THE INFLUENCE OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD) LECTURES ON REFERRALS IN THE MEDICAL PROFESSION

BY

NTHABELENG RAMMILE

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Professor J.A.A. Lazenby
(MBA, D. PHIL)

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DECLARATION

I declare that "*The Influence of Continuing Professional Development (CPD) Lectures on the Referrals in the Medical Profession"* is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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N.M Rammile Date

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ABSTRACT

The purpose of CPD lectures is to provide learning on a continuous basis to keep medical doctors up to date with the newest scientific developments. The major responsibility of CPD provision is to address two interrelated tasks, namely to sustain motivation among established general practitioners (GP's) and specialists for self-directed learning based on experience

and to device ways of sharing individual experiences.

In the process of fulfilling these two tasks, CPD lectures can also be utilized as a marketing tool for both the hospital and the specialist. This means that the specialist, in the process of presenting the lecture, can utilise this platform to market his/her expertise and the resources of the hospital from where he functions so as to increase the number of referrals he/she receives.

Consultation and referrals have always been important processes for both the GP's and specialists. It is of the utmost importance for specialists to establish networks with the GP's in order to establish a stable referral pattern. It is however also important that this network pattern grows due to the fact that competition for patients intensifies and because more and more health care organisations are devoting more resources to understand the factors that directly or indirectly influence patient volume. Once these factors are identified, it will be easier to influence patient volume for the benefit of the hospital and the specialist.

CONTENTS

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

The role of CPD (Continuing Professional Development) is of crucial importance and cannot therefore be ignored. CPD plays a role in ensuring that the workers are kept up to date with the current developments in their various professions (Armour and Yelling, 2004:97). CPD in the medical profession is particularly crucial because the patients and the public require better standards and faster delivery of service at a lower cost. CPD will help the hospital and the doctors to prepare for, and cope with the challenges that will face them in the future world of work (De Villiers, 2004:77). In order for CPD to be effective and continue being effective, it must be based upon an understanding of the complexities of the conditions of work and on the understanding of both the presenters and the attendees. In the process of CPD, the specialists will gain exposure to GP's (General Practioners) during the presentations because GP's have to attend these sessions to remain registered as GP's. Since the GP's play an important role in the referral process for many health care sources, the hospitals can also utilize CPD as a marketing tool (private hospitals depend on GPs who refer to specialists associated with them).

Bowers and John (1994) state that CPD lectures create the opportunity for specialists to market themselves personally (person to person) and not through a second or third medium. In order for the specialists to market themselves effectively they will need to be sensitive to modern learning styles. Networking and mentoring also play an important role in this regard because the specialists

do not make presentations to market themselves primarily, but to improve the knowledge, skills and competence of the attendees who are the GP's. CPD is essentially about individuals, their development needs and what they can do to meet them, and a reflective evaluation by the outcomes achieved (De Villiers, 2004).

Even though in this study CPD is going to be viewed as a potential marketing tool, this must not be clouded by the fact that the main emphasis of CPD is to develop and direct one's career. De Villiers (2004) supports this view in mentioning that the role of CPD is to encourage life-long learning habits in all the members, for their personal benefit and growth and to enhance the profession and their professionalism. This study examines the theoretical material pertaining to the marketing approach to CPD as a service followed by an empirical study to evaluate the delivery of customer service to the GP's during the CPD lectures. This chapter will examine the following aspects:

- The defining of concepts
- Motivation of study
- Contributions of the study
- The goal of the study
- The objectives of the study
- Research methodology and
- Summary and division of chapters

1.2 DEFINING CONCEPTS

1.2.1 CME (Continuous Medical Education)

De Villiers (2004:77) defines CME as consistent and constant improvement and maintenance of knowledge, skills and competence throughout a professional's

working life. The emphasis in the CPD programmes is on providing a supportive, stimulating and challenging environment for learning from direct experience (Connor et al., 2000:748). Since attending the CME professions is compulsory for medical doctors, the study will focus on various interactions between the specialists presenting the lecture and the GPs attending the lecture and the implications of these interactions on marketing.

1.2.2 CPD (Continuous Professional Development)

In South Africa CME is also referred to as CPD (Continuous Professional Development). In this study the understanding of CME and CPD are synonymous.

1.2.3 Referral

Javalgi and Benoy (1993) define referral as a process of building creative and ongoing programmes that promote physician relations, networking and outreach and it also represents a major strategic opportunity for specialists and referral recipients. The opportunity flows from the process of mentoring, supporting and assessing, when/during which a specialist also aims to build a relationship with the GP's. When a specialist has built a relationship with the GP's, it will be easier for the GP's to refer to that particular specialist (Connor et al., 2000:747)

1.2.4 The GP (General Practitioner)

A general practitioner or physician is an authorized practitioner of medicine, as one graduated from a college of medicine or osteopathy and licensed by the appropriate board (Miller and Keane, 2000:250). In this study the GP's will not only be viewed as the attendees of the CPD Program, but they will also be

viewed as the target market of the hospital and the specialists because they are the ones who refer patients to various hospitals and specialists. Hence various marketing activities will need to be embarked on to exert an influence on this particular market.

1.2.5 The Specialist

A specialist is a physician whose practice is limited to a particular branch of medicine, surgery, especially one who by virtue of advanced training, is certified by a specialty board as being qualified to so limit his or her practice (Miller and Keane, 2000:600). This study views the specialist as both the presenter of the lecture and the deliverer of quality service to his potential clients (Gp's). In other words the specialist will be viewed from a business perspective as the representative of the hospital with whom he is associated and also as the representative of his own services.

1.3 MOTIVATION

1.3.1 Background

1.3.1.1 Why CPD?

CPD must develop the GP's ability to look at diseases from a scientifically-based, psychological and social perspective. The challenge is to bridge the gap between scientific evidence, and the GP's knowledge, attitude, and performance. However this is not the only reason why hospitals and specialists play a role. The ulterior motive is to create more business through CPD. However, the research conducted by Olesen and Hjordahl (1999:17) indicated that the "how" aspect of achieving such goals is yet to be clarified, particularly in South Africa. One of the

ways that can assist in solving this particular challenge would be to empower the specialist with the skills necessary to provide state-of-the-art presentations (Dorman et al., 2004:264). The demonstration of commitment and competence by the specialist is thus crucial. CPD is an area where the Specialist can promote himself or herself.

1.3.1.2 GP's Perceptions

It is important to know the kind of perception the GP's have towards CPD because perception influences how an individual will respond to what is presented (Cant et al., 2002:99). Since CPD credits are mostly obtained from attending registered courses it is clear that some of the GP's attend from a sense of obligation. One of the factors that can have a bearing on perception is the format with which the lecture is presented. For example there are formal lecture-based seminars and courses which can be accessed at local hospitals, general practice departments at the medical schools and post-graduate medical societies (Goodyear-Smith et al., 2003:329). Goodyear-Smith et al. (2003:329) also mention that some GP's consult with practice partners on difficult cases, perhaps calling them into the consultation to provide a second opinion, with some having good working relationships with local specialists, whom they could telephone when encountering a problem that lies beyond their experience. These are the various formats which are both formal and informal.

The move from voluntary to compulsory CPD has advantages and disadvantages. Most GPs felt that the CPD lectures help them to maintain professional standards. Attending a lot of CPD lectures however, does not necessarily make you a good doctor (McCall et al., 2004:24). Furthermore the effectiveness and value of CPD in changing behaviour has been questioned over the years (Dorman et al., 2004:264). If the general perception is that CPD is not very effective in changing behaviour then the specialist and the hospital need to be

aware and come up with interventions that will help them to be more effective in influencing the behaviour positively. On a more positive aspect, some research has indicated that CPD enabled the GP's to meet their learning needs and that GP's valued personal interaction involved in meetings and this demonstrated an opportunistic rather than needs-based approach to learning (Moon, 2004:7). Clearly, changing behaviour is an evolutionary process. Some of the things that helped change the perception of the GP's positively included letters from specialists regarding referred patients, interactive workshops and quality assurance measurements (Moon, 2004:7).

Research by Moon (2004:9) indicated that when GPs have a positive perception towards CPD the following outcomes are achieved:

- Competence and knowledge increased
- GP's felt more comfortable and less frustrated,
- GP's were more confident
- Understanding increased
- There was an increased confidence in ability to manage patients
- GP's indicated that they were more aware of their professional limitations, which has resulted in change in their communication with their patients and altered referral patterns
- When GP's interact more, this helps to make the content of the work to be personally relevant.

As the hospitals and the specialists want to market themselves to the GPs, they must know what the perception towards CPD is, and if this perception is a negative one it must be dealt with accordingly. Since marketing is going to be done during the CPD event, the perception towards CPD will influence perception towards the marketing activities.

1.3.1.3 The role of networking

One of the ways to capture the GP market is through networking. In order for networking to be effective there must be good relationships that exist between the hospital and the GPs and between the GPs and the specialists. These relationships need to be taken care of and they are grown by mutual trust and shared benefits (Misner:2003). This study will also focus on networking because it is through networking that the hospital and specialists connect to their target market. Research shows that when the GPs know and trust both the specialist and the hospital, they refer more patients to them than the GPs who don't know or trust the specialists and the hospital (Farber, 2003).

The hindrances to effective networking result in a low rate of referrals. This challenge is due to a number of reasons. CPD can be utilized effectively to solve this problem. Till (2003) mentions that some specialists do not get referrals because they think a referral should come automatically, they are afraid to ask, they don't know how to ask and they feel uncomfortable asking a GP for a favour. The study of relationship marketing thus has an important role to empower the specialists to be strategic in generating referrals for themselves.

1.3.2 Awareness of the problem

South Africa re-entered the international arena, and CPD lectures are one of the prerequisites for meeting international standards in the medical profession. The marketing value of CPD lectures has not been determined by research before, which will motivate hospitals and specialists to participate and develop CPD lectures further, if the marketing value is significant. If the findings of the

research highlight the significance of the referral value it will motivate specialists to present CPD lectures.

As mentioned earlier in this chapter, the aim of CPD is to intervene in those areas of medical practice that can be improved upon. Again CPD should give individuals an edge: a competitive edge, in market terms. It should help in making them more competent in the job they do now and those they wish to carry out in the future. Although CPD is presented and individuals who attend attain credits, the goal of CPD of optimizing GP performance and outcomes has not been met (Wotoh et al., 2004:20). This view is supported by Stanley et al. (1993) in mentioning that although CPD is supported by public funds and perceived by the profession, as a means to maintain professional competence, there is little evidence that CPD for general practice is achieving this purpose. This is despite increases in knowledge evidenced by testing before and after CPD activities. Research shows that most CPD courses fail to change GP practices (de Villiers, 2004:77). Ekdahl (2000:10) suggest that GP's knowledge decreases after graduation from medical school, and new medical information fails to be integrated into routine practice. It is thus crucial for the CPD planners and the presenters to revisit the content of CPD, formulate new outcomes and employ different approaches to ensure that the impact of CPD moves beyond the mere accumulation of knowledge.

1.3.3 Problem Statement

The reason for doing this study is to determine the marketing value of the CPD lecture compared with previous referral sources. In the past GPs used sources like specialist lists from hospitals, word of mouth from colleagues, patient requests and family requests as sources or referrals. The CPD lecture is now an alternative referral source for the GP. Benefit of the CPD lectures is that they

create the opportunity for the specialist to make himself known personally to the GP.

According to Berry and Parasuraman (1991:68) most specialists have limited contact with GP's, and instead have left it to the hospitals to handle most of the interaction with the GPs. Clearly, hospitals have also been responsible for making most of the decisions regarding market selection, marketing approaches and service. This has lead to a progressive increase in the number of complaints between the hospital and the GP's (Kooy, 1995:52). There appropriate intervention would be to allow the specialists to interact more frequently with the GP's. It is apparent that the customer service activities in hospitals worked well in an uncompetitive environment. However, with the increase in competition and changing needs of GP's and patients, this service may not work so well.

The findings of a survey (Du Boulay, 1999:162-164) investigating the needs of GP's with regards to the hospital, CPD and the specialists identified the following areas warranding attention, namely:

- Greater knowledge on CPD is required
- The hospital should communicate with the GPs at various stages of their professions as their needs change
- A thorough understanding of CPD is required
- GP's were not sure that the information provided at CPD lectures was relevant
- GP's need to know and relate with specialists not only at a professional level but also at a social level

Constant communication with the GP's will assist in ensuring firstly that their needs are noted and secondly will ensure that the needs are met in a manner that is relevant to the GPs.

Viewed against this background it is apparent that hospitals and specialists need to focus on service excellence in networking and when creating referrals in order to gain a competitive advantage locally and globally. The medical fraternity needs to be customer driven, since their ultimate success depends on satisfying the needs of their respective target markets. Therefore, it is appropriate that the customer service provided by a leader in the industry should be empirically probed. A study of this nature to date has not been undertaken in South Africa.

The study will provide answers to the following questions, namely:

- Will networking based on the principles of relationship marketing lead to an increase in the number of referrals?
- Do the CPD lectures have marketing value for the specialists and the private hospitals?
- Do the GPs view the CPD events as a base for identifying specialists to whom to refer?

The reason for undertaking this study is to determine whether the CPD lectures will influence the GP's attending to refer to the particular specialist presenting the course.

1.4 CONTRIBUTIONS OF THE STUDY

There are two main parties that will benefit from the findings of the study. The hospitals and the specialists will be better equipped to apply customer-oriented marketing principles to their business operations. Customer-oriented businesses tend to be more profitable, have loyal customers that provide referrals culminating in increased sales, and exhibit better performance relative to competitors (Clutterbuck and Kernaghan, 1991:8-9). Consequently GPs will

benefit from improved service quality and delivery by service providers who will be in a better position to satisfy their needs.

Hospitals could use the recommendations and possibly develop strategies to adopt appropriate customer service practice that will enable the hospitals to achieve their objectives more easily. The research should evoke awareness among the hospital managers and specialists with regard to the opportunities and advantages of utilizing CPD lectures as a marketing tool.

The study undertaken is crucial because:

- Specialists will be encouraged to participate in CPD lectures
- GP's will be encouraged to attend the lectures
- Private hospitals will be shown the value of CPD lectures as a referral source for their hospitals
- Hospitals will make use of the marketing opportunity
- Hospitals will integrate CPD lectures as part of their marketing strategy to promote specialists associated with their hospitals
- GP's will be able to make more informed decisions when referring patients to specialists

1.5 GOAL OF THE STUDY

The goal of the study is to determine whether the CPD lectures have a marketing value for the specialist and the hospital by influencing the number of referrals received.

1.6 THE OBJECTIVES OF THE STUDY

In order to achieve the overall goal of the study objectives are essential. This study has both primary and secondary objectives

1.6.1 Primary objective

- To determine the marketing value of CPD lectures as a source of referral information

1.6.2 Secondary objectives

- To determine if CPD lectures do influence the referral pattern of GP's.
- To determine if the perception of specialists and GP's towards the CPD lectures has been changed.
- To identify the issues that influence the GPs when deciding to refer.
- To identify factors that influence the GPs' decision when referring a patient to the specialist.

1.7 RESEARCH METHODOLOGY

The objective of the study is achieved through a twofold process, namely a literature study and empirical research.

1.7.1 Literature study

A literature study was undertaken with the objective of establishing, assembling and integrating theoretical material pertaining to service marketing and referrals as a discipline. The theoretical framework was developed using textbooks,

journal articles, magazines and websites. From within this theoretical framework the service marketing principles and referral practices for the hospital were developed.

1.7.2 Empirical study

The study also entailed an empirical study by means of questionnaires administered among the specialists and GP's in the regions of the Free State province (Welkom, Bloemfontein and Bethlehem), North West province (Potchefstroom) and Nothern Cape province (Kimberley). There were two types of questionnaires administered. For the specialists 50 questionnaires were posted and 20 responded. For the GPs 150 questionnaires were posted and 68 responded.

The research was conducted in five cities lying in three provinces as mentioned above. The study was perceived important to bridge the gaps identified in the literature study and to provide to guidelines for the marketing component of the services provided by the hospital. The target population of this study comprised the specialists associated with private hospitals (Medi-clinic and Rosepark hospitals) and the GP's attending the CPD lectures.

All questionnaires were to be completed by the doctors. One type was to completed by specialists and the other type by the GPs. The questionnaires were distributed during the CPD meetings and the respondents were requested to post the questionnaires to the researcher at a given address. The questionnaires were then coded confidentially for control and follow-up purposes.

1.7.2.1 The study area and target population

The nonprobability sampling technique was utilized. This is "a sampling technique in which units of the sample are selected on the basis of personal

judgment or convenience; the probability of any particular member of the population being chosen is unknown" (Zikmund, 2003:297). The type of nonprobability sampling that was used was quota sampling. Quota sampling was particularly relevant because it ensures that various groups of a population will be represented on pertinent characteristics to the exact extent the investigator desires (Zikmund, 2003:300). This was achieved when the questionnaires were presented during the various CPD meetings and also at different meetings.

1.7.2.2 Construction of the questionnaire

Structured questionnaires were used. This was considered appropriate for the study as they consisted of a series of questions designed to elicit responses from respondents on CPD lectures. The questionnaires proved valuable in the attempt to obtain primary data from specialists and GP's through the survey method. Structured questions (with the exception of question 2.1) of a closed ended nature were used. Predetermined options were presented to respondents who were obliged to choose from the given alternatives. As many alternatives as possible were offered in view of the relatively large sample size.

Question 2.1 of section B was open ended in order to generate various responses in terms of individual opinions and feelings. The intention was to elicit responses pertaining to the reasons why both the GPs and the specialists aren't able to attend the CPD lectures. The intention was to identify responses that would otherwise not have been obtained by means of structured questions.

1.7.2.3 The questionnaire

A total of 30 questions was given to the GPs and a total of 24 questions was given to the specialists. The questionnaires were both in English and Afrikaans. A

copy of these questionnaires is included as Annexure "A". Both questionnaires were divided into four sections. These sections included:

- The first section comprises general information where the doctors gave their personal information
- The second section was on CPD lectures where the doctors gave their comments on CPD with regards to issues such as attendance and/ presentation and the impact on referrals
- The third section focused on referral. This section focused more on factors that influence referrals.
- The fourth and the last section focused on future needs. Once more, in this regard the doctors indicated how they would like their needs to be catered for.

1.7.2.4 Piloting the questionnaire

Preliminary questionnaires were distributed to 5 specialists and 10 GPs. Prior arrangements were made to meet each respondent and the questionnaire was completed in the presence of the researcher. Immediate feedback was obtained with regard to:

- Clarity of questions
- Understanding of questions
- Ambiguity
- Identification of semantic difficulties encountered when completing the questionnaire
- Identification of other queries and confusing aspects

A few changes were then made to the questionnaire before administering it to the study population. However, the responses of this pilot group wre not included in the data for making conclusions with regard to the study.

1.7.2.5 Administering the questionnaire

Each questionnaire was accompanied by a letter of introduction by the Study leader and researcher (Annexure B), which described the nature and purpose of the research and encouraged them to respond. Response was encouraged by the following means:

- The university letterhead was used to afford credibility to the survey
- Assuring respondents of absolute confidentiality
- Results of the study would assist in the improvement of the quality of CPD lectures

1.7.2.6 Problems experienced with the study

There are few South African publications on CPD and there are a few recent reference sources available. It also became apparent that CPD programmes particularly in the medical profession are more established overseas, but are still new in South Africa. The researcher could not gain access of the relevant material because it was only available in certain countries. The resources to help in this regard were limited. Hence chapter two (continuous professional development) has utilized limited sources utilized. A combination of old and new source has been made use of due to the lack of availability of sufficient sources.

Since CPD for the medical profession in South Africa is still a fairly new concept, some of the medical doctors were reluctant to participate in the research because of certain uncertainties.

1.8 SUMMARY AND DIVISION OF CHAPTERS

If South Africa is to compete effectively and efficiently globally, it must be diligent in creating its own competitive advantage. This can be achieved through effective resource allocation, productivity or customer service. Hence it is vital to identify problem areas and take corrective action. However it is generally accepted that a customer-oriented business promotes effectiveness of service dilivery (Addison, 1993:9-10).

Thus it is essential to explain the concept of CPD and the marketing perspective thereof so that the hospitals will be in a position to offer better quality service and the specialists are able to better network with the GP's and hence influence the referral patterns to their advantage. This study aims to determine empirically whether the CPD lectures have a role to play in creating referrals for the hospitals and the specialists involved. Viewed against this background the study is divided into six chapters namely:

- Chapter two: Continuous professional development
- Chapter three: The Role of marketing in a service business
- Chapter four: Referral networking in the medical profession
- Chapter five: Research findings
- Chapter six: Summary and recommendations

1.8.1 Chapter two: Continuous professional development

Chapter two analyzes the concept of CPD. This concept is also viewed from a medical perspective. It became apparent that much research still needs to be conducted with regards to CPD for the medical doctors particularly in South Africa. Much of the findings were based on literature addressing CPD at an international level. This chapter also indicates that the GP's view CPD as a crucial

element in their professions. Quality in such programmes also plays a vital role. Also, the relationship between the learner and the presenter cannot be ignored since it affects the learner's perception of CPD.

1.8.2 Chapter three: The role of marketing in a service business

When the specialists present the CPD lectures they are rendering a service to the attendees who are the GP's in this particular case. This chapter views various marketing principles as far as service business is concerned. The marketing mix was analyzed from a service business perspective. The relationship marketing concept was also looked at. It became apparent that the relationship approach to marketing is not a new concept. It is rather a refocusing of the traditional marketing mix and the development and maintenance of long-term customer relationships. Therefore, in order to achieve success an integrated corss-funcitonal approach to marketing is indispensable, thus the focus must be on a shift from customer acquisition to customer retention.

1.8.3 Chapter four: Referral networking in the medical profession

Chapter four provided an overview of the referral process. The elements of the referral process were looked at and also how to build more effective networks in order to generate referrals. Referrals were also viewed as part of the marketing strategy. This chapter also covers the possible suggestions which can be implemented to help generate referrals.

1.8.4 Chapter five: Research findings

Chapter five investigated the doctors' views on CPD lectures and also what influences them as far as the decisions on making referrals is concerned. This was achieved by means of an empirical study. The results obtained from the

survey yielded findings that provide a clear and specific indication of what the perception is towards CPD, what influences referrals and what role CPD lectures have to play.

1.8.5 Chapter six: Summary and recommendations

Chapter six serves to provide an overview of the preceding chapters. The results of the empirical study are discussed, followed by recommendations to hospitals and specialists and suggestions for future research.

CHAPTER TWO

CONTINUOUS PROFESSIONAL DEVELOPMENT

2.1 INTRODUCTION

The purpose of continuous professional development is to provide learning on a continuous basis to keep the doctors up-to-date with the newest scientific developments. Tolnai (1991:414), points out that it is crucial to prepare the medical graduate for lifelong learning and continuing self-education. This is why CPD lectures are an important component of the GPs' profession. It is important to realize that if the GP's are not trained to be lifelong learners, they won't be able to keep up with the changes that occur in the medical profession. According to Yeats (1994:281) medical education is generally made up of three sequential phases: undergraduate education supervised by universities, postgraduate education supervised by national colleges or councils and continuing medical education, the supervision of which is best described as varied. CPD programmes are already in place in South Africa, although from the perspective of theoretical research, little research has been done on this aspect. In this chapter the focus will be on the concept of CPD and how it affects the GP.

Realizing that learning is a life-long experience it makes sense to support the structure in which CPD is not an optional extra but a prerequisite. Continuing education should be part of a life-style. Since these lectures are on a continuing basis, the general practitioner will thus be competent and relevant in what he is doing. Since CPD lectures are compulsory, it means that, learning does not cease with undergraduate education at medical school, but continues through structured postgraduate training of junior staff, to their continuing education as

Consultants, Associate Specialists or Staff Grade doctors (Yeats, 1994:282). CPD serves to expose the doctors to what is happening and assists them to make informed decisions.

Continuing professional development programmes are not just imposed on the doctors as professionals but also as individuals they want to stay informed and relevant, thus continuous improvement on what the GP knows already is crucial. The broadminded doctor, like the good scientist, is usually dissatisfied with the state of clinical knowledge and technical practice in his field and he needs to be exposed to relevant new data, materials or procedural developments (Yeats, 1994:281). When the doctors have a positive attitude toward learning and CPD programmes are implemented accordingly, the doctors will have improved and better skills and the medical fraternity will be more effective in terms of the duties it performs. CPD should seek to truly educate by: the thorough physical and intellectual preparation of an individual as a disciple of postgraduate and continuing education (Murray et al, 1993:467).

Realizing that the aim of CPD is to provide learning on a continuous basis it is important to ensure that the curriculum and the present structure accommodate such a venture, otherwise the impact will not be realized. With the CPD programmes in place, there are curriculum changes that occur and new methods of teaching are put in place to ensure that not only one aspect of the doctors' practice and career is accommodated but that many aspects of the doctors' profession are accommodated (Tolnai, 1991 and Murray et al., 1993). This can only be attained through continuous evaluation of the impact of these new developments. This is why it is important to conduct much research in the area of CPD. This will serve for the purposes of continuous evaluation, feedback and direction as to where and how to improve the present system. Evidence supports the fact that CPD lectures are crucial in order to ensure that professional

environment remains relevant in its functions through skilling and educating the individual practitioner on a continuous basis.

While competence is the capacity of an individual to act in a given situation at the required level, performance describes the actions of the individual when, in reality, confronted by the situation. This distinction, which has not always been made in the literature on competence-based learning, is likely to be a critical one for general practice if we are to avoid, for example in reaccredidation, the fallacy of assuming that the competent, however this may be defined, always perform competently. Medical audit, which can evaluate clinical and organisational performance, is thus a crucial element of CME for general practice.

2.2 THE ROLE OF CONTINUOUS PROFESSIONAL DEVELOPMENT (CPD)

The following section will be explained according to Al-Sheri et al. (1993:251)

2.2.1 Provision

The major responsibility of continuing professional development provision is to address two interrelated tasks :

- First, to sustain motivation among established general practitioners for self-directed learning based on experience; and
- Secondly, to devise ways of sharing individual experience which both interpret and enrich learning

In order for CPD to attain this goal, the programme directors have to structure the system in such a way that it accommodates the fulfilment of these responsibilities.

2.2.2 Participation

2.2.2.1 Medical anecdote

The anecdote represents one outcome of reflection on specific experience and has been studied in other professional groups. Because the process of storytelling organises and interprets reality, the term 'anecdotal' has come to be used dismissively, particularly by the scientific community.

This standpoint neglects the value of the medical anecdote, which lies, not in its objective recall of reality, but in its subjective content for the narrator and listener. For example, the anecdote may exaggerate or diminish the prescience of the narrator, thereby revealing the key lessons which have been learned; and/or sharpen the dilemmas of the real situation in order to highlight issues of significance for the listener. Thus, the medical anecdote many be an important and neglected method of teaching/learning for established general practitioners which directly taps into the selection, organisation and interpretation of experience through the medium of reflection. Use of the professional anecdote merits encouragement among all general practitioners and further study within education and research.

2.2.2.2 Facilitation and mentorship

A helping relationship between facilitators, mentors and their clients is based on honesty and acceptance: it recognises the uniqueness of individuals, and their

right to make decisions and participate freely in a purposeful, goal-directed, watching interaction. Although elements of friendship are involved, there should also be an inspiration of trust, an exploration of self-defeating behaviour and the encouragement of systematic thinking.

Recently mentorship has been proposed as a solution to the problems experienced by young principals and facilitation, in the form of 'education brokers' has been proposed as a device to encourage practice-based learning.

Audit facilitators are seen as an effective way of increasing audit activity in a practice. While this is a welcome trend, it is important to set limits to the roles: continuing medical education facilitators and mentors should not attempt to get their hands on the total range of (GP's) learning, and should not attempt to guide it, manage it, or stamp it with their seal of approval at the end.

2.2.2.3 Reading and the journal club

Group members share and enrich both reflection on experience and contribution to reading as a means of understanding its significance. In this way the potential of the journal club is extended from its origins on the green hill of biophysical certainty to encompass uncertainty which is typical of practice in the bio-psychosocial 'swamp', including issues pertaining to the organisation, planning and resourcing of primary health care.

2.2.2.4 Reflection and the personal document

Although group discussion, problem case analysis and other methods have long been used in part to enhance reflection, they require resources which discourage busy practitioners from using them (preparation time, group-work skills, a special

setting and so on). Paradoxically, simple and practical methods like a log-diary or a personal journal, which have been shown to initiate and intensify reflection for individuals, have received little attention as resources for, such groups. It seems logical to propose that with the help of a group the reflection of individuals on such material will be both enhanced and shared.

2.2.2.5 Audit and group work

Audit groups are vulnerable to two risks: either they may fail to retain members who are seeking 'off the shelf' projects, or they may become an arena in which enthusiasts seek recruits for collaborative projects. The first reflects a failure to engage some general practitioners in audit as a personal activity; the second, a tendency for enthusiasts to see the significance of audit in terms of the scale of the project.

Moreover, it is perceived that there are tensions which hold between the role of audit in self-directed learning, which is fundamental, and the natural tendency of medical audit advisory groups to seek to address issues collectively, for both professional and National Health Services managerial reasons. It follows that those who convene small groups of general practitioners for the purposes of audit must be conscious of these risks and endeavour to empower and enable doctors to undertake an audit, which is meaningful for them as individuals. In this way an effective small audit group will become aware of the need to hold a balance between competing claims upon its members.

2.2.2.6 Other learning formats

The role for the provision of continuing medical education which supports and facilitates self-directed learning by established general practitioner, will require careful consideration of the training requirements of additional

tutors/mentors/facilitators – clearly a place remains for meetings and courses which either address these training needs or the minority if issues do not stem from individual professional experience.

Since validation for the postgraduate education allowance rests with regional advisers in general practice, decisions related to the proposed changes lie with the profession.

While this approach will diminish the distinction between teacher and learner, it is anticipated that there will be greater numbers of GP's involved in writing about and discussing their work with colleagues. In this sense we might, in a few years, be experiencing a true renaissance of general practice.

2.3 CPD FOR GENERAL PRACTICE

A CPD programme or a CPD lecture is obviously not designed in isolation but is designed in relation to the state of the general practice. With CPD in place, it's clear that there is a need for general practice to re-examine the theoretical basis of such a programme, to discover the actual determinants of competence in the established practice and to identify learning opportunities and outcomes which stem directly from professional experience (Stanley et al., 1993:210). In this way, the potential benefits of utilizing a CPD programme are less likely to be disregarded or misused, for instance, by choosing inappropriate CPD activities. Because of the methodological problems which could emerge, it is important to decide on the method of assessment in advance before implementation begins because underestimating such a situation can lead to possible failure. As Stanley et al. (1993:210) put it, a process of reaccredidation must adopt one of two approaches: measure input, in the form of participation in CPD; or output, by assessing competence for the role of general practitioner.

When conducting a CPD lecture the manner of approach as far as conducting the lecture is concerned, is of critical importance. The GPs are not like the students at the university, who don't have any experience, but they are in practice and the learning which they acquired from experience should be acknowledged. Thus Stanley et al. (1993: 210) concluded that self-directed learning based on experience should form the centrepiece of continuing education for general practice and that educational provision should adopt a complementary role in sustaining motivation to learn and by enabling learning from experience to be shared and enriched.

CPD is in place to ensure that professional competence is maintained, but practicalizing such a goal is more easily said than done. For example, CPD is supported by public funds in Great Britain but there is little evidence that CPD for general practice is achieving the purpose of maintaining professional competence (Stanley et al. 1993: 26).

The reason for the inability to achieve the goal of maintaining professional competence could be attributed to factors such as the prior educational experience of established general practitioners, the traditional way of learning utilized by CPD provision, inappropriate models of competence and not focusing enough on ensuring that CPD lectures are accommodative of all the practitioners. Such issues obviously need to be revisited and addressed accordingly

2.3.1 Ingredients of Continuing Professional Education

There are three important ingredients of CPE, namely the learner, context of learning, and goals: competence and performance. These ingredients

will be discussed according to the understanding of Stanley et al. (1993: 210-212) and according to a course the researcher attended during 2003[1].

2.3.1.1 The Learner

The students who are dependent normally look to the lecturer to "provide" education or information either directly or through making the "learning" materials available. On this basis, it is clear why the attraction of many established general practitioners to lectures by specialists and to the journals for their continuing medical education is great. It follows that a key task for continuing education is to help those entering general practice to understand the present stage of their educational development.

Survey evidence suggests that almost all established general practitioners acknowledge a professional responsibility to continue learning because of the constant change in the medical profession. However, general practitioners need coping strategies or mechanisms to manage the many factors which may hinder or disturb their motivation. These include, in the main, time pressures and family commitments; for some, low levels of job satisfaction and circumstantial factors are also involved. At present, education and training does not equip young lecturers with the time management and other skills required to understand and manage these problems.

Evidence from institutional education suggests that individuals have differing approaches to learning: surface, deep and strategic. Learners adopting a surface approach are motivated primarily by a fear of failure or a concern to qualify and hence memorise subjects with little or no understanding, whereas those adopting a deep approach are intrinsically motivated, more able to make a personal

[1] Course on Recognition for prior Learning presented by Dr. David Levin of the De Paul university Chicago, USA

meaning of their previous knowledge and experience, and are more autonomous. The strategic (or achieving) approach indicates competitive, ambitious learners who are determined to do well, whatever is required. The challenge now becomes to guide the learners on the path of deep approach.

However, the individual's approach to learning is influenced by many factors. These include the personality of the learner, the preferred learning style, learning formats and the context in which learning is taking place. While the deep approach will usually be the most appropriate one for established general practitioners, it may be simplistic to apply labels derived from the institutional education of young people to established professionals who must make their own choices about what and how to learn. The important lessons for CPD in general practice are that in its selection of learning formats and in the context of learning it should not encourage a surface approach as this type of learning will help the learners to be more competent and the learner will not be able to gain anything.

2.3.1.2 Context of learning

For adults, learning from experience is a natural process, albeit an inefficient one. General practitioners are responsible for running a small business, involving a range of managerial responsibilities; they must interact with a range of diverse professionals and organisations; and, as purchasers of secondary and community care, they are required to make strategic decisions involving the prioritisation of problems and resources. The majority of general practitioners see patients and practice as an important source of learning.

Experiential learning assumes that adults are self-directed, aware of learning needs, competence orientated in their learning approach and learn more effectively from experience. In other words the adult's way of learning is more

inclined toward learning that comes from what they are actually dealing or working with.

However, many learning opportunities are missed in the midst of daily actions: When you are caught up in a cycle of survival from one day or week to the next, it is very difficult, if not impossible, to pull back from the situation and take a good look at what is happening in the immediate environment. Thus, CPD should aim to create among general practitioners both a high level of awareness of, and a systematic approach to the learning opportunities presented by day-to-day experience.

2.3.1.3 Goals: Competence and performance

Competence is a quality possessed by an individual as a result of learning and can be defined as a wide concept which embodies the ability to transfer skills and knowledge to new situations. It encompasses organisation and planning of work innovation and coping with non-routine activities. It includes those qualities of personal effectiveness that are required in the workplace to deal with co-workers, managers and customers. There is considerable controversy about the nature of competence for medical practice and, particularly, how it might be measured.

A key issue for the newly established professional is the pattern of clinical competence to which he or she aspires. If as a dependent learner, this is derived in a large part from specialist explanatory models, it is likely to misdirect learning towards inappropriate goals. Becoming more patient-centred, through the acquisition of communication skills during vocational training, while a prerequisite, is not sufficient: established general practitioners who remain dependent learners will attempt competencies in their daily work. If, on the other hand, general practitioners are encouraged to use experience to identify

more appropriate patterns of clinical and organisational competence they will discover the advantages of self-directed learning.

This discovery, while an essential step, carries two risks: on the one hand, reflection of all continuing medical education provision could be viewed as irrelevant: on the other, dissipation of precious motivation upon unfocused small-group work could occur in an attempt to reach fellow sufferers. A key task, then, for continuing education is to help general practitioners find, not just the learning agenda required for competence, but also ways in which to focus their learning activity in their professional experience.

2.3.2 A model of self-directed learning

The term learning medium has been adopted to describe an activity undertaken with the aim of learning, which may or many not be well directed or methodical. The media chosen represent the familiar elements of self-directed learning for the established general practitioner: they represent habitual (reading, innate (reflection) and required (audit) means of learning from experience.

A more systematic approach to experiential leaning requires, not simply the identification of appropriate learning media, but also ways in which the media can be exploited more effectively by the learner. Three steps in the learning process are identified which fix and progressively refine experience for the individual, namely: selection, organisation and interpretation.

A change in emphasis to self-directed learning based on experience implies a higher level of participation by individuals and the adoption of providers of CPD of appropriate learning formats. The latter will both foster self-directed learning among participants and use the experiential learning outcomes of individuals as material from which others can learn. Mentorship, facilitation and small- group

work are examples of highly participative CPD provision, in which general practitioners are encouraged to draw upon their individual experience in order to share learning with colleagues.

2.4 GENERAL PRACTITIONERS' ATTENDANCE AT CPD COURSES

It is crucial to realize that if CPD programmes are to be effective the structures that are in place at present need to be revisited to support the concept of CPD. The danger of failing to implement the concept of CPD appropriately may lead to outputs that do not reflect on the goals of CPD. In Great Britain the general practitioners became reluctant to attend the CPD meetings when it was no longer an obligation to do so (Murray, 1992:157). From the incident that occurred in Great Britain, it is already clear that attending CPD should not be a choice but should rather be compulsory. Again the work of Murray (1992:157) indicated that the doctors who attended more sessions than their colleagues tended to have been qualified for between 10 and 30 years, to have been working in practices with five or more principals and were also more likely to hold additional appointments or to be trainers. Once more these findings show that CPD programmes should be more accommodative (i.e. be beneficial for all the doctors) and this will have a positive impact on the attendance to the meetings. It is thus important to ensure that the new amendments, which will be put in place, will create a structure that caters for all the medical professionals and not just a select few. The importance or relevance of the CPD lectures and the objectives must be communicated with those attending and those presenting so that everyone understands why it is important to partake.

Since general practitioners receive most of their information on continuing medical education from reading journals and medical publications and from

letters and discussions with consultants and colleagues (Difford 1992:290), it is important to clarify what attendance means in this context. This can be achieved through clarifying how attendance is achieved and evaluated and what factors play a critical role.

2.4.1 Which General Practitioners attend CPD Meetings?

In South Africa general practitioners often travel outside their city/town/health district in order to attend courses. However the work of Difford (1993:292) indicated that the GPs' main source of education needs must be provided by district postgraduate centres in order for general practitioners to carry out effective referrals, shared care, resource management and team work. It is thus clear that if the district postgraduate centres take over the responsibility of fulfilling the educational needs of the GP's, this will improve the attendance of GP's at the CPD meetings.

Practice size is an important factor in attendance at meetings. According to the research done by Murray et al. (1993:157) the low attendees tended to work in single-handed or two-partner practices. These findings indicate that GPs from smaller practices don't attend well and GPs from bigger practices tend to attend well. Difford and Hughes (1991:290-293) came to the realization that the GPs who don't attend as well as they should, could be experiencing problems in the areas of attitudes to education and motivation, which are of great importance. To eradicate this situation, those who are responsible for drawing up programmes should aim to address the issues of attitudes to education and motivation. In other words, the programmes should not only focus on giving information regarding medical care, but they should also motivate the GP to attend. One strategy that could be used to improve attendance for GP's who are from smaller practices would be to organize courses, which will run on several occasions which in turn can facilitate course development (Difford and Hughes

1991:290-293). A practice-based education is encouraged because of the considerable potential in peer learning and performance review (Difford F. et al. 1993; 42:159). Here it is clear that when GPs are also given a chance to learn from each other motivation is higher and hence their attendance will be influenced positively.
Murray et al. (1993:159) concluded from their findings that:

- If attendance at educational meetings alters the way doctors work, then it could affect quality of care given in the practice.
- The presence of a trainee in the practice encourages active teaching and this must also provide a stimulus to seek out education within the practice.
- The presence of a trainee in the practice may also make it easier for doctors to attend educational meetings.
- Course fees undoubtedly provide some restriction on attendance but a single annual charge many reduce this effect.

From these findings it can be deduced that even though there are some hindrances which prevent the GPs from attending, there are opportunities which still need to be explored to solve the problem of poor attendance (e.g. the presence of a trainee at the practice).

2.5 The Role of Quality Assurance in CPD

Quality is a crucial attribute that should be reflected in any programme that is put in place and must be a priority at all costs. Quality assurance is explained by Sheth et al. (2004) as a process of pursuing very high-quality standards in the products and services produced. A critical requirement which must be met if outputs are to be of high quality, is that inputs must also be of high quality. In other words, the specialists who present the CPD lectures, must be empowered

with skills other than the medical knowledge and medical skills they already have. Such skills would include: managerial skills, technical training, etc. When the specialists are more skilled and have up-to-date information, it would mean that CPD lectures are of a higher and better quality. Hence the quality needs of the GP's, who are the attendees of CPD lectures, would have been met.

The quality aspect of CPD is a crucial one because it influences how the lectures are perceived and valued by the GP's. Hays et al. (1993:175) suggest that if problems exist as far as implementation of CPD programmes is concerned, it is important to get assistance externally for proper regulation of the systems in place. In the area of CPD, quality is not only supposed to be reflected in structures, management and systems but it must also be reflected in the actual delivery of the service (the lectures in this case). Those responsible for delivering the CPD lectures must therefore be empowered with educational skills, they must be exposed to all possible ways of delivering the information and then choose what is most effective. It is important to keep this fact in mind because those attending the CPD meeting will also evaluate the quality of the content of information on the basis of who is providing it and how they're doing it.

Since quality is crucial, those responsible for the development of structures and programmes must see to it that evaluation is conducted on a regular basis. Hays et al. (1993:175) point out that one way of assuring and evaluating quality is through the use of self-regulation, which has the advantage of being more acceptable to members of professions, because peers understand the profession's difficulties, are familiar with the activities and are in control of the process. Therefore management does not only have the responsibility of ensuring that evaluation is in place but they have the responsibility of also assuring that before the implementation of evaluation, perspectives from different angles are considered. The challenge now involves creating self-regulation that is acceptable to the community and regulatory authorities (Hays

et al., 1993:175). This will then increase validity and reliability of self-regulation when the challenge is met. The curriculum also has a bearing on the quality of CPD and must therefore also be reviewed because it indicates the content and directs the educators toward what they should focus on. "Curriculum review is an ongoing process in most medical schools; a major revision of medical undergraduate curricula is underway in many faculties of medicine and is one of the principal subjects of discussion among medical educators" (Tolnai, 1996: 414). Self-regulation and reviewing of the curriculum are just a few factors, which play a role as far as quality in CPD is concerned. This then points to the conclusion that all factors, which play a role, must be identified and considered, and then a balance has to be created between all these elements. Again doing so is not an easy task, it is a process, which takes time and will definitely have a positive impact on quality assurance and will also ensure that the programmes will remain relevant.

Hays et al. (1993:178) stated five reasons for choosing the quality assurance approach:

- Regardless of where an individual lies on the competence continuum from poor to "excellent", all clinicians risk their knowledge and skills becoming outdated in a discipline which develops rapidly: improving the performance of all clinicians should have an impact on those at the lower end of the competence continuum.
- The philosophy underlying the 'weeding out of the bad apples' approach is punitive, and hardly likely to encourage clinicians to expose their weaknesses voluntarily.
- An approach, which focuses only on clinicians below a cut-off point, incorrectly implies that those above it do not need attention.
- Determining minimal competencies, as with defining competence more broadly, is a difficult task. Reliable, feasible, performance-based assessment

of competence for experienced professionals, taking into account case specificity and differences between performance of novices and experts, has yet to be developed.

- The career-long professional development model is consistent with the self-directed learning approach of the Family medicine Programme for vocational training.

These reasons support the argument that quality is a definite priority if the CPD programmes are to be relevant and effective.

The essential element of quality assurance was accepted as a cycle of assessment, learning and evaluation (Hays et al. 1993:176). All forms of CPD should be appropriate learning interventions within this cycle.

Quality has an impact on individuals and the wider community. It is thus important to accommodate these two prospects before concluding that quality has been assured. Quality must therefore include aspects of both the individual and the community as far as health care is concerned (Hays et al. 1993:176). "It was anticipated that the quality assurance program would itself assist in the development of better measuring standard of quality "(Hays et al. 1993:176). It is also important to realize at this point that the quality assurance programme in South Africa will vary from that one o f other countries, it must be looked at from a South African perspective

When quality is assured, (using the appropriate and relevant measuring standards) more specialists will be more confident when presenting the lectures and the GP's will also be more comfortable with the information they are receiving and hence there will be more support for such a programme.

2.6 STRATEGIES FOR CONTINUING MEDICAL EDUCATION

Those involved in the strategic planning of CPD for general practice should adopt as their mission the idea that education is aimed or directed at improving development and ordinary experience, and enhancing the possibilities or opportunities available for the general practitioner. To achieve this, general practice education subcommittees must recognise that established general practitioners are at various stages in the transition from dependent to self-directed learners; are working towards patterns of competence which are more or less appropriate to the work of the community-based generalist; and that much current CPD provision is irrelevant or dependency producing (Stanley et al., 1993: 312).

Thus an appropriate strategy for the general practice of continuing professional development will recognise the state of the learner (i.e. staring point), the learning potential of professional experience and the need to develop competence continually in response to the changing demands upon medical care or the medical profession. Those involved in validating CPD must first prevent learners from receiving information from the presenter or learning through dependency, and secondly, transform general practitioners to self-directed learners who use experience as their major source of learning. Thereafter, the form and content of CPD provision will be dictated by the experiential learning of individuals.

2.6.1 Educational theories

As mentioned earlier in this chapter, the approach to adult learning is different from that to students who don't have any work experience. With adult learners

the work experience is taken into consideration and influences the way learning occurs. The word "training", as used in higher professional training, may imply a pedagogic approach to learning the specific skills to be acquired, and goals which may be narrow and fixed (Pietroni 1992: 294).

According to Alsheri (1992:285) and Pietroni (1992:294) andragogy which contrasts with pedagogy, has four basic assumptions:

- Adults both desire and enact a tendency towards self-direction.
- Adults' experiences are a rich resource for learning. Adults therefore will learn more effectively through experiential methods of learning such as small group work and problem solving.
- Adults are aware of specific learning needs generated by real life tasks or problems.
- Adults are competence-based learners, in that they wish to apply their newly acquired skills or knowledge to their immediate circumstance. Adult are therefore performance centred in their orientation to teaching GP's, as adults need educationally sound learning approaches, which enable them to think creatively and work critically.

There is an increasing realisation that the traditional pedagogic approaches, which often depend on a one-way transmission of knowledge with the learner in a passive role are not suited to higher professional education, and that higher professional education, like continuing medical education, is a continuous process.

2.6.2 Principles of Facilitating Adult Learning

There are six important principles for facilitating adult learning. According to Al-Shehri (1993: 286) these principles include:

- Participation in Learning is voluntary.

This implies that GPs should have some innate motivation to participate e.g. increasing or modifying existing knowledge, experience or skills. All professionals are keen to improve their competence.

- Mutual respect between provider and learner must exist.

CPD provision should be a mutual enterprise for all of those concerned. Participants are to be valued as separate unique individuals deserving respect. A lecture by a specialist to GP's has been seen as a typical stereotype of CPD provision; currently, there is a shift towards more involvement and participation by GP's, using specialists as and when appropriate.

Research showed that GPs have increasing interest in organisational skills and interpersonal or caring aspects of medicine. Providers of CPD should, therefore, respond appropriately.

- "Providers and learners must be engaged in a collaborative spirit in the planning and decision making process".

This means that GP's are to be involved at all stages of the planning process: content, form, place (e.g. practice based), etc.

- The activity must include a cycle of action and reflection followed by collaborative analysis.

The principle emphasises the importance of group discussion, audit and other participatory activity. However, participatory courses, although effective, are stressful and require additional resources. Group discussion in the presence of a tutor is valued highly by many practitioners.

- The activity must foster a spirit of critical reflection.

By encouraging participants to reflect on a particular experience or idea and analysing it in the light of their own perceptions and work, they will be able to see the links between theory and practice. Unless the relevance and the application of new ideas to practice are clearly understood by GP's, few will adopt them. If practitioners become critical reflectors they many utilise their daily experience more efficiently and effectively.

- The activity must nurture self-directed empowered adults.

One of the classical anomalies of medical education is that while doctors must achieve and maintain autonomy of learning, the educational system from which they emerge has not equipped them with self-determining and co-operative skills and competencies. It can be argued that the CME providers should seize this opportunity of high attendance to create innovative approaches to learning which inspire self-directness and autonomy in learners whatever their initial motivation to participate. The challenge is to transform extrinsically motivated attendees into intrinsically motivated learners.

2.6.3 Educational strategies

To enhance adult facilitation, certain strategies need to be employed. Ideally learners should be involved in describing objectives and the use of learning facilities should be encouraged. The overall aim of higher professional education should be to foster personal and professional development (Pietroni 1992: 294).

Ideally, content should be mostly decided upon by the learners, although there may be other influences such as community needs, and the needs of the accreditors and providers. The perceived needs of learners often relate to areas which may be inadequately covered in vocational training, such as communication, ethics, socioanthropology, management, learning and teaching, and the concept of the 'wounded healer' (Pietroni 1992: 295).

Seven principles of adult learning, which need to be tackled by organisers of adult learning programmes, are: (Pietroni 1992)

- To establish a physical and psychological climate or ethos to learning
- To involve learners in mutual planning and curriculum directions.
- To involve learners in diagnosing their own needs.
- To involve learners in formulating their own earning objectives.
- To involve learners in identifying resources and devising strategies using these resources to accomplish their objectives.
- To help learners carry out their learning plans.
- To involve learners in evaluating their learning, principally through qualitative evaluation methods.

Andragogy (or 'freedom as learners') means that the methods of learning may include the setting of individual goals and the use of learning contracts and

"humanistic" (or 'freedom to learn') emphasises not only the 'whole person' but also the concept of the peer-learning community (Pietroni 1992:295). These processes and learner-centred approaches are more relevant to higher professional education as they recognise and value previously gained knowledge and experience and encourage reflection. By promoting the development of skills for continuous and independent learning, medical educators will be preparing students for the essential role of the physician as a lifelong learner.

2.6.3.1 Portfolio based learning

The portfolio serves as evidence of what the student or the learner has acquired/gained or learned from the material which was presented. Experiential learning may be considered to be a process involving: concrete personal experience or reflection, the formation of abstract concepts and generalisations and testing the implications of learning (Pietroni R., 1992: 295). Therefore, the experience of the learner can only be relevant when regarded as a source of acquired information or learning. Now the challenge posed is to move from a description of experience to an identification of the learning derived from that experience. Examples of a general practice portfolio could include: workload logs, individual case descriptions, videos, results of audit or research, commentaries on books or papers, as well as evidence of relevant learning from personal as opposed to work experience (Pietroni, 1999:295). Because of the important role of medical knowledge in clinical problem solving, it must be discovered how the GPs choose among the resources available to them. Donald et al. (1996:353) support this view in saying that it is important to understand how general practitioners decide to seek additional knowledge for patient-care decisions.

The portfolio may be used for two purposes. The learner may choose to share it with a mentor or supervisor who will identify, help clarify and facilitate the

demonstration of the learning (Pietroni, 1992:296). This process of reflection is a learning experience in itself, not only for the learner but also for the mentor. Portfolio learning will also ensure that learning which occurred before is recognized, as a portfolio may be used in a process of assessing and accrediting experiential learning (Pietroni, 1992:296). In this manner, the portfolio may contain identification of learning needs, details of learning experience and a demonstration of the new skills learned . This point outlines an important advantage of portfolio learning, which is that the mentor or the CPD presenter will be able to identify what the GP knows already and what the GP still needs to know, so that the presenter won't have to repeat what the GP knows already or overlook what the GP still needs to know.

Two new concepts to medical education play an important role in the assessment of higher professional education: the credit accumulation transfer system and the assessment of prior experiential learning (Pietroni, 1999:296). The credit accumulation transfer system is being used in many other areas of higher education. This system seeks to promote a more open and flexible system of higher education. Pietroni (1999:296) states that this system provides for the awarding of certificates, diplomas, degrees and masters degrees by the accumulation of credit points. In this way, previous experience and prior learning may be taken into consideration. It is compatible with the ideas of modular courses and portfolio learning and fits in well with the nature of the learner's work, allowing access to higher education for all at an individual pace (Pietroni 1992:296). In this system the learner does not experience the system being imposed on him or her but rather the system is designed in a manner that suits the needs of the learner.

Assessment of prior experiential learning concerns the assessment and accreditation of learning obtained from life and work experiences. Experiential learning refers to learning which has not been validated or taken into

consideration previously within an educational or professional system of accreditation. This form of assessment takes into consideration the fact that learning has occurred through experience and not through the formal procedures of the institution of higher learning and supports the argument that experiential learning is equally valid. Again Pietroni (1992:296) indicates that assessment of prior experiential learning focuses on the outcomes of learning and will allow wider access to higher education and it complements portfolio-based learning and the credit accumulation transfer system. The portfolio is presented as evidence for learning and used as the basis for accreditation. According to research this has been used successfully in many higher education institutes.

The shift from the traditional mode of learning to the new mode of learning (i.e. taking prior learning into consideration) is a particularly relevant shift in the sense that learners receive exactly what they need instead of wasting time and acquiring what they have already. Hence it's important for the presenters of CPD to make it their priority to accredit experiential learning.

2.7 SUMMARY

CPD plays an important role in ensuring that the GP's are kept up to date. Specialists must ensure that they include the views of GP's when presenting. The lectures must not be formal presentations but must allow for facilitation because GP's are adult learners who also learn from experience. The experience must be recognized during the lectures. Research needs to be conducted on the relevant approach for the learners. The aim should be on self-directed learning. Quality also plays a role as may influence the perception of the lectures.

CHAPTER THREE

THE IMPORTANCE OF MARKETING IN A SERVICE BUSINESS

3.1 INTRODUCTION

The CPD lectures presented by the specialists to the GP's are a specific form of a service. Thus, to market CPD lectures as a specific form of service, services marketing will also be applicable. Lovelock (2001:71) supports this in saying that the marketing function in service businesses is managed by services marketing. It is thus important to focus on how services marketing can be implemented so that the delivery of a service is successful. In order for service delivery to be a success, Zeithalm and Bitner (2000:120) suggest that three types of marketing must be followed, namely: external marketing, interactive marketing and internal marketing. In the case of external marketing, a company makes promises to the customer about what to expect and how the service will be delivered. Where CPD is concerned, the hospital offering CPD lectures communicates its offerings with the GP's as they will be receiving the service. This can be done through advertisements. Secondly, interactive marketing is very important to the customer since the company has to keep its promises. It occurs at the moment when the GP's interact with the specialists offering the CPD lectures and when the lecture is presented and received by the GP. Finally, internal marketing is when the specialist presenting the lecture is enabled to deliver through skills, abilities, tools and motivation. Accordfing to George (2001:97) a marketing programme must be in place as it assists in enabling and ensuring that employees deliver the best and quality service. This means that internal marketing classifies the specialist (CPD presenter) as an internal customer and

therefore it is important to focus attention on service quality, which lead to the presentation quality and performance of the presenter meeting the required standards.

3.2 CHARACTERISTICS OF SERVICES

Services marketing is different because of the nature of services (Ahmed, et al 1995). It is clear that in the marketing mix, customer service is the most intangible aspect. This results in the value of customer service being based on the perception of customers and the delivery being dependent on the employees (Peters, 1994:25). Before services marketing activities are undertaken, it is imperative that the nature of services or the characteristics of services are explained to the employees of an organization at all levels. The nature of services which cause them to differ from the products is basically their characteristics which Mudie and Cattam (1995) list as intangibility, inseparability, variability and perishability. As much detail is going to be accorded to the characteristics of services, it must be noted that since the success of a business is vitally dependent on the services provided by the business, the distinction between goods and services is somewhat artificial (Rust et al., 1996:7). The characteristics of services are explained in the section that follows below.

- **Intangibility**

Before services are bought, they cannot be seen, tasted, felt, heard or smelled. On the other hand the buyers of tangible goods are able to examine the goods for physical integrity, appearance and taste. The intangible characteristics which define services include reliability, personal care, attentiveness of staff and their friendliness (Palmer, 1998:11). These intangible characteristics can only be verified once a service has been consumed. It is thus clear that

misinterpretations of service delivery by the customers can occur. It is thus crucial to strategize accurately to stress symbolic clues or provide supplementary tangible evidence to indicate that promises about service quality will be kept (Zikmund and d'Amico, 1995:254).

The CPD lecture is a form of a service and hence it is intangible, it is difficult to define the lecture in terms of physical attributes, meaning that a GP will find it hard to understand service offerings and evaluate service alternatives. The GP cannot have any actual experience of the lecture before the delivery. The service provider (specialist presenting the CPD) must therefore find different ways of making the service more tangible (e.g. a brochure to help the GP see what the lecture offers, qualifications and good reports from past events). Because of the intangibility aspect of services, advertising is more critical in this regard than it is for product advertising. Effective communication or advertising serves three important roles which are: to provide necessary information and advice, persuade customers of the benefits of services and also to encourage them to act (Mudie and Cottam, 1995:40). Hence service advertising mainly emphasizes tangible cues and symbols of the service which can easily be understood by the customers.

- **Inseparability**

During the selling of services, services are produced and consumed at the same time (Mudie and Cottam, 1995:140). Essentially, this inseparability demands personal contact between the buyers and the seller and can cause distribution problems (Zikmund and d'Amico, 1995:256). Both the GP and the specialist must communicate about a time and place which is mutually convenient so that the service benefits can be passed. The GP needs to be physically present during the presentation of CPD lectures or he/she can receive information in written communication. The potential for inseparability of production and consumption

however remains. The conduct of the specialist presenting the lecture is important because it determines the likelihood of repeat business.

- **Variability**

Depending on who is providing the service, the quality will vary and service performance varies from one organization to the other. This may be due to personality traits of the specialist presenting the lecture which are difficult to detect. According to Mudie and Cottam (1995:141) variability could also be due to poor training and supervision, lack of communication and information and mostly lack of regular support. Services are performances, often involving the co-operation and skill of several personnel, and are unlikely to be the same every time. One way of reducing the perceived risk of variability for the CPD presentations is to train customer contact personnel (specialists) to address the individual customer needs (Rust et al., 1996:9).

- **Perishability**

Services cannot be put in storage and then be used later (Mudie and Cottam, 1995:141). The GP receives the information during the lecture (when the service is being rendered) and he or she makes use of the information by interpreting it i.e. the service being rendered is put to use already. The moments spent with the customer are thus vital because the customer determines the attitude of the business towards customers (Dorrain, 1996:39). The marketing tools that are commonly used to handle this characteristic are pricing and promotion (Palmer, 1998:15)

The ultimate goal of any organization is to create a sound customer service, which involves a mutual relationship between customers and the business. It is crucial that the dynamics of services be taken into serious consideration by

management. This will help the service providers to adjust their offerings to suit the needs of the customer using a planned approach.

3.3 RELATONSHIP MARKETING

The relationship marketing concept is one that is evolving and is growing in recognition. This is proven by Pettman and Dobbins (1997) when they mention that in the old model of selling, 70% of time and effort was devoted to making a presentation to the customer and closing the deal. Building trust and identifying the needs of the customer accounted for only 30% of time and effort. Pettman and Dobbins (1997) further note that in the new model of selling, only 30% of time and effort is devoted to presenting and closing the sale, whereas 70% is devoted to building trust and identifying the needs of the potential customer. Clearly there has been a shift from transactions to a relationship focus in marketing. It is thus advisable for the specialists and hospitals to build good relationships with the GP's to gain their loyalty. Customers become partners and the firm must make long-term commitments to maintaining those relationships with quality, service and innovation (Zeithhalm and Bitner, 2003:p157). When good relationships are maintained with the customers, Johnson and Bove (2000) point out that the business is likely to improve its performance and customer loyalty.

Clearly a business that has contact with its customers knows the needs of its customers. However as a business grows, relationship building based on personal contacts becomes more difficult to achieve. Interest in the ability to know customers has come about due to the increasing rate of competition, where good quality products and service alone is inadequate for a company to gain competitive advantage (Palmer, 1994:571-572). Zethhalm and Bitner (2003:p157) explain relationship marketing as a shift from transaction focus

toward retention-relationship focus (i.e. relationship marketing focuses on keeping and improving current customers rather than on acquiring new customers). Furthermore Pelton et al. (1997:118) define relationship marketing as: "establishing, maintaining and enhancing relationships with customers and other stakeholders, at a profit, so that the objectives of all parties involved are met; and this is done by mutual exchange accompanied by fulfilment of promises." This is particularly true when it comes to the realization that customers are more comfortable with an ongoing relationship with one organisation than with switching continually among providers in their search for value. Relationship marketing is not particularly about making new customers, but it is rather about maintaining ones who exist. This can clearly be seen in Lovelock's (1996:p86) explanation that the value of current customers and the need to provide continuing services to existing customers-so that they will remain loyal- is recognised by relationship marketing. Personal contact is one of the keys that can lead to success regardless of how big the organisation is. With the emergence of user-friendly customer databases, large businesses are striving to know more about their customers, recreating through the computer what small business mangers derived through personal contact (Palmer, 1994:571-572). The data has been provided by customers through their purchases, their payments, servicing or by completing questionnaires (Stone and Woodcock, 1995:21-22).

It is preferable, and cheaper, to keep a current customer than to attract a new one (Zeithhalm and Bitner, 2003:157). Therefore, if marketers are to be effective, they must come up with strategies for retaining customers. Since the medical services are health-care services intended to influence a person's health through procedures executed by medically educated personnel, relationship marketing can be used by specialists to establish ongoing relationships with general practitioners. This structure will ensure that the specialists continue to receive more referrals from the general practitioners with whom he/she has

established a relationship. According to Payne (1995:30), the approach in marketing should not only focus on marketing activities which emphasize customer acquisition, but must also focus on customer-retention activities.

3.3.1The importance of a relationship in a service Business

The general practitioner will need to know what the benefits will be, if he is to commit himself to an ongoing relationship with a particular specialist. At this point it is important to note that the specialists, who are the service providers, are not only providing a service but are also selling long-term relationships. Relationship marketing is an important tool which marketers can use for the following reasons: a base of committed customers who are profitable for the organisation can be built and maintained and a firm can focus on the attraction, retention, and enhancement of customer relationships (Zeithalmand and Bitner 2003). This means that an organisation can target a particular market where it wants to build lasting customer relationships and committed customers will most likely help to attract (through word of mouth) new customers with similar relationship potential. Once the customers decide to commit to a relationship with an organisation, they will most likely stay in the relationship, as long as they receive quality services and good value over time.
Clearly loyal customers are better customers if they buy more services and they also represent growth potential

There is a need for relationship marketing in private hospitals. This view is supported by Tuominen and Orava (2002) in mentioning that research indicates that patient-staff interactions are important and the trusting nature of doctor-patient relationships are also important. Relationship marketing can also have a positive impact on the patient in a sense that a satisfied patient can grow into a true promoter and give a powerful word-of-mouth endorsement for the private hospital. It helps to view customers as family members in this regard and not

just as buyers (Gummesson, 1994). The customer and the service provider are both active and they should see each other as partners in a win-win relationship. Gummesson (1994) proves this when he states also that in relationship marketing, everyone has a role to play as far as marketing is concerned.

3.3.1.1 Benefits for medical doctors

As mentioned, relationship marketing is about hospitals and specialists building relationships with the GP's. It is also important to realize that as part of nurturing these relationships, special benefits have to be made available to the GP's. This is because the general practitioner is more likely to remain loyal to the specialist of the hospital if he receives greater value relative to what he/she expects from the competing hospital (Zeithhalm and Bitner, 2003). Zeithhalm and Bitner (2003) add that the GP will be committed when the "gets" (quality, satisfaction, specific benefits) exceed the "gives" (monetary and nonmonetary costs).

The general practitioners can attain the following benefits if they are in an ongoing relationship with the specialist (Zeithhalm and Bitner, 2003):

- Confidence Benefits

Feelings of trust or confidence develop in the specialist, anxiety will be reduced and comfort will increase in knowing what to expect. As the general practitioners have many competing demands for their time and are continually searching for ways to balance and simplify decision making, maintaining a relationship with a specialist can save them time.

- Social Benefits

As time goes on, customers/the general practitioner develops a sense of familiarity and a social relationship with the specialist and even if he/she learns

about a new competitor, the likelihood of switching will be minimal. In most instances a customer's loyalty results from a close personal and professional relationship. By contrast, an organisation/hospital risks losing referrals from the general practitioner when a valued specialist leaves the hospital and takes the general practitioners with him or her.

- Special Treatment Benefits

These benefits include aspects such as, getting the benefit of the doubt, getting preferential treatment, etc. Research indicates that special treatment seems to be less important to customers.

3.3.1.2 Benefits for the Hospital

As much as a good relationship provides benefits for the customer, the ultimate aim is that the service providers (specialists and hospitals) should also benefit from such a relationship. The following benefits for the organisation/hospital are mentioned by Zerthhalm and Bitner (2003: - 160-163)

- Higher overall returns on investments
- Increased revenues over time from the customer/patient
- Reduced marketing and administrative costs
- The ability to maintain margins without reducing prices
- Increased purchases over time
- As consumers get to know a firm and are satisfied with the quality of its services relative to that of its competitors, they tend to give more of their business to the firm
- Lower costs i.e. the cost of attracting new customers, is higher than the cost of maintaining existing customers. Costs such as advertising and other

promotion costs, operating costs of setting up accounts and systems and time costs of getting to know the customers are highly reduced.

- Ongoing relationship maintenance costs are likely to drop over time.
- Once learning has taken place the customer will have fewer problems and questions and the service provider will incur fewer costs in serving the customer
- Free advertising through word of mouth. Word of mouth advertising is more effective compared to paid advertising and it reduces the costs of attracting new customers
- Employee retention because the base of satisfied customers is stable. Employees find it easier to work for companies with happy and loyal customers as they tend to spend more time fostering relationships than having to search for new customers
- Service quality will be greater as the employees stay with the firm longer and costs of turnover will be reduced

In order for a hospital to continue enjoying these benefits, there must be strategies in place that continue to enhance customer satisfaction because this will include the likelihood of the customer staying with the business. The section that follows will thus explain more on how a relationship is built between a service provider and the customer.

3.4 BUILDING THE RELATIOSHIP BETWEEN SERVICE PROVIDER AND THE CUSTOMER

Marketing is concerned with getting and keeping customers. Hence, building customer relationships can imply something in relation to interdependencies or mutual interests, repeat patronage, loyalty, emotions, personalised treatment, interpersonal rapport, targeted one-to-one communications, after-sale service,

customer satisfaction, word-of-mouth, or doing something long-term, to name a few (Martin and Claycomb, 2002). This indicates that customer relationships are intertwined with the consequences of those relationships. This fact is due to the fact that the relationship with a customer is not clearly defined (Martin and Claycomb 2002). Martin and Claycomb (2002) identified that managers expect relationship-building programmes to improve the customer's memory of the business, to enhance customer service, to increase the likelihood of customers spreading positive word-of-mouth information about the firm, to build customer trust in the firm, and to enhance customers' perceived value and enjoyment of conducting business with the firm. In other words the specialists need to be exposed to the relationship-building programmes so that they can use them to build good relationships with the GP's.

One of the ways of building a relationship with customers is through loyalty. This aspect is discussed below.

3.4.1 Developing customer retention through relationship building

It must acknowledged that it will be difficult to build relationships with customers who have no reason to remain in a relationship with one service provider. It is important to build a relationship with a customer if that relationship is beneficial to the service provider. This is mainly due to the fact that a customer in a relationship with an organization provides a higher profit contribution and has the potential to grow in terms of the value and frequency of purchases (Christopher, 1992:9).

Furtrell (1994:70) states that there are three levels of customer relationship marketing. There is transaction selling; where an offering is sold and the customer is not contacted again. Secondly there is relationship selling where after a purchase the seller contacts the customer in order to determine whether

the customer is satisfied and has future needs. Thirdly there is partnering where the seller works continually to improve the customer's operation.

People grow into loyal customers by stages. The process is accomplished over time by nurturing customers over time at each stage of growth. Each stage has a specific need (Griffin, 1995:34). By recognising each stage and meeting the specific needs, a company has a greater chance of transforming buyers into loyal customers. These stages will outlined below:

- Stage one: suspects to prospects

  Suspects are people who might possibly buy the product or service. When a suspect has a need for the product or service and has the ability to pay, the suspect becomes a prospect (Griffin, 1995:34). These are individuals or groups who have heard of the marketer's product or service but have not yet purchased. At this stage the company needs to identify the disqualified prospects. Disqualified prospects are those prospects about whom the business has learned enough to know that they do not have a need for or do not have the ability to utilize the business' offering (Griffin, 1995:35).

- Stage two: prospect to customer

  Once the individual or business has decided to purchase, the buyer is a customer and is described as the next link on the ladder. First-time customers are those who have purchased from the business at least once (Griffin, 1995:35). At this stage the buyer can be the company's customer and still be a customer of a competitor. The customer will form a set of perceptions based on the buying experience. Griffin (1995:35-39) complements this by adding that if the customer's perception falls below his or her expectations, the chance of a repurchase is much less. At this stage the buyer and the

seller are in the transaction phase, where the customer is likely to pay close attention to timeliness, accuracy and other facets of the offering provided.

- Stage three: customer to client

When the customer purchases on two or more occasions or buys two different products from the seller such a customer becomes a client. A client is one who will transact with the business on a repeat basis, but may be neutral or even negative about the business (Christopher et al., 1995:ix). As soon as the buyer has reached the client stage, the business has the opportunity to recognise each customer as an individual and offer products, services and information tailored to their unique need. It means that every interaction should be seen as an opportunity to add value in order to deepen the relationship. When this is accomplished, Griffin (1995:39-40) says that the customer will in turn respond with more information, and will become increasingly loyal to the business.

- Stage four: client to supporter

At the supporter stage of the relationship, the buyer feels a real commitment to buy from the business (Griffin, 1995:40). Hence it is clear that it is only when the business can convert a client into a supporter that the strength of the relationship becomes apparent. At this stage the buyer purchases a variety of products or services from the marketer over time, selecting the marketer's brands over those of other competitors; hence loyalty to the firm is exhibited (Vavra, 1995:84). The positive aspect of the relationship at this stage is that the relationship has progressed in terms of trust, dependability and accountability. Since each customer's requirements differ, the business needs to know explicitly and in depth exactly what each customer is buying.

The business must thus focus on how it can continue to offer additional satisfaction that will differentiate its offering (Payne, 1995:33).

- Stage five: supporter to advocate

Supporters may be persuaded to become advocates when they like being associated with the company. In other words they actively recommend the business, hence they play an important role as a referral source. This is the most valued and sought-after level of bonding, where word of mouth advertising flourishes (Payne et al., 1995:ix). The bond at this level is strong. An element of risk has been added, because the original buyer's relationship with the company is now visible to other customers (Griffin, 1995:41). Therefore, the business should promptly and professionally follow-up after a sale so that new customers feel as valued and important as the advocates who recommended them.

- Stage six: advocate to partner

Finally, the last stage is when the customer becomes a partner and seeks to identify further ways in which a mutual advantage can be gained from the relationship (Payne et al., 1995:ix). At this stage the business should strive to develop a partnership with their customers so that both can acquire some economic benefits. Some of the economic benefits of customer-relationship marketing include the fact that the marketing and transaction costs are reduced within the long term, the sales volume per customer is increased in relationships and mass customisation is facilitated. This would result in a combined advantage of large volume and differentiation (Juttner and Wehrli, 1995:226).

In short, there is a positive correlation between customer retention and profitability. Established customers tend to buy more, are more predictable

and usually cost less to service than new customers. They are less price sensitive and may provide free word-of- mouth advertising and referrals. By increasing service quality and customer satisfaction, a higher percentage of customers will be retained and this will result in competitors finding it difficult to increase their market share.

At all these stages customers need to be retained. There are a variety of options which can be utilize to ensure that the customer ends up as a partner. The following are the factors that must be put in place in order to build good customer retention.

3.4.2 Communication

Communication plays the role of adding value to the consumer's perception and also helps to inform the customer about what is being offered. Building a relationship with a customer is important as customers remember organisations that remember them (Martin and Claycomb, 2002). The hospital and the specialists need to keep in constant contact with the GP's to strengthen the GP's loyalty to both the hospital and the specialists. The findings of Martin and Claycomb (2002) show that long periods of time during which customers are not contacted should be avoided if a strong relationship is to be built. Martin and Claycomb (2002) provide the following examples of contacts which may be utilised by a firm (personal and non-personal media):

- company newsletters to keep customers informed about updated capabilities
- new services
- new people
- marketing trends
- regularly scheduled personal letters

- telephone calls
- targeted direct mailers
- management and sales representatives in the field calling on customers
- mass media advertising designed to stimulate telephone calls about the firm's offerings
- open houses for clients
- attendance at trade shows and conferences in which clients participate
- quarterly and annual user conferences

Because of the differences in the nature of products and services it must be kept in mind that when dealing with communication in services it is important to outline the differences between products and services as follows (Mudie and Cottam, 1995: p168):

- Because of the simultaneous production and consumption of services, the layout, the appearance and the manner of the staff are critical communication variables
- The risk taken by the consumer when buying an intangible product should be reduced by providing tangible clues (which come from all aspects of corporate communication) about the service offering
- In services, communication can help reduce heterogeneity by appropriately communicating service guarantee and demonstrating how well trained the staff is
- Promotional tools like advertising, sales promotion and direct marketing help to shape demand, considering that services are perishable

3.4.2.1 Communication with the organisation

An organisation is a valuable resource for the customers and a leader when there is ongoing contact with the customers (Martin and Claycomb, 2002). From this realisation, the principle emerges that the service provider should not only contact clients or customers to do business but that contact should continue through following up on past sales to ensure that promised benefits have been fulfilled, and should check to see if customers' needs, interests or circumstances have changed, recognising important events or celebrations in customers' lives (e.g. birthday and anniversary cards), passing along important information or just saying "hello".

3.4.2.2 Meaningful communication

Creativity in communication can catch both the customer's and the potential customer's attention and entice them into a relationship. In order to nurture the relationship and enhance the reputation of the service provider, helpful information will do and the process must be interactive. The case study of Martin and Claycomb (2002) shows that although personal contact leads to dialogue, less personal forms of communication can invite interactivity too e.g. newsletter, direct mail pieces and trade advertisement, because they show a firm's willingness to respond to customers' questions. Further methods of interaction include: encouraging customers to fill out reply cards to receive additional information or surveys to help the company assess customer needs, inviting customers to call or visit their store, logging on the company's web site, etc.

According to Lovelock (2001), much of the services communication or advertising is education-oriented. This means that services communication seeks to teach customers, especially new ones, about service benefits, where they can get hold

of the service, and finally, how customers can participate during the service delivery process. Brassington and Pettitt (1997) believe that services can be communicated through the testimonies of satisfied customers. This implies that the company can show people enjoying the service, and capitalize on word of mouth. The hospital offering the CPD lectures can utilize services communication for developing reliability, quality and trustworthiness to overcome the doubts of customers and the intangibility of services.

3.4.2.3 Word of mouth communications

Customers need to reduce the risk attached to the intangible and variable nature of the service. Hence the great need for word-of-mouth endorsement by the peer group (Mudie and Cottam, 1995: p174). Martin and Claycomb's (2002) study shows that word-of-mouth is most effective when the quality of service varies or when it is difficult to evaluate a service prior to purchase. Hence the service providers should stimulate positive word-of-mouth and minimise negative word-of-mouth.

Mudie and Cottam (1995) provide a list of options which service providers can use to stimulate positive word of mouth as follows:

- Start a friend scheme. Motivate the current customers to inform others of the good service
- Testimonials. When advertising, use the positive experiences of satisfied customers
- Persuade/target opinion leaders through public relations
- Promotional items can provide tangible clues implying "club" membership

- Incorporate these into the communication of a comprehensive complaints procedure. "If you're happy with what we do, tell them (friends, etc), if you are not tell us."

Effective communication will ensure that the customers are well informed about the offerings of an organization and about changes if they occur. Since communication is a two-way process, the organization will also have an opportunity to hear from the customers themselves about their needs. This information involves not only the customers' needs, but also reveals changes in those needs. Basically, if the communication channels and systems are well in place, the organization will remain relevant in terms of its offerings to the customers.

3.4.3 Service quality

Delivery of quality is essential when building and maintaining relationships. When services are the same, based on the quality of the service, customers can either be won or lost. This ties in well with McLachlin's (2000) statement, that client performance, improving client capabilities, changing organisational culture and particularly meeting promises, are the important aspects of engagement success. It is thus crucial for service providers to do what they say they will do. "Service" quality refers to the consistency with which customers' expectations are met and the general superiority of the service relative to that of the competition (Martin and Claycomb, 2002). In addition to the above, Martin and Claycomb (2002) mention that practices focused on identifying what services and service attributes customers want (doing the right things) are important and must be provided for them. This will contribute to customers' satisfaction and improve the competition. The firm also needs to consider the comments referring to efforts to raise standards and improve service performance. This includes listening to customers' preferences and ensuring that customers' requirements are met.

Since service offerings are intangible, customers usually base their evaluation of service quality on the perceptions of what they received, and the degree to which the service met or exceeded their expectations (Brassington and Pettitt, 1997). It is therefore imperative that service providers identify and understand the way customers judge service quality if it is to be improved. Lovelock (2001) identified the criteria for evaluating service quality. The criteria are listed below.

- Credibility refers to the trustworthiness, believability and honesty of service providers (e.g. does the hospital have a good reputation).
- Security assures freedom from danger, risk or doubt (e.g. are the specialists who present the CPD lecture well informed about the latest trends in the medical profession).
- Access refers to approachability and ease of contact (e.g. are the specialists concerned available for consultation).
- Communication refers to listening to customers and keeping them informed in a language which they can understand (e.g. if a GP has a complaint, is the specialist willing to listen?).
- Understanding the customer means that an effort is made to know customers and their needs (e.g. is the hospital offering the CPD lectures willing to accommodate the GPs' schedule).
- Tangibles refer to the appearance of physical facilities, equipment, person and communication materials (e.g. Does the brochure have sufficient information?).
- Reliability refers to the ability to perform a promised service dependably and accurately (e.g. did the lecture provide sufficient information?). Responsiveness is the willingness to help customers and to provide prompt service (e.g. when there is a problem, does the firm resolve it quickly?).

- Competence means that the service provider possesses the skills and knowledge required to perform the service (e.g. does the specialist appear to know what he is doing?).
- Courtesy refers to politeness, respect, consideration and friendliness of contact personnel (e.g. are the telephone operators consistently polite when answering calls?).

According to Zeithalm and Bitner (2000) this criteria must reflect reliability, responsiveness, assurance, empathy and tangibles. This will help to communicate the customers' organization of information about service quality in their minds.

3.4.3.1 Reliable service

Reliability is about the service provider delivering its promises. It involves consistent and dependable performance every time. This notion is supported by Martin and Claycomb (2002), who indicate that clients assert that providing friendly, professional, courteous and consistent service, which is fair and reliable is one of the best ways to establish and maintain customer relationships. This research shows that listening to customers is one way of developing ideas about how to please them. The provision of quality brings consistency to customers' expectations and management must support service quality practices and gain cooperation throughout the firm to successfully implement the service quality initiative. Reliability therefore instils confidence in customers and earns the service provider the reputation of having satisfied customers. Berry and Parasuraman (1991) identified the following potential benefits which attend the improvement of service reliability:

- Higher retention of, and more business from current customers
- Increased positive word of mouth communications
- Greater opportunity for charging premium prices

- Reduced cost of redoing service
- Higher employee morale and enthusiasm
- Lower employee turnover
- Improved marketing effectiveness and higher sales revenues
- Increased productivity and lower costs
- Higher profits

Dye and Grot (1999) provide the following guidelines which can be followed to increase service quality and ensure that the service is reliable:

- Establishing bi-directional channels of communication. Helping the customer avoid the frustration of difficulty in hearing, and helping them observe visual clues.
- Communicating effectively with the customer. Identifying the needs of a customer in order to be able to form realistic expectations. A mismatch between service offered and customer needs will benefit no one. Effectively communicating with the customer will help in the formulation of guidelines to deliver the required service.
- Communicating what is important and choosing the right form of communication. Establishing a relationship with the customer is important as the familiarity with the customer contributes to an easy understanding by the customer.
- Creating positive emotional capital. Providing the tie and motivation for future business.
- Avoiding the risk of destroying capital and/or creating negative emotional capital. Training should be provided to increase efficiency.
- Understanding the customer's perceived needs for the service. The needs must be identified and confirmed.
- Assessing the best way to deliver need fulfilment.

- Deciding how to reduce the risk of the service and the management of that risk.
- Acting to deliver the elements of service.
- Exerting the control necessary to insure that intended events occur. There must be proper management of the events and timing so that the delivery of service leads to fulfilment of customer expectations.
- Helping the customer to recognise service delivery and the fulfilment of customer expectations. Confirming service delivery.
- Returning to the results of the assessment of critical factors. Eliminating negative critical factors.
- Identifying potential shortfall effects. Delivering action which will eliminate potential negative effects.
- Determining action inhibitors for the customer with respect to the expected service event. Emotional discomfort can inhibit interaction. It is wise to develop a relationship with the client which will avoid emotional discomfort because such discomfort will block a customer's mind when receiving the service.
- Developing a plan to remove emotional discomfort. This will help reduce perceived risk and increase the perception of value.
- Recognising, providing for, and utilising positive residual effects. Admitting and exposing shortcomings, and correcting the situations.

The implementation of these guidelines will not only increase service quality but also lead to customer loyalty.

3.4.3.2 Responsiveness

Responsiveness refers to the employees' willingness to help their customers and also to deliver prompt or on-time services (Zeithaml and Bitner, 2000). This would mean that the period during which customers wait to get assistance, have

their questions answered or are given attention to their problems, communicates responsiveness to customers by the employees. Zeithaml and Bitner (2000) place emphasis on the responsiveness dimension because it relates strongly to attentiveness and promptness when dealing with requests, problems, questions and complaints from customers. Therefore, requests must be handled from the customers' point of view instead of the firm's point of view.

3.4.3.3 Assurance

When customers are first exposed to a service they perceive that risk is involved because they don't know what to expect. In such an instance it makes sense to say that the institution providing the service must provide its clients with assurance. According to Zeithaml and Bitner (2000) assurance plays an important role in services because it builds trust and confidence in clients. Furthermore, Zeithaml and Bitner (2000) continue to say that during early the stages of a relationship with a customer, tangible evidence is used to assess assurance by customers. It is therefore crucial for professional service providers to build confidence in customers through the use of visible evidence of achievements such as degrees, awards and/or special certificates in their institutions.

3.4.3.4 Empathy

In a service, empathy also plays an important role. When clients receive and experience empathy the, develop a sense of importance and appreciation toward the institution offering the service. This notion is supported by Berry and Parasuraman (1991) in saying that empathy provides the client with individualized care and personal attention. This can be attained through means such as easy access for clients to the service provider, good communications and customer understanding by employees as mentioned by Lovelock (2001). It is

clear that personalized or customized services are essential because they are vital in making a client feel understood by the service provider.

3.4.3.5 Tangibles

Since services are characterized by intangibility, it is crucial that the service provider makes use of the tangible elements of the service. Lovelock (2001) says that tangible elements include facilities, equipment, personnel and the appearance of communication materials. The above-mentioned elements offer representations and images of the service, physically, to customers so that they can evaluate the service quality. Institutions offering services can also use tangibles to enhance their image.

3.4.4 Personalisation

This section on personalisation is taken from the work of Martin and Claycomb (2002).

Personalisation refers to the customisation of some aspect of the service or its delivery, treating each customer as a unique individual with a unique set of service requirements, thereby creating unique fits between customers and services (Martin and Claycomb, 2002).
Personalisation can therefore serve as a link between customers and service providers and between customers and services themselves.

There are three levels of personalisation mentioned by Martin and Claycomb (2002):

- Interpersonal level. Learning and using customers' names and encouraging face-to-face contact between employees and customers.

- Operational level. Obtaining information on customers' processes and requirements leading to the provision of unique ideas to help clients.
- Organisational level. Assign the employees the responsibility of serving specific customers and personal relationships will be encouraged between the firm's representatives and the customer.

Cooperation is required if personalisation is to be implemented. This means that all organizational systems and personnel at all levels must be part of or at least support the concept of personalization.

3.4.5 Affective engineering

In their work, Martin and Claycomb (2002) and Olesen and Hjortdahl (1999) define affective engineering as "A range of efforts designed with the intention of evoking customers' emotional responses to make them feel good about the company and otherwise warm and cosy in the relationship with the firm." They specify that customers' affective commitment is positively related to their willingness to remain in a relationship with a service provider through practices such as community and civic events involvement, monetary sponsorship of community events, employee volunteerism, image advertising, and cause related advertising. In order to help position an institution positively in its community, involvement in community events and support for charitable organizations or social causes can generate favourable media publicity and word-of-mouth. This will help portray the institution as a good corporate citizen interested in giving back to the community from which it receives support.

3.4.6 Rewarding loyal customers

Part of building a good relationship with customers is to appreciate and acknowledge them for utilizing the services offered by the institution. Claycomb and Martin (2002) say that rewarding customers for their loyalty builds good and strong relationships with customers. Rewarding a customer can be viewed as a reinforcement practice that encourages customers to remain loyal. This is based on a principle that reinforced behaviours are more likely to be repeated than those not reinforced (Claycomb and Martin, 2002; Connor et al., 2000). There are other customer benefits which when provided to the customer serve to strengthen the relationship. The research findings by Claycomb and Martin (2002) showed that rewarding long-time customers with special advantages and reminding customers about renewals builds loyalty in customers.

3.4.7 Convenient systems

A system is convenient when it makes it easier for the customers to conduct business with the institution concerned. This involves making company representatives accessible, providing convenient locations for new facilities, providing lobby greeters whose job it is to educate customers, free parking, prepaid and pre-addressed return envelopes, fast response to customers' inquiries, removing contact barriers, ensuring that customer interfaces with technology are not overwhelming and not making customers wait for a service unnecessarily or perform tasks they would rather avoid (Claycomb and Martin, 2002). It can thus be concluded that unfriendly systems leave customers feeling frustrated, unwelcome and convinced that there must be a better way to acquire the service and this can cause customer relationships to suffer.

3.4.8 Building trust

Customers develop trust when they know that an institution will fulfil its promises and honour its commitments. Claycomb and Martin (2002) point out that trust is a cornerstone of any healthy relationship and customers must trust service providers before they are willing to pay for promises. Therefore, trust is an important element in a relationship-building programme, because it builds confidence and fosters cooperation. Trust gives a service provider a second chance when inevitable mishaps occur although it may not be possible to rebuild customer relationships when trust is broken.

3.4.9 Thanking customers

Thanking a customer means that they are not taken for granted and services are provided as promised. Thanking a customer also communicates that he/she is appreciated for doing business with the institution concerned. This can be done either in person or over the phone. This is supported by Zeithalm and Bitner (2003), who maintain that a personal letter or a personal phone call have a greater impact on the customer.

3.4.10 Innovations

As part of the need to encourage GP's to attend CPD lectures, the latest innovations in the medical vicinity can be used to help position the hospital offering CPD lectures as a market leader or winner with which the GP's want to associate. Innovations can serve to enhance customers' perceptions of value when customers know that they are purchasing the latest and most advanced service (Claycomb and Martin 2002). Innovations give GP's reasons to continually revisit, overcome boredom and continue to do business with the hospital.

3.5 CREATING VALUE IN A COMPETITIVE MARKET

Services need to be enhanced through increasing perceived value and providing service attributes which are not provided by the competitor i.e. giving customers something extra (Martin and Claycomb, 2002). Here the aim would be to eliminate competition by making the customer's experience more memorable. This can be attained through:

- Being creative in what you do
- Developing a niche
- Offering exclusive services

The work of Martin and Claycomb (2002) continue to indicate that sales promotions (i.e. sponsoring workshops and seminars), entertainment (e.g. hosting a breakfast) and affinity clubs (e.g. establishing senior clubs that offer travel opportunities) contribute to make a customer's experience memorable. As the firm provides the above-mentioned attributes to make a customer's experience memorable, it is important to bear in mind that there must be consistency otherwise the competitors are likely to take advantage of the inconsistency if it occurs. Martin and Claycomb (2002) stress that differentiation of this type will only be effective if customers value it and when the value added exceeds the cost added in providing it.

Because competition is increasing in the service business, it is important that businesses that offer services differentiate their offerings in ways with which customers can identify (as mentioned above). In order for a business to achieve this goal, it will need to focus on developing a strategy that will enable it to do so. In other words, the particular strategy must be concerned with creating and

maintaining distinctive differences that will be noticed and valued by those customers with whom the firm has a relationship (Lovelock, 2001).

This section will be discussed from the perspective of the marketing mix. Marketing mix is what the organisation has to offer to its customers and the value that customers receive (Ming and Pheng 1997). In order for the hospital to be effective in offering CPD lectures to the GP's, the management has to see to it that the marketing mix is put in place and well appropriated. The marketing mix for services is composed of 7 P's (Ming and Pheng, 1997 and Ahmed and Rafiq, 1995). The seven Ps of services marketing will be discussed below.

3.5.1 Adding value to the service product

Product refers to what the business offers to the prospective customer. Some decisions will need to be made in this regard to ensure that the correct and relevant product is offered. Planning and developing a product involves determining the characteristics and features customers want, and developing appropriate warranties and service plans and other decisions concerned with delivering the right service or product (Zikmund and d'Amico, 2000:11). When it comes to satisfying customers, a product's intangible aspects are generally more important than its tangible characteristics. The objective of most specialists when presenting a CPD lecture is to satisfy the needs of the GP. This objective is important to the specialist because its attainment will influence the value of their presentations. Furthermore, Ming and Peng (1997) conclude that the right types of services have to be developed to satisfy needs.

One way of ensuring that customers are satisfied is to develop customer prototypes. Customer prototypes describe the customers in the target market for a service (Lovelock:2001). Such descriptions are crucial as they help the

company to envision how services and the marketing mix can be combined to maximize the company's effectiveness.

For the quality to increase, the service providers (the specialists presenting the CPD lecture) must be reliable in their work, be able to solve the customer's (GP attending the lecture) problem and account for their responsibilities as well as to provide continuous information updates for clients (GPs). It is also important to note that providing the existing service efficiently, will not lead to success but success will come when new approaches to the service are created (Lovelock, p245 2001).

New service approaches which firms can utilize include (Lovelock, p245 2001):

- Major service innovations which are new core products for markets that have not been previously defined
- Major process innovations which consist of using new processes to deliver existing core products in new ways with additional benefits.
- Product line extensions which are additions to current product lines by existing firms
- Process line extensions which represent distinctive new ways of delivering existing products
- Supplementary service innovations which take the form of enhancing service elements to an existing core service
- Service improvements which involve modest changes in the performance of current projects
- Style changes which serve to motivate employees, create excitement and are often highly visible

If a hospital adopts these approaches to services, it will have a competitive advantage. This is due to the fact that innovative companies stand out from the rest (Lovelock, 2001).

The availability of resources must be considered when deciding on the services to be offered (Gegnali, 2001). The specialists must have the integrity and professionalism to handle all sessions in order to gain the GP's confidence because the GP's may also use past track records as a guide when choosing the specialist for referral. This is supported by Lovelock (2001) when he mentions that a good understanding of customers' behaviour will lead to an improved service.

3.5.2 Price

Price is the means of setting the exchange value between parties and the fees charged for the service will vary from business to business (Ming and Pheng 1997). In the medical profession, the GP's have to attend the CPD lectures to gain points as requested by MASA (Medical Association of South Africa). However, price can still be a critical factor when CPD is presented at a conference or seminar, where a specific amount is charged for attendance. This is particularly relevant since the financial dimensions of a relationship are the fraught with the greatest risk since it has the greatest potential for quarrel and disagreements. Therefore, the pricing aspect of the relationship marketing mix is crucial since it determines value (Cram, 1994:149). In this light, it makes sense to say that pricing decisions should be viewed as a tool for initiating and developing relationships.

When deciding on a price, firms need to consider the costs, competition and value to the customer. Lovelock (2001) defines cost-based pricing as follows: prices set relative to financial costs, competition-based pricing as prices set in relation to how competitors set their prices and value-based pricing as setting prices on the basis of how customers determine the worth of the service. If a hospital is to decide on a pricing strategy, much research will have to be conducted to ensure that the best and most effective strategy is put in place.

Another way of deciding on pricing is to define the unit of service consumption (Lovelock, 2001:279).

When looking at price, Vignali (2001) mentions that success can often be related to being able to adapt to a specific environment. In other words, rather than just having a different pricing policy, select the right price for the right market. This shows that the price is a reflection of quality and the value of the service offered. If a firm is unable to offer lower fees, it can get clients by differentiating services from those of competitors. The advantage of this is that some clients don't mind paying more if a firm has a good reputation (Ming and Pheng 1997). In other words, lowering the price is not the only option available, it all depends on the attributes in a situation at that particular time. Ming and Pheng (1997) continue to note that it is important to keep in mind that the way the clients perceive the image plays a vital role; they are not only influenced by price.

In embarking on lowering the price as a strategy, there must be a proper procedure to ensure that the implementation of this strategy will lead to the set goal. The following steps can be followed in determining a price for a particular market (Vignali 2001).

- Select the price objective
- Determine the demand
- Estimate the costs
- Analyse competitors' costs, prices and offers
- Select a pricing method
- Select a final price

Implementation of these steps will also assure competitive advantage.

3.5.3 Promotion

As part of promotion, hospitals can engage themselves in seminars to make themselves known. This can be attained through the use of means such as: providing eye-catching logos, building up the firm's reputation through consistent and efficient work and a proper compilation of the company's profile (Ming and Pheng 1997). This shows that there are a few options and the extent of involvement will vary from business to business. If the correct elements of the communication mix are not put in place to convey the message to the target audience, competitors will take advantage and lure the customers to themselves. This is proven by Lovelock (2001:307) who claims that if communication is not effective, customers may never learn of a service firm's existence, what it has to offer or how to use its services to best advantage.

The major tools of promotion as mentioned by Lovelock (2001:295-306) are:

- Personal Communication which is communication undertaken on a face-to-face basis. This includes personal selling (interpersonal encounters on a face-to-face basis in which efforts are made to educate customers and promote preference), customer service (delivering a service in the customers' presence and providing the needed information), training (providing a training course to customers so that they are familiar with the service that the company has to offer) and word of mouth (customers' comments about their experience regarding the service offered to them).
- Advertising which is used to create awareness and stimulates interest in the service offering, educating customers about service features and applications, establishing or redefining a competitive position, to reducing risk, and helping make the service more tangible. Included is broadcast (television and radio),print (magazines and newspapers), internet, outdoor, retail displays, Cinema/theatre, telemarketing (fax or e-mail) and direct mail

- Sales promotion which motivates the customer to utilize a specific service sooner. This includes sampling (gives customers a chance to learn more about a service by trying it free of charge), coupons (a price cut, or a discount), short-term discounts (price cuts available for short-term), sign-up rebates (membership organizations charging a sign-up fee for applying or joining), gift premiums and prize promotions.
- Publicity/public relations include efforts to stimulate positive interest in a firm and its services by sending out news releases, holding press conferences, staging special events, and sponsoring newsworthy activities. In this instance the strategy is to prepare and distribute press releases featuring stories about the company, specific services and its employees. Good relationships with journalists and other media specialists are important in building a receptive climate for news releases. Exposure can also be gained through sponsorship of sporting events and other high-profile activities, where banners and other visual displays provide continuing repetition of the corporate name
- Instructional materials which include web sites, manuals, brochures, video-audiocassettes, software/CD-ROM and voice mail
- Corporate design which includes signage, interior decor, vehicles, equipment, stationery and uniforms

From the above, it is clear that promotion plays a critical role in assuring the success of the hospital.

3.5.4 Positioning

The hospital needs to secure a place in the market which is distinctive. According to Lovelock (2001:200), in order to secure such a place, the hospital must establish a position in the minds of its targeted customers, its position should be singular, providing one simple message, and setting itself apart from competitors, realizing that it cannot be all things to all people – it must focus its efforts. It is clear that when the hospital implements these approaches it will

have a better competitive position. One simple example of positioning would be to realize that the hospital should be located at a place easily accessible by patients and doctors (Ming and Pheng 1997). This is due to the regular visits that doctors and patients pay to the hospital.

Lovelock (2001:204) mentions the following steps in developing a positioning strategy:

- Market analysis: needed to determine such factors as the overall level and trend of demand and the geographic location of this demand
- Internal corporate analysis: requires the organization to identify its resources, any limitations or constraints and the values and goals of its management
- Competitive analysis: the identification and analysis of competitors can provide a marketing strategist with a sense of their strengths and weaknesses, which in turn, may suggest opportunities for differentiation

The combination of such analysis should enable the hospital to develop an effective plan of action and to attain a desired position in the market place.

3.5.5 People

The "people' aspect of the mix, according to Ming and Pheng (1997) involve staff selection, motivation, and particularly, customer care training. Proper selection procedures need to be in place, employees need to be empowered through training so that they can carry out their responsibilities properly (particularly in service) because customers view employees as the core of the business. Interactions between customers and employees have to be monitored. According to Lovelock (2001), what the customer experiences and what the employees offer are two different events and top management has to ensure that what

employees offer is what the customer needs and wants, not what employees think customers want. Since production and consumption are simultaneous in services, employees influence customer perceptions of product quality (Ahmed et al. 1995). Employees form part of the product and therefore product quality cannot be separated from quality of the service provider. As a result, the performance of employees must be monitored as they tend to be variable in their performance, which means that the quality will also vary (Ahmed et al. 1995).

People are an important aspect of the marketing mix as they are a means through which services are dispatched (Ming and Pheng 1997). It is thus evident that that people are the most important assets of a firm. That explains why when firms select employees, they require employees who are qualified, experienced and have a good working attitude. It is also crucial that the management team of a hospital select the specialists who are qualified, experienced and those with a good working attitude. These factors will influence the way they present the lectures. Training must also be provided to ensure stability and constancy. Ming and Pheng (1997) point out that training is important to empower the staff to be able to handle the customers (e.g. Senior staff members can give a topic to junior employees on the procedures to be followed when undertaking a given task).

3.5.6 Physical Evidence

Physical evidence comprises everything from appearance, design, layout of service setting to brochures, uniforms, chequebooks etc. (Mudie and Cottaman 1995: p6). As mentioned above, physical evidence refers to the environment where the service is delivered. This also includes tangible goods that make performance and communication of the service easier (Ahmed et al. 1995). Furthermore, Ahmed et al. (1995), demonstrate that because customers use tangible evidence to assess the quality of the service provided, physical evidence

must be taken into consideration. As mentioned earlier CPD lectures are a form of service, but tangible evidence must be included to increase assurance to the customers. This is particularly relevant in a service business because the more intangible-dominant a service is, the greater the need to make the service tangible. Ming and Pheng (1997) state that the professionalism in the services offered is reflected by the physical evidence (e.g. if customers are clear about where cost figures are to be found, they will be more confident with the results delivered by the service provider). This proves furthermore that the physical office environment is important because if the office environment is pleasant the customers will have a good impression of the firm and the employees will be comfortable and encouraged to be more productive.

According to Ming and Pheng (1997), physical evidence has components such as:

- Physical environment (e.g. furnishings, colour, layout and noise)
- Facilitating goods that enable the services to be performed (e.g. specifications)
- Other tangible clues (e.g. brochures)

It is thus clear that when physical evidence is managed properly, the image conveyed will conform to the desired image. It is particularly true since physical evidence is part of the product itself (Ahmed, 1995). It is advisable, as Vignal (2001) puts it, for a service business to focus on consistent delivery of quality, service and cleanliness.

3.5.7 Process

The client's benefits are provided by the efficiency of the process. The process includes procedures, mechanisms and a flow of activities through which the

service is acquired (Ahmed et al. 1995). It is important to point out that marketers must see to it that customers understand the process of getting a service. Procedures are important as these provide clients with a tangible source of assurance of consistency in the service provided (Ming and Pheng, 1997). When consistency is sustained, the corporate image as perceived by customers will be enhanced. The hospital management must therefore see to it that the GP's understand the procedures and are at ease because this will serve as part of the tangible aspect of CPD lectures.

Services are not tangible according to Ming and Pheng (1997) and Mudienad Cottam (1995:p6) explain that customers judge services by efficiency and effectiveness of the service process, which includes the following aspects:

- The policies and procedures adopted
- The degree of mechanisation used in the service provision
- The degree of employee discretion
- The client's involvement with the process of service performance
- The flow of information and service

3.6 SUMMARY

CPD lectures are a form of a service and hence the principles of services marketing are applicable. Marketing approach in CPD programs must be based on the nature of services. Relationship marketing principles are also important as they will ensure that effective relationships exist between the GPs and specialists and; GPs and hospitals. The relationship approach to marketing, whilst recognising the four marketing mix elements (product, price, place and product), reflects the need to create an integrated cross-functional focus of marketing, thus shifting from customer acquisition to customer retention and ensuring that the appropriate allocation of resources are directed at these key tasks.

CHAPTER FOUR
REFERRAL NETWORKING IN THE MEDICAL PROFESSION

4.1 INTRODUCTION

The traditional exchange of medical expertise between physicians for patient benefit has been accomplished by referral (Williams et al. 1994). Consultation and referral have always been important processes for the GP's and the specialists. The rapid expansion of highly technical diagnostic and therapeutic procedures makes consultation and referral particularly salient in current medical practice (Curray et al. 1980). The specialists need to establish networks with the GP's so that the referral pattern is stable and continues to grow. This is due to the reason that competition for patients intensifies. Again, because of increasing competition for patients, health care organisations are devoting more resources to understanding the factors that directly or indirectly influence patient volume (Gombeski et al. 1990). Once these factors are identified, it will be easier to influence patient volume for the benefit of the hospital and the specialist.

The GP serves as an important source of referrals for many health care services. Specialists and tertiary care hospitals depend on GP referrals for much of their patient volume (Javalgi et al. 1993). This is because GP's see large volumes of unscreened patients in the office setting. The specialists don't see all the patients and then decide which patients need their specialized offerings. Instead the GPs play the role of selecting patients who need specialized offerings form a particular specialilst. Referral to more specialised colleagues is always an option and discretionary factors may place an important role in the referral decision (Lawler et al. 1990)

Since the GP's are the ones who refer patients to the specialists/hospitals, much attention has to be focused on influencing the GP to refer to the particular hospital/specialist. Gombeski et al. (1990) support this view in saying that the influence of GP's in steering patients to an organisation has become an increasingly important focus of health-care marketers. This can be attained as there are several means which can be utilized to achieve this goal. For example, GP's have several external sources of information available when referring a patient to a specialist (Bowers et al 1994).

There are several sources of referrals available, which can be utilized.The most used sources were a GP, followed by the specialist, the patient or the patient's family and to a lesser extent, hospital-controlled sources including referral directories, calls services, and sales representatives (Bowers et al. 1994). The hospital offering the CPD lectures must know which sources of referrals are available and which ones are most effective. It is important to do so because according to Dorecus (1992), health-care decisions are made through informed choices. Hospitals, which expand their market beyond GP referrals, are discovering that consumers are interested in taking a more active role in deciding which hospital to go to and managed-competition programmes may be one of the first concepts to fine-tune a new broad-based health care system (Dorecus, 1992).

The referral process plays a critical role for the specialists and the hospitals because it influences the amount of patients who will go to the hospital or to the particular specialist concerned. This is particularly true because GP referrals are the lifeblood of many organisations, the difference between prosperity and ruin; and the physician referral process is difficult to understand and manipulate (Mackesy and Mulligan 1990). Again GP referral can shape the survival and growth of specialised physicians and organisations, making them an important focus for health-care marketers (Bowers et al. 1994).

Because of increasing competition among hospitals, each hospital needs to have its referral network in place as an assurance of receiving patients. As a result, many GP's and hospitals are developing proactive programmes designed to strengthen their referral base and the success of such programmes may hinge on selecting effective sources of information to use in communicating with referring physicians (Bowers et al. 1994). As there are many role players in a referral process, proper management must be in place. Increasing competition among physicians and hospitals, a more sophisticated consuming consumer public, shorter hospital stays, and more active third-party payers have resulted in the need for better understanding and management of the referral process (Bowers et al. 1994).

4.2 THE REFERRAL PROCESS

A referral is a process which occurs when one GP is limited in his/her resources to help a patient. Such a GP then refers a patient with the special needs to the relevant specialist. A referral may be defined as a temporary or permanent transfer of responsibility for a patient's care from one physician to another and consultation denotes the practice where one GP asks advice from another about a patient, with the implication that the first physician will continue to care for the patient after the consultation (Curry et al. 1980). The referral process plays a crucial role in the medical profession because it ensures proper facilitation between GP's and specialists. Referrals help promote, encourage and take advantage of missed opportunities (Till, 2004). Through referral networking, a specialist can move from a passive state of waiting for chance opportunity to an active state of gaining referrals.

GP's do not practice in isolation. Assistance is frequently needed from colleagues to manage patients, and these colleagues in turn require assistance to manage their patients. This exchange of expertise may occur through consultation, where advice or special studies are requested while responsibility for a patient remains with the initial GP, or through referral, where some or all responsibility for the patient's care is transferred from one GP to another. These are two distinct modes of exchanging expertise, differing primarily in duration and permanence form some sense in certain repects, a referral may be viewed as a longer-term consultation (Schaffer et al. 1985). Both methods, however, share the common purpose of pooling medical knowledge for the patient's benefit.

An important part of the referral process is the decision of where (to whom) to refer a patient. That decision is dependent on the referring GP's knowledge of specific specialists to whom they can refer a patient. In general, such knowledge is available to the referring physician through various external sources of information (Bowers et al. 1994). This kind of knowledge must create a favourable impression on the GP. This can be achieved since one of the most important advantages of referrals is that they can be built and executed with little or no help (Till, 2003).

A basic premise of decision-making theory is that a decision is preceded by an information search (Bowers et al. 1998). This search can involve internal sources of information (memory) and external sources of information (sources other than memory). When internal sources of information do not permit the referring GP to identify an acceptable alternative, external sources are used in deciding to whom to refer a patient. The principal motivation for information search is the identification of a specialist to whom to refer a patient (Bowers et al. 1998).

Some important variables such as GP age and specialty and patient age and sex clearly affect referral rates. One key factor affecting referral rates is the form of reimbursement for the physician (Schaffer et al. 1985). These variables cannot be changed by the specialist. There are however other variables that the specialist can manipulate for his or her advantage. The specialist can reinforce his/her value to the GP, he/she can create new events to communicate with GP's and he/she can offer meaningful rewards to GP's who refer to him/her.

The referral rate of the patient is dependent on a number of different factors. A low rate, for example, can mean that a GP is competent to handle most medical problems he/she encounters, that a preponderance of his/her patients are well or have illness of low technical complexity or severity; that the consultative network is of limited availability; that he/she is unsophisticated in building and using referral lines; or that he/she has low recognition of disorders that he/she ought to refer to others (Kassebaum 1987). Some important variables such as GP age, speciality and patient age and sex clearly affect referral rates (Schaffer et al. 1985).

When a GP is faced with the decision of referring a patient, there are a few factors which influence his decision. This is seen from the work of Schaffer et al. (1985) who asset that the most pertinent information available is from clinical studies and practitioner interviews, which show that the referral decision has two parts, whether to refer, and to whom to refer. One broad-based study of the referrals of general practitioners found that the decision to refer was made on the basis of the practitioner's personal clinical knowledge and skills, clinical judgement and the prevailing local standards of medical practice (Schaffer et al. 1985). Good communication and good relations between the referring GP and specialist play a key role in ensuring that the patient receives the best available treatment. Adequate communication between a GP initiating a referral and the consultant involved is essential for high quality medical care (Curry, 1980).

The factors involved in the consultative referral process as mentioned by Curry (1980) and Schaffer et al. (1985) include:

- The primary care provider's awareness of needing assistance
- The consultant's recognition of the problem to be addressed and his ability to supply help
- Adequate communication between providers about the nature of the problem and the degree to which each assumes responsibility for the patient's care and
- Adequate communication with the patient

The referral process also benefits the GP's as far as networking is concerned. Referrals are also used by new GP's to develop contacts and enter local practice networks (Schaffer, 1985).

Six problems involved in the consultation process as mentioned by Curry et al. (1980) are:

- Resistance to referral on the part of the family physician
- Resistance on the part of the patient to consultation. This resistance may be due to apprehension of the unknown, a failure on the part of the patient to take his illness seriously enough, or the threatened financial burden
- Failure of the referring physician to follow through. He/she frequently has an obligation to remain an active participant in the patient's care during and after consultation
- Failure to convey adequately the patient's personal and family background to the consultant thereby denying the patient the benefit of the referring physician's perspective and insight

Solving most of these problems requires that GPs and consultants establish adequate communication links.

Concern for personal income, status in the local professional community, and generation of reciprocal referrals affect consultant selection. One cannot estimate the weight of these concerns separately, as reciprocal referral is commonly known to carry substantial weight among practising GP's (Schaffer, 1985). The medical and political use of referrals is widely regarded as an astute business technique. So long as it is not carried to extreme, it is unlikely that these opportunistic practices affect patients unfavourably. Patient care may actually be improved by the additional attention, observation and cumulative physician time (Schaffer, 1985).

Reimbursement restrictions or organisational barriers can prohibit the use of accustomed consultants and require practitioners to use unfair specialists. Flexibility in the degree of consultant involvement in case management can also be sharply curtailed by a policy of shortages (Schaffer et al. 1985). Many health care systems are aggressively assembling vertically integrated corporate networks comprising of satellite hospitals, ambulatory clinics, and alliances between institutions designed to "feed" new patients into institutional programmes and garner their market share (Schaffer et al. 1985).

Patients who are acquired by a system and taken to institutional programmes are not attached to individual physicians. These patients "belong" to the system and must be distributed among the medical staff by some means. In some cases these referrals are distributed as incentives and rewards by the institution's administration for the physicians' cooperation with in other matters (Schaffer et al. 1985).

In the new environment of medical practice, four areas of concern for physicians emerge (Schaffer et al. 1985):

- Physicians independently making referral decisions must make sound patient-based decisions in radically different practice surroundings
- Physicians in these systems must preserve the professional sovereignty essential in making referral decisions that protect patient welfare and meet their professional needs
- All physicians must be aware of the potential legal implications of their referral decisions
- All practising physicians must review commitment to ethical traditions and evaluate new practice formats for potential conflicts of interest

The decision to seek medical consultation or to refer a patient has traditionally been made independently by the GP treating a patient. Once the decision to refer has been made, a specialist or colleague, with whom the GP feels comfortable and who is a respected peer, would be given the referred patient. The GP and specialist in this instance would share similar backgrounds, interests, and perhaps educational or postdoctoral training (Schaffer et al. 1985).

Medical advice was sought from whomever the physician required. In urban settings, advice was exchanged between peers within the same institution and in rural settings; advice was obtained by sending the patient to a specialist in a nearby urban centre (Schaffer et al. 1985). In both settings, the physician typically drew from a cadre of specialists personally known to him or her, although a new consultant could be selected on the basis of word-of-mouth recommendation, a joint consultation experience, or a favourable encounter in a medical staff conference (Schaffer et al. 1985).

From this arrangement, the patient benefited by receiving state-of-the art care for problems outside his/her own GP's expertise from consultants who are respected and known by the GP (Schaffer et al. 1985).

4.2.1 Elements of the Referral Process

In the process of making a referral, certain elements play a significant role. Variables that influence the referral process may be classified into three broad categories (Rajshelchar et al. (1993) and Kassebaum 1987):

- Patient-related characteristics
- GP-related characteristics
- Professional and community-involvement variables

4.2.1.1. Patient-related characteristics

Patient-related characteristics include type of illness and patient demographics. Previous evidence suggests that patients, at times, can play key roles in the referral process, even to the point of initiating referrals either on their own or through their physicians

4.2.1.2 Physician-related characteristics

The second element influencing the referral process is physician-related and may be organised into three categories:

- Physician's practice characteristics
- Physician's social background
- The extent of the physician's professional and community involvement

Practice characteristics may include type of practice (solo, group, partnership, hospital-based) , years in practice, office location and so on. Social background variables may comprise the usual socio-economic characteristics (age, education, etc.), type of specialty, and whether or not the physician is board-certified.

4.2.1.3 Professional and community involvement

Professional and community involvement includes the degree of physician participation in local/regional/national/professional associations and the level of involvement in local community organisations.

In addition to patient and physician-related characteristics, community-related variables also seem to have an impact on the referral process. Examples include whether the community is urban or rural or whether it has a medical school.

4.2.2 Exchange theory and the referral process

Exchange theory posits the interaction between individuals with the expectation that the mutual association will result in a positive out-come (reward exceeding costs). In the context of physicians' referral behaviour, a physician will be motivated to interact through the referral process with a consulting physician or hospital if the physician expects a profitable exchange (that is, a positive outcome) to result from the interaction (Rajshelchar et al. (1993) and Kassebaum 1987).

From this interaction, both the referring GP and the consulting specialist may receive several types of rewards. The referring GP feels rewarded if he/she receives the best treatment available, if communication from the consulting

specialist is prompt and efficient, if the referral process is easy and convenient, if the patient is returned to him/her for continuing care, and if the patient is satisfied (Rajshelchar et al. (1993) and Kassebaum 1987).

In addition to the rewards, the consulting GP has the opportunity to exercise his specialised skills (or learn new skills if the patient's illness is complex) and enhance his prestige and professional reputation.

Clearly, exchange theory provides a theoretical framework for the referral process by which a patient can be transferred from one physician to another for continuity of care (Rajshelchar et al. (1993) and Kassebaum 1987).Exchange relationships between referring GP's and consulting specialists or hospitals, exist within a dynamic environment, one which defines the context within which referral decisions are made. As a result, the environment affects the relationship between the referring GP's and the consulting specialist.

Medical doctors with different levels of status within a given medical community perceive different rewards and costs associated with referral behaviour as measured by referral rates. The referral rate is a nebulous quantity unless the frame of reference is defined and the diagnosis and case severity held constant (Rajshelchar et al. (1993) and Kassebaum 1987). It is an uncertain measure of professional growth and competence unless there is some authoritative validation that referral in individual cases is or is not appropriate for quality of care reasons.

Clients most often give referrals when a series of chance, simultaneous events happen: they are asked by a colleague to refer a service provider, they remember the service, and they happen to remember contact information (Till, 2003). However when giving referrals the problem could be inconvenience. Either they do not remember the service when asked, they don't have a business

card handy or it is the wrong time to give a referral. For this reason, it is important to build referral networks strategically.

4.3 Building Referral Networks

Building channel relationships represents a major strategic opportunity for physicians and referral recipients. To consulting physicians and tertiary-care facilities, the referring physician represents a critical "middleman" or intermediary who is instrumental in "selling" his or her specialised services to patients, the ultimate consumers.

Networking is not about making a "quick sale" but about helping others who, in turn, will help you (Schoew, 2004). Sharing information, making recommendations, and building trust are key to effective networking. This concept emerges from a growing realisation among medical doctors and hospitals about their mutual interdependence. According to Rajshelchar et al. (1993) a physician surplus, compounded by competitive pressures on independent and affiliated practitioners, have led medical doctors to realise the importance of cooperating with "channel members" who provide referrals as well as with those to whom referrals are made. This will ensure a stable competitive position for the hospital and the specialists. When specialists cooperate with GP's, there will be a pay off in the sense that more referrals will be received and partnerships will be created (Schoew, 2004). However, it must be kept in mind that networking is not about keeping scores, it is rather about building relationships that grow slowly and naturally.

Among the health care distribution channels currently being developed, most are sponsored or initiated by hospitals. Medical doctors bonding with each other and the need to expand services were primary reasons for such activities.

A majority of referring GP's rate location and delivery systems as relatively less important than the technical skill/medical services of the consulting physician or facility (Rajshelchar et al. 1993). However, a basic element of the strategy for delivering health-care services to the patient is the location of the main facility and nearby or feeder branches. Such branch expansions of tertiary care services invite new market opportunities and help strengthen referral relationships with physicians in geographically remote or distant markets.

Rajshelchar et al. (1993) states that such satellite programmes assist not only in maximising revenue growth through modification of the service mix and redistribution of clinical resources, but also in expanding the patient base of the hospital or the consulting physician through the creation of news services. To be effective in this particular approach, it is important to provide a high level of service in the first place. If the service is not exceptional, no referrals will be forthcoming (Zeller, 2004). Contact must also be maintained to succeed in referrals or networking.

The strategic challenge lies in building creative and ongoing programmes that promote physician relations, networking and outreach. For example, in the United States of America the Cleveland Clinic Foundation (CCF) – a major referral centre – recently introduced a physician liaison programme called the Compre-Care Affiliate Program. This programme was designed not only to strengthen the already existing relationship between CCF's staff physicians and referring physicians but also to create new relationships (Rajshelchar et al. 1993). When a relationship exists between specialist and GP, loyalty will result. Because of the importance of such a relationship follow-up or feedback is crucial. Hence follow-up tools can serve to motivate the GP to remain loyal to a specialist with whom he relates. Sean and Lyden (2002) identify these tools as thank-you notes, postcard mailings, e-mail updates, getting together over coffee or lunch, special occasions (birthday, anniversaries) and follow-up on well-being.

Rajshelchar et al. (1993) continue to mention that a networking programme should offer new affiliates several special benefits including: the ability to participate in a computerised communications network; a 24-hour seven-days-a-week hotline for appointment scheduling or for discussing urgent and emergent cases; a newsletter to keep physicians abreast of new activities at CCF; and social events that allow staff doctors (GPs and specialists) and affiliates to get to know each other better. What could be of even greater benefit to the Doctors, would be the use of memory hooks during their networking events. Memory hooks are things that are said in the introduction that vividly describe what the GP or specialist does, aspects which are clearly visualized in people's minds (Misner, 2003).

As a result of this effort, CCF accomplished many objectives including a 7% increase in physician-referred new-patient activity (Rajshelchar et al. 1993). A spin-off, computerised communication programme called "comprelink," was also developed and implemented to provide direct links for communicating, scheduling appointments, conducting clinical tests and sending reports and records speedily (Rajshelchar et al. 1993).

Given the role and importance of referring physicians in the marketplace for specialised health-care services, managers who serve the interests of consulting physicians and tertiary-care facilities need to understand better the attitudes, perceptions, and decision-making criteria that underlie the referral process.

Important factors to consider when building referral networks include: the medical skill of the consulting specialist, positive experiences with past referrals, availability for consultation, patient's preferences, and the likelihood of the patient being returned to the referring physician for continuing care (Rajshelchar et al. 1993). This will help create effective and efficient networks. Furthermore,

the specialists can gain a competitive advantage if they make use of rewards in referral marketing programmes. When used correctly, using rewards and thank-you gifts can be a powerful incentive for GP's to provide referrals to the specialists (Till, 2003). Rewards can be used as a creative method to boost the number of contacts a specialist receives while providing new relationship-building events with the current GP's.

4.4 Ethical Considerations in Networking

Patients must be able to trust doctors with their lives and well being. Doctors therefore have a duty to maintain a good standard of practice and care. Ethics are important because they ensure that a patient is cared for, respected, regardless of their views, and their right to being fully involved in decisions about their care are maintained (Good Medical Practice, 2001). The practice of medicine has been defined as a unique and intrinsically moral profession that stands alone among the professions because of its primary activity. Healing is both in principle and in fact, distinct from the activity of gaining remuneration for healing medicine is also unique in prohibiting the payment of fees for the referral of patients (Driscoll and Schieble 1992) and Schaffer (1985). These split fees are an important revenue source for attorneys and other professionals, but are outlawed to physicians on both ethical and statutory grounds. It is crucial to mention this point of view because it affects relationships with patients and colleagues. Professional ethical obligations must be observed constantly. The GP's and specialists must recognize and work within the limits of their professional competence and when referring a patient to a specialist, the specialist must be well informed (Good Medical Practice, 2001).

Hospital management should closely examine any activities currently conducted with medical doctors. As mentioned by Driscoll and Schieble (1990:13-22) and

Schaffer (1985), this is done to determine whether each activity, both organised and operated, furthers the hospitals' charitable mission of promoting the health of its community, rather than merely enhancing the financial health of the institution itself. The hospital thus has a duty to ensure that the doctors it employs are kept up-to-date by taking part regularly in educational activities which maintain and further develop their competence and performance (Good Medical Practice, 2001).

Medical doctors historically charge certain fees for certain services and therefore can bill common patients separately for services rendered by different physicians. A fee-splitting referral system for medical doctors is unnecessary because of the way in which medical fees are generated and billed (Driscoll and Schieble 1992: 13-22) and Schaffer (1985). Fee splitting is undesirable for many reasons, one of which is its potential to distort and subvert relationships between medical doctors and patients, and between medical doctors themselves. Good communication between patient and doctor about fees is thus fundamental since it plays a critical role. The doctor must be honest and open in any financial arrangements with patients. According to Good Medical Practice (2001) the doctor should provide information about fees and charges before obtaining patients' consent to treatment; he/she must not exploit patients' vulnerability or lack of medical knowledge when making charges for treatment or services and must not put pressure on patients to accept private treatment. It means that a patient must be given a balanced view of the options. Where a patient's capacity is in doubt, or where differences of opinion about his/her best interests cannot be resolved satisfactorily, the doctor should consult more experienced colleagues and, when appropriate, seek legal advice on where it is necessary to apply to the court for a ruling (Good Medical Practice, 2001).

Lawyers, on the other hand, take many of their cases on a contingent-fee basis, sharing the recovery with the client on a percentage basis (Driscoll and Schieble,

1992:13-22) and Schaffer (1985). When there is more than one lawyer representing a client, the lawyers must necessarily share the common fee with each other on a percentage basis. The referral system for lawyers, with the splitting of fees allowed, tends to enhance the quality of legal services to the client. Fee-splitting encourages a referring lawyer to bring an expert, win the case, and still receive a fee, as opposed to handling a case outside of his area of competence and risk losing the case and thus, the fee (Driscoll and Schieble (1992:13-22) and Schaffer, 1985). The doctor is the advocate who looks out for a patient's interests, and not the interests of the insurance plan a patient holds, or demographic group, or even society at large. The loss of such an advocate, especially at a time when the interests of all the other parties within the healthcare system are centred on cutting costs, would be catastrophic (Your Doctor in the family, 2005).

There are frequently rumours that some medical specialists may actually pay referring physicians in exchange for patients in highly competitive or overcrowded medical communities. A GP must act in his/her patient's best interests when making referrals. Thus the GP must not ask for or accept any inducement or gift which may affect or be seen to affect his/her judgement (Good Medical Practice, 2001). There is, however, a report of physicians paying a company to gather and refer patients (Driscoll and Schieble, 1992:13-22 and Schaffer 1985). The company was paid according to the volume of new patients it generated, and the patients were apparently not informed of the arrangement. If a doctor has a financial or commercial interest in a hospital or a company to which he/she plans to refer a patient for treatment, he/she must tell the patient about his/her interest (Good Medical Practice, 2001). This is for the sole reason that, when a doctor agrees to help a patient, he/she actually agrees to honour the trust the patient has given. The doctor concerned is therefore the patient's advocate in all matters related to health and the patient's interests must be

placed above all others including his own personal or financial concern (Your doctor in the Family, 2005).

Two ethically acceptable motivations for patient referrals are when assistance is required in the care of the patient, and when consultation is requested by the patient or his or her agent (Driscoll and Schieble, 1992:13-22) and (Schaffer 1985). The physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of the patient. Doctors must therefore, respect patients and their rights and may never use their knowledge, in any activity which implies the infringement of rights or manipulation of conscience (Col-legidemetges, 2005).

Collusion with colleagues for personal financial gain is morally reprehensible. Wherever possible, a doctor must respect the patient's right to choose his/her doctor and health centre and change them (Col-legidemetges, 2005). Reactivated concern over financial conflict of interest now includes physician equity ownership in hospitals where his/her patients are treated, satellite clinics that refer patients to his/her ambulatory surgery centres where he/she does the surgery, and the nursing home used to board his/her patients (Driscoll and Schieble, 1992:13-22) and (Schaffer 1985).

A number of studies have documented that patients without health insurance have less access to doctors and receive less care from them, when they eventually do gain access and research has also demonstrated that different payment structures affect physician behaviour (Hughes, 2004). Another form of potential conflict has arisen in the prepaid health insurance plans where a physician's remuneration may be affected by the use of consultations (Driscoll and Schieble 199:13-22 and Schaffer 1985). There may be pressure to select the cheapest consultant rather than the best. Driscoll and Schieble, (1992:13-22) and Schaffer (1985) continue to say that other insurance plans may bill the

physician directly for consultants, a fee which is paid from a fund the physician administers and shares in the year-end residual balance. These arrangements place physicians in awkward positions, bearing moral responsibility for consultant's actions, yet gaining financially from the use of lower-priced consultants. The way remuneration is handled in this case, will also affect the institution for which the doctor is working. Thus, it must be kept in mind that a doctor is bound to take care of the good reputation of the institution in which he is working and to promote its qualitative improvement (Col- legidemetges, 2005).

In structuring new transactions and examining existing arrangement, the following principles should be kept in mind (Driscoll and Schieble 1992:13-22 and Schaffer 1985):

- Transactions should not be premised upon increased utilisation or physician referrals. Enhancing or protecting market share, even for the purpose of preserving an institution's presence in the community, will in all likelihood no longer be accepted as a justification for pursuing joint venture arrangements. In justifying such ventures, management must distinguish between benefiting the community and benefiting the institution.
- Transactions where existing services or equipment are "spun off" to a hospital-physician joint venture run serious risks of enhanced IRS scrutiny.

- Transactions creating or providing new facilities or services should be more favourably perceived; participants other than the hospital take an active role in managing the venture. When the hospital is the sole general partner and merely manages what it would have managed had there been no physician investors, the question of why medical doctors are involved will likely be of greater concern that it has been in the past.

- Medical doctors must be vigilant in avoiding any potentially compromising monetary involvement, for in the final analysis no external factors should interfere with the dedication of the medical doctor to provide care for his patient.

Medical fees must therefore be equitable and constitute a form of abuse. At all times the aim should be to benefit the patient and not the physician's material interests. The doctors must thus be guided by an egalitarian universalism rather than a personalized particularism (Hughes, 1994). Unfortunately, physicians' financial incentives to treat, and patients' ignorance of their true needs, lead to inappropriate over-treatment, which meant higher payment (Hughes, 1994)

4.5 Referral as a Marketing Strategy

Medical advertising was first allowed in 1980, and medical doctors of all specialties responded by advertising their services directly to the public with accelerating intensity (Schaffer, 1985). This involves building a rich network of business contacts and requires considerable time, effort and money. However, after establishing a well-rounded network, maintaining the professional relationships may be the most important strategic component to success (Cook, 2005). This means that the time invested in networking will be turned into referrals.

Findings by Schaffer (1985) indicate that advertising by medical doctors in many instances now rivals the marketing sophistication of large health care institutions. This also involves a process of exchanging, leads, recommendations and information through networks of established relationships (Cook, 2005). Several levels of presentation and communication, including public relations techniques, are used to position physician services in a particular niche in the market place

by creating an overall image the appeals to the public. In order for specialists to be effective in networking, important principles need to be considered. For example, Douglas (2001) mentions that the specialist needs to carefully choose where he/she networks, focus on few people at each networking event and look for people to refer. Schaffer (1985) further mentions that larger medical groups and institutions can advertise basic health services directly to consumers, but it has not yet proved effective and efficient to market tertiary or specialty doctors' services directly to patients. This shows that it will be more effective for specialists to network with GP's who will then refer patients.

According to Schaffer (1985) services are more efficiently marketed to medical doctors who treat consumers. Once the targeted medical doctors' commitment has been obtained through a marketing programme, the patients requiring tertiary and specialty services will be referred to them. This view is supported by Zeller (2004) in mentioning that when quality service is provided, the clients will also want to help the business to be successful. Such clients would want others to experience the same service quality.

Some of these marketing techniques may not require large sums of money in order to be effective. For example, in the United States, a number of unaffiliated specialty doctors practicing in the same city established a company to market their services to primary physicians (GP's) in outlying areas (Schaffer, 1985). This cooperatively owned company attempts to cultivate patient referrals by currying favour with established and potential referring physicians (GP's) (Schaffer 1985). The company's marketing programme includes a monthly newsletter, free comprehensive physical examinations for referring physicians (GP's), and expensive dining, entertainment and sporting junkets for these physicians. Additional benefit programmes for referring participants, such as practice management consulting, bulk purchasing discounts and investment services may also be provided by the group. Schoew (2004) indicates that the

benefits of such networking include: raising awareness of a particular company, sharing ideas and solving business problems, building stronger relationships and rapport and developing potentially new business relationships.

More customary and restrained examples of the marketing of referrals may include educational services and professional courtesy for the treatment of the families of referring physicians (Schaffer, 1985). Referrals are particularly important because people who refer others, know that that person will be interested and it also indicates that they are happy with the service, so word of mouth is effective in this case (Defiore, 2005). Excellent levels of patient care, accessibility, and dignified treatment of the referring physician are essential components as well. Such components can be exposed via promotional materials like brochures and newsletters.

Schaffer (1985) states that programmes to market physician referral services also exist in academic medical centres. Schaffer (1985) further mentions that regional telephone referral programmes with toll-free numbers using the university staff as consultants began to spread early in the 1980s. Dozens of programmes now exist allowing a physician anywhere to call for an immediate and personal consultation or to make a referral directly to a faculty member. University hospital in-house consultative services have been revamped to provide easier access for the community physician and also for other academic specialty services.

The expensive and permanent technique to secure patient referrals is simply to purchase the source, as large regional hospitals have done by acquiring smaller neighbouring hospitals. The smaller units serve as satellites, "feeding" patients to the patient institution. Free-standing ambulatory clinics have recently emerged as sources of patients, and institutions have begun to build or acquire clinics in city-wide sites to extend the referral base for patients. The success of

such a technique will largely depend on carefully choosing where to network, allowing trust to develop naturally, follow-up and the maintenance of contact (Douglas, 2001).

Another method of assuring permanent patient sources is a joint venture between a physician group and an institution. "Physician locator" programmes have been mounted with heavy media support in many cities. Run by the institutions, those programmes advertise their medical staff to the public and encourage patients to call the hospital for referral to a member of their staff (Schaffer, 1985). This is proven by Maduk (2001) in research that showed that networking is effective as it opens communication channels with new prospects and people responded in a genuine fashion to business. This will then lead to referrals replicating themselves.

Closer scrutiny by regulatory and licensing agencies for potential conflicts of interest may be applied to non-traditional marketing programmes directed to physicians, and to business arrangements that require treating medical doctors to use only one institution or panel of consultants (Schaffer, 1985). More formidable obstacles to the spread of these programmes may arise from consumers.

Resentment and resistance may develop as consumers legitimately question the motivation and intent of physicians (GP's) referring them to consultants (specialists) under these circumstances (Schaffer, 1985). A loss of consumer confidence will certainly develop if it is revealed that a doctor's income is affected by his referral decisions.

The enduring core of any successful long-term medical marketing strategy will be the excellence of its clinical programmes coupled with qualified, accessible, personable, and compassionate consultants.

4.5.1 Making Referrals

It must be remembered that in the patient's mind the referring physicians (GPs) always bear the moral responsibility for the actions of the consultant. In some cases the GP or the specialist may also bear the legal responsibility.

Malpractice suits against medical doctors who have referred patients to another medical doctor where the patient was damaged in some way is not a new concept. Schaffer et al., (1985) states that the basis of the charge against the referring physician (GP) is that he either assisted the consultant in damaging the patient, or should have known of the consultant's incompetence to treat the patient properly

It is clear, however, that certain types of medical practice arrangements can increase the liability exposure of the referring physician for the damaging acts of his consultants. If the consultant is employed in any manner by the referring physician (GP or specialist), liability for the negligent acts of the consultant is readily extended to the referrer (Schaffer et al., 1985). When referring and consulting physicians work closely to manage a patient jointly and the care is later adjudged to have been negligent, both physicians can be held liable.

If a medical doctor refers patients to a consultant (specialist) known to be inadequate or unsatisfactory, the medical doctor may bear liability for any bad result because of negligence in recommending that consultant.

Consent must be obtained from the patient and recorded before a referral is made and not only for ethical reasons. In at least one case, in the United States of America, the referring physician was not held liable for the consultant's negligence because the patient had consented to the referral at the time it was

made (Schaffer et al., 1985). Patients should not be pressured or coerced to use an institution for care simply because of internal protocols or propriety interests. If a patient does not consent to an internal referral program, he or she must not be abandoned, and every effort and consideration must be extended to assist that patient in receiving care from a chosen source.

Once referral is made, the referring medical doctor must make a clear-cut clinical decision on the level of involvement and interaction with the consultant and the consultant's treatment of the patient. Involvement should be either complete and closely coordinated, or restricted and peripheral to the consultant (Schaffer et al., 1985). In many respects, the less involved the referring physician, the less liable he or she will be for cases of negligence and errors of the consultant.

Referring physicians who remain involved with consultant care as a part of total patient management must continually monitor the performance of their consultants, relying not only on written reports, but also on patient feedback and their own subjective impressions.

An appraisal of consultants' credentials and background should be made before referring. When newer technical procedures are contemplated the referring physician should be familiar with the consultant's training, experience, and frequency of performance of these techniques before advising a patient (Schaffer et al., 1985).

Consultants receiving a referred patient share common ethical and legal responsibilities. According to Schaffer et al. (1985) there must be assurances that the patient willingly accepts the consultative services, and the extent of those services must be understood by the patient-referring physician and the consultant.

It must be clear as to whether an opinion, a specific procedure or treatment, joint management of the case, or full assumption of responsibility desired, is temporary or permanent. The consultant can assume full responsibility only at the spontaneous request of the patient, or at the request of the referring GP (Schaffer et al., 1985).

4.6 SOURCE ATTRIBUTIONS

Source attributes are characteristics or qualities ascribed to an information source and are designated as reflecting either a cost or the benefit of using a particular source (Bowers and John, 1994). This cost-benefit demarcation is based on the attribute's presumed primary influence.

4.6.1 Availability

This attribute refers to the ready physical availability of the source to the potential user. Researchers have found that convenience of access was a basis of the physician's first choice of an information source and that costs related to accessibility appear to much more influential in the decision to use a source than are the source characteristics (Bowers and John, 1994). The evidence indicates that the greater the availability of a source, the greater the likelihood of the source being used. According to Cook (2005), availability attribute will be more effective when the professional relationships are maintained as they are the most important component in the success of the business.

Availability was defined for the respondents as an information source and is considered 'available' if it is readily available and accessible when one needs it and it does not require that one spend much time to reach or gain access to it (Bowers and John, 1994). It thus makes sense to mention that information that is availabe must remain relevant at all times. This view is supported by Cook

(2005) when he mentions that the business must frequently update profiles, providing detailed contact-to-contact relationship information and enabling continual follow-up with leveraged contacts.

4.6.2 Ease of use

Physical access to the source and access to the actual information in the source are independent dimensions. Ease of use refers to the ease with which information can be found in or obtained from a source once the source is in hand (Bowers and John, 1994). The primary objective of ease of use should be to give others an understanding and the means to solve their problems (Kouzes, 2000).

Some researchers have concluded that accessibility and ease of use are important predictors of a health-care professional's choice of and information source. Hence, sources are used in proportion to their accessibility and ease of use (Bowers and John, 1994). According to Misner (2002), ease of use, doesn't have to be traumatic, frightening or a waste of time because when managed properly, it can make a difference to the amount of business that is received. Thus, when the right approach is used, wealth of resources and contacts can be built up and this will contribute to the success of a business.

Other researchers found that an individual's preference for a specific information source is more likely to correspond to his or her estimate of the ease of using the source than to an estimate of the amount of information expected from the source (Bowers and John, 1994). In such cases it would be useful to find out the preferences and expectations of target individuals as far as ease of use is concerned.

In addition to information being easily obtained from the source, the information also must be easy to understand. This is particularly relevant, since information sources differ in the organisation and clarity of their information.

Difficulty in understanding the information contained in the information contained in the source places heavy time and energy costs on the medical doctor and decreases the likelihood of the source being used. To solve this problem, Misner (2003) recommends that visibility and credibility must be given priority. In other words the specialists must communicate well and listen well.

4.6.3 Informativeness

The informativeness attribute refers to the breadth, extensiveness, and quality of the information contained in or provided by, the source (Bowers et al., 1994). In general, the more information a source contains the more the medical doctor can benefit from the source and thus the greater the likelihood of its use. Fundamentally, the source must indicate who the specialist is, what services, he/she can provide and how he/she can be accessed (Silver, 2004).

4.6.4 Credibility

Studies of source credibility have shown that individuals often choose information because of the trustworthiness of the source rather than its expertise, and that the reliability (credibility) of a source was an important determinant of the source's use (Bowers and John, 1994). This is important to note because trust does not just happen, it must be nurtured. Trust grows stronger with experience and familiarity and results in commitment (Misner, 2003).

Credibility is the quality of being reliable and worthy of confidence (Misner, 2003). Since credibility is an essential attribute, it must be strengthened. Credibility is strengthened for example, when appointments are kept, promises are acted upon, facts are verified and services are rendered. Failure to live up to expectations can kill a business.

4.6.5 Relevance

An information source is considered relevant if one of more of its domains of information has a close and logical relationship to the decision under consideration (Bowers and John, 1994). The domain of information is situation-specific that is, even though a source might contain a vast amount of information, only a portion of the information may be relevant to the decision at hand.

The ideal source of information would be one that is readily available, easy to use and understand, credible, and providing a wide range of information relevant to the decision to be made (Bowers and John, 1994). However, information sources vary widely regarding these attributes, and choices must be made. Because of this fact, it is important to communicate with clients to ensure that relevance is maintained. To do this, LaPlante-Dube (2004) says that clients must constantly be asked what problems they are trying to solve, how able is the business in solving problems and what services they think should be included to help them with their problems.

4.7 Cost-Benefit Model for Sources Selection

The following section is discussed according to Bowers and John. (1994):

Information seeking and selection among information sources is a recurring decision for practising physicians. Source selection can be conceptualised as involving costs and benefits to the physician, with a given source having both costs and benefits associated with its use.

The concept of a cost-benefit base to information seeking is drawn from economic theory, and the basic premise is that a person will seek information as long as the benefits derived from the information outweigh the cost of acquiring the information (Bowers and John. 1994).The decision of where to seek information can be viewed as balancing the costs of obtaining the information with the potential benefits to be derived from the information.

This process represents a compromise between two conflicting goals: obtaining information that will reduce uncertainty, and a resistance to expenditure of time, effort, or money needed to obtain the information.

A model to explain external information source selection by medical doctors holds that information-search behaviour is a function of the availability of the information, the ability to use the information based on effort, and the usefulness of the information.

The Beach and Mitchell model posits that the process of selecting a strategy from among a repertoire of strategies is viewed as a cost-benefit analysis in which the decision maker selects a strategy expected to provide the maximum net benefit (Bowers and John, 1994). Strategy selection is contingent upon a cost-benefit

compromise between the decision maker's desire to make a correct decision and the negative feelings about investing time and effort in the decision-making process.

The expected value of an information source results from a trade-off between the perceived benefits of obtaining information from the source and the perceived costs of obtaining the information. The costs and benefits of a particular source are reflected, though the attribute is postulated to reflect either cost or a benefit of using the source.

Source attributes can be demarcated as either a cost or a benefit. In this context, a cost can be defined as a resource which the information seeker would have to expend in order to use the source; costs are incurred before information can be obtained from the source. A benefit can be defined as the utility derived from using the source and occurs during and after source usage. Furthermore, the evidence indicates that the costs are more significant in determining the use of a source than the benefits.

The significance of costs in the decision to use a source as compared to the potential benefits, is to be derived from its use. Furthermore, individuals tend to place great emphasis on avoiding expenditure necessary to utilizing a source, in contrast to benefits derived from source use.

4.8 POSITIONING THE HOSPITAL TO TARGET THE REFERRING GENERAL PRACTITIONERS

Because of increasing competition, hospitals need to adapt or risk losing patients. According to Javalgi et al. (1995), it is vital for hospitals to engage in creative marketing which implies the following: identifying market opportunities,

selecting target markets, understanding buying motives, understanding decision-making styles and developing programmes to serve those markets effectively. In this instance positioning needs to be considered as it will build and maintain a distinctive image in the mind of the GP.

4.8.1 Marketing programmes

Hospitals and specialists rely on referrals from the GP's for patient volume. The GP's initiate or authorize a referral when a patient needs special care from a hospital or from the specialist. In other words referrals generate new patients, build revenue, and enhance the hospital's reputation. Referrals from the GP's therefore play a vital and strategic role in ensuring the survival and growth of the hospitals (Javalgi et al., 1995). Hence understanding referring GP's perceptions of the hospitals to which he/she can refer is critical to the development of effective marketing programs.

Javalgi et al. (1995) identified evidence that suggests that the GP is important to the hospitals for at least three major reasons :

- GP's decide the length of the patient's hospital stay
- GP's decide whether to admit their patients to a particular hospital based on past experiences and perceptions of the hospital and its offerings
- GP's decision to admit patients to a hospital affect that hospital's cost per patient-day

The evidence above indicates that the GP remains a key buying influence in consumers' selections of many health-care providers. It is thus important for hospital marketers to identify their target GP markets carefully, and understand GP's attitudes, perceptions and preferences before developing and implementing marketing programmes.

4.8.2 Marketing position of a hospital

GP's draw conclusions about a hospital's overall image from impressions they have formed about the strengths and weaknesses of its offerings and these images are formed from past experiences, word of mouth and marketing communications. For example, attitudes about a hospital and its attributes are formed from objective cues (e.g. availability of a specific treatment) as well as subjective cues (e.g. perceived quality of care) and are perceptually connected to the attitude object, the hospital (Javalgi et al. 1995).

4.8.2.1 Formulating the marketing strategy

An important decision in formulating marketing strategy aimed at a referring GP is the design of effective communications programmes that stress the hospital's distinctive specialties. Javalgi et al. (1995) point out that in using marketing communications (e.g. advertising, publicity, personal or telephone contact), the hospital manager must attempt to reach current and prospective referring GP's with information about the hospital's new and existing offerings and about the hospital's special strengths. Therefore in order to attract GP's into new markets or ones who have not made referrals in the past, the hospital must promote its strengths or competitive advantages in credible public relations campaigns and regular promotions programmes. For example, informing the referring GPs about newly appointed, nationally-reputed specialists will enhance the hospital's credibility as a referral center. These efforts can help to attract new referring GP's and further strengthen the loyalty of the hospital's existing GP base.

4.8.2.2 Differentiation strategy

A differentiation strategy refers to how a business is set apart from its competitors (Knight, 2004). In other words this strategy will help the hospital to

attract and keep more customers than the competition. Hospitals can be differentiated by the quality and reputation of the medical staff, availability of quality equipment and technology, and the reputation of the selected specialties. Javalgie et al. (1995) point out that a hospital should not just be one of many facilities but should rather aim to position itself to be associated positively and vividly with its strongest offerings. To successfully differentiate itself, the hospital needs to study the needs and behaviour of its clients, learn what they consider to be important, what is valuable to them and what they are willing to pay for (Thompson and Strickerlan, p 147, 1996). When this is achieved, the hospital will have a competitive advantage.

4.8.2.3 Defensive strategy

Defensive strategy can help the hospital to lower the risk attack and also weaken the impact of its competitors (Thompson and Stickerland, 1999:168). In other words the hospital will be able to maintain its position in the market. As part of the defensive strategy, significant internal restructuring and cost control are pursued along with collaboration with other similar size nearby hospitals (Godiwalla and Godiwalla 2002). This would mean that each hospital needs to evaluate the cost/benefits of each service and then determine the service it would give up so that the other hospital could retain and receive the patients from the first hospital. Godiwalla and Godiwalla (2002) suggest that services which require expensive equipment and staff but which have fewer patients should be disbanded in favour of those services which require less expensive equipment and staff but which enjoy more patients. Such a strategy would enable the service not only to break even but also to provide a contribution to the hospital's profits. Such an economic analysis between cooperating hospitals can lead to better chance of survival. As part of their research, Godiwalla and Godiwalla (2002) found that the elimination of duplicate and unprofitable services within a group of affiliated hospitals has resulted in more efficient use of

resources among the group hospitals. Such elimination can thus reduce the unnecessary economic burden on hospitals. Hence a thorough analysis of organizational internal and external environments is essential when formulating organizational strategies. The defensive strategy can help the hospital to remain competitive. Through the defensive strategy, the hospital will make it less attractive or prohibitive for the competition to attack, by raising the entry barriers (Madras Management Group, 2002). When the entry barrier is high, the profits will be less for the competitor.

4.8.2.4 Concentration strategy

Hospitals need to identify a manageable number of services which are in great demand and can be delivered effectively and profitably by integrating strategy and systems in order to successful. To help the hospital attain this goal, Godiwalla and Godiwalla (2002), identified the sequence of questions for the formulation process which need to be addressed as the following:

- Analysis of target market segments
- How does each segment define "good service"
- What activities and resources are needed to deliver "good service"? What are different characteristics, elements and activities of "good service"? How do the employees perceive the good service and the prospective methods to deliver them? Define "good service" as evaluated by different segments
- Can the "good service" be delivered in a cost-efficient manner? Through mass standardization, quality control, controlling supply or demand, farming out certain unimportant services.
- How can the hospital people's professional pride, dignity and development be enhanced? What extrinsic rewards are valued most by the hospital staff?
- Can structural reorganization enhance a better match between hospital units or departments and their respective patient groups or market segments? Are

the characteristics of the market segments (or patient groups) properly analyzed and adequately used in the formulation of strategies?

- Are all the strategies and activities properly synthesized or integrated?
- Do the hospital staff and supervisors communicate adequately with each other in the development of integrative methods so that the patients receive good service and the early identification of latent problems which helps to avert these problems?
- What are the long-term competitive strategies of the hospital? What are the significant activities of the hospital as judged by the patient groups and as evaluated for technical sophistication and effectiveness by peer hospitals?
- The current and desired areas of excellence must first be evaluated to determine if there is a growing market for them. If there is anticipated growth in certain market segments the hospital may then pursue the expansion of services in those areas.

These questions will help give competitive advantage for the hospital

4.8.2.5 Cooperative strategy

In cooperative strategy, hospitals cooperate with each other through combining their resources and services. Godiwalla and Godiwalla (2002) note that individual institutions are not able to pursue services very effectively individually for a variety of reasons, particularly the economic reasons and it is competitively more advantageous for two hospitals to combine their resources. It would then be appropriate for multiple hospital chains to pursue this strategy if they are nearby and this would further strengthen their specific services. This would ensure the survival and competitive enhancement of the hospitals' services. Godiwalla and Godiwalla (2002) raise the importance of realizing that these strategies are similar to defensive strategies, with the important exception that these are aggressive, and not defensive in nature.

The hospital can also facilitate its entry into the global market through cooperate relationships. This is due to the advantage that cooperative relationships provide potential access to resources and capabilities that the hospital may not possess (Kendal et al., 2000). Again, a cooperative strategy provides the hospital an economic and flexible means to cope successfully with greater levels of market turbulence and uncertainty (Kendal et al., 2000). Therefore, the cooperative strategy is necessary because it can help the hospital gain access to the resources which permit it to enter other markets where it could not do so alone.

4.9 ESTABLISHING NETWORKING PROGRAMS

The challenge facing hospitals is to build creative and ongoing programmes that promote physician bonding and loyalty. Javalgi et al. (1995) mention that the stronger the perceived image of the hospital and its offerings, the easier it is to establish networking programmes and relationships with the referring GP market. It is particularly crucial to network with the referring GPs because patients do not deem it important to choose the specialist; they are more comfortable with the reference which the GP makes. This point of view is supported by the research findings conducted by Amyx et al. (2000), in mentioning that freedom to choose a specialist is not as important to patients as was originally thought. Again it is widely assumed that general practitioners consider the medical, technical quality of the service delivery as the most important service aspect; as it is easier for them to judge medical technical quality than it is for patients, one could expect this aspect to be decisive in the selection of hospitals and specialists (Boonekamp, 1994). To strengthen the relationship with the GP's, steps should be taken to ensure that everyone is familiar with all the services available and that the specialists relate well with the GP's. Boonekamp (1994) adds that several studies have shown that GPs' preferences are also influenced by their (personal) relationships with the specialists. For GP's, personal contacts with the

specialists are a means for creating mutual understanding of and consensus for the division of tasks, which are the prerequisites for the continuation of the referral relationship. It means that when a GP and specialist's professional relationship reaches a level where it becomes a personal relationship, the recommendations from such a GP will increase. Compensating GP's for referrals will strengthen his/her relationship with the specialist and this will lead to a steady stream of referrals which is the lifeblood of any successful small business (Donlin, 2001). Hence communication and respect are the conditions in the referral-based relationships with the GPs.

Taking advantage of the interdependencies in the network is another option for the organization to create possibilities to serve the market in a better way. This can be done by means of attractive contracts with suppliers and financiers, joint ventures with competitors and vertical integration (Boonekamp, 1994). In order to activate the network, it must be seen to it that no one contacts a practice without ascertaining how that person knew about the firm. The way referrals are handled will solidify relationships with sources or networks (Gordon, 2002). When this is achieved, it can be used to determine whether any particular marketing tool – brochures, media advertising, newsletters, etc. – is working; and when this occurs through a reference, this must trigger immediate action should be trippered (Wilson, 1994). After all, what matters most is cultivating current customers or clients and creating an ongoing programme to generate referrals (Gordon, 2002).

It is clear that the referral system is one of the most important practice development tools available to all professions. Maister (2002) identified the steps to be taken to establish a strong referral system as the following:

- Identify sources of referrals
- Acknowledge the recommendation to the referrer (with patient's permission)
- Offer reciprocation where appropriate

- Compile a centralized list of referrers
- Circulate the list and dossiers internally and check who uses it at frequent intervals, how it is used, how often it is used and why it is used
- Keep referrers (with clients' permission) informed of progress
- Establish reasons for referral

When the above-mentioned steps are implemented, a strong referral system will result. However, a higher value should be placed on maintaining and preserving the relationship among network members than on the outcomes pertaining to whether referrals were generated (Maister, 2002).

4.9.1 CPD programs

The presenters of CPD lectures may be specialists from the hospital's staff or may be someone with a regional or national reputation. The specialist then shares his or her latest findings with an audience composed of referring GP's which are invited by the hospital. Because of the nature of CPD programmes, they can be used to create and to reinforce the image and reputation of the hospital (Javalgi et al., 1995). Image and reputation are things that are not clearly on the surface. Thus the secret is getting customers to see the invisible feature (Lindy, 2002). When, in a CPD meeting, a GP spots a favourite feature he responds positively to the specialist. As a result, the GP will relate to the service of the specialist personally because the specialist understands his/her observations (Lindy, 2002). The response of the specialist is thus critical. By being where the GP is, listening and acknowledging, fully participating in a conversation, in other words, when the specialist is himself/herself, he/she will be facilitating the flow of common ideas.

The sponsorship of such programmes by referral centres can strengthen the bonds between the centre and its referring physicians. According to Javalgi (1995), this is made possible by the fact that the participating GP's are expected to earn a certain number of CPD credits annually.

The personal contacts between referring GP's and the referral centre can strengthen the ties that make for a successful and satisfying referral network. This is made possible when the GP's learn about new techniques by exercising them under the supervision and guidance of an expert at the hospital. This enhances valuable experiences for both the instructor and the "student" (Javalgi, 1995). Specialists need to keep in mind that one of the best services that can be given to GP's is to solve their problems. The specialist must look at every aspect of his/her service through the eyes of the GP and to further improve their services they must solve the GP's problems before they even know they have a problem (Lindy, 2002).

4.9.2 Articles

Articles are one way of ensuring that the specialists are exposed to the referring GP's. According to Ferguson (1996), it is therefore vital that articles be written not to demonstrate the professional's specific expertise but to demonstrate clearly, in the terminology of the industry, their understanding and application of that expertise. The article must therefore be well written to the specific relevant audience (the target market). Ferguson (1996) suggests that the hospital has to find ways of ensuring that the specialists' article is read by his/her target clients.

4.9.3 Conferences

Conference speaking carries a high level of credibility and commands respect, particularly if the speaker is well informed. There are ways that a speaking

engagement can be turned into an opportunity to follow up and encourage the target client to desire a meeting with the speaker. Ferguson (1996) mentions that one way to attract the client is to get the speaker not to give too much information away at the event. When not too much information is given, then the audience feels that the event was worthwhile and will also be motivated to ask more questions and understand the content. Ferguson (1996) also says that when the speaker keeps something back, then he/she can:

- Send the material to clients afterwards. This provides an opportunity to make contact and to check that they have received the information. This allows for further dialogue which could develop a better understanding of the potential client's requirements
- If they show an interest in the event, explain that there is more material available and arrange a meeting to deliver the material and discuss their interest further.

4.9.4 Seminars

Seminars provide an opportunity to focus on issues which are of particular relevance to clients and simultaneously demonstrate their authority, knowledge and expertise. According to Ferguson (1996), face-to-face contact with existing potential clients in a focused environment can be extremely effective in building and reinforcing relationships. This will help make these types of events appropriate and productive business development tools for professional institutions. Furthermore, no matter how interesting and pertinent the seminar may be, without clear marketing objectives and procedures, important opportunities will be missed (Ferguson, 1996). It is thus clear that management has to invest considerable amounts of time, planning and money to ensure that their marketing objectives are attained.

4.10 SUMMARY

Referral networking can play a role in generating referrals. However, communication must be a priority, awareness of what a specialist is skilled at must be clarified and various marketing strategies need to be implemented in order to achieve this goal. CPD lectures present a strategic marketing opportunity for the hospital and the specialists. In the process of conducting these lectures the ethics must be maintained to avoid any side tracking. Specialists need to work closely and jointly with the GP's because GP's value this. The sources that provide information must be available, easy to use, informative, relevant and credible. In order for the hospital to gain more referrals it must formulate a marketing strategy that will ensure that it gains competitive advantage. The strategies include: differentiation strategy, defensive strategy, concentration strategy and cooperative strategy. Articles, conferences and seminars can also be utilized as networking opportunities.

CHAPTER FIVE

DATA ANALYSIS AND FINDINGS

5.1 INTRODUCTION

Chapter one to four examined the theoretical framework of the CPD lecture concept, and the role of marketing and referrals with regards to networking. In this chapter, the principles which were examined in previous chapters will be adapted for an empirical study concerning CPD lectures. The study focuses on the role of CPD on referrals with specific reference to the marketing approach. The ideal way to evaluate the influence of CPD on referrals is to evaluate the perceptions of both the specialists and the GP's and various factors that might influence them when making referrals. A detailed analysis of the findings will be presented with numerical tabulations and graphical representations.

Firstly a frequency analysis on each of the questionnaires was conducted. This was particularly relevant in identifying what the perceptions of medical doctors are, what influences referrals in each of the two cases, etc. The findings of the statistically significant relationships are depicted in tables with corresponding interpretations. The frequency analysis of the GP's will be discussed first, followed by those of the specialists.

5.2 DESCRIPTIVE DATA OF GP'S

5.2.1 Demographic analysis of the GP's

The age interval for the GP's younger than 30 years was 10.3%, 30 – 39 years was 30.9%, 40 – 49 years was 27.9% and 50 and older was 30.9%. The

majority of the respondents in this section were between the age of 30-39 and 50 years and older. The duration in practice for 1 – 5 years was 17.6%, 6 – 10 years was 16.2%, 11 – 15 years was 17.6% and 16 and more was 48.5%. Those who had been in practice for 16 years and longer were in the majority and those who practised for 6 years to 10 years were in the minority. Of all the respondents, 51.5% were in sole practice, 45.6% were in partnership and 2.9% did not respond. The results also indicated that the majority of the respondents were from the rural areas (54.4%) and the minority was from the city (45.6%).

5.2.2 Analysis of GP's on attendance of CPD Lectures

Most of the GP's (70.60%) said that they are regular attendants of the CPD lectures. Figure 1.1 indicates these findings.

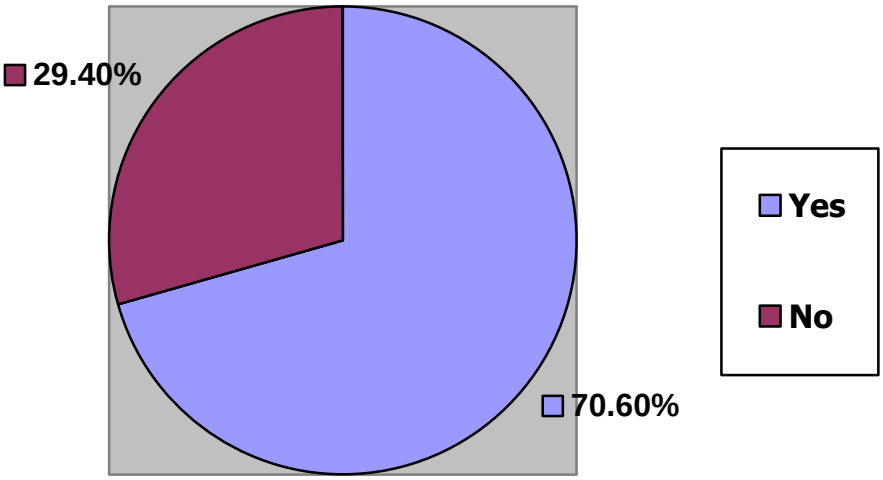

Figure 5.1 Regular attendance of CPD lectures

Since most GP's are regular attendants of the CPD lectures, this implies that there are more opportunities that the marketers and specialists can utilise to influence the GP's positively to generate referrals that the presenting specialists can receive. Those who are not regular attendants of the CPD lectures had

various reasons for non attendance. These included unsuitable times of the lectures (11.3%), travelling (19.6%), poor communication of opportunities to attend (4.1%), lack of quality of events (6.2%), lack of motivation (2.1%), other commitments (10.3%) and other reasons (8.2%). Of those who are not regular attendants, 33% of them did not respond. In general the attendance of GP's is high (70.6%). These findings indicate that the organizers must come up with ways to accommodate the minority that are not able to attend.

5.2.3 Analysis of change in perception

When asked if their perception of CPD lectures changed since the introduction of CPD, 57.4% said that it has changed and 42.2% said that it has not changed. Of those who said that their perception changed, 78% said that the change was positive, 14.6% said that it was negative and 7.3% were uncertain. It is thus clear that most of the GPs whose perception changed, changed positively (78%). Since most of the change in perception was positive, it means that there is a strategic opportunity which needs to be harnessed. For example the marketers can identify those whose views have changed positively and get them to communicate their views to other GP's whose views have not yet changed or those whose views are negative.

It appeared that the GP's valued the knowledge of the specialist most during the CPD lecture and the aspect of relevance to topics covered was not of crucial importance to the GP's. Since the attribute of knowing the specialist is important during the presentation of a CPD lecture, the introduction of the presentation should be an opportunity where the specialist markets himself/herself through making himself/herself more known to the GP's. The GP's did not find the topic to be either important or relevant. It is thus advisable to include the GP's views on the topic before the presentation. This will ensure that the GP's can identify

with what is being presented. The referral value during the CPD lectures was moderate. Table 5.1 indicates these results.

Table 5.1 The perceived value of CPD lectures

	Poor				Excellent
Academic value	4.8%	3%	29.9%	44.8%	22.4%
Social interpersonal Value	4.5%	10.4%	44.8%	29.9%	10.4%
Referral value	6.1%	10.6%	43.9%	31.8%	7.6%
Knowledge of the specialist	3%	7.5%	14.9%	50.7%	23.9%
Relevance to topics covered	16.7%	22.7%	51.5%	9.1%	0%

5.2.4 Analysis of issues when referring

Figure 5.2 indicates that the issue of whether to refer and when to refer was the most important. When looking at issues involved when referring, the issue of whom to refer to was the least rated. This is indicated in figure 5.2 below

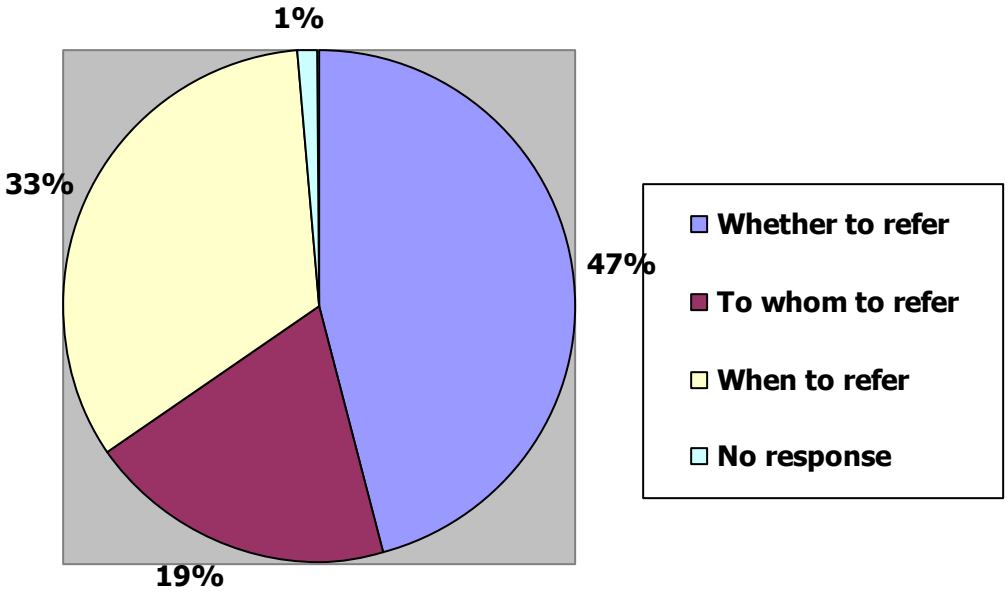

Figure 5.2 Issues when referring

When referring to the specialist, CPD involvement of the specialist was not important to the GP's (55.9% said that it was not important) and generation of reciprocal referrals was also considered to be unimportant (50% said that it was not important). CPD involvement of specialists is not viewed as being crucial. However, the specialist's involvement in CPD can be made to be viewed as being crucial if the lecture can also be approached from a marketing perspective and not just from an academic perspective. In other words, one of the specialist's objectives should be to influence the GP's positively. The most important attribute to the specialists when referring were the specialist related-characteristics (69.1) and professional and community involment of the specialist (41.8%). Once more, it is evidenced that the GP's value knowing in the specialist and in this instance, his involvement in the community, is important.

The general practitioners also indicated that their final decisions to refer were influenced mostly by the availability of specialists' list of hospital (84.7%), referral due to custom (68.7%), specialists' involvement with specific hospital (57.4%) and patients' choice (55.2%). Clearly when the GP decides to refer the

availability of specialists' list of hospital is the most vital factor. Since specialists' list is important, it must be updated regularly. Hospitals which are valued by GP's must be identified and marketing activities should also target the patients since the patients also communicate with the GP's and hence they also influence them.

The factors which least influenced the GP when deciding to refer, included the CPD lecture presented by the specialist (77.9%), feedback from specialist (57.4%) and the qualifications of the specialist (56.1%). As mentioned above this could be due to the fact that CPD lectures are presented only from an academic perspective and not a marketing perspective.

The most important sources of information to the GP when making a referral are opinion of patient request and opinion of colleagues. The least important sources of information included; act of CPD presenter, writer of medical articles and hospital brochures. In this instance the specialists who receive referrals from GP's must see to it that they promote good relationships between the GP's and patients. This will play a role when the GP of concern communicates with his/her colleagues and also with patients. Table 5.2 indicates these results.

Table 5.2 Sources of information

	1=not important	2=important	3=very important
Opinion of colleague	13.2	66.2	20.6
Opinion of patient request	10.4	55.2	34.3
Act of CPD presenter	48.5	44.1	7.4
Hospital brochure	70.1	26.9	3
Writer of medical articles	49.3	44.8	6

The choice of the GP when referring patients to a particular hospital is influenced by factors indicated in Figure 5.3

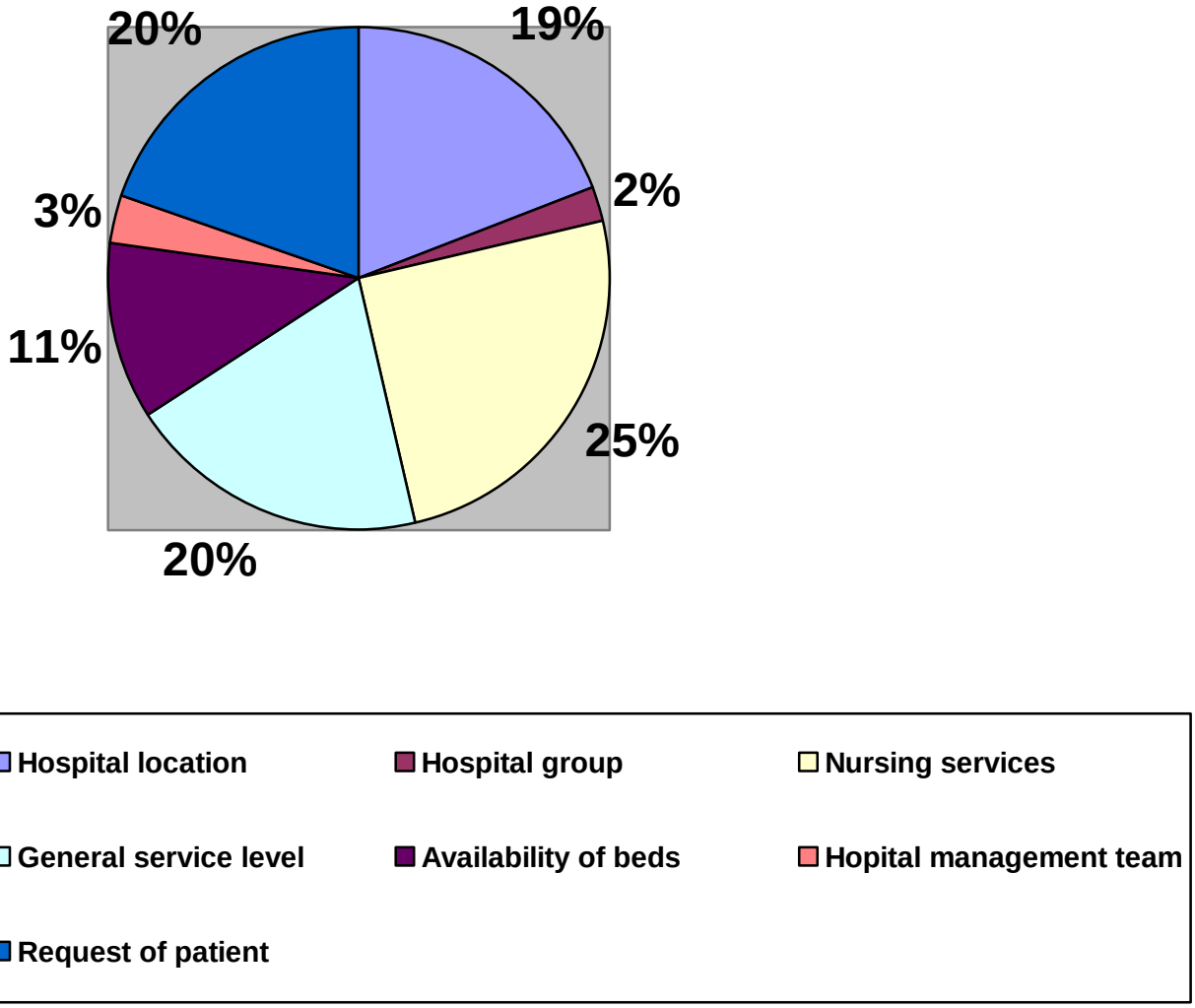

Figure 5.3 Factors influencing the GP when deciding on the hospital to refer to

From figure 5.3 it is clear that the requests of patients and the locality of the hospital have the most influence on the GP when referring to a hospital. This is because a patient wants to be more comfortable with the practitioner by whom

he/she wants to be treated and things are made easier when the hospital is easily accessible. The hospital group and hospital management were least important. When deciding upon the specialist to refer to, the factors which emerged as important were the following:

- the patient should receive the best treatment(98.5%)
- communication from the specialist should be prompt and clear(88.2%)
- referral process should be easy and convenient(77.9%)
- the patient be returned for continuing care(77.9%)
- patient must be satisfied(94.1%)

It will serve to the advantage of the specialist to communicate during the CPD lectures that the above-mentioned factors will be attended to, and will perhaps also include a report of successful events in this regard.

Furthermore 95.5% of the GP's said that the medical skills of the specialist are very important when considering referral to a specialist. Other factors which were important to the GP's when considering referring a patient to a specialist included positive experiences from past referrals (92.5%), availability of specialist for consultation (77.6%) and feedback on patient (89.6%). The factors which were least important to the GP's when considering a referral were the medical school from which the specialist graduated (72.7%), brochures (68.2%) and CPD lectures given on a specific topic (55.2%). Positive experiences must be constantly recorded and updated because this will assure the GPs that they made and continue to make the right decisions when referring to the particular specialist concerned. Furthermore the specialists need to commit to making time to give feedback to the GP's on patient progress. They must also encourage the patients to communicate with their GP's.

5.2.5 Analysis of sources of referrals

When looking at the sources of referrals, certain factors are important to the GP's, and these factors are indicated in table 5.3

Table 5.3 Sources of referrals

	1= not important	2= important	3= very important
Availability of referral information	13.4%	55.2%	31.3%
Ease of use of information	14.9%	50.7%	34.3%
Informativeness of the source	17.9%	40.3%	41.8%
Credibility of the source of information	11.9%	41.8%	46.3%
Relevance of the source of information	11.9%	47.8%	40.3%

According to table 1.3, 41.8% of the GP's said that the informativeness of the source is very important, 46.3% of them also indicated that the credibility of the source of information is very important and 40.3% pointed out that the relevance of the source of information is of crucial importance. The source that will be considered by the GP's must have sufficient and relevant information, be credible and relevant. Marketers must see to it that the sources used have these attributes. Availability of referral information was rated second (i.e important) by 55.2% of the GP's. Ease of use of information was also rated second by 50.7% of the GP's. Clearly credibility of the source is most favoured by the GP's.

Most of the GP's(48.4%) were not sure if the presentation of CPD lectures by a specific specialist influenced their referral pattern. 27.9% said that their referral patterns were not at all influenced by the CPD lectures and 23.5% said that their referral patterns were definitely influenced by the CPD lecture. This implies that more work must still be done to influence referral patterns of the GP's. This

further stresses how important it is to make sure that the sources of information have necessary attributes such as positive experiences and giving patient feedback.

5.2.6 Future needs

The GP's also wanted the CPD to cover some categories. 20.6% said that the lecture should cover clinical issues, 7.4% said ethics should feature and 72.1 indicated that all categories should be covered. These findings indicate that further research must be conducted to identify what other needs still need to addressed.

5.3 DESCRIPTIVE DATA OF SPECIALISTS

5.3.1 DEMOGRAPHIC ANALYSIS OF SPECIALISTS

The results from the questionnaires that were sent to the specialists indicated that there were no specialists who were younger than 30, those who were between the ages of 30 – 39 constituted 30%, those who are 40 – 49 years constituted 25% and finally those who were 50 years and above constituted 45%. Table 5.4 indicates the length of time that the specialists spent in practice. The majority of the specialists (50%) had been in practice for 16years and longer and 10% had been practising for between 6 and 10 years.

Table 5.4 Length of time spent by the specialist in practice.

Number of years	Percentage
1 – 5 years	20%
6 – 10 years	10%
11 – 15 years	20%
16 and more	50%

Of the total respondents, 75% are in sole practice and 25% are in partnership. Of those who are in partnership, 14.3% have one partner, 28.6% have two partners, 14.3% have three partners and 28.6% have four partners. It is clear that the majority of the specialists have not embarked very frequently on partnerships. From research it is clear that when specialists engage more with partnerships, there is a positive bearing on referrals they receive. 90% of the respondents were from the city and 10% were from the rural areas. With the GP's, 45.6% were from the city and 54.4% were from the rural area. This indicates that the rural areas have a limited number of specialists but the number of GP's is sufficient. The specialists who are in town, must make time in their schedules to consult in rural areas as this will lead to generation of referrals since they will be closer to patients. It will also be comfortable for a patient to go to a specialist he/she knows.

5.3.2 ANALYSIS OF SPECIALISTS ON CPD LECTURES (PRESENTATIONS) AND REFERRALS

More than half of the respondents (55%) presented the CPD lectures regularly and 45% did not present these lectures regularly. This implies that the specialists have more opportunities, not just to present these lectures but to market their services as well. The specialists who did not present the CPD lectures regularly had the following reasons for their lack of regular presentation:

- lack of time

- problems to travel
- poor communication of opportunities to present
- lack of quality of events
- lack of motivation
- other commitments
- other reasons

The reason that most prevented the specialists from attending the lectures were lack of time and other commitments. The organizers have a role to play in ensuring that the specialists who want to present the lectures are accommodated.

5.3.3 The influence of CPD lectures on referrals

The results also showed that the CPD presentation did have an effect, to a certain extent, on the number of referrals which the specialists received. Figure 5.4 indicates these findings.

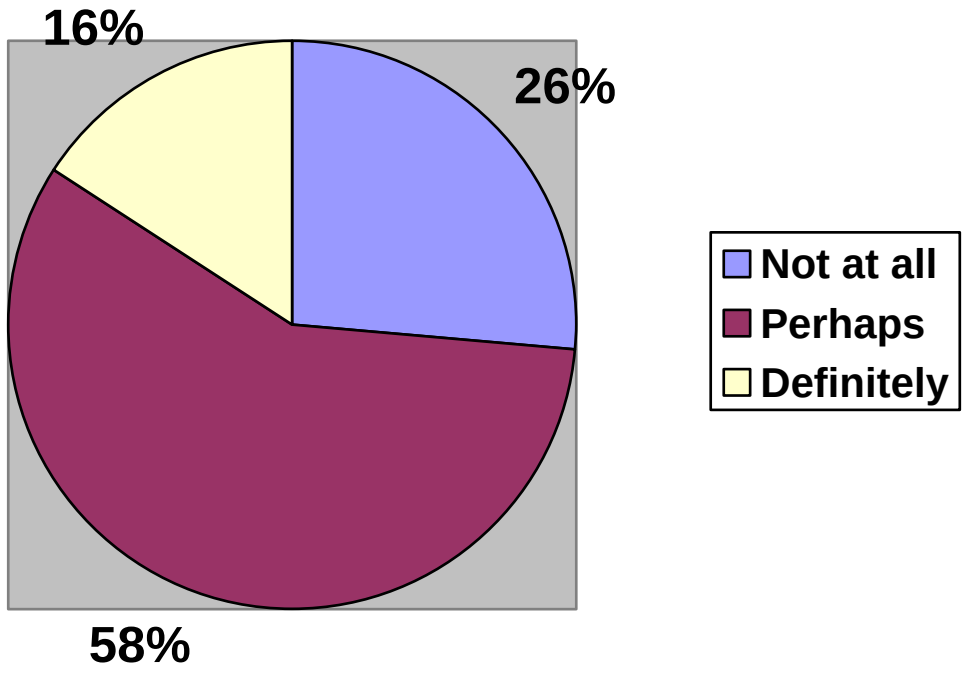

Figure 5.4 The impact of CPD lectures on the number of referrals received

From figure 5.4 it is clear that CPD lectures definitely influenced 16% of the referrals received by the specialist, 26% was definitely not influenced and perhaps 58% was influenced. This means that 58% is the potential area. As mentioned in chapter one, the concept of CPD lectures is fairly new in South Africa. However 16% of referrals to specialists is due to CPD and 58% could be because of CPD lectures. This shows that if CPD lectures can be approached form a marketing perspective, over a period of time the referrals to the presenters of CPD could increase. Those referrals which were influenced by the CPD lectures were due to the topic which was covered, (38.5%) was due to the CPD lecture, 30.8% was not due to the topic covered and 30.8% was a combination, i.e. some came as a result of topics covered and others came because the specialist is a presenter of these courses. It will be useful to consult the GP's on the topics to be covered and the manner and approach that will be

utilized to deliver the lecture. This can play a role in influencing the perceptions positively.

Again 26.3% of the specialists said that the presentation of the CPD lectures lead to an increase of referrals and 73.7% said that there was no increase as a result of CPD lectures. Hence the necessary changes must be implemented accordingly and time must be allocated to see if these changes contribute towards the increase of referrals. Although there was no increase, 70% of the GP's said that their perception of these lectures has changed and out of those whose perception has changed, 78.6% of them said that it has changed positively. It was also clear that most of the GP's received most of the referrals from the GP's in general (26.3%), the GP's who attended their CPD lectures (21.1%) and specialist colleagues (26.3%). The fewest referrals were from the patients (33.3% of the specialists indicated that referrals of this type were very poor) themselves and other specialists who attended the CPD lectures (21.1% of the specialists indicated that referrals of this type were very poor).

5.3.4 Future needs

In the last category of the questionnaire the specialists were asked which types of categories they prefer to present. 80% of the specialists want the CPD lectures to cover the clinical issues, 10% want non-clinical issues and 10% want all categories to be covered. Although most of the specialists want categories to cover clinical issues, they need to consider that GP's want other categories to be covered. Catering for the needs of GP's during the CPD lectures can serve as a strategic move.

5.4 DETERMINATION OF RELATIONSHIPS BETWEEN DEFFERENT VARIABLES

5.4.1 Relationship between GP attendance and various characteristics

From the questionnaire that was assigned to the general practitioner, the question on whether the general practitioner is a regular attendant of the CPD lectures was cross tabulated with the question that asked the GP to rate the following characteristics in order of importance:

- Patient-related characteristics
- Specialist-related characteristics
- Professional and community involvement of specialist
- CPD involvement of specialist
- Generation of reciprocal referrals

The findings indicated that there was no significant relationship between a GP's attendance and patient-related characteristics on a 95% confidence level. This is because the chi-square value was 0.637 and the probability value was 0.727 which is higher than 0.05 ($p = 0.727 \geq 0.05$). This indicates that the patient-related characteristics do not have an influence on whether the GP will or will not attend the CPD lectures. The cross tabulation between attendance and specialist-related characteristics also indicated that there is no significant relationship on a 95% confidence level. The findings indicate that the characteristics of the specialists don't influence the GP when referring. The chi-square value was 1.441 and probability value was 0.487.

However the findings indicated that there was a significant relationship between attendance and professional and community involvement of specialists ($p<0.05$ on a 95% confidence level). The results are indicated in table 5.5

Table 5.5 Relationship between attendance and professional and community involvement of specialist.

	1=not important	2= important	3=very important	total
1= Yes	14	9	24	47
2= No	7	9	4	20
Total	21	18	28	67
X^2= 6.851 P = 0.03 df = 2				

During the CPD lectures the specialists must communicate their professional and community involvement since this plays a role in influencing the GPs' attendance. Furthermore, there was no significant relationship between attendance and CPD involvement of the specialist ($p = 0.445 \geq 0.05$), because the probability value was 0.445 (which is more than 0.05 on a 95% confidence level) and the chi-square value was 2.67. This means that the specialist's involvement with CPD does not have an influence on whether the GP will attend the CPD lectures. If CPD involvement of the specialist is to influence GP's attendance, then the attributes of the GP's value must be included in CPD. Again the GP's attendance did not lead to the specialist receiving reciprocal referrals from the GP's because he or she presented the lectures. This is proven by the fact that the probability value was 0.996 (which is more than 0.05 on a 95% confidence level).

5.4.2 Relationship between attendance and factors that influence GP's decisions when referring a patient to a specialist

The GP's were also asked to indicate which factors influence their decision when referring a patient to the specialist. They were asked how important each factor

was. This question was cross-tabulated with the question on whether the GP is a regular attendant of the CPD lectures. The factors that the specialists had to rate included the following:

1. Patient's choice
2. Availability of specialist
3. Availability of specialist's list of hospital
4. Locality of specialist
5. Whether the specialist will refer the patient back to the GP
6. Referral due to custom
7. Qualifications of specialist
8. Specialist's personality
9. Specialist involvement of with specific hospital
10. Medical school where specialist studied
11. CPD lecture presented by specialist
12. Feedback from specialist
13. Recency of completion of studies

The results are indicated in table 5.6

Table 5.6 Relationship between attendance and various factors that influence a GP's decision on whether to refer

	P value *	X2 value
1. Patient's choice	0.866	0.287
2. Availability of specialist	0.1	3.952
3. Availability of specialist's list of hospital	0.367	2.002
4. Locality of specialist	0.1	3.753
5. Whether the specialist will refer the patient back to the GP	0.266	2.648

6. Referral due to custom*	0.956	0.090
7. Qualifications of specialist	0.037	6.570
8. Specialist's personality	0.773	0.516
9. Specialist involvement of with specific hospital	0.983	0.034
10. Medical school where specialist studied	0.308	1.039
11. CPD lecture presented by specialist	0.611	0.986
12. Feedback from specialist	0.029	4.781
13. Recency of completion of studies	0.740	0.601

From table 5.6 it is clear that there is almost a significant relationship between attendance and availability of specialist; attendance and locality of the specialist; attendance and qualifications of the specialist and attendance and feedback from the specialist. In other words the GP's will be influenced positively to attend the CPD lectures if the specialist has time to allocate to the GP when necessary and if the specialist is easily accessible to the GP. The qualifications of the specialist must be perceived as being relevant to the GP and it is also crucial that the specialist give feedback constantly to the GP about the outcome of the referred patient. This accomplishment will motivate the GP's when attending the CPD lectures.

5.4.3 Relationship between attendance and various sources of information

The findings also indicated that there was no significant influence between the various sources of information and attendance. The chi-square value of 1.821 and the probability value of 0.402 were attained for attendance and the opinion of colleagues. From these findings, it is therefore clear that there is no significant influence (on a 95% confidence level) between attendance and the opinion of

* (on a 90% confidence level)

colleagues. Similarly there was no significant relationship between attendance and opinion of patient request (chi-square=1.077 and p=0.584 on a 95% confidence level) and between attendance and acts of CPD presenter (chi-square=0.231 and p=0.891 on a 95% confidence level). The implication of this is that the sources of information lack value as far as influence on the GPs' attendance is concerned. Sources of information do not provide the GP's with adequate information. See table 5.7.

Table 5.7 The influence of the acts of CPD presenter on the GP's attendance

	1=no influence	2=some influence	3=definite influence	total
1=Yes	23	21	4	48
2=No	10	9	1	20
total	23	30	5	68
X^2=0.231 P=0.891 df=2				

The hospital brochures also did not influence the GP's attendance (chi-square=0.984 and p=0.612 on a 95% confidence level) and nor did the writer of the medical articles (chi-square=2.834 and p=0.242 on a 95% confidence level). These results indicate that all the sources from which the GP can obtain information, do not have an influence on whether the GP will attend the CPD lectures. Sources of information must make the specialist more known to the GP, specialist list must be available and community involvement must also be communicated.

5.4.4 Relationship between attendance and referrals

The data further indicated that if the GP's who attended would be influenced to refer to the specialists who presented the CPD lectures. This was achieved when the GP's were asked to indicate their views on various factors relating to referrals. The cross tabulation showed that the GP's who attended the CPD lectures would not refer to the specialist because of his medical skills. This is because the chi-square value of 0.058 and the probability value of 0.809 ($p>0.1$ on a 90% confidence level) was obtained. There is therefore no significant relationship between attendance and the medical skills of the specialist. It was also evident that the GP's who attended the CPD lectures would refer to the specialists who presented if the specialists themselves were available for consultation. This is indicated by table 5.8.

Table 5.8 Relationship between attendance and availability for consultation

	1=not important	2=somewhat important	3=very important	total
1= Yes	1	13	34	48
2= NO	0	1	18	19
total	1	14	52	67
$X^2=4.500$ P=0.1 df=2				

From table 5.4, it is clear that there is a significant relationship between attendance and availability for consultation.

The values for the relationship between attendance and whether the specialist would send the patient back for continuing care were as follows (table 5.9):

Table 5.9 Relationship between attendance and referral of patient back to the GP for continuing care.

	1=not important	2=somewhat important	3=very important	total
1= Yes	4	11	23	48
2= No	0	9	10	19
total	4	20	43	67
X^2=4.861 P=0.088 df=2				

With a chi-square value of 4.861 and a probability of 0.08 (P<0.1 on a 90% confidence level), it is clear that there is a significant relationship between attendance and referral of a patient back to the GP for continuing care. In other words, the specialist who presents the CPD lectures must also refer the patients back to the GP's for continuing care because this factor plays an important role in whether the GP will continue to refer to the specialist concerned. In the same manner there was no significant relationship between referrals and established relationship with the specialist (Chi-square=1.071 and P=0.586 on a 90% confidence level). There was a significant relationship between the referral guides and attendance. The chi-square value was 4.772 and the probability value was 0.092 (on a 90% confidence level). From this it can be deduced that the referral guides play an important role in assisting the GP's when making referrals.

5.4.5 Relationship between specialists' presentation of CPD lectures and specialists' change in perception of CPD lectures

Cross-tabulations were also conducted on the questionnaire to the specialists. The cross-tabulations were firstly conducted to see if there was a significant relationship between the specialist's presentation of the CPD lectures and the

specialist's change in perception of the CPD lectures. The results showed that the chi-square value was 2.781 and the probability value was 0.427 ($p>0.05$ on a 95% confidence level). Therefore there is no significant relationship between the specialist's presentation of the CPD lectures and the specialist's change of perception. This shows that the fact that the specialist is the one who presents the CPD lecture does not necessarily mean that his perception of the CPD lecture will change on those bases. There was also no significant relationship between the specialist's presentation and the choice of whether to attend or present if he/she was not obligated to do so. The chi-square value was 3.673 and the probability value was 0.299 ($p>0.05$ on a 95% confidence level). This means that whether the specialist presents the CPD lecture or not, there is no relationship with whether or not he would attend or present if he was not obligated.

5.4.6 Relationship between specialists' presentation of CPD lectures and various categories

The cross tabulation was also conducted to see if the specialist presenting the CPD lectures values the following categories:

- Academic value
- Social interpersonal value
- Referral value
- Knowledge
- Relevance to topics covered

Table 5.10 indicates the findings.

Table 5.10 Relationship between specialist's presentation and various categories of CPD

	P value *	X^2 value
1. Academic value	0.945	5.365
2. Social interpersonal value	0.085	15.238
3. Referral value	0.664	4.093
4. Knowledge of the specialist	0.001	21.754
5. Relevance to topics covered	0.938	1.789

From table 5.10 it is clear that there is no significant relationship between the specialist's presentation and academic value, referral value and relevance to topics covered. This shows that the specialist does not view the presentations as being valuable in terms of academic importance and relevance. Again the presentations do not have the referral value for the specialist. However there is a significant relationship between the specialist's presentations and social interpersonal value. This indicates that the CPD lectures provide the specialist with the opportunity to socialize and get to know the attendees and whtether the specialist concerned values this attribute. There is also a significant relationship between the specialist's presentation and knowledge of other specialists (as indicated in table 5.10). It is thus clear that the specialists value the opportunity of social contacts. This is crucial for referral networks. When networking and referring the GP's and specialists need to be confident that they are referring or networking in a relevant manner. Social contacts are important to specialists, since this gives them the opportunity to make themselves known at a personal level to their audience.

* (on a 90% confidence level)

5.4.7 Relationship between referrals received by specialist and various perceptions relating to CPD lectures

Again the cross tabulations were conducted to see if there was any significant relationship between the referrals the specialist received and the following varied factors which will be discussed. Table 5.11 indicates the findings on the relationship between the referrals received and the change in perception.

Table 5.11 Relationship between the referrals received and the change in perception of CPD lectures.

	1= Yes	2= No	total
1= positively	3	1	4
2= negatively	6	2	8
3= definitely	1	0	1
total	10	3	13
X^2=0.325 P=0.850 df=2			

Since p>0.05 (on a 95% confidence level) with a chi-square value of 0.325, there is no significant relationship between referrals received and the change in perception of CPD lectures. This is due to the fact that specialists who presented the CPD lectures did not receive more referrals as a result of their presentation (this is shown in the chapter on frequency analysis). Referrals received did not influence the specialist's perception. These results show that the CPD lectures have not had much influence regarding the increase in referrals that the specialists received.

The analysis continued to determine if a relationship exists between CPD lectures and the number of referrals received by the specialist. Table 5.11 outlines the outcome.

Table 5.11 The relationship between CPD lectures and the number of referrals received by the specialist.

	1= Yes	2= No	total
1= not at all	3	2	5
2= perhaps	2	9	11
3= definitely	1	2	3
total	6	13	19
$X^2=2.787$ P=0.248 df=2			

Since P>0.05 (on a 95% confidence level) and chi-square value of 2.787, it is acceptable to conclude that there is no significant relationship between CPD lectures and the number of referrals received by the specialist.

5.4.8 Relationship between CPD presentation and referrals

It was also crucial to determine if CPD lectures did influence the number of referrals the specialists received, and whether it would be due to the following factors:

- Academic value
- Social interpersonal value
- Referral value
- Knowledge of the specialist
- Relevance to topics covered

Table 5.12 The relationship between CPD presentation and referrals

	P value (on a 90% confidence level	X^2 value
1. Academic value	0.415	8.186
2. Social interpersonal value	0.780	3.224
3. Referral value	0.090	10.939
4. Knowledge of the specialist	0.589	1.059
5. Relevance to topics covered	0.582	2.859

Hence there is no significant relationship between the number of referrals the specialist received and academic value, social interpersonal value, knowledge of the specialist and relevance to topics covered. However there is a significant relationship between the number of referrals the specialist received and referral value. It is critical to note that in the frequency analysis the GP's said that knowing the specialist will influence them to refer to a particular specialist. There is, however, no significant relationship between the two. However, when the appropriate interventions are implemented, this view might change over time.

SUMMARY

Chapter five examined the present perception of medical doctors, their participation in CPD with special reference to referrals. The aggregated findings were determined by computing numerical tables that were illustrated graphically followed by statistical calculations in order to determine the inter-relationships

between the various dimensions of CPD. To determine the inter-relations between service dimensions the Pearson value was calculated to ascertain the statistical significance of such relationships.

The CPD programmes implemented should be reviewed. The perception towards CPD seems to have changed positively for both the GP's and the specialist but there is more room to implement relevant customer-driven marketing activities. At present it appears that GP's still rely on other sources of information other than CPD to decide on referring. However since most GP's are regular attendants of CPD lectures the presenters have exposure to this market.

There seems to be a lack of effective implementation and monitoring of marketing activities. Furthermore it is apparent that the managing of marketing activities is inadequate, especially since GP's find such activities to be irrelevant. The specialists also do not make effective use of the marketing opportunity during their presentations. However the specialists are not the only ones to play a role. If the impact and the influence of CPD is to make a difference to referrals, management of the hospital at all levels must be committed to implement strategies towards attaining and sustaining a strong customer focus. Management needs to see to it that it empowers specialists to network more effectively at the CPD events.

The last chapter will provide a summary of the previous chapters, followed by conclusions and recommendations.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The study focused essentially on the CPD lecture concept, referrals and various marketing activities, particularly in service business. It also provides a survey in this regard. This chapter serves to outline the relevant aspects for the theoretical principles of CPD as a concept and a service, a brief discussion on the findings of the empirical study, and recommendations for the hospitals and specialists in order to utilize more effectively the opportunity presented by CPD.

The key issue investigated in this study is whether the CPD lectures have a role to play in the generation of referrals for the hospital and specialists and whether there is consistency with the theoretical framework presented in the literatrure review. Results suggest that the service marketing principles are not practised during the CPD lectures. Clearly service marketing and networking principles are applicable in this regard. It became clear that the strategic approach to CPD lectures could be used effectively by specialists to differentiate themselves thereby creating a competitive advantage. Conclusions and recommendations are made for a review of the present practices in CPD. The study is subsequently examined.

6.2 SUMMARY

A preliminary study of literature pertaining to CPD and marketing highlighted the need for improving the CPD lectures for the advantage of creating referrals. A brief outline of the study is as follows:

Chapter two focused on continuous professional development (CPD). The CPD concept and the role it plays was analyzed. It became apparent that CPD plays an important role in ensuring that the medical doctors become life long learners and that they are kept up to date with information. CPD must also improve and promote competence and performance of medical doctors. This chapter also showed various ways which can be used to ensure that CPC achieves its goals.

Chapter three focused on the importance of marketing in a service business. This was done because specialists render a service to the GP's. The characteristics of the the service business were outlined. This indicated that the approach that should be used to be effective should be based on the nature of the business. Various principles on how to retain a customer were looked at. These principles can be utilized in CPD. Relationship marketing was also looked at and it showed that the aim of CPD should not just be to capture new clients but rather to maintain the existing ones.

Chapter four focused on referral networking in the medical profession. The referral process was looked at. This chapter outlined that CPD lectures are an opportunity to create referral. This can only be achieved if the specialist creates networks with the GP's through making use of the marketing approach. The specialists should not only network for the sake of making more referrals but also for mentoring and assisting the GP's where they may need help. Certain

marketing strategies which can help in building effective networks were also looked at.

Chapter five examined the current state of CPD lectures by means of an empirical study. The results obtained from twenty specialists and sixty eight GP's indicate that the CPD lectures are not the main source of influence on referral patterns in the medical profession, however CPD has a role to play. Marketing orientated approach is not utilized yet in these lectures. The results point out that the perception towards the CPD lectures has changed and this is the first step towards change. In order to improve the generation of referrals at CPD meetings and gain a competitive advantage, greater emphasis should be placed on customer oriented activities.

6.3 CONCLUSIONS OF THE STUDY

6.3.1 Findings on the GP's

6.3.1.1 Perceptions of the GP's

The results showed that the perception of the majority of the GP's has changed positively towards CPD. The GP's also value the knowledge that they receive from the specialist during the lecture. However the findings also indicated that the topics that are covered during these sessions are not relevant to the GP's who are attending. Clearly the views of the GP's are not considered. As mentioned in chapter one, CPD is a fairly new concept and as time goes on, there might be some improvements.

6.3.1.2 Referrals

The CPD involvement of the specialist did not play a significant role as far as generating referrals is concerned. What seemed to have influenced the GP's when making referrals was the specialist list and also the request of patients. The CPD lecture also did not effectively create the generation of referrals. This is due to the fact that only the academic approach is utilized. The GP's further indicated other factors that influenced them when making referrals to hospitals. These included: general service, nursing service, hospital location, hospital group, best treatment for the patient and communication with the GP on the progress of the patient that he/she referred. What also plays a role in referring is the uncomplicated nature of the referral process.

6.3.1.3 Sources of referrals

GP's utilized the sources of referrals when these reflected certain qualities which were important to them. In order for the source to be used by the GP's, it must be informative, credible, relevant and easy to use. The research also indicated that there was uncertainty regarding the question of whether the CPD lecture can be utilized as a source of information.

6.3.1.4 Needs

72.1% of the GPs indicated that they require all the categories to be covered during the CPD presentations. These categories can be identified as clinical, non-clinical and ethical. There must be a greater quantity of research conducted to expose more of the needs of the GP's because it is important that they feel accommodated in these sessions.

6.3.2 Findings on specialists

6.3.2.1 The influence of CPD lectures on referrals

Specialists indicated that 16% of the referrals they receive is due to the CPD lectures that they present. Given that CPD is a new concept, this shows that there is room for improvement. 58% were uncertain and a greater percentage of specialists did not experience an increase in referrals due to their presentation of the CPD lecture. However the majority of the perceptions of specialists about the CPD lecture had changed positively. This can be viewed as a strategic opportunity.

6.3.2.2 Needs

80% of the specialists indicated that the category they require to be covered most often is the clinical one and this is how the CPD lectures have been carried out. This is true because the specialists are the presenters and because of this they decide on the manner of approach. This is contradictory to what the GP's had to say. 72.1% of the GP's want a combination of the categories to covered.

6.3.3 Relationships between different variables

6.3.3.1 Relationship between attendance and various characteristics

There was no significant relationship between GP attendance and patient-related characteristics, specialist-related characteristics, CPD involvement of the specialist and generation of reciprocal referral. However there was a significant relationship between GP attendance and professional and community involvement of the specialist.

6.3.3.2 Relationship between attendance and factors influencing referral patterns

There was a significant relationship between attendance and availability of the specialist, qualifications of the specialist and feedback from the specialist.

6.3.3.3 Relationship between attendance and sources of information

There was no significant relationship between attendance and sources of information. The sources of information lack value as they are irrelevant. If the sources of information are viewed as being ineffective by the GP's who happen to be the ones who make referrals then the impact on the referrals is a negative one.

6.3.3.4 Relationship between attendance and referrals

There was a significant relationship between attendance and the referral of the patient back to the GP. However the was no significant relationship between referral and an established relationship with the GP. Again there was a significant relationship between attendance and referral guides.

6.4 RECOMMENDATIONS

6.4.1 Findings of the GP's

6.4.1.1 Change in perception

Since the perceptions of the GP's and specialists have changed positively toward CPD lectures, this presents a strategic opportunity for both the specialists and hospitals. This also indicates that the uncertainties which existed are now beginning to dissipate. It turned out that knowledge about the specialist did not influence the GP to refer to the particular specialist concerned. However the GP's value more knowledge about the specialist. The specialists must therefore take the opportunity to make themselves known from a marketing perspective. In order to achieve this goal, management will thus have to invest in skills development training for the GP's. The management must also be involved and see to it that specialists maximize this opportunity. The GP's indicated that the topics covered were not relevant, so it is important to consult with the GP's before deciding on the topics to be covered so that they are also catered for.

6.4.1.2 Referrals

The involvement of the specialist with CPD did not have an influence on the referrals received. The suggestion in this case is to approach the lectures from a marketing perspective. In this instance management of the hospitals has a role to play to empower the specialists with networking and marketing skills. Since the specialist's list has an influence on the referrals received, it must be availed of. The marketing activities of the hospital must also target patients since they also influence the GP when making a decision on whether to refer.

The specialist can also play an important role in this regard. He/she must see to it that he promotes good relationships between the patient referred to him and the patient's GP. CPD lectures did not have much influence in generating referrals. This means that there must be other interventions which should be put in place. For example the specialists must review their approaches and say more about what they do and what they have achieved. The hospital must run promotions on their offerings and create a database that will enable them to keep in touch with the market of GP's.

The referral process must be made as easy as possible because the GP's value this. The service offered at the hospital can create a competitive advantage for the hospital if it is maintained and improved regularly. Most GP's are influenced by quality of service offered by the hospital when deciding to refer.

6.4.1.3 Sources of referrals

The hospital must see to it that the sources of information are kept informative, credible and relevant. They must also be easy to use. This convenience influences the GP's to utilize the source of information when deciding to refer.

6.4.1.4 Needs

The majority of the GP's want to have all the categories catered for during the presentations. Further research needs to be conducted to identify what the needs of GP's are. This will help when restructuring the CPD programme and will also help the specialists when preparing for their presentations.

6.4.2 Findings on specialists

6.4.2.1 The influence of CPD lectures on referrals

A small percentage of the referrals received by the specialists was due to the fact that they presented the CPD lectures. The majority of the specialists did not receive referrals as a result of their presentations. However since their perception is positive, it means that CPD meetings are still a potential area for marketing. The marketing perspective needs to be incorporated.

6.4.2.2 Needs

The majority of the specialists require the clinical category to be covered during the lectures. The GP's want all categories to be covered. The specialists will need to employ a holistic approach whereby they will be catering for all the categories which the GP's require to be covered.

6.4.3 Relationships between different variables

6.4.3.1 Relationship between attendance and various characteristics

Since there is a significant relationship between attendance and professional and community involvement of the specialist, the specialist must be more involved in these two activities. He/she must also see to it that the GP's attending are aware of his involvement and his contribution.

6.4.3.2 Relationship between attendance and factors influencing referral patterns

The GP's refer more to the specialists who are available, whose qualifications they know and those who provide feedback. The specialists must thus take note of these factors and embark on them. At all times they must assure the GP's that they are available not only for consultation but also to assist GP's with their problems. They must clarify their qualifications and those of other specialists with whom they work and definitely give feedback to the GP's.

6.4.3.3 Relationship between attendance and source of information

At present the sources of information do not play a significant role in influencing the attendance of the GP's. This issue must be revisited.

6.4.3.4 Relationship between attendance and referrals

Since there is a significant relationship between attendance and referral of the patient back to the GP and referral guides, it is clear that the specialists and the hospital need to utilize this competitive advantage more effectively and efficiently.

6.4.1 Recommendations for further study

Research in the area of CPD in the medical profession must be encouraged to a greater degree in South Africa. The researchers must focus particularly on identifying the approaches that will make CPD more relevant and also on CPD how they can be used for the benefit of not only the specialists and the hospital, but also the GP's.

6.5 FINAL REMARKS

The goal and objectives of the study were achieved (see 1.5 and 1.6).

ANNEXURE A

Dear respondent

In order to improve the quality of medical care and professional competence of CPD lectures, you have been selected to take part in a research project on "The influence of CPD lectures on referrals in the medical profession".

This letter serves to confirm that Ms. N.M. Mosebi is a registered student at the Department of Business Management of the University of the Free State and that she is conducting this research in partial fulfillment of her Masters studies.

I therefore respectfully ask you to assist her in this venture by completing the included questionnaire. Your participation is completely anonymous and all that is required is your honest opinions. These opinions will not be to your disadvantage in any way, but will rather contribute to the improvement of the CPD lectures you receive/give.

Thank you for your contribution.

Yours sincerely

…… ……..

DR. I.P. DU PLESSIS MS. N.M. MOSEBI

SUPERVISOR STUDENT

Geagte respondent

Ten einde die kwaliteit van mediese dienste en professionele toepaslikheid t.o.v. VPO-lesings te verbeter, is u gekies om deel te neem aan 'n navorsingsprojek rakende "Die invloed van VPO-lesings op verwysings in die mediese professie".

Die doel van hierdie brief is om te bevestig dat Me N.M. Mosebi 'n geregistreerde student van die Departement van Ondernemingsbestuur van die Universiteit van die Vrystaat is en dat sy hierdie studie doen as een van die vereistes vir die verkryging van haar Meestersgraad.

Daarom versoek ek u eerbiedig om haar te ondersteun in hierdie onderneming deur die ingeslote vraelys te voltooi. U deelname is volkome anoniem. Al wat benodig word is u eerlike opinie. Hierdie keuses sal geensins tot u nadeel wees nie maar sal eerder bydra tot die verbetering van die VPO-lesings wat deur u aangebied of ontvang word.

Dankie vir u bydrae.

U dienswillige

…… ……

DR. I.P. DU PLESSIS MS. N.M. MOSEBI

STUDIELEIER STUDENT

QUESTIONNAIRE TO GENERAL PRACTITIONERS
VRAELYS AAN ALGEMENE PRAKTISYNS

SECTION A (GENERAL INFORMATION)
AFDELING A (ALGEMENE INLIGTING)

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SLEGS VIR KANTOORGEBRUIK

1 2 3

Indicate with an "X" in the appropriate block next to each of the following:"
Dui met 'n "X" aan in die toepaslike blokkie by elk van die volgende:

1. In which age interval are you?
   In watter ouderdomsgroep val u?

Younger than 30 / Jonger as 30	1	**4**
30 - 39	2	
40 - 49	3	
50 and older / en ouer	4	

2. How long have you been in practice?
   Hoe lank praktiseer u reeds?

1 - 5 yrs / jre	1	**5**
6 - 10 yrs / jre	2	
11 - 15 yrs / jre	3	
16 and more / en meer	4	

3. Are you in sole practice or partnership?
   Is u in 'n enkelpraktyk of 'n vennootskap?

Sole practice / Enkelpraktyk	1	**6**
Partnership / Vennootskap	2	

3.1 If in partnership, how many partners?
   Indien 'n vennootskap, hoeveel vennote?

1 Partner / Vennoot	1	**7**
2 Partners / Vennote	2	
3 Partners / Vennote	3	
4 Partners and more / Vennote en meer	4	

4. Are you practicing in the city or rural area?
Praktiseer u in die stad of platteland?

City / Stad = Bloemfontein, Kimberley, Welkom & Bethlehem

City / Stad	1
Rural area / Platteland	2

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SLEGS VIR KANTOORGEBRUIK

8

SECTION B (CPD LECTURES)
AFDELING B (VPO LESINGS)

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SLEGS VIR KANTOORGEBRUIK

Indicate with an "X" in the appropriate block next to each of the following:
Dui met 'n "X" aan in die toepaslike blokkie by elk van die volgende:

1. How many CPD lectures did you attend in the last year?
   Hoeveel VPO lesings het u bygewoon gedurende die laaste jaar?

1 - 5	1	
6 - 10	2	
11 - 15	3	**9**
16 and more / en meer	4	

2. Are you a regular attendant of CPD lectures?
   Woon u die VPO lesings gereeld by?

Yes / Ja	1	
No / Nee	2	**10**

2.1 If no, what are your reasons for not being able to attend regularly?
Indien nee, wat is u redes waarom u nie die VPO lesings nie gereeld bywoon nie?

Time of lecture / Tyd van lesings	1	
Travelling to attend / Moet reis om by te woon	2	
Poor communication of opportunities to attend Swak kommunikasie van geleenthede om by te woon	3	
Lack of quality of events / Gebrek aan kwaliteit van byeenkoms	4	
Lack of motivation / Gebrek aan motivering	5	
Other commitments / Ander pligte	6	
Other reasons / Ander redes	7	

If other reasons please specify / Indien ander redes spesifiseer asseblief

.....

.....

11 - 18

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SLEGS VIR KANTOORGEBRUIK

3. Did your perception of CPD lectures change since the introduction of CPD?
Het u persepsie van VPO lesings verander vanaf die bekendstelling van VPO?

Yes / Ja	1
No / Nee	2

19

3.1 If yes, how has your perception of CPD lectures been changed?
Indien ja, hoe het u persepsie van VPO lesings verander?

Positively / Positief	1
Negatively / Negatief	2
Uncertain / Onseker	3

20

4. If you were not obligated, would you attend the CPD lectures?
Indien u nie verplig was nie, sou u die VPO lesings bygewoon het?

Not at all / Geensins	1
Perhaps / Miskien	2
Definitely / Definitief	3

21

5. How would you rate the CPD lectures on the following categories?
Hoe sal u die VPO lesings takseer betreffende die volgende kategorië?

	Poor				Excellent
Academic value / Akademiese waarde	1	2	3	4	5
Social interpersonal value Sosiale interaksie waarde	1	2	3	4	5
Referral value / Verwysende waarde	1	2	3	4	5
Knowledge of the Specialist Kennis van die Spesialis	1	2	3	4	5
Relevance to topics covered Toepaslik tot bespreekte onderwerpe	1	2	3	4	5

22 - 26

SECTION C (REFERRALS)
AFDELING C (VERWYSINGS)

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Indicate with an "X" in the appropriate block next to each of the following:
Dui met 'n "X" aan in die toepaslike blokkie by elk van die volgende:

1. When referring a patient, which referral issue is the biggest?
   Wanneer 'n pasiënt verwys, watter verwysings keuse is die belangrikste?

Whether to refer? Moet die pasiënt verwys word?	1	
To whom to refer? (Specialist) Na wie toe om te verwys? (Spesialis)	2	
When to refer? Wanneer om te verwys?	3	

27 - 29

2. When referring to specialists how important are the following?
   Wanneer na 'n spesialis verwys word, hoe belangrik is die volgende?
   1 = Not important / Nie belangrik nie
   2 = Important / Belangrik
   3 = Very important / Baie belangrik

Patient-related characteristics Pasiënt verwante eienskappe	1	2	3	
Specialist-related characteristics Spesialis verwante eienskappe	1	2	3	
Professional and community involvement of specialist Professionele en gemeenskaps betrokkenheid van spesialis	1	2	3	
CPD involvement of specialist VPO betrokkenheid van spesialis	1	2	3	
Generation of reciprocal referrals Ontstaan van wederkerige verwysings	1	2	3	

30 - 34

3. When referring a patient to a specialist, which of the following influence your final decision?
   Wanneer 'n pasiënt na 'n spesialis verwys word, watter van die volgende beïnvloed u finale keuse?
   1 = No influence / Geen invloed
   2 = Some influence / Geringe invloed
   3 = Definite influence / Definitiewe invloed

Patients choice / Pasiënt se keuse	1	2	3	
Availability of specialist / Beskikbaarheid van spesialis	1	2	3	

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Availability of specialist's list Beskikbaarheid van spesialis se lys	1	2	3	
Locality of specialist / Omgewing van spesialis	1	2	3	
Specialist will refer the patient to you Spesialis sal die pasiënt na u toe verwys	1	2	3	
Referral due to custom / Verwysing as gevolg van geloof	1	2	3	
Qualifications of specialist / Kwalifikasies van spesialis	1	2	3	
Specialist's personality / Spesialis se persoonlikheid	1	2	3	
Specialist's involvement with specific hospital Spesialis se betrokkenheid by 'n spesifieke hospitaal	1	2	3	
Medical school where qualified Mediese skool waar gekwalifiseer is	1	2	3	
Specialist area (discipline) / Spesialis se plek (dissipline)	1	2	3	
Feedback from specialist (patient report) Terugvoer vanaf spesialis (pasiënt se verslag)	1	2	3	
Recency of completion studies Onlangsheid van voltooïng van studies	1	2	3	

35 - 47

4. How would you rate the following sources of information (regarding the specialist involved) when making a referral?
Hoe sal u die volgende bronne van informasie takseer (betreffende die betrokke spesialis) wanneer u 'n verwysing doen?

1 = Not important / Nie belangrik nie
2 = Somewhat important / Bietjie belangrik
3 = Very important / Baie belangrik

Opinion of colleagues / Opinie van kollegas	1	2	3	
Opinion of patient request Opinie van pasiënt se versoek	1	2	3	
Acts of CPD presenter / Optredes van VPO aanbieder	1	2	3	
Hospital brochures / Hospitaal brosjures	1	2	3	
Writer of medical articles Skrywer van mediese artikels	1	2	3	

48 - 52

5. When referring patients to a hospital, which of the following influences your choice?
Wanneer ‘n pasiënt na ‘n hospitaal verwys word, watter van die volgende beïnvloed u keuse?

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Locality of the hospital / Omgewing van die hospitaal	1	
Hospital group / Hospitaal groep (Medi-clinic; Afrox; Netcare)	2	
Standard of nursing services Standaard van verplegingsdienste	3	
General service level of hospital (Including administration, catering, etc.) Algemene dienste vlak van hospitaal (Ingeslote administrasie, verskaffingsdienste, ens.)	4	
Availability of beds / Beskikbaarheid van beddens	5	
Availability of hospital management team Beskikbaarheid van hospitaal se bestuurspan	6	
Request of patient / Versoek van pasiënt	7	

53 - 59

6. How important are the following for you as a referring GP, when making a decision to which specialist to refer?
Hoe belangrik is die volgende vir jou as ‘n AP, wanneer u ‘n besluit neem na watter spesialis toe om te verwys?

1 = Not important / Nie belangrik nie
2 = Somewhat important / Bietjie belangrik
3 = Very important / Baie belangrik

Patient receives the best treatment available Pasiënt ontvang die beste behandeling beskikbaar	1	2	3	
Communication with/feedback from specialist is prompt and efficient Kommunikasie met/terugvoer vanaf spesialis is vinnig en doeltreffend	1	2	3	
Referral process is easy and convenient Verwysings proses is maklik en gerieflik	1	2	3	
The patient is returned to you for continuing care Die pasiënt is teruggestuur na u vir deurlopende sorg	1	2	3	
Patient satisfaction / Pasiënt satisfaksie	1	2	3	

60 - 64

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7. Are you influenced by hospitals to refer to specialists associated with them?
Word u deur hospitale beïnvloed om te verwys na spesialiste wat by hulle betrokke is?

Yes / Ja 1

No / Nee 2

65

7.1 If yes, what action or circumstances influence you?
As ja, watter aksies of omstandighede beïnvloed u?

Specialist has consulting rooms at the hospital
Spesialis het spreekkamers by die hospitaal 1

Specialist has theatre list at the hospital
Spesialis het 'n teater lys by die hospitaal 2

Specialist has other colleagues to consult at the hospital
Spesialis het ander kollegas om te raadpleeg by die hospitaal 3

Specialist list of the hospital (brochure)
Spesialis se lys van die hospitaal (brosjure) 4

Social functions/events of the hospital
Sosiale funksies/gebeure van die hospitaal 5

Hospital representatives visiting your practice
Hospitaal verteenwoordigers wat u praktyk besoek 6

CPD - events organised by the hospital
VPO - gebeure georganiseer by die hospitaal 7

66 -72

8. When referring to a specialist which is the most important criteria?
Wanneer na 'n spesialis verwys word wat is die mees belangrikste kriterium?

Specialist / Spesialis 1

Facility (hospital) / Fasiliteit (hospitaal) 2

Both / Albei 3

73

9. How important are these factors when considering to refer to a specialist?
Hoe belangrik is hierdie faktore wanneer oorweeg word om na 'n spesialis te verwys?

1 = Not important / Nie belangrik nie
2 = Somewhat important / Bietjie belangrik
3 = Very important / Baie belangrik

His/her medical skills (clinical)
Sy/haar mediese vaardighede 1 2 3

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Positive experiences from past referrals Positiewe ondervindings van vorige verwysings	1	2	3	
Availability for consultation Beskikbaarheid vir konsultasie	1	2	3	
Patient prereferences / Pasiënt se voorkeure	1	2	3	
Sending the patient back for continuing care Die terugstuur van die pasiënt vir nasorg	1	2	3	
Established relationship with specialist Gevestigde verhouding met die spesialis	1	2	3	
Medical school graduated Mediese skool waar gegradeer	1	2	3	
Working at a specific hospital Werk by ‘n spesifieke hospitaal	1	2	3	
Commitment to ethical code Toepassing van etiese kode	1	2	3	
Feedback on patient/report Terugvoer betreffende pasiënt/verslag	1	2	3	
Personality of the doctor to whom referred Persoonlikheid van die dokter waarna verwys is	1	2	3	
Availability of the specialist (access for GP) Beskikbaarheid van die spesialis (toegang vir AP)	1	2	3	
Referral guides or brochure Verwysings gidse of brosjures	1	2	3	
Years of experience in specialist field Jare ondervinding op spesialis gebied	1	2	3	
CPD lecture given on a specific topic VPO lesing gegee oor ‘n spesifieke onderwerp	1	2	3	

74 - 88

10. How important are the following factors when looking for sources of referrals?
Hoe belangrik is die volgende faktore wanneer gekyk word na bronne van verwysing?

1 = Not important / Nie belangrik nie
2 = Somewhat important / Bietjie belangrik
3 = Very important / Baie belangrik

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Availability of referral information Beskikbaarheid van verwysings informasie	1 2 3	
Ease of use of information Gemaklikheid van gebruik van informasie	1 2 3	
Informativeness of the source Beskikbaarheid van inligting van die bron	1 2 3	
Credibility of the source of information Waardigheid van die bron van informasie	1 2 3	
Relevance of the source of information Toepaslikheid van die bron van informasie	1 2 3	

89 - 93

11. Does the presentation of a CPD lecture by a specific specialist influence your referral pattern?
Beïnvloed die aanbieding van ‘n VPO lesing deur ‘n spesifieke spesialis u patroon van verwysing?

Not at all / Geensins	1
Perhaps / Miskien	2
Definitely / Definitief	3

94

SECTION D (FUTURE NEEDS)
AFDELING D (TOEKOMSTIGE BEHOEFTES)

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SLEGS VIR KANTOORGEBRUIK

Indicate with an "X" in the appropriate block next to each of the following:
Dui aan met 'n "X" in die toepaslike blokkie by elk van die volgende:

1. On which media would you prefer to do a CPD lecture?
   Op watter media sou u verkies om 'n VPO lesing aan te bied?

Internet	1	
Medical journals (articles) / Mediese joernale (artikels)	2	
Seminar (Workshop) / Seminaar (Werkswinkel)	3	**95**

2. CPD occasions should be:
   VPO geleenthede behoort te wees:

Combined with social events Gekombineerd met sosiale gebeure	1	
Not combined with social events Nie gekombineerd met sosiale gebeure nie	2	
Doctors only / Slegs dokters	3	
Doctors and spouses / Dokters and gades	4	
Family events / Familie aangeleenthede	5	
Symposiums in Bloemfontein / Simposiums in Bloemfontein	6	
Symposiums at local Medi-Clinic Simposiums by plaaslike Medi-Clinics	7	
Road shows / Reisende skoue	8	
Hospital based / Hospitaal gebaseer	9	**96 - 104**

3. The CPD presenter should / Die VPO aanbieder behoort:

Lecture (formal) / Lesing (formeel)	1	
Facilitate and allow more participation (discussion) Groter deelname fasiliteer en toelaat (besprekings)	2	
Combine both / Albei kombineer	3	**105**

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4. Which day of the week would you prefer to present the CPD lecture?
Watter dag van die week sou u verkies om die VPO lesing aan te bied?

Monday / Maandag	1	
Tuesday / Dinsdag	2	
Wednesday / Woensdag	3	
Thursday / Donderdag	4	
Friday / Vrydag	5	
Saturday / Saterdag	6	
Sunday / Sondag	7	

5. Do you prefer a CPD meeting to be:
Verkies u dat die duur van 'n VPO vergadering moet wees:

106 - 112

1 Hour / 1 Uur	1	
2 - 3 Hour sessions / Uur sessies	2	
A whole day / 'n Hele dag	3	**113**

6. In which categories do you prefer the presentation a CPD lectures?
In watter kategorië verkies u die aanbieding van 'n VPO lesing?

Clinical / Klinies	1	
Non-clinical (Practice management) / Nie klinies (Praktyk bestuur)	2	**114 - 119**
Ethics / Etiek	3	
All categories / Alle kategorië	4	

THANK YOU FOR YOUR PARTICIPATION - DANKIE VIR U DEELNAME

Please return the complete questionnaire to: Stuur asseblief die voltooide vraelys aan:

Ms N.M. Mosebi
The University of the Free State
Department of Business Management
Box 339
Bloemfontein 9300

ANNEXURE B

Dear respondent

In order to improve the quality of medical care and professional competence of CPD lectures, you have been selected to take part in a research project on "The influence of CPD lectures on referrals in the medical profession".

This letter serves to confirm that Ms. N.M. Mosebi is a registered student at the Department of Business Management of the University of the Free State and that she is conducting this research in partial fulfillment of her Masters studies.

I therefore respectfully ask you to assist her in this venture by completing the included questionnaire. Your participation is completely anonymous and all that is required is your honest opinions. These opinions will not be to your disadvantage in any way, but will rather contribute to the improvement of the CPD lectures you receive/give.

Thank you for your contribution.

Yours sincerely

…….	……..……..
DR. I.P. DU PLESSIS	MS. N.M. MOSEBI
SUPERVISOR	STUDENT

Geagte respondent

Ten einde die kwaliteit van mediese dienste en professionele toepaslikheid t.o.v. VPO-lesings te verbeter, is u gekies om deel te neem aan 'n navorsingsprojek rakende "Die invloed van VPO-lesings op verwysings in die mediese professie".

Die doel van hierdie brief is om te bevestig dat Me N.M. Mosebi 'n geregistreerde student van die Departement van Ondernemingsbestuur van die Universiteit van die Vrystaat is en dat sy hierdie studie doen as een van die vereistes vir die verkryging van haar Meestersgraad.

Daarom versoek ek u eerbiedig om haar te ondersteun in hierdie onderneming deur die ingeslote vraelys te voltooi. U deelname is volkome anoniem. Al wat benodig word is u eerlike opinie. Hierdie keuses sal geensins tot u nadeel wees nie maar sal eerder bydra tot die verbetering van die VPO-lesings wat deur u aangebied of ontvang word.

Dankie vir u bydrae.

U dienswillige

…… ……

DR. I.P. DU PLESSIS MS. N.M. MOSEBI

STUDIELEIER STUDENT

QUESTIONNAIRE TO SPECIALISTS
VRAELYS AAN SPESIALISTE

SECTION A (GENERAL INFORMATION)
AFDELING A (ALGEMENE INLIGTING)

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SLEGS VIR KANTOORGEBRUIK

1 2 3

Indicate with an "X" in the appropriate block next to each of the following:"
Dui met 'n "X" aan in die toepaslike blokkie by elk van die volgende:

2. In which age interval are you?
In watter ouderdomsgroep val u?

Younger than 30 / Jonger as 30	1	**4**
30 - 39	2	
40 - 49	3	
50 and older / en ouer	4	

2. How long have you been in practice?
Hoe lank praktiseer u reeds?

1 - 5 yrs / jre	1	**5**
6 - 10 yrs / jre	2	
11 - 15 yrs / jre	3	
16 and more / en meer	4	

3. Are you in sole practice or partnership?
Is u in 'n enkelpraktyk of 'n vennootskap?

Sole practice / Enkelpraktyk	1	**6**
Partnership / Vennootskap	2	

3.2 If in partnership, how many partners?
Indien 'n vennootskap, hoeveel vennote?

1 Partner / Vennoot	1	**7**
2 Partners / Vennote	2	
3 Partners / Vennote	3	
4 Partners and more / Vennote en meer	4	

4. Are you practicing in the city or rural area?
Praktiseer u in die stad of platteland?

City / Stad = Bloemfontein, Kimberley, Welkom & Bethlehem

City / Stad	1
Rural area / Platteland	2

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SLEGS VIR KANTOORGEBRUIK

8

SECTION B (CPD LECTURES)
AFDELING B (VPO-LESINGS)

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SLEGS VIR KANTOORGEBRUIK

Indicate with an "X" in the appropriate block next to each of the following:
Dui met 'n "X" aan in die toepaslike blokkie by elk van die volgende:

2. How many CPD lectures did you present in the last year?
Hoeveel VPO-lesings het u aangebied gedurende die laaste jaar?

1 - 5	1	
6 - 10	2	
11 - 15	3	**9**
16 and more / en meer	4	

2. Do you present the CPD lectures regularly?
Bied u die VPO-lesings gereeld aan?

Yes / Ja	1	
No / Nee	2	**10**

2.1 If no, what are your reasons for not presenting CPD lectures?
Indien nee, wat is u redes waarom u nie VPO-lesings aanbied nie?

Lack of time / Gebrek van tyd	1	
Problems to travel / Probleme om te reis	2	
Poor communication of opportunities to present Swak kommunikasie van geleenthede om aan te bied	3	
Lack of quality of events / Gebrek aan kwaliteit van byeenkomste	4	
Lack of motivation / Gebrek aan motivering	5	
Other commitments / Ander pligte	6	
Other reasons / Ander redes	7	

If other reasons please specify / Indien ander redes spesifiseer asseblief

.....

..... **11 - 18**

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SLEGS VIR KANTOORGEBRUIK

3. Did the presentation of CPD lectures have any effect on the number of referrals you received?
Het die aanbieding van VPO-lesings enige invloed gehad op die hoeveelheid verwysings wat u ontvang het?

Not at all / Geensins	1	
Perhaps / Miskien	2	
Definitely / Beslis	3	**19**

3.1 If yes, were the referrals you received related to the topic covered?
Indien ja, het die verwysings betrekking gehad op die onderwerp van bespreking?

Yes / Ja	1	
No / Nee	2	
Yes & No / Ja & Nee	3	**20**

4. Did the presentation of CPD lectures lead to an increase of referrals you received?
Het die aanbieding van VPO-lesings gelei tot ‘n vermeerdering van die hoeveelheid verwysings deur u ontvang?

Yes / Ja	1	
No / Nee	2	**21**

5. How many CPD lectures did you attend in the last year?
Hoeveel VPO-lesings het u bygewoon gedurende die laaste jaar?

1 - 5	1	
6 - 10	2	**22**
11 - 15	3	
16 and more /en meer	4	

6. Did your perception of CPD lectures change since the introduction of CPD?
Het u persepsie van VPO-lesings verander vanaf die bekendstelling van VPO?

Yes / Ja	1	
No / Nee	2	**23**

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6.1 If yes, how has your perception of CPD lectures been changed?
Indien ja, hoe het u persepsie van VPO-lesings verander?

Positively / Positief	1
Negatively / Negatief	2
Uncertain / Onseker	3

24

7. If you were not obligated, would you attend/present the CPD lectures?
As u nie verplig was nie, sou u die VPO-lesings bygewoon/aangebied het?

Not at all / Geensins	1
Perhaps / Miskien	2
Definitely / Definitief	3

25

8. How would you rate the CPD lectures on the following categories?
Hoe sal u die VPO-lesings takseer betreffende die volgende kategorië?

	Poor				Excellent
Academic value / Akademiese waarde	1	2	3	4	5
Social interpersonal value Sosiale interaksie waarde	1	2	3	4	5
Referral value / Verwysende waarde	1	2	3	4	5
Knowledge of the Specialist Kennis van die Spesialis	1	2	3	4	5
Relevance to topics covered Toepaslik van bespreekte onderwerpe	1	2	3	4	5

26 - 30

SECTION C (REFERRALS)
AFDELING C (VERWYSINGS)

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Indicate with an "X" in the appropriate block next to each of the following:
Dui met 'n "X" aan in die toepaslike blokkie by elk van die volgende:

3. From which of the following did you receive most patients?
Van watter van die volgende het u die meeste pasiënte ontvang?

Patient direct, without referral Pasiënt direk sonder verwysing	1 2 3 4 5	
General practitioner / Algemene praktisyn	1 2 3 4 5	
GP who attended your CPD AP wat u VPO bygewoon het	1 2 3 4 5	
Specialist colleagues / Spesialis kollegas	1 2 3 4 5	
Specialist who attended your CPD presentation Spesialis wat u VPO-aanbieding bygewoon het	1 2 3 4 5	

31 - 35

4. When admitting patients to a hospital, which of the following influences your choice?
Wanneer 'n pasiënt tot 'n hospitaal toegelaat word, watter van die volgende beïnvloed u keuse?

Locality of the hospital / Ligging van die hospitaal	1	
Hospital group / Hospitaal groep (Medi-clinic; Afrox; Netcare)	2	
Standard of nursing services Standaard van verplegingsdienste	3	
General service level of hospital (Including administration, catering, etc.) Algemene diensvlak van hospitaal (Ingeslote administrasie, voedseldienste, ens.)	4	
Availability of beds / Beskikbaarheid van beddens	5	
Availability of hospital management team Toeganklikheid van hospitaal se bestuurspan	6	
Request of patient / Versoek van pasiënt	7	
Marketing activities of the hospital Bemarkingsaktiwiteite van die hospitaal	8	

36 - 43

5. What percentage (%) of your referrals is from the rural areas?
Watter persentasie (%) van u verwysings is afkomstig van die platteland?

0 - 5 %	1
6 - 10 %	2
11 - 20 %	3
21 - 30 %	4
31 % and more / en meer	5

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☐ **44**

6. Do you have a need to increase your referrals from the rural areas?
Bestaan daar ‘n behoefte om verwysings vanaf die platteland te vermeerder?

Yes / Ja	1
No / Nee	2

☐ **45**

SECTION D(FUTURE NEEDS)
AFDELING D (TOEKOMSTIGE BEHOEFTES)

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SLEGS VIR KANTOORGEBRUIK

Indicate with an "X" in the appropriate block next to each of the following:
Dui aan met 'n "X" in die toepaslike blokkie by elk van die volgende:

7. By which media would you prefer to present a CPD lecture?
Deur watter media sou u verkies om 'n VPO-lesing aan te bied?

Internet	1	
Medical journals (articles) / Mediese joernale (artikels)	2	
Seminar (Workshop) / Seminaar (Werkswinkel)	3	**46**

8. Which day of the week would you prefer to present the CPD lecture?
Watter dag van die week sou u verkies om die VPO-lesing aan te bied?

Monday / Maandag	1	
Tuesday / Dinsdag	2	
Wednesday / Woensdag	3	
Thursday / Donderdag	4	
Friday / Vrydag	5	
Saturday / Saterdag	6	
Sunday / Sondag	7	

9. Do you prefer a CPD meeting to be: **47 - 53**
Verkies u dat 'n VPO-vergadering moet wees:

1 Hour / 1 Uur	1	
2 - 3 Hour sessions / Uur sessies	2	
A whole day / 'n Hele dag	3	**54**

10. In which categories do you prefer to present a CPD lecture?
In watter kategorië verkies u om ‘n VPO-lesing aan te bied?

Clinical / Klinies	1	
Non-clinical (Practice management) / Nie klinies (Praktykbestuur)	2	**55**
Ethics / Etiek	3	
All categories / Alle kategorië	4	

THANK YOU FOR YOUR PARTICIPATION - DANKIE VIR U DEELNAME

Please return the complete questionnaire to : Stuur asseblief die voltooide vraelys aan:
Ms N.M. Mosebi
The University of the Free State
Department of Business Management
Box 339
Bloemfontein

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