MMed research mini-dissertation:

Exploring the perceived impact of a leadership training module on clinical family medicine practice: a qualitative study

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The declaration page

I declare that this research report is based on independent work performed by the me and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree to any other university.

This work has not been submitted for publication prior to my commencement of this degree.

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Abbreviations:

Abbreviation	Meaning	Page number
COP	Community of practice	22
DOH	Department of Health	11
e.g.	For example	22
ERs	Emergency rooms	16
Et al	And others	7
FM	Family Medicine	7
FP	Family Physician	6
HIV/AIDS	Human Immunodeficiency virus/acquired immunodeficiency syndrome	12
HPCSA	Health Professions Council of South Africa	7
L&G	Leadership and Governance	6
MMed	Master of Medicine	5
NHI	National Health Insurance	21
NLO	National learning outcomes	9
SA	South African	7
SAAFP	South African Academy of Family Physicians	9
TB	Tuberculosis	12
UCT	University of Cape Town	6
UHC	Universal health coverage	7
UK	United Kingdom	7
USA	United States of America	7
WC	Western Cape	13

Abstract

Background: Family physicians are the senior clinicians responsible for clinical governance in the District Health System. Their training programmes must prepare them for the leadership roles they are expected to fulfil.

At the University of Cape Town, family medicine registrars enrolled in a four-year Masters of Medicine (MMed) degree complete a four-month Leadership and Governance module during their third year of study. This module consists of seminars, a leadership profile, and critical reflection sessions. While the immediate feedback is useful, the relevance of this module to the actual work of these family physicians is not known.

This study aimed to understand how the postgraduate L&G module at UCT helped prepare qualified family physicians working in the Western Cape Province public sector for their leadership role.

Methods: Ten graduates were purposively sampled for online semi-structured interviews, which were recorded, transcribed, and analysed using the framework method. Data were analysed deductively and assigned to the relevant theme. Where coded data did not fit into these themes, a new theme was generated if the data was sufficiently cohesive.

Results: The following themes were identified : key leadership qualities and fit for purpose training. Two additional themes were generated: early experiences of the FP as clinical leaders and Resources used by FPs.

Conclusion: This qualitative study explored recently qualified family physician consultants perceptions on their leadership training. Four key themes emerged that describe their leadership journeys, highlighting aspects of the current training that could be strengthened. Future research should explore workplace-based leadership training models, the impact of leadership role-modelling, and provide ongoing evaluation of fit for purpose training programmes.

Keywords: leadership and governance, qualitative evaluation in education, family medicine, qualitative research, fit for purpose

1. Background

Family medicine (FM) has been recognised as an established specialist discipline by the Health Professions Council of South Africa (HPCSA) since 2007, with about two decades of various forms of postgraduate training preceding this date. The formal recognition of FM as a specialised discipline ushered in the 4-year registrar programme across nine universities in the country.[1] Before this, it had already been well recognised in many other parts of the world, including the United States of America (USA), Canada, the United Kingdom (UK), Australia and Europe. Family medicine has continued to evolve and adapt to each country's changing medical landscape. In Africa and South Africa, many authors have discussed the changing environment within primary and district health care as well as the importance of effective leadership in the form of family physicians.[2, 3,4,5,6] Ilori et al. highlight family physicians' role in improving the quality of care and outcomes in Nigeria, specifically relating to equity of care.[6]

South African (SA) training programmes adopted, as a core component of their curriculum, the teachings of Ian McWhinney, a Canadian professor of FM, who outlined the foundational principles of the discipline.[7] He emphasised nine different principles, all equally important to the practice of family medicine and primary care, including an open-ended commitment to patients, understanding the context of illnesses, use of all visits for preventative purposes, viewing the practice as a population at risk, to make use of the community-wide networks of resources, to integrate life and work, to try and appreciate the subjective aspects of medicine and resource management. Regarding the last-mentioned principle, resource management, McWhinney described how family physicians (FP) need to utilise their skills as first-contact physicians in managing resources. This becomes especially poignant in certain parts of the world where resources are severely limited.

Within SA, many of the challenges relating to persisting inequalities in the healthcare system stem from the political past. Even though progress is being made towards universal health coverage (UHC) outlined in policy,[2] the difficulties in service delivery faced by many communities remain financial, structural and governance. A more considerable emphasis has been placed on decentralising health care within South Africa and using teams in communities to enhance access to both primary and appropriate specialist care.[2] With this reinforced mandate to enhance access to equitable primary health care for South Africans, ensuring better governance and management of human and other resources is imperative, representing a function of effective leadership. In the SA context, family medicine training

programmes provide leadership and governance training to registrars, anticipating their future roles as FPs. [8,9]

In the South African context, Mash continues to explore the latest contributions of family physicians in health care and reports that the family physician's role and contribution are still mainly clinical. [10] Family physicians made a relatively minor contribution to governance in South African health care specifically, and this could be for several reasons.[10] Much of this stems from the organisation and structural hierarchies within the SA health care system, within which the FPs are in the process of asserting themselves. These findings suggest that the family physicians' ability to lead and govern is not yet fully recognised. This is surprising, given the efforts to strengthen the curriculum and training programmes to address this need in the public and private sectors. There is still much ambivalence around the leadership qualities of the family physician, as expressed by established leaders in government and policy development.[3, 4] The questions that arise are: What is a leader? What is a leader within the health care sector? What attributes constitute an effective leader?

A systematic review of leadership within the healthcare system by Mukwankungu et al. explains the many challenges clinicians face within the healthcare and managerial space.[11] They highlight that many health practitioners lack not only the necessary skills but also the confidence to carry out leadership roles, which compromise the administrative performance of the health system. They also outline the specific training that leaders would need to complete in order to strengthen their confidence, skills, as well as the theories they would have to familiarise themselves with. They report that clinicians are not earmarked for this kind of training yet are often asked to step up and be managers of units and facilities. It is also noted that the leadership training for doctors and nurses would differ. Despite courses and managerial programmes being available, their efficacy is yet to be proven.[11] It may also be a preference of the clinician to focus more on the clinical part of their job as this their main area of competence rather than the managerial aspect.

Gilson and Daire outline three key leadership abilities that can transform health care:[12]

- The ability to use the extensive variety of information and data in decision-making to identify constraints within operations.
- Involve people in decision-making rather than impose.
- Develop strong relationships with higher levels of political support and other resourceful parties outside the system.

The above skills may seem additional to clinical training and have been noted to be outside the scope of undergraduate programmes, but they are definitely within the scope of a trained family physician.

This idea of lack of confidence regarding leadership was re-iterated by Gallagher et al., who conducted a cross-sectional quantitative survey with junior registrars in Canada.[13] This survey reaffirmed the idea that family physicians see themselves as leaders after training but that even registrars felt that they needed more specialised training concerning leadership and governance. Their curriculum only deals with basic leadership skills and knowledge. They suggested more in-depth teaching on other advanced concepts such as administration, coalitions, and system transformation.[13] These advanced concepts are in line with Gilson and Daire‘s key abilities for leadership, which could suggest an interesting framework for thinking about a leadership curriculum for clinicians.

The proposed roles and expectations of the FP within the South African context are explored further in the latest position paper by Mash, written on behalf of the South African Academy of Family Physicians (SAAFP).[9,10] He describes the FPs scope of practice and training and how they are trained in leadership across all their roles. However, he notes that despite clinical and corporate governance being part of the scope, FPs are not trained primarily to be managers.[10] As discussed previously, family medicine in South Africa has been a recognised speciality since 2007 and is continually evolving.[1] Many policies discuss the need for better coordinated decentralised care for communities, better governance and resource management, and strong leadership.[2, 3, 4, 5, 6] Family physicians are trained ideally for primary and district-level care and cannot be effectively utilised in tertiary settings. Their broad training and skill set place them as key role players in the district health system when implementing policy and rectifying systems as the needs arise within each community.[10] As South Africa grows and attempts to lessen the divide of equality within the country through basic service delivery and policy implementation aimed at addressing the past's wrongs, the family physician's leadership role within primary care has become increasingly important.

The national learning outcomes (NLO) within the national portfolio of learning for family medicine training, which forms the basis of the MMed programme to ensure uniformity across South Africa, have a specific NLO dedicated to leadership and governance.[14,15] This NLO outlines many skills and attributes that need to be learned and practised over the four-year training programme. These attributes may differ from what Gilson and Daire listed, but they overlap and are possibly more comprehensively explored within the family medicine programme. Mash et al. discussed in the upgraded programmatic learning outcomes how the initial learning outcomes came about in 2012 and the importance of regular revision of

these outcomes as guided by the needs of our health system. [15] The discipline agreed upon the new guidelines published in 2021 because of the actual competencies observed and utilised by family physicians over the ten years before this revision.[15] Mash also suggests the need for possible expanding and improving upon the curriculum when taking the contribution of FP in to account to ensure that the specialty is effectively utilised in the health system.[10]

The Leadership and Governance (L&G) Module run at the University of Cape Town (UCT) was revised in 2022 aligned with the latest NLO published, as well as taking into consideration points raised in both publications by Mash et al.[6,15] The course outline prior to 2021 was oriented towards clinical service delivery, with key topics covered over seven modules. The main topics were discovery of individual personality profiles, leadership within the district health system, understanding of corporate governance, and looking at specific clinical governance activities (Appendix 2). These key topics align with the latest position paper by Mash et al., suggesting again that the contribution from qualified family physicians remains largely clinical.[7, 15]

The updated 2022 L&G module's key components are now presented over an expanded twelve-session module (see Appendix 2) and include sessions involving a group coaching approach dedicated to leadership development, sessions on clinical and corporate governance content, a leadership or personality style assessment measured by the Enneagram [16] and positioning all the content sessions within a reflection on context to assist with transferring learning into practice. The key changes in the latest module highlight points relevant to South Africa's evolving healthcare system and mirror some of the leadership qualities mentioned by Gilson and Daire.[12] The improvements were also informed by previous graduates' reflections, which proved valuable in helping to shape the dynamic process of curricular reform linked to this evolving module.

The South African Academy of Family Physicians (SAAFP) has started a new initiative in 2021, the Next5 special interest group, to help newly qualified FP develop in their roles and careers through mentoring and certain activities as determined by member needs.[17] . SAAFP held a survey asking members to identify learning gaps that could be addressed in this special interest group. The activities chosen highlighted themes such as communication and marketing, graduation and registration, mentoring and networking There is no mention of specific managerial topics or mentoring re-enforcing leadership and governance qualities. This is a possible unidentified need, but it is also important to note that only registered SAAFP members could contribute to the survey. The numbers of registered members shown

in the same article, albeit on the increase was still low compared to the number of actual graduates[17]

Within the South African context, a few papers have been written attempting to understand and evaluate different teaching interventions within the sphere of family medicine. Many of these articles have been qualitative studies exploring experiences of different aspects of the family medicine post-graduate curriculum.[18, 19, 20] None of the above articles has addressed specific teaching interventions around a particular L&G module in the country or looked at the experiences there of newly qualified FPs. Britz et al. have discussed the need for an assessment framework, related to clinical assessments, but also raise valid points about the challenges around maintaining assessment quality. It is mentioned that assessments are multi-dimensional and that no assessment is perfect. This is particularly interesting in the setting of clinical medicine, but it also helps validate how even more challenging assessing a softer, less tangible skill like leadership and governance would be in the setting of a structured curriculum.[21]

The need for clinical leadership in primary and district care services has been addressed within the curriculum, but more needs to be known about the effectiveness of formal leadership training. This represents a significant gap in the educational literature in relating training programmes to clinical platforms. The outcomes of this research will potentially fill this knowledge gap and may provide evidence for educators who want to strengthen their efforts and, in turn, encourage improvement in the curriculum. By understanding how previous versions of the Leadership and Governance training module at UCT in the MMed curriculum helped prepare newly qualified family physicians for their leadership roles in the public sector, we can enhance the curriculum to better equip future family physicians.

1.2 Aim and objectives

The study aimed to understand if and how the previous postgraduate Leadership and Governance training module in the MMed curriculum at UCT helped prepare newly qualified family physicians for the Western Cape province of South Africa's public sector.

1. To describe the experiences of participants of the L&G module in relation to their work.
2. To identify learnings from the L&G module perceived as useful by participants.
3. To describe competencies identified by workplace experience not covered in the curriculum.
4. To identify additional resources participants used to enhance their leadership competence.
5. To identify perceptions of effective leadership attributes needed on the district clinical platform.

2. Research methods and design

2.1 Study Design:

A narrative analysis using an interpretive and exploratory strategy was adopted in this qualitative research design, as described by Mabuza et al.[22]

2.2 Setting:

This study setting focused on FPs practising at Department of Health (DOH) facilities. It was more focused on the educational exposure to the UCT module and the follow-up of those FPs specifically located within the Western Cape.

These facilities within the province can be divided into rural or metro sites. The Cape Metro health district has eight legislated sub-districts serving over 4.1 million people, according to the latest population statistics from 2018 to 2019. There are 152 Primary Health Care facilities and 8 district hospitals. There are also tuberculosis (TB) hospitals, but they support the broader Western Cape in delivering TB inpatient services.[23] The rural sites are defined as all the municipalities outside the Cape Metro health district, which complied with the definition of “rural” as being one hour or more by road transport or 80 km away from a referral centre.[24] The range of services covered at a typical district health facility includes:[25]

- Child Health
- Emergency Medical Services
- Family Planning
- Forensic Pathology Services
- Women’s Health
- TB and HIV/AIDS
- Men’s Health
- Psychiatric Services
- Home Based Care

2.3 Study population and sampling strategy:

Participants were purposively sampled with specific inclusion and exclusion criteria, as tabled below (Table 1). The sample size was determined by data saturation. Participants were contacted via email requesting their voluntary participation in the study from an alumni list compiled by Division of Family Medicine. Due to various challenges including availability of consultant posts following graduation and response rate of participants to this study,

specific criteria pertaining to years following the exposure to the MMed programme, needed to be extended to aid in recruiting participants.

Inclusion	Exclusion
✓ FP who have completed the UCT four-year MMed training programme in the last three to seven years with or without completion of their research component. ✓ FP noted to be in formal leadership positions or consultant FP posts. ✓ FP working in the public sector in WC.	■ FP not trained in South Africa or not exposed to the UCT L&G module during their four years of MMed training. ■ FP trained at any other institution.

Table 1: Sampling strategy

2.4 Data collection and analysis:

Data was collected through semi-structured interviews with an interview guide and initial demographics portion (Appendix 3).[26] The interview guide was developed in alignment with the stated objectives and submitted with the original protocol. It was piloted on two senior family medicine registrars and amended accordingly.

The primary researcher conducted the interviews at the participants convenience. All interviews took place online using the Zoom meeting platform. Interviews were conducted in English and recorded using the same platform.

Professional transcription services manually transcribed the audio recordings. Before analysing the data, the transcriptions were checked for accuracy, and mistakes in transcription were corrected against the original recording.

The data was analysed deductively using the framework approach. [27] The framework was constructed by reviewing the literature on clinical leadership models, family medicine (globally and locally), and an initial data analysis.

The research team consisted of the primary researcher and her two supervisors. The researchers familiarised themselves extensively with the data, listening to the audio recordings and reading the transcripts. This was done repeatedly and in a phased approach as the transcriptions took time to be generated following each interview .Categories were

generated from this process that included two initial themes: ‘key leadership qualities required’ and ‘fit for purpose training’. During coding, two further categories emerged, reported below, providing a framework with four categories, later termed themes because they contained data that provided a cohesive narrative. Initial codes were extracted from the data and categorised within the framework. Subthemes and themes emerged from these codes.

Data quality was assured by adhering to the Lincoln and Guba trustworthiness criteria.[22, 28] Measures taken to ensure credibility were prolonged engagement with the data as well as researcher triangulation during the analysis phase using field notes and interview transcriptions. This also attempted to reduce observer bias. Member checking also known as respondent validation was performed by presenting the study's preliminary findings at a group forum attended by participants. The presentation and themes resonated well with the group, with no additional data being generated, indicating that data saturation had been achieved in the semi-structured interviews. It is difficult to completely exclude selection bias in this study as the participants were purposely sampled from a list compiled by the Division of Family medicine. All participants contacted worked in the government sector as per the inclusion criteria but who and the number of participants that consented were out of the researcher’s control.

Transferability was achieved a data was collected over an extended period using thick descriptions with a clear audit trail. The interview guides were piloted ,interviews were audio recorded and transcribed to ensure accurate records of interviews and analysis process supervised following training in qualitative research analysis .These above also help ensure dependability.

With regards to reflexivity, the main researcher, currently in her final years of residency, has extensive experience in South Africa's primary and district health care systems. She acknowledges that intuitive knowledge helped inform her research question and that personal bias exists as she is embedded in the training program however attempts were made to minimize this bias, through conversations with the supervisors, personal reflections and the above steps to help ensure trustworthiness of this study. To manage subjectivity, she approached the analysis methodically and engaged with only the data provided.

2.5 Ethical considerations:

This study was guided by the Declaration of Helsinki on medical research involving human subjects.[29] The University of Cape Town Human Research Ethics Committee (reference number 342/2023) approved this low-risk study, and written informed consent was obtained from all participants prior to the commencement of data collection.

3. Results

Demographics:

Thirteen FPs were invited to participate in the study. Two FPs did not respond despite several communication attempts, and one FP declined to participate in the study as she felt she was not in a typical FP role. Ten participants were interviewed, and seven participants were male. The youngest participant was 34 years old, and the oldest was 53 years old. The years of graduation vary, with 50% of the candidates graduating between 2018 and 2022. Seven participants were in FP consultant posts, one was a clinical manager, and two were in medical officer (non-consultant) posts due to a scarcity of FP posts.[30]

Themes:

The data were organised into subthemes and themes (Table 2). Saturation was reached by the sixth interview. However, data collection continued to ensure that all ten participants were interviewed.

Theme	Sub Theme
1. The *early experiences* of FP's as clinical leaders	A challenging start
	Realisation of the broad scope of practice
	Various job availability at the time of qualifying
2. Self-identified *key leadership qualities* required from FPs	Communication and transparency
	Absence of traditional hierarchy
	Relationship building, teamwork and skills development
3. Fit for purpose training	Concern of practicalities of actual job description not adequately covered
	Knowledge gaps specific to administrative skills and governance roles and responsibilities
4. *Resources used by FPs* to overcome perceived shortcomings of formal training	Making use of a community of practice
	Governmental circulars and courses

Table 2: Themes and sub-themes

3.1 The early experiences of FP's as clinical leaders

3.1.1 A challenging start

During the course of this study, it became evident that despite the differences in years of work experience between the participants, most still found their time as clinical leaders a positive experience. Many shared the sentiment of a challenging start but usually, with time and experience, there was an improvement in both skill set and confidence within their role. One participant stated: *"It's been rewarding but an interesting rollercoaster. I think that first few years were really tough*" [1.28, 43 yr. F]

Many expressed that even after completing their formal training, there were still many knowledge gaps regarding their roles as leaders, many of which were filled with on the job training. "It *was very difficult in the beginning, like finding my feet, and there's a lot of things that are not taught that you kind of have to learn on the job"* [4.41, 39yr.F].

3.1.2 Realisation of the broad scope of practice

Upon reflection on their journeys to this point, many participants shared an overwhelming realisation and acceptance that their potential scope of practice is so vast. *"So… there is much that is involved in the role."* [3.45,47yr M] Some participants embraced that challenge and utilised all their skills daily within their sphere of influence: "*Everything I have studied during registrarship really comes into fruition when you are actually in the role, like in the role because you do everything."[* 10.86,39yr F]. While others still grapple with their roles and responsibilities, which are no longer primarily clinical: *"Administrative things that leadership people in the state sector should know about and that I found that I didn't know much about"* [8. 126,34yr M]. Senior participants expressed a more mature view towards previous expectations of a FP, stating that during their training, FPs were not considered to function as managers and that it was impossible to cover everything: *"We were brand new. So, look in, in, in all fairness, I don't think they knew what they were teaching us in the beginning anyway"* [7.125,47yr M]

3.1.3 Various job availability at time of qualifying

A driver that influences where FPs work, their work experience and subsequent roles as leaders is job availability at time of graduating. FPs throughout the years have expressed different experiences of this with one of the more senior candidates stating: *"…there were jobs available because we were the first lot to finish"* [7.74 47yr M]. Conversely, many of the

junior FPs have had to find medical officer (non-specialist) posts while waiting for FP or clinical manager posts to open *up: "So I'm the medical officer… family physician… working as (in) a medical officer post."* [6.24 47yr M] One participant requiring to find work overseas post-graduation due to job scarcity and has found himself now with a different challenge being: "*I'm a senior doctor in the cruise industry… So, I work in the maritime healthcare space. I am a doctor at sea, but I still do locum work when I'm on holiday, in ERs (Emergency Rooms) in Cape Town... my biggest challenge now is that I haven't worked in a family physician post in South Africa."* [2.38 47yr M]

3.2 Self-identified key leadership qualities required from FPs

3.2.1 Communication and transparency

Participants were able to reflect on their years of lived experience and draw on some of the key learning points about the leadership skills required: knowing and building up your team, transparency, and communication. Participants were able to express a sense of self-awareness and awareness of their teams and could acknowledge points that their teams valued. One of these was the sharing of information and transparency regarding the workings of the facility and staff members*: "so… whether that's integrity or transparency, but transparency also in this is how the system works*" [1.371,43yr F].

3.2.2 Absence of traditional hierarchy

By doing this, they were able to create a culture which aims to decrease the old traditional hierarchies often present within the health sector and use what this participant described as a bottoms-up approach: *"I also think that bottoms-up approach.. so… I think also the way that you need to be very open to innovation and change. Okay... So, it's not meant to be a hierarchy."* [4.343, 39yr F] This practice aids in the FP getting to know their team members, more than just on a skills level. They can draw on team members' strengths as well as navigate and eventually work on their weaknesses, therefore building and strengthening the team up as a unit, with this participant reflecting: *"You need to know what the other people are doing and how you can lean on them, and how they can lean on you"* [7.725,47yr M], and another participant similarly stating: *"You need to have, have an understanding of the system. You need, and I think that's why I think family physicians are, are, are quite good because we don't just look at a single speciality. You need to, you need to have a little bit of a bird's eye view of what's going on and be respectful and understanding of, you know, what's, what the nursing side is, what the, you know, the support services side because it's not just the doctor that makes a hospital run.*"[7.260, 47yrM].

3.2.3 Relationship building, teamwork and skills development

This emphasis on relationship building and respect of their team members is important because as people, life continues to happen outside of the workspace. The importance of preserving the work-life balance among the team and this, in turn, helps build resilience and creates the culture at work where people want to do more because they feel valued as team members. This sensitivity is reflected by this participant stating: "…*on the team that we have and having some small things, that sort of build resilience, but also its protective of, of people not burning out… Is key, and I mean that, that goes from like having a, a coffee club at work, having specific social events and a lot of, you know, sort of not building a culture of people working for each other….And that's sometimes challenging, but I think we are working on it."* [8.279 34yr M]

They were also able to make decisions using all available data and resources and, when appropriate, involve the team in this process, reflected in this participant saying: "*The other thing is whenever a decision is being taken, it is important to seek the opinion, the view of the team as a whole"* [3.183,47yr M]. This teamwork in decision making and policy implementation solidifies the above sub-theme of doing away with traditional hierarchies, emphasising the importance of working well within and between teams, as this participant reflected: *"…so teamwork is, is also a very important attribute that you must, must, must have because you need to be able to work well with the other heads of departments and also work well with the staff and I feel if you don't have that teamwork, then it causes very poor work ethic in the workplace*,"[4.351 39yr F].

Another quality of being a leader, as well as a being a core value within family medicine, is to upskill and capacitate the team. This participant reports that this is an enjoyable part of the job: " *Because like yes, we need to teach a lot, but we need to also be open to learning, like continuously learning. And then I think that I also … I love teaching. So, like teaching and training the staff to do the right thing"* [10.208 39yr F] Whether that be in-service training or supporting staff going to specific training but the investment in staff in this way is valued greatly, suggesting that this participant understands the needs of their team: *"I think being a trainer, so like, I think staff like to be upskilled. Staff like to be upskilled all the time*" [4.357 39yr old F]

3.3 Fit for purpose training

This is when training programmes ensure that local needs and context are being met with their curriculum which includes both theoretical and practical knowledge and aims to better equip the graduate for their future role and responsibilities.[31]

3.3.1 Concern of practicalities of actual job description not adequately covered

Some participants expressed concerns that some of the practicalities of the job were not addressed in their formal training. Participants identified particular gaps linked to the knowledge of systems and human resource processes that they needed in order to be effective. Comparing his preconceived ideas about leadership and the actual experience thereof, this participant reflected that "*I found that it was very different once we were in the real sort of life doing it.*" [8.85 34yr M]

For those participants that found the module useful, their perception of the module's value were heavily centred around personality or leadership style testing, which was a prominent feature throughout the various iterations of the module. Participants were able to think critically about what kind of leader they could be and how others may perceive their styles. This participant benefited from this self-reflection based on an established psychometric model: *"I really enjoyed the theory of what, of sort of stimulating what your own leadership style might be and, and doing, going through sort of thought process of thinking about what type of leader you want to be "[* 8.78, 34yr M] These self-reflections and softer skills also helped in other areas like being able to connect with different team members and build relationships, as stated by this participant: *"…that stuck with me was more personality profile that was done, and part of that was learning other personality profiles"* [1.90,43yrF]

3.3.2 Knowledge gaps specific to administrative skills, governance roles and responsibilities

These knowledge gaps were mainly administrative, like managing grievances, complaints, patient safety incidents, and difficult staff-related problems. The roles and responsibilities of FP at a management level including human resource management processes such as progressive discipline, management of absenteeism and finances of a facility, were identified as a clear gap in the training, as indicated by this statement: *"Complaint, progressive discipline. Managing absenteeism is something we were never exposed to."* [3.106 47yr M] This was echoed across most interviews, especially where the participants were in FP posts, as shown in this excerpt: *"I mean, some of the, you know, some of them were just learnt on the job and usually that was in the face of a crisis when it comes to management and that*

happened quite early on, and then, you know, one also learns and upskills a lot around rules and processes with, with respect to HR. "[5.183 53yr M]

3.4 *Resources used by FPs to overcome perceived shortcomings of formal training*

3.4.1 Making use of a community of practice

As explored throughout the study, all the participants discussed various learning points from lived experience versus formal training, and all were able to identify specific knowledge gaps. Depending on their experience in the role, the perceived amount of time available, and the importance of the subject matter, many have attempted to close these gaps through the relevant channels to function effectively as leaders within their space.

Participants instinctively learned from, and leaned on, their local team and other FPs for support during their earlier challenging years. This participant explicitly stated: *"To be able to learn from, from others, and so, yeah, I mean amongst us and particularly now, we, we have a, a couple of really excellent managers"* [5.218,53yr M] A similar concept was stated by another participant: *"Asking people for help, so, knowing, knowing who my, my Cape Town based resources were."* [9.184,41yr M]. Some participants were also grateful that they felt well-supported despite being in a reasonably remote facility: *"We are five family physicians, and we meet monthly, and we also communicate quite often with each other*" [10.220,39yr F]. Participants often look to other local team members for support and guidance: *"It's been a very good learning curve but manageable in the way that there is a lot of support, a lot of senior people that has been… that has (have) experience" [*8.50, 34yr.M]

3.4.2 Governmental circulars and courses

Some participants were not able to attend specific courses due to time constraints and service delivery expectations. This participant was challenged in her time-management to prioritise attending available training courses: "*I've always put it down in my skills plan that I would like to do management courses, but never actually got there. I think they are always quite time consuming*" [1.328 43yr F]. These participants made use of Department of Health (DOH) circulars and guidelines which were sent out frequently. *"Having access to resources, like typed up documents and specific things that they… that is available.* [8.221 34yr M]

Other participants, with the support of their line managers, were able to utilise courses through the DOH, *“Fortunately the Northern Tygerberg, basically allow us to choose courses or subjects we really want to develop ourselves in*. “[3.118 47yr M] while others sought private courses and diplomas provided externally to enhance their skills. “*So subsequently after family medicine had done like other things and one of the things I did was the Oliver Tambo Fellowship Program at UCT*.”[4.84 39 yr. F] One participant even sought training that is internationally accredited: “…*then I'm currently doing a leadership management course through University of Washington.”* [1.350 43yr F]

4. Discussion

This study used qualitative methodology and framework analysis to describe how previous versions of the postgraduate Leadership and Governance training module in the UCT MMed curriculum helped prepare newly qualified family physicians for the public sector in the Western Cape province of South Africa. The key findings are summarised in four themes: 'early experiences of qualified FPs', 'key leadership qualities', 'fit for purpose training' and 'resources utilised by FPs'.

The results of this study displayed an appreciation of the rich data given the diverse experiences of the FPs interviewed, the many possible variations of the training module that they were exposed to, and how they utilised that information. The first key finding looked at the early experiences of the FP. This theme highlighted the collective lived experience of FPs, with many expressing similar challenges in their jobs. This challenging or "teething" phase post registrar training has been explored in the literature. A qualitative cross-speciality study was undertaken in the UK by Morrow et al., looking specifically at the transition from registrar to consultant. This study highlighted similar learning gaps pertaining to leadership, service management, people management and exposure to the consultant role.[32] Acknowledging that this transition period is present across all specialities and even across different resource settings is important, and this could be an opportunity to provide additional support for the junior consultant.

The next notable finding from this study was the identification of key leadership qualities needed to work within the public sector, as reflected on by the participants. Family physicians are not intended to be employed at regional or tertiary hospitals or as clinical managers, as outlined by the latest position paper by Mash et al.[10] More emphasis has been placed on FPs as leaders and custodians within the district health system, especially with SA's health system moving towards National Health Insurance (NHI).[2] A more recent study exploring the career pathways of new FPs showed that 55.4% of FPs were still in the public sector, with 38,5% of those FPs in leadership positions.[33] The leadership qualities identified by our participants were aligned with Gilson and Daire's list of abilities needed to transform health care.[12] These key qualities, which were similar amongst all the participants despite various years of experience in their roles, outline two things. Firstly, leadership qualities or abilities are similar in the public sector across leadership roles, and because of this, it is possible that training of senior registrars or junior consultants , in this regard ,could be standardised across disciplines. Secondly, it provides evidence that could inform curriculum transformation in post-graduate family medicine training programmes that better aligns training and the realities of the workplace.

Following reflection on their formal training, participants were asked to look at the comprehensiveness of the module and identify strengths and knowledge gaps. A theme that emerged from these reflections was the concept of fit for purpose training. Reflecting on the importance and relevance of fit for purpose training in an editorial from 2011, Burch and Reid explored the many reasons within the South African context as to why fit for purpose training is necessary. [34] They discussed the gross inequalities within the health care system stating that 46% of south Africa's rural population is service by 12% of the country's doctors. Furthermore, some of our medical schools have the greatest proportion of emigrating health care professionals in the world. They had suggested that major curriculum reform, including looking at assessment structures, was needed to address the gross inequities of the SA health system at the time as well as look for ways to improve doctor-to-population ratios in public health care facilities, and distribute doctors better so as to address the health care needs of marginalised communities .The reflections by the participants and the insights from Burch and Reid's editorial highlight the key feature of fit for purpose training which is essentially that alignment between the curriculum and the future roles and responsibilities of graduates within a specific context. Elaborating further on this, Dudley et al reviewed the medical undergraduate curriculum and found that health systems, health leadership and management teaching were weak, and important public health competencies in human rights and health advocacy received little attention. Recent graduates wanted more integrated, practical, problem-based teaching in environments where they would one day work and their teachers be role models for the competencies students were expected to acquire. [31] Similarly, Taber et al. discussed a fit for purpose framework looking at the accreditation of programmes, which appreciates the local contexts of the graduates and the health system in which they will work.[35] Building on this theme of socially responsive curricular transformation, the findings from our study potentially improve the possibility of SA training programmes becoming more socially just and context specific.

As previously mentioned, participants also reflected on the shortcomings of formal training, and many raised the issue of not being exposed to daily governance or administrative problems during their registrar time. Participants appreciated the theoretical components of formal training but felt the knowledge gap when it came to utilising these skills when ultimately in the role. This suggests that the formal training could be made fit for purpose by adding a service-learning component, which offers the opportunity for role-modelling clinical leadership. This could include leading Morbidity and mortality case meetings, joining finance meetings, sitting on an interview panel or managing a Patient safety incident under the guidance for a FP supervisor.

Using a community of practice (COP) to fill knowledge gaps within the clinical leadership role came up as a key finding. Wenger describes the concept of a community of practice as being comprised of three things: it is a joint enterprise that's continually receiving input from its members, it functions off mutual engagement from members that bind them together as a society, and this helps them in turn, to share and develop a vast number of communal resources. These are developed and strengthened by the members around matters that are important to that society.[36] This principle of collaborative practice is a core principle of family medicine, and helps strengthen the discipline and the local communities they serve. Leveraging the existing COP to support new consultants or mentor registrars could significantly strengthen the formal training programme.

4.1 Recommendations

The recommendations from this study would be to use the findings in a process of curriculum review and transformation, as it pertains to leadership training. The relevant stakeholders could investigate developing a stronger, more dynamic, and more relevant module that balances theoretical knowledge with practical skills.

Workplace exposure to the leadership role with different leaders, e.g. clinical managers and FPs, could improve graduates' preparedness to deal with corporate and clinical governance activities and processes. Further research could also be done in other universities to see how they conduct this module and if their graduates have similar feedback. Research can also be conducted across healthcare disciplines to assess if they run a similar course and then assess the perceived usefulness of the course once graduates are qualified and employed.

Health system leaders could also use these findings to strengthen support systems and resources, especially once FPs are already in management positions. This support package could be extended to all managers and could include mandatory introductory courses and short courses into human resources processes should be encouraged. This could create more confident leaders and managers within district health systems and decrease the time it takes to adjust to their new roles, while improving adherence to governance practices and regulations.

The South African Academy of Family Physicians (SAAFP) has a mentorship program (Next5) which aligns with the COP concept, currently aimed at junior consultants. However, it should also be aimed at final-year registrars so that they can also know their options going forward; this way, the SAAFP would offer holistic support to its members.

4.2 Limitations of the study

The small sample of participants resulted in findings that are not generalisable; however, it does give interesting ideas about fit for purpose leadership training for FP. Purposive sampling was done; therefore, a wide variety of views was not obtained. The large range of years of experience between candidates with their many iterations of the L&G module, despite all being run by UCT, gives participants different views and reflections on their version of the module and not necessarily the same module.

The deductive method with framework analysis that was used limits the interpretation to specific themes.

5. Conclusion

This qualitative study used semi-structured interviews to gather data from recently qualified family physician consultants on their leadership training. The key findings are summarised in four themes: ‘early experiences of qualified FPs’, ‘key leadership qualities’, ‘fit for purpose training’ and ‘resources utilised by FPs’. These themes helped to describe their leadership journeys, highlighting aspects of the current training that could be strengthened. Future research should explore workplace-based leadership training models, the impact of leadership role-modelling, and provide ongoing evaluation of fit for purpose training programmes.

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Appendices

Appendix 1:

National Learning Outcomes [13]

Unit standard 1: Effectively manage themselves, their team and their practice, in any sector, with visionary leadership and self-awareness in order to ensure the provision of high-quality, evidence-based care.

1.1 Developing self optimally as a leader:

1.1.1 Demonstrating self-awareness and reflection in terms of one's personality, personal values, preferred learning and leadership styles, and learning and development needs

1.1.2 Demonstrating effective methods of self-management and self-care

1.1.3 Demonstrating willingness to seek help, when necessary

1.1.4 Demonstrating an ability to implement and monitor strategies for self-growth and personal development

1.2 Offer leadership within the healthcare team and district health system by:

1.2.1 Communicating and collaborating effectively

1.2.2 Demonstrating an ability to build capability, mentor or coach members of the healthcare team

1.2.3 Demonstrating an ability to engage and influence others through advocacy, group facilitation, presentations, critical thinking, or behaviour change counselling

1.2.4 Working effectively as a member of the sub/district healthcare team

1.3 Describe and contribute to the functioning of the district healthcare system

1.3.1 Demonstrating an understanding of the principles of the district health system in the context of existing and developing national legislation and policy

1.3.2 Demonstrating an ability to contribute to the management of a facility, sub-district, or district

1.4 Lead clinical governance activities

1.4.1 Demonstrating the ability to lead a quality improvement cycle in practice

1.4.2 Facilitating reflection on health information (e.g. monitoring and evaluation, national core standards) in order to improve quality of clinical care (e.g. rational prescribing and use of investigations) in the sub-district/district

1.4.3 Facilitating risk management processes and improving patient safety (e.g. conduct morbidity and mortality meetings, assess competence of new clinical staff, perform root cause analysis, manage patient complaints) in the sub-district/district

1.4.4 Facilitating the implementation of clinical guidelines in the sub-district/district

1.4.5 Critically reviewing new evidence (e.g. research) and applying the evidence in practice

1.4.6 Contributing to the development or revision of guidelines by generating new evidence (e.g. perform research) or representing the viewpoint of the district health services in the process

1.5 Understand and influence corporate governance

1.5.1 Understand the principles of human resource management (e.g. labour relations, recruitment, disciplinary procedures, and grievances)

1.5.2 Demonstrate the ability to complete performance appraisals of staff

1.5.3 Understand the principles of financial management (e.g. budgets, health economics, financial planning)

1.5.4 Understand the principles of procurement and infrastructure (e.g. supply chain, equipment, buildings)

1.5.5 Understand the principles of health information and record-keeping systems

1.5.6 Understand the principles of rational planning of health services

1.5.7 Be able to communicate effectively with those responsible for corporate governance

Appendix 2 Leadership and Governance Module 2022/23 course outline

Leadership & Governance module

Updated planning for 2022/2023
UCT Division of Family Medicine

25 April 2022

Klaus von Pressentin (convenor)

2016 https://www.tandfonline.com/doi/full/10.1080/20786190.2016.1148338

South African Family Practice 2016; 58(6):232–235
http://dx.doi.org/10.1080/20786190.2016.1148338

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OPINION (OPEN FORUM)

Leadership and governance: learning outcomes and competencies required of the family physician in the district health system

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The South African National Development Plan expects the family physician to be a leader of clinical governance within the district health services. The family physician must also help to strengthen the services through leadership in all his/her other roles as a clinician, consultant, capacity-builder, clinical trainer and champion of community-orientated primary care. In order to deliver on these expectations the nine training programmes must ensure that they prepare registrars appropriately for leadership and clinical governance. Currently training programmes differ considerably in what they teach and in workplace-based training and assessment. This article reports on a national process to reach consensus on what training is required for family physicians in this area. The process outlined the key conceptual principles and competencies required for leadership, clinical and corporate governance; it culminates in a new set of learning outcomes for the training of family physicians.

2021 https://safpj.co.za/index.php/safpj/article/view/5342

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AOSIS

Page 1 of 4 Open Forum

Updated programmatic learning outcomes for the training of family physicians in South Africa

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The training of medical specialists should constantly be re-aligned to the needs of the population and the health system. The national Education and Training Committee of the South African Academy of Family Physicians reached consensus on the updated programmatic learning outcomes for the training of specialist family physicians in South Africa. Learning outcomes were first developed to guide training programmes when the speciality was recognised in 2007. Fifteen years later, it was time to revisit and revise these learning outcomes. Learning outcomes define what family physicians are able to do at the end of 4 years of postgraduate training. This revision presents five unit standards and 83 programmatic exit-level learning outcomes.

Keywords: family physicians; health professions education; learning outcomes; education; curriculum; competency-based education.

2021 https://safpj.co.za/index.php/safpj/article/view/5342

TABLE 1: Definitions of unit standards and capabilities required.

Unit standard definitions	Unit standard capabilities
Unit standard 1: Effectively manage themselves, their team and their practice, in any sector, with visionary leadership and self-awareness in order to ensure the provision of high-quality, evidence-based care.	A person who has achieved this standard is capable of effectively managing themselves, their team and their practice, regardless of the sector, shows self-awareness in their personal and professional approach and provides high-quality care based on current evidence

Updated programmatic learning outcomes: to be achieved over 4-years.

The University training programmes need to be aligned with these new outcomes.

College of Family Physicians needs to ensure alignment with the national exam blueprinting.

SAAFP ETC also aims to align these outcomes with a set of entrustable professional activities and observable practice activities – linked to a new electronic portfolio of learning.

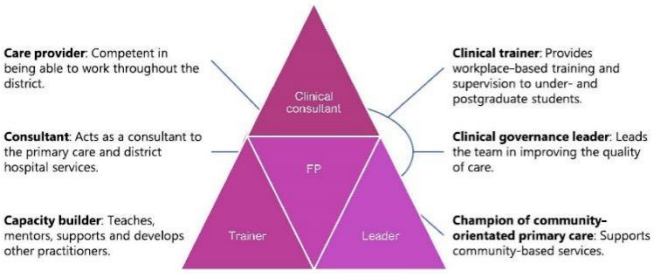
2021 https://safpj.co.za/index.php/safpj/article/view/5342

TABLE 2: Programmatic learning outcomes.

Unit Standard	Description
Unit standard 1	Effectively manage themselves, their team and their practice, in any sector, with visionary leadership and self-awareness in order to ensure the provision of high-quality, evidence-based care.
1.1 Developing self optimally as a leader:	1.1.1 Demonstrating self-awareness and reflection in terms of one's personality, personal values, preferred learning and leadership styles, and learning and development needs 1.1.2 Demonstrating effective methods of self-management and self-care 1.1.3 Demonstrating willingness to seek help, when necessary 1.1.4 Demonstrating an ability to implement and monitor strategies for self-growth and personal development
1.2 Offer leadership within the healthcare team and district health system by:	1.2.1 Communicating and collaborating effectively 1.2.2 Demonstrating an ability to build capability, mentor or coach members of the healthcare team 1.2.3 Demonstrating an ability to engage and influence others through advocacy, group facilitation, presentations, critical thinking, or behaviour change counselling 1.2.4 Working effectively as a member of the sub/district healthcare team
1.3 Describe and contribute to the functioning of the district healthcare system	1.3.1 Demonstrating an understanding of the principles of the district health system in the context of existing and developing national legislation and policy 1.3.2 Demonstrating an ability to contribute to the management of a facility, sub-district, or district
1.4 Lead clinical governance activities	1.4.1 Demonstrating the ability to lead a quality improvement cycle in practice 1.4.2 Facilitating reflection on health information (e.g. monitoring and evaluation, national core standards) in order to improve quality of clinical care (e.g. rational prescribing and use of investigations) in the sub-district/district 1.4.3 Facilitating risk management processes and improving patient safety (e.g. conduct morbidity and mortality meetings, assess competence of new clinical staff, perform root cause analysis, manage patient complaints) in the sub-district/district 1.4.4 Facilitating the implementation of clinical guidelines in the sub-district/district 1.4.5 Critically reviewing new evidence (e.g. research) and applying the evidence in practice 1.4.6 Contributing to the development or revision of guidelines by generating new evidence (e.g. perform research) or representing the viewpoint of the district health services in the process
1.5 Understand and influence corporate governance	1.5.1 Understand the principles of human resource management (e.g. labour relations, recruitment, disciplinary procedures, grievances) 1.5.2 Demonstrate the ability to complete performance appraisals of staff 1.5.3 Understand the principles of financial management (e.g. budgets, health economics, financial planning) 1.5.4 Understand the principles of procurement and infrastructure (e.g. supply chain, equipment, buildings) 1.5.5 Understand the principles of health information and record-keeping systems 1.5.6 Understand the principles of rational planning of health services 1.5.7 Be able to communicate effectively with those responsible for corporate governance

Figure 1: The 'I-we-it' model of leadership scheme.[6]

https://www.tandfonline.com/doi/full/10.1080/20786190.2016.1148338

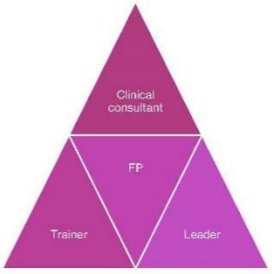


https://safpj.co.za/index.php/safpj/article/view/4844

The interplay between context and family physicians

- A recurring theme was the issue of the FP's ability to influence his/her context.
- An expectation of FPs in the DHS is that they will help the healthcare system to improve, expand and develop.
- FPs who were seen to be 'at the mercy of the system' were those lacking leadership skills and not able to integrate themselves into the clinical team.
- Role clarification and support were identified as enabling factors.
- Some DMs mentioned the mentoring support of senior FPs and other specialists to newly qualified FPs.
- Newly qualified FPs appeared to gradually embrace all of their six roles in an incremental process as they gained experience and maturity.
- An understanding of the complexity of the DHS environment was also seen as beneficial.
- FPs with leadership qualities, resilience and the ability to be change agents were seen as FPs able to shape their context.
- A supportive team and management were identified as pivotal enabling factors.

The bird's-eye perspective: how do district health managers experience the impact of family physicians within the South African district health system? A qualitative study



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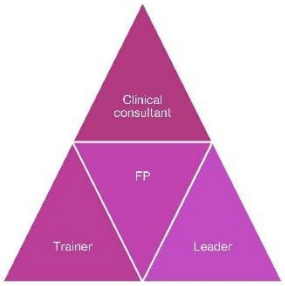
The role of leadership within the DHS context

- The DMs provided rich data on the need for the FP to demonstrate leadership in collaboration with the local managers in order to create a supportive environment in which healthcare workers and the quality of their work could flourish.
- Collaborative leadership between FPs and the local managers has also been showcased in the Western Cape with regard to the implementation of the clinical governance framework.
- The importance and nature of leadership competencies in the training of FPs have also been emphasised recently and new learning outcomes created to guide the South African training programmes.
- The FP should add value through his/her leadership ability in all his/her roles, in keeping with a collaborative and complex adaptive leadership style.
- The conversation around leadership should also include the need for the district health system to integrate with the educational system (academic family medicine departments) to enhance the support of the teaching and learning environment.
- This is needed to train the district workforce in the appropriate context, including future FPs, and for the educational system to understand the evolving needs of the district-level services.

The bird's-eye perspective: how do district health managers experience the impact of family physicians within the South African district health system? A qualitative study



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2021

Self → We Team → It System

Blueprinting of the 7 sessions over a 3 – 4 month period (second semester year 3)

2 sessions (1,2)

Insights Discovery Personality Profile

Reflective assignment

1.1 Developing self optimally as a leader

3 sessions (5,6,7)

1.2 Offer leadership within the healthcare team and DHS

1.4 Lead clinical governance activities

3 sessions (3,6)

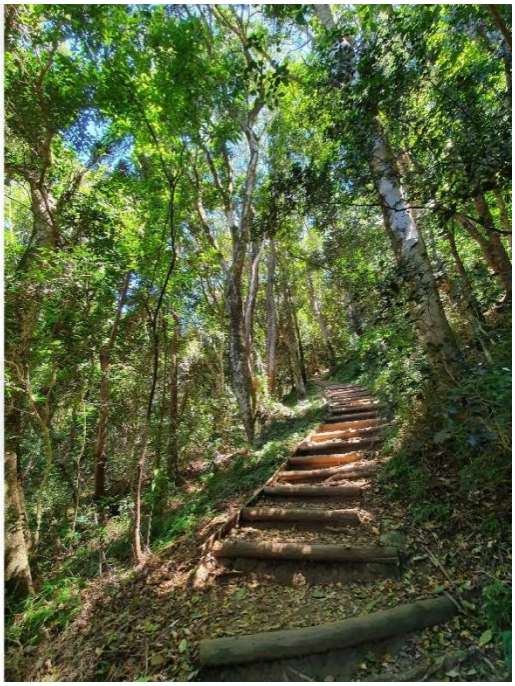
1.3 Describe and contribute to the functioning of the district healthcare system

1.4 Lead clinical governance activities

1.5 Understand and influence corporate governance

Reflection on 2021

- Valuable content
- Mix of presenters
- Time allocated to sessions
- Content to cover in 7 sessions
- Opportunities for reflection



2022

Questions & Discussion

- Stakeholder engagement
  - Students
  - Facilitators/Faculty
  - External
- Feasibility in terms of time and resources
- Reflection on change from Discovery Insights to Enneagram
- Reflective assignment and/or other forms of assessment
- Ensuring student preparedness for FCFP(SA) exit examination
- Incorporation of learning & reflections into the electronic portfolio of learning
- Monitoring and evaluation
- Other thoughts and suggestions?

2022

Updated planning for 2022

Feedback from stakeholder engagement, including registrars and faculty

- Retain module in year 3: no sessions in year 4 preferred as this interferes with the planning and preparation for the FCFP(SA) exit examination and completion of research dissertation.
- Support for new format to including facilitated learning and more sessions to spread the teaching content: registrars who completed the module in 2021 agreed that the sessions were content-heavy with inadequate time for reflection on learning and application in context.
- Review assignment(s) and assessment: plan and communicate assignments ahead of module and plan in collaboration with module convenor (in 2021 there were unplanned assignments which caused confusion).

2022

- Blueprinting of the 12 sessions, split over 2 semesters (retained in year 3).
  - *After stakeholder consultation, including registrars and faculty, we agreed to use year 3 for the full module.*
- Change from Discovery Insights to Enneagram personality profile.
  - *Change accepted.* Both profiles are acceptable and evidence-based. Facilitator preference allowed.
- Incorporating a group coaching approach – 4 x dedicated leadership development sessions.
- The 8 x content sessions will cover the clinical & corporate governance learning outcomes.
- Each content session will be followed by a facilitated reflection on the leadership role in context.
- Positioning the content in context will facilitate the transferability of learning.

2022

Proposed new session format

13h30 – 16h45
Thursday afternoons

90 min:
Content session by a content expert(s)
-followed by-
90 min:
Facilitated reflection on learning by a coaching expert(s)

Example

1.5 Corporate governance 13h30 – 15h00	Facilitated reflection 15h15 – 16h45
Dr S Naidoo Understand the principles of financial management Be able to communicate effectively with those responsible for corporate governance	Dr P Pampallis, Dr A de Sa The group could look at scenarios where they have had to address the tension between managers and clinicians around cost issues. Possible questions: • How do we manage a team that feels their value is only measured in quantity and not quality of their work – the eternal stats issue. • How do we present our arguments for the re-allocation of resources... how do we see ourselves in relation to those who hold the purse strings?

Planner: UCT MMed (FamMed) Leadership & Governance Module 2022
(version: 25 April 2022)

*With A de Sa
#Possibly with G Perez

	Session	Theme	Topic	Lead facilitator	Unit std	Date
Semester 1, Year 3	1	L/ship	Leadership development	P Pampallis*	1.1, 1.2	12 May 2022
	2	L/ship	Leadership development	P Pampallis*	1.1, 1.2	26 May 2022
	3	Corp/gov	DHS functioning & team	K Murie #	1.3	9 June 2022
	4	Clin/gov	The FP contribution to DHS	K von Pressentin #	1.4	23 June 2022
	5	Clin/gov	Risk management, M&E	H Mohamed	1.4	7 July 2022
	Mid-year break					
Semester 2, Year 3	6	Clin/gov	Clinical guidelines, evidence	A Isaacs	1.4	4 August 2022
	7	Clin/gov	Rational medicine use	M Namane	1.4	18 August 2022
	8	Corp/gov	Planning health services	D Pienaar	1.5	1 September 2022
	9	Corp/gov	Health information	R Dyers	1.5	15 September 2022
	10	Corp/gov	Financial management	S Naidoo	1.5	29 September 2022
	11	L/ship	Leadership development	P Pampallis*	1.1, 1.2	27 October 2022
	12	L/ship	Leadership development	P Pampallis*	1.1, 1.2	10 November 2022

[L/ship = Leadership development; Content sessions: Clinical and corporate governance; Unit std = national unit standard]

Thank you for your support!

A/Prof Klaus von Pressentin

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Appendix 3: [25] Interview guide

Demographics:

- Name:
- Age:
- Graduation year
- Currently working at?
- Rural or Metro?
- Current position/role description (FP, MO, Clinical Manager, other)

1. How has your experience as a qualified family physician been so far?
2. Reflect on your L&G module in your 3/4th year. How would you describe your overall experience of the module?
3. Are there any specific lessons or skills that have remained with you during your current practice?
4. Reflecting of your time now as a qualified family physician, are there any skills that you have identified for yourself as a knowledge gap pertaining to Leadership and Governance?
5. Did you make use of other resources while working to gain knowledge and confidence with regards to L&G outside of the structured module?
6. What personal attributes do you think contribute to shaping an effective leader in the public sector?

Appendix 4: Informed consent

Informed consent form

Section A

Study title: Investigating the perceived impact of a leadership training module on clinical family medicine practice: a qualitative study

What is the purpose of the research?

The purpose of this research is to understand if and how the current postgraduate Leadership and Governance training module in the MMed curriculum at UCT helped prepare newly qualified family physicians in the public sector within the Western Cape province of South Africa.

What will the research involve for me, as a participant?

As a participant, you will be requested to participate in a 45min long interview at a convenient time and place for you. If you would prefer online-this can also be arranged.

What are the risks of taking part in this research project?

This research is of very low risk to you, as you will only be asked to reflect on your perception of the leadership and governance training you received at UCT during your registrar training.

What are the benefits of taking part in this research project?

Your involvement will help the research team close the knowledge gap between what is currently offered by the educational programme, and what is needed on the clinical platform. Your valuable experiences and insights will provide evidence for educators who may want to strengthen their efforts and in turn encourage improvement in the curriculum.

What if I refuse to take part in this research?

You have the right to refuse participation in this study at any time. This includes if you have signed consent but change your mind afterwards. Your refusal or withdrawal will not result in any negative consequences in any way.

Who will have access to the information obtained in this research?

The actual research data will be kept strictly confidential until all identifying information has been removed from it. Thereafter, the research team and statistician will analyse the data. The overall results, which will have no personal details, will be shared with all participants. It will also be shared with interested parties in the University community, and a formal write-up will be submitted as part of my MMed research.

Who are the researchers to contact with any comments or questions?

Primary Investigator: A/Prof Tasleem Ras
FaCE/Div of Fam Medicine Division
UCT

Co-supervisor: A/Prof Klaus von Pressentin
FaCE/Div of Fam Medicine
Head of Division of Family Medicine
UCT

MMed candidate: Dr Samantha Dladla
Registrar
FaCE/Div of Fam Medicine
DLDSAM007@myuct.ac.za
Samanthavanwyk37@gmail.com
0844665644

Which institution has given permission for this research to be conducted?

This proposal has been reviewed by the University of Cape Town, Faculty of health Sciences' Health Research Ethics Committee (HREC). The approval number is :
The HREC contact details are:
Email: HREC-Enquiries@uct.ac.za
Tel: 021 406 6492

Is there any remuneration that will be paid during this research?

There is no remuneration for being part of this study.

Section B

1. I, _____ (participant name), confirm that this research project has been explained to me, and that my questions have been answered to my satisfaction. I voluntarily and freely make my own decision to join in this project. I understand that I can withdraw at any time, with no disadvantage to me.

   Name: _____ Signature: _____

   Date: _____ Place: _____

2. I, _____(investigator name), confirm that I have explained the project to this participant, and answered all questions to the best of my ability. The participant has freely and voluntarily agreed to participate in this project, and retains the right to withdraw at any stage, with no disadvantage to him/her.

   Name: _____ Signature: _____

   Date: _____ Place: _____