The professional relationship between professional nurses and clinical associates in selected district hospitals

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Dissertation submitted in fulfilment of the requirements for the degree *Master of Nursing Science* at the North-West University

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Student number: 23973293

MORENA KE MODISA WAKA

Psalm 23

SOLEMN DECLARATION

1. Solemn declaration by student

I, Emmah Mohlware Mokoena,

declare herewith that the research proposal titled:

The professional relationship between professional nurses and clinical associates in selected district hospitals

which I herewith submit to the North-West University, Potchefstroom Campus, in compliance with the requirements set for **the *Master's in Nursing Sciences* degree**, is my own work and has not already been submitted to any other university.

I did my best to acknowledge all the references used in the research proposal. I tried by all means to paraphrase their words to the best of my ability, while still portraying the meaning of their words. Due to extensive reading on the topic, I might have internalised some of the information in my thinking, but care has been taken to give recognition where due to the original authors.

Signature of student

14 November 2019

EM MOKOENA **DATE**

ID number: 810914 0635 088

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PREFACE

Professional relationships among healthcare professionals in the practice environment (PE) and beyond are fundamental in ensuring service delivery and quality patient care. They are the engine that propels the core of the whole health system. Without professional relationships, those in contact with the patients stand little chance of delivering quality patient care. The intention of carrying out this study was to explore and describe the professional relationship between professional nurses (PNs) and clinical associates.

The objectives are for the first time researched from a nursing perspective. As the researcher pondered the unexplored world of the professional relationship between PNs and clinical associates, it is the researcher's wish that the study would provide substantial and valuable insight into the professional relationships among the study group and possibly healthcare professionals (HCPs) in general. Secondly, the researcher anticipates that the breadth and ambition of the study results will reach the right people and create dialogue in scrutinising and paying attention to the seriousness of professional relationships between PNs and clinical associates and other HCPs as that will ultimately improve service delivery.

In the interest of relaying information, communicating the researcher's message as well as reporting the results to the target audience, the study was written in an article format. *Chapter 1* includes a comprehensive overview of the study, an in-depth literature review on key concepts as well as a detailed description of the methodology of this study. *Chapter 2* is an article in the format required by the author's guidelines (original research papers) for the *International Journal of Nursing Practice*. *Chapter 3* comprises the study's conclusions of each objective of the study and recommendations for nursing practice, research, education and policy. Lastly, the limitations of the study, personal journal of the researcher, and a chapter summary are given.

ACKNOWLEDGEMENTS

- To God be the glory! It is by His grace and mercy that I made it this far. I am full of praise, thankful, blessed, and highly favoured and know without a shadow of a doubt that I can do all things through Jesus Christ who strengthens me!

- Looking back at this experience, it was not easy at all. Somewhere I lost the vigour and strength to carry on. Everything seemed so daunting and difficult to comprehend. But God in his infinite wisdom places angels along our path to guide, encourage, and support our endeavours. Therefore, I would like to express my deepest gratitude to the following people whose immense support contributed to me succeeding:

- Dr T. Rabie, my supervisor. I cannot thank you enough! I thank God for your guidance, unwavering support, motivation, patience, and objective criticism. I convey my endless gratitude to you for your extraordinary dedication in encouraging me to complete this dissertation. May God grant you more wisdom and dedication to continue assisting others in achieving their goals and dreams.

- Dr A. du Preez, my co-supervisor, you have never turned away from my work, you always provided timeous feedback and constructive criticism. Thank you so much for your support, guidance, and encouragement.

- My husband Dr Edwin Mokoena, thank you for the consistent emotional and financial support you displayed throughout this phase. Thank you for believing in me when I did not believe in myself. My relentless cheerleaders, my children. Thank you for understanding. You remain the reason I took on this challenge. I hope this achievement will be a motivation to you.

- My late mother, Rebotile Letago Mojalefa. The dreams and hopes you had for me and my siblings have been my motivation throughout this research study. I know you would have greatly been excited to be here with me at the end of this study journey. May your precious soul rest in peace. To my dad, you are appreciated indeed Tau. It was not easy, but you tried your best to be there for my siblings and me.

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“BENG BAKA, MORENA AARON ABATATE, MOTLOTSWA WA MORENA LE LEWATLE…TSOHLE DI A KGONEGA KA LENA.”

ABSTRACT

INTRODUCTION

The South African public health sector is facing the crisis of a shortage of healthcare professionals, particularly physicians. Even though the shortage is global, South Africa is more affected due to the high number of citizens receiving their medical care from the public healthcare sector. In developing countries such as South Africa, the shortage of healthcare professionals, particularly physicians and nurses, inequitable distribution of workforce, and a lack of resources have seen to it that the global policy on universal health coverage, which was developed to ensure positive service delivery and quality patient care, is not met. The South African government employed multiple strategies to address the shortage of physicians with varying degrees of success. One of the strategies was adopting a double-pronged strategy to increase the number of physicians to meet the healthcare needs; this entailed an output of local training institutions and outsourcing medical training to Cuba by annually sending 1 000 students from poor rural communities to train as physicians. The other strategy adopted was the introduction of the relatively new cadre of professionals known as clinical associates. Clinical associates were introduced to augment the shortage of physicians especially in district hospitals and primary healthcare settings. This meant that the clinical associates have to work closely together with professional nurses. Due to the relative newness of the clinical associates' profession and lack of clarity about the role of clinical associates, some of the healthcare professionals, especially professional nurses, were not well informed about their scope of practice and role and that has led, in the practical experience of the researcher as a professional nurse, to conflict in the practice environment, causing a lack of professional relationships among especially these healthcare professionals which could negatively affect service delivery.

RESEARCH PURPOSE

The purpose of the study was to explore and describe the professional nurses and clinical associates' perceptions of the professional relationship between them.

RESEARCH DESIGN

A qualitative description design was used in this study.

RESEARCH METHOD

Data collection took place in district hospitals (N=7; n=4) in Gert Sibande district, Mpumalanga province. Twelve (N=12) semi-structured individual interviews were done consisting of six (n=6) professional nurses and six (n=6) clinical associates. All interviews were recorded with a digital voice recorder in a private room after consent had been obtained from all participants. The anonymous interviews were then transcribed by an independent transcriptionist and thereafter data were analysed using Tesch's eight steps of data analysis with the assistance of a co-coder. After independent analysis of the data by the researcher and co-coder, the results (main themes, and sub-themes) where confirmed by both parties and the supervisors to ensure a true reflection of the results to ensure trustworthiness.

RESULTS

The findings of the study indicate that although professional nurses and clinical associates understand what a professional relationship is and their role in the district health system, challenges are present and could negatively impact service delivery. Many of the findings between the professional nurses and clinical associates were similar, but there were a few unique findings.

Three main themes emerged from the professional nurses' interviews namely professional relationship defined (1), professional relationship characteristics (2) and professional relationship challenges (3). The *first* main theme professional relationship defined had two sub-themes namely colleagues working together and relationship amongst professionals. Sub-themes for main theme *two* named professional relationship characteristics consisted out of positive and negative characteristics and main theme *three* professional relationship challenges included sub-themes attitude, functional – clinical associates and ministerial, interdepartmental and intra-professional collaboration.

Four main themes emerged from the clinical associates' interviews, namely: (1) professional relationship defined, (2) professional relationship characteristics, (3) professional relationship challenges, and (4) personal professional challenges. Main theme *one* (professional relationship defined) had interaction between two people, collegial relationships, and goal orientation as sub-themes. The *second* main theme's (professional relationship characteristics) sub-theme was positive characteristics. Main theme *three* (professional relationship challenges) had the sub-themes attitude, functional – clinical associates, functional – professional nurses, and ministerial collaboration. Lastly, the *fourth* main theme (personal professional challenges) included the sub-

themes lack of independence, poor remuneration, poor career progression, and supporting profession to physician shortages.

CONCLUSION

Professional relationships form the basis of success for the healthcare system. The professional relationship between professional nurses and the relatively new cadre of healthcare professionals called clinical associates has not been the focus of research studies. There are various challenges in this relationship that need to be addressed as it can negatively impact service delivery. Although some challenges revealed by both professional nurses and clinical associates were very similar in the practice environment, there were also unique personal professional challenges that the clinical associates had.

Both populations could define a professional relationship between themselves, although the clinical associates had perceptions of a more personal connection in their professional relationships by mentioning that it is a ‘collegial relationship’, ‘interaction between two people’, and ‘goal orientation’, whereas the professional nurses’ perception was that it was only ‘colleagues working together’ and ‘relationship amongst professionals’, i.e., there does not have to be a relationship between themselves. The professional nurses added positive and negative professional relationship characteristics whereas the clinical associates only perceived positive characteristics in their relationship with professional nurses. The professional relationship challenges revealed that both populations perceived attitude as a challenge, whereas the professional nurses only experienced functional challenges related to clinical associates; clinical associates, on the other hand, perceived that there were functional challenges for themselves and the professional nurse. Both populations revealed that there is a ministerial collaboration challenge that needs to be addressed, while the professional nurses added interdepartmental and intra-professional collaboration. Lastly, clinical associates also added that they have personal professional challenges, such as a lack of independence, poor remuneration, and career progression, and that it is a supporting profession to physician shortages which was not perceived by the professional nurses.

Although there are many types of challenges affecting the professional relationship between professional nurses and clinical associates, these challenges could be addressed without difficulty through ministerial, interdepartmental, and intra-professional collaboration. Ministerial collaboration though media, workshops, and roadshows could be an accomplishable method to communicate. Interdepartmental (outpatient, casualty, and theatre departments) communication could be improved through meetings and availability of the scope of practice of all healthcare

practitioners including the new cadre of clinical associates in the standard operating procedure files. Intra-professional communication signifies two or more disciplines (professional nurses and clinical associates) within the same profession (healthcare) engaging in learning and collaborating together in the practice environment through in-service training. In-service training can focus on what a professional relationship entails and how to improve and address positive and negative professional relationship characteristics and professional relationship challenges. Lastly, personal professional challenges of the clinical associates should be addressed on a governmental level by the Minister of Health or a regulating body such as the Health Professions Council of South Africa.

Keywords: professional nurses; clinical associates; professionalism; professional relationship; scope of practice; service delivery.

OPSOMMING

INLEIDING

Die Suid-Afrikaanse sektor vir openbare gesondheid ondervind 'n tekort aan gesondheidsorgpersoneel, veral dokters. Al is die tekort wêreldwyd word Suid-Afrika meer geraak weens die groot aantal burgers wat hul mediese sorg in die openbare gesondheidsorgsektor ontvang. Hierdie tekort aan gesondheidsorgpersoneel, veral dokters en verpleegkundiges, die ongelyke verdeling van arbeidsmag, en 'n gebrek aan hulpbronne veroorsaak dat dit nie in ooreenstemming is met die wêreldwye beleid oor universele gesondheidsdekking wat ontwikkel is om positiewe dienslewering en kwaliteit pasiëntesorg te verseker nie. Die Suid-Afrikaanse regering het verskeie strategieë gebruik om die tekort aan dokters tot wisselende mates van sukses aan te spreek. Een van die strategieë was die implementering van 'n dubbele strategie om die aantal dokters te vermeerder om aan die gesondheidsorgbehoeftes te voorsien; dit het behels die produksie van plaaslike opleidingsinstansies en die uitkontraktering van mediese opleiding aan Kuba deur jaarliks 1 000 studente uit arm landelike gemeenskappe te stuur om as dokters opgelei te lword. Die ander strategie wat aangeneem is, is die bekendstelling van die relatiewe nuwe kategorie van professionele persone wat bekend staan as kliniese medewerkers. Kliniese medewerkers is bekendgestel om die tekort aan dokters in distrikshospitale en primêre gesondheidsorg aan te vul. Dit het beteken dat die kliniese medewerkers met professionele verpleegkundiges moes werk. Vanweë die relatiewe nuutheid in die beroep van kliniese medewerkers en 'n gebrek aan duidelikheid rakende die rol van kliniese medewerkers, was sommige van die professionele gesondheidsorg professionele persone, insluitend professionele verpleegkundiges, nie goed ingelig oor hul praktyk en rol nie, en dit het uit praktiese ervaring van die navorser gelei tot verwarring en konflik in die praktykomgewing, wat 'n gebrek aan professionele verhoudings onder veral hierdie gesondheidsorg personeel veroorsaak, wat 'n negatiewe effek kan hê op dienslewering.

DOEL VAN NAVORSING

Die doel van die studie is om die professionele verpleegkundiges en kliniese medewerkers se persepsies van die professionele verhouding tussen hulle te ondersoek en te beskryf.

NAVORSINGSONTWERP

In hierdie studie is 'n kwalitatiewe beskrywende ontwerp gebruik.

NAVORSINGSMETODE

Data-insameling het in distrikshospitale (N=7; n=4) in die Gert Sibande-distrik, Mpumalanga, plaasgevind. Twaalf (N=12) semi-gestruktureerde individuele onderhoude is gevoer bestaande uit ses (n=6) professionele verpleegkundiges en ses (n=6) kliniese medewerkers. Alle onderhoude is met 'n digitale klankopnemer in 'n privaatkamer opgeneem nadat toestemming van al die deelnemers verkry is. Die anonieme onderhoude is daarna deur 'n onafhanklike transkribeerder getranskribeer en daarna is die data met behulp van 'n mede-kodeerder met behulp van Tesch se agt stappe van data-analise geanaliseer. Na onafhanklike analise van die bevindings deur die navorser en mede-kodeerder is die resultate (hooftemas en sub-temas) deur beide partye en sudieleiers bevestig om 'n ware weerspieëling van die resultate te verseker om betroubaarheid te verseker.

RESULTATE

Die bevindinge van die studie dui daarop dat hoewel professionele verpleegkundiges en kliniese medewerkers verstaan wat 'n professionele verhouding is en hul rol in die distriksgesondheidstelsel, is daar uitdagings wat die dienslewering negatief kan beïnvloed. Baie van die bevindings tussen professionele verpleegkundiges en kliniese medewerkers was soortgelyk, maar daar was 'n paar unieke bevindings.

Drie hooftemas het na vore getree uit die onderhoude met die professionele verpleegkundiges, naamlik: (1) professionele verhouding gedefinieer, (2) eienskappe van professionele verhoudings en (3) uitdagings vir professionele verhoudings. Die eerste hooftema, professionele verhouding gedefinieer, het twee sub-temas gehad, naamlik kollegas wat saamwerk en verhouding tussen professionele persone. Die sub-temas van hooftema twee genaamd professionele-verhoudingseienskappe het bestaan uit positiewe en negatiewe eienskappe, en hooftema drie, professionele-verhoudingsuitdagings het sub-temas houding, funksionele – kliniese medewerkers, en ministeriële, interdepartementele, en intra-professionele samewerking ingesluit

Vier hooftemas kom na vore uit die onderhoude met kliniese medewerkers, naamlik: (1) professionele verhouding gedefinieerd, (2) eienskappe van professionele verhoudings, (3)

uitdagings van professionele verhoudings en (4) persoonlike professionele uitdagings. Hooftema een, professionele verhouding gedefinieerd, het sub-temas interaksie tussen twee persone, kollegiale verhoudings, en doelgerigtheid as subtemas gehad. Die tweede hooftema, karaktereienskappe van professionele verhoudings, se sub-tema was positiewe eienskappe. Hooftema drie, uitdagings van professionele verhoudings, het die sub-temas gesindheid, funksionele – kliniese medewerkers, funksionele – professionele verpleegkundiges, en ministeriële samewerking ingesluit. Laastens het die vierde hooftema, persoonlike professionele uitdagings, die sub-temas gebrek aan onafhanklikheid, swak vergoeding, swak loopbaanvordering, en ondersteunende beroep tot geneesheertekorte ingesluit.

AFSLUITING

Professionele verhoudings vorm die basis van die sukses van die gesondheidsorgstelsel. Die professionele verhouding tussen professionele verpleegkundiges en die relatiewe nuwe professionele gesondheidspersoneel wat kliniese medewerkers genoem word, was nog nie die fokus van navorsingstudies nie. Daar is verskillende uitdagings in hierdie verhouding wat aangespreek moet word, aangesien dit dienslewering negatief kan beïnvloed. Alhoewel sommige uitdagings wat deur professionele verpleegkundiges sowel as kliniese medewerkers aan die lig gebring is, baie dieselfde was in die praktykomgewing, was daar ook unieke persoonlike professionele uitdagings wat die kliniese medewerkers gehad het.

Beide bevolkingsgroepe kon 'n verhouding tussen mekaar definieer, hoewel die kliniese medewerkers 'n persepsie van ‘n meer persoonlike konneksie in hulle professionele verhoudings gehad het deur te noem dat dit 'n “kollegiale verhouding”, “interaksie tussen twee persone” en “doel-oriëntasie” is, terwyl die professionele verpleegkundiges se persepsie was dat dit slegs “kollegas wat saamwerk” en ’n “verhouding tussen professionele persone” is en nie 'n verhouding tussen mekaar hoef te wees nie. Die professionele verpleegkundiges het positiewe en negatiewe eienskappe van professionele verhoudings bygevoeg, terwyl die kliniese medewerkers slegs positiewe eienskappe ervaar het in hul verhouding met professionele verpleegkundiges. Professionele verhoudingsuitdagings het aan die lig gebring dat beide bevolkings houding as ’n uitdaging ervaar het, terwyl die professionele verpleegkundiges slegs funksionele uitdagings ervaar het wat verband hou met kliniese medewerkers, en kliniese medewerkers het gesien dat daar funksionele uitdagings vir hulself en die professionele verpleegstekundiges is. Beide bevolkings het aan die lig gebring dat ministeriële samewerking ’n uitdaging is wat aangespreek moet word, terwyl die professionele verpleegkundiges interdepartementele en intra-professionele

samewerking bygevoeg het. Ten slotte het kliniese medewerkers ook bygevoeg dat hulle persoonlike professionele uitdagings het, soos 'n gebrek aan onafhanklikheid, swak vergoeding en loopbaanvordering, en dat hulle ‘n ondersteunende beroep is tot geneesheertekorte, wat nie deur die professionele verpleegkundiges waargeneem is nie.

Alhoewel daar baie soorte uitdagings is wat die professionele verhouding tussen professionele verpleegkundiges en kliniese medewerkers beïnvloed, kan hierdie uitdagings sonder probleme aangepak word deur ministeriële, interdepartementele en intra-professionele samewerking. Ministeriële samewerking soos media, werkwinkels en padvertoning kan ‘n haalbare metode wees om te kommunikeer. Interdepartementele (buitepasiënt, ongevalle, en teater departmente) kommunikasie kan verbeter word deur vergaderings te hou en deur die beskikbaarheid van die praktykomvang van alle gesondheidsorgpraktisyns insluitend die nuwe kategorie kliniese medewerkers. Intra-professioneel kan twee of meer dissiplines (professionele verpleegkundiges en kliniese medewerkers) binne dieselfde beroep (gesondheidsorg) leer en saamwerk in die praktykomgewing deur middel van indiensopleiding. Indiensopleiding kan fokus op wat 'n professionele verhouding behels en hoe om positiewe en negatiewe eienskappe van professionele verhoudings en uitdagings met betrekking tot professionele verhoudings te verbeter en aan te spreek. Laastens moet persoonlike professionele uitdagings van kliniese medewerkers op ‘n regeringsvlak aangespreek word deur die Minister van Gesondheid en 'n regulerende professionele liggaam soos die Raad vir Gesondheidsberoepe van Suid-Afrika.

Sleutelwoorde*:* professionele verpleegkundiges; kliniese medewerkers; professionaliteit; professionele verhouding; omvang van praktyk; dienslewering

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LIST OF ABBREVIATIONS

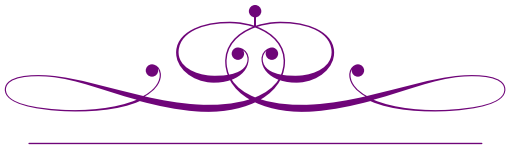
A		
	AD	Anno Domini
B		
	BCMP	Bachelor of Clinical Medical Practice
D		
	DoH	Department of Health
E		
	EU	European Union
G		
	GHWA	Global Health Workforce Alliance
H		
	HCPs	Healthcare Professionals
	HIV/AIDS	Human immunodeficiency/Acquired Immune Deficiency Syndrome
	HPCSA	Health Professions Council of South Africa
	HREC	Health Research Ethics Committee
	HRHSA	Human Resource for Health Strategy South Africa
I		
	ICN	International Council of Nurses
M		
	MDGs	Millennium Development Goals
	MLWs	Mid-level Workers
	MoH	Minister of Health
N		
	NDoH	National Department of Health
P		
	PE	Practice Environment
	PHC	Primary Healthcare
	PNs	Professional Nurses

	PHASA	Public Health Association of South Africa
R		
	RNAO	Registered Nurses' Association of Ontario
S		
	SAMA	South African Medical Association
	SAMHS	South African Military Health Services
	SANC	South African Nursing Council
	SDGs	Sustainable Development Goals
U		
	UK	United Kingdom
	UP	University of Pretoria
	USA	United States of America
W		
	WHO	World Health Organisation
	Wits	University of Witwatersrand
	WSU	Walter Sisulu University

DECLARATION OF DISSERTATION PREPARATION

- **Chapter 1:** named ‘Overview of the study and literature review’ and Chapter 3 named ‘Conclusions, recommendations, and limitations of the study’ used the Harvard referencing style as specified by the NWU.

- **Chapter 2:** named ‘Manuscript’ was prepared for the journal named the *International Journal of Nursing Practice*. The APA referencing style was used for the manuscript as indicated in the author guidelines.



CHAPTER 1
OVERVIEW OF THE STUDY AND LITERATURE REVIEW

CHAPTER 1:
OVERVIEW OF THE STUDY AND LITERATURE REVIEW

1.1 OVERVIEW OF THE STUDY

Firstly, the introduction, background, and significance of the study are discussed; thereafter, the problem statement, research questions, purpose and objectives, researcher's assumptions, research design and method, trustworthiness, ethical considerations, research report outline, chapter summary, and references are presented. This dissertation is presented in article format, and the manuscript is prepared according to the author guidelines of the *International Journal of Nursing Practice* which is the accredited international journal of choice. The last chapter consists of the introduction, conclusions, recommendations, and limitations of the study, personal journal of the researcher, and chapter summary.

1.2 INTRODUCTION

Globally, healthcare professionals (HCPs) are seen as the backbone of the healthcare system. Therefore, it is important that there is a sound professional relationship between HCPs to ensure optimal service delivery. However, recent reports have indicated that the shortage of HCPs, which includes physicians, is beyond manageable. These shortages have negatively affected sub-Saharan Africa, which includes South Africa, since many trained HCPs have been migrating abroad mainly to the United States of America (USA) and the United Kingdom (UK). This has led to the South African Department of Health (DoH) exploring other mechanisms of increasing the quantity and quality of skilled HCPs as well as reducing the shortage of physicians and professional nurses (PNs), especially in rural areas, hence the new cadre of mid-level workers (MLWs) known as clinical associates being introduced (Doherty *et al*., 2012:833). According to Doherty *et al.* (2012:833), clinical associates form an integral part of a collaborative district-level clinical team which includes the physicians and PNs.

The need for the introduction of these MLWs was to reduce the shortage of physicians, especially in rural areas (Tshividzo, 2008:1). In 2004, a National Task Team was asked to develop a training curriculum which identified the scope of practice and outcomes for a new MLW. South Africa adopted and developed the concept of clinical associates from Kenya, Malawi, Mozambique, the Netherlands, Tanzania, and the USA who have similar cadres (Couper & Hugo, 2014:1). A three-year Bachelor of Clinical Medical Practice (BCMP) degree was designed to train these MLWs in South Africa. This new cadre of MLWs is now known as

clinical associates. Once the clinical associates graduate, they are able to do history taking and physical examinations, deal with emergencies, and conduct routine diagnostic and therapeutic procedures under the supervision of a physician (Doherty, 2013:1), and form part of the clinical team. Therefore, a clinical associate is described as a "health professional providing a long-term solution to human resource constraints in district hospitals" (Doherty *et al.,* 2012:833). Clinical associates are mostly recruited from the remote and disadvantaged areas throughout South Africa. Recruitment is mostly done by the participating provincial departments and more recently bursaries were also offered by the South African Military Health Services (SAMHS) and provincial governments.

1.3 BACKGROUND

Prior to the introduction of clinical associates, various strategies were adopted and implemented to address the shortage of physicians. Firstly, the introduction of community service for physicians was introduced by the Minister of Health in consultation with the Health Professions Council of South Africa (HPCSA) in late 1996 for inclusion in the Health Professions amendment bill. The bill was finally passed by the National Council of Provinces in November 1997 and was signed into law in 12 December 1997 (Nkabinde *et al*., 2013:930). Community service for physicians commenced in 1998. Community service was initially aimed at retaining newly qualified physicians but later expanded to other HCPs. Dentistry and pharmacy started in 2000 and 2001, respectively. In 2003, seven more professional categories started doing community service, namely clinical psychology, dietetics, environmental health, occupational therapy, physiotherapy, radiography, and speech, language, and hearing therapy. In nursing, community service became mandatory in 2008. During community service, graduates are expected to complete an additional period of one year doing community service in South African district hospitals or primary healthcare (PHC) facilities, working for the public healthcare sector. This is a prerequisite for recognition of the completed degree leading to registration with the relevant professional body in South Africa and to practise as a professional physician or a PN (South Africa, 2011:36). The introduction of community service was a welcome intervention as it had a positive impact on staffing in district hospitals as some had medical or therapy staff for the first time in many years (Couper *et al*., 2005:121). However, this strategy alone did not yield satisfactory results because, as mentioned by Makholwa (2014:1), the intern physicians prefer to do community service in urban areas as they believe that there is no equity in the distribution of resources between rural and urban hospitals, making them opt for urban hospitals.

Another strategy focussed on the recruitment of foreign-trained physicians which was implemented in 1994 as recommended by the World Health Organisation (WHO, 2006). This

was a bilateral agreement between the South African government and Cuban government whereby South African medical students can be sent to Cuba to study medicine and Cuba offer the services of their already qualified physicians (National Department of Health [NDoH], 2011:36). According to the Human Resource for Health Strategy South Africa (HRHSA), there are about 3004 foreign physicians in South Africa currently, which is just about 10% of the medical workforce (NDoH, 2011:36), and therefore it can be concluded that the introduction of foreign physicians did not do enough to address the challenge of a shortage of physicians. The introduction of foreign physicians has come with its own challenges. In Ireland, foreign physicians are investigated more frequently as compared to their counterparts who trained in Ireland and are likely to face fitness-to-practice inquiry if complaints are brought forward against them (Gartland, 2012:1). South Africa is also posed with challenges as the South African Medical Association (SAMA, 2015) mentioned that physicians with no proper medical qualifications are widespread. This is mostly blamed on inadequate vetting processes at the HPCSA, as well as the recruitment of Cuban physicians based on bilateral government-to-government agreement (NDoH, 2011:36).

As the use of foreign physicians has its own shortfalls, the introduction of rural and scarce skills allowance as well as the occupational-specific dispensation to attract and retain physicians was expected to address the issues of shortages with little impact. Differences in the implementation of allowances according to Couper *et al*. (2005:121) led to fragmentation, inefficiency, and inequity in terms of salaries paid out by different districts, and this posed a human resource challenge. Regrettably, money is not all that provides contentment to workers: job satisfaction, good working conditions, further training, and career opportunities are other issues that need attention. Another strategy that was introduced by the government to increase the number of health professionals was engaging the Higher Education Institutions to increase the output of undergraduate health professionals, including physicians, from 1300 graduates per annum to 2400 graduates per annum. Even though the Higher Education Institutions tried to increase the output, the needs are still far from being achieved to curb the shortage of health personnel, in particular physicians (NDoH, 2011:36).

In December 2002, the decision was taken to implement another strategy by the then South African National Minister of Health (MoH) Dr Manto Tshabalala-Msimang to develop the so-called MLWs known as clinical associates. This decision was taken based on the 2001 report by the Ministerial Task Team on Human Resources for Health. The rationale behind the development of this new cadre (clinical associates) was to assist physicians in carrying out their clinical tasks in district hospitals. During the launch of the HRHSA Strategy (NDoH, 2011:36), the former MoH Dr Aaron Motsoaledi acknowledged that the healthcare sector needs to be staffed with appropriate and skilled health personnel. These skilled health personnel will be able

to respond to the disease burden as South Africa is overwhelmed by four clear health problems that have been described in the Lancet Report as the quadruple burden of disease, namely Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), tuberculosis, high maternal and child mortality and morbidity, and non-communicable diseases such as diabetes mellitus and heart problems, injury, and violence (Coovadia *et al*., 2009:1; Lawn & Kinney, 2009:2). Another reason for the implementation of MLWs (clinical associates) is a need to address the issue of healthcare personnel shortages in order to ensure continuation of quality patient care and the citizens' expectations of quality service, as stated by Matsoso and Strachan (2011:50, 2011). They further acknowledged that the healthcare practitioners are the most expensive asset in any organisation and therefore should be managed carefully (Matsoso & Strachan, 2011:50). The WHO (2010) also encourages countries to adopt the most efficient mix of healthcare skills and cadres possible to address their population's health needs. It is also stated that giving MLWs a more prominent role may assist in the citizens responding better to healthcare services and may save money in the long run (Lassi *et al*., 2013:824). The WHO and the European Union (EU) have thus committed R4.7 million and R15 million, respectively, and funded the first group of students in 2008 (Caelers, 2008:1).

The concept of clinical associates was first introduced in the USA as part of addressing healthcare professionals' shortages. They are called physician assistants in the USA. However, the clinical associates were initially known as medical assistants, but some of the clinical associates trained in other countries like the USA and Malawi expressed their disagreement with the utilisation of the word "assistant" and they argued that it implied subservience to and service of the physician. The term "clinical" was preferred over "medical" because of its accuracy in describing the actual role of the clinical associates. The concept "clinical officers" is mostly used in other parts of Africa, but it was felt to be "militaristic" or rank-related in the South African context. Thus, the term "clinical associates" was born.

The training of clinical associates was first introduced in 2004 but only took off in 2008. In 2005, the clinical associates' framework BCMP was developed and an invitation was extended to the deans of eight medical schools with an aim of developing the BCMP programme in their faculties. Only three universities responded positively, namely Walter Sisulu University (WSU), the University of Witwatersrand (Wits), and the University of Pretoria (UP), with the inclusion of the University of Limpopo at a later stage. The first 23 clinical associate students started with the BCMP programme at WSU in 2008, followed by Wits in 2009 with 25 students, and UP with 56 students, respectively. The WSU students graduated in 2010 and entered the job market properly in 2012, followed by Wits and UP (Doherty *et al*., 2012:833). These clinical associates are mostly put in the district hospitals for much of their training in provinces linked to the three institutions, namely the Eastern Cape (WSU), Gauteng (Wits & UP), Mpumalanga (UP), North

West (Wits), and SAMHS (Wits & UP). Once the clinical associates graduate, they can do history taking and physical examinations, deal with emergencies, and conduct routine diagnostic and therapeutic procedures only under the supervision of a physician.

The progress in the production of clinical associates has not been of a high level as there are factors such as practical difficulties associated with setting up and implementing new training programmes, constraints in adopting new cadres into the existing health system, tensions between different cadres over role definition and working conditions, and the "brain drain" into the private sector (Doherty *et al.,* 2013:1). The clinical associates are more saturated in the public sector. Even though there are opportunities available in the private sector, there is a fear that they might be exploited by performing activities that the physicians should perform but will be paid for (Doherty *et al*., 2012:102). This can cause legal problems for the clinical associates being exposed to litigation cases as their skills are generalist rather than specialist (Doherty *et al.*, 2013:1). According to Doherty *et al*. (2013:149) and Doherty *et al.* (2012:833), the clinical associates' scope of practice only allows them to work under the direct supervision of a physician and therefore the physician acts as their role model and mentor. Historically, the relationship between the physician and the PN was characterised by hierarchy, medical supremacy, and nursing subservience (Tang *et al*., 2013:292). Traditionally, the professional relationship between PNs and physicians was also characterised by dominance of the physician, lack of teamwork due to role confusion and poor communication, as well as status, gender, power, and perspectives (Qolohle *et al*., 2006:17; McKay & Narasimhan, 2012:52). Leape *et al*. (2012:845) also added that there is a level of disrespect between the PNs and physicians, poor communication and teamwork, belittling treatment of PNs, and passive-aggressive behaviour. According to Tang *et al.* (2013:292), until today, these hostile and confrontational relationships also exist in many Western countries. Therefore, out of the researcher's experience, PNs feel threatened by the introduction of this new cadre of healthcare professionals hierarchically and due to poor role clarification. Hierarchical structures are usually associated with power and authority. Due to the fact that clinical associates are seen as physicians' assistants, clinical associates themselves and other HCPs could see them as higher in the professional hierarchy than PNs. Therefore, there is a potential risk that the professional relationship between PNs and clinical associates could be affected.

1.4 SIGNIFICANCE OF THE STUDY

There are previous studies done internationally; however, they are more specifically focussed on the role of the clinical associates and other HCPs in a practice environment (PE) as perceived by the physicians. The importance of non-physician providers in the PE such as

clinical associates who possess the necessary skills and knowledge to provide care to patients is well known (Burgess *et al*., 2003). Even though international studies were done about physician assistants (known as clinical associates in South Africa), there is no evidence of such studies in the South African context, especially regarding the professional relationship among PNs and clinical associates.

Therefore, this study is unique and significant in the South African context. Completion of this study will contribute to the body of knowledge and provide scientific evidence about the current professional relationship between PNs and clinical associates. This scientific knowledge could potentially strengthen the professional relationship between PNs and clinical associates and improve service delivery to patients.

1.5 PROBLEM STATEMENT

There have been studies done internationally on the role and relationship of physician assistants, known as clinical associates in South Africa, and other HCPs, especially physicians. However, these studies do not address the professional relationship specifically between the PNs and the clinical associates who also work very closely together in the PE. The professional relationship between HCPs in the PE is pivotal to improve service delivery to patients. According to Couper and Hugo (2014:5), a professional relationship is vital to the effective functioning of all HCPs and forms a basis of teamwork. According to Doherty *et al.* (2012:835), there is a concern that there could be confrontations and tensions between the clinical associates and the existing healthcare team in which PNs are included.

According to the clinical associates' scope of practice, they must work under direct supervision of a physician and the physician acts as their role model and mentor (Doherty *et al*., 2013:149; Doherty *et al.,* 2012:833; South Africa, 1974). However, throughout history, the professional relationship between PNs and physicians (who are the role models and mentors of the clinical associates) was characterised by dominance of the physician, lack of teamwork due to role confusion and poor communication, as well as status, gender, power, and perspectives (Qolohle *et al*., 2006:17; McKay & Narasimhan, 2012:52). Physician is the clinical associates' role model and mentor and clinical associates obtain their qualification in a medical school in comparison to PNs that obtain their qualification in either a School of Nursing Science or a Nursing College. From the researcher's experience in the PE, there are professional hierarchal challenges between PNs and clinical associates, because some clinical associates consider themselves superior based on the fact that they obtained their qualification in a medical school and due to their scope of practice as they must work closely with the physicians.

This study is strengthened by the fact that no previous studies could be found in the South African context focussing on the professional relationship between PNs and clinical associates. Therefore, the following research questions are posed.

1.6 RESEARCH QUESTIONS

- What are PNs' perceptions of the professional relationships between themselves and clinical associates?
- What are clinical associates' perceptions of the professional relationship between themselves and PNs?

1.7 PURPOSE AND OBJECTIVES OF THE STUDY

In the following section, the purpose and objectives of the study are given.

1.7.1 Purpose of the study

The purpose of the study was to explore and describe both the PNs' and clinical associates' perceptions of the professional relationship between them.

1.7.2 Objectives of the study

To achieve the purpose of the study, the objectives were:

- To explore and describe the PNs' perceptions of the professional relationship between themselves and clinical associates.

  To explore and describe the clinical associates' perceptions of the professional relationship between themselves and PNs.

1.8 RESEARCH ASSUMPTIONS

The meta-theoretical and theoretical assumptions of this study are discussed below to define the structure according to which the researcher conducted the study.

1.8.1 Meta-theoretical assumptions

Meta-theoretical assumptions explain the researcher's view of the world and their natural philosophy and therefore cannot be tested (Botma *et al*., 2010:187). The researcher is a Christian and thus believes in the teachings, values, and beliefs of the Bible and believes that God created man to reign over creation and be an inhabitant of the earth to honour Him. These teachings, values, and beliefs will help the researcher formulate her assumptions regarding man, environment, health, and nursing.

- **Man**

The researcher believes that all human beings are holistic beings characterised by physical, psychological, and spiritual aspects. All human beings are created by the image of God (Bible, 1995) and therefore nobody is superior to another irrespective of their background. The physical is the body which represents the physiological part, the psychological is the mind which is for emotions, and the spiritual aspect is that integral part that is in relationship with God.
In this study, *man* refers to the PNs and clinical associates working in the district hospitals in Gert Sibande district, Mpumalanga Province. Both PNs and clinical associates are unique human beings but also important members of the HCP team and community.

- **Health**

According to the WHO (1948), health is defined as a "state of complete physical, mental and social well-being, not merely the absence of disease or infirmity". To heal means the restoration of wholeness or health, thus the extrinsic and intrinsic environments influence a human being's health. The professional relationships of HCPs, especially PNs and clinical associates, have a direct influence on service delivery as they work very close together. The researcher believes that the kinds of relationships a human being enters into during his or her lifetime are greatly influenced by extrinsic factors. Their professional relationship among HCPs is paramount as it has the potential to affect the *health* of the patient, the healthcare system, and service delivery. The researcher also believes that having a good attitude, being emotionally stable, and recognising the emotional needs of others all contribute to effective professional relationships.

- **Environment**

The *environment* of this study refers to district hospitals, specifically the outpatient, casualty, or theatre departments where PNs and clinical associates render health services to individuals, families, and community.

- **Nursing**

The International Council of Nurses (ICN, 2010) defines nursing as a profession that encompasses the autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. According to the South African Nursing Council (SANC, 2005), nursing is a regulated profession comprising a body of scientific knowledge and skills practised by persons referred to in section 30 of the Nursing Act and registered in terms of section 31 of the Nursing Act. Nursing also includes the promotion of health, the prevention of illness and the care of ill, disabled, and dying people. Nursing is thus not a profession of merely addressing people's physical health, but a profession of touching lives every day and assisting with spiritual health. Hence, successful nursing of patients is based on a professional relationship of HCPs, especially PNs and clinical associates who are the focus of this study, to ensure optimal service delivery.

1.8.2 Theoretical assumptions

The theoretical assumptions include the central theoretical statement and conceptual definitions of this research study.

1.8.2.1 Central theoretical statement

In the following section, the central theoretical statement and conceptual definitions are discussed.

The exploration and description of the PNs' and clinical associates' perceptions of the professional relationship between themselves assisted the researcher in formulating recommendations for nursing practice, research, nursing education, and policy on strengthening their professional relationships.

1.8.2.2 Conceptual definitions

- **PNs**

  A PN is someone trained by a professional body or institution to care for the sick, skilled, and competent in their own category of nursing as stipulated by the SANC. A PN is registered as a nurse in terms of the Act on Nursing, Act 50 of 1978 as amended in 2005 (Act 33 of 2005; SANC, 2005), who had completed a four-year degree or diploma in nursing. In this study, a PN refers to PNs working in a hospital in Gert Sibande district, Mpumalanga Province.

- **Clinical Associates**

  Clinical associates are the relatively new MLWs in South Africa, who completed the three-year BCMP degree of a tertiary institution. They were introduced to address the shortage of physicians within the district health system and community health centre level of the public healthcare sector (South Africa, 2011:69). In this study, a clinical associate refers to a person working in a hospital in Gert Sibande district, Mpumalanga Province in the outpatient, casualty, or theatre departments.

- **Professionalism**

  Professionalism refers to the professional attributes of the practitioner who practises the profession and it implies that she or he fulfils all the expectations of the professional practitioner (Muller, 2009:7). The Registered Nurses' Association of Ontario (RNAO, 2007) describes professionalism in nursing as an essential ingredient in achieving a healthy PE and is enabled by the context of practice. Professionalism elicited by HCPs has different characteristics. Nik Mat and Zabidi (2010:139) mentioned that a professional is a person that is valued by humanity and elicits a respectable reputation, takes pride in their work, and pledges commitment to quality care and service delivery. Professionalism between PNs and clinical associates should involve confidentiality, continuity, trust, honesty, and compassion to achieve good professional relationship.

- **Professional relationship**

  A professional relationship amongst HCPs is the basis of the entire healthcare system and has its own unique demands and concerns which may affect service delivery and patient

care (Grosz, 2012:2). Establishing proper professional relationships between HCPs such as PNs and clinical associates is pivotal for effective service delivery.

- **Scope of practice**

  Scope of practice means the parameters within which a category of nurse who has met the prescribed qualifications and registration requirements may practice (SANC, 2005).

- **Service delivery**

  Mdluli (2008) defines service delivery as the overall name for every activity performed to render quick and safe services in order to respond and resolve community or citizen problems. In this study, service delivery refers to the service delivered by both the PNs and clinical associates to the patients in the outpatient, casualty, or theatre departments in the district hospitals.

1.8.3 Literature review on key concepts

HCPs are the backbone of every country's healthcare system (Rabie *et al*., 2017:2; Wiklund, 2016:1). However, globally, there is still a critical shortage of HCPs and the situation is worsening (Darzi & Evans, 2016:2577). WHO (2015) mentions that the shortage of HCPs is further worsened by the fact that their skills, competencies, clinical experience, and expectations are often not on par with the needs of the communities they serve. This shortage is also weighing heavily on the outpatient, casualty, and theatre departments. According to Khan and Al Johani (2014:58), the casualty department staff is the first line in dealing with all types of medical emergencies and disasters. The WHO further alludes that over 400 million people worldwide have no access to quality healthcare services due to HCPs shortage, imbalanced skill mix, and uneven geographical distribution of the HCPs (WHO, 2015). According to the WHO (2015), 6% of this population which are from low- and middle-income countries are driven further into poverty. This is due to spending more money on healthcare. With the introduction of the MLWs, referred to as clinical associates in South Africa, the international experience suggests that their role has been pivotal in addressing human resource shortages and improving healthcare access to equity, especially in low- and middle-income countries (Hooker & Everett, 2012:20), hence the worldwide introduction of MLWs to address the issue of a shortage of HCPs. The MLWs are described as a category of HCP who render

healthcare in communities and hospitals with a more restricted scope of practice than other professionals (Lehman, 2008:2). Lassi *et al*. (2013:825) define MLWs as the frontline health workers in the community who are not physicians but who have been trained to diagnose and treat common health problems, to manage emergencies, to refer appropriately, and to transfer the seriously ill or injured for further care such, as PNs and clinical associates. Both these HCPs play an important role in service delivery and carrying out physician's orders regarding the patient. As the two professions, the PNs and clinical associates, have to work together in the district hospitals, it is vital for them to always strive for teamwork and a good professional relationship which shows professionalism at all times. The PNs should always practise within their scopes of practice in the provision of quality patient care and without compromising service delivery.

An in-depth discussion of each of the key concepts of this study (PNs, clinical associates, professionalism, professional relationship, scope of practice, and service delivery) follows.

PNs

In the following section, the international and national history of PNs is discussed.

- **International history of PNs**

The history of nursing as a profession can be traced back to as far as 300 Anno Domini (AD) during the height of the Roman Empire (Smith, 2017:1). It was during this time, as stated by Smith (2017:1), that the Roman Empire looked into building a hospital in each town under its rule, leading to a high need for PNs who worked alongside physicians to assist in the in-patient medical care (Smith, 2017:1). This marked the entry of women in particular in nursing leading into the 19th century where professional nursing programmes were introduced.

The word nurse originated from the Latin word *nutrire* which means to suckle (referring to breastfeeding), attaining its modern meaning of a person who cares for the infirm in the late 16th century. The profession of nursing in general became more prominent in Europe in the middle ages. In Europe, before modern nursing, Catholic nuns and the military were responsible for the provision of nursing-like services. During the middle ages, the majority of nurses were nuns and even monks because nursing was largely based on religion (Nursing School Path, 2012). In this period, there were many innovations and advancements that took place which eventually went on to form the basis of contemporary nursing, as it is currently known (Smith, 2017:2). Two fully developed hospitals were built within the great city of Constantinople which had both female and male nurses (D'Antonio & Buhler-Wilkerson, 2013). These nurses were

referred to as *hypourgoi* for men and *hypourgisses* for women. They played an important role in pushing nursing forward at a more global scale.

Around late 500 and early 600 AD, the first Spanish hospital was built in Merida, Spain, with many of its nurses supplied by the Catholic church (Smith, 2017:2). These nurses were working under clear instructions to care for the sick irrespective of their religion or ethnic origin. However, in 800 AD, the European hospitals began to deteriorate due to negligence until Emperor Charlemagne began to restore and equip them with the latest medical equipment of that time.

According to Smith (2017:2), the dawn of the 10th and 11th centuries saw the nursing profession beginning to expand due to changes in rulings within Europe like monasteries and cathedrals. Monasteries started running hospitals in their premises, as well as a separate infirmary. The separate infirmary was used only by those identified as religious (D'Antonio & Buhler-Wilkerson, 2013). An infirmary is a place where sick or injured individuals receive care and treatment (Merriam-Webster Dictionary, 2018). During this period, nurses provided a wide range of medical care services, as was required, even beyond traditional healthcare (Smith, 2017:2). This kind of all-encompassing nursing model gained popularity in Germany and France and continues to be used and serves as guideline on how nurses are expected to treat patients even today (D'Antonio & Buhler-Wilkerson, 2013). During this period, it was mandatory for churches to have hospitals within their structures. However, this became a challenge with time as the churches were finding it difficult to maintain and keep the hospitals in a good condition. The priests were required to assist in the hospitals within their churches. This brought about a positive outcome in the short and long term; Germany managed to build over 150 hospitals between the years 1200 and 1600, expanding the role of nurses in Europe dramatically (D'Antonio & Buhler-Wilkerson, 2013). At the beginning of 17th century, nursing was negatively affected due to the monasteries being shut down during the Protestant reformation (Smith, 2017:2).

The roots of the modern nursing began to take shape in the 18th and 19th centuries. These are the years that saw Britain and North America at the forefront of innovations within the nursing industry. This was the era of Florence Nightingale, a well-educated daughter of wealthy British parents. Florence Nightingale began her nursing career within the Crimean war in the mid-1850s, tending to the injured soldiers. Florence Nightingale played a significant role in changing the face of the nursing profession in the 19th century. She wrote a book named *Notes on Nursing* between 1856 and 1860 which served as a guideline for nurses (Nursing School Path, 2012). According to D'Antonio and Buhler-Wilkerson (2013), it was during this time that the role of nurses continued to expand as their expertise was needed on the front lines of wars, form the

Crimean war to the Civil war. Florence Nightingale campaigned for improved hygiene standards in the hospitals attending the injured soldiers. The nursing profession flourished in Europe when Florence Nightingale opened the first nursing school in London called Florence Nightingale School for Nurses (Nursing School Path, 2012). This was the beginning of many other nursing schools being founded for prospective nurses to receive their training and education.

Even though Florence Nightingale made a huge mark in the 1800s, there are other nurses who provided advancements to nursing in the 1800s. These included nurses like Clarissa Harlowe Barton who founded the American Red Cross after the Civil war, and Malinda Ann Judson-Richards and Agnes Elizabeth Jones who helped create nursing schools throughout the USA and Japan during the mid- to late 1800s (Nursing School Hub, 2015).

At the end of the 19th century, more nurses started working towards changing policy in leadership and education in nursing schools, acknowledging their role as more than that of a bedside caregiver. During the second half of the 20th century, the number of baccalaureate and graduate programmes in nursing grew rapidly (Nursing School Path, 2012).

- **National history of PNs**

For most parts of the 19th and early 20th centuries, religious institutions were predominantly responsible for nursing education as nursing was historically viewed as a religious vocation. In South Africa, formal nursing education was set up by an Anglican Sister, Henrietta Stockdale, on the Kimberley Diamonds mines in 1877 (Blaauw *et al*., 2014:2). Before 1976, nursing training was hospital-based as it was viewed as a “hands-on” career. It was around 1984 when the SANC, which was established in 1944, gradually introduced nursing in the tertiary education system in the form of a four-year degree in line with the nurse-based PHC approach in South Africa (Blaauw *et al*., 2014:2). The SANC is a juristic body that has been established to control nursing practice in South Africa (Act No. 33 of 2005). According to Blaauw *et al*. (2014:2), the first university degree programmes in the country were introduced in 1956 with a relatively small uptake. The SANC therefore has the responsibility to regulate the training of nurses, accredit training facilities, monitor the process of nursing education in different institutions, and enable nurse practitioners to practise through a process of licensing and registration (Bezuidenhout *et al*., 2013:2). In 1986, a more significant policy shift was brought about as stated by Blaauw *et al*. (2014:2), whereby all nursing colleges throughout South Africa were required to be affiliated with university-based nursing departments, placing the nursing colleges within the higher education system. It was during this time that the scope of practice and nursing curriculum were amended. There is also a four-year diploma done in the nursing colleges. Even though the nursing qualifications are obtained from different institutions, on completion, the university and

college trained PNs earn the same salary and follow the same stream of training regulated by the same Nursing Act, Act no. 50 of 1978 as amended with specifications stipulated in Regulation 425 (R.425; SANC, 2005). The new curriculum of new nursing courses has been introduced and will take effect in 2020.

South Africa's DoH, after consultation with the SANC, has through section 40(3) of the Nursing Act 2005 (Act No. 33 of 2005) and in the Regulations Relating to Performance of Community Service published in the Government Notice No. R765 of 24 August 2007, introduced the one-year community service for the newly qualified nurses, both from university and nursing college in 2008. The main objective of introducing the community service for nurses for a period of one year was to promote equal distribution of health services to the people of South Africa as well as to assist nurses to develop further practical skills, knowledge, critical thinking, and professional behaviour during the period of compulsory community service (Hatcher *et al*., 2014:2).

In 2019, the current nursing curriculum was phased out to accommodate a new modified curriculum. The changes in curriculum were brought upon by the NDoH and SANC. For PNs, it will now be a four-year bachelor's degree as compared to a four-year diploma of the previous curriculum. In the following section, the researcher elaborates on the international, sub-Saharan, and South African history of clinical associates. The clinical associates play a broad and expanding role in the healthcare system, internationally and locally, and it is therefore important to understand the beginning of the clinical associate cadre.

CLINICAL ASSOCIATES

History of clinical associates

In the following section, the history of clinical associates is discussed using the following headings: international, sub-Saharan, and national history.

- **International history of clinical associates**

Like so many other countries in the world, the South African health system faces a human resources crisis with rural areas most affected (Moodley *et al.,* 2014:1).The worldwide shortage of HCPs, particularly physicians, led to the birth of the MLWs concept which was introduced in many countries (Eyal *et al.,* 2016:149). The difference between a MLW and an HCP is that MLW is a cadre trained for two to five years to acquire basic skills in diagnosing, managing common conditions, and the prevention of diseases through health promotion (WHO & Global

Health Workforce Alliance [GHWA], 2013:10). In their first year, the MLWs learn clinical theory and practice in the medical school of a University with their focus being on a detailed medical history, conducting a thorough physical examination, and determining possible diagnosis, as compared to PHC PNs who are also trained to do history taking, physical examination, diagnosis, and treatment. The remainder of the other two years is spent on clinical practice at allocated hospitals where a mentor (physician) is allocated to them. An HCP can be described as an individual who provides preventive, curative, promotive, and rehabilitative healthcare services in a systematic way to individuals, families, or communities.

Even though the MLWs have been in the health system for over 100 years, their role has only been taken seriously in the last 10 years in the light of Millennium Development Goals (MDGs) (Lassi *et al*., 2013:824) which were replaced with Sustainable Development Goals (SDGs) in 2015. The set of MDGs' eight measurable goals and 21 targets was from 2000-2015, and was replaced with SDGs 17 goals and 169 targets from 2015-2030 (Kumar *et al*., 2016:1). Globally, the concept of clinical associates, also known as physician assistants, was first introduced by the USA as part of addressing healthcare professionals' shortages and uneven distribution of physicians in 1960s. Over the years, the clinical associates' profession expanded globally from giving vaccinations against small pox in India in the late 19th century to being medical assistants for physicians during World War II in Papua New Guinea (WHO & GHWA, 2013:13). According to Danielsen *et al*. (2012:10), military veterans of the mid-1960 era who had served as medics in the military were given training to provide medical support under the supervision of a physician. However, on their return from World War II, the medics could not be utilised anywhere; Duke University in the USA was the first university to expand upon their skills to meet the need for more HCPs and to address the shortage of physicians. The educational model for physician assistants was based on the fast-tracked training of physicians during World War II. Hooker *et al*. (2011:709) mentioned that the physician assistants in the USA have proved their competence, skills, and usefulness over 30 years, from 50 accredited programmes in 1971 to 5700 available first year physician assistant student positions to an expected 5300 new physician assistants graduating every year (Miller *et al*., 2011:3). In the USA, the role of physician assistants is clear with over 70 000 practising in 2010 and the numbers are expected to grow to over 125 000 in 2025 (Hooker *et al*., 2011:708). This has led to other countries such as Australia, Canada, Britain, the Netherlands, Germany, Ghana, and South Africa following suit. According to Miller *et al.* (2011:1), in Australia, the MLWs were considered as a possible solution given the challenges faced by the healthcare services in the country. Consideration of MLWs was mainly due to an ageing population, increased patient expectations, and the burden of chronic illnesses putting a strain on a health system that is already understaffed.

The concept “clinical officers” is mostly used in other parts of sub-Saharan Africa but was deemed “militaristic” or “rank-related” in the South African context. Thus, the term “clinical associates” was born in South Africa.

- **Sub-Saharan history of clinical associates**

Fifty-seven countries worldwide have a critical shortage of HCPs which is equivalent to a global deficit of 2.4 million physicians, PNs, and midwives, of which 36 of these countries are located in sub-Saharan Africa. In the Western pacific region, the ratio of physicians to PNs is 1:5, while in the sub-Saharan African region a ratio of 1:8 exists, which places emphasis on the importance of MLWs to assist in these regions. MLWs are found in their majority in South East Asia and are the backbone of the PHC system in East Africa, with more than 10 000 clinical associates trained in Uganda, Tanzania, and Kenya alone. Kwesigabo *et al*. (2012:39) mentioned that in Tanzania, for instance, there is a very small proportion of HCPs as compared to MLWs. The clinical associates, like all other MLWs such as pharmacist assistants, dental assistants, and nurse assistants receive less training and their scope of practice is more restricted than other HCPs (Kwesigabo *et al*., 2012:39). The shortage of HCPs has renewed an interest in most parts of Africa to vigorously train and integrate the MLWs in the healthcare system. Countries like Zambia have been training clinical associates since 1936 to provide service at PHC level and also in anti-retroviral treatment programmes due to an increased number of patients seeking treatment and care. In Burkina Faso, a six-month special curriculum was developed to train clinical associates in emergency surgery whereas in Nigeria, a similar curriculum was developed as a one-year course. WHO and GHWA (2013:104) predict that the world will be short of 12.9 million HCPs by 2035; currently, that figure stands at 7.2 million. The WHO report and GHWA (2013:104) further mentioned that the deficit of HCPs specifically in sub-Saharan Africa is estimated at 1.8 million and is expected to increase to 4.3 million by 2035. While reasons for human resources in health crisis differ from country to country, Jensen (2013:19) identified four common underlying reasons: the insufficient supply and training of health workers, their inadequate distribution, their inefficient utilisation, and migration. According to Webb (2011:7), Europe trains 173 800 physicians a year as compared to 5 100 physicians trained per year in Africa. That is about 34% less physicians trained in Africa as compared to Europe. In all the 47 sub-Saharan African countries, there are only 168 medical schools. Eleven of these countries have no medical schools and twenty-four countries have only one medical school each. This lack of medical schools leads to insufficient production of qualified physicians and is continuing to impact negatively on the African continent due to 24% of the world’s disease burden on its shoulders, according to 2015 WHO data. With the 24% disease burden, Africa has access to only 3% of HCPs and less than 1% of the world’s financial resources.

The poor state of health systems in many African countries is a red flag to HCPs. Other countries such as Ethiopia have 0.2 physicians per 1000 people, Uganda 0.12 physicians per 1000 people, Egypt 2.3 physicians per 1000 people, and South Africa 4.3 physicians per 1000 people (WHO, 2015). These rather disturbing statistics can be pinned to the medical brain drain whereby high-income countries such as Australia, Canada, Saudi Arabia, the US, the UK, and the United Arab Emirates recruit medical graduates from developing regions including countries in sub-Saharan Africa, leading to the relatively high physician-to-population ratio (Ighobor, 2017). Medical brain drain refers to the departure of educated or professional people from one country, economic sector, or field to another, usually for a better salary or better living conditions (Merriam Webster Dictionary, 2013). The WHO then tried to curb the medical brain drain by developing a code of practice on international recruitment of HCPs. Brain drain is the emigration of highly trained or qualified people from a particular country to another. The code of practice was adopted in 2010. The purpose of the code was to urge high-income countries to support affected countries which are mostly developing countries by reducing the medical brain drain. However, Ighobor (2017) also stated that the code did not yield any positive results as it was more a moral guide than an enforceable legal instrument. The WHO (2013:9) noted that the shortage of HCPs is a major obstacle to the realisation of the MDGs which have since been replaced with SDGs and other international health goals such as good health and well-being including universal coverage. Campbell *et al*. (2013:860) maintains that achieving universal coverage and improved health outcomes depends critically on human resources for health, as healthcare is by nature labour intensive. Hence the introduction of the clinical associates, which is still a young fast-growing profession that is moving into global health in response to the overwhelming needs of the healthcare workforce created by multiple issues affecting health and health disparity. Most of these clinical associates are recruited from rural and poor areas and tend to work in those areas. One of the reasons the concept of clinical associates was implemented is that clinical associates are less likely to move within the country or overseas than the physicians and PNs. Within physicians' and clinical associates' relationship, clinical associates exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services.

- **National history of clinical associates**

In 2011, in an effort to curb the shortage of HCPs in South Africa, the South African government launched a Human Resource for Health Strategy for South Africa under the heading *A Nation at Work for a Better Life for All* with the aim of addressing human resources development needs throughout the country. However, the shortage of HCPs, in particular medical physicians, in South Africa still paints a bleak picture in the light of the planned National Health Insurance scheme. According to economics research consultancy Econex (2015:8), up to 17% of newly

qualified physicians might be emigrating, while up to 80% of these physicians prefer not to work in the public sector due to poor working conditions. South Africa as compared to other middle-income countries in terms of ratios has the lowest. In 2013, there were just 25 state physicians and 92 private sector physicians per 100 000 patients in South Africa. The average is 60 per 100 000 while the global average is 152 per 100 000. Ratios per 100 000 from other middle-income countries as compared to South Africa are: India (70), Brazil (189), and China (194) (Econex, 2015:8).

For a better life for all to be achieved, there should be strong district health systems that reach even the most disadvantaged and remote communities (Doherty *et al*., 2013:147). According to the Public Health Association of South Africa (PHASA, 2013) the shortage of HCPs in South Africa is a big challenge as it was estimated at approximately 80 000 HCPs in South Africa in 2013. Even though there are private and public health sectors in South Africa, this study is focussed on the public health sector because that is where clinical associates are employed. The PHASA (2013) also noted that the private sector in South Africa employs 70% of the physicians even though it serves only 16% of the population, with 87% of the country's population utilising the public healthcare services (Rabie *et al*., 2016:2) while only assisted by 30% of the country's physicians. One contributory factor as stated by the PHASA (2013) is the failure of the country's medical schools to produce a high graduate output as most universities have the capacity to enrol a certain number of students as per lecturer-student ratio (SAMA, 2015). This, according to the Minister of Higher Education and Training, put the country in danger of falling short of its human health skills target. The PHASA (2013) also noted that graduate output has been a challenge since the 1980s, with the country's medical schools producing on average 1300 physicians annually, and only 35% working in the rural areas for longer.

With the introduction of the National Health Insurance plan, which is currently in its pilot phase, the shortage in the public sector will be even more evident (Econex, 2015:11). This, according to Econex (2015:11), has led to the National Health Insurance being under a big threat due to unequal distribution of HCPs between the public and private sector and urban and rural areas. Moosa *et al.* (2012:795) mentioned that the physicians in the private sector see 22 patients on average per day and work 288 days in a year. Moosa *et al.* (2012:795) further elaborated that based on this workload, 25 569 physicians will be required to serve South Africa's population of 54.002 million. Twenty-one percent (21%) of all metropolitan areas are affiliated to a medical aid in comparison to the 5% of rural households where private care is very limited (South Africa, 2011).

The African National Congress as the ruling party since the first democratic elections in 1994 had always endorsed the concept of MLWs (Doherty *et al*., 2013:149). Even though there was initially opposition from some quarters regarding the introduction of this new cadre of MLWs, their doubts were deflated through a process of consultation with different stakeholders. The stakeholders consulted, as stated by Doherty *et al*. (2013:149), included PHC PNs and physicians, provincial and national ministries of health and politicians, the ministry of education, medical schools, professional organisations of physicians and PNs, and professional councils. The decision was taken in December 2002 to develop and implement a strategy by the then South African National MoH Dr Manto Tshabalala-Msimang through the National Health Council (Couper & Hugo, 2014:2; Moodley *et al*., 2014:14; Doherty *et al*., 2012:833) as one of the measures to increase healthcare in district levels. In 2005, the National Task Team presented the curriculum and the course outline to the deans of eight medical schools in South Africa. Only three medical schools, WSU, UP, and Wits, responded positively to the invitation to offer the BCMP degree. Even though the training of the new cadre of clinical associates was introduced in 2005, the actual training started in January 2008 at WSU with 23 students. Since the beginning of training in 2008, the number of BCMP degree graduates has since increased to 400 in 2014 (Couper & Hugo, 2014:2874).

In South Africa, the BCMP degree programme is divided into three parts that are designed to produce the defined outcomes for the programme. The first part which is the first year is mainly focussed on individual health, the second year on family health, and the third year which is the final year on applied clinical practice and the hospital's role within the community (Clinical Associates Programme Snapshot, 2014:5). It can be said that the clinical associates were introduced to bridge the gap between both the urban and rural divide, in other words, the well- and under-resourced areas. Even though the student clinical associate receives early training at the university, within weeks they are dispersed to selected district hospitals that qualify and have the capacity to train the clinical associates. According to Koza (2014: online), district hospitals are an ideal starting point to train the clinical associates due to their well-defined and manageable level of care, as their competencies are directly in relation to the profile of diseases and conditions at district hospital level (Doherty *et al*., 2012:1). Bac *et al*. (2017:16) state that in 2016, Mpumalanga province made use of around 100 clinical associates. They formed about 10% of clinicians in the public sector in Mpumalanga. This had a great financial impact on the budget of the district hospitals and the province in general (Bac *et al*., 2017:16).

According to the NDoH, it is expected of the clinical associates to perform their duties within the PHC facilities and district hospitals. In district hospitals, they are currently mostly placed in outpatient, casualty, and theatre departments of the public healthcare sector, but can also be

placed in medical-surgical units and maternity units where they assist the physicians in basic surgical procedures such as incision, spinal anaesthesia, circumcision, evacuations, drainage, and caesarean sections including assisting physicians with emergencies (South Africa, 2011; Moodley *et al*., 2014:3). Doherty *et al*. (2013:149) also mentioned that the clinical associates' scope of practice includes patient consultation and physical examination, routine diagnostic and therapeutic procedures, assisting with emergencies, and inpatient care and counselling. Clinical associates, as stated by Doherty *et al*. (2013:149), perform most of the medical routine tasks, giving medical physicians' ample time to attend to more complex tasks. They also relieve the nursing staff of some of the duties that they are currently performing even though they are outside of their scope of practice. This is a form of task-shifting that takes place and is common in resource-poor settings (Ferrinho *et al*., 2012:34). With the introduction of clinical associates, it is expected that other HCPs will focus on fulfilling their own roles. The hospital care will be strengthened as the clinical associates will provide better access to healthcare for the rural communities thereby reducing the need for referrals (Doherty *et al*., 2013:149).

PROFESSIONALISM

Professionalism in the 21st century has progressed from a hierarchal practice that was defined by social structures to consider not only the knowledge and skills of HCPs but also their attributes and behaviours that must meet the expectations of society and the profession (Dhai & McQuoid-Mason, 2008:2; Wearn *et al*., 2010:1314). There is no universally agreed upon definition of professionalism in healthcare particularly (Hays *et al*., 2013:500). According to Morgan *et al*. (2014:28), professionalism can mean different things to different HCPs and therefore has proven difficult to define. The Merriam-Webster dictionary (2013) defines professionalism as the "conduct, aims, or qualities that characterise or mark a profession or a professional person". The term professionalism has also been described as "a broad term used to include conduct, aims and qualities that characterise a professional or a profession and relates to the behaviour expected of one in a learned profession" (Naidoo, 2016:166). The purpose of professionalism as stated by the Nursing and Midwifery Council (2017:3) is to "ensure the consistent provision of safe, effective, person-centred outcomes that support people and their families and carers to achieve an optimal status of health and wellbeing". Professionalism has been linked to improving care, safety, quality, and experience of patients in the PE (Dupree *et al*., 2011:447) and it is underpinned by continuing professional development (Morgan *et al*., 2014:28) and lifelong learning (Konukbay *et al*., 2014). In healthcare, professionalism can be regarded as the moral contract between society and the profession (McQuoid-Mason & Dada, 2011:39) as it sets values and standards that patients can expect

from the HCPs who care for them (McQuoid- Mason & Dada, 2011:39). According to Egener *et al*. (2017:1091), professionalism is based on a specific set of principles and commitments that are related to the thoughts and actions of a given profession. The term professionalism for HCPs can give guidance for decision making in the rapidly changing and ethically challenging PE (Egener *et al*., 2017:1091) as good health and care results are highly dependent on the professional practice and behaviour of HCPs.

Professionalism has also been used in various ways with Wynia *et al*. (2012:1327) arguing that there is HCP professionalism which is a normative belief system about how best to organise and deliver healthcare. According to Dhai and Etheredge (2011:16), HCP professionalism is extensive in public commitment as the HCPs are subjected to a professional code of conduct with corresponding ethical and moral obligations. Hence, HCPs are expected to present competent and skilful behaviour aligned with their profession (Van Wyk, 2014:1). Wynia *et al.* (2012:1327) further articulated that HCPs should collaborate to continually define, debate, distribute, and enforce the shared competency standards and ethical values that govern their work. Professionalism is much more than appearance and it requires recognition that healthcare is not restricted to external technical tasks which are the "what" of healthcare delivery; it is also about the internal human qualities which are the "how" of healthcare delivery (The Scottish Government, 2012:14).

Even though, as stated by Lesser *et al*. (2010:2732), professionalism may not be enough to drive the profound and far-reaching changes needed in the healthcare system, without it the healthcare system cannot fully function. In the PE, professionalism can be enabled by clearly laying out the employer's responsibilities, fostering a positive PE to raise issues like safety, quality, and experience when they arise (Nursing and Midwifery Council, 2017:4). The Nursing and Midwifery Council (2017:4) emphasised that in so doing the PE will be one that supports and enables professional practice and behaviours by:

- recognising and encouraging leadership,
- enabling autonomous and innovative practice,
- enabling positive inter-professional collaborations,
- enabling practice, learning, and development, and
- providing appropriate resources.

Within the context of healthcare delivery, professionalism should be viewed and accepted as a fluid construct as it is dynamic and multi-faceted and therefore applicable to all who work as part of a multi-disciplinary team, regardless of their title, status, role, or designation (Morrow *et al*., 2011:11). Professionalism should be based on trust and putting the needs of the patients above all other considerations (Brennan & Monson, 2014:644), which is the main focus of service delivery; in other words, quality patient care. According to Dupree *et al*. (2011:448), disruptive and unprofessional behaviour that goes unaddressed in the healthcare environment poses a threat to patient safety. It is important that HCPs work collaboratively to ensure that the appropriate causet-effective healthcare is provided in an efficient and timely manner (Jacobson, 2012:9). Ghadirian *et al*. (2014) further allude to the fact that professionalism should be defined in the science and practice of nursing in order to comprehend its nature and attributes. With professionalism, the HCPs are expected to incorporate the three principles, i.e., patient welfare, social justice, and respect for patient autonomy when dealing with patients (van Bogaert, 2011:3; Ziljstra-Shaw *et al*., 2011). Moreover, if the public's trust in the HCPs is to be sustained, professionalism is critical in meeting the standards of quality patient-centred care (Dhai & McQuoid-Mason, 2008:2; McQuoid-Mason & Dada, 2011:39).

Professionalism has emerged as a core competency for all HCPs globally (Adkoli *et al*., 2011:841) with maintenance and improvement of knowledge and skills, good communication, and understanding of ethics as its foundation. Professionalism is also associated with increased patient satisfaction, trust, adherence to treatment, fewer patient complaints, and reduced risk of litigation (Bahaziq & Crosby, 2011:1039).

The following eight attributes of professionalism, namely: accountability, advocacy, knowledge, innovation and visionary, collegiality and collaboration, spirit of inquiry, autonomy and ethics, and values are of importance as stated by the RNAO (RNAO, 2007:26-27). In the following table, each of the attributes is elaborated on.

Table 1 Attributes of professionalism (RNAO, 2007)

ATTRIBUTES OF PROFESSIONALISM	
Accountability	• Understanding the importance of the meaning of self-regulation and its implications for practice. • Commitment to work with patients and families to achieve desired results. • Actively engaging in advancement of quality healthcare. • Recognising personal capabilities, knowledge bases, and crucial areas of development. • Using legislature, standards of practice, and a code of ethics to clarify one's scope of practice
Advocacy	• Assisting patients with their health needs. Being involved in professional practice activities and initiatives to enhance healthcare. • Understanding the patients' perspective regarding healthcare. • Being knowledgeable about issues that have an effect on healthcare.
Knowledge	• A body of knowledge that is theoretical, practical, and clinical. • Using theoretical and/or evidence-based rationale for practice. • Using information or evidence from nursing and other disciplines. • Sharing and communicating knowledge with colleagues, patients, families to continually improve healthcare outcomes.
Innovation and visionary	• Fostering a culture of innovation to enhance healthcare outcomes. • Influencing the future of health professions, delivery of healthcare, the healthcare system, and collaboration with other professions. • Showing initiative for new ideas and being involved by taking action.
Collegiality and collaboration	• Developing collaborative partnerships within a professional context. • Acknowledging and recognising interdependence between healthcare practitioners.
Spirit of inquiry	• Being open-minded and having desire to explore new knowledge. • Striving to define patterns of responses from patients, stakeholders, and their context. • Being committed to lifelong learning.

Table 1 Attributes of professionalism (RNAO, 2007) (continue)

Autonomy	• Working independently and exercising decision making within one's appropriate scope of practice. • Becoming aware of barriers and constraints that may interfere with one's autonomy and finding ways to remedy the situation. • Recognising relational autonomy and the effects of the context and professional relationship on this autonomy.
Ethics and values	• Being knowledgeable about ethical values, concepts. • Applying knowledge in decision making. • Being able to identify ethical concerns, issues, and dilemmas. • Collaborating with colleagues to develop and maintain a PE that supports and respects the ethical and professional relationships. • Engaging in critical thinking about ethical issues in clinical and professional practice.

HCPs need to demonstrate attributes of professionalism in their daily practice as it impacts positively on patient satisfaction and health outcomes. The healthcare profession expects its professionals to maintain important values that have a positive impact on patients and other professionals (Lacy, 2017:online). Professionalism should be displayed, as stated by Lacy (2017:online), through meeting moral, confidentiality, and ethical standards. Lacy (2017) further points out that HCPs that demonstrate professionalism are more likely to render patient care of high quality. Maintaining a professional relationship requires a sense of professionalism as well as the desire to work in a positive PE (Richards, 2017:online). Maintaining a professional relationship further requires a good professional image and a positive professional attitude.

The Canadian Medical Protective Association (2012) states that professional image and professional attitude play a pivotal role in portraying professionalism in the PE amongst HCPs. Professional image is there to reassure and comfort patients, families, and communities. This is due to the fact that healthcare delivery relies on integrated care in the form of a multi-disciplinary team. The Canadian Medical Protective Association (2012) further alludes to the fact that healthcare delivery requires a shared understanding of what is expected of each HCP. This can only be achieved by clearly defined roles and accountabilities of HCPs in the PE.

Professional image is part of any profession and the way in which an individual appears to other disciplines and to the general public (Finkelman & Kenner, 2013:86). Finkelman and Kenner (2013:86) also stated that professional image and the perception of a profession impact on relationships with other HCPs and ultimately a profession's self-identity. Professionals can feel less effective if their professional image is viewed in a negative light, impacting on what the profession does or wishes to do. Professional image must be maintained in such a way that the profession will be well represented whenever an HCP mentions his or her line of work to the patient, family, or community. However, according to Al Jarrah (2013:149), the image of nursing in particular has changed in the past 50 years as the nursing profession has been faced with a negative image, resulting in discouraging others from joining the profession. According to Meiring and Van Wyk (2013:4), a study was conducted in the USA, Canada, the UK, and Australia to explore the perceptions of HCPs and the public regarding the professional image of nursing, in particular, and revealed that there are stereotypical and negative views about nursing. This is despite the advances in the nursing profession as nurses still face considerable challenges related to the nursing image. This image impacts on status, power, and the ability of nurses to bring changes in healthcare (Meiring & Van Wyk, 2013:5) as challenges such as generational issues, power, and empowerment can impact professional image (Finkelman & Kenner, 2013:86). Professional image, as mentioned by Finkelman and Kenner (2013:86), is also linked to effective communication which directly has an effect on the PE image, patient satisfaction, and professional relationships.

Professional attitude is also an important factor in ensuring professional relationships. Attitude is defined by Muoghalu and Jegede (2011:355) as a complex tendency of persons to respond in positive and negative ways in a given situation. Negative attitudes are more prevalent among HCPs through labelling, ignorance, communicating in a minimal way, verbal harassment, using unsuitable isolation techniques, and avoidance (Ozakgul *et al*., 2013:929). A number of factors such as low reputation of the profession in the society, no definite job description, no autonomy in the profession, and poor remuneration can determine the attitude of HCPs (Patidar *et al*., 2011:176).

The professional relationship between PNs and clinical associates is especially important in the South African context as they serve a larger population in the public sector and rural areas in terms of healthcare provision.

PROFESSIONAL RELATIONSHIP

In the following section, the professional relationship between PNs and clinical associates is discussed. PNs and clinical associates hold an important place in the healthcare system as healthcare is a team effort. Each of them has a special role to play in improving quality and efficiency and lowering causets. Quality patient care is non-negotiable in healthcare (WHO, 2011:29). It is expected that both HCPs be able to work with colleagues and patients from different walks of life and it is therefore mandatory that they form collaborative relationships with each other. Collaborative relationships can have a positive effect on both the health processes and patient health outcomes (Gucciardi *et al*., 2016:12). Little evidence exists regarding the role of the clinical associates in the hospital setting (Laurant *et al*., 2009:36). But according to Hamm *et al*. (2016:1), the bottom line is that with the presence of clinical associates, more people have access to healthcare. Many physicians rely heavily on PNs and clinical associates to provide care within the PE; however, with the introduction of clinical associates, many physicians' and PNs' views of clinical associates are exceedingly doubtfull, especially regarding the clinical associates' scope of practice.

From the researcher's experience, there is an apparent tension between the PNs and the clinical associates that can potentially affect their professional relationship. The lack of a professional relationship could lead to poor communication, thereby jeopardising patient care regardless of how knowledgeable the HCPs are in their profession (Babiker, 2014:9). A lack of role clarification, especially regarding the clinical associates, has brewed to a certain extent of feelings of uncertainty among the PNs. This is in terms of how nurses view the introduction of the clinical associates in the hospital setting, whereas it was previously the physician and the PN. The questions that arose were more of a superiority nature, whereby PNs felt threatened by the clinical associates. This has potential of leading to negative attitudes and behaviour in the PE. A professional relationship between PNs and clinical associates within the healthcare setting plays a major role in increasing and improving service delivery and quality patient care (Hamlan, 2015:16). The essence of each profession is different yet required to achieve the same goal, which is quality patient care (McKay & Narasimhan, 2012:53). According to the Modern Thought Leaders, there are five important factors in professional relationships (Richards, 2017: online):

- Mutual respect – PNs and clinical associates need to engage in a professional relationship to create a positive and healthy PE for all concerned. For a professional relationship to prevail, each profession needs to respect the talents and beliefs in addition to their respective professional contribution.

- Communication – understanding the benefits of effective communication will help the PNs and clinical associates to focus on developing an environment which is conducive to them as well as the patients.

- Trust – the more the PNs and clinical associates learn about one another, the easier it will be to develop a relationship based on trust and professionalism.

- Welcome diversity – accommodating diversity and being inclusive in the PE are imperative in developing a professional relationship.

- Mindfulness – mindfulness can assist in conflict management between the PNs and clinical associates regarding hierarchal tensions.

There are features that clearly distinguish PNs from clinical associates. Firstly, PNs have completed basic nursing training through a four-year degree or diploma and most have obtained a postgraduate qualification. Therefore, as compared to the clinical associates, their basic training is four years compared to the three years of training for clinical associates. PNs do not practise under the supervision of a physician, unlike the clinical associates. However, the PNs are trained at nursing colleges or Schools of Nursing Science in accordance with the nursing model which places an emphasis on patients and their outcomes, whereas clinical associates are trained in programmes that are more in line with the medical model in medical schools which is more orientated towards disease pathology.

Both HCPs emerge from their training with different viewpoints regarding healthcare and medicine. This can have an influence – good or bad – on their professional relationship. While PNs are afforded an opportunity to specialise in a variety of postgraduate qualifications like trauma, for instance, clinical associates by virtue of their training are specifically focussed on outpatient, casualty, and theatre departments. From a professionalism point of view, this could lead to the two HCPs developing a negative attitude towards each other in terms of a lack of role clarification and professional identity, in particular of the clinical associates, as they are rather new to the public health sector (Mapukata-Sondzaba & Dhai, 2015:26). Without understanding the roles of other HCPs, the process of developing a professional relationship would be a significant challenge. Favourable attitudes about a subject or a group are strongly influenced by knowledge and understanding (Liendo, 2011:3).

When there is a true professional relationship between the PNs and the clinical associates, the PE becomes interpersonally rich and fulfilling, leading to the optimisation of patient care and a positive PE. A positive PE can be defined by features of an organisation that can either smoothen or restrain the professional PE (Rabie *et al.,* 2017:2). Professional relationships in

healthcare are beneficial to both the patient and other multidisciplinary team members. The multidisciplinary team involves a range of healthcare professionals from one or more organisations, working together for service delivery. The professional conduct of one HCP to another HCP is important in ensuring that their professions maintain their continued status and trust in the community. The HPCSA (2017) outlined ethical guidelines on professional relationships which also apply to PNs and clinical associates. These are as follows:

- HCPs need to work collaboratively and cooperatively with other HCPs in pursuit of the best healthcare for all patients.
- HCPs should not discriminate against each other because of their views, their race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any other vulnerability.
- HCPs need to refrain from speaking ill of fellow HCPs.
- HCPs should not make a patient doubt the knowledge or skills of fellow HCPs by making comments about them that cannot be fully justified.
- HCPs should support fellow HCPs who uphold the core values and standards embraced in the HCPSA guidelines.
- HCPs need to advice those HCPs who are impaired to seek professional assistance.

SCOPE OF PRACTICE

Scope of practice is generally defined as the activities than an individual HCP performs in the delivery of patient care (Dommerholt, 2013:59). Looking at the scope of practice between these HCPs, it can be concluded that as much as there are similarities, there are also differences in terms of how the two professions function. Young *et al*. (2007:41) explains that for a profession to grow and develop, the community and the members of that particular profession need to recognise the importance of the profession. The level of training and experience, as explained by Young *et al*. (2007:60), determines the care that HCPs are providing to the patients. Young *et al*. (2007:60) further mentioned that HCPs need to take cognisance of the fact that the scope of practice regulations put emphasis on the professionalism and integrity of the individual professional.

In South Africa, clinical duties and regulations of PNs and clinical associates are formalised and governed by the SANC and HPCSA, respectively (McQuoid-Mason & Dada, 2011:77). In the following section, the PNs' and clinical associates' scopes of practice are discussed and compared.

- **Scope of practice of PNs**

The SANC (Nursing Act no. 33 of 2005) defines scope of practice as the parameters within which a category of nurse who has met the prescribed qualifications and registration requirements may practise. The scope of practice of a nurse entails "the acts and procedures which may be performed by the scientifically based physical, chemical, psychological, social, educational, and technological means applicable to healthcare practice as reflected in the SANC (2014). The SANC is a regulatory body responsible for setting standards of practice and education for nurse practitioners in South Africa. PNs are expected to comply with policies and legislation governing their profession so that they are able to pick up complications and intervene accordingly (Maputle & Hiss, 2010:5). Nursing has been recognised by the community as a profession and assigned a certain status to the profession. Nursing is both a science and an art whereby its knowledge base includes nursing science, philosophy and ethics, bio-psychosocial sciences, skills, and organisational and technological sciences (Mathews, 2012:3). The professional solidarity and sense of identity of nurses have facilitated the autonomy of the profession by means of a prescribed scope of practice (Young *et al*., 2007:41). The Nursing Act, the Acts and Omissions, and the Scope of Practice form the main pillars of the legal framework of professional nursing in South Africa. The PNs' scope of practice does not specify the skills and methods that nurses should use when caring for their patients (Young *et al*., 2007:60). It is therefore the responsibility of every nurse to ensure that she or he is competent to carry out the actions required to meet the needs of the patient as stipulated in the scope of practice.

PNs' scope of practice is more focussed on patient care, whereas the clinical associates' scope of practice is more focussed on patient cure. It should, however, be noted that the role of PNs at PHC level is similar to that of clinical associates in terms of patient history taking, physical examination, diagnosing, and prescribing medication as regulated by R48 (qualification in clinical nursing science, health assessment, treatment, and care).

- **Scope of practice of clinical associates**

The scope of practice for clinical associates is specifically adapted for and defined by the context and needs of district hospitals. According to Hooker *et al*. (2017:51), the scope of practice of clinical associates here in South Africa allows them to assist physicians predominantly, although not exclusively, in the district health services. The emphasis of the

scope of practice is more focused on generalist skills rather than specialist skills (Doherty, 2013:3). The focus of the clinical associates' scope of practice is mainly on emergency care, skilled clinical procedures, and inpatient care (Miller *et al.,* 2011:14). According to Professor Khanya Mfenyana (Executive Dean of Health, WSU), clinical associates' scope of practice is different from that of nurses and similar to that of physicians by virtue of their training taking place in medical schools and their programme which is regulated by the HPCSA (Doherty *et al.*, 2012:102). Clinical associates' scope of practice is intentionally broad as it serves to guide practice and provide protection for clinical associates as well as physicians by clearly defining the roles and responsibilities (Henn, 2016:22). However, some HCPs, e.g., PNs, are uncomfortable with the competency-based scope of practice and rather prefer a more narrowly defined job description for the clinical associates (Doherty *et al.*, 2012:1). This can have a negative impact on the professional relationship between the clinical associates and other HCPs.

Clinical associates' scope of practice is defined within the requirements of district hospitals with a focus on emergency care, skilled procedures, and inpatient care. Clinical associates are permitted to provide any medical service as delegated by the supervising physician only if such service is within his or her scope of practice and is provided under the supervision of a physician. Their scope of practice is further guided by the written clinical protocols of the district hospital.

- **Scope of practice of PNs versus clinical associates**

Differences in scopes of practice of PNs and clinical associates as well as the reporting lines need to be clarified to avoid overlap of roles (Doherty *et al*., 2013:151). According to Doherty *et al*. (2013:152), confrontations around the demarcation of scopes of practice are looming between the clinical associates as well as other HCPs which include PNs.

PNs in the district hospitals cannot order procedures, e.g., x-ray, or interpret results, e.g., blood results, or perform minor surgical procedures, e.g., circumcision, as compared to clinical associates, as it is not in their scope of practice. But clinical associates can perform a great deal of minor surgical procedures such as circumcisions, and order tests and interpret them. Having said that, PHC nurses are more independent as they don't work under supervision in the PHC clinics, as compared to clinical associates.

PNs' scope of practice is more focussed on disease prevention and health promotion. The similarities are that they can both give education and counselling to meet patient needs. In most of the procedures, clinical associates can order, perform, and interpret under the supervision of a physician whereas PNs can only perform and record findings. The difference in their

respective scopes of practice is vast and this can impact negatively on their professional relationship. The difference in scope of practice entails different roles and hierarchical structure which can work against a well-functioning and effective team (Babiker, 2014:2).

Table 2 **Comparison between PNs' and clinical associates' scope of practice (South African Nursing Council, 2005; *Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1987*; Regulation R.2598, in terms of the Nursing Act no. 50, 1978 as amended; South Africa, 1974; Health Professions Act no. 56 of 1974; Regulations defining the scope of practice of clinical associates [Government notice no: R433]; *Government gazette,* 38816, 25 May).**

PNs	Clinical Associates
• The diagnosing of a health need. • The execution of a programme of treatment. • Administration of medication to a patient. • Monitoring of vital signs and side effects to medication. • The prevention of disease and promotion of health. • Family planning, teaching, and counselling. • The prescribing, promotion, or maintenance of hygiene, physical comfort, and re-assurance of patient. • The promotion of exercise, rest, and sleep with a view of healing and rehabilitation of a patient. • Supervision over and maintenance of supply of oxygen. • Supervision over and maintenance of fluids, electrolyte, etc. • Opportunity to specialise in other nursing fields, like PHC, maternity, etc, and therefore being able to practise independently in clinics and maternity wards. • PNs can become specialists in other	• Obtaining patient history and performing physical examination. • Ordering and/or performing diagnostic and therapeutic procedures. • Interpreting findings and formulating a diagnosis for common and emergency conditions. • Developing and implementing a treatment plan. • Monitoring the effectiveness of therapeutic interventions. • Assisting at surgery. • Offering counselling and education to meet patient needs. • Making appropriate referrals to other HCPs. • Working under physician's direct supervision. • Prescribing competencies limited and physician must countersign. • Career path unclear. • Do not have independence and must work under supervision of a physician.

PNs	Clinical Associates
fields such as paediatrics, trauma, and theatre and therefore be considered experts in those fields. • Involvement in research and contributing to formulation of health policies.	

SERVICE DELIVERY

According to McLennan (2009:21), service delivery is commonly understood to mean "the provision of goods or services by a government or other organisations to those who need or demand them". Good service delivery is an important element of any health system (WHO, 2010:3).

Outpatient, casualty, and theatre departments

Outpatient and casualty departments are generally the departments with the highest patient load within the district hospitals and they are characterised by a high degree of complexity. They are also the departments where the clinical associates mainly work. The departments' complexity leads to physicians and nurses being under great pressure, both mentally and physically, due to huge shortages of both types of HCPs in the district hospitals. An increased number of people are being referred to the public outpatient services (Matchar *et al*., 2018:71). It is well researched that public health facilities in rural parts of South Africa are more often than not under-resourced in terms of human resources and equipment, affecting service delivery negatively. Good service delivery means that the persons entrusted to assist the public do their work in such a manner that the needs of the citizens are met at the right time and place. Poor quality healthcare is against the vision and mission statement of the NDoH. The vision of the NDoH is "a long and healthy life for all South Africans" and their mission is "to improve health status through the prevention of illnesses and promotion of healthy lifestyles and to consistently improve the healthcare delivery system by focussing on access, equity, efficiency, quality and sustainability" (South Africa, 2010:10). The vision and mission are supported by the Batho Pele principles. Batho Pele means "putting people first". The Batho Pele principles set the framework for the standard and requirements guiding the performance of public employees and are used as a benchmark on which service delivery is measured (South Africa, 1997:15-22).

Interest in improving global healthcare, including South Africa, is greater than ever, especially to break the cycle of poverty and disease in developing countries (Kim *et al*., 2013:1). The theatre

department is no different from the outpatient and casualty departments in terms of the shortage of staff; hence the introduction of clinical associates even in theatres to assist the physicians during surgical procedures and to do minor surgical procedures such as circumcisions.

South Africa embodied the international experience and introduced clinical associates to strengthen the district health system and to deal with South Africa's human resources shortage in the public health sector. It has been researched that the introduction of clinical associates has yielded positive results. However, the health system dynamics in the PE were overlooked in terms of conflict that might arise with the introduction of clinical associates thereby having an unpleasant effect on professional relationships with the PNs.

1.9 RESEARCH DESIGN AND METHOD

Research design and method is an overall basis of philosophy that guides practice in a specific area (Maltby *et al*., 2010:24). Botma *et al*. (2010:210) as well as Fouche and Schurink (2011:323) define research design and method as a process that adopts the application of various standardised methods and techniques in pursuit of knowledge. In the following section, the research design and method will be discussed.

1.9.1 Research design

The research design guides the researcher in planning and implementing the study in such a way that the intended goal is achieved (Creswell, 2013:49). Brink *et al*. (2012:92) describes the research design as the set of steps taken by the researcher to answer the research question which determines the methodology used to obtain information. The research design will be a qualitative description design. Sandelowski (2000:336) added that qualitative description is a useful qualitative method in most medical researches. Sandelowski (2000:336) further affirms that qualitative description demands of the researcher not to commit to one particular standpoint. The researcher chooses to describe the facts in everyday language while resisting the opportunity to put their own interpretive spin on what they hear from the participants. The main goal of qualitative description is to produce a straightforward description of participants' experiences in words similar to what the participants said as accurately as possible. Qualitative descriptive studies seek to achieve a comprehensive summary of events in the everyday terms of those events (Sandelowski, 2000:336). Researchers conducting qualitative descriptive studies seek to capture as much data as possible in order to capture the events as they unfold.

They seek descriptive validity of events in such a way that those people observing the same event would concur that the event is accurate (Sandelowski, 2000:336).

1.9.2 Research method

The research method includes the population, sampling and sample size, pilot study, data collection, and data analysis.

1.9.2.1 Population

Polit and Beck (2010:306) state that a population is a set of individuals or objects having some common characteristics. According to Brink *et al.* (2012:123), a population refers to a group of persons who meet the inclusion criteria of the study known as the target population and that is of interest to the researcher. In this study, the target population consisted of PNs and clinical associates working in outpatient, casualty, or theatre departments at district hospitals in the Gert Sibande district in the Mpumalanga province, South Africa.

In Gert Sibande District, there are seven (N=7) district hospitals where clinical associates are employed; however, only four (n=4) district hospitals' PNs and clinical associates agreed to participate.

1.9.2.2 Sampling and sample size

Polit and Beck (2010:567) describes sampling as the process of selecting a portion of the population to represent the entire population and sample size as the number of participants included. In this study, the researcher used multi-level sampling as there were various sampling methods used.

In the following section, the sampling and sample size of the district hospitals, PNs, and clinical associates are discussed.

- **District hospitals**

The sample included all-inclusive sampling of all the district hospitals where clinical associates were employed (N=7), however only four (n=4) district hospitals' PNs and clinical associates agreed to participate in the study.

- **PNs**

Purposive sampling was used for the PNs included in the study. According to Matthews and Ross (2010:167), purposive sampling is a method of sampling used during small, in-depth studies which focus on exploring and interpreting experiences and perceptions. Purposive sampling enables the researcher to include specific participants to be able to receive the most information-rich cases when investigating a certain topic. In this study, six (n=6) PNs working with clinical associates in the outpatient, casualty, or theatre department were willing to participate in the study.

In the following section, the inclusion and exclusion criteria are discussed. Inclusion criteria are the characteristics that a subject or element must possess to be part of the target population and exclusion criteria are those characteristics that may cause a person to be excluded from the target population (Grove *et al*., 2013:352).

Inclusion criteria

- PNs working with clinical associates at the seven hospitals in the Gert Sibande district where clinical associates are employed in the Mpumalanga province, South Africa.
- Any PN that works in the outpatient, casualty, or theatre departments with clinical associates.
- PNs who are English literate.
- PNs willing to participate in the study.

Exclusion criteria

The following PNs were excluded:

- Any nurse that was not a PN; these include enrolled nurses, auxiliary nurses, and caregivers.
- Unit managers working at the outpatient, casualty, or theatre departments. Unit managers were excluded because they are more involved with the administrative part of the PE.
- Any nurse that working in an outpatient, casualty or theatre department that did not have work experience with a clinical associate.

- **Clinical associates**

All-inclusive sampling was used to ensure that the highest possible number of participants be obtained to be able to generalise the findings of the study population (Brink *et al.,* 2012:132). All-inclusive sampling was employed to include all clinical associates (N=16) working in the outpatient, casualty, or theatre departments of the seven (N=7; n=4) district hospitals who agreed to participate. However, only six (n=6) clinical associates in four district hospitals were willing to participate in this study (see 1.9.2.2).

Inclusion criteria:

- Clinical associates employed in the seven hospitals in the Gert Sibande district, Mpumalanga province, South Africa.
- Clinical associates working with PNs in either the outpatient, casualty, or theatre department.
- Clinical associates who completed their BCMP degree and are registered with HPCSA as clinical associates.
- Clinical associates willing to participate in the study.
- Clinical associates who are English literate.

Exclusion criteria

- Student clinical associates were excluded.
- Clinical associates who worked in PHC facilities in the Gert Sibande district.

1.9.2.3 Pilot study

A pilot study was conducted prior to the main study on persons with the same inclusion and exclusion criteria of the studied population. The purpose of the pilot study was to investigate the feasibility of the proposed study and to detect possible problems with the research questions before data collection (Creswell, 2013:165). One semi-structured individual interview was conducted with the PNs and clinical associates each. No problems were found during and after the interviews with both the populations and all the developed questions were included in the interview schedule (see Appendix M and Appendix N).

1.9.2.4 Data collection

Data collection is defined by Matthews and Ross (2010:43-45) as the collection of facts which is analysed to draw conclusions through verbal and non-verbal communication. After ethical approval from the Health Research Ethics Committee (HREC) of the North-West University (see Appendix A) was obtained, a letter seeking permission to carry out the study was submitted to the Head of Research and Ethics Committee, Provincial DoH in Mpumalanga province (see Appendix B). After approval from the DoH Head of Research and Ethics Committee, a letter was sent to each of the Chief Executive Officers of the hospitals to conduct this study; all seven hospitals gave permission (see Appendixes D-J). The researcher then arranged a date and time with the head matrons (for PNs) and clinical managers (for clinical associates) who were the gatekeepers, leading the researcher to the outpatient, casualty, and theatre departments for each of the district hospitals.

PNs not working in the outpatient, casualty, or theatre department acted as mediators for each hospital, because they had no power relationship with any of the potential participants. All the mediators received a presentation to orientate them on the prospective research study. The mediators were involved in communicating information to the participants (the PNs and clinical associates) in the outpatient, casualty, or theatre departments. After approval of the unit managers of each of the three departments was obtained, the researcher did a presentation to the potential participants. The mediators were present during the distribution of information letters and consent forms with a blank envelope (see Appendixes K and L) and when consent was obtained from the participants. The PNs and clinical associates were given a period of one week to go through the information leaflet and decide if they want to participate. Those that were interested where given a consent form. All the signed consent forms were then placed in the blank envelopes by both the PNs and clinical associates and given to the mediators, for safekeeping and confidentiality. The researcher collected the signed consent forms from the mediators at all the district hospitals. The researcher telephonically contacted both the PNs and clinical associates who gave consent to confirm a date and time suitable to them for data collection.

According to Matthews and Ross (2010:479), semi-structured individual interviews can be described as a data collection method whereby the questions and words used during the interview schedule can differ in phrasing and length. Questions on the topic and other aspects in relation to the topic under investigation were included in the interview guide (Kvale & Brinkmann, 2009:130). Kvale and Brinkmann (2009:3) state that “an interview is a conversation that has a structure and a purpose; it goes beyond the spontaneous exchange of views in everyday conversations”. According to Kvale and Brinkmann (2009:74), the researcher should

adhere to the scientific quality so that the information and knowledge disseminated to the world is correct and represents the study under investigation. The semi-structured individual interviews were guided by an interview guide on the next research questions to ask for both the PNs (see Appendix M) and clinical associates (see Appendix N).

The semi-structured individual interviews with open-ended questions gave the researcher the opportunity to probe the interviewees as a means of exploring and gaining a richer and deeper understanding of the research question. Therefore, the researcher was able to obtain a detailed picture of the viewpoints and explanations of the participants (De Vos & Strydom, 2011:359).

On the day of data collection, the researcher introduced herself and after explaining the purpose of the study, obtained verbal consent before continuing with the semi-structured individual interviews. The interviews were conducted in a private room in the unit where the participant worked, at a convenient time, therefore not interfering with patient care. The place was chosen by the participants for their own comfort with limited distractions. The chosen place was private, convenient, and accessible to the participants. A “do not disturb” sign was put on the door to maintain privacy. The interviews were recorded using a digital voice recorder. The interviewees were made aware of the recording and permission was obtained from them. The interview guide with open-ended questions was used during the semi-structured individual interview to guide the discussion. The interview schedule (Appendix M & N) consisted of six questions listed below:

1. What is your view on the concept ‘professional relationships’?
2. What is your view on the professional relationship between the PNs and clinical associates?
3. What in your view is the role of clinical associates in the PE?
4. What in your view is the role of PNs in the PE?
5. In your opinion what do you think PNs do to improve the professional relationship with clinical associates?
6. In your opinion what do you think can a clinical associates can do to improve the professional relationship with PNs?

Each semi-structured individual interview lasted between 45 minutes to one hour depending how an interviewee answered the questions.

1.9.2.5 Data analysis

Data analysis is a process of bringing order and meaning to a large dataset by creating smaller, manageable segments that can be retrieved or revised (De Vos & Strydom, 2011:397). According to Grove *et al*. (2013:46), data analysis can be described as the process by which the researcher reduces, organises, and gives meaning to the research data.

Firstly, the anonymous interviews were sent to a transcriptionist to transcribe. A confidentiality form was signed by the transcriptionist (see Appendix O). Thereafter, the anonymous datasets were sent to the co-coder who also signed a confidentiality form (see Appendix P). The co-coder is an experienced co-coder. The objectives and data analysis technique (Tesch's steps) were shared with the co-coder to ensure correct analysis. Sets of data from both the PNs and clinical associates' populations were analysed independently by the researcher and co-coder. After coding, the researcher and co-coder compared and discussed their results and thereafter confirmed with the supervisors to ensure a true reflection of the analysed data. Tesch's eight steps of data analysis as outlined in Botma *et al*. (2010:223) are as follows:

1. All data collected through interviews, digital recorder, and observations were transcribed into written text with the date, time, and place where the interview took place.
2. The researcher read through the data several times to obtain a general sense of the information and to reflect on its overall meaning.
3. Several transcripts were read through and highlighted or had segments (phrases) in them.
4. A list was compiled of all the topics that came to the researcher's mind.
5. The researcher used the compiled list to analyse the transcripts by looking for segments (phrases) from the transcripts that fit the topics.
6. All the segments that fitted a particular topic were put together and given descriptive names as sub-themes.
7. The sub-themes were sorted and grouped together, then given descriptive names as themes.
8. Lastly, recordings were done.

1.10 TRUSTWORTHINESS

Trustworthiness refers to the manner in which qualitative data are dependable, consistent, stable, predictable, and reliable, thus producing the same results or outcomes in the future as it had in the past (Delport & Roestenburg, 2011:177). Four criteria were suggested by Lincoln and Guba (*in* Polit & Beck, 2012:584-585) for developing trustworthiness of qualitative inquiry: credibility, transferability, dependability, and conformability.

- **Credibility**

Botma *et al*. (2010:292) state that credibility means the researcher reports perspectives of the participants as clearly as possible. The researcher ensured the credibility of the study through prolonged engagement. By prolonged engagement, the researcher was in the study setting until data saturation was reached. The researcher appointed an independent co-coder to assist with coding of the interviews. The supervisors thereafter confirmed the findings of the analysed data to ensure it was credible.

- **Transferability**

Transferability is the extent to which findings can be transferred to or have applicability in other settings or groups. In this study, transferability was ensured by providing an in-depth description of the context and research method which included sampling, characteristics of participants, data collection, and data analysis (Polit & Beck, 2012:585). This ensured that this study could be exactly repeated by other researchers in other contexts.

- **Dependability**

Dependability refers to the findings that will not change if a similar study with the same participants and in a similar context is done at different time (Polit & Beck, 2012:585). Dependability was ensured by including the full description of the research methods applicable to the study to enhance the possibility of the study being repeated by another researcher in another context. The researcher dealt with dependability by ensuring that detailed accounts were kept of the changing contexts and circumstances during the study (Marshall & Rossman, 2011:253). The researcher used a co-coder and supervisors to ensure that the results are a true reflection of the interviews (Babbie & Mouton, 2010:278).

- **Conformability**

According to Polit and Beck (2012:585), conformability refers to the objectivity or neutrality of the data; there must be an agreement between two or more independent people regarding the data's relevance and its meaning. The researcher made use of a co-coder during data analysis. Smith and Davies (2010:155) mentioned that coding does not constitute the totality of data analysis, but is a method to organise data so that underlying messages portrayed by the data may become clearer to the researcher. The co-coder is an independent objective consultant who had no knowledge of the topic under study. The co-coder signed a confidentiality agreement. The main themes, sub-themes and sub-sub-themes that emerged during data analysis are discussed in Chapter 2.

1.11 ETHICAL CONSIDERATIONS

Ethical considerations were included in every aspect of the research, from conceptualisation, planning, and implementation to writing the report and disseminating the data (Botma *et al*., 2010:4).

1.11.1 Consent form

Informed consent (see Appendix K and Appendix L) can be defined as the voluntary agreement of a participant to participate in a research study. The participant must have a full understanding of what the study entails before the study begins (Brink *et al*., 2012:203). The principles such as explaining the nature of the research study and the research expectations of the participants, their right to freely give or withhold information without fear of being penalised, and the awareness of the anticipated risks and benefits were explained in the consent form. The interviews were not conducted until informed consent was given verbally and in writing. The researcher with the assistance of a mediator handed out the informed consent to the participants. Before the signing of the consent form, the participants were given a period of a week to go through the consent form and to decide on whether they want to participate in the study or not. The consent forms were signed by the participants in their PE in a private room in the presence of the mediator. The interviews were conducted after hours in a private room in the department, where there were no distractions. A "do not disturb" sign was put on the door.

During the interview, anonymity was ensured by using codes instead of the participants' names. The transcriptionist also signed a confidentiality form before transcribing the data. The

independent co-coder signed a confidentiality form before co-coding the data. The data were kept on the researcher's password-protected computer until after transcription and were then deleted. The documents were shredded and a memory stick is kept in the Director of NuMIQ's office in a locked cupboard. After five years, the data on the memory stick will be deleted by the Director of NuMIQ's office.

No remuneration was given to the participants so as not to exert undue influence on the research outcome. No financial implications were incurred by the participants as the interviews were conducted in a place chosen by them.

1.11.2 Principle of beneficence

Beauchamp and Childress (2013:79) state that the principle of beneficence "includes the professional mandate to do effective and significant research to better serve and promote the welfare of our constituents". The principle of beneficence is grounded in the premises that a person has a right to be protected from harm and discomfort and one should do good and above all, no harm (Botma *et al*., 2010:20). The researcher ensured that the participants were not exposed to any harm, trauma, or discomfort during the interviews (Burns *et al*., 2013:174). The participants were protected from any harm by means of making sure that they were interviewed in their place of choice, their identity was kept anonymous, and their right to withdraw if they experienced any discomfort was communicated to them and respected. According to Brink *et al*. (2012:35), the well-being of the participants needs to be secured as they have a right to protection from discomfort and harm – be it *physical, psychological, emotional, spiritual, economic, social, or legal.* The researcher is not an employee at any of the district hospitals; this allows the study to be free from bias as there will not be any power relationship with the participants. The possibility and extent of anticipated risks for participants in this study was small; however, there was a potential conflict that arose when talking about their perceptions, but the researcher guarded against this by staying objective throughout the interviews and keeping to the interview schedule. The researcher also ensured that participants were not exposed to harm by informing them before the study commenced that they were free to terminate participation at any time should they want to (Burns & Grove, 2011:666) without discrimination or any penalty against them. In the following section, the researcher will elaborate on each of the potential risks.

- The participants were not exposed to any physical risks, except discomfort for sitting still on a chair for the duration of the interview. The researcher gave each participant

something to drink during the interview and made sure the interview schedule was kept to prevent any physical discomfort.

- Psychological risk included boredom of participants to answer the questions in semi-structured individual interviews and negative experiences by PNs and clinical associates in relation to their professional relationship that they may have come across in the PE. According to the researcher's knowledge, no participants experienced any form of psychological stress during the semi-structured interviews, as the interviews were conducted in a comfortable setting, and through ensuring that the participants were aware that they could stop the interviews at any time if they felt uncomfortable.

- Emotional risk was minimal as the participants were informed that the study is voluntary and they signed a consent form. The study, however, had a risk of triggering emotional experiences by the participants as they verbalised their experiences in the PE. No participant according to the researcher's knowledge experienced any emotional trauma during the interviews.

- Spiritual risk – the study did not explore any religious beliefs of the participants.

- There was no economic risk, as each and every participant was allowed an opportunity to choose a place where she/he feels comfortable to be interviewed. There was no risk of any of the participants losing employment by participating in the study.

- Social risk – there was no risk of social stigma or chance of participants being ostracised or shunned for participating in the study; everyone that met the inclusion and exclusion criteria could participate. The reason for excluding social risk is that the participants were interviewed privately, anonymously, and the names of the hospitals were not mentioned during the interviews.

- Legal risk – the study did not have any legal implications such as risk of prosecution on the side of the participants and the researcher.

1.11.3 Direct and indirect benefits to the participants

The *direct benefits* of the study were that the study gave the PNs and clinical associates an opportunity to reflect on the dynamics of the professional relationship between themselves and the importance of having a professional relationship between themselves in the PE to improve service delivery to patients. The participants also might have gained insight into the factors that

affect their professional relationship and received an opportunity to talk about their experiences regarding professional relationships in order to improve and perform their work optimally in the HCP team.

Indirect benefits of the study are the scientific knowledge obtained to understand and potentially strengthen the professional relationship between PNs and clinical associates in order to improve service delivery to patients.

1.11.4 Principle of justice

Participants have a right to fair selection and treatment (Brink *et al*., 2012:36). Only PNs and clinical associates who volunteered to participate in the study and were working together in outpatient, casualty, or theatre departments in the selected district hospitals were included during data collection. The participants were informed that honesty is to be maintained throughout the study. Only participants who understood what the study entailed and voluntarily signed the consent form were interviewed.

1.11.5 Anonymity

According to Brink *et al*. (2012:198) and Burns and Grove (2011:181), anonymity is when the identity of a research subject cannot be linked to an individual, even by the study investigator. The names of the participants as well as the names of the hospitals were not mentioned anywhere during the interviews by the researcher. All data were only coded to ensure the datasets stayed separate, as there were two datasets. All interview transcriptions were shredded after data analysis by both the researcher and co-coder.

1.11.6 Right to privacy

Data were collected in a private room with a “do not disturb” sign on the door. The participants’ views were recorded with their permission. Both the PN and clinical associate interviewees were given an opportunity to choose the interview venue suitable to them to help create a calm, comfortable, and relaxing environment and to ensure privacy. The researcher informed the interviewees about the use of a digital recording device and that all interviews were conducted anonymously, to protect the interviewees’ privacy.

1.11.7 Right to confidentiality

According to Burns and Grove (2011:117), confidentiality is maintained by the researcher's management of private information shared by participants, which must not be shared with others without the authorisation of the participants. Burns *et al*. (2013:171-172) adds that it is the responsibility of the researcher to protect all the data collected from being available to any other individual. The researcher ensured that the participants' details are not divulged by refraining from calling them by name during the interview. The data were collected through semi-structured individual interviews, where only the participant and researcher were present, thereby ensuring confidentiality. No personal information was requested or required from the participants during the interview. Codes were used during the interviews for both populations as there were two sets of data to analyse. All interviews were deleted from the digital voice recorder after transcription.

1.11.8 Storage of data

The consent forms were kept safe in a locked filing cabinet in the office of the researcher. They will be kept for five years after the completion of the study and destroyed by shredding.

The interviews were deleted from the digital recorder after being loaded on the transcriptionist's password-protected computer. After the transcriptionist completed transcribing of the anonymous interviews and gave the electronic interviews to the researcher, the researcher asked the transcriptionist to delete the interviews from his/her computer. After data analysis was completed, the data analysis papers and documents used by both the researcher and co-coder were shredded using a shredding machine. The electronic interviews were loaded on a memory stick and deleted from the co-coder and researcher's computers. The memory stick containing all the data will be kept in the Director of NuMIQ's office for five years, in a locked cabinet (Botma *et al*., 2010:19). After the five years have lapsed, the contents of the memory stick will be deleted by the Director of NuMIQ's office.

1.12 RESEARCH REPORT OUTLINE

The chapters of the study are divided as follows:

Chapter 1: Overview of the study and literature review.

Chapter 2: Manuscript prepared for the *International Journal of Nursing Practice*.

Chapter 3: Conclusions, recommendations and limitations of the study.

1.13 CHAPTER SUMMARY

Professional relationships are of importance in the healthcare setting to ensure quality service delivery. It also important for HCPs to display competent and skilful behaviours in alignment with their profession. This chapter gave the introduction, background, and significance of the study, the problem statement, research questions, purpose and objectives of the study, researcher's assumptions, research design and method, trustworthiness, ethical considerations, research report outline, chapter summary, and references.

In the following chapter, the manuscript prepared for the *International Journal of Nursing Practice* is presented.

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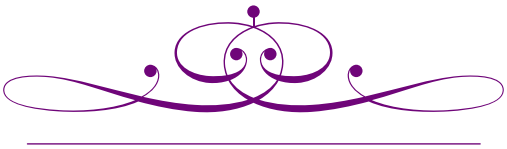

CHAPTER 2

MANUSCRIPT

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DECLARATIONS OF MANUSCRIPT PREPARATION

- The manuscript was prepared for the 'International Journal of Nursing Practice'. Please see Appendix Q for the author guidelines.

- Please note that the manuscript and abstract in this study are longer because it is a dissertation; the manuscript and abstract will be shortened prior to submission to the journal.

- The manuscript was prepared for the category in the author guidelines: 'Original research papers'.

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TITLE PAGE

The professional relationship between professional nurses and clinical associates in selected district hospitals

RUNNING TITLE

Professional relationships in healthcare

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The authors declare no conflict of interest.

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All authors meet the authorship criteria and all authors are in agreement with the content of the manuscript.

ETHICAL CONSIDERATIONS

Ethical approval number (NWU-00355-16-A1) was obtained for the study.

ABSTRACT

Aim: The aim of this study was to explore and describe professional nurses' and clinical associates' perceptions of the professional relationship between them.

Methods: Twelve (N=12) semi-structured individual interviews with open-ended questions using an interview schedule were conducted with professional nurses (n=6) and clinical associates (n=6) in district hospitals in a province of South Africa.

Results: Both populations defined a professional relationship as a relationship among colleagues. Positive and negative professional relationship characteristics were revealed as well as professional relationship challenges such as attitude, functional, ministerial, interdepartmental, and intra-professional collaboration. The clinical associates also revealed personal professional challenges which could influence their professional relationship; this was not mentioned by the professional nurses.

Conclusion: The professional relationship between the professional nurses and clinical associates is affected by various challenges, but could be improved through ministerial, interdepartmental and intra-professional collaboration.

SUMMARY STATEMENT

What Is Already Known About This Topic?

- It is well established that a positive professional relationship in the practice environment is essential in improving service delivery.
- The professional relationship has been studied between professional nurses and other healthcare professionals; however, there is limited knowledge of the professional relationship between professional nurses and clinical associates in the practice environment.

What This Paper Adds:

- This is one of the first studies to explore and describe the professional relationship between professional nurses and clinical associates in the practice environment.
- There are various challenges in the professional relationship between professional nurses and clinical associates.
- Ministerial, interdepartmental, and intra-professional collaboration can improve professional relationship challenges.

Implications of This Paper:

- This paper gives insight to the specific challenges faced in the professional relationship between professional nurses and clinical associates.
- Challenges could easily be addressed through ministerial collaboration in the media, workshops, and roadshows to alleviate and address misunderstandings brought by the new cadre of clinical associates; due to the relative newness of the clinical associate

profession to fellow healthcare practitioners such as professional nurses and the community.

- Interdepartmentally, collaboration through meetings and availability of the scope of practice of all healthcare practitioners, including the new cadre clinical associates in standard operating procedure files, should be encouraged.
- Intra-professional collaboration should be enhanced through in-service training on how professional relationships are defined, positive and negative professional relationship characteristics, and improvement of professional relationship challenges.
- The Minister of Health and Health Professions Council of South Africa should investigate and improve personal professional challenges experienced by clinical associates.

Keywords: professional nurses; clinical associates; professionalism; professional relationships; scope of practice; service delivery

INTRODUCTION

Healthcare professionals (HCPs) are considered the backbone of the healthcare system throughout the world (Rabie, Klopper, & Coetzee, 2017; Wiklund, 2016). Their contribution is one of the most important components of the healthcare system's ability to effectively and efficiently deliver services and provide quality care and to ensure equal access to healthcare for all concerned. However, it has been estimated that there is a shortage of HCPs globally of approximately 17.4 million, of which almost 2.6 million are physicians and 9 million are nurses (World Health Organisation [WHO], 2014). In 2015, the WHO reported that an estimated 1 billion people worldwide were without healthcare. The WHO (2014) also warned that if the current trend continues, the situation is bound to worsen by 2035, with the global HCPs shortage to be tripled from 4.3 million to an estimated 13 million. The largest need-based shortage is

found in East Asia and African regions. Sub-Saharan Africa is the most affected by the shortages of HCPs, although it bears 24% of the world's burden of disease (Taylor, Hwenda, Larsen, & Daulane, 2011).

Since 1994, the performance of South Africa's healthcare system has been declining due to a highly fragmented, inequitable, predominantly curative and racially segregated health system that was inherited from the previous government (South Africa, 2014). However, one of the most prominent causes of poor service delivery is the low HCP ratios, especially the patient-physician ratio (Awases, Bezuidenhout, & Roos, 2013; WHO, 2010). This is despite good policy and high spending as a proportion of gross domestic product services is fragmented between public and private sectors. The public sector serves 83% (41.7 million) of the population as compared to the private sector's population at 17% (8.3 million) (Rabie, Klopper, & Watson, 2016; Taylor et al., 2011). A large majority of the South African population alongside other developing countries is dependent and has to contend with a less effective public healthcare sector due to the shortage of physicians (National Planning Commission, 2012). This has put a burden on the available physicians and professional nurses (PNs). The shortage of physicians in South Africa as compared to other middle-income countries is at a larger scale in terms of the ratios of physicians to patients (Ntuli & Maboya, 2017). In South Africa, the ratio is 60:100 000 as compared to 152:100 000 internationally. In South Africa, factors such as the growing rates of HIV/AIDS, tuberculosis, diabetes, heart diseases, violent crimes, high mortality rate among children younger than five years, and women who die during pregnancy are contributory to the poor physician to patient ratios. In order to address this problem, the South African government proposed the need for medical schools to train more physicians to meet the health needs of the population which is growing at a rate of 1,58% per year (Bateman, 2013). However, on completion of their studies, 70-80% of physicians have no intention to work for the state and migrate to other countries after their community service year; the main reasons being poor pay,

poor working conditions, lack of medical equipment, and heavy workloads (Wildschut, 2019). The migration of physicians from developing countries to developed countries is a well-documented phenomenon contributing to a compromised healthcare system and service delivery with detrimental consequences to the health of developing countries' populations. This hugely interferes with the National Department of Health's goal to provide quality healthcare service to the South African population (Muller, 2011). This is of concern as mobility from country to country resulted in a 'brain drain' which has already devastated much of Africa's health workforce (Taylor et al., 2011).

South Africa's transition into the democratic dispensation has dramatically transformed the healthcare system, health professions, and human resources establishments (van Rensburg, 2014). Through these changes, the global Human Resources for Health has grown and intensified the search for feasible solutions to develop strategies that will help counteract the shortage of physicians, both globally and country-based. Cawley and Hooker (2018) state that some of the reasons why clinical associates were introduced were that their education was less expensive and time-intensive than that of physicians.

In the beginning, the South African government did not consider introducing clinical associates who are also known as mid-level workers (MLWs) to address the shortage of physicians. A few strategies were adopted and implemented to try and curb the shortage of physicians by signing a co-operation agreement with the Cuban government for their physicians to practice in South Africa and for Cuba to allow South African medical students to study in Cuba. South Africa was pinning its hopes on Cuba to train more physicians needed for its implementation of the National Health Insurance. About 1000 students were sent to Cuba to train as physicians in 2012 (Bateman, 2013). Other measures taken included employment of foreign physicians, introducing compulsory one-year community service for physicians after qualifying, as well as occupational-specific dispensation. Occupational-specific dispensation refers to

revised salary structures that are unique to specially identified occupations in the public service sector (Netshiswinzhe & Mulaudzi, 2015).

Even though the agreement between South Africa and Cuba was yielding results, it was not enough to address the shortage of physicians. Thus, in December 2002, the South African government decided to develop a new cadre of HCPs known as clinical associates modelled after physician assistants from the Americas (Bert, 2013) to address shortages. In countries other than the USA and Malawi, clinical associates are known as advanced clinical practitioners in the UK, assistant medical officers in Tanzania and Malaysia, Feldsher in Russia, Feldscher in other former Soviet republics, surgical technologists in Mozambique, and assistant medical practitioners in Fiji (Miller et al., 2011).

The clinical associates were introduced as part of the clinical team at district hospitals working under the supervision of the physician (Moodley, Wolvaardt, Louw, & Hugo, 2014).

In 2004, the National Task Team was tasked to develop a training programme for the clinical associates which included their scope of practice and outcomes. The Bachelor of Clinical Medicine Practice (BCMP) degree was implemented specifically for clinical associates. Clinical associates started working in the Eastern Cape in 2011 upon completion of their three-year BCMP degree studies at Walter Sisulu University, which was the first medical university to train 23 clinical associates in 2008. The University of Witwatersrand and University of Pretoria followed suit in 2009 with 25 and 56 students, respectively. As of 2017, there are 920 clinical associate graduates stationed in hospitals in all nine provinces of South Africa (Cawley & Hooker, 2018). The training of clinical associates was based on generalist rather than specialist skills (Doherty, 2013). PNs have a more independent scope of practice. Esterhuizen (2016) mentioned that it is explained in the scope of practice of a registered nurse in the Nursing Act that the nurse is responsible for “diagnosing a health need and prescribing, providing and executing a nursing regimen to meet the needs of a patient or group of patients”. This, according

to Esterhuizen (2016) confirms the changing scope of nurses from being dependent, basic hygienists in the 19th century to independently functioning scientific and holistic care givers in the 20th century. Clinical associates have a limited scope of practice and have to work under the supervision of a physician. Their scope of practice is tailored to the specific context and needs of the district hospital, steering away from overlapping with primary healthcare (PHC) nurses functioning at clinic level (Doherty, Couper, & Fonn, 2012). Clinical associates assist physicians in providing emergency care, performing diagnostic and therapeutic procedures and in-patient care, and they are also expected to have consultation, physical examination, and counselling skills (Doherty et al., 2012).

Even though the aim of introducing clinical associates was not to substitute PNs or physicians, uncertainties from other HCPs, particularly PNs, emerged. They were not exactly well received by all HCPs, especially PNs, even though there are studies indicating that with the introduction of clinical associates, the health workforce as mentioned by Cawley and Hooker (2018) has improved tremendously in several countries including South Africa. Liendo (2011) further emphasised that due to minimal exposure of PNs to the clinical associate profession, its role, and its responsibilities, it can be said that the PNs' attitude towards the clinical associates is less favourable. This is alarming as the WHO (2017) advocates that members of the healthcare team are guided by a code of ethics and their commitment to professionalism. Professionalism as mentioned by the Nursing and Midwifery Council (2015) is characterised by autonomous evidence-based decision making by members of an occupation who share the same values and education. The Registered Nurses' Association of Ontario (RNAO; 2007) also issued a document, *Professionalism in Nursing Guideline*, which identified and recommended the following comprehensive approach to standards of professionalism in nursing: knowledge, spirit of inquiry, accountability, autonomy, advocacy, innovation and visionary, collegiality and collaboration, ethics and values. According to Hayward, Bungay, Wolff, and McDonald (2016),

negative inter-professional relationships can be identified as some of the factors that can lead to frustration in the practice environment (PE), which can be fatal. This is especially true for outpatient, casualty, and theatre departments which are the focus of this study, as these are the district hospital departments where PNs and clinical associates are mostly allocated to work together. Mapukata-Sondzaba and Dhai (2015) further explains that today's healthcare provision is patient-oriented and therefore requires that HCPs maintain professional standards from the beginning of training to the PE; for good service delivery to the patient. According to Bert (2013), the lack of professional relationships between different HCPs includes newness of the clinical associates' profession, lack of clear knowledge by other HCPs on the scope of practice, and challenges in being accepted into the already established healthcare teams, potentially causing poor professional relationships. According to Shohani and Zamanzadeh (2017), professionalism is one of the fundamental concepts in healthcare, especially nursing. According to the RNAO (2007), professionalism, which consists of i) advocacy, ii) knowledge, iii) innovation and visionary, iv) collegiality and collaboration, v) spirit of inquiry, vi) autonomy, and viii) accountability, is pivotal to demonstrate professional standards, which could also be expected of other HCPs such as clinical associates in service delivery. Service delivery and quality patient care are a constitutional obligation in South Africa (Stuckler, Basu, & McKee, 2011). However, Barron and Padarath (2017) note that health problems in South Africa have been worsened by an unequal distribution of HCPs between private and public sectors. This is coupled with unequal distribution of public sector HCPs among the provinces. Despite a number of commendable goals having been adopted by the South African government such as the introduction of clinical associates for improvement of service delivery and quality patient care, it has been revealed through media reports that services in the public sector were failing to meet basic health standards (South Africa, 2012).

METHODS

Aim

The aim of this study was to explore and describe both PNs' and clinical associates' perceptions of the professional relationship between them.

Design

This was a qualitative description study (Sandelowski, 2000).

Sample

Six PNs (n=6) and six clinical associates (n=6) working in the outpatient, casualty, and theatre departments of four district hospitals (N=7; n=4) in a province in South Africa were included in the study. Three district hospitals' PNs and clinical associates did not agree to participate.

Inclusion criteria for PNs and clinical associates were those working with clinical associates in the outpatient, casualty, or theatre department of district hospitals in the Gert Sibande district and those willing to participate. Exclusion criteria for PNs were any nurse that is not a PN and unit managers working in the outpatient, casualty, or theatre departments.

The inclusion criteria of the clinical associates were those who are employed in the in the outpatient, casualty, or theatre department of district hospitals in the Gert Sibande district, working with PNs, who completed their BCMP degree and are registered with the regulatory body, the Health Professions Council of South Africa (HPCSA) as clinical associates, and those willing to participate in the study. Exclusion criteria were student clinical associates and clinical associates working in PHC facilities.

Data Collection

During 2018, twelve (N=12) semi-structured individual interviews (Kvale & Brinkmann, 2009) with open-ended questions using an interview guide were conducted. The interviews were

conducted in English, recorded with a digital voice recorder, and lasted approximately 45 minutes to one hour. All interviews were transcribed verbatim. Of the twelve (N=12) participants, four were female and eight were male. Age categories ranged between 20-40 (three women and six men) and 41-60 (one woman and two men). The interview guide included the following questions: What is your view on the concept 'professional relationships'? What is your view on the professional relationship between PNs and clinical associates? What in your view is the role of clinical associates in the PE? What in your view is the role of PNs in the PE? In your opinion, what do you think can PNs do to improve the professional relationship with clinical associates? In your opinion, what do you think can clinical associates do to improve the professional relationship with PNs?

Ethical Considerations

Ethical approval was granted. Thereafter, the researcher asked permission from the Research and Ethics Committee of the Department of Health in Mpumalanga Province and thereafter from the Chief Executive Officer of each of the district hospitals (N=7; n=4). Only four district hospitals' PNs and clinical associates were interested to participate in the study. Participation in the study was voluntary and participants were recruited from the outpatient, casualty, and theatre departments. Information leaflets of the study were distributed to the potential participants and they were given one week to decide if they want to participate. Consent forms were then given to participants interested in participating in the study. All participants who signed the consent form were contacted telephonically to establish a date and time suitable for the interview. The interview venue was a private room in the unit where the participant worked, felt comfortable, and anonymity and confidentiality were ensured. The interviews were conducted at a convenient time not interfering with patient care. Verbal consent was obtained prior to conducting semi-structured individual interviews and all participants were

ensured that they could withdraw from the interview at any time without any penalty held against them.

Data Analysis

Data were analysed using Tesch's steps of content analysis (Creswell, 2013). Both the datasets of the PNs and clinical associates were analysed separately with the assistance of a co-coder. Firstly, the first set was read several times to obtain a general sense of the information and to reflect on its overall meaning; thereafter, segments (phrases) were highlighted. A list was compiled of all the topics that emerged, where after the list was compared to the transcripts. All the segments that fitted a particular topic were put together and given descriptive names as sub-themes. The sub-themes were sorted and grouped together, then given descriptive names as themes. Results were confirmed with a co-coder to ensure trustworthiness of the analysed data. The same steps explained above were repeated with the second dataset.

RESULTS

The results were described in two parts: firstly, the perceptions of the PNs and thereafter, the clinical associates' perceptions regarding the professional relationship between them. Quotations from the interviews are provided as examples of common themes. The coding that appears at the end of each excerpt, for example "(7/1:77)", identifies that excerpt by interview number (7), page number (1), and line (77).

PNs

In examining the perceptions of PNs on the professional relationships between themselves and clinical associates, three main themes emerged: professional relationship defined, professional relationship characteristics, and professional relationship challenges, with their respective sub-themes.

Table 1

Perceptions of PNs of the Professional Relationship between themselves and Clinical Associates

Main Themes		Sub-themes	
1.	Professional relationship defined	1.1	Colleagues working together
		1.2	Relationship amongst professionals
2.	Professional relationship characteristics	2.1	Positive characteristics • Support • Open communication • Teamwork
		2.2	Negative characteristics • Distrust • Disrespect • Unprofessionalism
3.	Professional relationship challenges	3.1	Attitude
		3.2	Functional – Clinical associates • Lack of designation • Superiority • Uncertainties about scope of practice • Lack of independence • Role clarification in PE • Physician shortages
		3.3	Ministerial, interdepartmental and intra-professional collaboration • Media • Workshops • Roadshows • In-service training

Professional relationship defined. Two sub-themes cited by the PNs to define a professional relationship were colleagues working together and a relationship among professionals.

A professional relationship is an on-going interaction between two or more professions. This relationship observes a set of established boundaries or limits under ethical standards. The nature of a professional relationship with colleagues can determine success in the chosen profession.

A professional relationship is what us as colleagues or people who are working together (1/2:1)

The relationship between the other healthcare professionals (2/1:8)

That is the relationship amongst professionals (3/1:6)

Professional relationship characteristics. In the professional relationship characteristics, it was evident that they were positive and negative in nature.

Positive characteristics were portrayed by the PNs as support, open communication, and teamwork. Support among professionals contributes to improved service delivery and clinical practice, better patient outcomes, workplace satisfaction, and increased workplace morale, and is imperative for patient safety.

All we need to do is to support each other in everything that we do. I believe that once we have a strong support system as a team, that we…there's nothing that we cannot conquer and that there will be un…there'll be no animosity (4/8:453-458)

Open communication is crucial for teamwork success and both PNs and clinical associates should prioritise and continuously refine their communication skills through consistent and accessible communication channels.

PNs and the clinical associate. First thing…this people they need to sit down and talk, for the sake of the patient (6/6:331-332)

So we need to sit down and talk and leave our pride aside (6/6:336-337)

Teamwork is globally recognised as an essential tool for developing a more effective and patient-centred healthcare delivery system. In delivering healthcare, effective teamwork can immediately and positively affect service delivery, patient safety, and outcome.

I think at the end of the day what is more important in order for us to be successful in whatever we are doing as a Department of Health is that we should be a team. We should

be able to work together as a team, we should be able to build on each other (4/8:448-450)

Negative characteristics were also portrayed by the PNs and included distrust, disrespect, and unprofessionalism. Distrust in especially the healthcare team is undeniably the most important factor that could cause relationship failure and poor service delivery which is fundamental in the PE. The PNs verbalised their reservations about the trust issues they have with clinical associates

These people [clinical associates] *are in contact with our relatives, our mothers, our kids and stuff. So if you come to me, you need to trust me. Myself if I can have...my child…if they can call me and say my child is sick, I cannot call a clinical associate (5/14:794-796)*

They [clinical associates] *come, they go out and do everything that they're doing outside there that we don't know and that is a problem, we cannot trust them (1/4:171-172)*

Disrespect among HCPs in the PE can be incredibly frustrating. In this case, some of the PNs felt that some of the clinical associates did not show enough respect in the PE.

It clearly shows that there's no respect because my profession is not respected here (1/3:158-159)

For the sake of the patients, we are trying to have it. We need to respect them [clinical associate], *they need to respect us* [PNs] *(5/7:394-395)*

Yes I feel undermined as a PN because how can a person that knows that we are working for the same objective come to work and leave me working…it means that person is my employer right now that's why I feel undermined by the clinical associates (1/4:166)

Unprofessionalism was another negative characteristic of the professional relationship between the PNs and clinical associates which should be addressed by management.

I [PN] *can't be professional because it's weighing down on me so I feel that they* [clinical associate] *should decide where they stand so that…and then be professional about the work (4/5:273-275)*

Professional relationship challenges. Professional relationship challenges were evident as attitude, functional with specific reference to the clinical associates and ministerial, interdepartmental, and intra-professional collaboration. Attitudes between the PNs and the clinical associates was evident as being problematic in the PE.

Yes there is an attitude…bad attitude from them, towards nurses (2/4:134)

I [PN] *feel it's either they* [clinical associates] *need to change their attitude to become more positive* (4/9:372)

Functional challenges with reference to the clinical associates included lack of designation, superiority, uncertainties about scope of practice, lack of independence, role clarification in the PE, confusion of roles, and physician shortages.

Clinical associates have a lack of designation in the PE and this came evident as PNs, physicians, and patients did not know how to address the clinical associates. Designation in PE is an important aspect as it determines the lines of authority and accountability.

Even now I [PN] *don't understand it exactly because to me I don't think they* [clinical associates] *do even have a designation (5/2/73-74)*

Even the doctors, the doctors themselves, they don't understand cause' they ended up themselves calling them "doctor so and so come and assist me here". They don't have a real designation…they formulated this thing but they failed to give them a real designation (5/6:305-308)

Even other patients when they leave the hospital, they will say "I was seen by the doctor" but while they were seen by the clinical associate. It means they don't introduce themselves as clinical associate (2/8:359)

It was evident that tensions regarding superiority should be actively managed between the PNs and clinical associates in the PE.

I don't know it's either by the people who introduced the profession to them, what they [clinical associates] *were told about the profession or is it them belittling my profession as a nurse and that is what is causing most of the time the clash between us and them because they* [clinical associates] *feel superior and they…they are not (4/2:68)*

Yes there is a problem when it comes to seniority… they are like seniors to me whereas they cannot even do anything on their own and that is the problem that we are facing as PNs *(1/1:86)*

Uncertainties about the scope of practice of the clinical associates were evident as it seems that the scope is not readily available in the PE. Scope of practice is regarded as an important component of any profession, especially in the health system, and it is important for every HCP to have it and to be familiar with its contents.

I've never seen their [clinical associates] *guideline or scope of practice (1/2:70)*

What is their [clinical associates] *scope of practice? I have never seen it…when you ask them…one of them…some will say it's been under review, but no one has ever physically seen the scope of practice in the file (4/5:195-196)*

Clinical associates have a lack of independence, which causes PNs to feel that the introduction of this cadre of HCPs did not alleviate the problem of physician shortages but escalated it as clinical associates are not allowed to work without supervision.

No, it's not improved, it's not improved it's still the same 'cause they [clinical associates] *work with the doctor. If the doctor is only one and they are four all of them must wait for*

the doctor so nothing has changed cause the doctor have to see all of the patients that they have saw (2/4:124-126)

A medical doctor must sign, it cannot go alone, that prescription, without being countersigned by a real medical doctor, meaning "bona" they are in between so they cannot work alone meaning that they are independent themselves (5/2:59-61)

Role clarification in the PE seems to be challenging as it seems that neither the PNs nor clinical associates are clear on what procedures they can do as they must always work under supervision.

They [clinical associates] *don't know their role actually or maybe they're doing it purposely 'cause they treat themselves as doctors (2/8:432-433)*

But clinical associates, we [PNs] *don't have that understanding of what they're supposed to do (3/2:42*)

Addressing physician shortages rather than training clinical associates to address the shortages becomes a clear preference, mainly because clinical associates must always work under the supervision of a physician.

It's better for Department of Health to train the clinical associates to become doctors so that they can work on their own (2/6:296-298)

Why didn't the government, our government, spend money training doctors (1/13:704)

Ministerial, interdepartmental, and intra-professional collaboration. Most PNs verbalised that the Minister of Health and departments in the district hospitals should have given more information and introduction of the new HPC cadre clinical associate. This could have been done through the media, workshops, roadshows, and in-service training.

Minister must start to use things like media, workshops, roadshows and there must be a task team that is appointed to go around South Africa, informing people about clinical

associates so that people will have an idea, they will have bright view of clinical associate work and what to call them (1/3:126-129)

The department…if they can provide…if they may provide full information about their scope of practice, of clinical associates to be visible, transparent, known by everyone at the facility, and then when they come the department need to do in-service training to the nurses, informing them about the clinical associates(2/9:379-382)

Clinical Associates

In examining the perceptions of clinical associates on the professional relationships between themselves and PNs, four main themes emerged: professional relationship defined, professional relationship characteristics, professional relationship challenges, and personal professional challenges with their respective sub-themes.

Table 2

Perceptions of Clinical Associates of their Professional Relationship between themselves and PNs

Main Themes		**Sub-themes**	
1.	Professional relationship defined	1.1	Interaction between two people
		1.2	Collegial relationships
		1.3	Goal orientation
2.	Professional relationship characteristics	2.1	Positive characteristics • Mutual respect • Support and help
3.	Professional relationship challenges	3.1	Attitude
		3.2	Functional – Clinical associates • Lack of designation • Superiority • Role clarification in the PE • Uncertainty about scope of practice

Table 2

Perceptions of Clinical Associates of their Professional Relationship between themselves and PNs (continue)

Main Themes		Sub-themes	
		3.3	Functional – PNs • Sharing of experience, giving of advice • and guidance • Superiority • Conflict in the PE
		3.4	Ministerial collaboration • Healthcare system
4.	Personal professional challenges	4.1	Lack of independence • Application of professional skills • Prescribing of medication
		4.2	Poor remuneration
		4.3	Poor career progression
		4.4	Supporting profession to physician shortages

Professional relationship defined. Three sub-themes cited by the clinical associates to define a professional relationship included interaction between two people, collegial relationships, and goal orientation.

> *Professional relationship is an on-going interaction between two people (2/1:13-15)*
>
> *Professionalism, for an example colleague to colleague, they can have a good relationship, doctor to patient – they might have a professional relationship (3/1:13-16)*
>
> *We must work together professionally to help, to win the goal, which is the patient (2/3:166-167)*

Professional relationship characteristics. Only one sub-theme namely positive characteristics emerged in the professional relationship characteristics between the clinical associates and PNs and consisted of mutual respect, support, and help.

*We must have mutual respect towards each other, whereby we must also have tolerance for the sake of the patient (*2/3:158-159)

When you come to a place you respect those people that you work with, they will respect you back (5/12:603-604)

They do support us (3/4:205-206)

They are supportive in if you've got a query then you go and ask them and then they'll assist you (6/2:87-88)

They're [PNs] *willing to help, if you ask for help (1/1:29-30)*

So whenever we [clinical associates] *want something from them they help us with it, so we work very nice (6/1:34-35)*

The nurses…they're helping us (6/2:87-88)

Professional relationship challenges. Under this main theme, four sub-themes emerged namely attitude, functional with specific reference to both clinical associates and PNs, and ministerial collaboration. There was an obvious challenge with the attitude of the PNs according to the clinical associates.

But instead they're [PNs] *giving us attitude, they're difficult to work with (2/4:213)*

It's about our job but if you're [PN] *still continuing to give us such bad attitude, I think I also I'll have to retaliate also (3/7:361-362)*

Functional challenges specifically to clinical associates included lack of designation, superiority, role clarification in the PE, and uncertainty about scope of practice. Currently, there is no standard designation for clinical associates as different names exist globally. When asked about their designation, this is how clinical associates responded:

Patients tend to become confused, when they see us they'll be like "doctors", so we don't know how to correct them so we need that profession to be also put into the picture (2/1:40-41)

A clinical assistant it's an in-between a doctor, nurse, patient, so it's confusing…it's really confusing (3/2:105-106)

Superiority of professionals in the HCP team can affect functionality in the PE which could affect patient care. The clinical associates elicited superiority toward PNs.

They [PNs] *undermine us, they say we're acting as doctors, reason being we are the ones who work closely with the doctors whereas them they work behind the scenes (2/1:26-28)*

What I can say…advanced qualification than the nurses, so…yes, our relationship is not yet balanced (3/1:29-34)

The role clarification of clinical associates in the PE seems to be problematic as both clinical associates and PNs were not clear of clinical associates' role.

*They'll [*PNs*] have a clue what is going to happen, what is our* [clinical associates] *role (3/2:96-97)*

Yes we do have hope, if only our [clinical associates] *roles can be clarified (2/4:221)*

Uncertainty of the clinical associates' scope of practice in clinical associates and other HCPs also emerged. Currently, their scope of practice is tailored for the district hospital level and is specifically defined in the Health Professions Act no. 56 of 1974, but there were uncertainty among both the clinical associates and PNs.

There was one [scope of practice] *that was actually released in 20…either 2015 or 2016…the latest one that was actually released by the MEC* [Member of Executive Committee] *(4/3:139-140)*

Another problem we [clinical associates] *don't have a scope* (*3/6:332-333*)

So who's responsible for letting nurses know what my scope of practice is, is it me or the head of the department or the clinical manager (5/4:181-183)

Yes we [clinical associates] *are familiar with it but I don't think most of us use it. We work based on what we were taught at school* (*1/2:76-77*)

Functional challenges, specifically with the PNs, emerged through sharing of experience, giving of advice and guidance, superiority, and conflict in the PE. The sharing of experience and giving of advice and guidance amongst HCPs can either facilitate or hinder optimal service delivery and patient care. Some of the clinical associates felt that PNs should share their experience and their knowledge with them in the PE.

Nurses should make sure that they share their experiences with us (2/4:190-191)

The nurses they should give us advice and they must give us guidance" (3/1:42-43)

Superiority of some PNs were experienced by clinical associates, which affected their professional relationship.

There is no good relationship because they [PNs] *think they're better qualified than this ones* [clinical associates]*, so that's why there's always clash there at workplace (3/29-30)*

A new cadre starting to work in the PE without proper introduction can cause conflict. This was the case with PNs when clinical associates were introduced.

They [PNs] *know nothing about us so it creates conflicts at work* (*3/6:333-334*)

There is conflict here and there between PNs and us, clinical assistants but then we're hanging in there, we're pushing (*2/1:18-19*)

Ministerial collaboration challenges in the healthcare system also emerged as some clinical associates still feel that not enough has been done to introduce them to the public healthcare sector. They mentioned that the Minister of Health foresees all health human resource issues in the country. He has a responsibility to ensure that all sections of the healthcare sector are well represented which includes them.

So if our minister, our current minister can introduce us properly to the system and register us as…like nurses who have been long there well get along together and the working environment will be of the right state (2/2:58-60)

I think the minister didn't introduce this course very well (6/3:109)

I think someone should come and tell everyone about us and explain what it is we have to do, what it is we don't have to do (1/5:222-223)

Personal professional challenges. Personal professional challenges included four sub-themes namely lack of independence, poor remuneration, poor career progression, and being a supporting profession to physician shortages.

In the PE, the clinical associates have a lack of independence as they must work under direct supervision of a physician as per their scope of practice. This hinders most of the clinical associates to function optimally as they need supervision for the application of most of their professional skills.

They changed everything. They…on the procedures they said "under supervision and they wrote all the procedures but they wrote "under supervision (6/4:188-189)

They changed everything…even for oxygen they write at the top it's under supervision (6/4:189-190)

There are certain skills I believe we [clinical associates] *should do without any supervision (6/7:327)*

I can work independently (4/11:519)

We [clinical associates] *can't be supervised for whole life (6/7:329-330)*

Clinical associates are currently not authorised to prescribe medication independently, which is also causing a lack of independence.

I can prescribe but it needs to be counter-signed (5/5:210)

Cause they [physicians] *always counter-sign, the senior physician counter-sign (1/3:104-105)*

Poor remuneration was also mentioned as a frustration amongst clinical associates; they feel that their salaries do not reflect the kind of work they are doing on a daily basis. This could also potentially affect the professional relationship among HCPs because poor remuneration could reflect a lower professional reputation in the PE

Because if you put supervision in everything, obviously the salary must decrease (6/10:489-490)

I don't know how to explain it but we're really underpaid (6/10:499-500)

We didn't get gradings or whatever they call it, we just stuck…even the salary, cause a clinical associate who started working six or five years ago, still get the same salary I get so (1/10:484-485)

Poor career progression was also evident as many clinical associates felt that they are stagnant due to poor career progression as there are no promotion opportunities and no future plans in place for them regarding their career path.

Career progression. Once you are a clinical associate, like I've been qualified since 2012, nothing different has changed. Nothing different has changed. Still it's the same way. We don't have senior clinical associates, chief clinical associate, things like that (4/6:306-309)

There is no improvement career-wise (3/8:433)

Some clinical associates agreed that their profession was a supporting profession to physician shortages experienced in the country.

It [the clinical associate profession] *was introduced just to breach the gap (5/6:301-302)*

It's to fill the gap, the void that the shortage of doctors (3/3:129)

So there is a huge gap for doctors. So… as this course was introduced, it was to just patch on the gap (6/9:459-461)

LIMITATIONS OF THE STUDY

Due to the nature of the study, data collection was time consuming. This was due to the fact that the participants were clinical associates allocated in different district hospitals allocated a far distance from each other within Gert Sibande district.

In this study only 4 of the 7 district hospitals (N=7; n=4) participants agreed to participate, therefore the sample size where small, however data saturation where reached in both populations interviewed. The findings could therefore only be used as guide in other PEs.

There is no literature available on professional relationship between PNs and clinical associates, as there was no previous research found on their professional relationship, leading to limited information for literature control.

DISCUSSION

Optimal professional relationships in the PE are pivotal to improve service delivery and deliver quality care. Currently, developing countries such as South Africa are affected by various healthcare challenges, especially shortages of HCPs caused by poor economic growth and unemployment, taking into account that 83% of the population visit the public healthcare sector for healthcare (Rabie et al., 2016).

In order to address the shortages of HCPs, specifically physicians, the South African government implemented various plans to address these shortages and improve service delivery in PHC facilities and district hospitals by introducing clinical associates (Martin, 2016). Clinical associates' main purpose was to address the shortage of physicians in the rural areas and public

healthcare sector (Doherty & Couper, 2016). From practical experience as a PN, it is clear that there are various challenges affecting the professional relationship among PNs and clinical associates which should be addressed to improve service delivery.

In order to ensure good service delivery, Doherty, Conco, Couper, and Fonn (2013) found that having and maintaining professional relationships in the PE require a sense of maturity, a sense of professionalism, as well as a desire to work in a positive PE (Owens, 2019). Therefore, it is important for HCPs, especially PNs and clinical associates who are the focus of this study, to understand the importance of professional relationship. The findings revealed that both populations understood what a professional relationship entails and it could be concluded as colleagues working together, the relationship amongst professionals, interaction between two people, having a collegial relationship, and being goal-orientated.

However, the professional relationship characteristics were positive and negative, of which the latter should be addressed. Some positive characteristics included support and help, mutual respect, open communication, and teamwork. Support and help between HCPs are important to ensure the success of a PE. Another characteristic, mutual respect, is also a universally accepted ethical virtue and is a fundamental component of any professional practice (Tsou, Shih, & Ho, 2015) and vital for service delivery and quality patient care (Bookey-Bassett, Markle-Reid, McKey, & Akhtar-Danesh, 2016; Kar, 2014). Mutual respect for professional character and abilities of all HCPs is essential to work in teams and during collaboration with others (Zamanzadeh et al., 2014). Research also found that if HCPs demonstrate effective communication, it is more likely to foster teamwork (Dinndorf-Hogenson, 2015). Additionally, communication and teamwork can be improved when HCPs demonstrate acceptance of one another and do not dominate each other in the PE (Okuyama, Wagner, & Bijnen, 2014). Teamwork and communication are critical characteristics for PNs to possess in order to have a highly reliable and safe PE (Yee-Shui Law & Chan, 2015) and less adverse safety events

(Agnew & Flin, 2014; Dinndorf-Hogenson, 2015; Hamric, Arras, & Mohrmann, 2015). Negative characteristics included distrust, disrespect, and unprofessionalism. Disrespectful behaviour negatively affected communication and collaboration, undermined staff morale, and created and unhealthy and hostile PE (Grissinger, 2017) which includes distrust. Addressing disrespectful behaviour should start with an absolute belief by all HCPs that no one deserves to be treated with disrespect. Grissinger (2017) mentioned that disrespectful behaviour can be addressed by establishing a committee consisting of HCPs to create a code of professionalism, establishing a standard, assertive communication process, develop policy to manage conflict, train staff, and implement a reporting programme for disrespectful behaviour. Unprofessionalism should also be addressed, as Bahaziq and Grosby (2011) found that there is a correlation between unprofessional behaviour, patient dissatisfaction, complaints, lawsuits, and poor service delivery.

Both PNs and clinical associates elicited various professional relationship challenges caused by, among others, attitudes, which emanate from a lack of professionalism (Owens, 2019). In this study, uncertainties about the scope of practice and role clarification contributed to functional challenges. Clinical associates had a lack of designation and independence because HCPs and patients do not know what to call them and clinical associates are required to practice under the supervision of physicians which clinical associates cannot be guaranteed, as the clinical associates could end up working unsupervised due to the physician shortage (American International Health Alliance, 2011). Some of the PNs believed that the clinical associates are there to reduce the physician shortage and suggested the training of more physicians rather than clinical associates. However, research has pointed out that clinical associates have proved to be efficient and causet-effective (Jolly, 2008; Hamm, van Bodegraven, Bac, & Louw, 2016) and play an important role in addressing human resource shortages and improving healthcare access in low- and middle-income countries (Doherty, 2013). According to Doherty et al. (2013), clinical associates are part of the collaborative clinical team and they must assist physicians in

relieving the workload, allowing the physicians to focus on more complex cases, making it possible for patients to be treated sooner. However, uncertainty about scope of practice of the clinical associates proved to be a challenge. Doherty et al. (2013) also confirmed that in an area where HCPs are not well informed about the scope of practice of HCPs such as the clinical associates in this study, the cadre is likely to be received with distrust. The scope of practice is compiled as a flexible framework in order to make provision for different areas of practice (Geyer, 2016). However, according to Doherty et al. (2012) some HCPs are not comfortable with the competency-based scope of practice of the clinical associates and want a more narrowly defined job description as found in this study. It is also true as revealed in the findings of this study that existing confrontations between the clinical associates and other HCPs around boundaries of scope of practice and prescription competencies are still looming (Doherty et al., 2012). Clinical associates' scope of practice should be clear and transparent to all concerned in the PE. Clinical associates mentioned that the current scope of practice and curriculum should be revised as it does not reflect their full potential, compared to physicians' scope of practice. The scope of practice of clinical associates is more specifically defined in the Health Professions Act no. 56 of 1974 (South Africa, 2015).

Functional challenges experienced from PNs by the clinical associates included that sharing of experience, giving of advice, and guidance by the PNs proved to be important to some of the clinical associates. Information and knowledge are a valuable resource and key to success in the health system (Khanum, de Lourdes de Souza, Naz, Sasso, Bruggemann, & Heideman et al., 2016). A superiority complex was also a challenge identified by both populations and is mostly due to hierarchical structures in the PE, causing counter-productiveness and leading to PNs and clinical associates losing sight of the common goal: the patient (Babiker, Husseini, Nemri, Frayh, Juryvan, Faki et al., 2014). Another challenge, namely conflict in the PE, can hinder service delivery professional relationships. In practice, one of the reasons that can be

pointed out regarding conflict in the PE is the difficulty in incorporating clinical associates within the South African health system (Mgobhozi, 2019) which was not foreseen during curriculum development of this cadre. This finding opposes the initial understanding of the incorporation of clinical associates into the South African health system and physician assistants internationally (Couper, 2014; Doherty et al, 2012; Hooker & Kuilman, 2011). Ministerial, interdepartmental, and intra-professional collaboration in the introduction of clinical associates has proven to be important to both PNs and clinical associates. Intra-professional collaboration is a collaboration between two or more disciplines within the same profession, make use of their individual skills and talents to achieve quality patient care by engaging each other, sharing perspective, planning and providing patient care together (Janssen, Sagasser, Laro, de Graaf, & Scnerpbier-de Haan, 2017). These introductions could improve or enhance professional networking and education and public health programmes (Farnan, Snyder, Worster, Chaudhry, Rhyne, & Arora, 2013). Collaboration with the Ministry of Health to give support plays an important role in formally introducing HCPs and the community on the role and scope of practice of clinical associates through the media, workshops, and roadshows. Inter-departmentally, collaboration through communication could be improved through meetings and availability of all HCPs' scope of practice, especially the new cadre of clinical associates. Intra-professionally, collaboration through in-service training can focus on defining professional relationships, how to improve and address positive and negative professional relationship characteristics, and professional relationship challenges. The Minister of Health and the regulating body, the Health Professionals Council of South Africa, could collaborate to address personal professional challenges experienced by clinical associates.

Lastly, clinical associates revealed that they have personal professional challenges such as a lack of independence to apply professional skills and prescribe medication, poor remuneration and career progression, and some feel that their profession only supports physician

shortages. They feel that ministerial collaboration is necessary but not always present. This is confirmed by Couper and Hugo (2014) in that backing of the Ministry of Health has not always seen as a supportive factor, there have been negative experiences with government in the past, and some faculties added that the BCMP degree was being thrust upon them. According to the scope of practice, clinical associates are only allowed to practice under supervision in accordance to their level of education, training, and experience (Hamm, van Bodegraven, Bac, & Louw, 2016). Therefore, the presence of a physician should form an integral part of the functioning of clinical associates (Public Health Association of South Africa [PHASA], 2013). However, in PHC facilities and district hospitals, clinical associates will be expected to perform their tasks without the required supervision as doctors are not always available (Doherty et al., 2013). With the lack of independence came partial application of skills such as prescribing of medication, as the physician has to countersign the prescriptions. The prescribing competencies of clinical associates need to be revisited and addressed (PHASA, 2013), as well as poor remuneration, poor career progression, and clinical associates as a supporting profession for physician shortage. Salary is perceived as a key factor affecting job satisfaction, employment, and retention or migration of HCPs within and across the country (Zhang & Liu, 2018). Lower salary is linked to HCP job satisfaction which, in turn, is linked to undesirable patient outcomes (Abelsen & Olsen, 2012; Sarma, Devlin, Belhadji, & Thind, 2010). Salary levels highlighted in the study can have a detrimental effect on the clinical associates as they are still low and do not take into consideration the clinical associates' workload in the PE (Mgobhozi, 2019). No overtime policies and allowances are in place (PHASA, 2013). Poor career progression of the clinical associates can also have a detrimental effect. The career path for clinical associates needs to be clarified to prevent a 'brain drain' to the private sector once new graduates have worked their bursaries (Doherty et al, 2012). The BCMP degrees should not be a dead end but should be fully recognised and should allow for further academic progression (Couper & Hugo, 2014).

According to PHASA (2013), clear career pathways and improved working conditions are of importance if clinical associates are to be retained.

Clinical associates were introduced as a supporting profession to the physician shortage in South Africa. Their contribution to the health system at the district level is noticeable. But due to a lack of role clarification and the unrefined brand of the profession (Mgobhozi, 2019), the clinical associate profession is less favourable. This can be rooted in a lack of professional identity as they are seen as a supporting profession to the physician shortage. Consequently, due to a lack of designation, the clinical associates manifest physician identities, as is apparent in the results. This false identity caused by a lack of designation is dangerous for patients and could breach ethical principles where patients have a right to know the true identity of the practicing HCPs (Mgobhozi, 2019).

CONCLUSION AND RELEVANCE TO CLINICAL PRACTICE

Professional relationships form the basis of success for the healthcare system. The professional relationship between PNs and the relatively new cadre of HCPs called clinical associates has not been the focus of research studies. There are various challenges in this relationship that need to be addressed as it can negatively impact on service delivery. Although some challenges revealed by both PNs and clinical associates were very similar in the PE, there were also unique personal professional challenges that the clinical associates had.

Both populations could define a professional relationship between themselves, although the clinical associates had a perception of a more personal connection in their professional relationships by mentioning that it is a ‘collegial relationship’ and ‘interaction between two people’ and ‘goal orientation’, whereas the PNs’ perception was that it was only ‘colleagues working together’ and ‘relationship amongst professionals’; there does not have to be a relationship between them. The PNs added positive and negative professional relationship

characteristics, whereas the clinical associates only perceived positive characteristics in their relationship with PNs. The professional relationship challenges revealed that both populations perceived attitude as a challenge, whereas the PNs only experienced functional challenges related to clinical associates. Clinical associates, on the other hand, perceived that there are functional challenges for themselves and the PNs. Both populations revealed that there is a ministerial collaboration challenge that needs to be addressed, whereas the PNs added interdepartmental and intra-professional collaboration. Lastly, clinical associates also added that they have personal professional challenges, such as a lack of independence, poor remuneration, career progression, and that it is a supporting profession to physician shortages; these were not perceived by the PNs.

Although there are many types of challenges affecting the professional relationship between PNs and clinical associates, these challenges could be addressed without difficulty through ministerial, interdepartmental, and intra-professional collaboration. Ministerial collaboration though the media, workshops, and roadshows could be an accomplishable method to communicate. Interdepartmentally (outpatient, causality, and theatre), communication could be improved through meetings and availability of the scope of practice of all healthcare practitioners including the new cadre of clinical associates in the standard operating procedure files. Intra-professionally, two or more disciplines (PNs and clinical associates) within the same profession (healthcare) should engage in learning and collaborating together in the PE through in-service training. In-service training can focus on what a professional relationship entails, how to improve and address positive and negative professional relationship characteristics, and professional relationship challenges.

Lastly, the personal professional challenges of the clinical associates should be addressed on a governmental level by the Minister of Health and regulating bodies such as the HPCSA.

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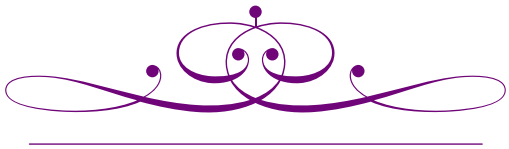

CHAPTER 3

CONCLUSIONS, RECOMMENDATIONS, AND LIMITATIONS OF THE STUDY

CHAPTER 3
CONCLUSIONS, RECOMMENDATIONS, AND LIMITATIONS OF THE STUDY

3.1 INTRODUCTION

This chapter includes the conclusions and recommendations for practice, research, education, and policy. Thereafter, the limitations of the study, personal journal of the researcher, and chapter summary follow. The conclusion provides an insight to reaching each objective of the study.

3.2 CONCLUSIONS

This chapter presents an overview of the findings and conclusions reached during the course of the study. This is a unique study as research on the professional relationship between PNs and clinical associates has never been conducted before. The South African healthcare system faces many challenges such as HCP shortages, especially physicians. Therefore, decentralisation of healthcare services to promote service delivery has been done. Various strategies were implemented by the South African government to address the shortages of physicians of which one was to introduce the new cadre of HCPs (clinical associates), especially in rural areas, to ease service delivery to the South African population. Despite the improvement in quality patient care and service delivery, the public healthcare system is still facing many challenges (Matlakala & Botha, 2016:49).

The research design and method were purposefully developed and reviewed by various committees which included the NuMIQ Focus Area and HREC to achieve the objectives of the study, and the conclusions drawn from the results which indicate that the study was a success. The semi-structured individual interviews with two populations (PNs and clinical associates) assisted the researcher to get a rich understanding of the professional relationship among both populations which were separately explored and described. The findings by the researcher in this study are consistent with the literature and problem statement.

The most unique findings that came from both populations were that there are various challenges in the professional relationship between the two populations. There were many similar findings but also unique findings in both populations. The following main themes emerged from the PNs: professional relationship defined, professional relationship

characteristics, and professional relationship challenges. The following main themes emanated from the clinical associates: professional relationship defined, professional relationship characteristics, professional relationship challenges, and personal professional challenges. The themes were discussed in detail in Chapter 2. Even though there are challenges that were identified, they could easily be addressed through ministerial, interdepartmental, and intra-professional collaboration.

Objective 1: to explore and describe the PNs' perceptions of the professional relationship between themselves and the clinical associates

The findings of the study suggest that some of the PNs are not completely receptive of the clinical associates in the PE. There were challenges that emanated from the professional relationship in the PE. These challenges were solely focused on the perceptions of the PNs regarding clinical associates. Both PNs and clinical associates defined a professional relationship according to their own understanding. The PNs mentioned that a professional relationship is about colleagues working together and relationships among professionals. Professional relationship characteristics also manifested which were positive and negative. Positive characteristics included support, open communication, and teamwork. Negative characteristics included distrust, disrespect, and unprofessionalism. Distrust emanated from the lack of clarity in the clinical associates' scope of practice. PNs felt that there was a lack of transparency and clarity regarding the clinical associates' scope of practice. PNs felt that the scope of practice should be made available and easily accessible. Role clarification was also pinpointed as one of the factors that can have an effect on the professional relationship between PNs and clinical associates. The issues of trust and work ethics mentioned have negatively impacted on the professional relationship between the PNs and clinical associates. PNs felt disrespected by the clinical associates in the PE. The feeling of unprofessionalism was derived from some behaviours that the clinical associates were displaying that PNs felt were unprofessional.

Professional relationship challenges were also stated by the PNs. The challenges identified were attitude, functional challenges specifically to the clinical associates which included lack of designation of clinical associates, superiority, uncertainties about the clinical associates' scope of practice as it is not transparent and easily accessible, lack of independence as clinical associates work under supervision of a physician, role clarification of the clinical associates in the PE, and physician shortage to supervise clinical associates as they need constant supervision from the physician. Some PNs felt that more physicians should be trained rather than clinical associates. Ministerial, interdepartmental, and intra-professional collaboration was also mentioned as a challenge that can hinder professional relationships in the PE. The PNs felt

the need for the Ministry of Health to utilise the available media, roadshows, and workshops to introduce and promote the clinical associate cadre to other HCPs and the community at large, as well as interdepartmental meetings and ensuring that all HCPs including clinical associates' scope of practice is in the standard operating procedure files. Intra-professionally, HCPs especially PNs and clinical associates, can engage in learning and collaborating together in the PE through in-service training. In-service training should focus on how the professional relationship is defined and how to improve and address positive and negative professional relationship characteristics and professional relationship challenges relating to attitude, functional – clinical associates, functional – PNs, ministerial, interdepartmental, and intra-professional collaboration.

Objective 2: To explore and describe the clinical associates' perceptions of the professional relationship between themselves and the PNs

Clinical associates were introduced in the district health system to help reduce physicians' workload and as a long-term solution to human resource challenges in PHC facilities and district hospitals (Doherty *et al.,* 2012:833). However, there are factors that negatively impact on their job (Doherty, 2013:2). The clinical associates' definition of professional relationship stated that it is about interaction between two people, collegial relationships, and being goal-orientated. Clinical associates mentioned only positive professional relationship characteristics which were mutual respect, support, and help.

During the data collection, it was noted that clinical associates are also experiencing professional relationship challenges. The challenges mentioned were attitude which also emanated from the PNs. Functional challenges for both clinical associates and PNs were revealed. The functional challenges, specifically for clinical associates, included lack of designation as clinical associates have settled to be called physicians by patients, which is ethically wrong as patients have a right to know the identity of the treating HCP. Superiority was based more on the fact that clinical associates felt that by virtue of having a degree as a qualification and the clinical skills that they were taught at the university, they should be superior to PNs. Role clarification of the clinical associates in the PE has proved to be one of the challenges faced by both clinical associates and PNs. There is uncertainty regarding the scope of practice of clinical associates. This does not only affect the PNs but clinical associates as well. Clinical associates feel that the current scope of practice does not reflect their expertise as a whole, as it is more focused on generalist skills and therefore they cannot apply their professional skills independently. The issue of clinical associates working under the supervision of a physician was also not well received even though it is stated in the literature that it can help reduce conflict around scope of practice. Functional challenges with specific reference to PNs

included clinical associates mentioning that PNs should share their experience and give advice and guidance. Conflict in the PE exists because of most of the challenges mentioned. Clinical associates also mentioned that ministerial collaboration is necessary and that the Ministry of Health should reflect on the healthcare system as a whole with the assistance of the HPCSA to identify personal professional challenges that need attention, especially for clinical associates.

Lastly, clinical associates are confronted with personal professional challenges such as lack of independence, specifically the application of professional skills and prescribing of medication, poor remuneration and career progression, as well as being a supporting profession to physician shortages. Clinical associates are currently not authorised to prescribe medication independently. This, however, is not a reflection of their training but a direct consequence of the current laws and regulations that govern healthcare in South Africa (see Chapter 1, Table 2). As a supporting profession to the physician shortage and the kind of skills that they possess, the clinical associates feel that they are poorly remunerated. This could lead to job dissatisfaction and can have a negative effect on the professional relationship. Currently, career pathways of the clinical associates are not clear. Clinical associates vented their frustrations regarding poor career progression as they feel stagnant. Involving the HPCSA in ministerial collaboration regarding the clinical associate profession role and scope of practice is therefore very important, as well as to revise their scope to ensure more independence and assist clinical associates to reach their full potential and be able to work independently and not only be seen as a supporting profession to physician shortages.

As a result, the findings of the research study clearly showed that there are challenges between the PNs' and the clinical associates' professional relationships in the PE, but both populations understand that support between them is pivotal to reach one common goal which is service delivery.

3.3 RECOMMENDATIONS

Recommendations were formulated by the researcher for practice, research, education, and policy.

3.3.1 Recommendations for practice

- The role, scope of practice, and function of clinical associates to all HCPs, especially PNs working closely with them in the PE, should be communicated and the scope of practice should be available in standard operating procedure files. Nurse managers of units should

take the responsibility with other HCPs, especially clinical associates, to see that these are in place.

- Introduction of on-going in-service programmes aimed at role and scope clarification for clinical associates, PNs, and other HCPs in the PE.
- Establishment of special meetings, education and training platforms like workshops to alleviate any challenges between PNs, clinical associates, and other HCPs.
- All HCPs, especially PNs and clinical associates, should receive in-service training on the attributes, consequences, and empirical importance of developing and maintaining professional relationships.
- The activation of strategies focussing on interpersonal communication skills to assist PNs and clinical associates in developing and maintaining professional relationships.
- Encouraging awareness of differences and respect between HCPs, especially PNs and clinical associates in the PE.
- Encouraging the bridging of communication between all levels of HCPs, especially PNs and clinical associates, through team building among HCPs in order for them to realise how much they need each other and that all share a common goal, namely service delivery.
- Encouraging professional autonomy and respect thereof.
- Implementation of a mentoring programme by management of the PE to support PNs, clinical associates, and other HCPs.
- Clear policy guidelines in terms of hierarchical structure, power, and authority on the notice boards and standard operation procedure files in the PE.
- Encouraging a culture of accommodating diversity in terms of different professions in the PE.
- Ensuring that all HCPs, especially clinical associates, who do not have distinguishing devices wear name tags with their name, surname, and profession.
- All HCPs should be encouraged to share experience, give advice, and give guidance to all HCPs in the PE to improve service delivery.

- In-service training for all HCPs, especially PNs and clinical associates, in the PE on the importance of professionalism and what it entails.

3.3.2 Recommendations for research

The researcher identified a large gap in research regarding the professional relationship between PNs and clinical associates and therefore suggests the following topics for future research.

- Larger studies should be done focussing on other HCPs to explore their professional relationship with clinical associates.
- It is recommended that a larger population should be included to ensure the results are more representative of a larger population.
- Future research should be explored regarding the role of clinical associates in the improvement of service delivery and quality healthcare as well as their opinion about their role in the district health system.
- Researching the perceptions of physicians on the effectiveness of clinical associate profession as they are not allowed to practice independently.
- Examination of the impact of the clinical associates' scope of practice on conflict with the PNs as well as the impact on the professional relationship among the two HCPs.
- Research based on diversity of different HCPs in the PE.
- Research on what causes barriers between different HCPs in the PE and how they should be handled.
- Research on integration of conflict management amongst HCPs in the PE.
- Research on tailoring of the PE based on PE sensitivities.
- Research on the specific role of clinical associates in district hospitals and PHC facilities respectively in order to clarify any misunderstandings between PNs and clinical associates.

- Research could be undertaken to determine what clinical associates' designation is in order to inform all HCPs and patients what they should be called.

3.3.3 Recommendations for education

The subsequent recommendations were made towards improving nursing education:

- The PNs should be educated regarding the clinical associates' scope of practice and their limitations.
- Enhance awareness and understanding of the clinical associates' role as members of the HCP team in the PE.
- Developing appropriate measures in dealing with challenges which could cause conflict and tensions between the PNs and the clinical associates.
- Orientation programmes regarding clinical associates' role should be put in place and encouraged by the nursing managers in the PE.
- Ongoing administrative and leadership support should be given to the PNs to encourage teamwork and how to prevent and/or handle challenges such as superiority elicited by other HCPs.
- Developing strategies such as interdepartmental collaboration and practice-based interventions designed to help PNs and clinical associates work more effectively together.
- Education and training on professionalism which includes professional relationships and what it entails in the PE.

3.3.4 Recommendations for policy

The following recommendations are made to assist in policy making in order to improve the professional relationship between PNs and clinical associates.

- The DoH making the clinical associates guidelines accessible to all HCPs in the district health system through the availability and transparency of the clinical associates' scope of practice and policies.

- Developing policies on management of current challenges between different HCPs.
- Making it a prerequisite for all current and new employees to attend diversity and inclusiveness workshops to promote and support integration between the HCPs.
- In-service training on different HCPs' scope of practice.
- Definitive need for more dissemination of information regarding the role and scope of practice of clinical associates through media, roadshows, and workshops.
- All HCPs' scope of practice should be available in standard operating procedure files.
- Clinical associates should have noticeable distinguishing devices.

3.4 LIMITATIONS OF THE STUDY

The following limitations of the research study were identified:

Time frame: Data collection took a lot of time as the participants were allocated in different hospitals in the Gert Sibande district; this is because a maximum of three clinical associates are allocated to district hospitals.

Sample size: The sample size played a big role in obtaining the expected results. Due to a low number of participants that were willing to participate, the findings of this study can only be used as a guide to understanding the professional relationship between the PN and clinical associate population of South Africa. A larger sample size which includes more districts could be used in future studies.

Unwillingness to participate by other participants: Many clinical associates were reluctant to participate in the study due to the fact that the researcher is a PN. The researcher wanted to guard against this by using a person as co-interviewer that was not a PN, but the clinical associates were still unwilling to take part. Some signed the consent forms but when the interviews were scheduled to take place, some of them did not arrive for the scheduled appointment or sign the consent forms. This behaviour did not, however, derail the researcher from obtaining data from the few willing participants.

Scheduling time: Scheduling of the individual interviews proved to be a challenge. The researcher made means to schedule appointments after hours or at the most convenient time

for the participants, but this also proved to be a challenge as some participants could not honour the appointment and/or withdrew unexpectedly.

The usage of digital voice recorder: Most of the participants were willing to take part in the study; however, the idea of being recorded had an effect. Most verbalised that they preferred a questionnaire over an interview. The researcher explained to them that their interviews will remain anonymous and confidential. As the research study is voluntary, the participants were granted the right not to participate in the study.

Clinical associate concept: During the interviews, it was clear that PNs were not well informed about clinical associates' role in the district health system even though only PNs working with clinical associates were included in the interviews. This led to limited data being generated as the focus was more on working conditions and career pathways issues.

Literature: There is no literature available on the professional relationship between PNs and clinical associates, as no such previous study was done. As a result, limited information was available for literature control.

Context of the study: This study was only limited to and focussed on the district hospitals at Gert Sibande District in Mpumalanga and not necessarily representative of all public healthcare settings (hospitals and primary healthcare facilities); therefore, the results can only be used as a guide for other districts, provinces in South Africa, and other countries. However, it should be noted that the study has provided sufficient insight into the professional relationship, level of knowledge, and the perceived role of clinical associates by PNs and vice versa.

3.5 PERSONAL JOURNAL OF THE RESEARCHER

Completing my master's degree in nursing management is surely the highlight of my nursing study journey throughout the years. I can honestly say it has been one of the biggest challenges I have ever encountered in my academic career. My research journey has changed the way I view everything scientific, and in the process, I have gained the outmost respect for all researchers universally. Feelings regarding the chosen topic: the research process brings so much more than just being able to properly conduct a research study. It is from engaging in the actual study to being aware of how your own bias and prejudice as a researcher can have an influence on the research process. The dynamics involved and explored during research process have opened a world of possibilities in terms of how a problem can actually have a solution if and when researched properly.

Through my journey with this degree, I have realised that good supervisors are like skilled midwives who, having been on the same road many a time, acquired the wisdom that no two encounters are the same. I was so blessed and favoured to have a supervisor (Dr T. Rabie) who guided me with her expert knowledge and research skills to conduct this study, and my co-supervisor (Dr A. du Preez) for her support. It has been such a challenging but fulfilling journey which has brought joy, frustration, and tears throughout the years, but their support and guidance through it all can never go unnoticed. The joy it brought me was the excitement of partaking in something (master's degree) that was once upon a time a pie in the sky.

The main frustration of the study was conducting the interviews. Scheduling of interviews was difficult and cancellation of interviews at the last minute was very frustrating as the district hospitals were allocated far from where I work. I recollect having to drive close to 2 hours to an interview appointment at one hospital, only to get there and be told by the participants (clinical associates) that they are not interested in participating in the study based on the fact that I'm a nurse, after having received an information leaflet before the time and a consent form which specified my profession and the focus of the study. This was very discouraging; I was so down after hearing that, but at the same time accepted that a research study is voluntary. I literally shed some tears because their reaction actually showed me that there is indeed a bigger problem than realised in the professional relationship between PNs and clinical associates. Overall, I have grown a lot as an individual throughout this journey. I'm truly thankful for the opportunity given to me by the North-West University to sharpen my skills as a researcher.

3.6 CHAPTER SUMMARY

In this chapter, the researcher reflected on the objectives of this study. The recommendations and limitations of the study were mentioned. In conclusion, it is important that clinical associates and PNs should to be more aware of the importance of each of the two disciplines in the PE to ensure successful service delivery. The findings of the study made it clear that there are challenges between PNs and clinical associates that can, if not curbed in time, lead to dire consequences in the healthcare system at large. However, there were PNs and clinical associates who were optimistic about improving the professional relationship in the PE regardless of different opinions, which was very encouraging. The professional relationship between PNs and clinical associates can be improved through implementing ministerial, interdepartmental, and intra-professional collaboration measures to accommodate and understand each other's role in the PE and to ensure and improve service delivery.

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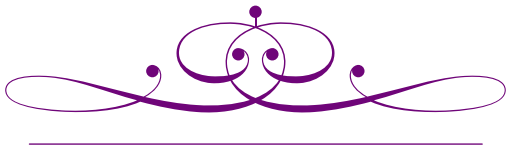

APPENDIXES

APPENDIX A:

ETHICAL CLEARANCE CERTIFICATE – HREC NWU

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom,
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Tel: (018) 299-4900
Faks: (018) 299-4910
Web: http://www.nwu.ac.za

Research Ethics Regulatory Committee
Tel: +27 18 299 4849
Email : Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by **Health Research Ethics Committee (HREC)** on **11/09/2017**, the North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby **approves** your study as indicated below. This implies that the NWU-RERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: The professional relationship between professional nurses and clinical associates in a selected district hospital
Study Leader/Supervisor: Dr T Rabie
Student: EM Mojalefa-23973293
Ethics number:

N	W	U	-	0	0	3	5	5	-	1	6	-	A	1
Institution				Study Number						Year			Status	

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single study
Commencement date: 11/09/2017 **Risk:** Minimal

Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The study leader (principle investigator) must report in the prescribed format to the NWU-RERC via HREC:*
  - *annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *Annually a number of studies may be randomly selected for an external audit.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these amendments at the HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility the NWU-RERC and HREC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the study are revealed or suspected,*
    - *it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,*
    - *the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately,*
    - *new institutional rules, national legislation or international conventions deem it necessary.*
- *HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.*

The RERC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the RERC or HREC for any further enquiries or requests for assistance.

Yours sincerely,

Prof Refilwe Phaswana-Mafuya
Chair NWU Research Ethics Regulatory Committee (RERC)

APPENDIX B: PERMISSION – RESEARCH AND ETHICS COMMITTEE, MPUMALANGA PROVINCE

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
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Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Enquiries: Themba Mulungo (013) 766 3511

23 March 2017

Ms. Emmah Mojalefa
P.O Box 179
Nucam
2355

Dear Ms. Emmah Mojalefa

APPLICATION FOR RESEARCH & ETHICS APPROVAL: THE PROFESSIONAL RELATIONSHIP BETWEEN PROFESSIONAL NURSES AND CLINICAL

The Provincial Health Research and Ethics Committee has approved your research proposal in the latest format that you sent. This approval is valid for one year.

PHREC REF: MP_2017RP47_119

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

MS. TZ MADONSELA
MPUMALANGA PHRC

MPUMALANGA PROVINCE
DEPARTMENT OF HEALTH
PLANNING & INFORMATION
2017 -03- 24
PRIVATE BAG X 11285
NELSPRUIT 1200

24/03/2017
DATE

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX C:

PERMISSION - DISTRICT MANAGER, GERT SIBANDE DISTRICT

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REPUBLIC OF SOUTH AFRICA

MPUMALANGA
THE PLACE OF THE RISING SUN

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Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Letter of Support Signed by Chief Director (CD)/CEO/District Manager (DM)/Programme Manager (PM)

1. Name & contact no. of Applicant	Miss Emmah Mohlware Mgolefa 0735129931		
2. Title of Study:	The professional relationship between professional nurses and clinical associates in selected district hospitals		
3. Aim and population target:	The purpose of the study is to explore and describe the professional nurse and clinical associate's perceptions of the professional relationship between them. Population target: professional nurses and clinical associates		
4. Period to undertake the study	From: 03 April 2017 to: 31 May 2018		
5. Resources Required from Facility/Sub-district/Community			
5.1: Facility Staff Required to assist with the Study	(Yes)		NO
	How many:		
	Nurses:	2 in each hospital	
	Doctors:	N/A	
	Other, please specify:	N/A	
5.2: Patient Records/Files	Yes		(NO)
5.3: Interviewing Patients/ participants at Facilities	Yes		(NO)
5.4: Interviewing Patients/ participants at Home	Yes		(NO)
5.5: Resource Flow (Are there benefits to Patients/community)	Yes		NO
	Please list:		
5.6: Resource Flow (Are there benefits to Facility/District)	(Yes) Direct and indirect benefits		NO
	Please list: attached.		
6. Availability of Required Clearance			
6.1: Ethical Clearance	(Yes)	Pending	NO
	Clearance Number: NWU-00353-16-S1		
6.2: Clinical Trial	Yes	Pending	(NO)
	Clearance Number:		
6.3: Vaccine Trial	Yes	Pending	(NO)
	Clearance Number:		
6.4: Budget	(Yes)		NO
	Source of fund: Researcher		

Declaration by Applicant:
I Mr/(Ms)/Dr/Prof/Adv. Emmah Mohlware Mgolefa agree to submit/present the result of this study back to the CEO/Institution/District.

Comment by CEO/DM/PM: **Supported / Not Supported**
Ethical study will make own arrangement with hospital CEO

Signature of CEO/CD/DM/PM
Name:

17/02/2017
Stamp/Date:

Please email completed form to: JerryS@mpuhealth.gov.za **or** ThembaM@mpuhealth.gov.za

Please note that this letter is not an approval to undertake a study, but a support letter from identified facility/distrct.
i.e. the CEO/District Manager acknowledges to have been consulted on the study

APPENDIX D: PERMISSION - ERMELO PROVINCIAL HOSPITAL

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

01 Joubert Street, Ermelo, 2350
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ERMELO HOSPITAL

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Enquiries: G.T Nkambule 2058 Tel: 017 811 2031

TO : **Ms E MOJALEFA**

FROM : **Ms. C.M MBUYANE**
: **CHIEF EXECUTIVE OFFICER**
: **ERMELO HOSPITAL**

DATE : **24 JULY 2017**

SUBJECT : **PERMISSION TO CONDUCT RESEARCH: ERMELO HOSPITAL**

1. The above matter has reference:
2. Ermelo Hospital Management hereby grants permission for research to be done regarding the relationship between Professional Nurses and Clinical Associates in our facility.
3. Thank you

.....
Ms. M.C Mbuyane
Chief Executive Officer
Ermelo Hospital

24/07/2017
Date

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX E: PERMISSION - BETHAL HOSPITAL

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Bethal Hospital, Wicht street, Bethal, 2309, Mpumalanga Province. Private Bag X1005,
Bethal, 2309, Mpumalanga Province
Tel I: +27 (17) 647 6341

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Enquiries: MS. S LUNDALL (017 647 6341 X 2336)

TO: **WHOM IT MAY CONCERN**

FROM: **MR M.E MTEMBU KAMABUZA**
CEO – BETHAL HOSPITAL

DATE: **25 MAY 2017**

SUBJECT: **PERMISSION TO CONDUCT RESEARCH: BETHAL HOSPITAL.**

Bethal Hospital Management hereby grants permission for research to be done regarding the relation between Professional Nurses and Clinical Associates at Bethal Hospital.

Thank you

MR ME MTEMBU KAMABUZA
CEO – BETHAL HOSPITAL

2017-05-25
DATE

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX F: PERMISSSION - CAROLINA HOSPITAL

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

20 Pearce Street, Carolina, 1185, Mpumalanga Province
Private Bag X 708, Carolina,1185, Mpumalanga Province
Tel I: 017 843 1026, Fax: 017 843 1914

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

TO : **MS EM MOJALEFA**

FROM : **MS MG NDLOVU**
CHIEF EXECUTIVE OFFICER
CAROLINA HOSPITAL

DATE : **26 JULY 2017**

SUBJECT : **ACKNOWLEDGEMENT OF RECEIPT**

Kindly take note that the Carolina Management has acknowledge your letter dated on the 04 April 2017.

Permission to conduct your study in Health Research and Ethics at Carolina Hospital has been granted.

NB: All information and the results there after will be share with the hospital concerned.

Hope all the confidentiality will be taken into consideration.

MS MG NDLOVU
CHIEF EXECUTIVE OFFICER
CAROLINA HOSPITAL

26/07/2017
DATE

APPENDIX G: PERMISSION - EMBHULENI HOSPITAL

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Stand no 40B, Diepgezet road Elukwatini B 1192 Mpumalanga Province, Republic of South Africa Private Bag X 1001, Elukwatini 1192, Tel: 017 883 0093, Fax: 017 883 0044, int: +017 883 0044

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

11 October 2017

Ms. Emmah Mojalefa
PO 179
Nucum
2355

Dear Ms. Emmah Mojalefa

RE: APPLICATION FOR RESEARCH & ETHICS APPROVAL: THE PROFESSIONAL RELATIONSHIP BETWEEN PROFESSIONAL NURSES AND CLINICAL ASSOCIATES

Embhuleni hospital has approved your research proposal in the latest format that you sent. This approval is valid for one year.

Clearance number NWU- 0035 – 16 – S1

The title study: The professional relationship between Professional Nurses and Clinical Associates in selected district hospitals.

The purpose of the study: To explore and describe the Professional Nurses and Clinical Associates perceptions of the professional relationship between themselves.

The objective of the study: To explore and describe the Professional Nurses perceptions of the professional relation between themselves and Clinical Associates.

To explore and describe the Clinical Associates perceptions of the professional relationship between themselves and Professional Nurses.

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Recommended by

Dr. J.K Mohale
Clinical Manager Embhuleni Hospital
Specialist Family Phys.c an
MMED (Fam Med) PCFP

2017/10/12
DATE

DR. JK MOHALE
CLINICAL MANAGER
EMBHULENI HOSPITAL

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX H: PERMISSION - PIET RETIEF HOSPITAL

MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel I: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Letter of Support Signed by Facility Manager/CEO/District Manager (DM)/Programme Manager (PM)

1. Name & contact no. of Applicant	Emmah Mohlware Mojalefa. Cell: 073 512 9931/064 658 3079, Email: emmojalefa@gmail.com		
2. Title of Study	The professional relationship between Professional nurses and Clinical associates in selected district hospitals		
3. Aim and population target	To explore and describe the Professional nurses and Clinical Associates perceptions of the professional relationship between themselves. Population: Professional nurses and Clinical Associate		
4. Period to undertake the study	From: to:		
5. Resources Required from Facility/Sub-district/Community			
5.1: Facility Staff Required to assist with the Study	**Yes** **How many:** Nurses: Doctors: Other, please specify:		**NO X**
5.2: Patient Records/Files	**Yes**		**NO X**
5.3: Interviewing Patient at Facilities	**Yes**		**NO X**
5.4: Interviewing Patients at Home	**Yes**		**NO X**
5.5: Resource Flow (Are there benefits to Patients/community)	**Yes X** Please list:		**NO**
5.6: Resource Flow (Are there benefits to Facility/District)	**Yes X** Please list:		**NO**
6. Availability of Required Clearance			
6.1: Ethical Clearance	**Yes X** Clearance Number:	**Pending**	**NO**
6.2: Clinical Trial	**Yes** Clearance Number:	**Pending**	**NO X**
6.3: Vaccine Trial	**Yes** Clearance Number:	**Pending**	**NO X**
6.4: Budget	**Yes X** Source of fund: Self funding		**NO**

Comment by CEO/DM/PM: **Supported / Not Supported**

Signature of CEO/DM/PM
Name:

DEPARTMENT OF HEALTH
MPUMALANGA
PIET RETIEF HOSPITAL
2017 -08- 23
Stamp/Date:
P/BAG X9, PIET RETIEF, 2380

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX I: PERMISSION - STANDERTON HOSPITAL

Health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Kruger Street, Standerton, 2430, Mpumalanga Province
Private Bag X 2003, Standerton 2430, Mpumalanga Province
Tel: +27 (017) 712 9600, Fax: +27 (017) 719 1112: +27 17 712 1588

Litiko Letemphilo | Departement van Gesondheid | Umnyango WezaMaphilo

To: Ms. Emmah Mojalefe

From: Ms. K.S Hlatshwayo
Acting CEO: Standerton Hospital

Date: 06 July 2017

RE: APPLICATION TO CONDUCT RESEARCH ON THE PROFFESSIONAL RELATIONSHIP BETWEEN PROFFESSIONAL NURSES AND CLINICAL ASSOCIATES.

Standerton hospital is hereby giving you permission to conduct the above – mentioned research proposal.

Kindly ensure that the study is conducted with minimal disruption and impact on the hospital staff.

Kind regards,

Ms. K.S Hlatshwayo
Acting CEO
Standerton Hospital

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX J: PERMISSION - EVANDER HOSPITAL

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

c/o Bologna and Lauzanne Street Evander, 2280, Mpumalanga
Private Bag X1005, Evander, 2280, Mpumalanga Province
Tel I: 017 6322127/8,int:+27 17 6322127/8, Fax:017 6322222, Int+2717 6322222

Litiko Lelemphilo Departement van Gesondheid UmNyango WezeMaphilo

To : **MS EMMAH MOJALEFA**

FROM : **MR JS APHANE**
CHIEF EXECUTIVE OFFICER
EVANDER HOSPITAL

DATE : **19 JUNE 2017**

SUBJECT : **APPROVAL TO CONDUCT RESEARCH AND ETHICS IN EVANDER HOSPITAL**

Kindly take note that your application requesting approval to conduct research and ethics in Evander Hospital has been granted.

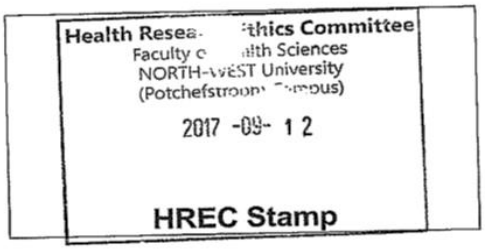
Mr JS APHANE
CHIEF EXECUTIVE OFFICER
EVANDER HOSPITAL

2017.06.19
DATE

MPUMALANGA
THE PLACE OF THE RISING SUN

APPENDIX K: INFORMATION LEAFLET AND CONSENT FORM - PROFESSIONAL NURSES

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS



PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR PROFESSIONAL NURSES

THE PROFESSIONAL RELATIONSHIP BETWEEN PROFESSIONAL NURSES AND CLINICAL ASSOCIATES IN SELECTED DISTRICT HOSPITALS.

REFERENCE NUMBERS: NWU-00355-16-S1

PRINCIPAL INVESTIGATOR: EMMAH MOJALEFA

ADDRESS: INSINQ, SCHOOL OF NURSING SCIENCE, NORTH-WEST UNIVERSITY, BUILDING F7B, POTCHEFSTROOM, 2520

You are being invited to take part in a research project that forms part of my Masters degree in Health Science Management. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00355-16-S1)** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

- This study will be conducted in a private room within the ward that you are working after hours and will involve semi-structured individual interviews with an experienced health researcher, trained in research methodology.

The objectives of this research are:

- To explore and describe the professional nurses' perceptions of the professional relationship between themselves and the clinical associates.

- To explore and describe the clinical associates perceptions of the professional relationship between themselves and the professional nurses.

Why have you been invited to participate?

- You have been invited to participate because you are a clinical associate working with the professional nurses in your practice environment.

- You have also complied with the following inclusion criteria:

    - Professional nurses working with ClinAs at the seven hospitals in the Gert Sibande district where ClinAs are employed in the Mpumalanga Province, South Africa.

    - Any professional nurses that work in the outpatient, casualty and theatre departments with ClinAs.

    - English literate.

    - Professional nurses willing to participate in the study.

- You will be excluded if:
-

    - Any nurse that is not a professional nurse, these include enrolled nurses, auxiliary nurses and caregivers.

    - Unit managers working at the outpatient, casualty and theatre departments

What will your responsibilities be?

- You will be expected to take part in semi-structured interview which will take between 45 minutes to 1 hour. This interview will be conducted after hours, in a private room within the ward that you are working for your own convenience, comfort and accessibility. It will be a once off interview.

Will you benefit from taking part in this research?

- The direct benefits for you as a participant will be:
  Direct benefits to the participants are that the study will give the professional nurses and Clinical Associates an opportunity to understand the dynamics of good professional relationship and the importance of having a professional relationship between themselves, in the practice environment, for the sake of service delivery to patients. The participants will also gain insight into the factors that affect their professional relationship and getting an opportunity to talk about their experiences regarding professional relationship in order to improve and perform their work optimally.

- The indirect benefit will be:

Indirect benefits of the study are that the scientific knowledge obtained could potentially strengthen the professional relationship between professional nurses and Clinical Associates and improve service delivery to patients.

Are there risks involved in your taking part in this research?

The possibility of anticipated risk for participants in this study is small. The information collected is about the professional relationship between the professional nurses and the clinical associates and not personal information.

- The risks in this study are there are minimal risks.
  - **Physical risks could include**: Discomfort for sitting still on a chair for the duration of the interview and the fact that an interview could be time consuming to the participants. In this case the researcher will update the participants of time in 15 minutes intervals.
  - **Psychological risks:** Boredom during answering of questions in semi-structured individual interviews. The only psychological risk during the interviews could be of negative experiences that you as Professional Nurse could have had in relation to your professional relationship with the Clinical Associate that you may have came across in the hospital setting. There are psychological support services in the hospitals. Should a need arise; you will be referred as per hospital referral protocol.
  - **Social risks:** None to my knowledge.
  - **Legal economic risks:** None to my knowledge.
  - **Dignitary risks:** None to my knowledge.
  - **Community risks:** None to my knowledge.

- The benefits outweighs the risk.

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

- Should you have the need for further discussions after the semi-structured interview due to psychological stress, which the topic might have caused; an appointment will be arranged for consultation with the psychological support system available at the hospitals.

Who will have access to the data?

- Anonymity will be ensured by making sure that your name as well as the names of the hospitals will not be mentioned anywhere during the interview by the researcher. Information provided by you as a participant will not be made public or accessible to parties other than those involved in the study such as the supervisor and the researcher.
- Confidentiality will be ensured by making sure that participant's details are not divulged by refraining from calling you by name during the interview and by including your name in the research report. The data will also be collect with semi-structured individual interviews, where only you the participant and researcher will be present, therefore ensuring confidentiality. No personal information will be requested or required from you during the interview. Only codes will be used during the interview.

- Reporting of findings will be anonymous by using codes instead of names. Only the researchers and the co-coder will be able to access the findings in their natural form. The co-coder will sign a confidential agreement. Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected (As soon as data has been transcribed it will be deleted from the recorders.) Data will be stored for 5 years.

What will happen with the data/samples?

- The semi-structured interview will be transcribed and themes and sub-themes will be identified. This is a once off collection and data will be analysed by the researcher and co-coder. The hard copies of the interviews will be shredded and the data on the memory stick will be deleted.

Will you be paid to take part in this study and are there any costs involved?

- No, you will not be paid to take part in the study but refreshments will be served in the form of water. No travel expenses are anticipated as the interviews will be conducted in the ward that you are working in. There will thus be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact Miss Emmah Mojalefa at emmojalefa@gmail.com, 073 512 9931 or 079 216 5293 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2089 or carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- A PowerPoint presentation will be presented at the selected district hospitals for the hospital management as well as the participants.
- The findings of the research will be shared with you by an article that will be published in a peer reviewed journal.

Declaration by participant

By signing below, I ..... agree to take part in a research study titled: **the professional relationship between professional nurses and clinical associates in selected district hospitals.**

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.

- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) 2017

....

Signature of participant **Signature of witness**

Declaration by person obtaining consent

I *(name)* ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.

Signed at (*place*) ..... on (*date*) 2017

....

Signature of person obtaining consent **Signature of witness**

Declaration by researcher

I *(name)* ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above

Signed at (*place*) ..... on (*date*) 2017

....

Signature of researcher **Signature of witness**

APPENDIX L: INFORMATION LEAFLET AND CONSENT FORM FOR - CLINICAL ASSOCIATES

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR CLINICAL ASSOCIATES

THE PROFESSIONAL RELATIONSHIP BETWEEN PROFESSIONAL NURSES AND CLINICAL ASSOCIATES IN SELECTED DISTRICT HOSPITALS.

REFERENCE NUMBERS: NWU-00355-16-S1

PRINCIPAL INVESTIGATOR: EMMAH MOJALEFA

ADDRESS: INSINQ, SCHOOL OF NURSING SCIENCE, NORTH-WEST UNIVERSITY, BUILDING F7B, POTCHEFSTROOM, 2520

You are being invited to take part in a research project that forms part of my Masters degree in Health Science Management. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00355-16-S1)** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

This study will be conducted in a private room within the ward that you are working after hours and will involve semi-structured individual interviews with an experienced health researcher, trained in research methodology.

The objectives of this research are:

- To explore and describe the professional nurses' perceptions of the professional relationship between themselves and the clinical associates.

- To explore and describe the clinical associates perceptions of the professional relationship between themselves and the professional nurses.

Why have you been invited to participate?

- You have been invited to participate because you are a clinical associate working with the professional nurses in your practice environment.

- You have also complied with the following inclusion criteria:

  - ClinAs employed in the seven hospitals in the Gert Sibande district, Mpumalanga Province, South Africa.
  - ClinAs working with professional nurses in either the outpatient, casualty and theatre department.
  - ClinAs who completed their BCMP degree and are registered with HPCSA as ClinAs.
  - ClinAs willing to participate in the study.
  - English literate.

Exclusion criteria

  - Student ClinAs will be excluded.
  - ClinAs who work in PHC facilities.

What will your responsibilities be?

- You will be expected to take part in semi-structured interview which will take between 45 minutes to 1 hour. This interview will be conducted after hours, in a private room within the ward that you are working for your own convenience, comfort and accessibility. It will be a once off interview.

Will you benefit from taking part in this research?

- The direct benefits for you as a participant will be:
  Direct benefits to the participants are that the study will give the professional nurses and Clinical Associates an opportunity to understand the dynamics of good professional relationship and the importance of having a professional relationship between themselves, in the practice environment, for the sake of service delivery to patients. The participants will also gain insight into the factors that affect their professional relationship and getting an opportunity to talk about their experiences regarding professional relationship in order to improve and perform their work optimally.

- The indirect benefit will be:
  Indirect benefits of the study are that the scientific knowledge obtained could potentially strengthen the professional relationship between professional nurses and Clinical Associates and improve service delivery to patients.

been transcribed it will be deleted from the recorders.) Data will be stored for 5 years.

What will happen with the data/samples?
The semi-structured interview will be transcribed and themes and sub-themes will be identified. This is a once off collection and data will be analysed by the researcher and co-coder. The hard copies of the interviews will be shredded and the data on the memory stick will be deleted.

Will you be paid to take part in this study and are there any costs involved?

- No, you will not be paid to take part in the study but refreshments will be served in the form of water. No travel expenses are anticipated as the interviews will be conducted in the ward that you are working in. There will thus be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact Miss Emmah Mojalefa at emmojalefa@gmail.com, 073 512 9931 or 079 216 5293 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2089 or carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- A PowerPoint presentation will be presented at the selected district hospitals for the hospital management as well as the participants.
- The findings of the research will be shared with you by an article that will be published in a peer reviewed journal.

Declaration by participant

By signing below, I ..... agree to take part in a research study titled: **the professional relationship between professional nurses and clinical associates in selected district hospitals.**

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) 2017

....

Signature of participant **Signature of witness**

Declaration by person obtaining consent

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.

Signed at (*place*) ..... on (*date*) 2017

....

Signature of person obtaining consent **Signature of witness**

Declaration by researcher

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above

Signed at (*place*) ..... on (*date*) 2017

....

Signature of researcher **Signature of witness**

APPENDIX M: INTERVIEW SCHEDULE - PROFESSIONAL NURSES

The professional relationship between professional nurses and clinical associates in a selected district hospital

INTERVIEW SCHEDULE FOR PROFESSIONAL NURSES (PNs)

1. Introduce and welcome, thank the participant.
2. Explain the research (purpose and objectives) to the participant.
3. Explain how the findings will be used.
4. Explain the interview procedure
   a. Tape recorder; and
   b. Time (approximately 45 minutes – 1 hour)
5. Role of participant
   a. Expert in the interview, want to describe your view, tell your story, help the researcher to interpret and understand it.

Questions for Professional Nurses:

1. What is your view on the concept 'professional relationships'?
2. What is your view on the professional relationship between the PN and ClinAs?
3. What in your view is the role of ClinAs in the practice environment?
4. What in your view is the role of PNs in the practice environment?
5. In your opinion what do you think can a PN do to improve the professional relationship with ClinAs?
6. In your opinion what do you think can a ClinAs do to improve the professional relationship with PNs?

APPENDIX N: INTERVIEW SCHEDULE - CLINICAL ASSOCIATES

The professional relationship between professional nurses and clinical associates in a selected district hospital

INTERVIEW SCHEDULE FOR CLINICAL ASSOCIATES (ClinAs)

1. Introduce and welcome, thank the participant.
2. Explain the research (purpose and objectives) to the participant.
3. Explain how the findings will be used.
4. Explain the interview procedure
   a. Tape recorder; and
   b. Time (approximately 45 minutes – 1 hour)
5. Role of participant
   a. Expert in the interview, want to describe your view, tell your story, help the researcher to interpret and understand it.

Questions for Clinical Assistants:

1. What is your view on the concept 'professional relationships'?
2. What is your view on the professional relationship between the PN and ClinAs?
3. What in your view is the role of ClinAs in the practice environment?
4. What in your view is the role of PNs in the practice environment?
5. In your opinion what do you think can a PN do to improve the professional relationship with ClinAs?
6. In your opinion what do you think can a ClinAs do to improve the professional relationship with PNs?

APPENDIX O: EXAMPLE OF CONFIDENTIALITY UNDERTAKING BY THE TRANSCRIPTIONIST

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

CONFIDENTIALITY UNDERTAKING BY INTERVIEW TRANSCRIBER

entered into between:

I, the undersigned

Prof / Dr / Mr / Ms _____

Identity Number:_____

Address:_____

hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borcherd Street, Potchefstroom, 2520

(hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 "Commencement Date" means the date of signature of this undertaking by myself.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

1

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exception

The above undertakings by myself shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this _____ 20____

Witnesses:

1 .....

2 ....

(*Signatures of witnesses*) (*Signature*)

APPENDIX P: EXAMPLE OF CONFIDENTIALITY UNDERTAKING BY THE CO-CODER

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

CONFIDENTIALITY UNDERTAKING BY CO-CODER

entered into between:

I, the undersigned

Prof / Dr / Mr / Ms _____

Identity Number:_____

Address:_____

hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borcherd Street, Potchefstroom, 2520

(hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 "Commencement Date" means the date of signature of this undertaking by myself.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

1

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exception

The above undertakings by myself shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this _____ 20____

Witnesses:

1 .....

2 ....

(*Signatures of witnesses*) (*Signature*)

APPENDIX Q: INTERNATIONAL JOURNAL OF NURSING PRACTICE AUTHOR GUIDELINES – ORIGINAL RESEARCH PAPERS

Original research papers

ORIGINAL RESEARCH PAPERS

Guidance on good practice reporting is available at http://www.equator-network.org/

EMPIRICAL RESEARCH - QUANTITATIVE

Papers submitted to the *International Journal of Nursing Practice* should not exceed 4000 words for the main text, including quotations but excluding the abstract, summary statement, tables and references.

ORGANISING YOUR PAPER

See GENERAL POINTS IN MANUSCRIPT PREPARATION

If your quantitative study is a clinical trial, see clinical trials.

Main file:
Abstract:
Abstract: 200 words. Your abstract should include the following headings:
Aims (of the paper), Background, Design, Methods (including year of data collection), Results/Findings, Conclusion.

The abstract should not contain abbreviations or detailed statistics. The Aim should reflect the aim of the content of this paper, where a paper reports one section only of a larger study.

Summary Statement:
See the Summary Statement section

Keywords:
A maximum of 10, including nurses/midwives/nursing.

Main text:
To include the headings below, and references, tables, figure legends, appendices.

The main text of your paper should include the following headings and sub-headings:

INTRODUCTION

Clearly identify the rationale, context, international relevance of topic.

Present the scientific, conceptual or theoretical framework that guided the study, identifying and providing an overview of the conceptual model and/or theory where appropriate. Identify and define key concepts or study variables. Explain the connections between the scientific hypothesis, conceptual model or theory and the study variables. Explain connections between study variables and support those connections with relevant theoretical and empirical literature.

Provide a critical review of relevant theoretical and empirical literature.

METHODS

Aim(s)
State the aims of the study as a narrative study purpose or as research questions or hypotheses to be tested. For example, 'The aim of the study was to…'

Design
Identify the specific research design used: for example, correlational, experimental, quasi-experimental, cross-sectional, longitudinal study. If appropriate it may be helpful to include a CONSORT flow diagram to illustrate the design and conduct of the study.

Sample/Participants
Identify the sampling strategy/strategies used: random; stratified; convenience; purposive (state what purpose). For example, 'A convenience sample of Registered Nurses was recruited', 'A random sample of patients was recruited…'.

Identify the inclusion and exclusion criteria. For example, 'The inclusion criteria were…', 'The exclusion criteria were…' Explain how participants were recruited.

Identify the size of the sample (and the population, if appropriate). Report the sample size calculation, or power analysis, if appropriate; if not appropriate or not undertaken, provide another type of justification for the sample size.

Data collection
Use subheadings for different types of data collection techniques, if appropriate, e.g. questionnaires, assessments. For example, 'Data were collected using a questionnaire…', 'Individual assessments were conducted …'.

Instrument rigour: Provide types of and estimates for rigour of assessments and/or the psychometric properties of quantitative instruments. If translation has been required from the original language, please explain the procedures used to maintain validity of translated tools. If tools were developed for this study, describe the processes employed, including validity and reliability testing.

Piloting/pilot study – if done, what changes (if any) did this lead to for the main study?

Identify the period of data collection (e.g. between November 2012 - October 2013); usually data collection should have been completed no more than five years before submission of the paper. If the study entails reanalysis of earlier data, explain the continuing relevance of these data.

Ethical considerations
Identify any particular ethical issues that were attached to this research. Provide a statement of ethics committee approval. Do not name the university or other institution from which ethics committee approval was obtained; state only that ethics committee approval was obtained from a university and/or whatever other organisation is relevant. Explain any other approvals obtained, for example, local site arrangements to meet research governance requirements. If, according to local regulations, no formal ethical scrutiny was required or undertaken, please state this.

Data analysis
Describe the techniques used to analyse the data, including computer software used, if appropriate. For example, 'SPSS version X was used to analyse the data. Analysis of variance techniques were used to test the hypotheses.' If the paper contains statistical analyses, consider the guidance on statistical reporting.

RESULTS

Start with a description of characteristics of sample. For example: 'The study participants ranged in age from X to Y years…' Always include age (range and mean) and gender distribution.

Present results explicitly for each study aim or research question or hypothesis. Indicate whether each hypothesis was supported or declined.

Use subheadings as appropriate.

Use figures and tables as needed, but try to limit to no more than three or four tables and one or two figures. Each figure/table should be referred to in the text, but do not repeat in the text material which is set out in tables. Rather, identify key points in text, and refer readers to tables for detail. Tables/figures should be comprehensible without reference to the text, i.e. all abbreviations should be explained; all tests used identified, with provision of appropriate values.

DISCUSSION

Discussion must be in relation to the conceptual or theoretical framework and existing literature. Do previous research findings match or differ from yours?

Draw conclusions about what new knowledge has emerged from the study. For example, this new knowledge could contribute to new conceptualisations or question existing ones; it could lead to the development of tentative/substantive theories (or even hypotheses), it could advance/question existing theories or provide methodological insights, or it could provide data that could lead to improvements in practice. What readers want to know is what your work adds to this topic.

End with study limitations including but not confined to sample representativeness and/or sample size and generalisability/external validity of the results.

CONCLUSION

Provide real conclusions, not just a summary/repetition of the findings.

Draw conclusions about the adequacy of the theory in relation to the data. Indicate whether the data supported or refuted the theory. Indicate whether the conceptual model was a useful and adequate guide for the study.

Identify implications/recommendations for practice/research/education/management as appropriate, and consistent with the limitations.

CLINICAL TRIALS

The *International Journal of Nursing Practice* follows the CONSORT statement for the publication of randomised controlled trials, see http://www.equator-network.org/

ORGANISING YOUR PAPER

See GENERAL POINTS IN MANUSCRIPT PREPARATION

Title page file:
Identify the paper as a report of a randomised trial in the title.

Abstract
In a maximum of 200 words include:

Item	Description
BACKGROUND	Brief statement of key issues / rationale for the study
AIM/OBJECTIVE	Specific objective or hypothesis
METHODS	Design: identify the trial design (such as parallel, cluster, non-inferiority)
	Participants: Eligibility criteria for participants and the settings where the data were collected. How participants were allocated to interventions
	Blinding (masking): Whether participants, those delivering the intervention and those assessing the outcomes were blinded to group assignment
	Outcome(s): Clearly define at least the primary outcome for this report
RESULTS	Number of participants randomised to each group Number of participants analysed in each group
	Outcome: For at least the primary outcome, a result for each group and the estimated effect size and its precision Harms: Important adverse events or side effects
CONCLUSIONS	General interpretation of the results
Trial registration	Registration number and name of trial register

Keywords
A maximum of 10, including nurses/midwives/nursing.

Main Text:
The main text of your clinical trial paper should include the following headings and sub-headings:

INTRODUCTION

Clearly identify the rationale, context, international relevance of topic.

Include a critical review of relevant theoretical and empirical literature Present the theoretical framework of the research, identify and provide an overview of the conceptual model and/or theory that guided the study.

Summarise with conclusions drawn from the review for the study.

METHODS

Aim(s)
State the aims of the study as research questions or hypotheses to be tested. For example *"The aim of the study was to test the hypothesis that..."*.

Design
State the specific form of trial and describe the following (as appropriate):

Participants:	Eligibility criteria for participants and the settings and locations where the data were collected
Interventions:	Precise details of the interventions intended for each group and how and when they were actually administered.
Randomisation - Sequence generation:	Method used to generate the random allocation sequence, including details of any restrictions (e.g., blocking, stratification)
Randomisation - Allocation concealment:	Method used to implement the random allocation sequence (e.g., numbered containers or central telephone), clarifying whether the sequence was concealed until interventions were assigned.
Randomisation - Implementation	Who generated the allocation sequence, who enrolled participants, and who assigned participants to their groups.
Blinding (masking):	Whether or not participants, those administering the interventions, and those assessing the outcomes were blinded to group assignment. If done, how the success of blinding was evaluated.

Data collection:
Describe the following (as appropriate):

Outcomes:	Clearly defined primary and secondary outcome measures and, when applicable, any methods used to enhance the quality of measurements (e.g., multiple observations, training of assessors). Detail validity/ reliability of instruments, as appropriate

Rigour:
Describe trial governance processes.

Ethical considerations
Identify any particular ethical issues for this research.

Provide a statement of ethics committee approval. Do not name the university or other institution from which ethics committee approval was obtained. State only that ethics

committee approval was obtained from a university and/or whatever other organisation is relevant.

Data analysis:
Consider the guidance on statistical reporting. Describe the following (as appropriate):

Statistical methods:	Statistical methods used to compare groups for primary outcome(s). Methods for additional analyses, such as subgroup analyses and adjusted analyses. Identify software used.

RESULTS

Describe the following (as appropriate)

Participant flow:	Flow of participants through each stage (a CONSORT flow diagram is required). For each group report the numbers of participants randomly assigned, receiving intended treatment, completing the study protocol, and analyzed for the primary outcome. Describe protocol deviations from study as planned, together with reasons.
Recruitment:	Dates defining the periods of recruitment and follow-up.
Baseline data:	Baseline demographic and clinical characteristics of each group.
Numbers analysed:	Number of participants (denominator) in each group included in each analysis and whether the analysis was by "intention-to-treat". State the results in absolute numbers when feasible (e.g., 10/20, not 50%).
Outcomes and estimation:	For each primary and secondary outcome, a summary of results for each group, and the estimated effect size and its precision (e.g., 95% confidence interval).
Ancillary analyses:	Address multiplicity by reporting any other analyses performed, including subgroup analyses and adjusted analyses, indicating those pre-specified and those exploratory.
Adverse events:	All important adverse events or side effects in each intervention group.

DISCUSSION

Limitations: Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses.

Generalisability (external validity, applicability) of the trial findings

Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence.

Discussion must be in relation to the literature. Do previous research findings match or differ from yours?

Draw conclusions about what new knowledge has emerged from the study. For example, this new knowledge could contribute to new conceptualisations or question existing ones; it could lead to the development of tentative/substantive theories (or even hypotheses), it could advance/question existing theories or provide methodological insights, or it could provide data that could lead to improvements in practice.

CONCLUSION

Provide real conclusions, not just a summary/repetition of the findings.

Draw conclusions about the adequacy of the theory in relation to the data. Indicate whether the data supported or refuted the theory. Indicate whether the conceptual model was a useful and adequate guide for the study.

Identify recommendations for practice/research/education/management as appropriate, and consistent with the limitations.

APPENDIX R: EXAMPLE OF SEMII-STRUCTURED INTERVIEW TRANSCRIPT - PROFESSIONAL NURSE

PROFESSIONAL NURSE (2)

I: Interviewer
R: Respondent

QUESTION 1

I: Good day and welcome to this interview session. Thank you for agreeing to partake in it. How are you, Sir?
R: I'm good, thanks Ma'm.
I: I'm good thanks. Uhm... In your view as a professional nurse, what does the term "professional relationships" mean to you?
R: Ooh... In my view, I can say the relationship between the profession in the health facility...yeah...when conducting any duties while you're on duty there. The...yeah...the relationship between the other healthcare professionals...
I: Ok.
R: Yes, yes.
I: Alright. So, is there a relationship between...uhh...professional nurses and clinical associates...the new introduced...uhh...type of healthcare professionals? Is there any relationship of some sort?
R: Yes, there is a relationship...yeah...between professional nurses and clinical associates but sometimes it can be a positive one, sometimes it can be negative...the relationship.
I: Ok.
R: Yes.
I: Can you elaborate by positive...what do you mean by positive?
R: Yes. It means that sometimes the relationship may be good between clinical associates and nurses profession, as well as it can be also be not good, become very bad...
I: Ok.
R: Yeah, yes, sometimes. This relationship is not consistent always.
I: Ok.
R: Yeah...yeah.
I: Ok. So in your view, what can you say can be a good relationship/? What would've happened for you to say there is a good relationship between professional nurses and clinical associates?
R: Ok. In my view, I...what I may say is the way they introduced that profession of clinical associates. Nurses were not involve or informed about the...that profession coz seems like it's here to take the nurses' profession...err...very weak or is like it's undermining the nursing profession.
I: Mm...
R: Yes, yes.
I: Ok. What do you mean by undermining?
R: Err... If I may say...if they do the training for clinical Associate, is about 4 years...3 to 4 years, they complete their course but with the professional nurse you need to do 4 years, even more to qualify to be that nurse and then when the clinical associates comes at the hospital to work with, sometimes they don't consider the seniority as with ethical codes with us as professional nurse, they don't consider that. Sometimes they will use the senior professional nurse like a junior to them. They don't know actually their standing position.
I: Ok. Alright.
R: It's like they're more senior than us...yeah...it's what they did, most of them when they're at the workplace. If I may elaborate on that... If you...the patient comes he wants the vital signs, he will delegate the professional nurse to do the vital signs for him or her while in the meantime he can take that vital signs herself because she's also a clinical Associate, it doesn't mean that he is working...he's like a doctor now.
I: Ok. So...uhh... You mentioned that...uhh...you feel like their introduction into the system was in a way trying to undermine the professional nurses who are already there as qualified.

So I want to understand that do you think that whatever is it that they're bringing into the health fraternity, is it questionable, if I may ask? Is it questionable that these new people are introduced, clinical associates, they're coming in to work with the professional nurses but there is this feeling amongst nurses that they are undermining the nurses?
R: Yes. It's questionable 'cause while they introduced clinical associates, they first said they were gonna help the doctors with doing other procedures like putting of IC drain, doing lumbar puncture but now the clinical associates, they...they're also consulting now, they consult with the patient, doing consultation on their own without the doctor.
I: Ok.
R: Yes.
I: And according to their scope of practice there must be...whatever they do they must do it under the supervision of the doctor?
R: Yes.
I: Ok. Alright.

QUESTION 2

I: So, the qualifications...them going to school...the university for 3 years to get a degree and nurses going to university or nursing college to get that 4-year degree or 4-year diploma. Do you think that at that level since they went to the university and they did the 3 years degree which had...do you think that the skills that they were taught at the university are far...uhh...are far advanced than the ones that the nurses were taught? Like for instance, you talked about IC drain, can the nurses put in an IC drain...like do they...do they get taught that skill when they're at...yeah...?
R: The nurses...they are never given that chance to put a IC drain, it's the scope of the doctors, it's not under ours, under the scope of nursing profession or professional nurse but clinical associate, even them...if they come at the facility or institution they come not knowing these procedures...
I: Ok.
R: Yes, 'cause at the university level they only do the practical part...the theory part. If they come here, they learn from the nurses or this doctors show them, maybe twice or once to try and put this IC drain. Some of them they do, some of them they're still struggling specially with the IC drain but the most common one they normally do is the lumbar puncture...yeah...to take CSF but they becoming trained while they're at the hospital, they don't come knowing...
I: Already skilled...?
R: Yes. Even to put up the Ivy line, some of them they can't put it but they're here to assist the doctors. What we knew is that the clinical associate, they must assist the doctor to take...draw bloods and put IC drain and do these procedures.
I: Are they...uhh...the clinical associates, are they doing exactly what is expected of them as you mentioned it now that they were introduced to come assist the doctor?
R: No, they're not doing that, as they were introduced. As I have said that some of them they're seeing patient on their own without any supervision of the doctor and then delegate the nurses to commence medication that he already prescribed.
I: Mm...
R: Yes.
I: And they're not allowed to prescribe?
R: Mm...
I: Ok. Alright.

QUESTION 3

I: So, in terms of you as a professional nurse working hand-in-hand with the clinical associate, is it possible that you can work hand-in-hand with the clinical associates in your work

environment without the feelings of...feeling like you're inferior and he's a senior to you? Do you... Is it possible that you can work hand-in-hand with a clinical associate?
R: I don't think that is possible. I don't think it's possible. We work but as frustrated but with us...'cause I don't see any improvement that is done by the clinical...the availability of clinical associates 'cause even then...even if he is or he is around we still need the doctor to come. Some of these procedure he can't do and then he can't prescribe on her own, we still need the doctor to be here. Even then you need to train him now to do another procedures 'cause she doesn't know what to do, just to add numbers in the unit...
I: Ok.
R: But he's not helping us at all...
I: At all at your work environment?
R: No, no.
I: So do you think that...uhm...the depart...uhh...the national Department of Health should go back to the drawing board and try to review the whole clinical associates qualification as a whole?
R: Yes, yeah.
I: Ok.
R: Yes, that can be good. 'Cause it's better if they're just training doctors, qualified doctors not clinical associates...
I: Ok.
R: Yes, not clinical associates 'cause this it can make the Department of Health to have more of allegations...
I: Ok.
R: According to this, 'cause if...as I've said that some of them they practice on their own but with their scope, supposed that they must be supervised by the doctor. They must work under supervision so the allegations, they can come in.
I: Ok. So do you think that...uhm...they are not following their scope of practice?
R: Yes, they're not following it.
I: Ok. So in the...in your work environment, how do you...uhm...what is the word that I can use? How do you call them? What is the...do they have a rank of some sort or...yeah, what are they called?
R: They're called clinical associates, that's all.
I: Ok, alright.
R: Yeah, that's the way we call them.
I: So you never experience anything like them being referred to as doctors or anything?
R: Yes, some of the students when they write report that the patient has been seen by the small doctor, they normally say it like that, some of them.
I: Yeah...
R: But we...some of the nurses they don't know who...actually how they can call them, I heard of that..."small doctor saw the patient...small doctor" but...yeah...
I: Ok. So do you think that that happens whereby people don't know how to call them? Do you think that happens because they were never formally introduced?
R: Yes, yes.
I: So nobody actually know how to refer to these people? Nobody knows how to work with them.
R: Yes.
I: Do you think that's the pro...that is where the whole thing started?
R: Yes.
I: Ok. Alright.

QUESTION 4

I: So...uhm...their role as a whole, the clinical associates in your work environment, do you have any idea of what is it that they should be doing? Like are you familiar with their scope of practice, are you familiar with their...what do they call this...uhm...conditions of practice? Are you familiar with that? Have you ever seen...?
R: No, not at all.
I: Ok.
R: Never saw something talking to...about clinical associates or any protocol, even at the workplace.
I: Yeah.
R: That these are the procedures that...'cause they need to...we need to work the policies, that is what they're supposed to do...they can do this and this but we don't have any of that.
I: Ok.
R: Yes.
I: Ok. So but then in terms of...because sometimes I think the issue might be that they were introduced trying to bridge the gap of maybe patient waiting for longer periods... Has that improved in any way or it's still the same because they need to be taught something and then the patients still wait? Do you think that that has improved in any way, whereby they're pushing the lines, the patient gets seen quickly before...than before, actually?
R: No, it's not improved, it's not improved it's still the same 'cause they work with the doctor. If the doctor is only one they're 4, all of them they must wait for the doctor so nothing have changed...nothing have changed 'cause the doctor have to see all of the patients that they have saw, together with them. Actually it's delaying us even that...this 'cause the doctor is explaining to them the condition every time after seeing the patient.
I: Ok, but then how are they towards you as Professional nurses? Are they open to the idea of having a professional relationship whereby you have to treat each other with respect, you have to make sure that the patient wins at the end of the day or there is an attitude problem somewhere?
R: Yes, there is an attitude...bad attitude from them, towards nurses actually. Only to doctors where...'cause the doctors they sign for them, even the files...
I: Ok.
R: And then...yeah...but to nurses, they're having a bad attitude 'cause they are...I don't know maybe they don't like nurses but I don't know 'cause they're at the hospital to work with nurses. They see themselves like they're senior than the nurses.
I: Ok.
R: Yes. They see themselves like they're...like they treat themselves like doctors...yes...like doctors.
I: Ok. Have you ever tried, as professional nurses in that department, together with the Clinical associates to address these type of issues with the Clinical Manager for instance, someone who is in charge of them? Has it ever happened that...?
R: No.
I: It never happened?
R: Never.
I: Ok. Is there hope that it will happen whereby you sit down, all of you as professionals and discuss issues like these?
R: Yes, yes. There is, yeah.
I: Ok.
R: 'Cause they're facilitator, the one who is appointed to train them at our facility, is very...very open to be consulted.
I: Ok. So...as I mentioned earlier that maybe they can argue, the clinical associates, that...uhm...yes they went to school for so many years, the nurses went to school for so many years however they learned more skills than the nurses, hence they feel superior. They can argue and say that? How do you feel about that?
R: Err...that is what I may say that this profession is like is here to undermine the nursing profession...yeah...that is what is I can say about this 'cause their training...yes in theory they

can know but with practical...'cause witnessing...practical is the most important part...yes...but with theory, you may have the theory but practical side, they're lacking...
I: Ok.
R: Like...they're lacking...lacking...

QUESTION 5

I: Ok. So do you, together with them, the clinical associates, do you understand...is there role clarification? Are you clear of each other's roles?
R: Uhh...No...no.
I: Are they clear with the...with the professional nurse's role?
R: I don't think so, 'cause most of them they don't know that's why they tend to delegate or delegate the senior person...uhh...the professional nurse to be delegated by them, 'cause I don't know how they study on. They study ethics, they do the ethics when they...during their course of study, I don't know.
I: Ok.
R: Or Ethos, something like that.
I: Ok. You don't know if it's part of their curriculum?
R: Yeah, I don't know if it's part of their curriculum 'cause they're not...they seems like they're not having any understanding of that. Maybe if it's not there, they must introduce it...the ethical part.
I: Ok.
R: On their training.
I: Ok.
R: Is what I may...may be done or if there is, they must emphasize on it.
I: Ok.
R: Yes, if there is, they must...
I: Make it clear to...
R: To them, yeah...
I: Ok, alright. So that they can have a better attitude working with...
R: Yes, if they come to the hospital we'll see some...maybe a difference.
I: Ok, alright. But...uhm...as an individual, do you perhaps feel that the Department of Health did not do any justice to the health department as a whole regarding...to the health system yes...regarding the introduction of the new cadres, because you know why I'm saying that?
R: Yes.
I: It is more obvious to me that with the introduction of the clinical associates, like you mentioned earlier, nurses were not involved so in a way you might feel that these clinical associates were just dumped. You'll see that you have to work with them, they're there to assist the doctor even though they're not even assisting the doctor in a way. So is there a way of rectifying this...I'll call it predicament...because it's not clear to most professional nurses? Is there a way that the Department can actually rectify this? Should they still come and do roadshows to introduce them formally, do you think they should do that or they should just maybe stop training them for now until there is clarity?
R: Yeah...Yes...Mm...Ok. Is better if maybe they can stop the training...yeah...is better if they can stop the training for now, for clinical associates, and then try to introduce the ones who already are on the system.
I: Ok.
R: But what I may prefer it was that to train more nurses than not to introduce this career of clinical associates 'cause now it's also on the Persal. We need to use finances for their salaries but they're not doing nothing actually, than to employ...err...professional nurse and have that one doctor...two doctors, but employ more of professional nurses who are staying with the patient 7 to 7...
I: Ok.
R: Yes...Yes.

I: So the gap that is there, because according to statistics, there is a shortage of doctors in South Africa. You think the clinical associates is not actually...
R: Helping...
I: Helping?
R: Haai, is not at all helping.
I: Ok.
R: clinical associates not at all helping but is that straining from the finance of the Department of Health 'cause they have to pay them, the clinical associates, if you employ them but actually their role is none 'cause they work under supervision of the doctor. Is means that the doctors sees the patient, even them. All of these patients they are being seen by the doctor, have to see all of them...
I: Yeah.
R: Together with the clinical associates. Clinical associates will never work alone, they will never work alone than professional nurses. Professional nurses...there are some of other duties that they perform alone...
I: Ok.
R: Yes. Even at PHC...if you are skilled with the PHC post-basic course, you may do consultation on patients on your own.
I: Without any supervision?
R: Yes, without any supervision but clinical associates, they can't do that.
I: Ok. Alright. No, I understand very well. However, I have a question in terms of...are they, the clinical associates, according to you as a professional nurse. The ones that are already there now, do you think they should be kept there as clinical associates or they should be taken back to school, maybe to upgrade on whatever they already have as a qualification?

R: Yeah, with me I may say that the Department if they may take them to do medicine, to become doctors. If they credit them, they will credit them. Yeah, if it's possible but it's better for Department of Health to train the clinical associates to become doctors so that they can work on their own.
I: Ok.
R: Yes, it's better.
I: Ok. So for you, to deal with the shortage of doctors...
R: Yes.
I: Rather train doctors not clinical associates. Ok, alright.

QUESTION 6

I: So as professional nurses do you respect them as your fellow...uhm...should I say, colleague, at your workplace? Do you give them that due that they are clinical associates, "yes I don't really understand what is their role, but they're here and I have to work with them"? Is there that type of a thing with you?
R: Yes, yes. We do respect them 'cause we even teach them how to work and the procedures.
I: Ok, ok.
R: Yes.
I: So all you want in return...
R: After they're skilled...they've been skilled, their attitude changes. If you given them the information, next time when they come their attitude is no longer good towards nurses while they're knowing now the procedures that you taught them 'cause they come knowing nothing.
I: Ok. So how does that make you feel though that here you are, taking your time to empower this new qualified clinical associate and in return you get negative attitude? How does that make you feel?
R: Err... It make me feel very bad, yes. As I...what I saw, that this profession actually is here like to undermine the professional nurses at the workplace...yes.
I: So do you think their plan is to just to get as much as they can, skills-wise from the nurses and after that they change altogether?

R: Altogether.
I: Ok.
R: Yes.
I: Alright. So if you as nurses are giving them those skills, you're teaching them all those, where are the doctors, the people who are supposed to be...
R: With them?
I: Yes.
R: Yes, as we said there's the shortage of doctors, maybe there's only one but he's not always there. They find the sisters, the professional nurses, most of the time in the ward and they're the ones who are training them.
I: Ok.
R: Even the doctors they rely on us.
I: Mm...ok...alright. So in terms of scope of practice between you as a professional and clinical Associate, there are some similarities...some similarities between the scope of practice of professional nurses and clinical associates, and mentioned earlier that you've never seen anything that is clinical associate-related in terms of their conditions of practice, their scope of practice. So, how do you know that they can work but they can work until so far?
R: What we only know about them is that they're here, they were introduced that they're here to work and with doctors, assist the doctors only with the procedures to be done.
I: Ok.
R: Yes. Only with the procedures to be done, not to write maybe the scripts...everything, what I know is that only to do the procedures.
I: So nobody has ever brought the clini...their scope of practice to you as professional nurses that "this is the clinical associates' scope of practice, this is how they should work".
R: No one...no one, till so far.
I: Yeah, ok. Does that make you...maybe make you hold back a little?
R: Yes, yes.
I: In terms of...have you accepted them, though?
R: Yes, we have accept...yes. We work together with them so we can train them...mm...
I: But in terms of not knowing exactly what they should be doing... Has that made you hold back a little bit?
R: Yes.
I: In...
R: Because you can't train someone that you don't know what he's here for.
I: Mm...Ok.
R: How...how far are you gonna train him or her? Which skills...because you don't know what scope of practice is?
I: Ok.
R: Mm...
I: Alright. So...uhm... Can it be said that or should I...let me ask you this question... Do you think then that they are more of a risk than benefit?
R: Yes, yes. I may agree that they're more of a risk with this. They're more of a risk. They're more of a risk 'cause they don't have the full understanding of the patient.
I: Ok.
R: Even the type of medication that we use, some of them they don't know the medication, they just know the names but physically to know it, they don't know.
I: Ok.
R: Is easy for them to do...
I: To administer maybe?
R: Yeah...wrong medication 'cause they don't know the medication...they don't know at all.
I: Ok. So I've read somewhere, actually in their conditions of practice number 7, whereby it said that they as clinical associate should introduce themselves to you as a professional nurse, to other healthcare professionals actually, including the patients, as clinical associates and they should be referred as such. I just want to know, does that happen whereby when you come in then the person will say "Hi, I'm so and so, I'm a clinical associate". Does that happen?

R: No, it never happen.
I: Ok.
R: Even other patients when they leave at the hospital, they will say "I was seen by the doctor", but while she was been attended by the clinical associate. It means even to the patient, they don't introduce themselves as clinical associate.
I: Ok. Uhm... And, how comfortable are you working with them since they cannot even be honest and say "this is who I am, this is what I am going to offer". How comfortable are you working with them?
R: Yes, is make us to be not comfortable, to be at risk if you see the clinical associate around after you see the patient together. You know at any time anything can happen, anything bad can happen. You see them as risk, if you see the clinical associate...yeah...around...being around.
I: So they're not benefiting the Department of Health in any way?
R: No, no, they're not. They're risk...yes...they're risk.
I: Ok. So, according to you, what would you suggest that the Department of Health do to make the clinical associates to be known, to be more visible and for all healthcare professionals to know exactly what is their role? What do you think the Department...what do you suggest that the Department should...you know...consider in those terms?
R: Ok. The Department...if they can provide...if they may provide full information about their scope of practice, of clinical associates, to be visible, transparent, known by everyone at the facility, and then when they come the Department need to do in-service training to the nurses, informing them about the clinical associates...yes...to in-service the nurses so they can know what actually is their duty...
I: Ok.
R: Yes. When they come to the facility...yes...we need the in-service training to inform us, give full information of clinical associates and then we must know even their curriculum, which part the...which studies they do...
I: Ok.
R: Yes, at their...
I: At the University?
R: Yes, their university and to know where they stop working, that they work until this part 'cause this one was never...they were never trained about it and as I've said before they must emphasize the ethical side from their training so we can work together and then attitude...or they must...the attitude of the clinical associate, they must also deal with it while they are training that they need to be able to work with all the healthcare workers, it can be Professional nurse...yes...'cause we are working with them at all time. So they're attitude must be good...yeah...they must also train them and then they must have the skill and then...err...of dealing with these matters, the clinical associate...yes.
I: Ok. Alright. So, for now they can still...you know...stay in the hospitals, still rendering service to that certain extent that they're rendering it but however, you still emphasize that the Department should train them in ethics, in behaviour 'cause attitude is behaviour, they should also...uhm...make their scope of practice visible to everyone...or to the people that they're...they'll be working with directly?
R: Yes.
I: Ok. Alright. So in terms of ethics, is there something that they're doing in the workplace or in the work environment that is ethically unacceptable?
R: Yes, there is 'cause if you come to the unit that I'm working in, you just come and go straight to the patient. You don't introduce yourself, you just go straight to the patient but I don't know what you're doing...they normally come and do like that. They don't introduce themselves, telling us that "I'm Mr so and so, I'm a clinical associate", that is totally not acceptable, and even to interrogate your senior, that is not acceptable 'cause is mean that they don't know their role actually or maybe they're doing it purposely 'cause they treat themselves like doctors, as I've said and then even their dress code sometimes, is not good when they come to work...at workplace, their dress code sometimes is not good. I may mention maybe their "takkies"...yes...sneakers...their sneakers as they are wearing them. Some of them they

come with their sneakers "so vuil" like that but to come to see the patient as you see that this person is not professional, even the patient they're not comfortable sometimes to be seen by such a person who is like that.
I: Do they introduce themselves to the patients...do they introduce themselves?
R: No, they don't introduced themselves to patients.
I: Nametags? Do they have nametags that says "I am so and so"?
R: Nametags... Some of them with their blue attire, is having the initials...some of them but not all of them they... I never saw a clinical associate having any nametag with them.

QUESTION 7

I: So what do you think can make you as a professional nurse feel that you're not undermined by the Clinical associates? Is there anything that you think they should do as clinical associates to make you feel not undermined?
R: Yes, there is. They can improve on their attitude, they must improve on their attitude and then if they improve on their attitude they can...when they come they must introduce themselves and then tell the nurses that they're going to work with her of him "this is what I'm here for, I'm gonna do this procedures", explain to us so you know that why she's here, this is what she gonna do so we can know what she's here for 'cause we don't know why...what is their duties, actually. They must elaborate on their duties, tell the ones who's going to work with her.
I: Mm...
R: Yes, that can improve and make us more comfortable working with them.
I: Ok. So you mentioned that when it comes to nametags or them introducing themselves in a certain way other than saying "I'm so and so", but at least having a nametag you'll be saying "this is who I am". So if they don't have those things and they come into the ward, they do not talk to you or anybody in the ward, they go straight to the patient. Patient safety, how compromised is it?
R: Is compromised 'cause if you...someone can come in, just go straight to the patient, you don't know whether...what she is or what he's doing there, patient are no longer safe 'cause even the thief can come in...
I: Mm...
R: Yes...wearing that blue attire, go in and seeing...doing like...seeing the patient but we don't know 'cause even the Clinical Associate they don't have nametags, they don't wear their nametags when they're coming to...
I: Ok.
R: Even with their nametag, is supposed to have a picture of that person...yeah, yes. Is better to have a picture and your name, your full name and your surname on their nametag, that is what is supposed to be.
I: Ok.
R: Or student cards for the others who are still students but with the photo.
I: Ok.
R: Yes.
I: That shows that this is the person?
R: This is the person...
I: Ok. Alright

QUESTION 8

I: So, are the measures though at the place where you work, at the...your work environment whereby maybe security guards or something, like the...who would ask you when you enter "who are you, where are you going?". Is there such a thing?
R: Yes, especially only at Casualty.
I: Ok.
R: Yeah, but with other wards...their department, no.

I: There is no such?
R: There is no such.
I: Ok.
R: But with Casualty, yes, they've introduced the security then he is the one who asking why you entering there.

QUESTION 9

I: So going back to you. You mentioned earlier that rather than the Department training clinical associates, they rather train more professional nurses. Do you think that that will bridge the gap of the shortage of doctors? Do you think the nurses will bring diversity into the healthcare...err...err...setting?
R: Yes.
I: Rather than the clinical associates?
R: Yes. As I've said that there is a shortage of doctors but if you train more nurses, nurses are the ones who stays with the patient, day and night nurses are next to the patient but with doctors, they only see the patient and then they leave. All the other things are being done by nurses.
I: Ok.
R: Better you train more nurses and then some of these clinical associates, they may be taken to do Medicine...
I: Ok.
R: Full course of Medicine not this clinical associate, if they credit them they must do...the Department must ensure that they do the Medicine.
I: Ok.
R: Definitely, yeah, so they can work on their own. Not this clinical associate, no. Is not helping...is not helping at all.
I: Ok.
R: Yes.
I: So but then you believe that in a work environment, anywhere, not only in Nursing but even in other departments out of Nursing or health, there should be professional relationship?
R: Yes, I believe, yes.
I: Ok. No, that will be all for today. Thank you, thank you so much for giving me your time, really appreciated. Thank you, thank you, thank you!
R: Thank you very much, Ma'm!
I: You're welcome and thank you, I know it's late but here you are. Thank you so much...thank you for the compromises that you made!
R: It's a pleasure!
I: Thank you!

END

APPENDIX S: EXAMPLE OF SEMI-STRUCTURED INTERVIEW TRANSCRIPT - CLINICAL ASSOCIATE

CLINICAL ASSOCIATE (3)

I: Interviewer
R: Respondent

QUESTION 1

I: Thanks, I believe you're a clinical associate?
R: Yes, I am, Ma'm.
I: Uhm... What is your view on the concept, professional relationship?
R: Err... My view on professional relationship...err... I'll start by breaking it down.
I: Ok.
R: According to my knowledge. I think a professional relationship it's any relationship concerning profession... err... professionalism, based on professionalism, for example, colleague to colleague, they can have a good professional relationship, doctor to patient – they might have a professional relationship.
I: Mhm...
R: So, the concept...err... especially in a working environment, is very important to have a good professional relationship.
I: Ok. So in your view, do you as a clinical associate have... uhh... a professional relationship or a good professional relationship with other healthcare professionals, specifically professional nurses?
R: Err... According to my view... err... it's very... it's very... err... it's still new this concept of...err... Medical...err...
I: The Clinical associates
R: Clinical associates, it's still a new concept so some people they're still...err...neglecting us, some they're still... they don't see a point of us being placed on clinics, hospitals, medical institutions. So but...err... to put it in a good manner, the problem is that professional nurses and clinical associates, there's no good relationship because some they think they're better that this one's, some they think they have better qualification than this one's so that's why there's al... there's always clash there at works place because if you can look at it nurses, they've been long into the system, us we're new but us we have...err... what I can say... advanced qualification than the nurses, so... Yes, I can say our relationship is not yet balanced.
I: Ok
R: Yes.
I: So, when you say you have advanced relationship, what do you mean by that? Are you comparing your degree to their diploma?
R: Not comparing but if you can look at it, professional nurses they have... I think it took them 4 years to complete their diploma but it only took us 3 years to complete our degree. So if you can look academically, degree is bigger than a diploma so that's where a problem starts because us we want to go there and the nurses they should give us advice and they must give us guidance, instead they don't. They think us we're clever and they sabotage most of the things we do there.
I: Ok.
R: Yes, Ma'm.
I: So, how does that make you feel though because as you said a good pers... professional relationship is important in any workplace? How does it feel that now these nurses are giving you this attitude of not wanting to help you, trying to sabotage you like say? How does that make you feel?
R: Yeah, it's not easy to work at such environment because where... like any other job, when you arrive there you just hope that you'll get someone who will...err... show you the way, who will show you the ropes, every corner, every job that you're not familiar... but I can have an advanced degree, you can have a certificate or a diploma but you have experience and practical experience I don't have, I only have theory so I will look at it that I must get advice from you practically but we can share ideas, share knowledge and stuff so that we can join the hand, it should go forward.
I: Ok.

1

R: Yes, Ma'm.
I: So do you think there can be something...oh sorry... Is there something that can be done in terms of changing the prof... the kind of professional relationship that you have with the nurses? Do you think someone, somewhere must intervene so that things can go...?
R: Yes, yes. Yeah, according to... to... According to my explanation, I can explain it like this...err... Or what I have observed, before this things was...err... the programme was started, there was no like a presentation to sit the nurses down that "okay, due to shortages of doctors and shortages of 1-2-3 1-2-3, we're going to implement such a programme. The programme will include 1-2-3 1-2-3, will include such courses and these courses, if you're interested you can enrol and if you're not interested, we'll get some people. Please, those people are not superior than you or you're... they're not inferior than you, you're supposed to work together because a nurse, doctor and a clinical associate they must work hand-in-hand". So I think, yes, it can be eliminated by explaining what was the reason to implement such a programme in the hospitals and medical... other medical institutions.
I: Ok. So who must intervene in this?
R: Err... I think the Department of Health can intervene.
I: Ok.
R: Err... because I can't say a Minister of Health because they're the higher rank but for immediate attention we can ask the Department of Health to intervene so that this thing can... we can work, even if we're not buddies but at a workplace you have a healthy professional relationship.
I: Mhm...
R: Yes, Ma'm.
I: That is important, according to you?
R: Yes, that's very important because if we're always... if I'm pulling this direction, the other is pulling that direction, at the end of the day innocent souls are suffering. Patients will be the one's who are suffering.
I: Ok. So, earlier you spoke about being neglected. Are the nurses the one's neglecting you? Who's neglecting you?
R: Err...eish... On that one I can say okay, physically the nurses are giving us a hard time because you'll find you're looking for something, maybe you're looking for a certain bandage...
I: Yeah.
R: You're just looking for assistance, you're not ordering anyone around. They will just respond by "you're not a doctor, so stop acting like a doctor". So, I can't say...err...uhm... I put the blame on those... such nurses or not but all I can say, if those nurses they have received a proper training and clarity on the programme, such things will be eliminated before even the programme has started because already those nurses, they'll have clue what is going to happen, what is our role and what is their role and what is the doctor's role.
I: Mhm...
R: Yes, Ma'm.
I: Ok. Are the nurses only the one's that you feel are neglecting you in this matter?
R: No, I don't feel like that. Err... even the Minister of Health, he never bothered to introduce us as clinical associates. He only ... we only just went to school, we enrolled and after school they just deployed us in different medical institutions and you have to explain yourself that "okay, I'm a clinical assistance, I'm a...". "Whoa, what is that?", you can't even explain yourself. "Okay, a clinical assistant it's an in-between a doctor, nurse, patient", so it's confusing... it's really confusing. So, if at least the Minister gave some info...more info, maybe some two days info, one day come and present there what's going on, then I think most of the things will be better.
I: Ok, alright. Do you.....

QUESTION 2

I: Do you think there's a way forward in terms of getting you as clinical associates and the professional nurses working together? Is there a way forward, is there hope?

R: There is hope, in every situation you must always look at the brighter side of that situation because I think everything that I have stated there and said that if the Department of Health or the Minister intervenes, everything will be different. So, in so saying, I can say that we can try to implement something that we all agree upon so that we can have a way forward. I can now... we cannot be buddies, as I said, we cannot...err... maybe share a meal or something but at the end of the day if we do our job professionally, then everything will be fine. After work we can go different direction but at work we try to assist... we assist the patients the patients the way we can.
I: Mm...
R: Yes. So yeah, yes we... there's hope that one day this thing will work out but the... now there's a lot of job to be done so that we...err...we can be convinced also because even us we need clarity, how come our degree is 3 years, their diploma is 4 years but still we're treated... we are being treated like we're being inferior to them, they're superior. So we want to know what's going on because there's no clarity but we know our job at the end of... what we must do. It's to fill the gap, the void that the shortages of doctors have left so that the patients they can get the best service possible.
I: Ok.
R: Yes.
I: So do you think that the kind of uhm...treatment that the nurses are giving you is out of not really having a clarity of who you are, what you're about, what you're there to offer, as a Clinical Associate?
R: Yes, that's positive, that's the problem because if you can check the job that I do, mostly they're done by doctors. So those nurses, when you go there you're still young, you're fresh from the University so they take it as a threat like they... you're going to take their jobs or you're going... you're trying to look smarter than them, so that's the problem. I think if they can get clarity, what's going on, and they can feel safe around their job that no one is going to take their job. We're just here to fill the void that is there, the void that is... not like we're going to remove someone from their post so that we can work, no it's not like that. We're here to help the patient. Our primary task is to help patients, to give them the best medical institution ever.
I: Ok. So, if I hear you correctly, you feel like that the nurses actually felt threatened by your presence in the workplace?
R: Yes, they feel threatened because if you can see, now at a workplace there's two groups... two groups there, our groups and the nurses' groups. So you can see it's not healthy. So if someone like the Minister can come and intervene "okay, this is official...err... we've started this programme because of 1-2-3, so work together and do that and do that", and everything will be easy.
I: Ok.

QUESTION 3

I: So in your view, what is your role as a clinical associate in the work environment? Which role do you play?
R: Err... I can say our role is to... as... like if you can check, most of the medical institution, like clinics, you'll find that there's only one or two doctors and then there's a lot of people from the community. So us we're trained and we did courses that can assist... assist the doctors so that there won't be overcrowding of patients at the clinics, at the hospitals. We can do most of the jobs that the doctor can do, we're not doctors but we can fill the space that the doctors can't cover because of...err... If you can check, if there's two doctors and there's maybe hundreds of patients a day, the... a doctor cannot cope that stress so that's where we enter there to assist the doctor.
I: Yeah.
R: Yes.
I: Do you work on your own, like do you work independently or do you work under somebody's supervision?
R: Yes. Err... we work under doctor's supervision.

I: Ok.
R: Yes, we work under doctors' supervision. They supervise us, even if there's something that I need clarity, I go to the doctor, that's why I said we're not doctors we're just assisting the doctors. Also... we're also there to assist also the nurses because there are some task we can't perform but the nurse can, so we are a link between a nurse, a doctor; a doctor- patient, nurse-patient, so we are a link.
I: Ok.

QUESTION 4

I: So, do you know the role of the professional nurses in the work environment? Is it the same as your role?
R: No, our roles are not the same. Uhh... I can put it like... We are not different but our roles are not the same. The goal is one but we're... as I said... we are a link. Even nurses they can ask us around to assist something of which I have no clue. They can assist... they can also assist me, something which they don't have any clue about, same as a doctor, they can do that.
I: Ok.
R: Yes.
I: So after you clarified on your role and their role, do you think that these two roles plays a crucial role when it comes to giving or providing quality healthcare to all patients?
R: Yes, definitely...definitely. That's the reason at the first place they initiated this programme because if you can check there's lots of complaints that some patients they come and go back home not assisted so that's when the Minister announced this programme, he was trying to eliminate this thing so if there was clarity. If everyone has... is clear on this programme, I'm telling you South Africa will be a better place regarding healthcare
I: Ok.
R: Yes.
I: Alright.

QUESTION 5

I: So do the nurses respect you, do they give you a place as a clinical associate in the work environment?
R: Yes, yes, they do but the nurses are... sometimes they're somehow because, yeah they do support us because some... most of the time they're forced to but according to them if it was not a procedure... there was no procedure to be followed, they wouldn't...they wouldn't. They would just do fun...err... make funny comments like they just become nasty sometimes.
I: Ok. So, do they say certain things maybe that make you feel you are not welcome?
R: Yes, yes. Especially this one who like to say... they say err... government should train more doctors instead of clinical associates because clinical associates are babies who know nothing so that's the main problem... that's the main problem.
I: So how does that make you feel?
R: No, you feel unwelcome because every time you think of going work it's a problem because you know there must be a funny comment that you'll receive but you know this is not about you, it's not about the nurse, it's about the patient and that certain hospital or clinic.
I: Ok.

QUESTION 6

I: So how's your relationship with the patients? Did the patients welcome you, do they know who you are?

R: That's when a problem... that's where a problem starts there because you just go to a patient: "hi, my name is Mr (name removed). I'm a clinical associate", "What's a clinical associate, you're a doctor?" "No, I'm not a doctor" "You're a nurse?" "No, I'm not a nurse" "Who are you?" It's very very difficult to explain how does it work, you try and explain "okay, I've never been here, I'm assisting a doctor to do 1-2-3 so..." "No, I need a doctor". So some relationships, some people who know their staff they don't understand, the only thing they want to see it's a doctor then if you come you're a clinical associate, something he or she doesn't know anything about, it's a problem but some they co-operate so it's a 50-50 chance situation.
I: Ok. So you mentioned that uhh... some nurses say that...uhh...the government should train more clinical associates... I mean sorry, more doctors instead of clinical associates. Uhm... do you think it should be like that, do you think the government should train more doctors instead of clinical associates or do you think as a clinical associate you have a role to play in the healthcare system?
R: I think...err... it will be foolish to say government should train more doctors. You must bear in mind that to train a doctor it doesn't take 3 months, it doesn't take... So if a doctor goes to study, let's say for 7 years, so from now on till that doc... that certain doctor finishes his or her studies, what will happen in the medical institutions? What will happen? That gap that is left... If you can say South Africa or healthcare must... Department of Health must train more doctors, then how about the space that is... that void that is still left there? We must wait for that period until those doctors they finish school or must us as clinical associates fill that void? So I think we have a lot of job to do, we still...err... we have impact. I think this was made...err... this was the right decision by the Department. It was a right decision because...okay we can have enough doctors maybe in years to come, 20-30 years but from now on till 2030, what must happen? Should a patient co... continue to suffer or should us as clinical associates intervene and step in and assist, and get the... give the people the best healthcare?
I: Ok.
R: Yes.

QUESTION 7

I: So you as clinical associates, as you said, you have a role to play in the healthcare system. What is it that you need the nurses to do in terms of you feeling welcome? Is the issue... or is respect an issue, is being accepted an issue, is being welcome an issue or you feel that somewhere somehow those issues are not really there, it's just that because of this lack of clarification when it comes to your profession as a clinical associate, is the one that leads to people to look at you or to treat you somehow?
R: Mmm... If it was possible I would say professional nurses, they should just stick to their lane, us as clinical associates we must just stick to our lane but it won't be possible because now there's a gap again because we're pulling that direction, nurses a pulling that direction. So I think at the end of the day, all we need here... this thing is all about patients...patients... patients. The only thing is to do is that the community of South Africa can get the best healthcare ever. So I think if the... if the nurses they can just know their role and us if we can know our role, and if someone can just explain how are we going to link everything; nurses, doctor, patient, then I don't think it will be a problem, everything will be sorted and then we'll have a very very very healthy professional relationship between nurses and us as clinical associates.
I: Ok.
R: Yes.

QUESTION 8

I: Is there issues with regard to inferiority or superiority? Who's superior, who's inferior? Do think that also plays a role in affecting the professional relationship between you as the clinical associates and the professional nurses?

R: Yeah, there is because some they feel it's unfair. How come I have a degree but I did it 3 years, how come he or she has a diploma they did 4 years? So it's like the government has failed them. Why if we need a degree, why we don't go for a longer period of time? Of which they don't understand the primary task.
I: Mhm...
R: Yes. So they even talk about experience, of which yes they have experience and that experience, they must just provide. They must just assist us, guide us because there are some stuff we don't know, like to fill forms, we never done that...we've never done that. So if I can ask assistance and say "nurse, help me here", then that experience will assist me and then some of things we don't know, I can give it to you, I can show you "okay, this thing we do it like this, we do it like this".
I: Ok. So in your opinion, what do you think a professional nurse could do to improve the professional relationship with the clinical associate?
R: Only show a respect and knowing his or her own duties, and knowing my duty as a clinical associate, I think everything will just have a shift there. Our professional relationship will have a twist for the better.
I: Ok. Alright no, I understand.

QUESTION 9

I: So when you spoke about the professional nurses knowing their duties and you as a clinical associate knowing their duties, I believe that as a professional...err... person or as a healthcare professional you are under a governing body, like HPCSA, and then we can talk about your scope of practice, we can talk about the Acts that guide you, we can even talk about the guidelines that must work under... as well as Regulations. So, with regard to your scope of practice, has it been finalized or is it still pending?
R: Oh, yes yes, our scope has been finalized. It has been finalized and it has been taken back to the Council.
I: Ok.
R: Yes.
I: Ok. Why has it been taken back to the Council? Is it...is it... Do you have... because... Ok. I believe that the scope has been and it has been taken back to the Council, meaning that when it's been taken back to the Council or taken back to the Council, there is something that you as clinical associates didn't agree with in the scope. So you... did you take it back because maybe you feel the scope is exposing you too much and it doesn't do you any justice in terms of the kind of qualification that you've got?
R: Yes, yes.
I: Ok. So was it... Is it still with the Council?
R: Yes, it is still with the Council to be reviewed because we... there were somewhere we needed clarity, there were some sections we needed... we had problems with, so it must be reviewed then after that we'll take it from there.
I: Ok. So at this point in time you are practising as a clinical associate without a scope of practice?
R: Yes, that's correct.
I: Ok. So don't you think that can also have a...a question mark to some of the nurses in terms of they don't know how far you can practice too? They don't know the boundaries, do you think that might be the reason why some of them are they way they are because they don't... they have no clarity?
R: Yes, yes, yes, it's possible. I think that's also another point...err... the reason why they're behaving the way they're behaving because if... Even if you yourself you don't have your limitation, where you must... what you must do, where you must go or not go, then sometimes it becomes a problem because for us it's easier. When we went to study, we knew most of the things about nurses, what is their primary task, we knew but another problem we don't have a scope and they don't know nothing about us so it creates conflicts at work because it's like we don't know our story, we don't know where we're standing, we're just runners.

I: Mm...
R: Yes.
I: Have you tried to explain yourself to them in terms of... because I'm thinking, probably... you might be having something that you're working... or that is guiding you? Have you tried to explain to them that "I, as a clinical associate, this is how far I can work?" or you just left it like that, like you never even, you know, bothered yourself to say "okay nurses, here I am, this is what I'm...or..."? What happened there, have you ever tried to do that?
R: No, I don't see a point why should I explain such to the nurses because truly speaking, that's not my department to explain.
I: Ok.
R: Err... Before something takes place...err...those people who are already there, I think they should know what to expect, who's coming, who's not coming, who's leaving. So I take it they were briefed, already they were briefed...
I: I hope.
R: By a Clinical Manager that "there are some people called clinical associates, they are coming to assist us because of shortages of doctors, 1-2-3 1-2-3". So but if then the Clinical Manager didn't inform them, then it means it's his or her problem because you must explain before, because we can't just come there not knowing anything, that's why we'll get such treatment.
I: But you saying that you don't see why you should explain yourself to nurses, that sentence, does it sit well with you? Like...it's like you already have this animosity?
R: Yeah...
I: I might be wrong?
R: No-no, you're not wrong because I think if some people they're giving you such attitude then I think you also need.... sometimes you need to go out of line, just to show them that it's not all about...err... us who are working there, it's about our job but if you're still continuing to do... to give us such bad attitude, I think also I'll have to retaliate also.
I: Mm...
R: Yes.
I: Ok. So, retaliating...meaning what?
R: Meaning to show you that you can't just judge me while also you, you can't do your own research to find out what is a clinical associate, because if you can think about it, if you're also interested to know who... what is my task, what I must do, where must I go? You'll also wonder and re... do your own research or ask around "okay, who are these people, what do they want here, what is their job?". Then you'll know, that's why I said I don't see a point to explain.
I: Ok. So in other words you're saying if the nurses knew that they were going to be working with clinical associates, they should have went out of their way to find out who are these people?
R: Yes, they should have done that because... for example, if the...like... if you're a teacher, you're a old teacher in a school, sometimes there will be... there would come... they would bring new teachers who are still busy at school to do practicals. They will brief you that "okay, there's new teachers who are coming so you'll monitor them, if they want 1-2-3, you must give them. One time you must just give them the class to teach but under your supervision". But if something like that is... it didn't happen then there's a problem there.
I: Ok.
R: There's a big problem.
I: Alright. Other than uhm... the challenges that you're facing at the workplace with the nurses, uhh... is there other challenges, you know, out of your professional relationship that maybe also makes you feel that this new profession of clinical associate has not been uhh... clearly uhm...like there is no... how can I put this? Are there other challenges other than the professional uhh... relationship with the nurses that make you feel as a clinical associate that this profession was not really planned for?
R: Yes-yes-yes Ma'm. Eish, there are a lot, there are a lot. There are lot of problems we face outside. If you can check, even us we're not clear, what's going on. The thing we're clear about is we know what we must do and we know that we're clinical associates but based on like...on which...err... like on which...err... what can I say...on which level we are, we must fall in, we

don't know which level, which level we must be in. So, because sometimes even if you're trying to explain to someone, it's a problem. Myself, I can't explain and the calls at the hospitals...
I: Do you them?
R: Yes, we do calls at the hospitals. We do calls.
I: Is there a problem there with the calls or you're fine doing the calls?
R: We're fine doing the calls but the problem is that...err... salaries of those calls because they're different. Some when they're attending to calls, there's... there are some sort of ...err... how can I put it... I can say a sort of a salaries there that they're getting.
I: The overtime?
R: The overtime. They're getting some allowances of which us, there's none like that, we just work, we have one paycheck, finished.
I: So when you say some, do you mean the doctors?
R: Doctors, nurses. Nurses on call, he will receive an allowance and doctor who is on call, he will receive even bigger allowance. So but us, we're always on call but there's nothing.
I: Ok. So nurses being on call, you mean those nurses who are working overtime?
R: Those nurses Yes.
I: Ok, alright. And you mentioned something about salaries, I'm not sure if I heard you well? Is it part of the challenges that you're facing?
R: Yes, yes. Salaries are a problem because if I'm working out of my scheduled...err...or I can say out of my scope of work, then I must be compensated or something but the problem is that we do get those basic salary and those basic allowances like medical aid, that everyone gets if you're working for the government but there's no something from the medical institution to show that there's a compensation for overtime, compensation for calls, something like that.
I: How does that make you feel? Does it make you feel...? Do you think it will change in future?
R: Yeah, yes. I...I don't think so. I don't think sso it will change because the way I look at it they're just extra members to a shift, we're just passenger, just to help. I think just to help and I don't think this profession will also last for long but we just have to wait and see.
I: Why are you saying you don't think it's gonna last for long?
R: Because there is... this is just...err... we're just there to fill the gap.
I: Ok.
R: Then if there's enough doctors, what will clinical associates do? Nothing. Then unless if there's...err...maybe 80% enough doctors, maybe they will consider taking clinical associates to school so that they can be doctors or they can choose to be nurses too.
I: Ok. Is there something that you want to add there?
R: Yes, I can add some... We're not even given opportunity to study further like the nurses because nurses they can upgrade, they can always... they always go on courses to uplift...err...for better positions but us, we're stuck that being a clinical associates. There's no improvement salary-wise, there's no improvement career-wise, academically... We're stuck there, we're just there to assist, that's all. That's the reason I say...err...I don't think this career, it will last long because most of the thing that is happening, they show you that you're just there to assist. They just get you this basic education to assist, then after that you'll see yourself what you wanna be, a nurse or a doctor or you wanna leave the medical...err...the medical career altogether.
I: And do something different?
R: And do something different, yes.
I: Ok. So with... in terms of working in the hospitals then... because as you said, you work under the supervision of a doctor, meaning you work under the Clinical Manager who's in charge of all the doctors. So it's the Clinical Manager, the doctors and you, as clinical associates?
R: Yes.
I: Do you get enough support from the Clinical Managers at the hospital?
R: Yes, we sometimes get...err... I can say we get support because the Clinical Manager knows what's going on.
I: Mm...
R: Yes, we get that support sometimes but according to me it's not enough. It's not enough because there's some things which the Clinical Manager can't answer also. He'll refer us to the

Department, he'll refer us to the Minister because still this thing it's not like... I cannot say it's not official but I can say it was not properly introduced.
I: Ok.
R: Yes.
I: So this thing of it not properly produced is the one that is leading to all these challenges that you're mentioning?
R: That's the problem.
I: And it's the one that is leading to you as a clinical associate not having a good professional nurses...sorry... good professional relationship with the nurses?
R: Yes.
I: Ok.
R: That's the problem, that's the biggest one, that's the big problem.

QUESTION 10

I: What is the way forward? Who must do the clarification of the clinical associate profession? How must it be done? When must it be done?
R: I think the person... the main person who implemented this, must come clarify to us, to the nurses, to the doctors, everyone who need clarity, even us. As I mentioned previously that even salary-wise, we are not happy. We are not sure what\'s going on, we're not even sure if we're still going to stay for long here or we're just passing by and it can also clarify to the nurses, who are we, what must we do so that also us we must know and accept "okay, it means we're stuck here for this period". There must be a deadline that "okay, this career of yours is just for now, temporarily until we get enough doctors", or "no, this thing is right, this 3 years of yours you have done, you're going to continue with it, we're going to introduce something so that you can know because we are now also in the dark but all we have to do is just to work, it's just to perform our duties, do what we were called for.
I: Ok.
R: Yes.

QUESTION 11

I: So, as a clinical associate, what do you think you can do to improve the professional relationship between you and the professional nurses?
R: I think first we must know who we are, then if we can know... if we can explain ourself better then things will be easier. Only... the only problem it will be because of those stubborn people but most of the people, more especially in the patients, they will understand, then the nurses they will understand what is our job and what is the main...the main reason we're here. Then I think if... even if us we cannot be big-headed that our qualifications are bigger than the nurses', then problems... such problems will be eliminated.
I: Ok.
R: Yes
I: Alright. So you are basically, from what I'm hearing, is that you think that if someone can come, even if from the Department of Health, to come and formally introduce the profession of clinical associates to other healthcare professionals so that there is an understanding, so that there is clarity moving forward in order for you to have a professional relationship with them?
R: Yes. I think it will help a lot but according to my view, I think if first... first thing first, they can take us maybe for a day, explaining who are we. They will explain, tell us "okay, your job..." Okay, we know our job but for as... like in ranks, we don't know where we fall...we fall under, what's going on. So if the Minister can explain to us and tell us "okay, 1-2-3, 1-2-3". Okay, we know what we must do because we did go to school to study for the primary job we have to do at the healthcare facilities and then after that they can brief all of us "okay, these are your clinical associates. These people's task is 1-2-3, 1-2-3, 1-2-3, 1-2-3. They must do... they must assist

the doctors, they must assist the nurses", or we don't assist the nurses, they must assist us. We must know so that we can have clarity what's going on physically on the ground because we know what we must do but I don't know who's superior, who's inferior. Who must I...err... address or not address? So, if they can assist there, we are going to have a better...better, a very beautiful professional relationship.
I: Thank you so much for your time!
R: Ok, thank you Ma'm!

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