**

**SF**

**LINK**

**That a representative task group be assigned to give urgent attention to salaries, service conditions and career structure for PTs and PTAs in the future health care system**

**SF**

**NICHE**

**That the society try to obtain a national calender of all sporting events so that physio facilities can be made available & by so doing we can market ourselves professionally**

**MKT**

**LEGIT**

**That in order to assist PT working in areas for from institutions of higher learning who may be keen to continue with post grad training without having to relocate residence, the SASP should encourage universities to develop more curricula in ling distance learning in various fields, as is the case with most professions**

**ED**

**RES**

**DECISIONS 1996**

**That Urgent Action Be Initiated At National Level To Facilitate & Promote Full Participation By Members From Differing Cultural Back Grounds In The Affairs Of The SASP in order to meet the needs of the members as well as to ensure that future delegations to national & international gatherings are more truly representative of our countries diverse heritage**

**MN**

**LINK**

**That the National assembly investigate the establishment of a primary health care/community sub-committee of the SASP**

**SF**

**LEGIT**

**That the NA investigate the establishment of formal, regular and continual meetings with relevant health disciplines eg OT Logo social work**

**MKT**

**LINK**

**DECISIONS 1997**

**THE COUNCIL SUPPORTS THE Natal technicon in the development of a 4-year PT degree course, possibly based on a modular system**

**ED**

**NICHE**

**DECISIONS 1998**

**The SASP Should Recognise The Need For  
CBRW & Take An Active Part In The  
Development Of Training Guidelines, Evaluation  
& Monitoring**

**SF**

**NICHE**

**The SASP should lobby for rehabilitation centre**

**SF**

**RES**

University of Cape Town

**APPENDIX 14**  
**QUESTIONNAIRE SURVEY**

University of Cape Town

January 2000  
Dear Colleague

**THE PHYSIOTHERAPY PROFESSION**  
**GROUP DYNAMICS QUESTIONNAIRE**

I am currently conducting research for a PhD degree through the Graduate School of Business, UCT. My research is concerned with the Physiotherapy Profession in South Africa. I have been tracking how the development process of the profession has unfolded over 30 years. I have made use of a vast amount of information from the archives of the SASP, the Professional Board for Physiotherapy, policies, documents, laws that have been passed, Forum, international literature and organisational research.

**However I wish to take in an additional aspect to this study by combining your views with my assessment. This will provide extensive depth and description for understanding the physiotherapy profession.**

The Group Dynamics Questionnaire is a simple 50-item instrument designed to study group processes and describe group experiences. It has been extensively tested by researchers in the field of organisational management and group decision making. It can be easily answered by respondents and makes a detailed assessment of the physiotherapy profession..

As you answer the questions you will observe that you are building a picture of the physiotherapy profession and this is exactly what the questionnaire is designed to do. All physiotherapists views about the profession are very important.

Please, I would be most grateful for your help  
**PLACE YOUR REPLIES IN THE STAMPED ENVELOPE ENCLOSED**  
**PLEASE POST BY 24 MARCH 2000**

**THANK YOU AND ENJOY DOING IT**

Please ring me at 021-6856314 or email [pbowerbk@iafrica](mailto:pbowerbk@iafrica) if you need any clarification

**Pat Bowerbank**

## INSTRUCTIONS

Please study each pair of items which represent two polar opposite statements. Decide on the extent to which one or other of the extreme statements characterises the physiotherapy profession in South Africa.

Category	Label
Upper statement	
1	Highly characteristic
2	Quite characteristic
3	Slightly characteristic
Middle category	
4	Neither upper nor lower statement is characteristic
Lower statement	
5	Slightly characteristic
6	Quite characteristic
7	Highly characteristic

Eg Item 5

There is an infectious can-do spirit within the profession

Vs

The professions spirit is broken

1 2 (3) 4 5 6 7

You may decide that the upper statement is Slightly characteristic of the profession you will therefor circle (3)

Or Item 24

Power is concentrated within a small subgroup

Vs

Power is dispersed across a wide range of constituencies and interest groups

1 2 3 4 5 6 (7)

You may decide that the lower statement is Highly characteristic of the profession and circle (7)

***You MUST please answer all the questions***

***Please make careful choices – and at the same time -***

***You must identify THREE upper statements, and THREE lower statements***

***Which you judge to be***

***Highly characteristic of the physiotherapy profession in South Africa***

***Circle three upper statements (1) & circle three lower statements (9)***

This is to ensure that there are not too many extreme judgements, or, on the other hand too many choices which are fence sitters. It also allows you to judge what is particularly worthy of the profession.

1. There is a widely shared belief that members require technical or scientific knowledge unique to that industry

Vs

Members have no use for technical or scientific knowledge.

1 2 3 4 5 6 7

2. The profession deeply dislikes delegating power and sharing responsibility (i.e. control must be all or nothing)

Vs

The profession appreciates the value in delegating power and living with fluid, power sharing relationships.

1 2 3 4 5 6 7

3. The profession believes in a top-down, pyramidal, and control-oriented style of management (i.e. lots of rules, checks, and surveillance)

Vs

The profession believes in a bottom-up style of management that encourages initiative and self-control among members with minimal reliance on formal rules and surveillance.

1 2 3 4 5 6 7

4. The profession is aware of and believes that it should be responsive to community concerns

Vs

The profession is oblivious to or ignores community concerns.

1 2 3 4 5 6 7

5. There is an infectious can-do spirit within the profession.

Vs

The profession's spirit is broke (i.e. apathy, despair, and defeatism prevail)

1 2 3 4 5 6 7

6. Communication within the inner circle of decision makers is highly formal with few breaches of protocol.

Vs

Council assembly meetings are raucous informal affairs with frequent and loud interruptions. ( Note: Code as neutral if the meetings are orderly but relaxed)

1 2 3 4 5 6 7

7. The profession focuses exclusively on short-term concerns

Vs

Long-term concerns loom large in decision making.

1 2 3 4 5 6 7

8. The profession has core taken for granted competencies

Vs

The profession has flexible changing competencies.

1 2 3 4 5 6 7

9. The profession believes in sophisticated and sensitive means of monitoring trends, problems, and performance throughout the organization.

Vs

The profession does not place a priority on keeping in touch with important trends and problems within the organisation.

1 2 3 4 5 6 7

10. The profession always abides by the vested interest of powerful groups within the organization.  
Vs  
The profession is more sensitive to pressure from outside the organization
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
11. The profession has lost faith in its capacity to control events.  
Vs  
The profession feels fully in control of events.
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
12. The profession always take a single-minded approach  
Vs  
The profession tries to balance many objectives in decision making.
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
13. The profession places enormous importance on public relations (i.e. appreciates the need to manipulate public perceptions of the profession, the organization and its products).  
Vs  
The profession is oblivious to these concerns.
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
14. The profession is very unsure and self-conscious of its legitimacy. (Note: Item refers to profession' perception of its legitimacy, not to others' perceptions of the profession; see Item 93.)  
Vs  
The profession is confident in its legitimacy (i.e. it assumes there is widespread acceptance of its "right" to lead)
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
15. Advocates of a more risk-taking business strategy hold the upper hand within the profession.  
Vs  
Advocates of a more cautious strategy hold the upper hand within the profession.
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
16. The profession has achieved a balance of expertise, variety of constituencies and points of view  
Vs  
One functional section of the organization dominates decision making (i.e. key areas of expertise are not represented).
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
17. The profession perceives a serious external threat to its continued existence (e.g. unfriendly takeover, government regulators, tough competitors, creditors, etc)  
Vs  
The profession perceives the business environment to be placid and relatively benign (the environment may even be supportive).
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
18. The profession has complete control over who is admitted to the group.  
Vs  
The profession consists of individuals with autonomous bases of power (i.e. group members do not owe their positions to the leader).
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
19. There is a genuine common commitment to solving problems confronting the profession  
Vs  
Members invest little energy in their work.
- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|

20. The profession easily can cope with existing problems and challenges  
Vs  
The profession is under enormous pressure or stress (i.e. challenges far exceed capabilities).  
1 2 3 4 5 6 7
21. The profession is united on the pace of change  
Vs  
There is a serious rift within the profession between the forces of organizational change and forces supporting the traditions, privileges, and understandings of the past.  
1 2 3 4 5 6 7
22. The profession attaches great importance to preserving traditional arrangements and understandings.  
Vs  
The profession attaches no importance to preserving traditional arrangements and understandings.  
1 2 3 4 5 6 7
23. The profession consists of representatives of various interest groups and bureaucratic constituencies  
Vs  
The profession consists of generalists who are not obliged to represent any particular power base.  
1 2 3 4 5 6 7
24. Power is concentrated within a small subgroup  
Vs  
Power is dispersed across a wide range of constituencies and interest groups.  
1 2 3 4 5 6 7
25. The profession shows no team spirit and solidarity  
Vs  
The profession shows strong team spirit.  
1 2 3 4 5 6 7
26. The profession has distinctive, inimitable expertise  
Vs  
The profession has shared generic expertise  
1 2 3 4 5 6 7
27. The profession members are highly attuned to their environment and major changes occurring around them.  
Vs  
Members are extremely slow to recognize the major changes occurring around them.  
1 2 3 4 5 6 7
28. The profession has limited resource options due to strong regulatory (government) pressure  
Vs  
Profession is not affected by regulatory pressure  
1 2 3 4 5 6 7
29. The profession behaves in a stable, predictable manner.  
Vs  
The profession behaves in an unpredictable, even mercurial, manner.  
1 2 3 4 5 6 7

30. Members harbor serious doubts about the profession's effectiveness  
Vs  
Members are convinced that the profession possesses skills that are critical for achieving professional goals.  
1 2 3 4 5 6 7
31. The profession always is careful to act within the law.  
Vs  
The profession is unconstrained by law or common conceptions of morality.  
1 2 3 4 5 6 7
32. Members have as their main goal to maximize profit.  
Vs  
Members have no interest in financial gain.  
1 2 3 4 5 6 7
33. The profession recognizes that painful and divisive choices cannot be avoided  
Vs  
The profession believes that it will be possible to achieve everything on its wish list  
1 2 3 4 5 6 7
34. The profession has formidable problem-solving skills and is adept at improvising solutions  
Vs  
The profession has no problem-solving skills (i.e. clueless when something out of the ordinary happens).  
1 2 3 4 5 6 7
35. The profession acts impulsively (it makes emotional decisions)  
Vs  
The profession acts in a methodical and deliberate manner.  
1 2 3 4 5 6 7
36. A new generation of leadership recently has come to power  
Vs  
A new, fresh cohort of leaders systematically is being excluded.  
1 2 3 4 5 6 7
37. The profession seeks to establish itself as being cost-effective and market-responsive.  
Vs  
The profession is only interested in maintaining its integrity and autonomy.  
1 2 3 4 5 6 7
38. The profession believes that it should be responsive to members' concerns.  
Vs  
The profession is oblivious to members' concerns (in extreme cases, may even be hostile).  
1 2 3 4 5 6 7
39. The profession plausibly can blame others for current woes  
Vs  
The profession must accept responsibility for current woes  
1 2 3 4 5 6 7
40. The profession consists of innovative pioneers (i.e. create new technologies, open up new markets, etc)  
Vs  
The profession consists of professional managers and bureaucrats  
1 2 3 4 5 6 7

41. There is a radical atmosphere in the profession (i.e. rethink old approaches, adopt new strategies and goals).  
Vs  
There is a conservative, "don't-rock-the-boat" atmosphere in the profession.  

1	2	3	4	5	6	7
---	---	---	---	---	---	---
42. The profession blatantly discriminates against disliked ethnic, racial, or religious groups  
Vs  
The profession bends over backward to display its ethnic, racial, and religious impartiality.  

1	2	3	4	5	6	7
---	---	---	---	---	---	---
43. The profession is confident that even if its current plans fail, it will be "bailed out" by powerful protectors).  
Vs  
The profession realizes it is "on its own" (i.e. success or failure depends on its efforts).  

1	2	3	4	5	6	7
---	---	---	---	---	---	---
44. The profession respects the concerns and feelings of special interest members  
Vs  
The profession shows contempt for the special interest members  

1	2	3	4	5	6	7
---	---	---	---	---	---	---
45. The profession's legitimate authority has been utterly discredited  
Vs  
The profession's legitimacy is widely accepted. (Note: Item refers to perceptions of others)  

1	2	3	4	5	6	7
---	---	---	---	---	---	---
46. The profession's members are opportunists guided only by calculations of personal self-interest  
Vs  
Members are strongly committed to the norms, rules, and goals of the organization  

1	2	3	4	5	6	7
---	---	---	---	---	---	---
47. The profession makes decisions which are culturally objectionable  
Vs  
The profession is considerate towards traditional culture.  

1	2	3	4	5	6	7
---	---	---	---	---	---	---
48. The profession makes major effort to persuade members to redefine their goals and priorities.  
Vs  
The profession places little emphasis on persuading members (i.e. works within or around current opinion).  

1	2	3	4	5	6	7
---	---	---	---	---	---	---
49. There is an atmosphere of suspicion and fear within the profession (i.e. no one knows who will be next to fall out of favor and into oblivion)  
Vs  
There is an atmosphere of trust and mutual support among professional members.  

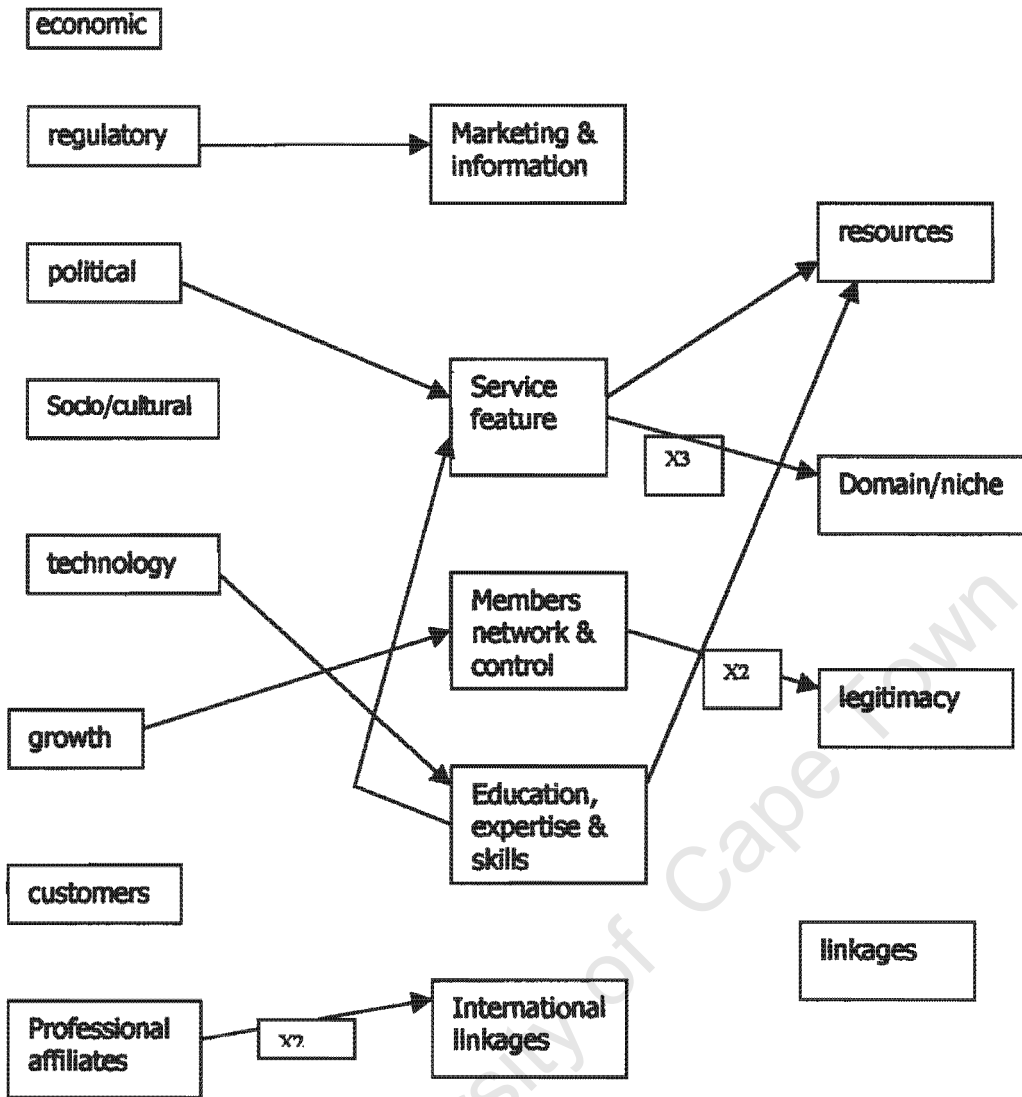
1	2	3	4	5	6	7
---	---	---	---	---	---	---
50. Virtually all we know about the profession is based on speculative reconstruction of fragmentary evidence.  
Vs  
There is a great deal of reliable evidence about the internal functioning of the profession.  

1	2	3	4	5	6	7
---	---	---	---	---	---	---

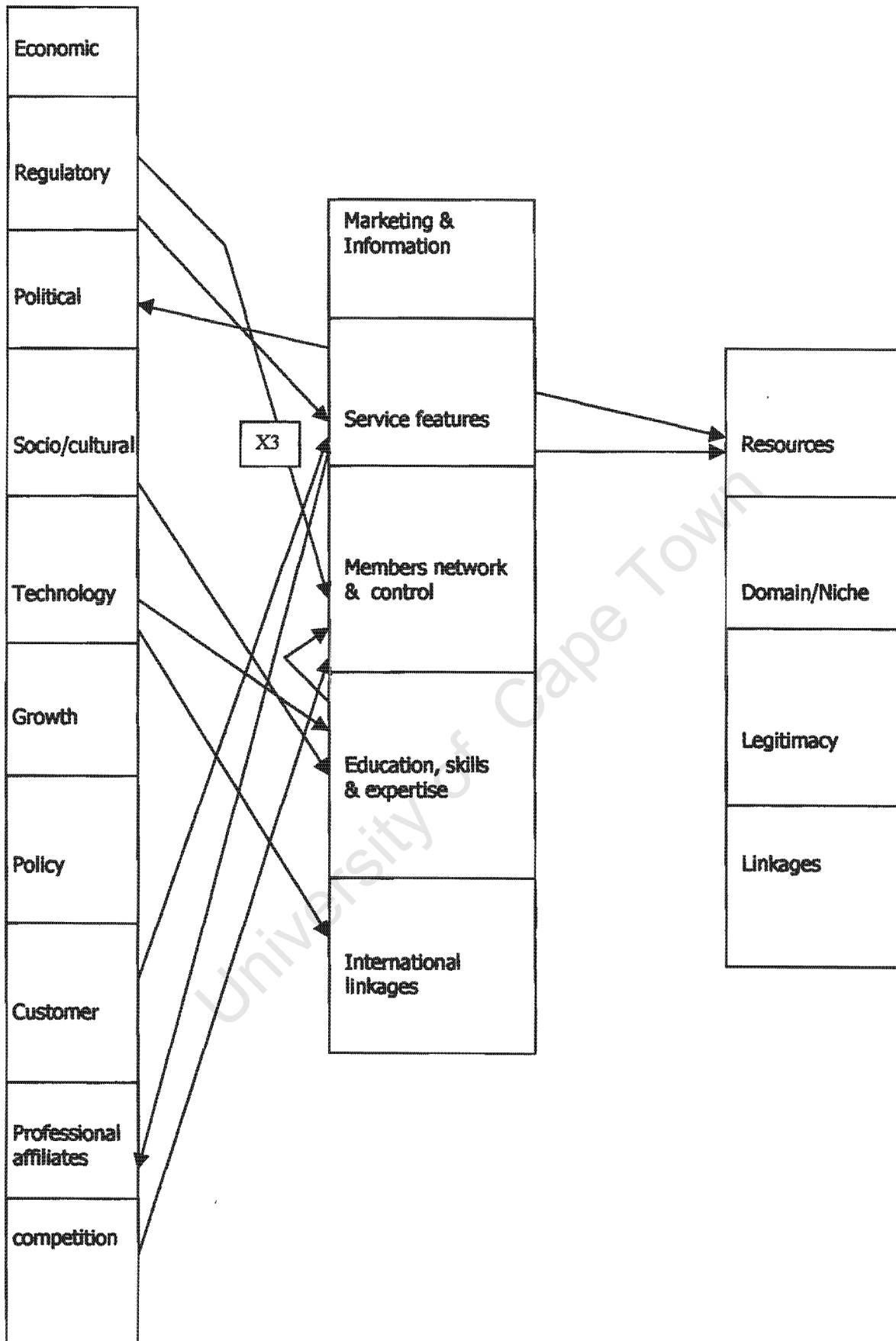
**THANK YOU FOR YOUR TIME**

**APPENDIX 15**  
**DIAGRAMS TO SHOW RELATIONSHIPS BETWEEN ELEMENTS IN THE**  
**COMBINMED CHAIRPERSONS REPORTS & DECISIONS MADE AT**  
**COUNCIL MEETINGS**

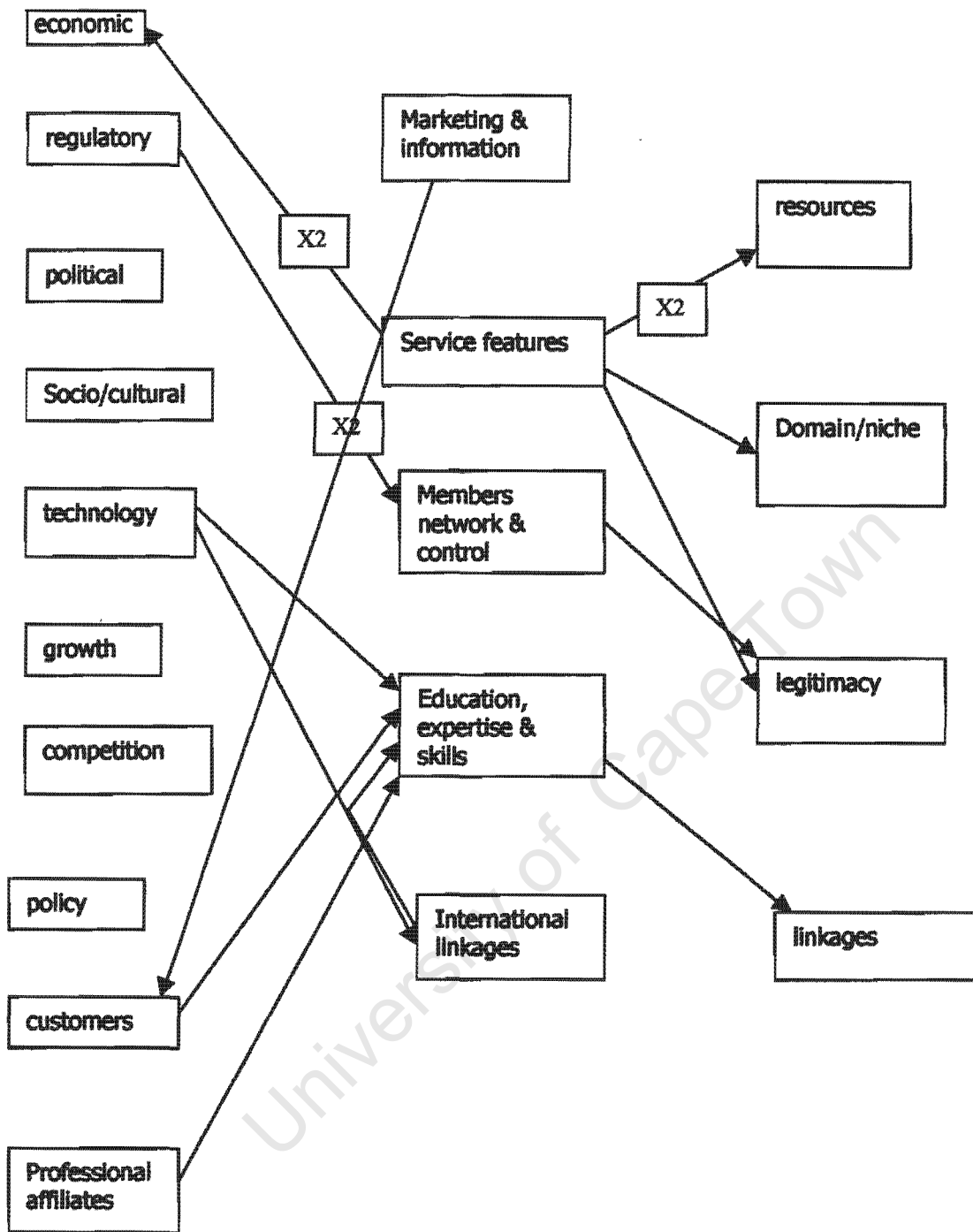
University of Cape Town



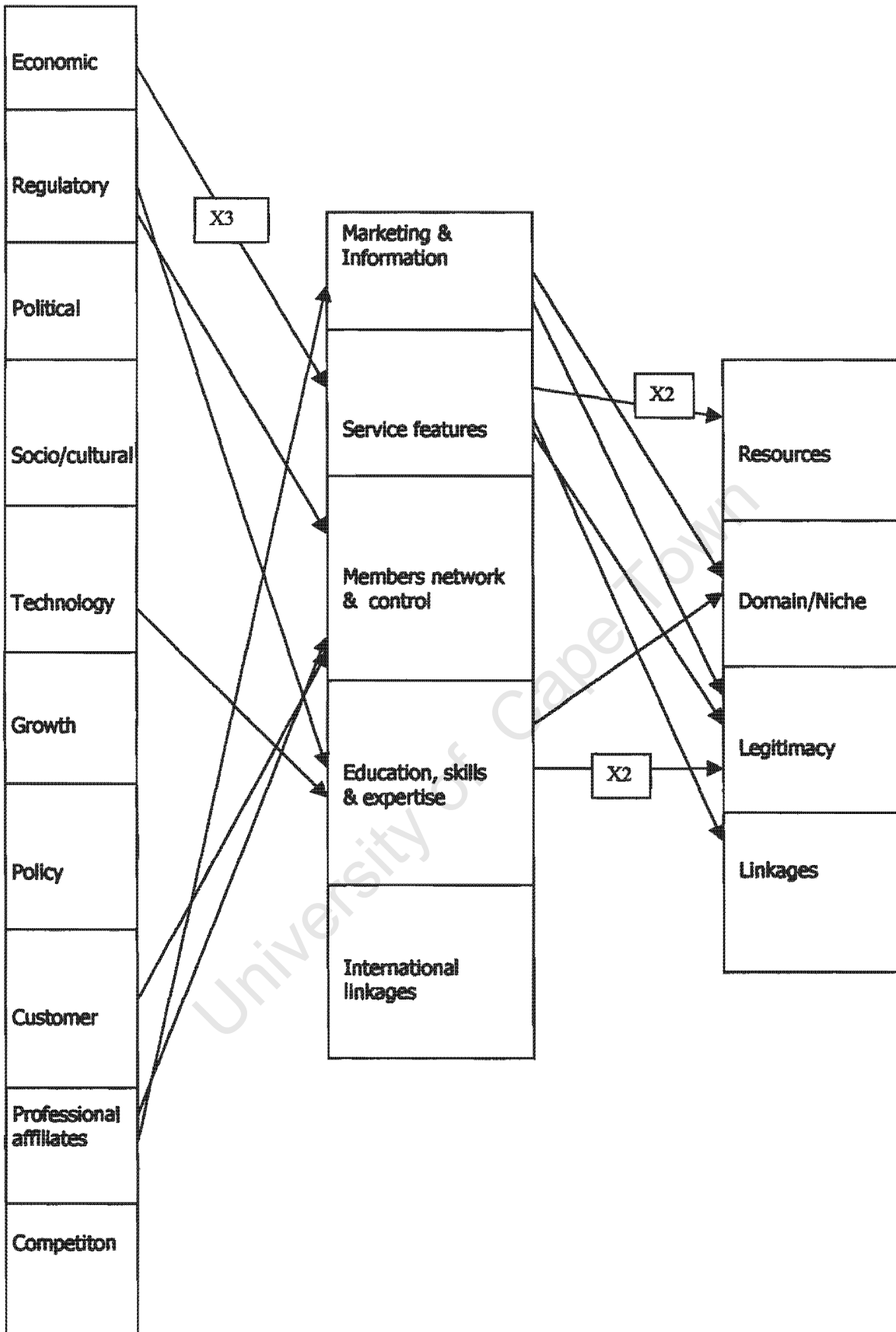
Graph To show connections from causal maps chairman's report & council decisions 1971



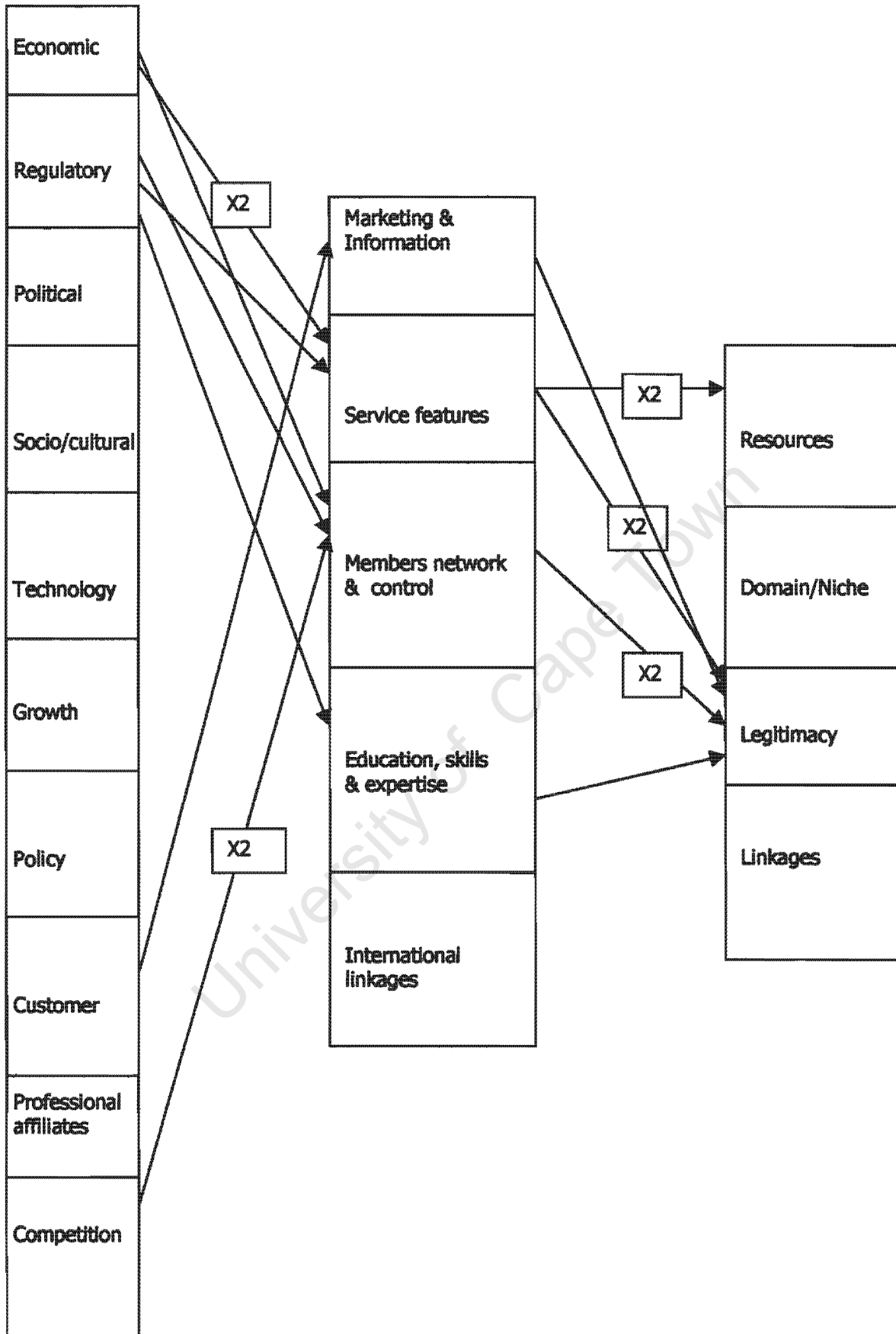
Graph: To show linkages between causal maps chairman's report & council decisions 1973



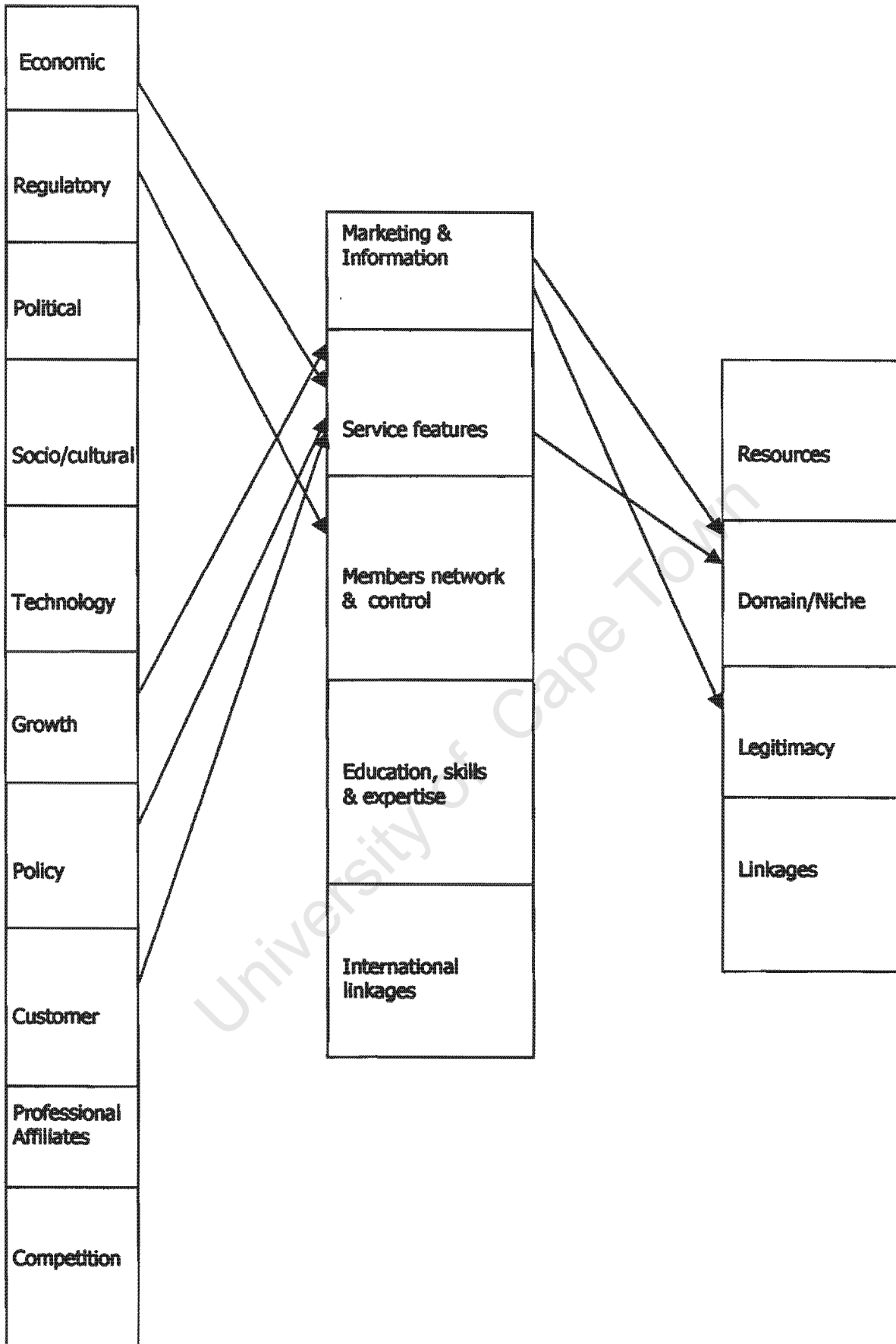
Graph: To show linkages from causal maps chairmans report & council decisions 1975



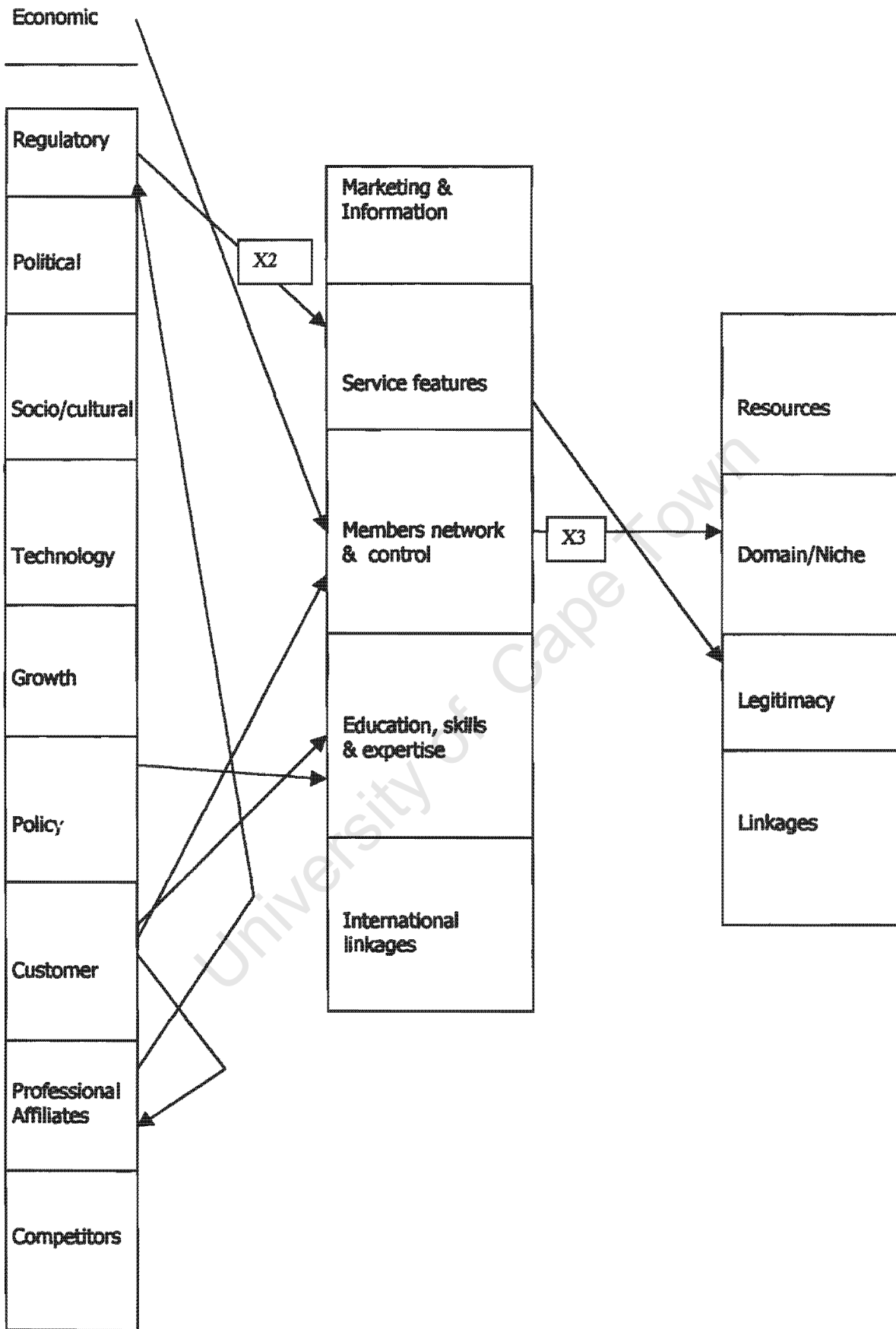
Graph; to show linkages from causal maps chairmans' report & council decisions 1977



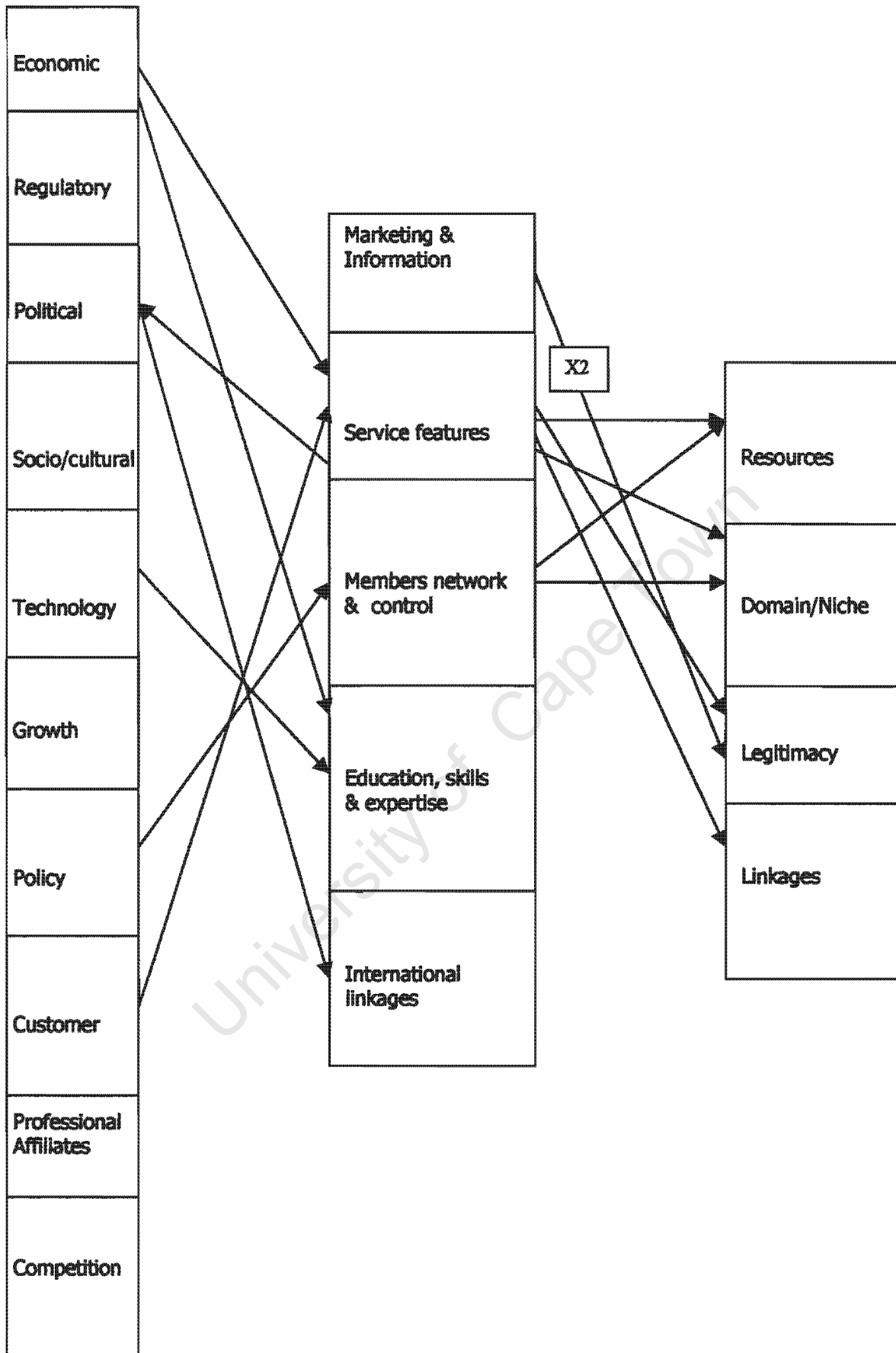
Graph: To show linkages from causal maps chairman's report and council decisions 1979



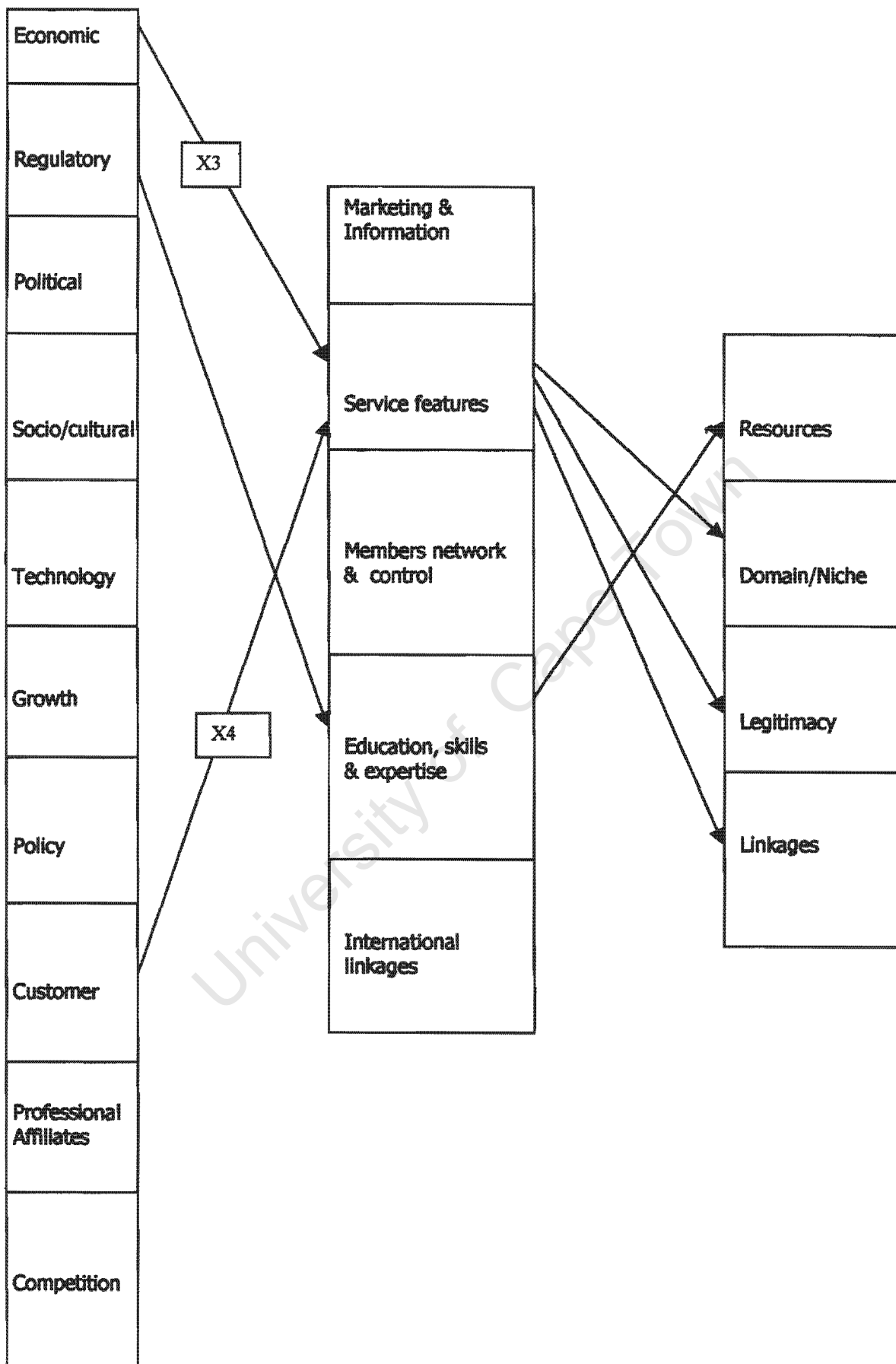
Graph: to show linkages from causal map chairman's report & council decisions 1981



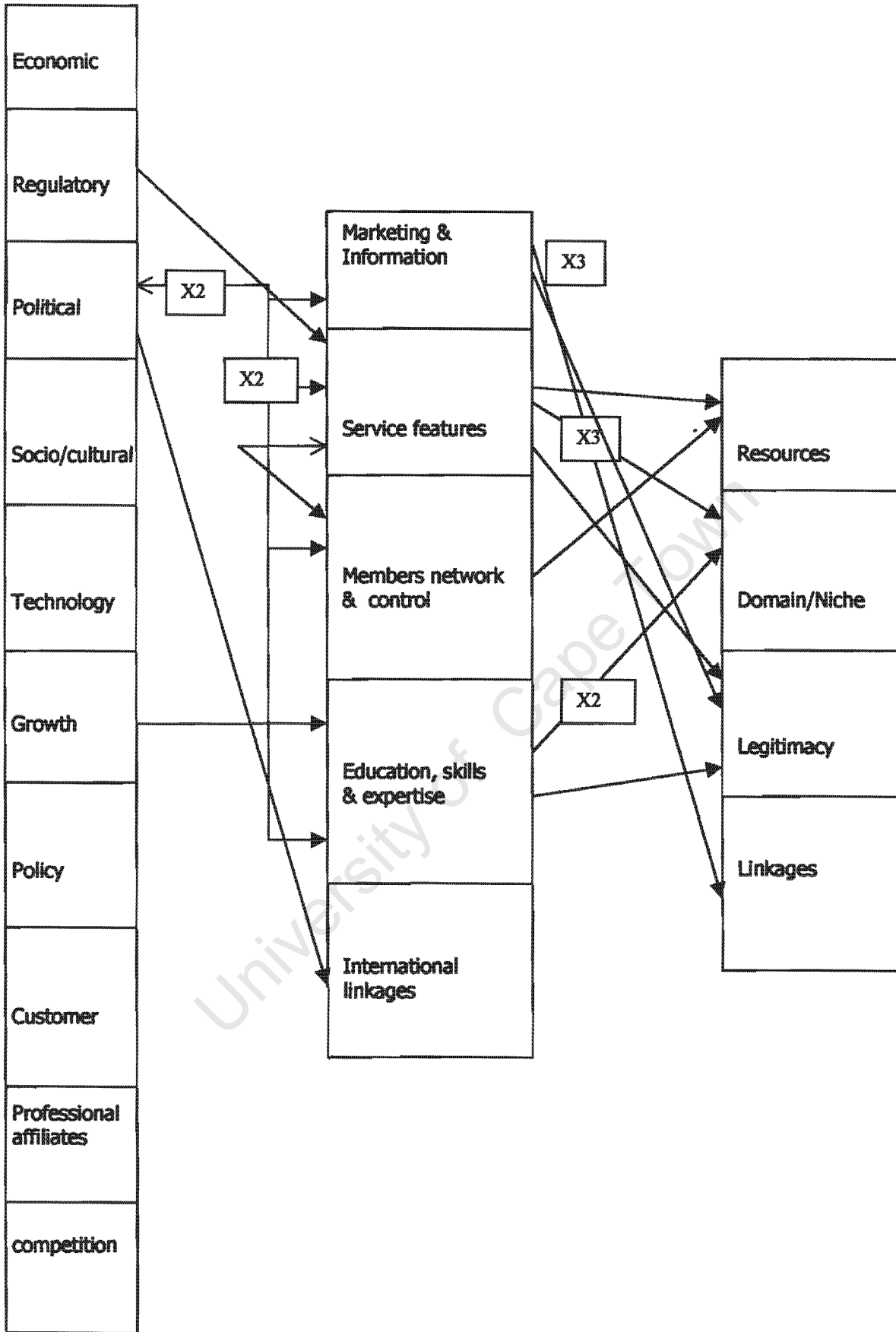
**Graph: To show linkages from causal maps chairman's report & council minutes 1983**



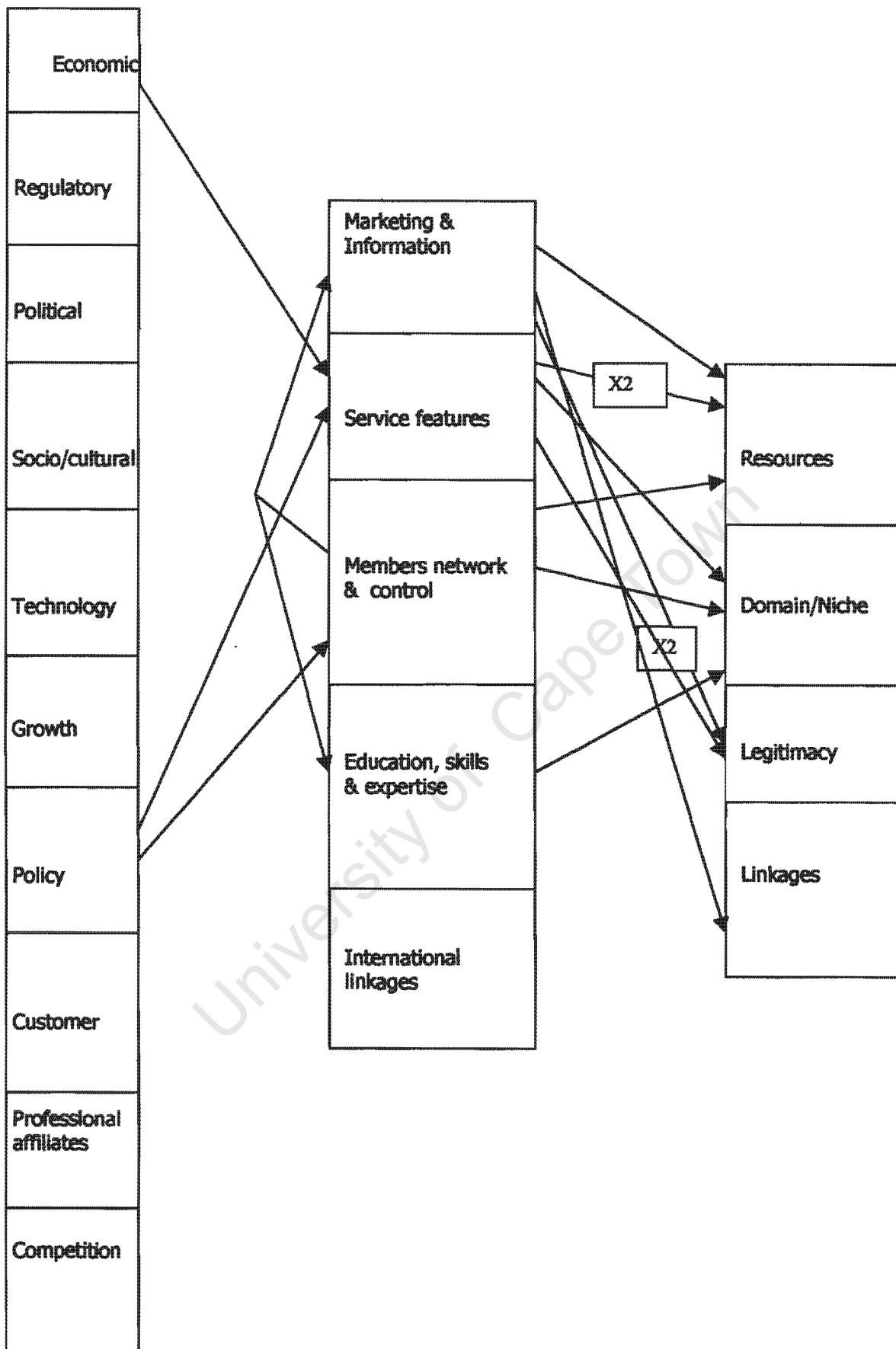
Graph: To show linkages from causal maps chairman's report & council decisions 1985



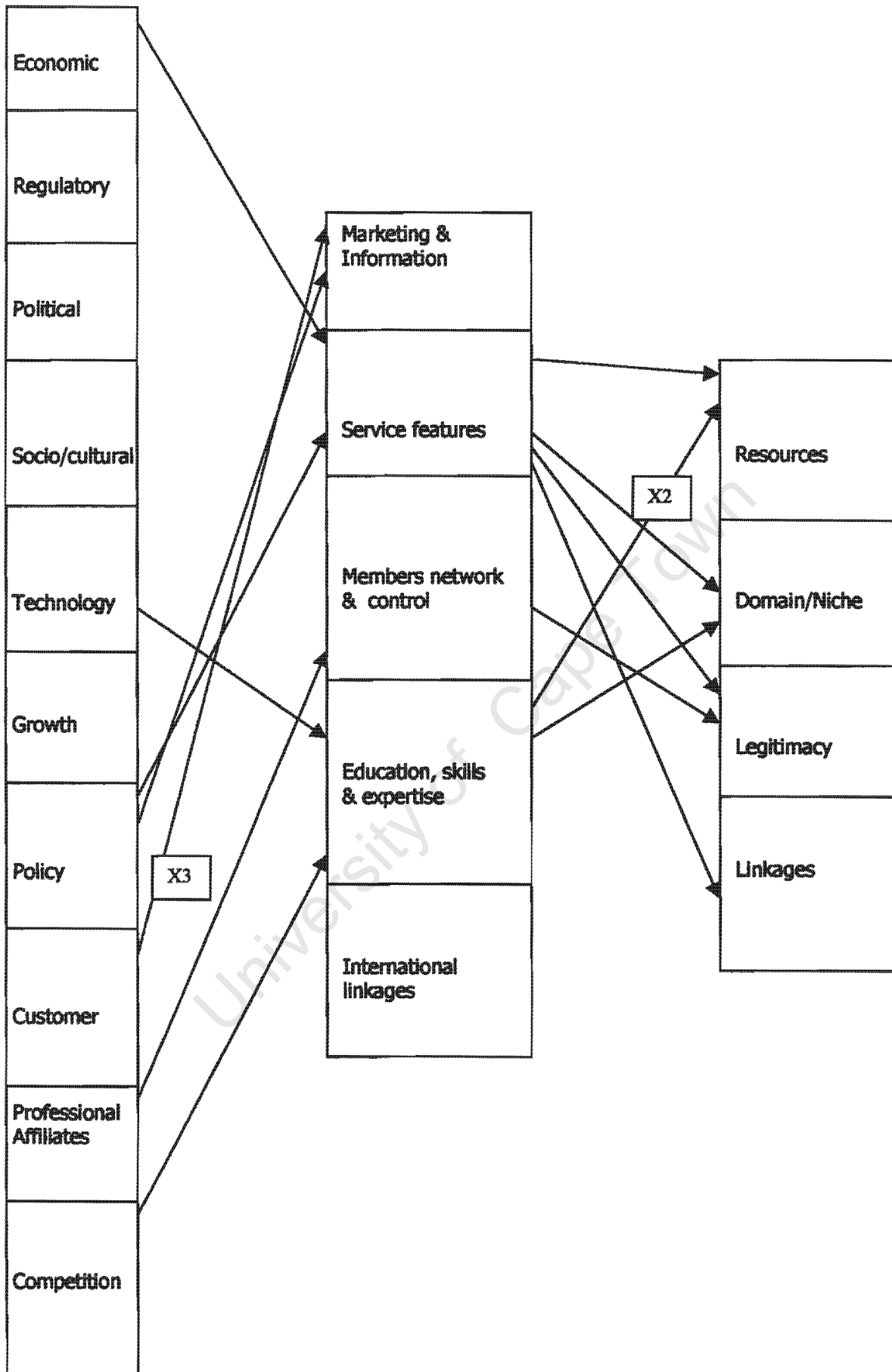
Graph: To show the linkages from causal maps chairman's report & council minutes 1987



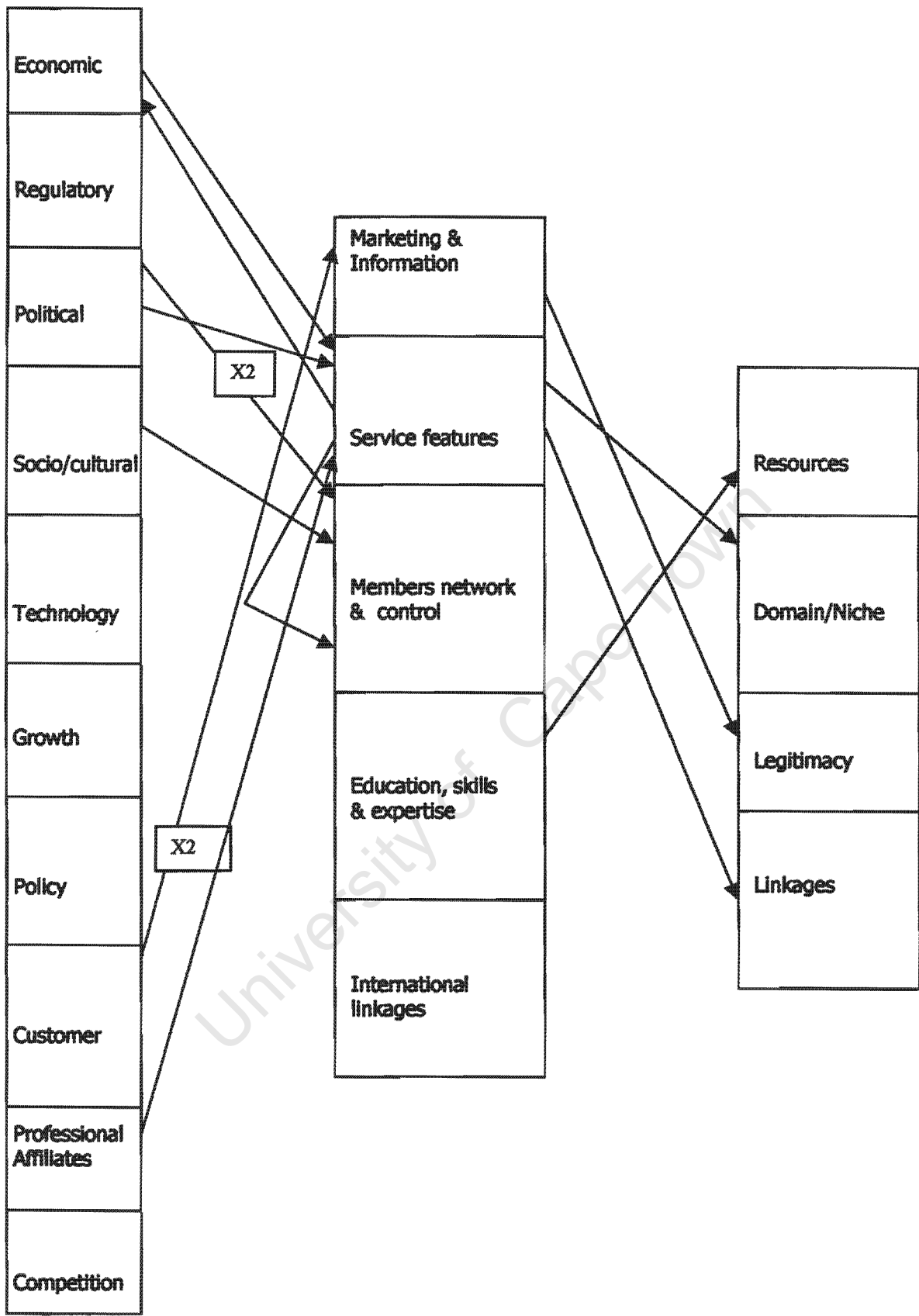
Graph: To show the linkages from the causal maps chairman's report & council minutes 1989



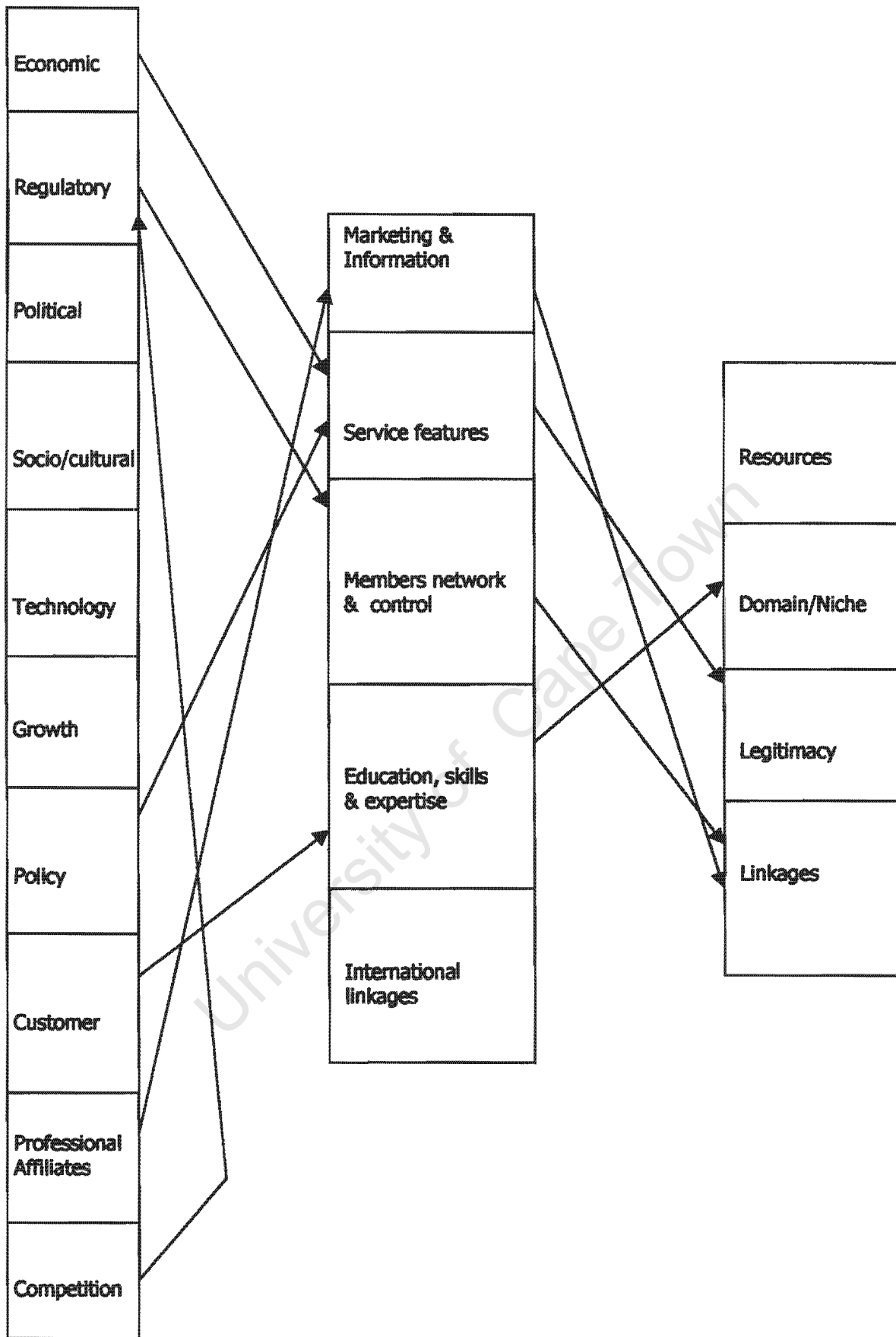
Graph: To show the linkages from causal maps chairman's report & council decisions 1991



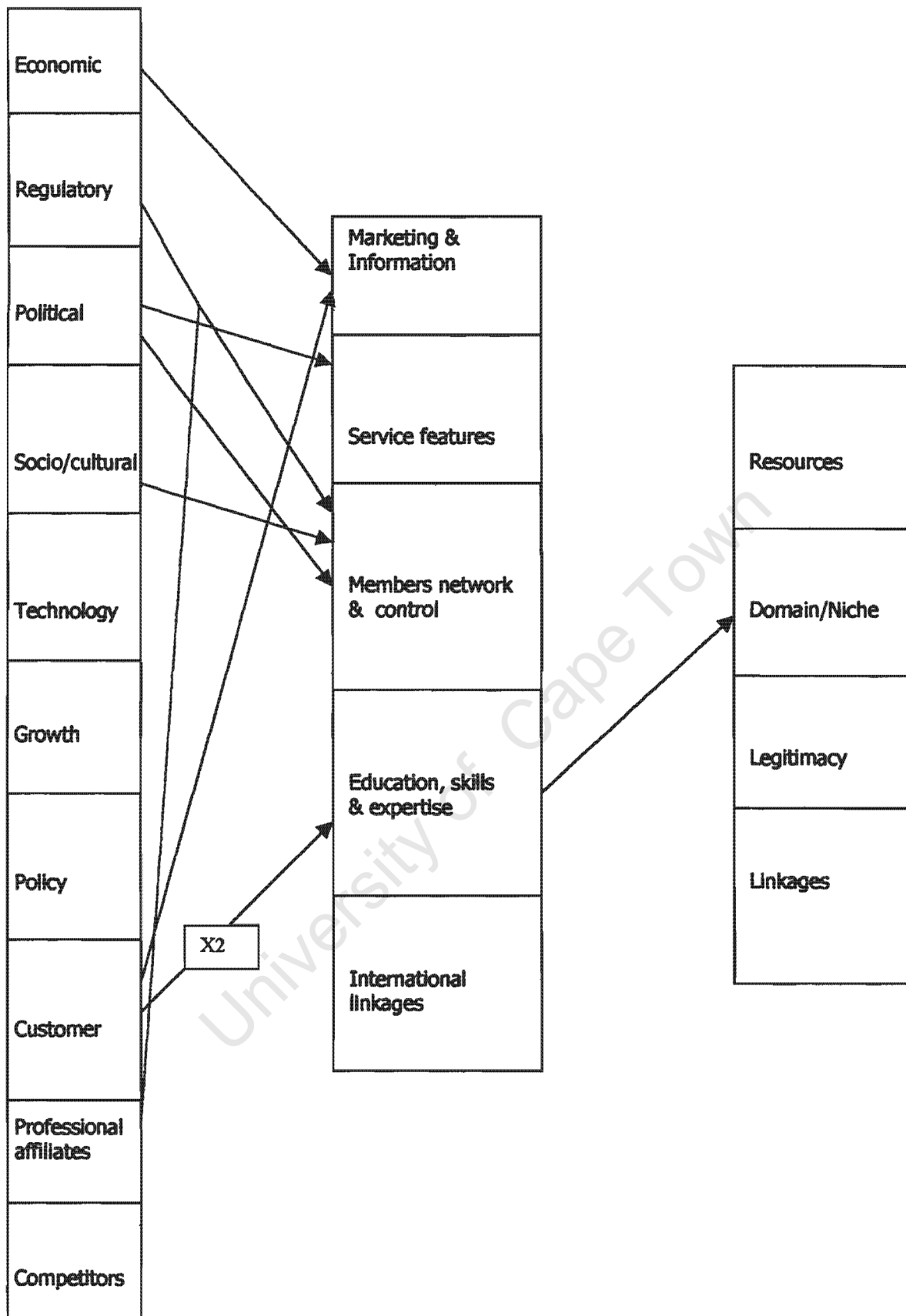
Graph: To show linkages from causal maps chairman's report & council decisions 1993



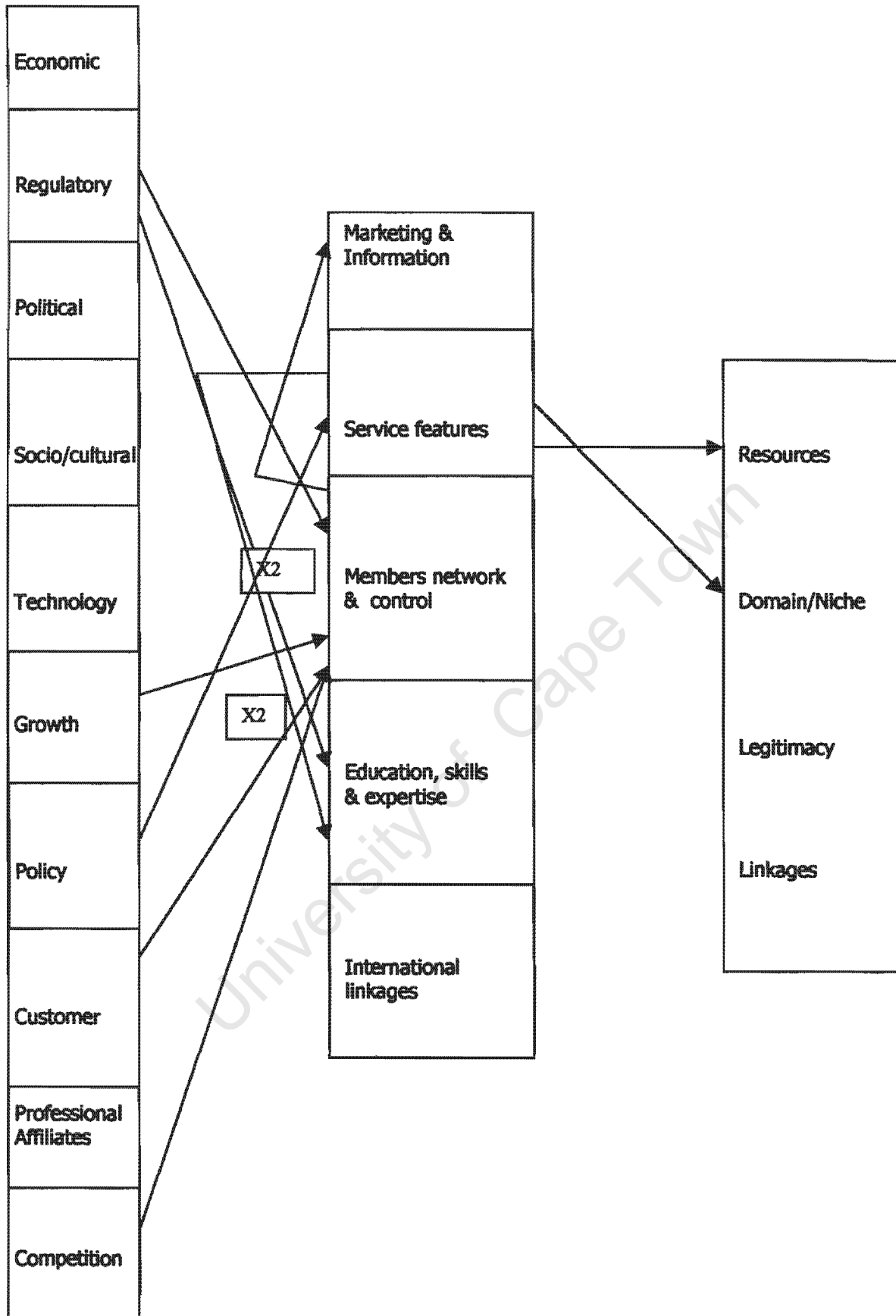
Graph: To show the linkages from causal maps chairman's report & council decisions 1994



Graph: To show the linkages from causal maps chairman's report & council decisions



Graph: To show the linkages from causal maps chairman's report & council decisions 1997



Graph: To show the linkages from causal maps chairman's report and council decisions 1999

**APPENDIX 16  
STEM & LEAF PLOTS**

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. stem q1

Stem-and-leaf plot for q1

```
0* | 11111111111111111111111111111111111111111111111111111111111111111111 ... (118)
0* | 22222222222222222222222222222222222222222222222222222222222222222222 ... (88)
0* | 3333333333333333333333
0* | 444
0* | 55
0* | 666
0* | 777777
```

. stem q2

Stem-and-leaf plot for q2

```
0* | 1111111111111111
0* | 22222222222222222222222222222222222222222222222222222222222222222222
0* | 33333333333333333333333333333333333333333333333333333333333333333333
0* | 44444444444444444444444444444444444444444444444444444444444444444444
0* | 55555555555555555555555555555555555555555555555555555555555555555555
0* | 66666666666666666666666666666666666666666666666666666666666666666666 ... (75)
0* | 77777777777777777777777777777777777777777777777777777777777777777777
```

. stem q3

Stem-and-leaf plot for q3

```
0* | 1111111111111111
0* | 22222222222222222222222222222222222222222222222222222222222222222222
0* | 33333333333333333333333333333333333333333333333333333333333333333333
0* | 44444444444444444444444444444444444444444444444444444444444444444444
0* | 55555555555555555555555555555555555555555555555555555555555555555555
0* | 66666666666666666666666666666666666666666666666666666666666666666666
0* | 77777777777777777777777777777777777777777777777777777777777777777777
```

. stem q4

Stem-and-leaf plot for q4

```
0* | 11111111111111111111111111111111111111111111111111111111111111111111 ... (87)
0* | 22222222222222222222222222222222222222222222222222222222222222222222 ... (76)
0* | 33333333333333333333333333333333333333333333333333333333333333333333
0* | 444444444444
0* | 55555555555555555555555555555555555555555555555555555555555555555555
0* | 66666666666666666666666666666666666666666666666666666666666666666666
0* | 777777777777
```

. stem q5























**APPENDIX 17**  
**DESCRIPTIVE STATISTICS FOR QUESTIONNAIRE DATA**

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Q1	Freq	Percent	Cum.
1.0	118	49.4%	49.4%
2.0	88	36.8%	86.2%
3.0	19	7.9%	94.1%
4.0	3	1.3%	95.4%
5.0	2	0.8%	96.2%
6.0	3	1.3%	97.5%
7.0	6	2.5%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	433	1.812	1.498	1.224	0.079
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	1.000	2.000	2.000	7.000	1.000

50%  
votes.

Student's "t", testing whether mean differs from zero.  
T statistic = 22.884, df = 238 p-value = 0.00000

Q2	Freq	Percent	Cum.
1.0	14	5.9%	5.9%
2.0	33	13.8%	19.7%
3.0	23	9.6%	29.3%
4.0	24	10.0%	39.3%
5.0	46	19.2%	58.6%
6.0	75	31.4%	90.0%
7.0	24	10.0%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1093	4.573	3.212	1.792	0.116
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	3.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 39.448, df = 238 p-value = -0.00000

Q3	Freq	Percent	Cum.
1.0	10	4.2%	4.2%
2.0	43	18.0%	22.2%
3.0	36	15.1%	37.2%
4.0	21	8.8%	46.0%
5.0	45	18.8%	64.9%
6.0	61	25.5%	90.4%
7.0	23	9.6%	100.0%

Total | 239 100.0%

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1040	4.351	3.212	1.792	0.116
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	3.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 37.535, df = 238 p-value = -0.00000

Q4

	Freq	Percent	Cum.
1.0	87	36.4%	36.4%
2.0	76	31.8%	68.2%
3.0	27	11.3%	79.5%
4.0	10	4.2%	83.7%
5.0	16	6.7%	90.4%
6.0	14	5.9%	96.2%
7.0	9	3.8%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	587	2.456	2.930	1.712	0.111
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	1.000	2.000	3.000	7.000	1.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 22.183, df = 238 p-value = 0.00000

Q5

	Freq	Percent	Cum.
1.0	34	14.2%	14.2%
2.0	68	28.5%	42.7%
3.0	57	23.8%	66.5%
4.0	24	10.0%	76.6%
5.0	26	10.9%	87.4%
6.0	19	7.9%	95.4%
7.0	11	4.6%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	758	3.172	2.823	1.680	0.109
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	7.000	2.000

Student's "t", testing whether mean differs from zero.

T statistic = 29.180, df = 238 p-value = 0.00000

Q6	Freq	Percent	Cum.
1.0	10	4.2%	4.2%
2.0	33	13.8%	18.0%
3.0	33	13.8%	31.8%
4.0	141	59.0%	90.8%
5.0	12	5.0%	95.8%
6.0	7	2.9%	98.7%
7.0	3	1.3%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	862	3.607	1.198	1.094	0.071
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	3.000	4.000	4.000	7.000	4.000

Student's "t", testing whether mean differs from zero.  
T statistic = 50.951, df = 238 p-value = -0.00000

Q7	Freq	Percent	Cum.
1.0	11	4.6%	4.6%
2.0	19	7.9%	12.6%
3.0	25	10.5%	23.0%
4.0	40	16.7%	39.7%
5.0	32	13.4%	53.1%
6.0	71	29.7%	82.8%
7.0	41	17.2%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1157	4.841	3.008	1.734	0.112
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	4.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 43.150, df = 238 p-value = 0.00000

Q8	Freq	Percent	Cum.
1.0	17	7.1%	7.1%
2.0	39	16.3%	23.4%
3.0	22	9.2%	32.6%
4.0	38	15.9%	48.5%
5.0	47	19.7%	68.2%

6.0	65	27.2%	95.4%
7.0	11	4.6%	100.0%
-----			
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1015	4.247	3.035	1.742	0.113
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	3.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 37.684, df = 238 p-value = 0.00000

Q9	Freq	Percent	Cum.
1.0	37	15.5%	15.5%
2.0	67	28.0%	43.5%
3.0	55	23.0%	66.5%
4.0	16	6.7%	73.2%
5.0	26	10.9%	84.1%
6.0	22	9.2%	93.3%
7.0	16	6.7%	100.0%
-----			
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	774	3.238	3.258	1.805	0.117
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	5.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 27.737, df = 238 p-value = 0.00000

Q10	Freq	Percent	Cum.
1.0	24	10.0%	10.0%
2.0	57	23.8%	33.9%
3.0	47	19.7%	53.6%
4.0	56	23.4%	77.0%
5.0	22	9.2%	86.2%
6.0	27	11.3%	97.5%
7.0	6	2.5%	100.0%
-----			
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	817	3.418	2.496	1.580	0.102
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 33.447, df = 238 p-value = 0.00000

Q11	Freq	Percent	Cum.
1.0	17	7.1%	7.1%
2.0	30	12.6%	19.7%
3.0	34	14.2%	33.9%
4.0	31	13.0%	46.9%
5.0	50	20.9%	67.8%
6.0	57	23.8%	91.6%
7.0	20	8.4%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1035	4.331	3.105	1.762	0.114
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	3.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 37.996, df = 238 p-value = 0.00000

Q12	Freq	Percent	Cum.
1.0	8	3.3%	3.3%
2.0	20	8.4%	11.7%
3.0	11	4.6%	16.3%
4.0	11	4.6%	20.9%
5.0	31	13.0%	33.9%
6.0	92	38.5%	72.4%
7.0	66	27.6%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1294	5.414	2.849	1.688	0.109
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	5.000	6.000	7.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 49.592, df = 238 p-value = 0.00000

Q13	Freq	Percent	Cum.
1.0	73	30.5%	30.5%
2.0	64	26.8%	57.3%
3.0	42	17.6%	74.9%

4.0		12	5.0%	79.9%
5.0		17	7.1%	87.0%
6.0		19	7.9%	95.0%
7.0		12	5.0%	100.0%

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Total		239	100.0%
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Total	Sum	Mean	Variance	Std Dev	Std Err
239	658	2.753	3.296	1.815	0.117
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	1.000	2.000	4.000	7.000	1.000

Student's "t", testing whether mean differs from zero.  
T statistic = 23.444, df = 238 p-value = 0.00000

Q14		Freq	Percent	Cum.
1.0		13	5.4%	5.4%
2.0		12	5.0%	10.5%
3.0		29	12.1%	22.6%
4.0		16	6.7%	29.3%
5.0		22	9.2%	38.5%
6.0		77	32.2%	70.7%
7.0		70	29.3%	100.0%

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Total		239	100.0%
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Total	Sum	Mean	Variance	Std Dev	Std Err
239	1250	5.230	3.329	1.825	0.118
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	4.000	6.000	7.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 44.314, df = 238 p-value = 0.00000

Q15		Freq	Percent	Cum.
1.0		7	2.9%	2.9%
2.0		13	5.4%	8.4%
3.0		15	6.3%	14.6%
4.0		60	25.1%	39.7%
5.0		37	15.5%	55.2%
6.0		66	27.6%	82.8%
7.0		41	17.2%	100.0%

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Total		239	100.0%
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Total	Sum	Mean	Variance	Std Dev	Std Err
239	1186	4.962	2.431	1.559	0.101

Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	4.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 49.200, df = 238 p-value = 0.00000

Q16	Freq	Percent	Cum.
1.0	33	13.8%	13.8%
2.0	67	28.0%	41.8%
3.0	39	16.3%	58.2%
4.0	19	7.9%	66.1%
5.0	29	12.1%	78.2%
6.0	27	11.3%	89.5%
7.0	25	10.5%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	842	3.523	3.830	1.957	0.127
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	5.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 27.829, df = 238 p-value = 0.00000

Q17	Freq	Percent	Cum.
1.0	64	26.8%	26.8%
2.0	73	30.5%	57.3%
3.0	44	18.4%	75.7%
4.0	21	8.8%	84.5%
5.0	12	5.0%	89.5%
6.0	16	6.7%	96.2%
7.0	9	3.8%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	645	2.699	2.791	1.671	0.108
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	1.000	2.000	3.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 24.973, df = 238 p-value = 0.00000

Q18	Freq	Percent	Cum.
1.0	43	18.0%	18.0%

2.0		42	17.6%	35.6%
3.0		21	8.8%	44.4%
4.0		42	17.6%	61.9%
5.0		22	9.2%	71.1%
6.0		43	18.0%	89.1%
7.0		26	10.9%	100.0%

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Total | 239 100.0%

Total	Sum	Mean	Variance	Std Dev	Std Err
239	908	3.799	4.178	2.044	0.132
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	4.000	6.000	7.000	1.000

Student's "t", testing whether mean differs from zero.  
T statistic = 28.734, df = 238 p-value = -0.00000

Q19		Freq	Percent	Cum.
1.0		47	19.7%	19.7%
2.0		55	23.0%	42.7%
3.0		50	20.9%	63.6%
4.0		17	7.1%	70.7%
5.0		18	7.5%	78.2%
6.0		28	11.7%	90.0%
7.0		24	10.0%	100.0%

-----  
Total | 239 100.0%

Total	Sum	Mean	Variance	Std Dev	Std Err
239	801	3.351	3.943	1.986	0.128
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	5.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 26.092, df = 238 p-value = 0.00000

Q20		Freq	Percent	Cum.
1.0		6	2.5%	2.5%
2.0		41	17.2%	19.7%
3.0		42	17.6%	37.2%
4.0		22	9.2%	46.4%
5.0		41	17.2%	63.6%
6.0		45	18.8%	82.4%
7.0		42	17.6%	100.0%

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Total | 239 100.0%

Total	Sum	Mean	Variance	Std Dev	Std Err
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239	1071	4.481	3.377	1.838	0.119
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	3.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 37.700, df = 238 p-value = 0.00000

Q21	Freq	Percent	Cum.
1.0	15	6.3%	6.3%
2.0	45	18.8%	25.1%
3.0	44	18.4%	43.5%
4.0	26	10.9%	54.4%
5.0	45	18.8%	73.2%
6.0	36	15.1%	88.3%
7.0	28	11.7%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	978	4.092	3.353	1.831	0.118
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	4.000	6.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 34.549, df = 238 p-value = -0.00000

Q22	Freq	Percent	Cum.
1.0	18	7.5%	7.5%
2.0	50	20.9%	28.5%
3.0	56	23.4%	51.9%
4.0	88	36.8%	88.7%
5.0	17	7.1%	95.8%
6.0	10	4.2%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	783	3.276	1.470	1.212	0.078
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	6.000	4.000

Student's "t", testing whether mean differs from zero.  
T statistic = 41.779, df = 238 p-value = 0.00000

Q23	Freq	Percent	Cum.
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1.0	68	28.5%	28.5%
2.0	81	33.9%	62.3%
3.0	40	16.7%	79.1%
4.0	22	9.2%	88.3%
5.0	10	4.2%	92.5%
6.0	13	5.4%	97.9%
7.0	5	2.1%	100.0%
-----			
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	601	2.515	2.335	1.528	0.099
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	1.000	2.000	3.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 25.442, df = 238 p-value = 0.00000

Q24	Freq	Percent	Cum.
1.0	37	15.5%	15.5%
2.0	39	16.3%	31.8%
3.0	33	13.8%	45.6%
4.0	10	4.2%	49.8%
5.0	26	10.9%	60.7%
6.0	50	20.9%	81.6%
7.0	44	18.4%	100.0%
-----			
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	992	4.151	4.784	2.187	0.141
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 29.337, df = 238 p-value = 0.00000

Q25	Freq	Percent	Cum.
1.0	19	7.9%	7.9%
2.0	22	9.2%	17.2%
3.0	19	7.9%	25.1%
4.0	29	12.1%	37.2%
5.0	53	22.2%	59.4%
6.0	71	29.7%	89.1%
7.0	26	10.9%	100.0%
-----			
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1109	4.640	3.156	1.776	0.115
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	3.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 40.382, df = 238 p-value = 0.00000

Q26	Freq	Percent	Cum.
1.0	25	10.5%	10.5%
2.0	69	28.9%	39.3%
3.0	24	10.0%	49.4%
4.0	35	14.6%	64.0%
5.0	24	10.0%	74.1%
6.0	48	20.1%	94.1%
7.0	14	5.9%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	881	3.686	3.544	1.883	0.122
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	4.000	6.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 30.271, df = 238 p-value = 0.00000

Q27	Freq	Percent	Cum.
1.0	20	8.4%	8.4%
2.0	61	25.5%	33.9%
3.0	37	15.5%	49.4%
4.0	17	7.1%	56.5%
5.0	34	14.2%	70.7%
6.0	41	17.2%	87.9%
7.0	29	12.1%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	940	3.933	3.861	1.965	0.127
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	4.000	6.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 30.944, df = 238 p-value = 0.00000

Q28	Freq	Percent	Cum.
1.0	40	16.7%	16.7%
2.0	58	24.3%	41.0%
3.0	64	26.8%	67.8%
4.0	37	15.5%	83.3%
5.0	14	5.9%	89.1%
6.0	14	5.9%	95.0%
7.0	12	5.0%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	734	3.071	2.638	1.624	0.105
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	7.000	3.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 29.233, df = 238 p-value = 0.00000

Q29	Freq	Percent	Cum.
1.0	61	25.5%	25.5%
2.0	101	42.3%	67.8%
3.0	39	16.3%	84.1%
4.0	18	7.5%	91.6%
5.0	7	2.9%	94.6%
6.0	6	2.5%	97.1%
7.0	7	2.9%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	572	2.393	1.971	1.404	0.091
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	1.000	2.000	3.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 26.356, df = 238 p-value = -0.00000

Q30	Freq	Percent	Cum.
1.0	17	7.1%	7.1%
2.0	23	9.6%	16.7%
3.0	27	11.3%	28.0%
4.0	11	4.6%	32.6%
5.0	27	11.3%	43.9%
6.0	66	27.6%	71.5%
7.0	68	28.5%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1195	5.000	3.933	1.983	0.128
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	3.000	6.000	7.000	7.000	7.000

Student's "t", testing whether mean differs from zero.  
T statistic = 38.978, df = 238 p-value = 0.00000

Q31	Freq	Percent	Cum.
1.0	150	62.8%	62.8%
2.0	55	23.0%	85.8%
3.0	14	5.9%	91.6%
5.0	1	0.4%	92.1%
6.0	10	4.2%	96.2%
7.0	9	3.8%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	430	1.799	2.304	1.518	0.098
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	1.000	1.000	2.000	7.000	1.000

Student's "t", testing whether mean differs from zero.  
T statistic = 18.324, df = 238 p-value = 0.00000

Q32	Freq	Percent	Cum.
1.0	21	8.8%	8.8%
2.0	53	22.2%	31.0%
3.0	53	22.2%	53.1%
4.0	82	34.3%	87.4%
5.0	17	7.1%	94.6%
6.0	6	2.5%	97.1%
7.0	6	2.5%	99.6%
21.0	1	0.4%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	798	3.339	3.082	1.756	0.114
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	21.000	4.000

Student's "t", testing whether mean differs from zero.  
T statistic = 29.402, df = 238 p-value = -0.00000

Q33	Freq	Percent	Cum.
1.0	28	11.7%	11.7%
2.0	75	31.4%	43.1%
3.0	63	26.4%	69.5%
4.0	36	15.1%	84.5%
5.0	22	9.2%	93.7%
6.0	11	4.6%	98.3%
7.0	4	1.7%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	715	2.992	1.992	1.411	0.091
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 32.773, df = 238 p-value = -0.00000

Q34	Freq	Percent	Cum.
1.0	28	11.7%	11.7%
2.0	87	36.4%	48.1%
3.0	63	26.4%	74.5%
4.0	25	10.5%	84.9%
5.0	17	7.1%	92.1%
6.0	15	6.3%	98.3%
7.0	4	1.7%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	694	2.904	2.054	1.433	0.093
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 31.325, df = 238 p-value = 0.00000

Q35	Freq	Percent	Cum.
1.0	5	2.1%	2.1%
2.0	14	5.9%	7.9%
3.0	16	6.7%	14.6%
4.0	22	9.2%	23.8%
5.0	33	13.8%	37.7%
6.0	95	39.7%	77.4%
7.0	54	22.6%	100.0%

-----+-----  
 Total | 239 100.0%

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1282	5.364	2.401	1.549	0.100
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	5.000	6.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 53.522, df = 238 p-value = 0.00000

Q36

	Freq	Percent	Cum.
1.0	11	4.6%	4.6%
2.0	81	33.9%	38.5%
3.0	51	21.3%	59.8%
4.0	65	27.2%	87.0%
5.0	17	7.1%	94.1%
6.0	9	3.8%	97.9%
7.0	5	2.1%	100.0%
-----+-----			
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	760	3.180	1.728	1.315	0.085
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 37.398, df = 238 p-value = -0.00000

Q37

	Freq	Percent	Cum.
1.0	45	18.8%	18.8%
2.0	78	32.6%	51.5%
3.0	30	12.6%	64.0%
4.0	32	13.4%	77.4%
5.0	23	9.6%	87.0%
6.0	19	7.9%	95.0%
7.0	11	4.6%	99.6%
52.0	1	0.4%	100.0%
-----+-----			
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	777	3.251	13.088	3.618	0.234
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	2.000	4.000	52.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 13.893, df = 238 p-value = 0.00000

Q38	Freq	Percent	Cum.
1.0	59	24.7%	24.7%
2.0	86	36.0%	60.7%
3.0	40	16.7%	77.4%
4.0	12	5.0%	82.4%
5.0	16	6.7%	89.1%
6.0	19	7.9%	97.1%
7.0	7	2.9%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	642	2.686	2.762	1.662	0.108
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	2.000	3.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 24.986, df = 238 p-value = 0.00000

Q39	Freq	Percent	Cum.
1.0	5	2.1%	2.1%
2.0	13	5.4%	7.5%
3.0	13	5.4%	13.0%
4.0	37	15.5%	28.5%
5.0	36	15.1%	43.5%
6.0	74	31.0%	74.5%
7.0	61	25.5%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1269	5.310	2.442	1.563	0.101
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	4.000	6.000	7.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 52.533, df = 238 p-value = 0.00000

Q40	Freq	Percent	Cum.
1.0	17	7.1%	7.1%
2.0	66	27.6%	34.7%
3.0	51	21.3%	56.1%
4.0	44	18.4%	74.5%

5.0		28	11.7%	86.2%
6.0		20	8.4%	94.6%
7.0		13	5.4%	100.0%
-----				
Total		239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	829	3.469	2.628	1.621	0.105
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	5.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 33.077, df = 238 p-value = -0.00000

Q41		Freq	Percent	Cum.
1.0		37	15.5%	15.5%
2.0		78	32.6%	48.1%
3.0		54	22.6%	70.7%
4.0		18	7.5%	78.2%
5.0		26	10.9%	89.1%
6.0		19	7.9%	97.1%
7.0		7	2.9%	100.0%
-----				
Total		239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	720	3.013	2.651	1.628	0.105
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 28.604, df = 238 p-value = -0.00000

Q42		Freq	Percent	Cum.
1.0		3	1.3%	1.3%
2.0		10	4.2%	5.4%
3.0		14	5.9%	11.3%
4.0		40	16.7%	28.0%
5.0		36	15.1%	43.1%
6.0		52	21.8%	64.9%
7.0		84	35.1%	100.0%
-----				
Total		239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1305	5.460	2.401	1.549	0.100
Minimum	25%ile	Median	75%ile	Maximum	Mode

1.000      4.000      6.000      7.000      7.000      7.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 54.480, df = 238 p-value = 0.00000

Q43	Freq	Percent	Cum.
1.0	5	2.1%	2.1%
2.0	11	4.6%	6.7%
3.0	6	2.5%	9.2%
4.0	12	5.0%	14.2%
5.0	26	10.9%	25.1%
6.0	77	32.2%	57.3%
7.0	102	42.7%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1399	5.854	2.210	1.486	0.096
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	5.000	6.000	7.000	7.000	7.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 60.879, df = 238 p-value = -0.00000

Q44	Freq	Percent	Cum.
1.0	74	31.0%	31.0%
2.0	84	35.1%	66.1%
3.0	36	15.1%	81.2%
4.0	16	6.7%	87.9%
5.0	10	4.2%	92.1%
6.0	12	5.0%	97.1%
7.0	7	2.9%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	585	2.448	2.450	1.565	0.101
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	1.000	2.000	3.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
 T statistic = 24.175, df = 238 p-value = 0.00000

Q45	Freq	Percent	Cum.
1.0	1	0.4%	0.4%
2.0	17	7.1%	7.5%

3.0		14	5.9%	13.4%
4.0		24	10.0%	23.4%
5.0		52	21.8%	45.2%
6.0		94	39.3%	84.5%
7.0		37	15.5%	100.0%

-----  
Total | 239 100.0%

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1256	5.255	1.998	1.413	0.091
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	5.000	6.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 57.482, df = 238 p-value = 0.00000

Q46		Freq	Percent	Cum.
1.0		8	3.3%	3.3%
2.0		19	7.9%	11.3%
3.0		27	11.3%	22.6%
4.0		26	10.9%	33.5%
5.0		54	22.6%	56.1%
6.0		59	24.7%	80.8%
7.0		46	19.2%	100.0%

-----  
Total | 239 100.0%

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1177	4.925	2.835	1.684	0.109
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	4.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 45.220, df = 238 p-value = 0.00000

Q47		Freq	Percent	Cum.
1.0		6	2.5%	2.5%
2.0		10	4.2%	6.7%
3.0		10	4.2%	10.9%
4.0		36	15.1%	25.9%
5.0		48	20.1%	46.0%
6.0		82	34.3%	80.3%
7.0		47	19.7%	100.0%

-----  
Total | 239 100.0%

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1261	5.276	2.159	1.469	0.095

Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	4.000	6.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 55.516, df = 238 p-value = -0.00000

Q48	Freq	Percent	Cum.
1.0	18	7.5%	7.5%
2.0	79	33.1%	40.6%
3.0	58	24.3%	64.9%
4.0	29	12.1%	77.0%
5.0	22	9.2%	86.2%
6.0	22	9.2%	95.4%
7.0	11	4.6%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	785	3.285	2.616	1.617	0.105

Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	2.000	3.000	4.000	7.000	2.000

Student's "t", testing whether mean differs from zero.  
T statistic = 31.393, df = 238 p-value = -0.00000

Q49	Freq	Percent	Cum.
1.0	9	3.8%	3.8%
2.0	22	9.2%	13.0%
3.0	21	8.8%	21.8%
4.0	40	16.7%	38.5%
5.0	40	16.7%	55.2%
6.0	79	33.1%	88.3%
7.0	28	11.7%	100.0%
Total	239	100.0%	

Total	Sum	Mean	Variance	Std Dev	Std Err
239	1146	4.795	2.718	1.649	0.107

Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	4.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 44.961, df = 238 p-value = -0.00000

Q50	Freq	Percent	Cum.
-----	------	---------	------

1.0		15	6.3%	6.3%
2.0		23	9.6%	15.9%
3.0		15	6.3%	22.2%
4.0		24	10.0%	32.2%
5.0		61	25.5%	57.7%
6.0		66	27.6%	85.4%
7.0		35	14.6%	100.0%

---

Total		239	100.0%
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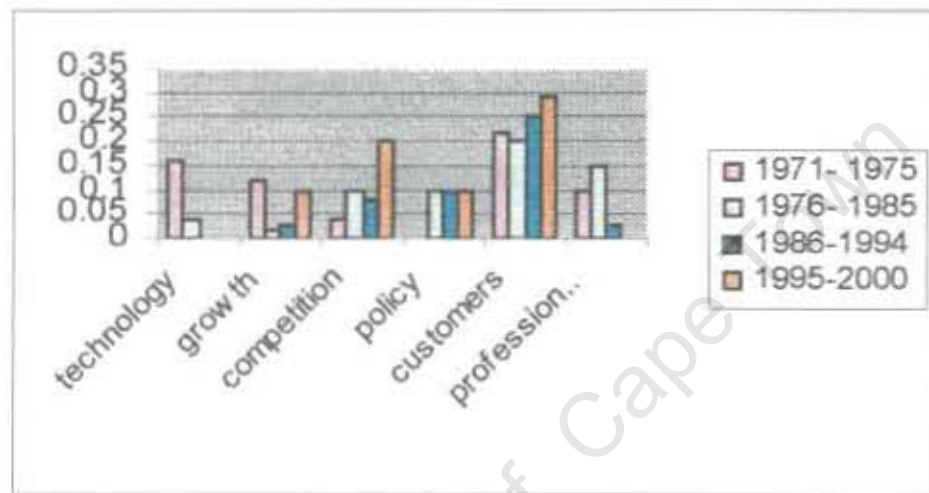
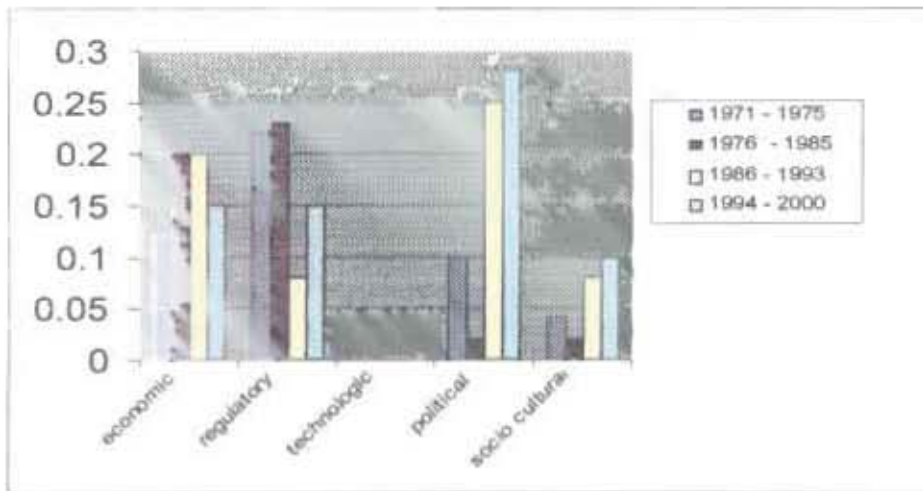
Total	Sum	Mean	Variance	Std Dev	Std Err
239	1148	4.803	3.058	1.749	0.113
Minimum	25%ile	Median	75%ile	Maximum	Mode
1.000	4.000	5.000	6.000	7.000	6.000

Student's "t", testing whether mean differs from zero.  
T statistic = 42.466, df = 238 p-value = -0.00000

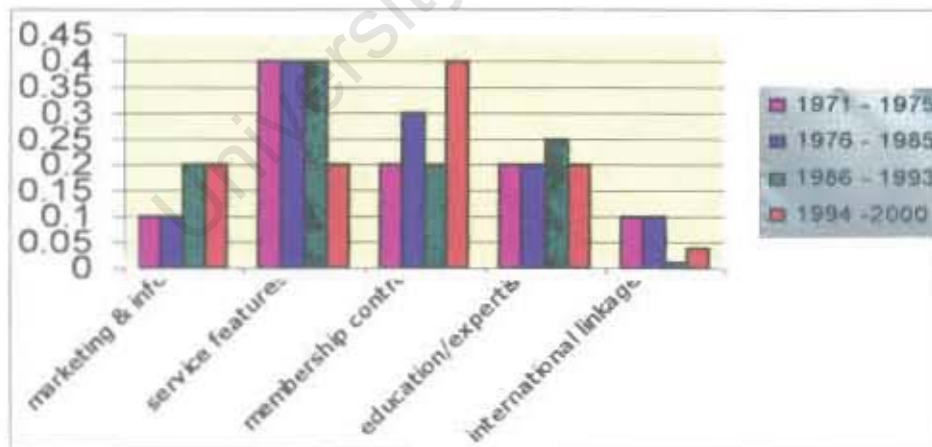
University of Cape Town

**APPENDIX 18**  
**GRAPH TO SHOW ELEMENTS & STRATEGY RECEIVING ATTENTION**  
**FROM CHAIRPERSONS**

University of Cape Town



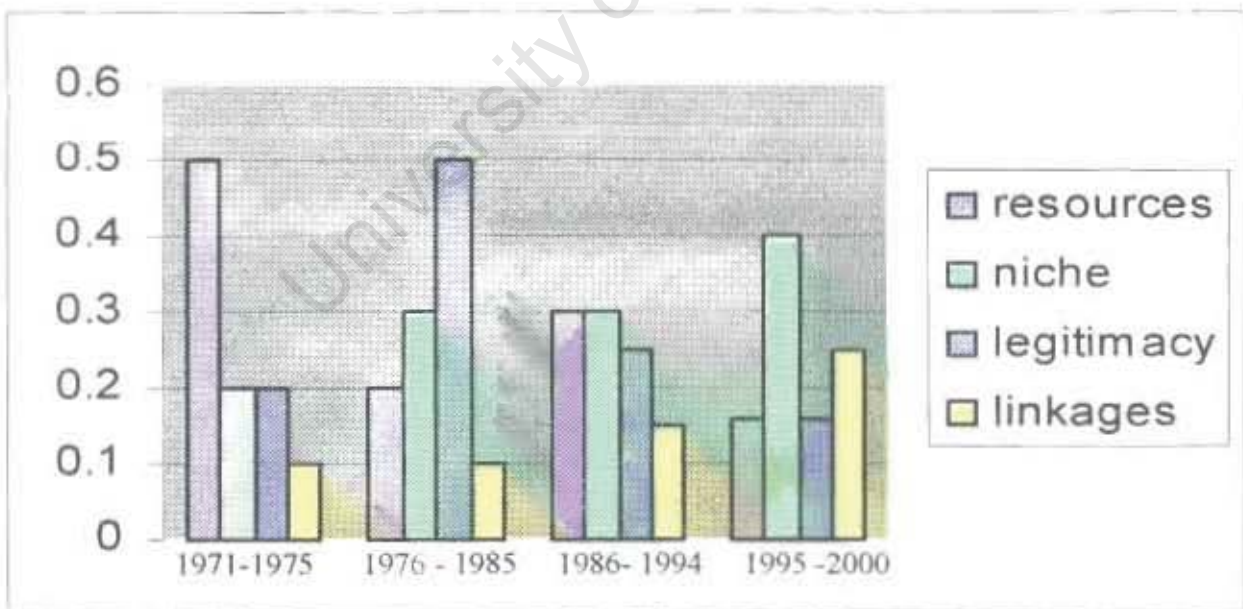
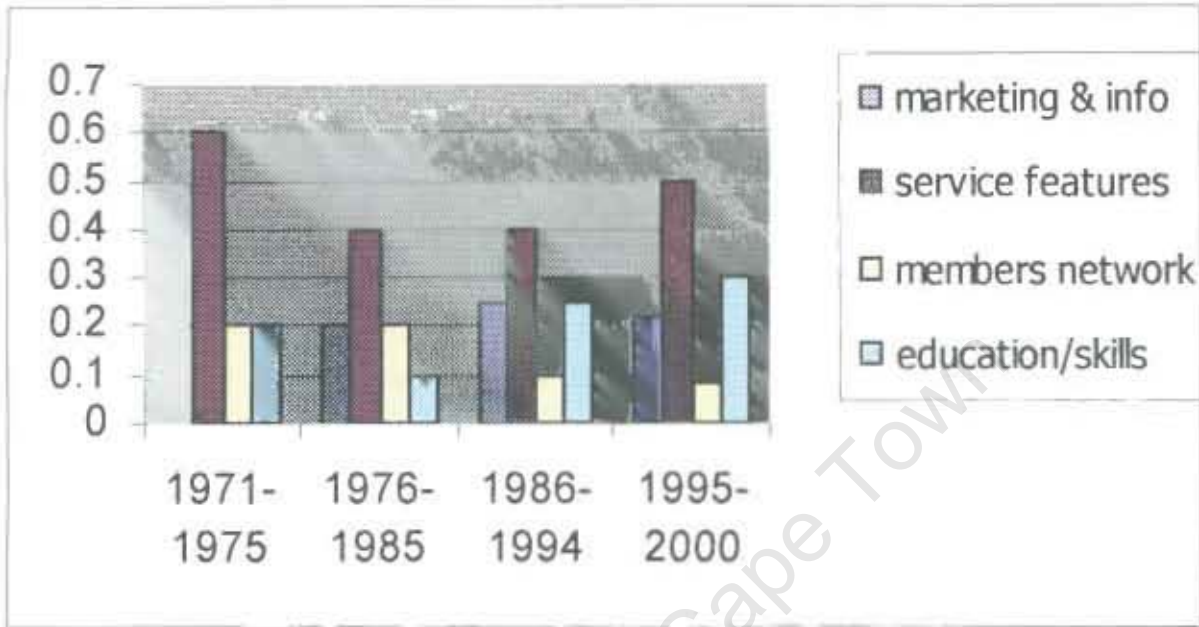
Appendix 18 Chairmen's reports: Elements in the external and health care receiving attention



Graph Chairmen's reports: Areas of strategic action

**APPENDIX 19**  
**GRAPH TO SHOW DECISIONS , STRATEGY & CRITICAL SUCCESS**  
**FACTORS MADE AT COUNCIL MEETINGS**

University of Cape Town



Graph Council Decisions: To show the strategies and key success factors

**APPENDIX 20  
PHYSIONET-WORKS**

University of Cape Town

# Managed Health Care

Sept/Oct 99



PhysioNet-Works represents a national network of physiotherapists in private practice, that are members of the SASP and PPA.

## Inside this issue:

Managed health care	1
PPO's	1
Contracts	1
Benefits of PhysioFocus	2
PhysioNet-Works	2
Shareholding in PhysioWorks	2
Upcoming meetings	2

## The implications to Physiotherapists

The realities of managed care in South Africa are reality and we, as physiotherapists need to be aware of the opportunities and challenges they brings to us.

What does the model of managed care aim to achieve?

*Managed care is the gradual transformation of the health care financing and delivery system through a choice of managed care plans, each competing to attract providers and subscribers by finding ways to improve quality of care while curtailing costs.*

The major funders are already implementing their different care plans and unless we are aware of these

realities, our profession as well as our incomes may be compromised.

The three main challenges of MHO to us are:

- Independence
- Financial adequacy
- Practising quality care

To address the changes in managed health care PhysioFocus has instituted a managed care portfolio as well as the formation of a network of private physiotherapists called PhysioNet-Works.

Through these structures we address the arising new opportunities as well as assist physiotherapists in making informed decisions

## Signing of contracts

With the changes in healthcare we are being exposed, as individual therapists and as provider groups, to an array of contracts. We suggest you do not sign any contracts unless you have had it scrutinized by a legal representative that understands the implications .

PhysioFocus has from time to time assisted members with advice about certain contracts and will continue to do so. You do , however take the responsibilities an individual to make your own decisions whether to sign a contract or not.



The Private Practitioners Association (PPA) of the South African Society of Physiotherapy( SASP )

### Preferred Provider Organisations (PPO)

These are a subset of managed care. Essentially any PPO is a practitioner or provider group that enters into an arrangement with a payer to provide a service for a pre-determined fee schedule. In return the funder encourages it's members to seek the services of the PPO physiotherapist.

### Checks before signing a contract.

- Does it comply with our ethical rules?
- Does our professional body endorse it or has your lawyer checked it?
- What are your responsibilities and what are the benefits ?
- Who has access to your data and information?
- What are the termination clauses?

## Regional Information Meetings

PhysioNet-Works is holding regional meetings at which we will discuss the following:

The implications of the changes in managed care for physiotherapists.

Sharing new opportunities and ventures.

Advice about the signing of contracts.

The importance of outcomes data and its ownership.

Shareholding in the company PhysioWorks.

Upcoming Meetings will be free for all PhysioFocus members. Non -PPA members R50.00

### Pretoria

**Saturday 2nd Oct**  
**8.30 -11.30 am**  
**HW Snyman Building**  
**"old Dean's office"**

### Kwa-Zulu Natal

**Thursday 5th Oct**  
**6.30pm**  
**Westville Hospital**  
**"lecture room"**

Contact  
Marge Walters  
(011) 6406611



PhysioNet-Works is committed to assisting our members to providing cost-effective, quality physiotherapy care, whilst ensuring that they prosper in the managed health care environment.

## PhysioWorks

PhysioWorks is an incorporated company that we have formed .

All paid up members of PhysioNet-Works can have shareholding.

*PhysioWorks provides business solutions for physiotherapists and other interested stakeholders*

### Opportunities within PhysioWorks.

Joint ventures and alliances

Electronic Communication

Product development

Data collection



If you are a private practitioner and want to stay informed please join PhysioFocus.  
Contact  
Marge Walters  
(011) 6406611

## Activities of PhysioFocus

PhysioFocus is the Private Practitioners Association within the SASP. We account for more than 2/3 of the Society's membership.

We specifically address the needs of physiotherapists in private practice, but in doing so, assist all members of the profession.

We assist members in providing quality care.  
Encourage continuing education to maintain excellent service.  
Provide a "New Member's" file on how to start your own practice.  
Set and negotiate tariffs every year.  
Educate members on our ethical and professional rules.  
Constantly inform members of the changes in the health care environment.  
Negotiate and advise members regarding contracts .  
Set up and implement practice accreditation standards.  
Educate members in good business practices.  
Founder member of the International Private Practitioners Association (IPPA) through which we maintain high standards of practice.

## WHAT IS PHYSIONET-WORKS?

*Tertia Smit introduces an organisation which provides a valuable service to private practitioners. PhysioNet-Works has been around for some months, but it's still a mystery to many a physio, so the overview is most welcome!*

**P**hysioNet-Works is a national network of physiotherapists in private practice that came into being on the 28th February 1998.

PhysioFocus saw the need for a network of practitioners that could negotiate and form agreements and joint ventures with different stakeholders in the health care environment.

PhysioNet-Works it is not an organisation in competition with the SASP and PhysioFocus (the PPA), but rather a group fulfilling certain newly-arisen needs of the profession.

To become a member of PhysioNet-Work, you have to be a member of the SASP and PhysioFocus.

### **Core Ideology**

Caring with Quality

### **Vision**

PhysioNet-Works is committed to assisting its members in providing cost-effective, quality, outcomes-based physiotherapy care to all their patients, whilst ensuring that they prosper in the managed health care environment.

### **We are committed to:**

Ensuring a high standard of professional physiotherapy service, that is cost-effective, efficient and outcomes-based.

Setting up a geographically representative network of physiotherapists in private practice that can fulfil the needs of all the stakeholders.

Assisting members in managing their practices more effectively, providing collective bargaining power, and negotiating new market opportunities.

Identifying and developing a

management system that effectively manages our clinical and financial data.

Being part of a private health care network that optimises the use of health care delivery systems.

Setting up protocols, accreditation, peer review, and authorisation structures.

Ensuring that we control our own destiny.

### **Present Situation**

An integral part of the success of our venture is to form strategic alliances or co-operation with certain stakeholders. One of these is an information technology (IT) company that can offer us a comprehensive service in data capture, billing, transfer, warehousing, and analysis of our clinical and financial outcomes data. Ultimately we would like to have the information and resources to do our own pre-authorisation of physiotherapy services for funders.

We are currently investigating going into a joint venture with an international software company who will provide a package that can collect clinical outcomes data (this company we are negotiating with already); and other companies who have a health care network infrastructure. Some of the companies we have been talking to are QEDI, MediSwitch (Usko), Brainware, Dimension Data, Interdoc, (IH Tech) and Mx Health. They all provide different functions in providing IT services in health care and we have to determine which of them can fulfill our needs.

There are some exciting new practice management systems emerging, which combine your billing, clinical management and your accounting management in one package. They are Windows-based and year-2000-compatible. If

you are thinking of upgrading your existing computer system or buying a new one I suggest you wait until early next year. We hope to be able to advise you by then on the best available programmes.

We are also currently talking to medical funders to see how we, as PhysioNet-Works Physiotherapists, can offer an effective service to their members without compromising our standards. Issues like the best uniform coding for diagnosis (ICD10 & ICDIH) and treatment (CPT4) for physiotherapists are also being explored.

We have also had talks with African Health Synergies and the South African Managed Care Coalition, the South African Medical Association (was MASA now SAMA). They are groups that represent doctors in a similar way to us. They are all interested in co-operating with PhysioNet-Works in the future.

What we are doing can benefit all physiotherapists in private health care. Being part of the PhysioNet-Works will enable you to keep abreast with the changes in the future health care environment, and you will be part of a network that can negotiate strategic alliances and, hopefully, preferred-provider status for you.

### **Important new news:**

We are investigating the feasibility of Occupational Rehabilitation Centres that will be used to rehabilitate and re-integrate people back into their work environment. This is a new market that has opened up, via the insurance companies and not the medical aids by means of a different fee structure. The start-up costs involved are manageable for an average-sized practice. These facilities have to be set up imminently; if anyone is interested please will you join PhysioNet-Works as soon as possible and contact Kitty Lamprecht at 0832612171.

Application forms: Marge Walters- Tel /Fax 6406611(011) ✻✻

# PHYSIONET-WORKS LAUNCHES NEW ERA FOR THE PROFESSION

In a move that has far-reaching implications for physiotherapy, a new body is being formed to guarantee the security and autonomy of physiotherapists in private practice. The organisation, PhysioNet-Works, will be a completely separate entity from the SASP and PPA, but physiotherapists wishing to join will need to belong to both these societies. Below is a reprint of a letter sent recently to all PPA members outlining the challenges facing physiotherapy and providing details on PhysioNet-Works. This letter is reprinted for the information of all physiotherapists. To find out more, contact Marge Walters at the PPA Head Office: Tel/Fax (011) 640-6611.

## *PhysioNet-Works* ARE YOU READY TO JOIN HANDS?

In our last leaflet, we spelled out the challenges facing Health Care and Physiotherapy in South Africa. We stated that Managed Health Care was a reality and we needed to be prepared for it. And we suggested that every physiotherapist in private practice should ask two questions:

- How can I be included in a business network?
- How can I obtain the best remuneration for my services within that network?

We then asked you to give us the mandate to negotiate on your behalf, so that we could begin to negotiate a secure future for you whilst ensuring your autonomy in private practice.

**Here's the good news. Fully 80% of PPA members have signed the mandate giving us the go-ahead to negotiate on their behalf! If you haven't done so yet, we urge you to sign as soon as possible. Remember, the more fully represented we are, the more easily we can negotiate better deals for Physiotherapy. And that means for *your* practice!**

Now the next step...

Through negotiations, SASP and PPA have established that Physiotherapy needs to form a separate legal entity in order to be contracted with health care funders. This body will be called PHYSIONET-WORKS, and will be a national network of committed physiotherapists that satisfy

preset criteria.

### WHO CAN BELONG?

PhysioNet-Works is a business organisation. To join it, you have to be an SASP and PPA member who has practised in the private sector for more than two years. (The full criteria will be stated in the constitution.) You will be charged a joining fee and a monthly contribution, both of which are specified on the application form. These are to cover start-up costs, implementing the data-capture package and the administration expenses of running PhysioNet-Works.

Initially, any physiotherapist who fulfils the criteria will be eligible to join. Once the network is in place, a person will be allowed to join only if there is a need for a practice in that area. Being a member of PhysioNet-Works will not preclude you from belonging to your local IPA (Independent Practitioners' Association).

### THE TASK OF THE TASK TEAM

The PPA has appointed a task team to set up PhysioNet-Works, write a proposed constitution for the body, and establish its membership. This team consists of Hester Huysamen (Chairman), Tertia Smit (Information Technology), Wilma Erasmus (Public Relations), Ingrid Klerck (Finance) and Marge Walters (Secretary). Please remember that the task team has merely set the wheels in motion. PhysioNet-Works will have its own inaugural meeting and will

appoint its own Management Committee.

Right now, though, we need YOU! The more physiotherapists who join PhysioNet-Works, the more skills and credibility the network will have. This will give us stronger bargaining power in negotiation with funders. And a powerful and effective network is vital for our destiny control in private practice. Consider the following:

DIRECT THREATS TO PRIVATE PRACTICE	THE SOLUTION!
The proposed future licensing of practices by the State.	By setting standards and organising an equitable demographic distribution of PhysioNet-Works, the necessity for licensing is addressed.
The nationalisation of the entire health industry.	PhysioNet-Works will increase services to the wider community and this will address the need for primary health care.
Government and funder interference in the private health sector.	PhysioNet-Works allows a fully representative group to negotiate on an equal footing with relevant stake holders.
Increased demands on, and diminishing funds in, health services.	A network will contract with stake holders to offer a quality service at a HIGHER REMUNERATION than that enjoyed by non-network physiotherapists.
Increased encroachment on our profession.	As part of a dynamic network, we shall be able to collect data to prove the effectiveness of Physiotherapy.
Individuals are unable to survive against big funders.	PhysioNet-Works will have the negotiating skills, resources and national representation to deal with any funder - State or private.
Clinical and financial data can be manipulated against Physiotherapy.	By collecting and owning our own data, we shall be able to use it to promote Physiotherapy as a progressive, dynamic, self-regulating profession.

### GET INVOLVED - THERE'S NO TIME TO LOSE!

**Fact:** PhysioNet-Works is on the verge of transforming Private Practice into a vigorous, fully independent business.

**Fact:** PhysioNet-Works will enable physiotherapists to maximise their opportunities within the new health care situation in South Africa.

80% of our members have given us the mandate to negotiate on their behalf - and that number continues to grow every day. Now let's take the next step together and build up PhysioNet-Works as rapidly as possible. Interested parties are standing by to negotiate with us; all we need is a fully representative body.

**APPENDIX 21**  
**DOCUMENT SUBMITTED BY THE PHYSIOTHERAPY PROFESSION TO THE**  
**TRUTH & RECONCILIATION COMMITTEE**

University of Cape Town

**SUBMISSION BY  
THE PHYSIOTHERAPY PROFESSION TO  
THE TRUTH AND RECONCILIATION COMMISSION**

CAPE TOWN, FEBRUARY 1998

**COMPILED BY  
THE NATIONAL PHYSIOTHERAPY COMMITTEE  
FOR THE TRC SUBMISSION**

Nº	GOAL	ACTION	RESPONSIBLE PARTY/IES
9	To work towards creating equity between historically black and white institutions and rural and urban areas in terms of: <ul style="list-style-type: none"> <li>• staff/client ratios</li> <li>• space</li> <li>• equipment</li> <li>• skills</li> <li>• finance</li> </ul>	Set targets, lay down guidelines/protocols, promote, advocate, monitor progress, and take action where progress is unsatisfactory.	HPCSA and Minister of Health through the Professional Board in collaboration with the SASP.
10.	To ensure relevance of the physiotherapy curriculum.	Invite participation of all members of the profession in contributing suggestions with regard to a relevant core curriculum.  Establish core curricula flexible enough to meet the needs of the country now and in the future.	Education Committee of the Professional Board/Education Board of the SASP through the Publications Division.  Education Committee of the Professional Board/Education Board of the SASP/members of the profession.

**PROMOTION OF RECONCILIATION AND REDRESS**

Nº	GOAL	ACTION	RESPONSIBLE PARTY/IES
1.	To admit that discrimination existed within the profession and to apologise to those physiotherapists who suffered in process.	Translation of the TRC Submission into relevant languages.  Publication and wide circulation of this document.	Provincial translation departments.  The national committee for the TRC submission, provincial physiotherapists, lecturers, SASP
2.	To find ways of redressing the discrimination suffered by physiotherapists on the basis of race and/or gender.	Request Public Service Administration and academic institutions to provide redress for lost benefits.	SASP to ask legal advice on this issue.

**Contact name and address:**  
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Salt River  
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**Tel: 761 1606 (h)**  
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November, 1998

Dear Colleague,

This collaborative document presents a reflection of our history, and of our vision for the future. Much consultation, discussion and time have gone into its preparation.

This document was submitted to the Truth and Reconciliation Committee (TRC), and we are grateful to the World Confederation for Physical Therapy (WCPT) for granting us funding, in order to be able to send every Physiotherapist and Assistant Physiotherapist in South Africa a copy.

None of us have come out unscathed by the ravages of the apartheid era. The preparation of this document has been a painful process of revelation of the memories of the indignities and unjust practices experienced in the past, and now lying dormant or even suppressed in people's memories.

It has provoked a collective response in us as Physiotherapists to take a new look at what happened in the past, and at what is happening in the present, so that we can pro-actively develop and implement a plan for change in the future.

Thus far, we have educated Physiotherapists in professional ethics and in curative or mainly medically based care, rather than empowering Physiotherapists to work with communities.

Thus, we are very learned in our discipline, but sorely lacking in the fields of promotive health, human rights and community development.

The Physiotherapy profession acknowledges the sins of omission during the apartheid era, and wishes to pledge its commitment to the reconciliation and transformation processes currently underway in this country as a whole, and the health care and educational systems in particular.

We trust that this document, and the actions that will ensure from it, will guide the profession in this process, and that future generations of Physiotherapists will learn from this chapter in our history.

**PATRICIA SWILLING**  
**PRESIDENT S.A.S.P**

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## INTRODUCTION

### BACKGROUND

In her January 1997 document *The Truth and Reconciliation Commission and the Health Care Sector*, Dr. Wendy Orr points out that the Promotion of National Unity and Reconciliation Act (1995) seeks to establish "as complete a picture as possible of the causes, nature and extent of the gross violations of human rights which were committed during the period 1 March 1960 to the cut-off date of 10 May 1994". From this, recommendations of measures to prevent the future violation of human rights should follow.

Orr states that while most health care professionals were not directly involved in gross human rights violations, they may have contributed to the creation and maintenance of an environment in which those violations could occur.

The request is made that as broad a group of professionals as possible make a submission to the Truth and Reconciliation Commission (TRC) and that these submissions should represent an honest, searching reflection on whatever aspects the report covers.

In a later document, *Discussion Document: A Steering Committee for the Promotion of Human Rights in the Health Professions* (29 April 1997), the TRC Health Task Team describes the process by which the Health Care Sector Hearings were initiated and an interim task group nominated. They also point out the following:

*The experience of the Interim Committee has been that without adequate resourcing, such an initiative is doomed to become a regional initiative. Participants from outside of Cape Town were severely constrained from participating unless they were part of an adequately-resourced organization, with the result that the Interim Committee effectively became a Cape Town-based affair.*

The physiotherapy submission developed as follows:

In September 1996 a physiotherapist, Ms Vanda van Speyk, expressed an interest in the TRC's Health Care Sector hearings to a psychologist colleague at the Trauma Centre for Victims of Violence and Torture in Cape Town, who was part of the steering committee and so obtained an invitation to the initial workshop.

Late in April 1997 it was realised that certain individuals and institutions had been invited to make submissions. However, the rehabilitation therapists had not been included in this group, which consisted of doctors (and psychiatrists), nurses and psychologists. This seemed to be a perpetuation of a long-standing professional hierarchy/hegemony, which needs to be challenged as part of the health care sector hearings. Ms Van Speyk contacted Ms Margaret Beattie of the Professional Board for Physiotherapy in this regard. Ms Beattie said she had been approached by a MASA doctor who felt that physiotherapists should also make a submission. She, however, felt that the South African Society of

Physiotherapy (SASP) would be in the best position to make such a submission. An initial working group was formed, consisting of Sheena Irwin-Carruthers, Marietta Uys, Mary Faure, Dawn Goodley and Vanda van Speyk. Pat Swilling was involved intermittently. These people were representative of the Professional Board, the South African Society of Physiotherapy (SASP), Universities and clinicians, both from the public and private sectors.

This group decided to draw up the submission as members of the physiotherapy profession in general, rather than through the SASP, to prevent a conflict of interests and the exclusion of those who were not members of the SASP. The group also informed the occupational therapists, speech therapists and Disabled People of South Africa, and encouraged them to consider making submissions.

Having obtained an extension from the TRC, the group met for the first time on 6 May 1997, and decided to draw up a draft submission which was to be circulated as widely as possible for comment. The group drew up a document under the following sections: Clinical Practice, The South African Society of Physiotherapy, Physiotherapy Education and the Professional Board for Physiotherapy. Each section was allocated to a particular person to facilitate, collate and correlate input. Under each section the following questions were posed:

- What did we, as physiotherapists, do during the period under consideration?
- What should we have done?
- What should we do now?

### AIMS

The aims were stated as follows:

- To take part in the historical process which is occurring in our nation
- To claim our place within the health sector
- To stand back and critically review what we did do, what we did not do, and what we should be doing/can do in terms of health rights, human rights and violations or abuses
- To be pro-active and market our profession.

### GROUND RULES

- This is a critical and constructive evaluation of systems, contexts and environments which permitted violations and abuses
- It should not be destructive (i.e. destroy present relationships and achievements)
- It should be factual
- It should acknowledge achievements.

Although there is a body of documentation available for use in drawing up parts 2, 3 and 4 of the submission, it proved more difficult to obtain information about the clinical sector. A questionnaire was drawn up and circulated as widely as possible to all physiotherapy provincial Assistant and Deputy Directors and those acting in that capacity. In the Western Cape, this

was also sent to hospitals and special schools since the preliminary drafts were drawn up, copies of the four draft documents were sent to these persons as well as to the South African Society of Physiotherapy, who distributed copies to the chairpersons of all their Provinces and Special (Interest) Groups.

The question then arose as to whether or not the group had a mandate from the profession to make the submission. The group's position was that it believed that the submission was an essential step for the profession to take and, given the lack of any other response, had taken the initiative. To obtain a mandate, it was decided that Ms Van Speyk should write an article and submit it to the *Physio Forum* (July 1997 issue). This was done, but due to a publisher's error it appeared only in the September issue. Input received in response to the article was, however, taken into consideration in the final drafts of the submission. The group also decided that if it did not receive a mandate from the profession, it would continue to make the submission as a group of concerned professionals.

Subsequent to this, the group was given the mandate by the majority of those who responded. On 19 September 1997, Section 3 of the submission - Physiotherapy Education - was approved by the full meeting of the Education Board of the SASP, which consists of representatives of all university training departments (whether members of the SASP or not), representatives of all Groups of the SASP, representatives from the College of Physiotherapists of South Africa, the Physiotherapy Research Foundation and the Education Trust, the editor of the South African Journal of Physiotherapy, and a physiotherapy educationalist from the SA Association for Academic Development (SAAAD), which is a non-governmental organisation. On 21 September 1997 Section 2 of the submission - The SASP - was approved by a full meeting of the National Assembly of the SASP.

The final drafts of all sections of the submission were redistributed to all bodies and persons previously mentioned above, as well as to Mrs L. Hawkesworth of the Gauteng Education Department who acted as liaison person for the physiotherapists in the special schools. A further notice was inserted in *Physio Forum* informing all readers of where copies of the submission were available and inviting further comment by 31 December 1997. It should be noted that this further extension has been made possible by the six month extension granted to the TRC itself.

#### CONTEXT

The domination of Positivist philosophy in the twentieth century, in addition to male domination of the sciences, has meant that a professional hierarchy has emerged, based on the scientific foundations and gender composition of the professions. The medical profession is no exception.

Since the origins of physiotherapy were in massage and gymnastics which belong more in the realm of art and craft than of technical rationality, it has been traditionally an occupation for women, and has been very firmly relegated to the status of the minor professions along with occupational and speech therapy. This is borne out by the terminology used to describe the group e.g. 'complementary', 'allied' or 'supplementary' medical or health

professions. Changes in the nature and autonomy of the physiotherapy profession which have occurred over the last twenty or so years have not been acknowledged by either the medical profession or state authorities. This has had two serious outcomes. Too much energy has been spent within these professions on trying to gain status and recognition; individual versus individual, and profession versus profession. Secondly, and more seriously, patient/client management has occurred within the framework of the hierarchy rather than being based on patient/client and community needs. Curative services have taken precedence over rehabilitative services at the expense of the patient's/client's quality of life. Both patient/client and practitioner have been disempowered.

We believe that the maintenance of this hierarchy within the larger sociopolitical milieu cultivated a health care sector environment in which abuses and rights violations could, and did, occur.

Rehabilitation therapists and disabled people only entered the TRC's health care sector investigations through their own efforts. The fact that the public hearings and steering committee included doctors, nurses and psychologists only, clearly reflects the existing hierarchy.

The other important aspect of the context of the physiotherapy profession is that it was transplanted to Africa by a white, english-speaking middle-class. It has made small, slow, largely ineffective attempts to move away from this base. These attempts have been reactive rather than pro-active. This, then, is the context out of which we have attempted to reflect, as honestly as possible, on past and present, and to envisage an environment for the profession and the client which is substantially and qualitatively different.

#### TERMINOLOGY

In order to formulate the submission, certain definitions were needed. The following were accepted by consensus and are used in the reports:

- **Human rights violation**  
An action which infringes upon another person's freedom and well-being, or which aids such infringement.<sup>1</sup>

- **Abuse**  
To misuse; wrongly take advantage of; violate; defile; misrepresent; adulterate; misuse confidence of; deceive; impose upon; maltreat or injure repeatedly; speak insultingly of; malign.<sup>2</sup>

- **Black, african, asian, coloured, indian, white**  
Black is used generically, as an adjective, to denote all people classified under the old Population Control Act as non-white. Distancing mechanisms such as inverted commas have not been used. Where it was necessary to differentiate between different groups in order to point out human rights violations, the terms african, asian, coloured, indian and white have been used.

- **Client, patient**  
The term client is used to denote an individual or group who requires

individual who is receiving services within a health-care facility.

1. Tom Lodge; All wars breach human rights, Mail and Guardian, May 9-15, 1997.
2. New Shorter Oxford English Dictionary.

## PART 1 : CLINICAL PRACTICE

In this section three areas of practice are considered: public hospitals, special schools and private practice. The situations of both the practitioners (their practice and knowledge) and their clients are described. This information is based on the very limited feedback received from clinical physiotherapists. Many people were reluctant to respond, hinting that at this time, given the current rationalisation of posts, it was not a good idea to become involved in bringing up the past. One person felt that individuals or racial groups might have different interpretations of events, whilst others felt that there was no point in bringing back the past. Unlike the other three sections of the submission, there is little formal documentation, such as minutes of meetings or published resolutions, on which to draw, and so the information presented depends more on the memories of the respondents. A further constraint was that it obviously was not possible to consult the clients and so, of necessity, a partial view is represented. A more holistic view might have presented a different scenario. Finally, there are areas which impinged both on practitioner and client. These have been included under the clients' section for the sake of convenience.

### PUBLIC INSTITUTIONS

#### Patients/Clients

Apart from a very few hospitals, most physiotherapy departments only began partial integration during the late 1980's. There has been no evidence that the integration was pro-active or based on the principles of human rights, but rather that it was expedient and occurred in response to staff and/or space constraints. By the early 1990's when the political climate was changing, full integration was achieved in the historically white hospitals. The historically black hospitals continued to serve the black populations only, reflecting both the slow social change outside and, more importantly, the gross inequalities between the institutions. Within the field of rehabilitation one example is that, with the exception of the mine hospitals, assistive devices were usually more readily available at the white hospitals, and were of a superior quality and range. The general conditions at the institutions also created the context in which the rehabilitation services were delivered. These can perhaps be graphically illustrated with a few examples from a tertiary institution for black people in 1987:

- \* patients sleeping, at night, on mattresses both beneath and between other hospital beds with rat traps placed at strategic intervals between the mattresses
- \* totally inadequate and disgusting ablution areas

- \* [lost or misplaced]
- \* lack of privacy
- \* substandard general hygiene in the surgical wards (e.g. cockroaches crawling through 'sterile' suctioning equipment);
- \* maggots (not deliberately introduced) floating off a horrified burns patient as she soaked her bandages off in a bath.

Physiotherapy services had to be delivered in this setting of limited space, dirt, infection (and the danger of cross-infection), lack of information concerning the patients, lack of privacy and limited equipment. In some rural hospitals, conditions were even worse. Within this general milieu, physiotherapists employed in hospitals for black people worked with a staff : patient ratio far less favourable than that in the white institutions, so that it cannot be claimed that all patients were treated equally. In addition to this many black patients suffered the indignity of being addressed in disrespectful and culturally inappropriate ways. When they were not fluent in English or Afrikaans, pigeon language that arose out of the exploitation of mine workers, was used as a means of communication. At best a translator or interpreter intruded on the therapeutic relationship.

It is no coincidence that, although the first physiotherapy assistant registered in the country was white, the training of physiotherapy assistants was developed and honed largely in the black hospitals. Physiotherapists based at the white hospitals saw no need for assistants, whilst black physiotherapists opposed the use of assistants as they perceived this as yet another second-class system which propped up an inferior service for black people. Community-based rehabilitation has been perceived similarly as another inferior service for poor black communities, engendering unnecessary resistance.

The training of physiotherapy assistants was not standardised throughout the country. They were trained for specific situations. This limited them to working in the institution for which they were trained, without the possibility of a career path.

There were some exceptions to the generally inferior rehabilitation services to black communities. The Natalspruit Hospital, for example, reports that during the period under review the rehabilitation of patients was effectively managed by a multi-disciplinary team and patients were only discharged when their rehabilitation was complete - a situation which still does not exist in even the traditionally white academic hospitals.

The relationship between physiotherapists and political prisoners/detainees was determined by the security apparatus e.g. political prisoners/detainees were often treated with guards in the cubicles and were walked down corridors shackled and chained around the ankles. At one tertiary institution prison warders and guards were often present in the physiotherapy gym, disturbing other patients. The ruling regarding prisoners from Robben Island that two prisoners brought for treatment simultaneously were not allowed to be treated in the same gym, was generally accepted without question. There is, however, evidence that individual physiotherapists did

challenge incidents like these, and as individuals "broke the law".

Many political activists did not have access to physiotherapy services in public institutions. Hospital staff (physiotherapists have not been implicated) colluded with the police in reporting the visits of those who were in hiding, or who presented with birdshot wounds, until eventually people were forced to develop alternative sources of medical and physiotherapy support.

### **Physiotherapists**

For physiotherapists, as for other health care personnel, there was legally-entrenched discrimination through job reservation. White therapists could obtain employment at any institution, whilst black therapists were barred from institutions for the white population. If white or indian therapists were employed at african hospitals situated in african townships they received the benefit of a travelling allowance which was paid according to a protocol. Amounts received differed from hospital to hospital.

The first black physiotherapist was employed at a white hospital as late as 1975 and could only be held against a temporary post. This was at Conradie Hospital, Cape Town. The starting salary for an indian physiotherapist at that time was 20% less than that of her white counterpart, but more than that of her coloured counterpart and considerably more than that of her african counterpart. There were also differing service benefits such as those relating to medical aid and pension provisions. Superimposed upon this racial discrimination there was gender discrimination, and male physiotherapists earned more than their female counterparts.

Job reservation was applied even within the groupings, as within the Cape Province which was a coloured labour preferential area where african physiotherapists did not easily obtain permanent posts. There are repercussions from this discrimination even today, in terms of pensions and voluntary severance packages which are calculated only for the number of years the staff member has been employed in a permanent post.

In contrast, white physiotherapists wishing to work in institutions in the independent homelands were not directly employable, but were seconded by the nearest provincial administration after having passed a security check. They were granted a territorial allowance for working outside the Republic. Their conditions of service were those of the province from which they were seconded.

The unchallenged practice of petty apartheid such as segregated tea room and ablution facilities in the hospitals was reported by some physiotherapists.

### **PRIVATE PRACTICE**

#### **Patients/clients**

The fact that approximately 75% of registered physiotherapists are in private practice means that the majority of physiotherapists in South Africa treated those patients privileged enough to be on medical aid or to be able to afford private fees. Only 25% or less of registered physiotherapists worked in the public institutions which serve the large majority of the

population.

Most private practitioners report that black patients were treated in white areas with no segregation of facilities (including waiting rooms, treatment rooms and toilets). Even in the late 1970's, restrictions regarding the use of separate waiting rooms, were included in the lease contracts of certain buildings.

### **Physiotherapists**

In small towns, private physiotherapy practitioners have been working in townships and rural areas for many years, often visiting patients in their homes as well as treating them in their practices.

The first black private practitioner practising in a white metropolitan area was Mr Shree Singh of Durban. He qualified in Edinburgh with a diploma in 1960. Black physiotherapists who qualified in South Africa have been in private practice in urban areas in Natal for the last thirty years. In the rest of the country, private practices were mostly situated in white areas and the majority of the practitioners and their clients were white. Black physiotherapists were not always welcomed as partners or locums in white practices. A specific example of a black physiotherapist who applied for a position in a white practice was cited. She was advised in no uncertain terms to open her own practice, although assistance to do this was offered.

### **SPECIAL SCHOOLS**

#### **Pupils**

In the Western Cape, coloured and indian pupils were accepted in special schools which fell under the administration of the House of Representatives (HOR) whilst white pupils attended special schools which fell under the administration of the Department of National Education (DNE). There was one special school for african pupils which fell under the Department of Education and Training. A similar system applied to other areas of the country. Most special schools for african pupils were in rural areas. Black pupils were accepted in House of Assembly schools only after 1993. The inequities in the per capita expenditure between the administrations is still reflected today in the discrepancies in the quality and quantity of the resources at the different facilities - most National Education and HOR schools have good physiotherapy staffing and equipment whereas the schools for african pupils, especially in the rural areas, have very limited facilities.

#### **Physiotherapists**

White physiotherapists were permitted employment at all special schools. In the Cape, african physiotherapists were prevented from being employed in either DNE or HOR schools.

### **KNOWLEDGE OF RIGHTS**

Few public sector physiotherapists feel that they have adequate knowledge of the Bill of Rights, the Constitution and the Declaration against Torture. There are exceptions, such as the physiotherapists of the Centre for Care and Rehabilitation of the Disabled (constituted in 1992), University of Stellenbosch, at Karl Bremer Hospital. Not only are they conversant with

these documents, but also try to convey this information to disabled clients. They are trained as Lifeline counsellors and are able to recognise the signs of torture and violence. They are aware of referral channels should such cases come to their attention.

The response from many practitioners was equivocal. Although the South African Society of Physiotherapy had published guidelines for members when treating prisoners, political detainees and/or victims of unrest in 1988, some members had not read this document, which had been published in the South African Journal of Physiotherapy and sent to all members. This is a reflection of the lack of sensitivity of human rights issues amongst the profession in general.

### CONCLUSION

There is no evidence to suggest that clinical physiotherapists committed gross abuses of health or human rights. As a profession they did not question or speak out about the abuses which were visible. We quote from a response by a white physiotherapist:

*It was difficult not to notice the gross human rights violations and inequalities caused by the apartheid policies. I think for us to excuse ourselves as unknowing, innocent participants is dishonest. I think it would be more accurate to apologise for the apathy, the passive way we accepted apartheid by not challenging the status quo in the (hospitals) where we worked every day. Being white and sheltered is no excuse. We did not have blinkers and are not people who cannot think. I feel that integrity calls for us to apologise, admit to our blindness and acknowledge the sins of omission. We were wrong and we can learn from that.*

Many feel that physiotherapists worked long and hard to treat patients to the best of their ability under appalling conditions. Others, however, feel that those who did so and yet failed to speak out against the conditions in which they worked, acquiesced through silence and served to prop up and provide the acceptable face for an iniquitous system.

In conclusion, the physiotherapy profession lacked, and may still lack a human rights culture. In the past, issues relating to rights were too often confused with 'politics'. Our emphasis was all too frequently on a highly skilled, technical, one-to-one treatment situation, in which the context which defines the client, the physiotherapist and the service was ignored or neglected.

### THE FUTURE - RECOMMENDATIONS FOR A WAY FORWARD

- \* As has been suggested previously in this document the physiotherapy profession needs to apologise to colleagues, clients and the people of the country
- \* Members of the profession who either benefited by or were not victimised by the system need to listen to, and hear, the stories of their colleagues

- \* We need to consider in what way we can make concrete our commitment not to permit a repetition of the past, and to redress wrongs committed or permitted
- \* Workshops should be held to educate those who are not familiar with the Bill of Rights, the Declaration against Torture, and other relevant human rights literature
- \* Where this has not yet occurred human rights issues need to be integrated in the undergraduate curriculum
- \* Specific issues such as recognition of signs of torture and principles of treatment of victims of torture, should be included in all undergraduate curricula
- \* The profession would request the TRC to take the issue of lost benefits, due to discrimination, to the public service administration for redress. Physiotherapists who are still working and who suffered under the discriminatory practices of the apartheid system should be enabled to buy back pension years. Also, other means of redress need to be investigated.
- \* The equivocal status of the physiotherapy assistants finally needs to be addressed
- \* The concept of community-based rehabilitation needs to be re-examined
- \* Community-based services should be introduced into all communities, both as a response to needs and as a means of redistributing resources in the context of primary health care.

## PART 2 : THE SOUTH AFRICAN SOCIETY OF PHYSIOTHERAPY INTRODUCTION

In this part of the submission we give an outline of the history of the South African Society of Physiotherapy (SASP), an analysis of our achievements and our future vision.

The SASP has a proud record of upholding professional standards and ethics and of providing continuing professional education courses of international standards. However, as a professional organisation it failed dismally in addressing the needs of all of its members during the years of oppression.

As physiotherapists we are all accountable for the physiotherapy services which were developed in South Africa, as well as for the management and operational style of the SASP which resulted from our actions or omissions. Since its inception and up to a decade ago the SASP operated as though it were in an egalitarian state - while yet within the apartheid framework and ignoring the realities of oppression and exploitation which pervaded life in South Africa. As a professional organisation we were unwilling to rock the boat and take a firm stand against apartheid health policies and practices. We remained inactive whilst making lukewarm criticism during our meetings

involved in the struggle for human rights during the 1960's, there was a lull in overt political activity. The 1970s and 1980s saw a concerted campaign to isolate South Africa internationally, because of its racist policies, in sport, trade, academic and other arenas. SASP delegates thus found themselves confronted by a few hostile member-organisations of the World Confederation for Physical Therapy at the meeting held in Sweden in May 1982. Being thus prompted into taking a second look at itself, the stance of the SASP started to change from one of being "ethical, but not political" to one of trying to address some of the inequalities and human rights violations of the apartheid era.

For the indignities suffered by our members and for our complicity by nature of our silence, we accept blame and apologise unreservedly.

## THE PAST

### History

In 1921 a small group of masseurs in Cape Town banded together to form the Certified Masseurs Association, primarily in order to fight for inclusion in the forthcoming Medical, Dental and Pharmacy Act of 1928. In this they were partially successful and in 1931 registration of masseurs was gazetted, although it was not made compulsory. At the same time a similar group in Natal formed a branch of the UK Chartered Society of Massage and Medical Gymnastics. Realising the need for a national organisation, these two groups met to hold the inaugural meeting of the South African Society of Massage and Medical Gymnastics in December 1924. The first meeting of the Central Governing Board took place in August 1925. The first journal of the South African Society was published in 1929 and in 1932 the Society changed its name to the South African Society of Physiotherapists. After the second world war the name was changed to the present one - the South African Society of Physiotherapy (SASP).

The SASP was a founder member of the World Confederation of Physical Therapy and from 1963-1970 was represented on the Executive Committee. The first (1991) chairperson and the current chairperson and secretary of the WCPT - Africa Region are SASP members.

### Membership and Structure of the SASP

Membership of the SASP has always been open to all physiotherapists. During the gradual introduction of compulsory registration the only requirement for membership was that the professional qualification held should be registrable. All qualifications at South African training institutions were registrable. After the Professional Board for Physiotherapy was established in 1973, the requirement for membership was registration with the Board. Physiotherapy Assistants have also been accepted for membership since the inception of their registration with the Board.

### Mission and Objectives of the SASP

In 1986 the SASP formulated the following Statement of Intent, which was incorporated into a Mission Statement in the SASP Constitution in early 1987.

- The SASP does not and will not discriminate on the grounds of race, colour, creed, national origins, social status or gender in the practice of physiotherapy or in the administration of its organisation
- Together with the Professional Board for Physiotherapy, it will continue to ensure the quality of physiotherapy services to all peoples throughout South Africa
- It will continue to safeguard the welfare of its members and, as it has done in the past, will make representations against discrimination against any of its members
- Recognising problems which have been occasioned by the division of health service administrations, it supports unequivocally the provision of a unitary health service, at the same time supporting and encouraging the progress which already has been made in the integration of health services.

In 1993 the SASP published four position papers, making the following commitment:

*The SASP commits itself to participating in the planning and development of a national health care strategy, and to facilitating the provision of a comprehensive equitable physiotherapy service at primary, secondary and tertiary levels which is appropriate to the needs of the people of South Africa.*

The preamble to the first position paper reads:

*At present, physiotherapy services are not available to the majority of people of South Africa. The need for social upliftment and empowerment, together with the acknowledged need for improved primary health care and rehabilitation, demands reassessment of the services provided by physiotherapists. The training of physiotherapists must equip them to play an effective role in comprehensive health care, including promotive, preventive, curative, rehabilitative and educative aspects, as well as in research. Physiotherapists must ensure that their services are accessible, affordable, acceptable and effective, and are rendered in an accountable manner.*

The four position papers are:

- The role of the physiotherapy profession in future health care delivery systems
- The role of physiotherapy in primary health care
- The role of physiotherapy in rehabilitation
- The role of mid-level and grassroots-level workers in the provision of physiotherapy services

In 1995 a further position paper, Physiotherapy Education, was published. These position papers are available from the SASP Head Office.

## Political Involvement

The SASP has never overtly discriminated on grounds of race, colour or any other basis either in the practice of physiotherapy or in the administration of its organisation. This principle has always been accepted by SASP members, who have treated all patients with all the skills and resources at their disposal, and whatever their backgrounds have worked together as professional colleagues and as members of the Society. At the same time, however, many members originally felt that politics had no place in the work of a professional organisation and that the SASP should not, therefore, make political statements. It was also feared that the then government might restrict the activities of the SASP if it did enter the political arena. Physiotherapists adhered to ethical principles in the treatment of their patients, but most did not think to challenge the requirements of the apartheid era in respect of separate waiting rooms and treatment areas and other areas of petty apartheid.

Within this framework, the following actions were taken by the SASP prior to 1986:

- \* Unitary Health Service
  - Submission to the Commission of Enquiry into Health Services (1980).  
The SASP stressed the lack of preventative programmes and primary health care facilities, the fragmentation of health services, the lack of a coherent salary and post structure for all physiotherapists and the resultant move of skilled physiotherapists from the public to the private sector.
  - Multiple submissions to the Committee of Enquiry on Possible Future Facilities for Medical and Dental Training (1984).  
The SASP stressed the necessity of opening all universities to people of all races, of increasing the number of black physiotherapists, of placing more emphasis on primary health care and community health services and of considering alternate pathways and levels of training directed at fulfilling specific health needs within different communities.
- \* Parity of salaries
  - Resolutions regarding parity of salaries were carried unanimously at each Council Meeting of the SASP, followed up by repetitive representations to the Government, from 1965 until full parity was achieved in 1986. In retrospect, it is evident that black physiotherapists felt that these efforts were obscured by representations for general improvements in salaries and conditions of service.
  - Twice in 1984 and again in 1986 the SASP acted on

behalf of black members who reported discrimination in the implementation of salary scales and conditions of service.

Documents produced by the SASP did not contain any direct input by those physiotherapists who were suffering under apartheid. Input for this submission from physiotherapy lecturers at Medunsa reads as follows:

*Our contribution reflects the other side of the story, of the people who experienced the human rights violations imposed by the apartheid era. While the SASP was doing the things outlined in the draft document, we were suffering in the process and we need those sufferings to be revealed. It will therefore be incomplete to submit what the SASP has been trying to do while not revealing what had been happening for it to take the stands it claims it did. We believe that a stand cannot be taken in a vacuum, something triggers it. If the document goes out ... omitting the other side of the story, it may be destructive to the relationships that are already existing and further distance the black physiotherapists from the SASP.*

Increasing awareness of human rights violations led to a change of attitude, initiated by the formulation of the above Mission Statement in 1986. In early 1987, the Legitimerade Sjukgymnasters Riksförbund (LSR), which is the WCPT member-organisation in Sweden, challenged the membership of the SASP in WCPT on ethical grounds. An official legal hearing was held in Sydney, Australia, in May 1987 - after which the WCPT published the following statement:

*The WCPT Executive Committee, after an official legal hearing in Sydney in May 1987, found no evidence that the SASP had contravened the WCPT Ethical Principles and therefore had no grounds upon which to recommend to the General Meeting that the membership of the SASP should be terminated.*

At the ensuing General Meeting of WCPT, also in Sydney, the SASP delegation signed a statement disdaining government regimes which were contrary to the delivery of equitable health care. The 1987 General Meeting of the WCPT did not have a quorum due to a boycott of the meeting by the Danish and Indian member-organisations on the basis of the SASP presence at the meeting. A Special General Meeting of the WCPT was therefore held in London in 1988. At this Special General Meeting, the LSR again queried SASP membership of WCPT on the grounds of Paragraph 40/64(1) No. 9 of the Resolutions on Apartheid adopted by the United Nations General Assembly in 1985. The SASP reminded the Assembly that they had already signed the statement referred to above. They declared further that they were totally opposed to discrimination in any form whatsoever and were gravely concerned about the provision of health services in South Africa. The General Meeting agreed to the SASP's continued membership of WCPT and passed a motion (proposed by the Danish member-organisation) that WCPT support SASP in their efforts to obtain equality of physical therapy services in their country. In conclusion, WCPT declared that

their current knowledge is that the SASP opposes all acts and policies of racial discrimination and strives to ensure the quality of physical therapy services to all peoples in South Africa. A press release issued by WCPT in July 1988 confirms the above.

During 1988 the SASP also published statements on the following discriminatory practices:

- \* The provision of health services
- \* The health needs of political detainees
- \* The Group Areas Act
- \* Academic isolation
- \* The economic situation as a result of the apartheid system
- \* Gender discrimination regarding taxation
- \* Housing subsidies for married women

A series of letters were written to the Cabinet Ministers concerned regarding the abolition of the Group Areas Act and the necessity for unitary health and educational systems. The guidelines for SASP members when treating prisoners, political detainees and victims of unrest were published in the *South African Journal of Physiotherapy*.

In 1988 the Executive Board of the World Health Organisation considered its relationship with the WCPT. They decided to defer its review of those relations until the 83<sup>rd</sup> Session in January 1989 in order to enable the WHO Secretariat to ascertain the facts concerning the policy of the WCPT with regard to the membership of the SASP. In response to queries received from the WCPT and WHO, the SASP sent a detailed memorandum to WCPT on 10 June 1988.

In 1989 the WHO agreed to continue its relations with the WCPT.

At the 1989 Council Meeting of the SASP the following resolutions were passed:

- \* THAT this Council endorses the steps taken by the outgoing National Executive Committee in initiating action against discrimination, and enjoins the incoming NEC to continue and intensify its efforts in this direction.
- \* THAT this Council instructs the National Executive Committee to initiate immediate action at both branch and national levels to encourage participation by black members.
- \* THAT it be resolved that the SASP is opposed to the policy of apartheid and to all discriminatory practices, not only as such policy and practices affect the provision of health services in the RSA and its neighbouring countries, but also as such policy and practices affect the lives, well-being and aspirations of all our colleagues, patients and fellow-countrymen. Furthermore, that it be resolved that the SASP will do everything in its power to encourage the abolition of such policy and practices.
- \* THAT the SASP condemns any act of violence, torture or humiliation perpetrated by any individual or group on any other individual or group.

The following two motions were defeated:

- \* That the Society shall remain a non-political organisation at all times
- \* That the National Executive Committee has acted outside its jurisdiction in taking a stand on a political issue such as the Group Areas Act.

### **Professional Status and Professional Practice**

In 1985 physiotherapists were granted primary contact status when the regulation requiring medical referral of patients was abolished. Physiotherapists now work in close collaboration with the medical practitioner, but may legally evaluate patients, arrive at a physical diagnosis, plan and implement treatment and take decisions regarding termination of physiotherapy treatment. The SASP has laid stress on educating its members regarding the increased professional, legal and social responsibilities implicit in primary contact status.

### **Physiotherapy Education**

The training of physiotherapists in South Africa started in the 1940's, but it was only in the 1960's that training became available for black students. This, combined with the inequitable educational system, has prevented the training of a representative number of black physiotherapists. The SASP, through representations to the universities and via its members in tertiary institutions, lobbied for the opening of all universities to students of all races. This was achieved in six of the eight university training centres by 1980 and in the remaining two by the mid-1980s.

The SASP was also instrumental in the upgrading of all training courses to a four-year B.Sc and in two instances a B.Phys. degree. This is in accordance with the minimal requirements of the WCPT which recommends a four-year university or university equivalent course.

In 1987 a need was identified for the provision of an alternative pathway for training. This pathway would allow increased numbers of students to enter the profession, would provide multiple entrance and exit points for disadvantaged students and would allow the existing physiotherapy assistants a means of upgrading their qualifications. The SASP entered into negotiations with the Natal Technikon and a course has been designed which has been approved in principle.

### **THE PRESENT AND THE FUTURE**

#### **Membership and Structure**

At present, membership of the SASP stands at 3731, representing 81,75% of registered physiotherapists. It is not possible to give a breakdown by race as this is not recorded in any way, but the majority of members are white. This is largely due to the fewer number of physiotherapists trained from the disadvantaged communities in the past, but it must also be acknowledged that some black physiotherapists perceive the SASP as a largely "white" organisation, or as one which displays a paternalistic attitude. Steps which have been taken in the past to promote black members of the SASP have

which were regarded as white-occupying, especially by black physiotherapists who are not themselves members of the SASP. A submission received from a group of coloured, Asian and African physiotherapists reads as follows:

*Being in the physiotherapy profession was but an extension of our general oppression and life experiences (job reservation, lower salary scales, segregation within employment institutions, limited prospects of promotion). The profession was, and remains, largely white-dominated, more specifically English colonial in perspective. Generally the physiotherapy profession has been insensitive, ineffectual, apathetic and not even reactive in servicing and promoting the profession in black communities and in meeting the needs of their black colleagues during the years of oppression and exploitation.*

Until 1995 the governing body of the SASP was the Council, on which the ten Branches of the Society were represented proportionally. By 1991 there were three black members on the twelve-member National Executive Committee and at least half of the ten branches had black Branch Executive Committee members. At the last Council Meeting in 1995 approximately 20% of the delegates were black.

The SASP was then restructured completely in an attempt to achieve greater representation of members at branch and provincial level, with only the chairpersons of provinces, professional service groups (including the physiotherapy assistants) and special interest groups represented on the new governing body - the National Assembly. This well-intended restructuring resulted inadvertently in even less diverse representation at national level. However, as from January 1998 there will be three black members on the National Assembly, one being the chairperson of South Gauteng Province, one being the chairperson of the Education Board of the SASP and one representing the physiotherapy assistants. The first two will also be members of the five-person Management Committee of the SASP.

Better representation has also been achieved on the Education Board and the National Physiotherapy Lecturers' Forum, a special interest group of the SASP. The membership of both of these national bodies of the SASP reflects well the diversity of cultures in South Africa.

The National Assembly of the SASP realises that it is imperative to give black physiotherapists both a sense of ownership in the SASP and empowerment as decision makers within the SASP. Steps must be taken immediately to redress the imbalance, but the SASP acknowledges that it is still seeking a solution which will be acceptable to both its black members and those black physiotherapists who feel themselves alienated from the SASP.

#### **Professional Practice**

Approximately 75% of SASP members are in private practice. The drift towards private practice is being reinforced by the poor salaries in the

public sector. An entry grade physiotherapist with a four-year, honours equivalent degree earns R43 899, whereas a pharmacist starts at R54 684. Reversal of the drift into the private sector can be achieved only with the introduction of more equitable salaries and more favourable conditions of service. In the meantime, a group of members in private practice has formed a community interest group, the members of which are providing professional services on a sessional basis in a variety of community, day hospital and clinic settings - often for no remuneration. This initiative started in the Western Cape and has spread to other Provinces. A recommended further level of development would be the establishment of intersectoral partnerships in collaborative ventures with an educational focus.

It is also true that approximately 80% of members practise in urban surroundings. Virtually all the public service posts are hospital based and there is an urgent need for the creation of posts in rural and peri-urban clinics. Many members have expressed interest in rural and peri-urban community practice at primary health care level.

The SASP will continue to press for the creation of community posts and posts in rural hospitals and clinics as well as for an improved salary structure. This will redress the inequalities of the past which have existed between the salaries and post structure of the physiotherapy profession as compared with that of other professions of similar or lower levels of training. It is important that such posts are established within a networking and support structure. We recognise that the basic unit of support is another person with whom to confer. Physiotherapists have suffered from the discriminatory practices of former national and provincial health authorities which have not recognised their level of qualification. One of the reasons for this could be the perception of physiotherapy as a predominantly female profession and the failure to recognise the demand for physiotherapy in the private sector.

#### **Physiotherapy Education**

The adoption of the new SASP Constitution in 1996 allowed for the formation of a Division of Education. The inaugural meeting of the Education Board was held in February 1997 and a second meeting in September 1997. The priorities identified at these meetings are discussed below:

- \* Criteria for student selection - in line with national education policy most universities have developed more flexible admission criteria, taking non-academic credits into consideration and making special provisions for disadvantaged scholars. Studies have shown that although finance, language and perceptions play a role in student applications, by far the greatest reason for lack of applications from black students is lack of exposure to and knowledge of physiotherapy. A sub-committee is to tackle the problems of achieving an intake more representative of the population, as well as proposals for a system of inter-university

referral in accordance with the proposals of the National Commission on Higher Education. The SASP careers booklet is being revised and translated into all the main languages used in South Africa, with the aim of targeting scholars.

- Financial assistance to disadvantaged students - an Education Trust has been founded, with the primary aim of financing the training of disadvantaged students.
- Technikon training programme - negotiations are continuing for a programme offering exit points after the first or second years and making provision for continuation to a full B.Tech. degree in Physiotherapy after four years. Provision will also be made for distance education programmes for the existing physiotherapy assistants in order to upgrade them to the second-year entry level.
- Curriculum development - a sub-committee has been appointed to work on proposals for a core curriculum which will meet the needs of the country and of the profession, possibly based upon a modular system. Universities are being encouraged to increase the amount of clinical teaching at primary health care level and in the community. Most are making good progress in this respect. Although it is felt that future graduates will be equipped with improved community skills, there is still a need for education in cultural and social differences, adult education, interpersonal skills and management, especially change management. This has been pointed out to the universities.
- Vocational training for independent practice - the SASP is opposed to the proposed scheme. It is inequitable in that such additional "training" is not required of any university graduates outside the health professions. It also reflects poorly on the training process in South Africa in relation to training elsewhere in Africa and in the world. It will also impose financial hardships upon graduates, particularly those from disadvantaged backgrounds. The SASP has made representations to the Professional Board for Physiotherapy against this discrimination. The SASP is in favour of encouraging work in primary health care settings and secondary hospitals by means of improved salaries and working conditions in the public service.
- Distance education - the SASP considers the development of distance education modules and networking to be a priority in order to promote placement in rural hospitals and clinics during undergraduate training. This will also provide continuing physiotherapy education programmes and post-graduate education modules which will meet the needs of physiotherapists working in more remote areas. Distance education methods are also being promoted to implement a quality assurance programme.
- Student representation - The SASP is encouraging the

incorporation of the National Physiotherapy Students Council as a Special Interest Group of the SASP, which will entitle them to a seat and a vote on the National Assembly of the SASP.

The SASP has also made a submission to the National Commission for Special Needs in Education and Training and the National Committee on Education Support Services. The two main concerns are:

- Measures to enable the admission of disabled students into training for physiotherapy. The SASP will initiate discussions with the universities and the Professional Board in order to establish criteria for professional competencies.
- Measures to ensure that disabled scholars obtain the physiotherapy services which they require within the schools system - at pre-primary, primary, secondary and tertiary levels of education.

### CONCLUSION

The SASP realises that it has failed to recognise and address the needs of all its members during the apartheid years. It is in the process of finding ways to redress the imbalances in its membership. The SASP also recognises its responsibility to be involved in the transformation process in health care services and physiotherapy training.

## PART 3 : PHYSIOTHERAPY EDUCATION IN S.A.

### THE PAST

#### History

The first physiotherapy training in South African was a diploma course instituted at the University of the Witwatersrand in the 1940's. It was followed by the National Diploma in Physiotherapy, which was first offered in Pretoria in 1949 and later in Bloemfontein, Durban and at Medunsa. The University of Cape Town offered their own diploma course from 1957.

The University of the Witwatersrand converted their training course to a four-year B.Sc. degree in the 1950's and a B.Sc. degree course was started at Stellenbosch University in 1966. Following the international trend, and in accordance with the requirements of the World Confederation for Physical Therapy, the remaining five training institutions changed to four-year university degree courses by 1980, being joined by the University of the Western Cape to make a total of eight training centres, each being part of a university faculty of medicine, and in the case of UWC - a faculty of health sciences.

All persons with South African qualifications, including diplomas, are eligible for full registration with the Professional Board for Physiotherapy. Initial training courses were based upon the British model. Clinical education took place exclusively in the large teaching hospitals attached to the medical schools. In the Western Cape these hospitals catered for all races. In other provinces there were separate hospitals for black and white patients. White students at medical schools treated patients of all races, whereas students at Medunsa and Durban-Westville received their clinical education entirely with black patients.

at the time, was on curative therapy and functional re-education. Although rehabilitation was taught, this was all institution-based. Preventive, promotive and educative aspects of health care received little attention. Physiotherapy education in primary health care and in community rehabilitation was largely unknown.

Training courses also reflected the health care needs, educational needs and aspirations of a small section of the population. The strict ethical codes fostered in students tended to be related to medical ethics and professional behaviour only, with the objective of developing attitudes and values which would ensure effective and equitable physiotherapy treatment for patients of all races. The larger realm of human rights was not addressed.

### **Selection and Admission of Students**

During the apartheid years, physiotherapy training departments were established on a racial basis. Black students were admitted to the Medical University of Southern Africa, the University of Durban-Westville and the University of the Western Cape. Even within this grouping it was initially difficult to admit other than african students to Medunsa, asian students to Durban-Westville and coloured students to the Western Cape. Only white students were admitted to the Universities of Pretoria, the Orange Free State and Stellenbosch. The position at the Universities of Cape Town and the Witwatersrand was less clear. Despite its reputation as an "open" university, the Physiotherapy Department at the University of Cape Town admitted the first student of colour only in 1961, and for many years admitted no more than two coloured or indian students per year. African students were excluded. Until the 1980s, the University of the Witwatersrand excluded black students on the grounds of having insufficient facilities to accommodate them.

Physiotherapy educators did not unite in any serious attempt to change the status quo of the entrance requirements dictated to the universities by the apartheid regime. Furthermore, as all the lecturers and the majority of students were from white communities, their insight into the needs and aspirations of both prospective students and the patients was limited. This was largely due to the success of the apartheid system as a social experiment in fostering multiracial ignorance. Insensitivity to cultural diversity led to feelings of humiliation in african, asian and coloured students. An example is the full-length photograph, in swimsuit, required for admission to some universities. This was a universal requirement for admission to British training centres at the time, but its use by British-trained lecturers at black universities was perceived as discriminatory, humiliating and of dubious intent.

By 1980, theoretically all university training was open to students of all races. In practice, however, few students other than white students were being admitted to the Universities of Cape Town, Stellenbosch and the Witwatersrand, but the students at the Universities of the Orange Free State and Pretoria were still only white.

asian and white school leavers, resulting in applications in excess of 1000 being received at some universities, for only 40 places. Apart from at Medunsa, relatively few applications from african students have been received at most universities until recently. Reasons for this could include poor career guidance and inadequate education in the sciences at black schools and lack of exposure to physiotherapy. Until recently, the profession has not made a concerted effort to publicise physiotherapy as a career among african and rural communities. In the last few years, applications for admission to physiotherapy at English language universities have increased, but very few applications have been received from african students for admission to Afrikaans language universities.

## **THE PRESENT**

### **Admission Criteria**

Since physiotherapy training has been open to all races at all universities, selection has been on academic merit. The use of academic criteria does not serve to redress the position of scholars disadvantaged by the old education system. However, for the last three years most universities have been using a combination of academic criteria, non-academic credits and a certain degree of differential selection in an attempt to identify students who have the potential to be successful in the profession. All universities are represented on the Education Board of the South African Society of Physiotherapy which has accepted the formulation of equitable selection criteria as a priority in the drive to achieve better representation of black students in the universities.

Many universities now offer bridging courses, largely concentrating on the sciences and on verbal and written communication skills, to students who appear to have academic potential. Following completion of the bridging course, promising students may either progress to an academic support or academic development programme, or may be accepted into the main stream. The problem of insufficient black applicants and even fewer black admissions to some of the formerly white universities, in particular the Afrikaans language universities, remains. All three of these universities have adopted a more flexible language policy, but still have to overcome the legacies of the past in order to attract black applicants. A recent student research project at the University of Stellenbosch revealed that there was very poor knowledge of physiotherapy as a profession amongst african scholars, due to their lack of exposure to physiotherapy services. Once introduced to the profession they expressed keen interest, tempered mainly by financial constraints. After finance, however, the two reasons expressed as to why they would be unlikely to apply to the University of Stellenbosch were the language policy and their perception that this university favours the white elite.

### **Academic Support**

Most universities now offer some type of academic support or development programme for the physiotherapy course, coupled with more flexible

readmission criteria. Some academic support programmes are initiated in that they cover only first-year subjects (often splitting the first year over two years) and the support is not carried through on a formal basis to the second, third and fourth years of physiotherapy training. Some universities offer tutorials throughout training for disadvantaged students, particularly for those lacking in communication skills. There is generally a lack of formal structures for academic support in the later years of the course.

At some universities, students may split their levels of study so that they may be studying subjects from different years - but this is not yet common practice. At least two universities are considering a modular approach which will allow students to pass modules at their own pace.

#### **Course Content**

In response to the paradigm shift in health care, physiotherapy education has attempted to become more relevant to the health care needs of the whole population. Primary health care now forms an important part of the core curriculum, with the emphasis on promotion of health, prevention of disease, trauma and disability, and also rehabilitation at all levels of health care.

Clinical education no longer takes place in the teaching hospitals only, but for the last few years has increasingly been moved to secondary hospitals, community health centres, clinics, schools, geriatric centres and other community settings - including both peri-urban and, where possible, rural facilities. In this respect the physiotherapy profession has implemented changes in advance of those which have occurred so far in medical training.

Further placement of students in these centres is hampered by the shortage of posts for physiotherapists in the community and in rural hospitals.

#### **THE FUTURE - RECOMMENDATIONS FOR THE WAY FORWARD**

##### **Access to Training**

Despite the attempts to redress the inequalities in student admission to physiotherapy courses, there remain gross discrepancies in the proportions of students from different population groups. Suggestions from physiotherapy educators include rigorous promotion of the physiotherapy profession in black schools and in the media, and a search for ways of increasing exposure to physiotherapy services. A central admissions referral system between universities has also been proposed. This might result in referrals of potentially successful students from universities which receive more black applicants than they can accommodate.

The universities, and the profession, also need to investigate ways of supporting more adequate secondary education in mathematics and science. It is proving difficult to increase the overall number of student admissions - largely due to the difficulty in finding suitable placements for clinical education during training. This is an area in which to develop inter-sectoral partnerships. There are insufficient physiotherapy posts (either available or filled) in the peripheral hospitals and clinics to allow adequate supervision and teaching, and the very small number of physiotherapy lecturers have to

spend valuable time travelling to outlying institutions for this purpose.

An alternative pathway to qualification as a physiotherapist was proposed by the South African Society of Physiotherapy in 1987 and planning for its implementation at the Natal Technikon is ongoing. It is hoped that other Technikon will follow suit.

This pathway will offer multiple entry and exit points and will cater for the following:

- students who do not currently qualify for admission to the universities
- physiotherapy assistants who wish to further their career
- students who leave the university course and wish to utilise already learned skills within the field of physiotherapy.

The proposed course satisfies the recommendations of the National Qualifications Framework and could eventually lead to the acquisition of a B.Tech degree in Physiotherapy after four years.

Students with different disabilities have also expressed the wish to enter the physiotherapy profession and consideration must be given to ways and means of accomplishing this.

Appropriate support should be available at all stages to those institutions who do admit disabled students.

##### **Academic Support**

An unacceptably large proportion of students from disadvantaged schooling systems progress in university by failing and repeating. More effective support systems need to be devised to accommodate a range of learners with a variety of backgrounds, abilities, learning styles and academic entry levels - throughout the four years of study.

##### **Course Content**

Both the Bill of Human Rights and the proceedings of the Truth and Reconciliation Commission have highlighted the inadequacies of the existing physiotherapy courses in addressing the broader range of human rights issues in relation to health care. It is recommended that course content includes information on the following issues:

- More specific knowledge on the needs, expectations, behaviours and beliefs of the diverse cultural groups.
- Education relating to the identification of clients who have been subject to human rights violations - including the abuse of children and women as well as those who have been tortured whilst in custody or detention.
- More specific education on the assessment and treatment of the victims of torture.
- Information on routes of referral and report of these clients, as well as avenues for protest and advocacy.
- Further development of communication and interpersonal skills, team management and community development skills with a focus on adult learning.

It is suggested that, in order to redress inadequacies in past physiotherapy education, courses on these aspects also be offered in continuing

physiotherapy education programmes to meet the needs of already qualified practitioners and to encourage participation in change and transformation.

### Finance

The provision of more bursaries and study loans is an urgent necessity. In general, insufficient funding is available to students from all cultural backgrounds, but the need is acute for disadvantaged students.

### CONCLUSION

In order to move forward from the past and educate physiotherapists well prepared to deal with present and future challenges, we need to promote a spirit of reconciliation and redevelopment on all levels of education. In line with national education policy, we support the principle of inclusion in the context of education for all as we strive to play our part in meeting the needs of the people of South Africa.

## PART 4 : THE PROFESSIONAL BOARD FOR PHYSIOTHERAPY OF THE INTERIM NATIONAL MEDICAL AND DENTAL COUNCIL OF SOUTH AFRICA

### THE PAST

The first physiotherapists to register with a statutory body in South Africa did so in 1946. This was an informal registration and was not compulsory.

Seventeen physiotherapists registered as such. The first Professional Board for Physiotherapy was established in May 1973. Their first task was to work towards compulsory registration of all physiotherapists. This was achieved in 1974, when 1242 physiotherapists were registered. The reason for compulsory registration is to protect the public from treatment by unqualified practitioners, to maintain standards of practice and to act in the event of complaints of unprofessional practice. In 1984 registration of physiotherapy assistants also became compulsory. They are registered with the Professional Board for Physiotherapy.

The Board functioned under the auspices of the South African Medical and Dental Council. Each Board was elected for a five-year term of office and five Boards have been elected since its inception. Nominations for election to serve on the Professional Board are called for in the Government Gazette and any registered physiotherapist may stand for election. A democratic election by postal vote takes place subsequent to nominations having been received.

In the past, persons of all racial groups have stood as candidates for election to the Board. Persons who are known to the electorate because of their active participation in the South African Society of Physiotherapy, or in its sub-groups such as the private practitioners or special interest groups, or physiotherapists involved in student training have been the most likely to be elected to the Board by the majority vote of the registered physiotherapists.

No discrimination against any physiotherapist has, to the knowledge of the

level. Two complaints relating to racial discrimination have ever been received by the Board, either from physiotherapists or from their clients. There have been, however, two complaints of sexual misconduct against registered physiotherapists, which were dealt with by disciplinary enquiries. We do not know why patients have not complained about treatment or discriminatory actions. Physiotherapists have a reputation of being caring in their treatment of all patients, but the lack of complaints may also be due to the political climate during the apartheid era, or to a lack of knowledge about their rights.

The Professional Board for Physiotherapy saw itself as functioning within the given system, and admits to not being pro-active in changing the way in which health services in the country operated.

### THE PRESENT

There are now 3731 registered physiotherapists and 274 registered physiotherapy assistants. The registers do not indicate race, and it is thus not possible to indicate the numbers and percentages representing different racial groupings. Physiotherapists are registered purely on grounds of their qualifications. It is known, however, that considerably more white physiotherapists have, to date, been trained at South African universities than physiotherapists of other racial groups.

The fifth Board is at present serving and the term of office of the present Board is due to end in May 1998. In 1996 the Board, formerly all white members, appointed a coloured member and a black member to the Board, one a physiotherapist and one a physiotherapy assistant. The public representative on the Board is a coloured person.

The Professional Board for Physiotherapy publishes, through the INMDC of SA, the ethical rules and regulations and the code of conduct governing current physiotherapy practice. It also promulgates the scope of the physiotherapy profession. However, these documents do not address the broader issues of human rights, nor the rights of clients in relation to physiotherapy services.

### THE FUTURE

At present the Interim National Medical and Dental Council is operating during the phase of restructuring the professional boards. It is envisaged that the new professional board for the physiotherapy profession will be the Professional Board for Physiotherapy, Biokinetics and Podiatry, and that registered physiotherapists will hold five of the eight professional seats on the Board. Provision is also made for representatives of the public. It is possible that the term of the present Board members may be extended to cover the transition period.

The Professional Board recognises the fact that not enough has been done to educate the public about their rights as patients in general and in relation to physiotherapy services specifically. Also, not enough has been done to ensure that physiotherapists are aware of broader human and health rights. This will be addressed in future. The Board should commit itself to safeguard the quality of physiotherapy services to all peoples throughout

South Africa and should collaborate pro-actively with the South African Society of Physiotherapy and with the training institutions in planning action towards this end. The Board should also take steps to ensure public awareness of its role and functions.

### IN CONCLUSION

This collaborative document presents a reflection of our physiotherapy past and our vision for the future. Much consultation, discussion and time have gone into the preparation of this document. We do realise, however, that this is only the starting point if we are truly committed:

- to the reconciliation process
- to the redevelopment of our profession, and
- to changing attitudes in the context of our society and our profession in the process of transformation.

We need to take cognisance of the lingering effects of our past culture of exploitation and oppression and to work together to create the affirming environment of a human rights culture.

None of us has come out unscathed by the ravages of the apartheid era. The preparation of this document has been a painful process of revelation of the memories of the indignities and unjust practices experienced in the past and now lying dormant or even suppressed in peoples' memories. It has provoked a collective response in us as physiotherapists to take a new look at what happened in the past and at what is happening in the present so that we can pro-actively develop and implement a plan for change in the future.

By expanding our perspective through examining that which we had previously taken for granted, had overlooked and had accepted unquestioningly, we can now begin to take responsibility for our attitudes, behaviours and actions both in terms of commissions and particularly of omissions. Taking responsibility for ourselves individually and collectively as physiotherapy professionals, forms the basis for working together towards change and transformation in this country in collaboration and co-operation with all sectors.

In the preceding four sections we have introduced some ideas for future planning for the physiotherapy profession. These have been introduced on the basis of critical analysis of all the material currently at our disposal. As we see throughout the document, the three basic issues that need to be addressed urgently are the lack of an underlying human rights ethic, the small number of trained black physiotherapists and the fact that we need to develop strategies which will encourage and enable all the members of the physiotherapy profession to work together in collaborative partnership.

Thus far we have educated physiotherapists in professional ethics and in curative or mainly medically-based rehabilitative, preventative and promotive care, rather than enabling physiotherapists to work with communities:

- to analyse their health problems related to physiotherapy, the causes thereof and the effects of socio-political economic systems

on these problems,

- to identify their physiotherapy needs and goals, and
- to work towards creative solutions to the problems in partnerships based on mutual respect and trust.

Thus we are very learned in our discipline, but sorely lacking in the field of health and human rights. We must broaden our training to embrace the spirit of Ubuntu, a knowledge of the Bill of Rights and the various Declarations against Torture (UN, SASP, etc). Our professional goal might be more effectively achieved by enabling our clients to deal with their daily challenges successfully and empowering people to take control of their own lives through taking responsibility for their own health and well-being.

Physiotherapy as a profession also has to be marketed more vigorously in black communities to improve the demographic representation. Until there is a more equitable distribution of health workers from different language and cultural backgrounds, human and civil dignities will continue to be affronted. It should be the rule rather than the exception that clients receive treatment in their mother tongue and are spared the embarrassment and indignity of having a third party in the consulting room.

The SASP should be more pro-active in serving its members who are employed in state institutions and the Professional Board be more pro-active in its protection of the members of the public through education.

We also need to free ourselves from the hierarchical structure of the medical profession and from gender discrimination.

The physiotherapy profession therefore, acknowledges the sins of omission during the apartheid era, and wishes to pledge its commitment to the reconciliation and transformation processes currently underway in this country as a whole and in the health care and educational systems in particular. We trust that this document and the actions that will ensue from it will guide the profession in this process, and that future generations of physiotherapists will learn from this chapter in our history and use what has been learnt.

Finally, we wish to thank the TRC for the opportunity offered us to examine and reflect on our past and to develop a constructive and pro-active plan to work towards expiating our past. We would welcome any recommendations from the Commission relating to this document.

## CONTRIBUTORS

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If any contributor has inadvertently been omitted from this list, the Committee apologises unreservedly.

## SUBMISSION OF THE PHYSIOTHERAPY PROFESSION TO THE TRUTH AND RECONCILIATION COMMISSION

The national physiotherapy committee for the submission to the TRC finalised their document submitted it on 10 February 1998. We received a very positive response from Dr. Wendy Orr, Deputy chair, Reparation and Rehabilitation Committee of the TRC, congratulating us and thanking the profession for submitting such a comprehensive and balanced document. She felt that our document was good in its own right and in relation to the other submissions, and included elements which added value to the fund of group knowledge.

The submission will have been of very little worth if it is only destined for the archives. The committee has therefore already sent copies of the document to:

- the Deputy Director-General, Department of Health of all 9 provinces
- the Principal Subject Adviser (Health Therapists), Education Department of all 9 provinces
- the heads of physiotherapy training institutions of all 8 universities
- the SASP
- the Professional Board

Each of the above was requested to distribute it and make it known as widely as possible, as well as to act where appropriate.

The committee is also of the opinion that the profession should make a commitment to action to prevent a repetition of the past, to promote reconciliation and to request redress in cases where wrongs were permitted or committed. This proposed action plan is set out below and covers the suggested *goals* that we should try to realise, the envisaged *action plans* and the *responsible parties*. It is envisaged that most of these actions can be instituted in 1998 and that all mechanisms should be in place within the next 2 years. This action plan will be submitted to all the identified parties for their response and action.

We believe that the success of this action plan depends not only on our commitment as a group but also on the individual commitment and involvement of each and every member of the profession. If we all bear this in mind when reading the document, we can each begin to identify areas where we can make a personal contribution.

The committee welcomes any further suggestions which will enable the profession to turn this into dynamic working document through collaboration and co-operation. We would value suggestions from physiotherapists as to how we can use this action plan effectively and work together to realise our common goal of learning from the past in order to improve our present practice and create a better future together.

We hope to be able to report back on the progress made with this action plan by the end of October 1998.

## ACTION FROM THE PROFESSION

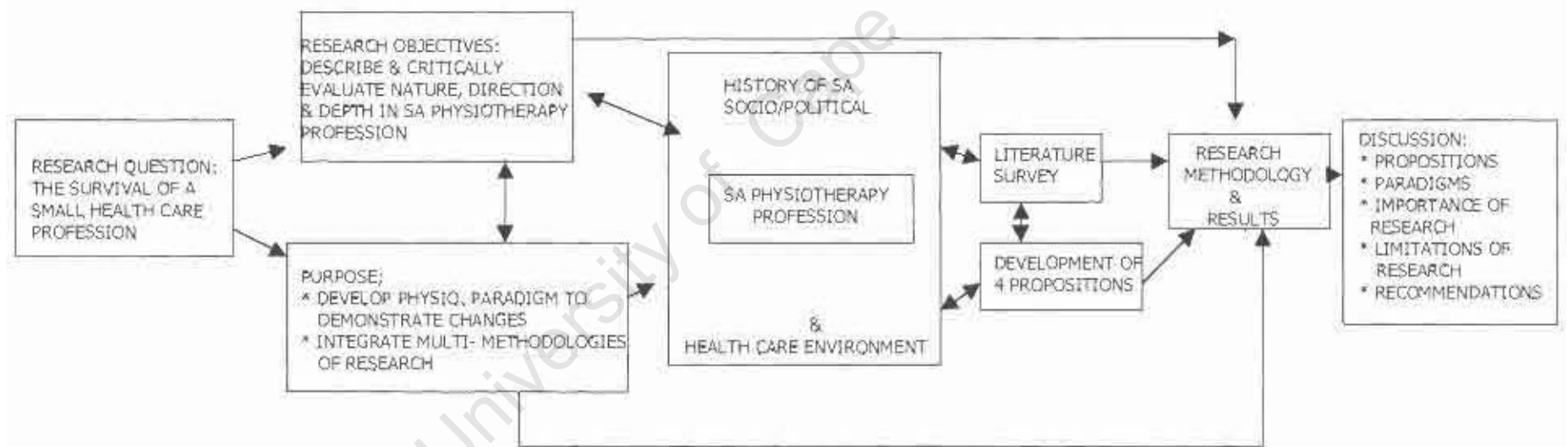
### LEARNING FROM THE PAST TO CREATE A BETTER FUTURE

N°	GOAL	ACTION	RESPONSIBLE PARTY/IES
1.	To help physiotherapists know what happened in our past, understand how this affects the present and to encourage working together towards changing the future.	The TRC submission, should be taught as part of curriculum (e.g. incorporated in ethics courses)  Physiotherapists should hold regional workshops to promote understanding of the past and planning for the future.	Training Institutions/Education Board.  National initiative through the SASP, using the services of former rights-outher resolution 2000's where possible.
2.	To create an awareness of the possible effect of gender on status and professional practice.	Investigation of the role that gender plays on the status of the profession and making this known to physiotherapists.	Ad hoc committee of the SASP to call for nominations in Forum and appoint an ad hoc committee to interact with the Gender Commission.
3.	To improve physiotherapists' knowledge of all aspects of human rights and of their understanding of a Civil Society.	Accessing as much as possible of the existing information on such issues as: Bill of Rights & Constitution, Declaration against torture, Patients' Rights Charters, etc.  Arranging workshops and displaying posters at congresses to inform physiotherapists about these issues.  Publishing this information in Forum.	SASP to appoint an Accessing and Dissemination's Officer for this purpose.  Refer to the next SASP Congress Committee.  SASP Publications Division.
4.	To create a culture of health, well being and human rights in the physiotherapy profession.	Evaluation and changing of the professional rules and regulations to include a moral, right-based set of ethical guidelines to protect practitioners and patients/clients.  Request the SASP to review their mission statement to ensure that it is in accordance with the revised guidelines of the Board and other information gained.	Ad hoc committee of the Professional Board.  SASP.
5.	To provide guidelines and support for physiotherapists who observe unethical or negligent treatment of, or behaviour towards, patients/clients.	Develop guidelines for dealing with and reporting misconduct.  Establish a subcommittee to provide guidance and support to physiotherapists wishing to complain about misconduct of colleagues/other health care professionals.  Publish these guidelines.	Ad hoc committee of the Professional Board.  Ethics Committee of the SASP.  Publications Division of SASP.

N°	GOAL	ACTION	RESPONSIBLE PARTY/IES
6.	6.1. To create an awareness of the role of the physiotherapist patients/clients who have been subjected to violence, abuse or torture.  6.2. To provide guidelines and support for physiotherapists who identify the effects of violence, abuse or torture in patients/clients.	Include the role of physiotherapists in relation to patients/clients subjected to violence, abuse or torture in the undergraduate curriculum.  Arrange regional workshops to promote an awareness of these issues.  Develop guidelines for dealing with, reporting and referring survivors of violence/abuse/torture.  Establish a subcommittee to provide support to physiotherapists to report such violence/abuse/torture.  Publish these guidelines.	Training Institution/Education Board of the SASP.  National initiative through the SASP.  Ad hoc committee of the Professional Board.  Ad hoc committee of the Professional Board/SASP.  Publications Division of the SASP.
7.	To make information about physiotherapy and the rights of patients/clients within the physiotherapeutic relationship available to the public.	Adapt different Patients'/Clients' Rights Charters for the physiotherapy profession.  Make this known to the public through media campaigns, e.g. Soul City, press releases, TV talk shows.  Produce audio tapes/video's to be used in waiting rooms of practices/physiotherapy departments.	Ad hoc committee of the Professional Board.  Professional Board.  SASP media person.
8.	To improve the: 8.1. demographic representation on the Professional Board  8.2. demographic make-up of the profession. 8.3. demographic make-up of the SASP. 8.4. ratio of private to public sector practitioners. 8.5. relationship between PT and PT Assistants. 8.6. access to physiotherapy training.	Encourage participation/interest in the affairs of the Professional Board and encourage physiotherapists to make themselves available for nomination on ad hoc committees.  Bring to the attention of the Professional Board people who could be valuable resource persons on ad hoc committees.  Encourage participation/interest in the affairs of the SASP and the profession in general. The profession should consider the appointment of an Ombudsman/Commission for each aspect (8.1 - 8.6) to set targets, plan and ensure action, monitor progress, take action where progress is unsatisfactory.	National committee for the TRC submission should request the Board to advertise for nominations when setting up ad hoc committees.  SASP.  Professional Board/SASP.

**APPENDIX 22**  
**FLOW DIAGRAM TO SHOW RESEARCH PROCESS**

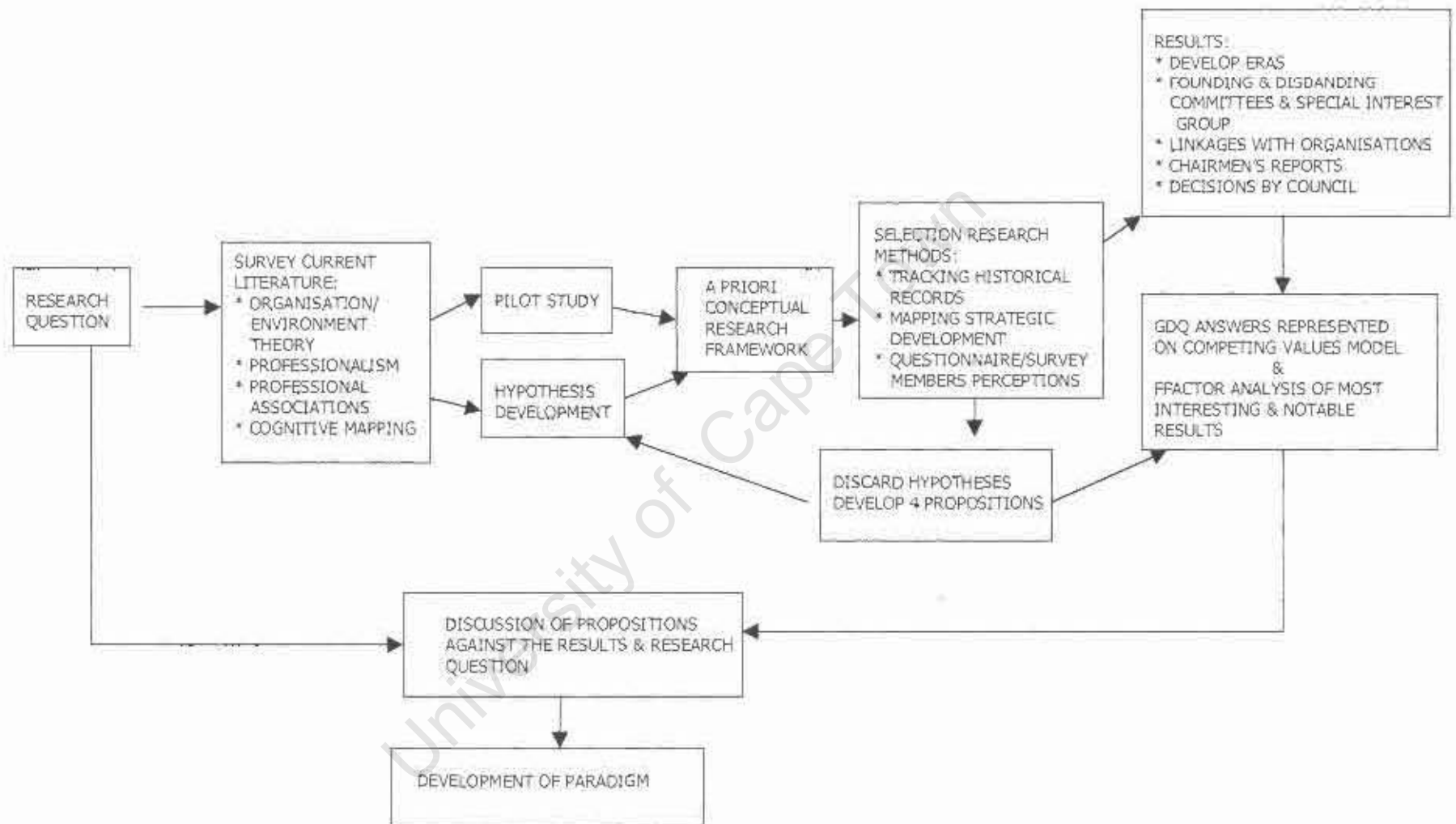
University of Cape Town



FLOW DIAGRAM OF RESEARCH PROCESS

**APPENDIX 23**  
**FLOW DIAGRAM TO SHOW RESEARCH METHODOLOGY**

University of Cape Town



FLOW DIAGRAM TO SHOW RESEARCH METHODOLOGY

## INTRODUCTION BACKGROUND

In her January 1997 document *The Truth and Reconciliation Commission and the Health Care Sector*, Dr. Wendy Orr points out that the Promotion of National Unity and Reconciliation Act (1995) seeks to establish "as complete a picture as possible of the causes, nature and extent of the gross violations of human rights which were committed during the period 1 March 1960 to the cut-off date of 10 May 1994". From this, recommendations of measures to prevent the future violation of human rights should follow.

Orr states that while most health care professionals were not directly involved in gross human rights violations, they may have contributed to the creation and maintenance of an environment in which those violations could occur.

The request is made that as broad a group of professionals as possible make a submission to the Truth and Reconciliation Commission (TRC) and that these submissions should represent an honest, searching reflection on whatever aspects the report covers.

In a later document, *Discussion Document: A Steering Committee for the Promotion of Human Rights in the Health Professions* (29 April 1997), the TRC Health Task Team describes the process by which the Health Care Sector Hearings were initiated and an interim task group nominated. They also point out the following:

*The experience of the Interim Committee has been that without adequate resourcing, such an initiative is doomed to become a regional initiative. Participants from outside of Cape Town were severely constrained from participating unless they were part of an adequately-resourced organization, with the result that the Interim Committee effectively became a Cape Town-based affair.*

The physiotherapy submission developed as follows:

In September 1996 a physiotherapist, Ms Vanda van Speyk, expressed an interest in the TRC's Health Care Sector hearings to a psychologist colleague at the Trauma Centre for Victims of Violence and Torture in Cape Town, who was part of the steering committee and so obtained an invitation to the initial workshop.

Late in April 1997 it was realised that certain individuals and institutions had been invited to make submissions. However, the rehabilitation therapists had not been included in this group, which consisted of doctors (and psychiatrists), nurses and psychologists. This seemed to be a perpetuation of a long-standing professional hierarchy/hegemony, which needs to be challenged as part of the health care sector hearings. Ms Van Speyk contacted Ms Margaret Beattie of the Professional Board for Physiotherapy in this regard. Ms Beattie said she had been approached by a MASA doctor who felt that physiotherapists should also make a submission. She, however, felt that the South African Society of

Physiotherapy (SASP) would be in the best position to make such a submission. An initial working group was formed, consisting of Sheena Irwin-Carruthers, Marietta Uys, Mary Faure, Dawn Goodley and Vanda van Speyk. Pat Swilling was involved intermittently. These people were representative of the Professional Board, the South African Society of Physiotherapy (SASP), Universities and clinicians, both from the public and private sectors.

This group decided to draw up the submission as members of the physiotherapy profession in general, rather than through the SASP, to prevent a conflict of interests and the exclusion of those who were not members of the SASP. The group also informed the occupational therapists, speech therapists and Disabled People of South Africa, and encouraged them to consider making submissions.

Having obtained an extension from the TRC, the group met for the first time on 6 May 1997, and decided to draw up a draft submission which was to be circulated as widely as possible for comment. The group drew up a document under the following sections: Clinical Practice, The South African Society of Physiotherapy, Physiotherapy Education and the Professional Board for Physiotherapy. Each section was allocated to a particular person to facilitate, collate and correlate input. Under each section the following questions were posed:

- \* What did we, as physiotherapists, do during the period under consideration?
- \* What should we have done?
- \* What should we do now?

### AIMS

The aims were stated as follows:

- \* To take part in the historical process which is occurring in our nation
- \* To claim our place within the health sector
- \* To stand back and critically review what we did do, what we did not do, and what we should be doing/can do in terms of health rights, human rights and violations or abuses
- \* To be pro-active and market our profession.

### GROUND RULES

- \* This is a critical and constructive evaluation of systems, contexts and environments which permitted violations and abuses
- \* It should not be destructive (i.e. destroy present relationships and achievements)
- \* It should be factual
- \* It should acknowledge achievements.

Although there is a body of documentation available for use in drawing up parts 2, 3 and 4 of the submission, it proved more difficult to obtain information about the clinical sector. A questionnaire was drawn up and circulated as widely as possible to all physiotherapy provincial Assistant and Deputy Directors and those acting in that capacity. In the Western Cape, this