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Perceived Managerial and Leadership Effectiveness Within Turkish Public Sector Hospitals

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Abstract

The main purpose of this study is to report the results of a study of managerial and leadership effectiveness carried out within Turkish public sector hospitals. 'Effective' and 'least effective/ineffective' manager and managerial leader behavior, as observed by managerial and non-managerial employees were collected using the critical incident technique. These critical incidents were then content analyzed to identify a smaller number of discrete behavioral statements and criteria of effectiveness.

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Keywords: managerial and leadership effectiveness, cross-nation research, healthcare management.

1. Introduction

'Evidence-based management' needs to be married with 'evidence-based medicine' if sustainable improvement in the delivery, quality, cost and outcomes of care are to be achieved. These calls for an effective partnership between academics and practitioners to ensure relevant practice-grounded research is correctly translated for practicing healthcare managers to use in their day-to-day activities (Grazier, 2004). Hamlin suggests the following definition for evidence-based human resource development (HRD). "Evidence-based HRD is the conscientious, explicit and judicious use of current best evidence in making decisions about the development of individuals, groups and organizations, integrating individual HRD practitioner expertise with the best available external evidence derived from systematic research" (Hamlin, 2002a).

In an attempt to find evidence in support of evidence-based practice in healthcare management, Axelsson (1998) concluded that few management studies published over the past 100 years could be generalized beyond the organizational settings and populations of managers studied. Similarly, Braithwaite (2004), commenting upon the status of clinician-management research in support of empirically-grounded management practice in healthcare, argues that despite a vast body of literature on management, a a notable amount of it is anecdotal and subjective, where there are a few 'scattered empirical islands' in a sea of relative ignorance. Then, the published literature on physician leadership (more than 300 articles) is normative, prescriptive, anecdotal, or observational, based on qualitative opinion surveys (Xirasagar et. al., 2005).

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Of the management and leadership studies undertaken in North America, only a few focus on leader, manager, and administrator behavior in the healthcare sector. According to Hamlin, Ruiz and Wang (2011), the most notable are the works of Shipper, Pearson, and Singer (1998) and of Shipper and White (1999). But all of their research appears to have been deductive survey-based studies using predetermined questionnaires based on a set of managerial behaviors originally identified over 30 years ago by Wilson (1978). Two rare examples of such research in the UK, other than the studies of Hamlin and his various co-researchers, are those of Alban-Metcalfe and Alimo-Metcalfe (2001) and Gaughan (2001), summary details of which can be found in Hamlin and Cooper (2007). Thus, the body of best evidence available to support evidence-based managers and evidence-based HRD practitioners in the healthcare sector is sparse, limited in scale, and lacking generalizability. This finding suggests that further studies of managerial and leadership effectiveness in healthcare management are warranted (Hamlin, Ruiz & Wang, 2011).

Management behaviors viewed as desirable in one cultural context may not be viewed as such in another, and that management behavior is deeply embedded in culture. In the absence of a sound and sufficient body of nation-specific and cross-nation empirical evidence, the universal versus contingent nature of management and leadership continues to be the subject of conflicting views (Hamlin, Nassar & Wahba, 2010).

This study is carried out against this empirical background. It replicates within public sector hospitals in Turkey the studies of R.G. Hamlin (2002a, 2002b) and Hamlin and Cooper (2005; 2007) which were originally carried out in acute and specialist NHS Trust hospitals in the United Kingdom. We also replicate three other public sector hospitals studies carried out by Hamlin, Ruiz and Wang (2011) in Mexico, by Hamlin, Nassar and Wahba (2010) in Egypt, and by Patel, Hamlin and Iurac (2010) in Romania.

Empirical evidence seem to suggest that organizations that follow the strategic management framework with leadership are high performers. As high-performing organizations, they initiate and lead in their respective industries, they do not just react and defend. They launch strategic offensives to out-innovate and out-maneuver rivals and secure sustainable competitive advantage, then use their market edge to achieve superior financial performance according to Thompson and Strickland (1996). In other words, strategic management seems to interact with leadership skills. Therefore, the findings of this study can potentially be employed in strategic management.

2. Literature Review

An abiding concern of mainstream research in theorizing management and leadership has been to identify the 'traits', 'selection of styles' or 'conjunction of circumstances' that determine manager and leader effectiveness (Knights and Willmott 1992). To this end, four main approaches have been used and continue to be used. As Parry & Bryman (2006) states, the trait approach was dominant up to the late 1940s; the style approach held sway from then until the late 1960s; the contingency approach dominated the 1970s and early 1980s; and the new leadership approach – which focused initially on the transactional and transformational leadership of top managers but latterly on dispersed and servant leadership, has been the major influence on management and leadership research since the late 1980s. Two contrasting paradigms of management and leadership have emerged from all this research and theorizing, which House and Aditya (1997) refer to as the universalistic 'manager and leader behavior paradigm' theories and 'contingency paradigm' theories respectively. The guiding assumption underpinning the 'universal theories' is that the characteristics (traits and behaviours) required of managers and leaders will remain the same regardless of the stage of development of the organization, the environment (culture) in which it exists, or the people who work in it (Horner-Long and Schoenberg 2002). In contrast, the guiding assumption underpinning 'contingency theories' is that managers and leaders need to use a style of behaviour that matches the environmental (cultural) and organizational context; and that specific behaviours effective in influencing and motivating people are determined in the situation, but these can be moderated by environmental factors.

In recent years many concerns and criticisms have been expressed about the nature of most management and leadership research. Hamlin and Sawyer (2007) classify the criticisms into four categories. Firstly; although over the past fifty years or so substantial amounts of research have been conducted into the nature of management work and what managers do, few studies have attempted to differentiate between what Hales (1986) refers to as good or bad management, or have been focused on the issue of managerial or leadership effectiveness (Barker, 2000). Consequently, there is still little agreement in the literature about what constitutes and is meant by managerial and leadership effectiveness (Hamlin and Sawyer, 2007).

The second criticism concerns the lack of generalizability across organizational settings, sectors and cultures. Relating to specific criticisms concerning the lack of generalizability of most management and leadership research, Axelsson (1998) claims few studies have produced empirical results that can be generalized beyond particular organizational settings. A similar situation exists in the field of leadership research (Kim and Yukl, 1995). An explanation provided by Avolio, Bass and Jung (1999) is that weaknesses in research design, such as the lack of central control over the consistency of procedures utilized in most management studies, have been the cause of limitations on the generalization of findings in this field, but these weaknesses could be overcome through replica studies that adopt common research designs and methods.

The third criticism is that most management and leadership research continues to be divorced from the world of practice (Adler, Shani and Styhere, 2004).

The fourth criticism concerns the fact that despite various calls in recent years for the introduction of evidence-based approaches to management practice, particularly in the field of healthcare management, there is a dearth of general knowledge and generalized best evidence to support the concept of evidence-based management (Axelsson, 1998).

3. Methodology

This research aims to report the results of perceived managerial and leadership effectiveness within Turkish public sector hospitals.

Our research design comprised two stages as follows:

Stage 1: We followed R.G. Hamlin (2002a) by using Flanagan's (1954) critical incident technique (CIT) to collect our primary data because our study was a replication research. According to R.G. Hamlin (1988); various leading researchers had claimed it was one of the best techniques for focusing on the more important aspects of managerial behavior.

We planned to collect from a purposive sample of 25-30 managers and non-managerial employees, a total of about 250 critical incidents (CIs) of managerial behaviors which they consider examples of effective and ineffective management/managerial leadership. Establishing contact with people willing to participate in the research was achieved through snowball sampling method (Bryman & Bell, 2007) facilitated by Author 2's personal friend who works at hospital. This actually resulted in a convenience sample of only 24 CIT informants (10 males and 14 females) were being interviewed; all of them were employed in the medical, nursing departments and general administrative services. Of the 24 participants, 8 were middle managers, 7 were first-line managers, and 9 were non-managerial staff.

Each participant was told the purpose of the research; what was hoped to be achieved at the CIT interview; what was meant by certain key terms that would be used, namely critical, incident, and critical incident; what the interviewee would be asked at the interview and how to prepare for it; and the academic code of ethics that would be applied. The participants were also briefed on these two definitions:

1. Effective managerial performance is "behavior which you wish all managers would adopt if and when faced with a similar circumstance."

2. Ineffective managerial performance is "behavior which, if it occurred repeatedly, or was seen once in certain circumstances, might cause you to begin to question or doubt the ability of that particular manager in that instance."

The CIT interviews were typically lasted for 60 to 90 minutes, during which time the interviewee was asked to describe up to a total of 10 CIs that he or she had personally observed within the past 6 to 9 months. The CIs could relate either to behavior exhibited by managers above, at the same level, or below them in the organizational hierarchy. For each CI, the researcher posed and strictly adhered to these three standard questions:

1. What was the background situation, circumstance, or context that led up to the critical incident you have in mind?

2. What and in what way exactly did the subject (the manager you observed) do/say or not do/say that was either effective or ineffective?

3. What was the specific result or outcome of the critical incident that you have described and, on reflection, why do you perceive/judge this to be an example of "effective" or "ineffective" managerial behavior/ managerial performance?

As and when required, these questions were followed by probing and explicatory questions to ensure that the critical facet or aspect of the observed behavior had been correctly identified. Responses were then recorded as far as possible using the same words used by the CIT informant when describing the incident. Those CIT informants who

were managers were not allowed to offer CIs based on their own managerial practice. Because of the strict code of anonymity, informants were asked not to reveal the identity of the manager whose behavior they were describing. A total of 207 CIs were obtained. These were subjected initially to a variant of content analysis using first-level open coding at the semantic level, in order to identify the discrete unit of meaning of each incident and to disentangle those where two (or more) units of meaning were identified (Flick, 2006). No additional CIs resulted from this process.

Stage 2. The 207 CIs were subjected to inductive thematic analysis (Wiling & Rogers, 2008) using second-level open coding at the semantic level (Flick, 2006). The aim was to search for themes and patterns as identified within the explicit or surface meanings of their respective discrete units of meaning. Three of the CIs were considered unsuitable for analysis because of insufficient development, unclear meaning, or because they were focused on non-behavioral factors. Hence, in accordance with the research process protocol used in common for all of the previous replication studies; these 3 CIs were excluded from the data set. This left 204 CIs for further analysis. Of the remaining 204 usable CIs, 114 were examples of positive (effective) managerial behavior, and 90 of negative (least effective/ineffective) managerial behavior. 41 semantic themes emerged from the thematic analysis, of which 22 related to effective and 19 to ineffective management. Each theme was comprised of between a minimum of 3 and a maximum of 9 CIs. In some cases, one CI was selected as a representative description of the overarching meaning of that particular theme; in other cases, a composite statement was created to encapsulate the meaning held in common to all of the constituent CIs. The themes were then referred to as behavioral statements (BSs).

4. Findings and Conclusions

From the Stage 1 and Stage 2 processes, 22 effective and 19 ineffective behavioral statements were identified as the behavioral indications and contraindications of perceived managerial and leadership effectiveness applying within the Turkish public hospitals. To illustrate the range and richness of each group of interrelated CIs underpinning the derived behavioral statements, several examples are given in Table 1.

Table 1. Illustration of the groups of interrelated CIs identified at stage 1 that were perceived to underpin the respective behavioral statements derived at stage 2

Critical incidents	Behavioral statements
Effective managerial behavior	
There was an argument between the chief nurse and a nurse in intensive care and both sides complained about each other to the head nurse. Before the head nurse made a decision, listened to both sides and all staff working in the intensive care separately and tried to understand the event.	When there is an event or problem, the manager collects information appointing with the staff one by one.
Ineffective managerial behavior	As he doesn't make a plan, he leads to waste of resource.
The unit didn't serve for a week because of the dying-limewashing After two weeks passed, because the monitors on the walls were replaced, a new limewashing was remade. As the manager worked without a certain plan, there was dying-limewashing cost and the unit was out of service for a week.	

The full set of 41 behavioral indicators of managerial and leadership effectiveness is listed below:

Effective Managerial and Leadership Behaviors

1. The manager knows the capacity of the staff and assigns them in the positions accordance with their capacities.
2. He listens to the staff, behaves sensitively to the problems of the staff and supports them in every respect.
3. He knows the regulations and rules well, bases the reasons of his decisions on law and regulations.
4. He is well-connected, knows the managers and his colleagues in other hospitals.
5. When there is an event or problem, he collects information appointing with the staff one by one.
6. He inspects effectively. He inspects by disguising. He comes out of the manager room and sometimes inspects visiting everybody in their units.

7. He has an edge in interpersonal relations and when needed he takes up a position towards his staff.
8. He provides the resources under his control to be used effectively and productively.
9. He appoints according to qualification, he gets information about the staff before he appoints.
10. He supports and encourages his staff for their education and improvement.
11. He gives authority to his inferior ones but follows them.
12. Making awarding and punishment obviously, he encourages the desired behaviors, and prevents the undesired behaviors.
13. He behaves equally to all of his staff, doesn't make discrimination and makes the awarding-punishment fairly.
14. He tries to solve the problems effectively and focuses on the base of problems and prevents them from occurring again.
15. He provides the materials necessary for the treatment and care of the patient appropriately.
16. He struggles to raise the quality of the service.
17. When there is an over workload, he helps his staff.
18. He gets the idea of his staff, gives importance to their views and adopts the participative management concept.
19. He supports team works.
20. He has technical information and skills with his work and advises his staff.
21. He behaves tolerantly about permission, knows his staff well and behaves according to the person about giving permission.
22. He creates a positive atmosphere gathering his staff together with such activities as the celebration of important days.

Least Effective/Ineffective Managerial and Leadership Behaviors

1. He doesn't listen to his staff, decides opinionatedly.
2. He is directed by others.
3. He doesn't respect enough to his staff.
4. He keeps his staff at a distance, his power distance is high.
5. He doesn't appreciate a staff who has done a good job
6. He doesn't care about his staff's motivation
7. He doesn't behave equally and fairly to his staff.
8. He practices mobbing.
9. When there is a problem, instead of finding a solution based on the source of the problem, he finds practical solutions to save the day.
10. He decides sentimentally.
11. He gives much authority to an inexperienced staff.
12. He doesn't take initiative and risk.
13. He accepts and applies the demands of an upper management without questioning and doesn't protect his staff.
14. He doesn't know the laws and regulations well and take decisions unfit to the laws and regulations.
15. As he doesn't make a plan, he leads to waste of resource.
16. He shows much respect to some staff. He gives more than one critical duty to the same staff.
17. He behaves flexibly while punishing and when needed he doesn't punish, but ignores it.
18. He doesn't support the education and improvement of his staff because of his jealousy and thought of keeping his seat.
19. He doesn't care about the provision of equipment needed by the staff to do their job.

As a conclusion; this study has outlined a new approach for management in general and health care management in particular called *Evidence Based Management*. A development in this direction will have important consequences for healthcare management practice. Our research may help to improve the practice of healthcare management in many different ways, most of all by improving the quality of managerial decisions.

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