Key issues in clinic functioning – a case study of two clinics

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Objective. The aim of this research was to understand key issues in the functioning of two different primary care clinics serving the same community, in order to learn more about clinic management.

Design. An in-depth case study was conducted. A range of qualitative information was collected at both clinics. Data collected in the two clinics were compared, to gain an understanding of the important issues.

Setting. Data were collected in a government and an NGO clinic in North West province.

Subjects. This report presents the findings from patient and staff satisfaction surveys and in-depth individual interviews with senior staff.

Results. Key findings included the following: (*i*) there are attitudinal differences between the staff at the two clinics; (*ii*) the patients appreciate the services of both clinics, though they view them differently; (*iii*) clinic A provides a wider range of services to more people more often; (*iv*) clinic B presents a picture of quality of care, related to the environment and approach of staff; (*v*) waiting time is not as important as how patients are treated; (*vi*) medications are a crucial factor, in the minds of staff and patients; and (*vii*) a supportive, empowering organisational culture is needed to encourage staff to deliver better care to their patients. The management of the clinic is part of this culture.

Conclusions. This research provides lessons regarding key issues in clinic functioning which can make a major difference to the way services are experienced. A respectful and caring approach to patients, and an organisational culture which supports and enables staff, can achieve much of this without any additional resources.

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Primary health care clinics are the first line for health care delivery in South Africa and often the basis on which the health service is judged. It is therefore essential that these clinics function well.

Although staff in these clinics generally feel that they offer care of good quality,[1,2] there are problems in the areas of management and staff attitudes.[2] The latter is borne out by community surveys, where frequent complaints about negative attitudes of health care workers are raised.[3-5]

A variety of factors play a role in the functioning of district clinics, many of which are not clearly understood. The aim of this study was to gain an understanding, through a case study of two clinics serving the same community, of some of the factors involved in the functioning of primary care clinics. This was part of a broader case study looking at multiple aspects of clinic functioning.[6]

The two clinics chosen, referred to here as clinics A and B, are in the same neighbourhood in the North West Province, South Africa. The clinics serve the same population, are located close to each other and are staffed by personnel who are apparently equally well trained. Clinic A is a government-run, district clinic which offers a comprehensive 24-hour service. At the time of this study, it had six permanent professional nurses and three enrolled nurses working in shifts, and a number of clerical staff. There is no fee for service. Clinic B is a church-based NGO-supported, primary health care clinic which offers a day service only but provides a comprehensive service, including antenatal care but excluding deliveries, family planning and chronic psychiatric care. It had four full-time professional nurses and a number of clerical and assistant staff. The fee for service was R10.00 per visit.

Methods

A qualitative case study with structured questionnaires and in-depth interviews was used to understand how staff and patients perceive the functioning of each clinic.

Structured interviews using a standard questionnaire were conducted with 7 staff members in clinic A and 11 in clinic B. In-depth, unstructured interviews about their experience at the clinic were conducted with 3 senior professional nurses in each clinic.

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A questionnaire was administered to 30 randomly selected patients in each clinic.

Survey data from each clinic were analysed separately. A thematic analysis was done on data resulting from the in-depth interviews, and the findings were validated by the interviewees. The data sets were then analysed as a composite whole for each clinic. Thereafter, comparison was done between the clinics. A summary of all the information was presented to staff at each clinic for validation.

Results

Patients' perceptions

Questionnaire interviews were recorded for 30 patients in clinic A and 27 in clinic B. In both cases females predominated and most patients fell into the 20 - 40-year-old group.

Patients identified positive things in both clinics (Table I). In clinic B all the patients reported no problems while 7 patients in clinic A reported that there was nothing good about the clinic. The one uniquely good thing about clinic A is that patients do not pay. The lack of medicines and several interpersonal issues, including rudeness and problems with confidentiality, feature as negatives in clinic A.

Long waiting times are experienced at both clinics. In clinic A waiting time was reported as being related to arrival time and to staff tea and lunch times, while for clinic B there seemed to be more understanding of the reasons for waiting, verbalised by one response that 'it does not matter'. Clinic B had a 100% satisfaction rate compared with 60% for clinic A.

Most patients did not suggest improvements for clinic B; any suggestions made were related to increased personnel and extension of services. Suggestions for clinic A are related

Table I. Patient perceptions of the quality of service

Clinic A	Clinic B
What are good things about this clinic?	
Nothing (7)	Don't know (2)
Good/very good treatment (9)	Treat patients well/very well (7)
Treat patients well/very well (5)	Staff are kind/friendly (3)
Friendly nurses (1)	Good advice/health education (2)
Good advice/health education (2)	Help us with everything (2)
Family planning (2)	Take care of patients (2)
Cleanliness (2)	Service is satisfactory (1)
Help the community (1)	Reception is good (1)
Fast service (1)	Always have enough medicine (9)
Help with medicine (1)	Good treatment/right medicine (4)
Give treatment even if we don't have money (1)	TV and video (1)
Maintained well (1)	Hold prayers before treating patients (1)
What are the problems in this clinic?	
None (9)	None (27)
Shortage/lack of medication (11)	
'They mix medicine with water' (1)	
Negative attitudes of nurses/rudeness (5)	
Staff go to lunch for too long (2)	
Staff are slow (2)	
Problems not taken seriously (1)	
No confidentiality (1)	
Wait too long (1)	
No X-rays (1)	
Lack of doctors (1)	
How do the staff treat you at the clinic?	
Good/well/very well (13)	Good/well/very well (25)
Friendly/kind/positive (4)	All right (3)
Variable (5) ('the nurses differ'; 'some are good and some are harsh'; 'when the doctor is in, they treat us well'; 'there is one nurse who is rude to other people')	Kind (1)
	Everyone is satisfied (1)
Not well/very bad (4)	
Shout at patients (3)	
Rude (1)	
Unco-operative (1)	

to quality of care, provision of medicine and staff attitudes towards patients.

Staff perceptions

In the *structured questionnaire*, positive responses from clinic A staff related to the comprehensiveness and accessibility of the service and interpersonal relationships. Positive responses from clinic B staff related to the availability of drugs, the care of patients, the management of the clinic and the availability of equipment. There were many positive responses in clinic B regarding the management style, support and personal development opportunities.

There were major differences in responses regarding the problems. In clinic A, the issue of shortage of resources was prominent, while in clinic B financial difficulties were mentioned, but were not seen to translate into material shortages.

The most prominent aspects of enjoyment at clinic A were the respect and response from the community while in clinic B issues of learning, gaining experience, helping patients, supportive management, quality improvement through medical student projects and the calm and relaxed atmosphere were reported. One staff member in clinic B even reported that she enjoyed everything about the clinic.

Changes suggested by staff from clinic A staff were mostly related to improved management and support services while those from clinic B were more related to the extension and accessibility of services and pay increases.

Staff in clinic A demonstrated awareness that patients' experiences are mixed and that some may not be satisfied.

Table II. List of themes – in-depth interviews with individual staff members

Positive aspects of working at clinic A

A. Personal fulfilment
- Personal learning
- Respect from community
- Health education
- Innovation
- Occupational independence
- Getting to know the patients

B. Facilitating factors in the work environment
'Good interpersonal relations' among staff

Positive aspects of working at clinic B

A. Personal fulfilment
- Appreciation from the community
- Appreciation from colleagues
- Personal growth

B. Facilitating factors in the work environment
- Enabling leadership style:
  - Fostering independence
  - Encouraging empathy
  - Affirming personnel
- Good mood in the work environment
- Supportive environment
- Unity of staff

C. Attitudes towards patients
- Non-judgemental attitude
- Non-directive attitude
- Treating the whole patient

D. Availability and quality of medicines

Negative aspects of working at clinic A

A. Limited resources
- Transport problems
- Area surrounding clinic not maintained
- Lack of equipment
- Medicine shortages
- Water and electricity cuts
- Staff shortages
- Lack of ambulances

B. Poor responses to problems from management

C. Relations with community
- Communication
- Lack of a community health forum

Negative aspects of working at clinic B

A. Limited financial resources
- Poor salaries
- Funding

B. Patients from outside the locality

Clinic B staff expected patients to have a positive experience of the clinic as a result of the concepts of caring, namely enjoyment, comfort and respect.

Themes from the *in-depth interviews* were grouped around positive and negative aspects of working at each clinic (Table II).

Positive aspects of working at clinic A

Personal fulfilment was key. This has various aspects. Learning from visiting doctors and the Standard Treatment Guidelines was positive: 'You learn a lot taking care of the community and you start to learn the basic problems that end up taking people to hospital.'

Knowing their patients and feeling respected were reported: 'The community as such, they have a high regard for me, even when I meet them outside.'

One staff member said that the difficulties and isolation had forced her to innovate and be independent. 'When you're on your own you must make your own decision to save a patient, meaning that you are responsible. When supplies were limited, for example, she advised patients to 'use salt and water to wash wounds, or lemon and sugar for a cough'.

Facilitating factors in the work environment were identified. All the participants at clinic A mentioned the 'good interpersonal relations' related to helping each other, e.g. a cleaner assisting with tasks during a birth.

Negative aspects of working at clinic A

Limited resources create problems. For example irregular transport means that specimens do not reach the laboratory in time and have to be collected again, and the lack of ambulance service impacted on patient health and community perceptions.

The absence of a gardener results in the grounds being 'infested with snakes'. Limited equipment affected both staff practice and morale. 'It really affects us negatively, inadequate decisions are made ..., [and we] end up feeling inadequate.' There was also no stove to sterilise equipment, no cooking pots, no washing machine and no bleach.

Medicines orders are often late, incomplete and insufficient. It is demoralising to turn away patients who need medicine.

Frequent disruptions in the water and electricity supply affect the ability to function effectively and also depress the morale at the clinic.

Staff shortages and being called away to meetings and workshops create problems.

There were poor responses to problems from management. Often when problems and needs were reported to management, the response was either slow or problems 'were not taken up'. 'We'd report one and the same thing again, which does not get fixed.' Nurses reported spending their own money to travel to the district hospital to follow up on matters that had been reported.

Shortcomings exist in relations with the community. Although it was felt that communication between staff and patients was generally good, participants said that nurses could be disrespectful to patients at times: 'Maybe there's a nurse [who] may be harsh to a particular patient.' Similarly some patients, particularly those who are drunk, are rude to the nurses.

The failure to create an effective community health forum was largely blamed on the community, because people expect some form of compensation, asking 'Will we get something out of it?'

Positive aspects of working at clinic B

Personal fulfilment was again key. The community appreciate their work. 'I think that's what really makes one happy, for someone to come back and say: "You have really helped me."'

Facilitating factors exist in the work environment. Clinic B was contrasted with previous experience in the public service. 'You know, some of your mentors or matrons, sisters-in-charge would never give a junior sister room to voice whatever their concerns are.'

The leadership at clinic B actively encouraged nurses to take responsibility in patient care and they felt affirmed: 'You are allowed to be who you are.' They could empathise with patients and feel significant themselves.

The mood at the clinic was 'happy' and 'positive' and the environment 'warm' and 'homely'. One participant linked this to the religious foundations of the clinic. Another observed, 'They [patients] sense an atmosphere here ... there is a sense of tranquillity, there is no kind of loud talk or shouting around, or disturbance or distraction.'

Respondents experienced emotional support when encountering problems, both inside and outside the workplace and unity because of 'working as a family, there are no small groups'.

Attitudes towards patients are helpful: 'For me I never look at them like they are patients, they're just individuals, they are just respectable members of the family, I mean of the community. They are mothers, they are wives to somebody, they are husbands, and brothers you know.'

They also accommodate differences. 'This patient is a Christian, this patient a sangoma and we try to accommodate that, we respect whatever, you cannot impose yourself' and they attempt to treat 'the whole patient', going beyond the presenting problem. 'Here we are talking about a whole individual, who is a religious person, a mother, a father, and a patient. We look at them in their totality. We are not just treating the physical here.'

Medicine is available continuously: 'Patients are sure they are going to get treatment.'

Negative aspects of working at clinic B

Limited financial resources are an issue. Remuneration packages are less than those at government clinics, but this was not the primary consideration in their choice of work. However, uncertainty regarding the future funding of the clinic was a constant stressor.

Patients from outside the area reduce the effectiveness of care as home visits and follow-up are limited.

Discussion

The community appreciates the services of both clinics differently; clinic A is appreciated for the comprehensiveness and accessibility of service and clinic B for the quality of care related both to adequate physical care and treatment (examination, medicines, ambulance, etc.) as well as to environment, atmosphere and respect.

In clinic B, the NGO clinic, the picture is that of a well-functioning service appreciated by the patients and enjoyed by the staff. This relates to a package of a caring, respectful approach to patients **and** staff, facilitated by effective, experienced management. Suggestions for improvement relate to expansion of services.

In clinic A, the public clinic, the picture is a mixed one, in common with other public sector facilities.[2] There is appreciation of and satisfaction with essential services rendered. But there is significant evidence of dissatisfaction mainly about two issues, namely shortage of medicines, and staff attitudes and behaviour towards patients. Problems with nurses' attitudes were recently reported in Gauteng where one in every three respondents rated nurses' attitudes as bad or very bad.[7] Previous community research has raised the same issue.[3-5]

Rudeness to patients is a very disturbing phenomenon in health care. The evidence of rudeness and its effect on the experience of patients and the community in this and previous studies is too strong to ignore. It is completely contradictory in a health **care** service, and also difficult to understand at a human level – being rude to someone who comes for help because he or she is ill. The notion that the patient-health worker relationship mirrors the health worker-manager relationship[2,8] is supported by this study; the staff in clinic A do not feel respected and treated with dignity by managers, which impacts on how they behave towards their patients. In contrast, clinic B staff feel respected and supported by management, and patients experience the same attitude from staff. The staff in clinic A are aware of the importance of interpersonal issues in patient care. Interventions to address the problem have been described, such as 'Health Workers for Change',[9] but these interventions should include management building trust with health workers.[10,11]

The leadership style at clinic B was experienced by staff as being empowering with the responsibility for decision making shared. The consequence is that staff felt that they were significant and that they could make a difference. This feeling staff had about themselves was similar to the attitude they showed towards patients at their clinic.

Respondents from both clinics generally seemed to get on well with their colleagues, although respondents from clinic B specifically identified the emotional support they received from colleagues. Staff from both clinics identified factors that they found personally fulfilling; staff at clinic A mentioned issues related to their effectiveness as nurses, such as learning, education, innovation, knowing patients and occupational independence, while respondents from clinic B put more emphasis on the rewards of caring for patients.

Medications are a crucial factor, in both clinics, in the minds of staff and patients. Solving the medication shortage alone would substantially change the perceptions of differences between the clinics.

An interesting finding is that clinic A staff and patients are very aware of all the material shortages in the clinic while the staff at clinic B are aware of the financial difficulties as an NGO clinic, but these financial difficulties do not translate into material shortages. This was confirmed by random checks of essential medicines as part of the case study.[6] It suggests that the issue is about management and organisational capacity, rather than resource shortage. The NGO clinic was doing well with fewer resources but more local control and better management.

Long waiting times were noted in both clinics. In clinic A it was related negatively to staff tea and lunch times while in clinic B it was accepted positively. Patients complain less about waiting if the service they get after waiting is experienced as efficient, caring and respectful.

Patients in clinic B paid R10 per consultation, which is less than one-third of the cost of the service. Although the payment issue is mentioned, it seems as if patients are prepared to pay a small fee if the service they receive is acceptable. There was even a suggestion from a patient at clinic A that patients should pay a fee to help with the provision of medicine.

The management style of the two clinics differs markedly. The one is a typical public service facility where local staff try to render a good service despite serious management and supply deficiencies. The poor response from supervisors was clearly reported in the public clinic. At the same time, patients consider local staff accountable for attitudes and service, whereas the staff blame the off-site district office management for their problems. In contrast, in the NGO clinic, supportive, positive, accessible and professional management is mentioned often. The result of such management is that meagre resources are managed in a way that they provide a respected and appreciated service. Two different organisational cultures come to the fore with differing results.

This study suggests that to improve efficiency of public clinics, qualitative issues, including organisational culture, management style, staff attitudes and patient satisfaction need attention rather than large-scale adjustment of staffing levels, as has been suggested.[12]

In summary, this case study provides a picture, on the one hand, of a government clinic performing at least at an average level, providing an important, comprehensive, primary care service to the community, through the efforts of health workers trying their hardest in a difficult context. On the other hand, it provides a picture of an NGO clinic with limited resources, serving the same community with similar staff and resources, achieving much more in terms of satisfaction from everyone involved, as a result of health workers flourishing in a supportive environment. The difference appears to be the result of an organisational culture of local decision making, empowerment of staff and caring leadership.

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