NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
BUSINESS ADMINISTRATION PROGRAMME

ORGANIZATIONAL CULTURE ON THE INVESTIGATION OF THE INFLUENCE OF LEADERSHIP AND ORGANIZATIONAL STRUCTURE IN AFFILIATED HOSPITALS IN TURKEY

HALİL İBRAHİM İÇOĞLU

PhD THESIS

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THESIS SUPERVISOR
Assist. Prof. Ayşe Gözde KOYUNCU

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2020

ACCEPTANCE/APPROVAL

This study titled “Organizational Culture on the Investigation of the Influence of Leadership and Organizational Structure in Affiliated Hospitals in Turkey”, prepared by Halil İBRAHİM İÇOĞLU” was considered as successful as a result of the defense examination conducted on the date of …/12/2020 and accepted as Doctoral Thesis by our Jury.

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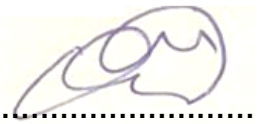

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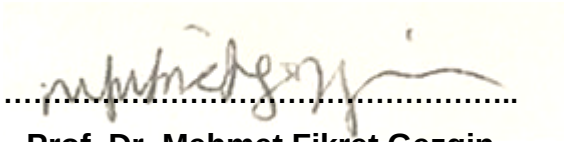

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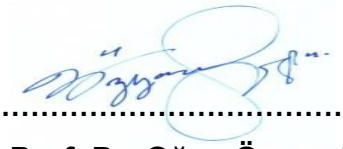

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DEDICATION

I dedicate my dissertation work to my family.

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HALİL İBRAHİM İÇOĞLU

ÖZ

TÜRKİYE'DE AFİLİYE HASTANELERİNDEKİ LİDERLİK VE ÖRGÜT YAPILARININ ÖRGÜTSEL KÜLTÜR ÜZERİNE ETKİLERİNİN İNCELENMESİ

Bu araştırmanın amacı, Türkiye'de faaliyetlerine devam eden Afiliye Hastanelerindeki liderlik ve örgüt yapılarının örgütsel kültür üzerine etkilerini incelemektir. Ayrıca sözkonusu hastanelerde görev yapan sağlık yöneticilerinin birer lider ve birer yönetici olarak etkililiklerinin ne olduğu ve yapısalcı, insan kaynağı, politik ve sembolik boyutlardan hangisinin/hangilerinin liderlik ve yöneticilik etkililiğinin yordayıcısı olarak ortaya çıktığı belirlenmeye çalışılmıştır.

Türkiye'de Afiliye Hastanelerinde hissedilmekte olan kültürün ne olduğu ve liderlik davranışları ile örgüt kültürü arasındaki ilişkinin tespit edilmesi de araştırmanın bir diğer konusunu oluşturmuştur. Araştırma Türkiye'de hizmet vermekte olan 19 Afiliye Hastanesi'nin Başhekim, Başhekim Yardımcısı, Müdür, Müdür Yardımcısı ve Süpervizör Birim Sorumlusu Hemşire olarak görev yapan 435 sağlık çalışanı ile gerçekleştirilmiştir. Araştırmada veri toplama araçları olarak; Sosyo-Demografik Veri Formu (SDVF), Yöneticilerin Liderlik Özellikleri Ölçeği (YLÖÖ) ve Denison Örgüt Kültür Ölçeği (DÖKÖ) kullanılmıştır.

Araştırmada İş odaklı liderlik boyutunda puan ortalaması en yüksek Afiliye hastane Erzincan Binali Yıldırım Üniversitesi Ağız ve Diş Sağlığı Eğitim ve Araştırma Hastanesi, çalışan odaklı liderlik, Değişim odaklı liderlik alt boyutlarında ve yöneticilerin liderlik özelliklerinde puan ortalaması en yüksek Afiliye hastane Erzincan Binali Yıldırım Üniversitesi Ağız ve Diş Sağlığı Eğitim ve Araştırma Hastanesi bulunmuştur. Yetkilendirme, Koordinasyon boyutunda puan ortalaması en yüksek Afiliye hastane Erzincan Binali Yıldırım Üniversitesi Ağız ve Diş Sağlığı Eğitim ve Araştırma Hastanesi, takım çalışmasında, yetenek geliştirmede, uzlaşmada, katılım kültüründe, değişimde, stratejik yönetimde, örgüt amaçlarında, vizyonda, uyum kültüründe ve örgüt kültürü genelinde Amasya Üniversitesi Sabuncuoğlu Şerefeddin Eğitim ve Araştırma

Hastanesi, temel değerlerde, müşteri odaklılıkta, örgütsel öğrenmede, Rize Recep Tayyip Erdoğan Üniversitesi Eğitim ve Araştırma Hastanesi bulunmuştur.

Anahtar kelimeler: Liderlik, Örgüt kültürü, Affliated Hastane, Sağlık çalışanı

ABSTRACT

ORGANIZATIONAL CULTURE ON THE INVESTIGATION OF THE INFLUENCE OF LEADERSHIP AND ORGANIZATIONAL STRUCTURE IN AFFILIATED HOSPITALS IN TURKEY

In this research, leadership and organizational structure in Affiliated Hospitals in Turkey it is to determine the impact on organizational culture. In addition, it was tried to determine what the effectiveness of health managers working in the said hospitals as leaders and managers and which of the structural, human resource, political and symbolic dimensions emerged as predictors of leadership and management effectiveness. Another secondary aim is what culture is being felt in the Affiliated Hospitals in Turkey and that is to determine the relationship between organizational culture and leadership behaviors. Research has been serving in Turkey 19 Affiliated Hospital Chief, Deputy Chief, Director, Deputy Director and Officer Supervisor Unit was conducted with 435 health care workers who work as nurses. In the research as data collection tools;Socio-Demographic Data Form (SDDF),Leadership Traits Scale (LTS) and Denison Organization Culture Scale was used.

In the study, the highest mean score in the business-oriented leadership dimension was found in Erzincan Binali Yildirim University Oral and Dental Health Training and Research Hospital, employee-oriented leadership, change-oriented leadership sub-dimensions and the highest average score in the leadership characteristics of the managers. Health Education and Research Hospital. Authorization, the highest average score in coordination dimension, Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital, teamwork, talent development, reconciliation, participation culture, change, strategic management, organization goals, vision, harmony culture, organizational culture Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital, Rize

Recep Tayyip Erdoğan University Education and Research Hospital has been found in the basic values, customer-oriented, and organizational learning.

Keywords: Leadership, Organizational culture, Affiliated Hospital, Health worker

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ABBREVIATIONS

DHC Healthcare **:** Delivering Quality Healthcare

OECD **:** Organization for Economic Co-operation and **Development**

SGK **:** Social Security Institution

SUT **:** Health Practice Communiqué

WHO **:** World Health Organization

LPC **:** Least Preferred Co-worker

INTRODUCTION

More than two non-dependent companies merge as a new legal entity by abstractly integrating all their values and assets that they possess and they can continue their actions as a non-dependent business (Ülgen and Mirze, 2010). Depending on this situation, enterprises can continue their functions and they integrate in a company and meet in the form of joint decisions and joint practices (Yücebaş, 2005).

The merging of business types are two types, legal and financial. The legal merger type can be carried out in its structure in two ways as formal and non-formal. Formal merger can be accomplished by keeping the current status of non-dependent units under protection (trust, holding, consortium, acquisition, joint venture), or by making non-dependent units dependent (merger, consolidation). In the non-formal merger type, business types keep their legal status under protection and ensure their continuity by working together on different issues. Gentlemen's agreements and cartels can be shown as a model for this merger type. (Akay, 1997; Yücebaş, 2005).

Financial merger types can be realized in horizontal, vertical or mixed (conglomerate) forms (Evans, 2004).

Horizontal merger is made to increase the price in the market by reducing the competition of the markets of enterprises that produce similar products, apply or sell different production procedures within the same sector (Cougherty and Duso, 2009; Pilsbury and Meaney, 2009).

Vertical merger is the merging of the companies in different stages of the different production procedure of the similar sector. In the said merger, the product of one business can be found as the raw material of the other business (Arnold, 2010).

Conglomerate merger is realized by merging businesses in different sectors. In the case of this merger, the aim is to be involved in a different working area and benefit from the monetary asset as much as possible. In this merger, the

production of one enterprise is not the raw material of another (Church, 2008; Morresi and Pezzi, 2014).

Affiliation, which is one of the combination and / or collaboration methods, is seen as the strongest form of merger (DHC Healthcare, 2013).

The University Hospitals-State Hospital Cooperation (Affiliation) Regulation dated 18.02.2011 and numbered 27850 gives the definition of affiliation as follows: “It is the action, support, and activity of those who are parties to the ministry and / or university types in the fields such as education, service and technique to realize their duties and services, and to achieve their common goals and benefits.”

Affiliation is a method chosen for the purposes of generating income through scale economy in general, increasing employee and buyer satisfaction and achieving optimum application results (DHC Healthcare, 2013).

This method, which is recommended to provide better health services with less expense by realizing a wider network geographically, also allows the academic actions of universities, the practice of medicine practiced in medical schools, and hospital administrative procedures to be managed by different and non-dependent boards (Medical Development Specialists, 2012; Uğurluoğlu, 2015). From this point of view, affiliation carries out qualified employees (training), ensures the production of information (research), provides health-related services (service) and reduces service costs.

In this regard, affiliation has important advantages such as training qualified manpower (training), producing information (research), providing healthcare (service), reducing the cost of service and enabling employees to improve themselves (Bor, 2015).

Apart from that, the affiliation parties have the benefits of taking advantage of each other's administrative and clinical forces, in order to meet the needs of the citizens in the best way (DHG Healthcare, 2013).

Considering all of these, the effects of leadership on organizational culture and organizational structure have been investigated in Affiliated Hospitals in

Turkey in this study. This study is important in that no research has been carried out on Affiliated Hospitals in Turkey so far. Therefore, it is believed that this study will guide future research types on this subject.

In the study, it is aimed to examine the effects of leadership and organizational structure in Affiliated Hospitals on organizational culture in Turkey. In line with this purpose, it is planned to firstly present, analyze and make recommendations for the leading styles of healthcare managers and for the effects of the organizational structures of Affiliated Hospitals on organizational culture.

As mentioned, the main purpose of this research is to reveal the effects of leadership and organizational structures in Affiliated Hospitals on organizational culture in Turkey. From this point of view, it is aimed to show, analyze and make recommendations for the connection of health managers with leader types and corporate culture. It is aimed to understand the impact of leadership and management of health care managers in Affiliated Hospitals in Turkey and to understand which / which of the structuralist, human resource; political and symbolic scales manifest themselves as influencing the position of being a leader and being a manager. The connection between organizational culture and leadership style shape with the formation of the organizational culture in Affiliated Hospitals in Turkey forms the basis of research.

In the light of the above information, the concept of leadership, the development of the concept of leadership, the development of leadership theories and major leadership theories are presented in the first chapter of the research.

Expansion of the concept of culture, conceptual expression of organizational culture, formation in organizational culture, values within organizational culture factors, types of norms, types of assumptions, forms of belief, symbol types, types of ceremonies, story types, functions of organizational culture, the connection of management and organizational culture, creating an organizational culture within health related organizations, the concept of matrix

culture, leadership types in matrix organizations and matrix organization chart are explained in the second chapter of the research.

The definition of management, the definition of health and hospital, the features in hospitals, hospital categorization, the concept of the affiliated hospital, reasons for the emergence of the affiliated hospitals in Turkey, and affiliation issues in Japanese management style are given in the third chapter of the research within the framework of the information available in the literature.

Affiliated hospital management, leadership in affiliated hospitals, problems encountered in the management of affiliated hospitals, positive and negative reflections of these problems, characteristics of organizational culture in affiliated hospitals, the functions of organizational culture in affiliated hospitals, factors affecting the formation of organizational culture in affiliated hospitals are examined in the fourth chapter of the research.

The fifth part is about the method of the research. A survey was conducted in the affiliated Hospitals in Turkey to determine which development areas are in the direction of the effects of leadership and organizational structures in hospitals on the development of organizational culture and to make recommendations related to the issue to 585 healthcare professionals acting in a leading position, including the Chief Physician, Deputy Chief Physician, Manager, Assistant Manager and Unit Supervisor Nurse, who were in the leading position in 21 affiliated hospitals in Turkey. The opinions of the managers about the positive development of their leadership styles and about improving the effects of organizational structures of affiliated hospitals on organizational culture were tried to be determined.

CHAPTER 1

LEADERSHIP

1.1. The Concept of Leadership

The concept of “leadership” has been studied by more than one researcher to date. Researchers wanted to analyze the concept of leadership and tried to improve its definition. Bennis (1959) argued that there was very little in the behavioral sciences other than what was written about leadership, in the study of the literature on leadership. Bass (1990) mentions that there are almost as many definitions of leadership as the scientist who has attempted to clarify the concept of leadership, thirty years after. In parallel with these thoughts, Burns (1978) clearly states this that leadership is the most watched and the least perceived celebrity in the world until today. Leadership is explained by different scientists with different definitions (Yukl,1994).

The types of definition related to leadership reveal as much differentiation in social life and connections. Today, some scientists examining the concept of leadership make more than one definition, different from another, of the type of leadership that has an impact. There are also similarities that allow us to categorize the definitions compared to the situation in question. Some of the types of definitions representing leadership are as follows: (Lunenburg and Ornstein, 1996):

- Being a leader is the process of influencing group activities to achieve goals.
- Being a leader means to influence. Being a leader is guiding within the framework of instructions, behavior and opinion.
- Being a leader is putting the other party under a beneficial influence.

- Being a leader is to form teams that are interrelated and focused on their goals.
- Being a leader means getting others out of their own needs and making them accept the goals of their groups as their own.
- Being a leader is to get individuals to move away from what they are personally interested in and to make individuals agree to follow a goal that is given importance to a group's well-being.

The leader is not only responsible for bringing out the vision of the organization, he/she has to be the person who regulates that vision and is accepted as an example in order to influence other employees simultaneously (Redman, Wilkinson, 2006).

Although being a leader and being a manager are used interchangeably to reveal similar meanings from time to time, they are essentially variant concepts. While the outstanding quality of leadership is towards innovation and differentiation, the main quality of being a manager is to keep and to protect (Lipham, 1964).

In the light of all these types of disclosure, we can state that the leadership situation is “the stages of influencing employees by optimally evaluating the tangible (individual and metafocal) and non-tangible (culture, value types, symbol types, forms of belief, etc.) foci in the organization.” (Hoy and Miskel, 2010).

1.1.1. The Development of the Concept of Leadership

The initial examinations were primarily to analyze the leader and studies were carried out on the qualifications of the leaders as the main signs of leadership. This restrictive form of review has been criticized for its lack of definition in the vital importance of leadership movements. The study, which personalized the influenced leaders with their movements, was named "Behavioral Leadership Theories" in the field.

Initial research has essentially become central to the leader and has been carried out in qualifications given to the leading individuals as the main signs of leadership status. This restrictive view has been criticized as it is faulty in

defining the vital importance of leading behavior patterns. The view that provides personality to the individual behaviors of the influencing leader is referred to as “Behavioral Leadership Theories” in the literature. Afterwards, “Power and Impact Theories” have been introduced in order to reveal the importance of the duties of the followers in a detailed way. Power and impact approaches are related to the origin, quantity and behavior of the use of power. “Situational Theories are focused on what will be the most effective leader movement that adapts to a situation as recommended by Bolman and Deal. Within the framework of the said situation, the behavior that reveals the quality of being a leader compatible with various situations cannot be mentioned; however, there are multidimensional opinions that define the individual with an effective leadership qualification at some point. Finally, “Cognitive Theories” have become relevant to the interpretation of the person and the construction of the meaning of leadership (Bolman and Deal, 2003).

1.1.2. The Development of Leadership Theories

In order to better understand the strength in Bolman and Deal model, it is important to analyze in the literature that has conducted leadership research. There is a great deal of published documentation about leadership issues. In our century, scientists have begun to research and put forward theories about leadership practices and styles at different times and conditions. By looking at concepts such as leadership, follower, sum of stages, and status from a certain window, many organizational ideas and approaches regarding leadership have emerged. Evidence has been shown that possessing distinctive qualities increases the likelihood that an individual making a leadership may be effective. However, this diagnosis does not mean “leaders are born” (Hoy and Miskel, 2010).

“Power and Impact Theories” have been introduced in order to know the importance of the roles carried by the followers that appeared later. Power and effect theories are related to the source, amount and attitude of power.

1.1.3. The Major Leadership Theories

Feature Approach

This approach, also called the “Great Man” theory, has influenced research related to leadership until the 1950s. In this approach, an attempt was made to identify the physical or mental qualities of the leaders that differ in relation with the behavior styles of the leading individuals. Scientists who make use of this approach try to find the qualities that make leaders different from their followers. Opinion about the key elements that make it clear that being a leader is related to the interior reveals the qualitative approach of leadership (Hoy and Miskel, 2010).

According to the perceptions of leadership who accept the feature approach, no level of education can make a person a leader unless he/she has the characteristics he/she brought together at birth (Bryman, 1986).

The feature approach was abandoned with the publication of a number of literature studies carried out in the 1940s and 1950s. For example, Ralph M. Stogdil examined 120 leadership studies related to the feature approach between 1904 and 1947. As a result of these reviews, Ralph M. Stogdil divided the individual elements about leadership into five general classes (Hoy and Miskel, 2010):

- Capacity (intelligence, vigilance, verbal skill, being original, ability to make accurate and fast decisions)
- Being successful (education level, scientificity, data, athletic success)
- Being responsible (being dependent on anything or person, being a starter, being persistent, being sociable, being active, trusting himself, desire to reach the best, being reliable)
- Participation (ability to be active, to be able to work collectively, to be coordinated, to be compatible, to be funny)
- Status (Income level, popularity in the community)

Afterwards, more than 200 studies conducted in fifty years have been analyzed by Myers, revealing the idea that the “A leader is formed by his/her qualities” approach is not sufficient. Myers' findings can be explained as follows: (Lunenburg and Ornstein, 1996):

- There is no relation between any physical quality and leadership.
- There is no relationship between superior intelligence and leadership.
- Applicable information types regarding the solution of the problems faced by the group make an important contribution to the emergence of leadership.
- There is an important relationship between feeling things, being assertive, working together, being passionate, balancing the feeling, being persistent, revealing the judiciary, ability in communication, being famous, being social, economic level, having self-confidence and leadership.
- There are no common qualifications in terms of leaders. There is not a common quality shared by all leaders.

The Behaviorists

Those who adopt the behavioral approach did not investigate the content of the concept of leader, showed interest in the behaviors and behaviors of the type of leader who could influence. Behavior-based approaches have sought to define definitions of leadership behaviors that support organizations to achieve their goals.

The Studies of University of Iowa

The first research that transforms the effects of different styles of leading behavior in the group into categories and works was carried out within the University of Iowa. In these researches, three different leadership styles were defined (Lunenburg and Ornstein, 1996):

1. Authoritarian Leadership: This type of leader gives a lot of guidance and does not welcome participation in decisions. He/she makes working conditions completely systematic for the employees. He/she has taken over all powers and responsibilities.
2. Democratic Leadership: These types of leaders direct the group to make more intellectual discussions and encourage members of the group to participate in the decisions to be taken.

3. Unconcerned Leadership: These types of leaders ensure that the group is free, and subordinates make decisions about themselves. In fact, those who are leaders do not lead the group.

In the researches carried out within the University of Iowa, it was observed that the employees preferred the type of unconcerned leadership to the authoritarian leadership type. While many groups managed by the authoritarian leader have more productivity among the groups managed by the democratic leader, the worst leader is far worse than the other two in terms of production is unconcerned leader (Lunenburg and Ornstein, 1996).

Even though Iowa leadership research takes a lot of variety in terms of the method they hold, it is considered important in terms of directing attention to the examination of leadership behavior styles. Apart from this, it also provides a suitable ground for categorizing and defining leading behavior styles (Lunenburg and Ornstein, 1996).

The Studies of Ohio State University

In the researches carried out within Ohio State University, it was aimed to define the direction of leadership behavior styles towards the organization and the group. In order to perceive the leadership style in different group types and situations, “Leader Behavior Description Questionnaire (LBDQ)” was used. As a result of the factor analysis carried out, the two dimensions that characterize the leadership behavior in many groups and situations that make up the sample have shown themselves. These dimensions are in the form of building and understanding. The dimension of building dimension refers to the target types of organizational performance, job descriptions and organization, recruitment, determination of connections with employees, evaluation of the products of the working forms in the group, and the types of leaders who put the communication channel types into the center of thought. The dimension of understanding means a leader who is confident, respectful, sincere, helpful and interested to make sure that his/her employees feel good (Lunenburg and Ornstein, 1996).

The Studies of University of Michigan

Research conducted under the University of Michigan was carried out in the same period as the Ohio State University studies. These studies are similar in terms of the determined leadership behavior types. Similar to the studies carried out by the University of Ohio, the leading behavior type has also become central on two grounds. “Production Oriented” and “Employee Oriented” are leading behavior types. It is important to achieve goals in production-oriented leadership. In employee-oriented leadership, it accepts employees as an indispensable factor of the organization (Şimşek, 2007).

The production-oriented leading behavior styles found in the research of the University of Michigan reveal the same leadership styles associated with the dimension of building the structure mentioned in the Ohio State University research. Namely, leader styles that focus on production establish strict working standards and closely control employees. In the leader styles that focus on the employee, they emphasize the personal needs of the subordinates and the improvement of the connections between individuals (Lunenburg and Ornstein, 1996).

When the scales of leadership behavior styles obtained in the research of the University of Michigan are examined, the question of which scale is put forward shows that the leadership behavior style has an effect on the organization's goals. The first studies reveal that the most productive research groups chose to work with the leader focus on the employee rather than the production. The results of the subsequent reviews reached the conclusion that the leader types, which ensure the best production, are the ones who focus on both the employees and the production. (Lunenburg and Ornstein, 1996). When the different results found in the examinations performed are examined, it is not possible to make a solid comparison between the dimensions.

Blake and Mouton's Leadership Matrix

It is one of the model types that express the leadership behavior type in two dimensions. They added two more dimensions to leadership behavior types that were found to be production-oriented and people-oriented (Lunenburg and Ornstein, 1996).

There are 5 key leadership styles in the matrix. The reason why Blake and Mouton's research is different is that there are 5 significant leadership type findings in a 9x9 scale matrix created on the axis ground (Şimşek, 2007).

Each approach to the matrix can be seen as a series of theories where power is used to activate individuals in production. In the event that each of its theories encounters a situation where certain levels of success can be achieved, a field with more than one mandatory administration is manifested. In order to increase the administrative passivity, there is a need to have knowledge about the methods in question and to be able to choose the best behavior that adapts to it from more than one possibility (Blake and Mouton, 1978).

The “Authoritarian Management” field, expressed in the form of 9.1. within the matrix, reveals the highest level of production-oriented and the lowest level of human-oriented leadership behavior. A manager who works with these approaches should rely on his/her authority, power and strict control to ensure top-level production.

The “Club Management” field, which is set out in the Matrix as 1.9. opposite to the above representation, matches the lowest level of production-oriented with the highest level of human-oriented leadership behavior. The interaction between those in the same profession and employees is personally dealt with. The “Impotent Management” field, which is expressed as 1.1. is the field with the least interest in production and human. Neither the presence nor the absence of the leader is evident. The “Balancing Management” area, described as 5.5. is located in the center of the matrix. It is expressed as "theory of finding the middle way". The "Team Management" field, which is expressed as 9.9. accepts that the focus of human and production is at the top level. Focused on target and striving for high quality and quantity results through participation, loyalty and conflict resolution (Blake and Mouton, 1978).

Likert System 4 Model

Another model that has been developed in connection with the understanding and grouping of the leader and the actions of the leader is the type of model that provides the four approach developed by Rensis Likert. According to this

model type, which has been developed as a continuation of Likert's studies at the University of Michigan, the movements of the administrators are divided into four groups. These groups include determined assumption types and movements. The first system to represent is the exploitative-autocratic model. The administration rarely allows subordinates to participate in decisions and does not feel relied upon the subordinates. As a procedure, the sanction is usually applied to. The second model that provides representation is the charitable-autocratic. At this point, the individual, who is the leader, has a reliance on his employees, and transfer is made to sub-administrators within the scope of various restrictions in more than one decision. Those who are in a subordinate position are also given a penalty in awarding motivation. The third system, which is named as the participatory model, is allowed to make technical decisions at lower levels of those who are in a subordinate position. In this way, it is ensured that employees can feel responsible. The structure shows four types of democratic leaders. The leader has a reliance on his employees. The decision-making situation has spread widely throughout the organization.

X and Y Theory of Douglas McGregor

Ways of examining the individual in the historical process were analyzed by Douglas Mcgregor and the views in question were systematized under two basic titles as “X” and “Y” theories. Mcgregor stated that the traditional organization is based on assumptions about the nature and individual motivation of the individual through decision making center, employee and executive connections and job control (Hersey and Blanchard, 1982).

Theory X is based on the theory that more than one individual has congenital inertia, needs to be steered, has excuses for not working, and has no qualifications. This approach, which is against the individual, has been the basis for the emergence of the idea that the individual is an organization that can be motivated with concrete motivants, which must be frightened by sanctions, and that creates not wide areas of supervision. Douglas Mcgregor has revealed that the theory of X is wrong when the universal applications of individual nature are applied, and that management theories, which are developed through these approaches, will lead to the misguided motivation of

many people working towards achieving organizational goals (Hersey and Blanchard, 1982).

Mcgregor thinks that the nature of the individual and the methods of motivating the individual must be thoroughly understood, and thus more success will be demonstrated. With this perception method, Mcgregor introduced the Y approach, which is also known as a preferable theory and as an individual behavior approach. This approach does not accept that the individual is congenital inertia and untrustworthy. As it is understood, Mcgregor tries to state that the forms of management provided by accepting individuals as the realizers of the decision types given by creating a wide area of control will not be enough to eliminate the personal expectations, therefore the level of influence of the organization will be affected from this. Apart from this, considering the theory, it would be correct to state that the individuals who are in the leadership position can evaluate the person, the decision-making stages of the organization, the methods of motivating the employees, and therefore the organizational system.

Tannenbaum and Schmidt Leadership - Style Continuity

Tannenbaum and Schmidt have researched in two leadership styles manifested in leadership-related studies carried out by feature and behavior approaches in detail. The Tannenbaum and Schmidt design has boss centered leadership at one end and subordinate-centered leadership at the other, and there is a combination that goes between the two ends. These compositions represent managerial authority and employee freedom between the two extremes and they are available at five points (Lunenburg and Ornstein, 1996).

Situationalists

Situationalists conducted a research on what kinds of forces exist between the viewers and the status that influence individual leadership movements. There is no single movement to be the leader by any situation.

- Fred Fiedler “Least Preferred Coworker Theory”

Situational leader effectiveness - Contingency model - Situational Theory is regarded as the ancestor of the individual and the theory that led to the

development of the Fiedler's situational leadership theory. Fiedler stated that there is no method of being a leader that is valid for a situation. There are various types of leadership that can act in the context of the current situation. The Least Preffered Co-worker- (LPC) scale supports employees to define and prefer the qualifications of the person with whom they can work well. Apart from that, the LPC level reveals the priority sequence regarding the completion of the person's work. Effectiveness in LPC is explained transparently. In all these cases, the leader is determined by checking whether he/she is effective and whether he/she has achieved the goal. However, when it is impossible to measure group performance objectively and reliably, the performance amounts of the leader or group are used. Fiedler states that leaders can be trained according to their situation at the same time (Hoy and Miskel, 2010).

The model has three situational variables:

a) Individual links of the leader among the elements in the organization (leader-member relationship),
b) System level of the task groups duties (structure of the task),
c) Power and authority (power of position) revealed by the position of the leader.

Fiedler states that these three variables can be categorized as being two main leaders, namely task-oriented and relationship-oriented (Fiedler & Mahar, 1979).

Fiedler identified three elements, revealing eight situations: good or bad leader-employee engagement, well-systemized or non-systematic task, high-level or low-level position, high or low power of position. (Hoy and Miskel, 2010).

Fiedler made three recommendations in terms of Contingency Theory:

1. In cases where auditing is very high, task-oriented leader types have more impact than relationship-oriented leader types.
2. Where audit is moderate, relationship-oriented leader types have more impact than task-oriented leader types.
3. In situations where control is low, task-oriented leader types have more impact than relationship-oriented leader types. (Hoy and Miskel, 2010).

Vroom’s and Yetton's Normative Contingency Theory

The contingency model of Vroom and Yetton, which is based on the prediction that organizational effectiveness is taken under the influence of leading behavior, is a result of the situational variables that interact with individual qualities (Hersey,1996).

In the decision-making stages, a leader is required to reveal the problems using quality and acceptable thoughts. The main problem in modern leadership within the framework of this theory is participation in decisions (Aydın,1991). This theory is important; because the development of leader types can be achieved with this theory and it has the ability to differentiate and diversify the leader styles that can resist different states (Hersey, 1996).

The problem for the leader is to analyze the characteristics of each situation and to act in the most effective way as a result (Aydın,1991).

Vroom and Yetton drew attention to the need to demonstrate what behaviors should be introduced in certain situations in order to increase the impact of the stage of becoming a leader. Vroom and Yetton have defined certain situations in which leadership styles can affect:

a) Autocratic process
b) Client process
c) Group process (Aydın,1991).

It would be wrong to consider that one of these leadership styles is randomly better than another. Because in this model, it is stated that each of these leader styles may be the leadership style that has the most harmonious effect according to the characteristics of the state it manifests. It is perceived that the leader style, which is compatible with one situation, will not adapt to another. Vroom and Yetton express the imperative to make a solution of the case in order to be able to prefer the most effective leader styles that are compatible with the situation they are in. In terms of the situation in question, they identified questions to support the analysis of the situation (Aydın,1991):

1. Does the problem that has to be solved obliged to take decisions immediately? Is time sufficient to get opinions from other people?
2. Is there sufficient information available to make a sound decision?

3. Is the problem systematic? Is the definition of the problem made and categorized?
4. Is it compulsory for the decision to be accepted by other persons in order to be implemented?
5. If the decision is made by the leader, what is the probability of its acceptance by others?
6. Are the objectives to be achieved shared by the others through the method of solving the mentioned problem?
7. Is there a possibility that the preferred alternative for the solution of the problem may cause conflict in the group elements?

Path-Goal Leadership Theory of House and Evans

The situation and its surroundings require different leadership behaviors that influence the followers with different products and different methods. The four leadership styles defined by House and Evans are as follows:

a) Supportive Leadership,
b) Directive Leadership,
c) Participative leadership,
d) Achievement-Oriented Leadership.

A supportive leadership approach is useful for the comfort of the business environment, if employees are lacking in trust or the work environment is strained. In addition to this, the Directive Leadership approach, which will provide a noticeable guide in terms of performing the task successfully if the work to be done is not certain or if the employee is inexperienced, can be used. If employees need expert knowledge, realizing the use of Participatory Leadership will increase group performance and satisfaction. Finally, if the task is very complex and high-level goals are set, Achievement -Oriented Leadership can be useful, which sets out the belief that employees have the level of competence to achieve those goals and high standards (Hersey, 1996; House, 1996:).

The theory is on a concept with two dimensions. The level of competence or maturity levels of link-oriented behavior and task-oriented behavior are added (Aydın,1991).

According to Hersey, Blanchard, and Johnson (1996), there are four different leadership styles of situational leadership:

1. Style 1 (S1) has been characterized as high level task related behavior and low level relationship behavior.
2. Style 2 (S2) has been characterized at the top level both as task related and relationship behavior.
3. Style 3 (S3) character was given as high level relationship behavior, low level task related behavior.
8. Style 4 (S4) has been formed in the form of task related and relationship in the lower level.

Three Dimensional (3-D) Leadership Theory of Reddin

Reddin has explored more than one review carried out within the scope of its leadership movements. He added the “dimension of effectiveness” to the scales named as the relationship and task that showed him in the previously conducted examinations, and provided the development of his theory. The way of analyzing the leadership and organizational effectiveness of Reddin in terms of these three dimensions has named the theory.

Leadership forms that are evaluated by Reddin to be effective are defined as follows (Aydın,1991):

a) Manager: It accepts a management thought that balances relationship and task dimensions.
b) Developer: It refers to the leadership style that shows more emphasis on the relationship and less emphasis on the task.
c) Well-intentioned autocrat: More than necessary attention is paid to the job and less than necessary attention to the person.
d) Bureaucrat: It shows minimum interest to the leader and the job itself.

Along with effective leadership styles, Reddin also defines ineffective leadership styles as follows (Aydın,1991):

a) Reconciliation: Reconciling leader is not a good decision maker. He/she is greatly affected by the enforcement.
b) Missionary: It is the way of being the leader in which the person is given maximum importance and the minimum importance is given to the task without being harmonized. Compliance is chosen as the main target.
c) Autocrat: Even if the harmony is not realized, the minimum importance is given to the person and maximum importance is given to the task. The autocrat administrator does not rely on anyone else.
d) Disinterested: It is the style of being a leader, with little attention, which is given much importance to both the person and the task in cases where it is not mandatory.

1.1.4. New Approaches to the Concept of Leadership

Almost all scientists who have researched and produced products in the field of management have definitions related to leadership. Nowadays, researches are noteworthy about the development of leadership classification rather than definition. While the first researches related to leadership were classified as authoritarian, democratic, unconcerned, production oriented and human oriented, today's researches such as "transformational", "instructional", "transactional", "distributor" are held.

Distributor Leader

Distributive leadership thought does not give increasing organizational obligations more than just one leader, but rather shows sharing and giving jobs to more expert employees. The involvement of more than one person in leadership related practices forms the distributional leadership core (Tanrıöğen, 2009).

Within this framework, the first work to be carried out after the leadership team is formed is to distribute 12 leadership responsibilities (Byfield, 2007):

1. Follow-up and evaluation,

2. Programming, teaching and evaluation data,
3. Progress in the teaching and evaluation of the program,
4. Gathering thoughts at one point,
5. Intellectual drive,
6. Elasticity
7. Exit points,
8. Conditional rewarding,
9. Providing social services,
10. Ensuring discipline,
11. Having an exchange agent,
12. Being Regulatory (Byfield, 2007).

The distributor leader should add to his / her own practices to monitor the other people and expand the classical constraints on leadership for other people who wish to actively lead the others. The distributor leader should keep in mind that other people also have leadership rights and responsibilities. In another way, the distributor leader creates opportunities for development both for his/her employees and provides support to those who try to improve themselves. For the distributor leader, knowledge is the most important asset, and in order to access this information, it is imperative to realize the participation event, to work together, to know the thoughts of those of the same profession. Distributor leader does not value people and their positions (Tanrıöğen, 2009).

Distributor Leadership aims at an organizational culture based more on task types than regulations. The distributor leader creates an environment of trust in the organization so that other people are demanding to be appointed (Tanrıöğen, 2009).

Instructional Leader

The importance of instructional leadership has increased as a result of the increased interest in the efforts of innovation in the phenomenon of education in the American society. The situation in question has made the political world close to each other of the professional institutions related to education. The task of the organization manager, who was previously accepted as a program manager, has changed as an instructional leadership with the influence of

modernity expectations of education policy makers outside the organization (Özden, 2004).

In general, the aim of instructional leadership is to clarify the strengths and behaviors that the organization manager, teacher and supervisors use to influence the people and situations associated with the organization. The most important aspect of instructional leadership that differs from other leadership concepts is that it gains intensity during the teaching stages in the organization. In this context, instructional leadership makes it necessary to be interested in teachers, students and teaching programs, learning and teaching stages in the organization. Management of the curriculum is among the leadership practice types determined in terms of instructional leadership (Southworth, 2002).

In a perception that the connected literature aims to increase the student achievement level by the instructional leadership, It will not be wrong to define the organizational manager especially the efforts shown by himself/herself and the others. Apart from this, those who are in the teaching staff of the organization are emphasized in creating this success, and it is reported that these people perform important duties in eliminating the problems. Instructional leadership is a resource donor who solves the organizational manager's instructional problems, a resource that provides the development of the teaching conditions of the classroom, a good communicator who can realize the use of all methods of communication phenomenon and an easily accessible leader (Çelik, 2000).

Burns' Transactional (Protective) and Transformational Leadership

Similar to the traditional “exchange theory” of sociology, it is a matter of exchange between the transactional leaders and their followers, categorized by James McGregor Burns in 1978 and defined by Burns (1978). In this way, they both get the one opposite. This change usually includes the audience of the leader. If the audience demonstrates the performance that meets the leader's expectations, their needs are met. For this reason, the leader is the individual who creates a high level of morale, motivation and performance in the team. Burns distinguishes leading individuals and power-holders. Burns (1978) stated that those who hold power possess the capacity to influence

others as a quality of their work. In order for a person to become a leader, it is imperative for the leader to encourage followers to achieve certain goals that fulfill the needs and demands, goals and expectations, and the types of values and motives of both the leader and his followers. Here, one or more people are concerned with leaders and followers to influence each other in order to gain a higher level of motivation and morale. Being a transacting leader basically accepts classical values, strong commitment to history and the future is revealed. Transactional or protective leaders are leaders who implement their administrative procedures efficiently and in compliance with the rules (Bowditch et al., 2001).

These types of leaders accept the leader audience connection as a “exchange stage” and often prefer the “rewarding” method (Schermerhorn et al., 1995).

Transactional leader types accept the ready-made system and organizational culture in the organization, but they cannot reveal substantial differences. When defining Transactional leadership, Burns shows that there is a simple change between the leader and his/her followers, which is based on economic or political reasons. The transformational leadership process is not a weak process. Transformational leaders are individuals who possess a protective structure as well as a more future-oriented form of administration in addition to those qualifications. By calculating the future, they prepare the organization for the future and provide a successful process for the organization (Savaş, 1998).

The difference between these two leadership styles is the following: Transactional leadership individuals comply with the existing principles, while Transformational leadership individuals examine the principles found in the future and set new principles. In the classical bureaucracy, they create an atmosphere compatible with being an entrepreneur and ensuring their own development and they have high level of energies (Çelik, 2000).

Functional and working qualities of transformational leaders were defined by Stone et al. (2002). In this context, the functional qualities of the individual who is a transformational leader are charismatic, having influencing power, providing motivation, and dealing with intellectuality. It is understood that the qualities of their subject of study are vision, trust, respect, sharing risk, finding

accuracy, shaping, participation in goals, realizing communication, ensuring demand, rationality, problem solving, engaging with the employee, following, listening, and strengthening. It can be stated that organizations that desire to make moves forward and follow innovative development policy types undoubtedly require a transformational leader type; because, it is obligatory for the employees to have a view that is open to innovations in the learning environment. Leaders have a lot of duty to reveal personal demand and enthusiasm, to improve themselves and to adapt to their environment. The transformational leader type not only focuses on innovation types and performance, they also consider increasing the trust and happiness of their subordinates. Research conducted in connection with transformational leadership reveals that this type of leadership has a leadership style that has an impact on achieving organizational goals. Leaders with transformational leadership qualities easily influence subordinates and can guide organizational goals (Buluç, 2009).

Ethical Leadership

Managers focus on the types of laws and regulations within the scope of their decisions made at organizational stages. It is mandatory to comply with ethics in the implementation stages of laws and regulations. It is thought that the ethical values of leaders influence the atmosphere of the organization from this point on the behavior of the employees. There is a relationship between popularizing organizational ethics and leadership behavior styles. In accordance with this situation, Pehlivan (2001) supports the idea that education managers are expected to comply with the ethical principles of their professions as well as the current laws and policy types while performing their duties. In the literature, it is stated that "institutionalization of organizational ethics is associated with an effective leadership behavior of the organization manager" (Özden et al., 2002).

The types of norms, symbol types and ritual types that have become habitual to perform in organizational culture may be the means of forming the structure of ethical values in the organization. It is hoped that the ethical perception, which is affected by the differentiation of time and the period, is applied to the organizations by the leader. An organization manager demanding to fulfill the

obligations of the century, must be honest, fair and moral, and try to increase the success levels of all students, in other words they must be ethical leaders (Gümüşeli, 2001).

The ethically oriented leader regards assessing the subordinates' ethical behaviors as a key factor. Only leadership skills are not sufficient. It is imperative that these abilities should be integrated with ethical forms of behavior (Buluç, 2009).

Visionary Leadership

Being able to plan a realist, credible future is considered as a talent that will take them to the future in their efforts, whose organizations are related to the uncertainty situation in rapidly changing conditions of the current period. Balcı (2001) has defined the concept of vision in the form of a dream and thought regarding the state of the organization recently. Özden et al. (2007) evaluated the visionary leadership type as a leadership that is at the center of creating the future together. Apart from that, Senge (1996) and Kotter (1998) accepted the concept of vision as a photograph that shows how the organization will be in the future. Visionary leader is a type of leader that plays a role in increasing the success levels of all students by facilitating the development of a learning dream shared and assisted by the elements of the organization, explaining, implementing and making it easy to follow. (Gümüşeli, 2001).

The visionary leader ensures that the subordinates have a thought about the future that will occur and will be related to what will be revealed. The visionary leader supports the understanding of long-term studies for subordinates and thus makes similar and long-term studies meaningful (Goleman et al., 2002:69).

Visionary leader creates a clear vision that collects long-term goals of individuals for the purposes of the organization (Oshagbemi and Ocholi, 2005:748; Bennis, 1997).

Super Leadership

It is the leadership style, led by Charles C. Manz and Henry P. Sims. It is a unique leadership method as a process that operates from top to bottom, which is often influenced by the threat that emerges from its authority regarding the

demands of the leader. The main subject in the individual who is a super leader is the imperative of self-leadership and the necessity of developing this energy with the superleadership style. In this way, individuals will use their talents most in the direction of their organizational goals (Neck and Manz,1996).

Being a super leader means trying to make others become leaders by themselves. For this reason, it makes various strategies. In addition, the super leader directs others to realize their leadership. The super leader establishes and implements the structure in a way that allows subordinates to be leaders in themselves (Manz, 2001).

It enables successful performance experiences, realizes the creation of a learning environment that does not have a threatening feature in terms of enabling positive spiritual and emotional experiences, struggles to create a positive persuasive effect that is transparent to experience and engagement (Neck and Manz, 1996).

Learning Leadership

The need for learning has manifested itself more rapidly than the speed of differentiation of an organization's environment. The fact that learning in organizations gained such importance has led him to show the concepts of learning organization and organizational learning (Özden,2002).

Peter Senge examined the concept of learning organization in his book “Fifth Discipline” in 1996. In his book, he mentions that the teacher event carried out by the learning leader has a purpose to help others learn. The most important feature of learning organizations is that they are sensitive to respond to differentiation (Töremen, 2002).

The concept of learning organization is not the name or title of a business or organization. The learning organization is a concept that is attributed to an organizational quality and used to distinguish the organizational quality from other qualifications (Korkmaz, 2008).

Argyris and Schön (1996) defined organizational learning as “error detection and correction process”. Organizational learning is the differentiation and growth of the information in the organization. It is a system that holds the values of organizational culture and promotes learning. The name of this

system is the learning organization. Everyone feels that there are opportunities for learning and development within the organizational culture created by the leader method found in learning organizations.

Instructional Leadership

Instructional leadership: "is the creation of an organizational climate in which the principal, teachers, students, families and the organizational board can work together to achieve the educational work." (Mc Evan, 1994).

Murphy (1998) claims that the differences in organizational management will continue to increase in the 21st century, and that the future administrators must be equipped with educational leadership tasks that can create organizational architecture, educational conditions that will facilitate learning and teaching, as well as the organizational architecture that can regulate the needs of their organizations in the direction of social life. Being an instructional leader is a leadership field that obliges to be directly involved with those who are educated according to other leadership fields, instructors, programs and teaching-learning processes on how to carry out teaching. There are three important forces that shape and define an organization. These forces are trained individuals, educators and social life. The lack of influence of the organization depends on the fact that these three forces operate within the scope of the curriculum program interaction. The main task of the organization administrators, who are in the form of instructional leaders, is to provide skillful coordination of these forces for the purposes of the organization in order to bring the quality of education to higher levels (Findley and Findley, 1992).

Charismatic Leadership

The charismatic leader is defined as an individual (Koçel, 2001: 483), who, by using his/her individual strength, can have a significant impact on his/her followers (Schermerhorn, Hunt and Osborn, 1995), and attract others to the side he/she wants. Within the scope of Weberian terminology, charisma is a concept that is used to bring definition to those who are given superhuman capabilities, who are understood to be different from other ordinary individuals, and who are believed to take social life away from the crisis (Aslan, 2003).

Charismatic leadership is a way of being a leader that usually manifests itself in crisis conditions, saves the situation, possesses extraordinary characteristics and strong character qualities. Strong common character qualities seen in such leaders, self-confidence, boldness, fascinating the others, power of persuasion, and raising motivation (Çelik et al., 2008).

Bolman and Deal's Multiple Leadership Approach

- Multiple Perspectives of Bolman and Deal to Leadership (Four Frame Model of Leadership)

Bolman and Deal's “Multiple Perspectives on Leadership” is based on the quad management theory developed by them. The leadership process has been influenced by the multiple perspectives brought to the organization. Bolman and Deal have developed four leadership approaches based on the four core organizational approaches (structuralist, human resources, political, symbolic) they have developed. These are the Structuralist Leader, Human Resources Leader, Political Leader, Cultural and Symbolic Leader. Leadership approaches are guiding windows to the world of leadership and management. The right window makes a job easier and the wrong window causes a detour (Bolman and Deal; 2003).

- Structuralist Leader

The structuralist leader focuses on the elements related to the "structure" dimensions of the organization. It reveals the side of the organization rather than the human. He thinks that the problems arise from the structure. Leaders who use structuralist leadership effectively are seen as "social architects", while leaders who put forward the chain of command and control function can become "cruel and autocrat" (Şimşek, 2007). In this context, the qualifications of the structuralist leader are shown below (Bolman and Deal,2003):

- Structuralist leaders clarify the organizational goals and tasks.
- Structuralist leaders regulate the working environment in accordance with the health conditions.
- Structuralist leaders do not act biased
- Structuralist leaders constantly experience, evaluate and differentiate.

- There is no principle stating that that "Structural leaders constantly use their authority".
- Structuralist leaders provide a modern work development compatible with the problem
- Structuralist leaders' procedures for solving problems are not a chain of command.
- Structuralist leaders and employees are aware of their roles and obligations and benefits to the organization.

A structured scenario directs managers and leaders to play key roles such as explaining goals, continuing relationships between building and the environment, and developing a clearly defined role and a bunch of relationships that are appropriate for what needs to be done. Without a useful structure, people are not sure about the things they need to do. The result will be confusion, frustration and conflict. In an effective organization, individuals comprehend their responsibilities and contributions. Policies, links and chain of command are straightforward and accepted. With the right structure, the organization can achieve its goals and individuals can see their roles in the great scheme of things. The main role of a leader is to focus on task, facts and logic rather than personality and emotions. Most human problems arise from structural defects, not personal limitations or obligations. The structural leader is not a strict authoritarian and does not try to solve every problem by ordering around (which is often an appropriate behavior). Instead, the leader tries to design and implement a process or adapt the existing structure to the situation.

Human Resources Leadership

There is a humanistic tone and emphasis on people. In this type of leadership, a human point of view is optimistic. Participatory democratic management is the most appropriate management for human nature. Effective human resource leader plays the role of "catalyst" in terms of accelerating the group, while excessive human focus can turn the leader into "toy" of subordinates (Şimşek, 2007).

Human Resources leadership style emphasizes the organizational order focused on individual needs to ensure satisfaction (Bolman and Deal; 2003).

Individuals whose needs are met are expected to fulfill their organizational role expectations and be productive (Barnard, 1938).

The individual who leads in this style supports and strengthens the image of an individual. The Human Resources leadership type includes the following (Bolman and Deal, 2003):

- The individual is the center of the organization
- Managers who have authority and are not sensitive cannot be successful leaders
- They work hard to achieve the goals of the organization and employees.
- They support and strengthen employees
- They believe and trust employees
- They are individuals with easy communication.
- They share information and support participation
- Those who are in the position of subordinate are strengthened by ensuring fair autonomy
- They are honest people, problems are solved together.

The human resources leader believes that man is at the center of any organization. If people feel that the organization is sensitive to their needs and supports their individual goals, they feel loyalty and devotion to the organization. Managers who are authoritarian or insensitive, who cannot communicate effectively or who are not affectionate to people can never be effective leaders. The human resources leader works for both the organization and its people and by seeking to maximize the interests of both parties. The leader's job is to support and strengthen. Support can take various forms: to show interest, listen to people's desires and goals, and to convey personal warmth and openness. The leader guarantees the freedom and support people need to do their jobs and empowers them by including them in decisions.

Political Leader

Every organization has a political reality and people are part of it. The political leader clearly shows what he/she wants and interprets the balance of power

in the organization and the expectations of different groups. Accordingly, the political leader has the following characteristics (Bolman and Deal, 2003):

- A political leader positively advances his/her relations with non-organizational groups affecting the organization and can manage in case of conflict.
- A political leader knows and explains what he/she wants and what he/she can get.
- A political leader makes a good assessment of force, needs and connections.
- A political leader makes use of people by paying attention to their strength. Not every person is given whatever they want. It creates the necessary conditions for bargaining between groups.
- A political leader naturally welcomes social orientations such as human competition, competition, acting together.
- He/she assumes a “coalition founder role” among the subordinates and between the internal and external stakeholders of the organization, by providing unity of interests.
- Those who use their political skills to mislead people emerge in a short time and become “charlatan and demagogue”. (Şimşek, 2007).

The leader, who can act politically, thinks that administrators have to recognize the state of political behavior and know how to deal with conflict. A number of interest groups, each with their own agenda, compete with each other to capture scarce resources inside and outside any organization. There will always be a conflict, as there is never enough resources to give all groups what they want. The task of the leader is to know the main shareholders, to improve the relations with the leaders of the stakeholders, and to manage the conflict situation as efficiently as possible. Leaders do not respond positively to whatever groups want, but they can create areas where groups can discuss and different situations and come to an agreement among themselves. Leaders should also try to bring together common points in every employee's wishes. In cases where there are many opponents other than fighting, it is useless for people to spend their energy fighting each other. Any group that

does not regulate their own behavior within themselves is defeated by outsiders.

Symbolic Leader

Culture is an organizational dimension that includes the invisible, intangible and non-objective aspects of an organization. There are cultural parties that distinguish organizations from other organizations. People's behaviors, perceptions, values are related to the culture dimension. Positive cultural elements help to generate behaviors that will ensure the organization's goals are achieved. On the other hand, the opposite is true in organizations whose cultural texture is not strong. Cultural leadership creates mechanisms for the development of positive cultural elements.

- Cultural leaders create organizations with their own atmosphere and strength, and increase the loyalty of the subordinates to the organizations.
- Employees feel that the work they carry out is important
- They are sensitive to the organizational structure and time.
- They use the values that come from the past of the organization and which are settled effectively to reveal a positive culture.
- They ensure the development of vision

Within the framework of this aim, leaders are expected to be able to use the existing symbols that can be used to motivate and mobilize the movements of the organization employees in line with the goals of the organization, and even to create modern symbols. The symbolic leader believes that the most important part of the topic of work is inspiration - giving something to individuals to believe. When individuals feel that their work is given importance, they get excited and commit themselves to their jobs. Symbolic leaders who have influence have an ambition to make the organization unique in their field, and they pass on this ambition to other employees. These leaders use dramatic types of symbols to excite individuals and give them the sense of mission of the organization. These individuals are traceable and energetic. They produce slogans, tell stories, ensure rewards, appear in the most unexpected moment and go around and manage employees. Symbolic leaders are sensitive to the

history and culture of the organization. They try to use the best in the traditions and values of an organization as a basis for creating an interdependent and meaningful culture. They clearly state a vision that conveys the organization's unique capabilities and mission.

The leadership behavior model used in our study was suggested by Randolph (1985), developed by Ekvall and Arvonen (1991) and adapted to Turkish by Tengilimoğlu (2005). The explanations about employee-oriented, production-oriented and change-oriented leadership behavior styles in the scale were prepared in order to determine the leading behavior characteristics of the manager.

CHAPTER 2

DEPARTMENT'S ORGANIZATION CULTURE

2.1. The Concept of Culture

The word of culture, derived from the word "cultiva" in Latin, means "cultivating the land, driving, agriculture". Starting from the 19th century, the intellectual side of civilization and the traditions and accomplishments of social life have been put into use (Gürçay, 1994).

In the 19th century, culture was used as an intellectual aspect of civilization as a concept that brings the common traditions and customs of social lives to their success. While Thurnwald (1921) explained the phenomenon of culture as "the system, perspective and values of social connections in a society where people are present", MacIver (1937) emphasized that culture is the way of life and thinking of individuals who make up social life, their daily connections, art, literature, religion, joy and entertainment (Özakpınar, 1997).

Culture was defined as "collective programming of reason" by Hofsted (1991). Ziya Gokalp, broadly defined culture phenomenon in Turkey. Ziya Gökalp (1923) explained culture as "the whole of the institutions that support the connection and solidarity of the elements of social life" (Erdoğan, 1994: 2).

2.2. The Concept of Organizational Culture

Organizational culture has several different definitions. In our study, the most used definitions were evaluated. Organizational culture can be defined as "the structure formed by the types of norms, behavior styles, value types, belief styles and habit types that direct the behavior of individuals in an organization" (Dinçer, 1992).

Organizational culture, which has definitions in more than one different scope, can be defined as "the structure formed by the norms types, behavior styles, value types, belief styles and habits that shape and shape the elements of an existing organization". While the definition of organizational culture is made in the form of “organizing progress and continuity of success in the workplace, value types, forms of belief, expectations, norms, types of handicrafts, types of fine arts, and the use of historical artifacts as a tool”, identities of organizational culture elements are also shaped (Kırel, 1989).

The characteristics that make up the organizational culture in question include those that often help people and social life. With the aim of continuing the progress of the organization and increasing the success levels of the enterprises to the upper levels, it realizes the emergence of the identities of individuals with the existing common value types and targets. Edgar Henry, one of the prominent names who examined the organizational culture, defined the organizational culture as “forms of belief shared by members of a group, numbers and value types, learning outcomes of group life, bringing together the problems of integration and compatibility in a random group in the pattern of assumptions that have developed in the learning process” (narrated by: Kırım, 1989).

Therefore, organizational culture, which is shared by the organizational elements and is not in contradiction with the value types of the organizational elements, gives an organization-specific character, shows the different sides of the organization from other organizations and ensures the unification of the organizational elements around the common goals and makes them motivated to achieve these goals (Çakır and Örücü, 1999).

Edgar Henry also conducted studies (1988) investigating the organizational culture, and as a result of these reviews, her claimed that organizational culture has assumptions in terms of the forms of belief, the types of subordination, the outcomes acquired outside the group life, the forms of assumption, the types of hypothesis, the types of common values and goals brought by the elements of a random group. The organizational culture, which is shared by the organizational elements in question and does not change the common

characteristics of its elements, is the most important feature that makes the organization and its elements different from other organizational systems. In this way, it realizes the orientation and motivation towards common goals and interests with the cultures of the organizational elements. Scientific research on organizational culture has intensified since the 1980s. Scientists from different disciplines such as anthropology, psychology, sociology, and management science conducted research in organizational culture and explored different aspects of organizational culture (Gizir, 2008). The reason for this situation is the desire to show the reasons of the decrease in the performance of American companies in other states and especially Japanese companies (Kırım, 1989).

The types of politics and strategy, principles of business, role types, attitudes and behaviors, norms and traditions that make up the content of organizational culture are the identities of organizations. The hopes of organizational elements to accept and adapt to the organizational culture remains up to date in every period (Zeytinoglu, 2007).

“It can be stated that different factors affect the formation of organizational culture. The founders of the organization have an important role in these stages of emergence. Because the founders are not limited to the types of philosophy and ideology before, it is natural that they have effects in the organization in which they will systemize the types of values and beliefs they hold” (Terzi, 2010).

Apart from this, not only the value types and belief forms of the founders of the organization but also the value types and belief forms of the elements have effects in the formation of organizational culture. After the organizational culture is created by the founder or leader of the organization and by those who spread their thoughts, it is imperative to transfer the organizational culture to the new entrants of the organization. The application forms of human resources are very important for the development of the organizational culture and acceptance by the employees. For example, the selection of suitable candidates during the recruitment of employees, the assignment of recruited employees to jobs compatible with their role definitions, providing in-service

and out-of-service trainings and ensuring their continuity, promotion activities, adaptation of beginners to organizational culture, awarding those who show compatibility, sanctioning of those who misbehave should be realized. The transfer of organizational culture to the employees can be conveyed in terms of story types, customs, symbol forms and the language of the organization (Gümüş, 1995).

2.3. The Elements of Organizational Culture

In terms of content, organizational culture is categorized according to the visible (concrete) and invisible (abstract) elements. While the invisible elements in this culture constitute the types of values, norms, assumptions and beliefs in the organizational culture, the visible elements are the material characteristics, symbol types, ceremony types, story types, legend types and hero types associated with the organization (Berberoğlu, Besler and Tosun, 1998).

The organizational culture for the organizational literature has produced two substantial supports. The first of these additions has been enriched in terms of content of the organization literature with the researches carried out against the organization system of concepts such as myth, ceremony story hero. The second support is that the elements belonging to the organization in terms of the concept of organizational culture can be interpreted again with the concept of culture. Except for explaining the systems of similarity with the division of labor in the organizational system, for example, within these scopes, it ensures that it is explained in terms of cultural activities such as ritual and myth, which are mandatory for organizational activities. Beyond being able to make long-term decisions of the plan types within the strategic scope, it also creates a cultural formation that makes it important for the organization to be able to comment on the events in the past (İpek, 1999: 2). The mentioned factors are explained below:

<u>Values</u>

In the corporate culture, the belief styles and value types that show the commonness of the organizational elements constitute a significant factor.

Culture emerges with the forms and beliefs of people sharing and revealing commonality. All of the mentioned value types form the basis of the perception structure in the organization and are selected at the stages of organization's internal and external compliance with this main philosophy (Akıncı, 1998).

Norms

Norms are the rules of the organization that are not usually determined in black and white, and the directional sets that show what the organization has to do or how they have to behave. (Bütüner, 2011).

Suppositions (Assumptions)s

The word "assumption" means to establish validity through mental approaches in the stages of proving or validating. On a different scale, the definition of "assumption" is defined as the meaning based on judgment, belief and generalization which is accepted as real and true. (Şişman, 2002).

Beliefs

Forms of belief in organizations are the types of values that limit the beliefs of the elements. In this respect, it affects individuals with the belief that success can be achieved as a result of the work carried out as a motivating belief and as a result of achieving a reward. The forms of belief that people possess constitute the formation and continuity of the organizational culture. In this respect, the values added by the belief styles to the people and their gains in communication and valuation are formed. Due to the situation in question, the elements allow organizations to have different views in one respect and enable them to be different from other existing organizations (Bakan, Büyükbeşe and Bedestenci, 2004).

Symbols

Organizational culture is perceptible with symbols that explain the representation of organizations in social life. The symbols that exist with gestures, mimics and behaviors that are created in abstract form and that show the culture of the organization create an environment for the emergence of desired ideas within the meaning or values they carry. These symbol types can

be colors, words, forms or activities that contain value and quality in terms of organizations. The sign types of the cultures and organizational structures in the organizations and the types of symbols are in a place that sends messages to the internal and external environment. On the external side, the symbol side is delivered with message types and approach forms that contain the characteristics of the organization (Bakan, Büyükbeşe and Bedestenci, 2004).

Ceremonies

The ceremonies have an important place since the organizations are collective interests created by people with similar target types and value types. There are more than one purpose for the realization of these ceremonies. In general, the main purpose of the ceremonies is to show the success of the organizational elements to other elements, to achieve the motivation and success of all the organizational elements like the person in question and to increase the loyalty of the employees to the organization. Generally, types of ceremonies are among the factors that aim to raise the levels of success of the elements to higher levels (Erdal, 2010).

Stories

Stories and elements are conveyed to the formation and stages of organizations, and to enable the founders of the organization to have a high level of potential and motivation in the eyes of the elements. The types of stories that are most frequently told within the scope of the aforementioned are the stages of the organization and the solutions to the problems faced. Due to the stories, the gains that the organization will provide can generally motivate the mission to realize the missions aimed by the formation by accepting the visions of the elements (Ozankaya, 1983).

2.4. The Functions of Organizational Culture

It is stated in the literature that there is a formation in terms of organizational togetherness, motivation, efficiency, effectiveness, performance, control, communication, socialization and problem solving factors related to organizational culture. The functions of organizational culture are listed below (Varol, 1989):

- It makes it possible to transfer the obtained and shared values to the future elements of the organization.
- It provides the identity of the organization and enables the identification of the elements with that identity.
- The elements at the bottom of the organizational steps are generally not knowledgeable about the processes.
- It adds innovations to the lives of the elements and socializes them.
- It facilitates the compulsory differentiations that can be found in the organization system.
- In terms of systemic factors, it integrates the tasks with its features such as culture, security, health, adding meaning to life and customer service.
- It is the basis for the continuity of the organization to be feasible.

2.5. The Relationship Between Management and Organizational Culture

In organizations where individuals are at the basis of their systems, the ability to become knowledgeable is on the same ground as the organizational culture. In this framework, the increase and the continuoity of success levels of organizations are present in the creation of organizational assets and in maintaining the commitment to these assets (Şahin, 2010).

The motivation of the elements in terms of organizational culture is possible only if the organizational and administrative amounts are increased, and the elements acquire the values created by the organization. These values are generally shown as final and support values. The final values in question constitute the qualities of the organizational culture regarding superiority, consistency, prediction, determination, acceptance of innovation, economics and ethics. Support values are business behavior, respect for traditions and authority, taking precautions, taking courage, honesty and taking risks. All these values are composed of elements that include the mission and official objectives of the organizations in terms of their features and factors (Şahin, 2010).

Organizations show different operational stages by including the main elements and factors of the administration in terms of their cultures and values.

In this framework, although the legal factors are similar and the stages and system formats of the organizations whose function areas show similarity, the results may show changes. The subject matter can be monitored in all of the state workplaces, volunteer-based organizations and organizations located in private workplaces. Although the functional areas of the organizations are similar, the efficiency, stability and success amounts are different in each (Şahin, 2010).

Whether the activity areas are state or private enterprises, the values of success and activity amounts in organizations reveal belonging to the activities of managers or administrations. The existence and success of the organizations are possible with effective management in the form of water and air, which are the most essential factors for individuals to sustain their lives. Cultural values of organizations in the social life in which life is maintained are possible with the administrations that ensure that the socio-cultural values of the people and the culture that the organizations possess include compatibility (Acuner and İlhan, 2002).

2.6. Creating Organizational Culture in Health-Care Organizations

The forms and beliefs of the elements are shaped by revealing the organizational culture. Since the elements constantly communicate and interact in the internal environment of the organization, the culture about evolution is self-created. In general, the emergence of a solid organizational system is formed by a culture that occurs on its own and which retains the features and values that the elements hold (Aktan, 2006).

Since the forces that provide and manage the organization do not belong to the factors that make up the culture as well as the individuals that are managed, they have the right to the formation of the corporate culture. Apart from this situation, the employees also realize the formation of a culture of their own factors and norms in the establishment of the corporate culture. Organizational culture, which indicates all of the common values of the employees, is formed within the scope of common values and beliefs at the stages of occurrence (Aktan, 2003).

The organizational culture, which has a learnable quality, should be learned primarily by the individual at the top of the organizational system. The statements of the administrators or the employees transform from ideas to attitudes, habits, characters and culture in priority. In these stages, culture affects the formation of organizational culture in a wide range (Aydın, 2000).

Organizational culture is formed due to the fact that the features that cover the values are on the same ground. These features constitute the basis of the dimension of people's feelings about the organization, the way they carry out their activities, and the behavior of the employees in the organization. Organizational culture is formed on the main features (Özkalp, 1999).

2.7. The Leadership Types in Matrix Organizations

* Senior Management (Leadership)

It is the individuals who determine the general policies of the organizations, determine and examine the targets and make the decisions that show vital importance in terms of the availability of the organization. These persons are mentally and physically distant from their employees. “If these managers provide charisma power, subordinates who are away from them will have the opportunity to identify with leaders as partners in their success while trusting the leader who will handle the affairs.”(Akat and Budak, 2002). In this way, these administrators integrate the employees in cases of crisis and economic wobbles.

- Mid-Level Management (Leadership):

In the light of the goals and policies that are formed, they deal with the unity of purpose with differentiations that have little effect. “They go to differentiations within the boundaries according to their appreciation, without excluding these aims and policies.” (Akat and Budak, 2002). On the one hand, these managers deal with the problems of their departments, while on the other hand, they are in relationship with other departments and people who are hierarchically above them.

- Sub-Level Management (Leadership):

They are the administrators with the highest relation to unskilled employees (employees who have not been given a random administrative obligation). “They meet with employees daily. The field of behavior dominance of these administrators is limited. They have to follow the instructions given to them in the best way.” (Akat and Budak, 2002). The sub-level managers have to know the problems of the employees and the technique of the job.

Job segmentation and specialization, which has been done in matrix type organizations, is another situation that causes systemic confusion. In particular, the vast advances in medicine and technology in the 20th century have led administrators in different styles to show themselves and specialize in medicine (Kavuncubası and Malhan, 1999). The reflection of these developments on matrix type organizations led to an increase in the number of employees and service departments. Leading forms of behavior include activities in organizing matrix-type organizational managers. Finding and evaluating the behavior information in question will determine the style of the leader managing matrix-type organizations and show the facts of organizational activity (Ofluoğlu, 2002).

As in all organizations of our age, matrix-type organizations are in differentiation and development. “The presence of mixed technology and intensive individual connections in matrix-type organizations, which constitute a significant part of organizations, causes administrative problems to occur. This situation causes the expansion of the areas where organizational services are responsible and affected.” (Velioğlu – Vatan, 2002). The success achieved at this point, or reaching the targeted places, or the effectiveness and efficiency of organizational services are closely related to the behavior of the leader. In matrix-type organizational structures, the manager manages the organization using the executive power given by the board of directors. “When examined in terms of execution, the organization's manager is at the top of the matrix-type organizational structures” (Seçim, 1991). One of the main duties of the matrix type organization manager is to coordinate and communicate in the organization, management board and organization sections of organizational services. “Another important task of the administration of the matrix-type organization is the development of long-term plans of matrix-type

organizations. In large organizations, the organization manager has several directors who are responsible for organizing finance, support and other organizational services and events" (Kavuncubaşı, 2000). In addition, the manager of the organization has a legal responsibility to the boss, social life, individuals and insurance companies. It is impossible for the master apprentice connection to be valid in the training of the management of the organization in conditions of Turkey. "The speed of role differentiation in the elements of the organization is very high. Apart from that, differentiating the administrators poses a lot of problems and it is impossible to realize information flow among the old administrators in the newly appointed ones" (Ateş and Sur, 1999). Therefore, the manager of the organization, who also lacks many benefits such as acquiring knowledge and skills on an untrained subject, and benefiting from the guidance of the literature, makes his/her decisions duly or, as is often seen, is under the guidance of his/her subordinates

While the wrongly made administrative decisions in a randomly selected industrial enterprise result in a decrease in production or financial loss, the wrong decisions in the management of the organization result in a decrease in the quality of individual life and destruction at the organizational level of social life. Apart from this, the decline in the quality of individual life, particularly related to organization and execution, results in destruction at the organizational level of social life. The misunderstanding levels of the organization managers reaching 60-70%, especially regarding the decision focuses related to the organization and the executive, are effective in the success of the administration in the organizations (Ateş and Sur, 1999).

Therefore, unlike other sectors, the value of bad administration in the health sector is paid with individual life. In line with the above-emphasized findings, when the leaders and leadership phenomena are investigated within the scope of today's organizational management, it can be stated that differentiation and innovation is a natural result, whereas leadership is not a mandatory stage to be achieved by strong leaders. It is seen that those who have strong charismatic leadership in one direction do not always have a positive effect on the institution or social life. Many negative charismatic leaders, who could not bring differentiation and innovations to institutional structures in order to

become indispensable for them, are still present in the past and today (Kılınç, 2002). In this center, there are issues that organizations must give importance to. These are not to reveal leaders, but to be careful to have transformational leaders who aim to institutionalize innovations and differentiation, build structures for institutions, and continue to lead by constantly raising the target point.

2.8. Matrix Organizational Chart

Matrix structure is an accepted system as of 1970. The nature of the matrix structure is the application of both product and functional systems at the same time or together. The matrix structure is an assembled view of the functional parts where those of the same specialty are grouped together and where a particular product obligation is grouped together in itself. Since these product groups do not contain the production abilities to be separated by difficulty, and employees can return to functional units or create production groups, they can be easily added, changed or distributed in proportion.

These product groups produced in matrix structure can be either temporary or permanent depending on the needs of the organization. First of all, it is this elasticity that makes the matrix structure very acceptable. But then, more than one organization found the matrix structure costly rather than useful. In the matrix structure, the employees are responsible for both the product manager and the functional department manager. Therefore, there is a double command chain in this structure. While other organizational systems generally have one-sided connections, the matrix structure has two-sided connections, namely both horizontal and vertical connections, and is equally important. By increasing the quality of communication, the matrix structure enables formal communication to occur not only with the existing vertical channel but also with horizontal channels.

The product manager and functional unit manager are liable to the top manager to achieve the determined targets. The role of the functional unit manager is to ensure the realization of the study subjects within his / her area of expertise in connection with the ongoing project. The role of the product manager, on the other hand, is to determine and coordinate what kind of work

will be carried out for the employees, consisting of different functional units, to complete the project on time and in the requested quantity. These product groups, which occur in the matrix structure, can take place temporarily or permanently according to the needs of the organization.

Matrix structure is a system used in medium and large-size organizations in an environment ready to differentiate where uncertainty level is high, when non-uniform technology is needed and where solidarity is required. The strengths of the matrix structure are: Elasticity, the ability of employees to spend all their time for the project, the project manager to coordinate the work related to a single project, and to collect and customize the technical skills required for the product or competitive environment. Weaknesses of the system in question can be listed as the fact that the dual authority system causes confusion and uncertainty, and the need for highly educated employees, which requires a lot of expenditure to bring together experts (Ofluoğlu, 2002).

CHAPTER 3

3. HOSPITAL AND MANAGEMENT

3.1. The Definition of Management

Management, in its most basic sense, is business through others. In other words, it is the process of achieving goals through people (Akmut, et al., 2003).

The availability of all the necessary resources available to achieve a goal does not guarantee the success of that goal. There is a need for an item to organize and organize these resources. This item is the management (Kavuncubaşı and Yıldırım, 2012).

Management, which is of vital importance for organizations, is a necessary and valid function in all organizations from the smallest to the largest (Güçlü, 2003).

The management function is under the duty and responsibility of the managers. Managers significantly affect the performance and efficiency of the organization with the decisions they take, the tasks they undertake and the operations they perform (Ersoy and Kavuncubaşı, 1996).

It can be argued that the concept of management started with human history. However, management in the sense of science exists in the last hundred years of humanity and the industrial revolution is seen as an extremely important event in terms of management (Baransel, 1979).

3.1.1. The General Features of Management and Executive Roles

There are certain qualifications required by a manager in businesses. In this respect, the manager should be in the form of decision-making, planning,

organizing, leading and motivating, representing differentiation, following and controlling employees, determining constraints, determining methods of information acquisition and entrepreneurs (Hitt et al., 1989).

Regardless of where they are located and where they are located stepwise, all administrators have a certain planning, organizing, direction, control, coordinate and decision making functions. Managers are required to have sufficient knowledge, skills and communication skills to perform all these activities (Gökçe and Şahin, 2003).

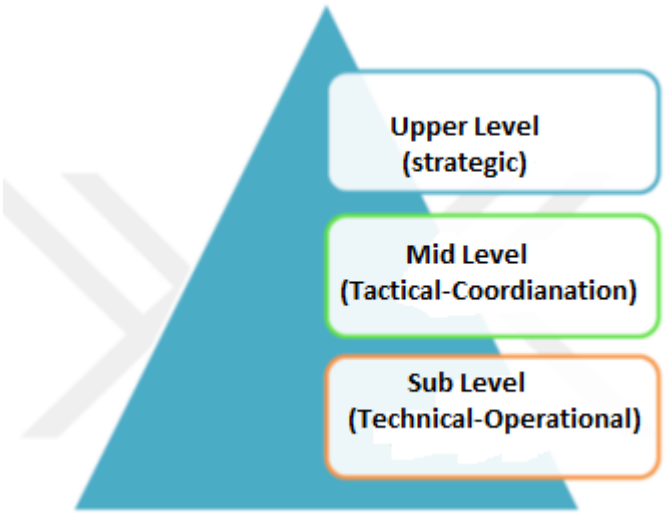

Figure 3.1. Management Steps in Businesses

Resource: (Tengilimoğlu, et al., 2012; Tuncer et al., 2009).

Managers work at different levels. In this context, there are three main levels of management in enterprises, as indicated in Figure 3.1. These levels are upper level (Strategic), middle level (Tactical - Coordination) and lower level (Technical - Operational). Top level managers increase the job satisfaction and motivation of the lower and middle level employees and ensure that the company achieves its goals and objectives (Şimşek and Çelik, 2011: 10).

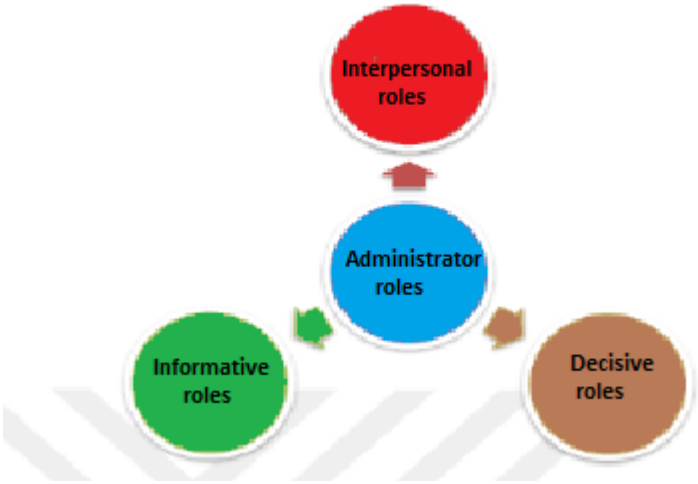

Figure 3.2. Executive Roles

Resource: (Kavuncubaşı and Yıldırım, 2012)

It relates to the roles of how managers do and play while emphasizing their functions and duties. Managers at different levels of management fulfill their roles in three categories defined by Mintzberg (Figure 3.2.) (Tuncer et al., 2009). Brief information about the manager roles is given below:

Interpersonal Roles

While explaining the concept of management, it can also be defined in the way that individuals can be directed in order to achieve the determined goals. When acting from this point, it is imperative that individuals are recognized in order to manage individuals. Assuming that the management is a process that relies on working together, it can be said that the manager has to communicate effectively with all people and work together. Interpersonal tasks include the roles of establishing relationships, chairing and influencing (Kavuncubaşı and Yıldırım, 2012). The interpersonal role of a manager includes subordinate and superior relationships, linking individuals within and outside the enterprise, and work based on structuring relationships. These roles are tasks carried out within the framework of interpersonal relations (Tuncer et al., 2009).

Decisive Roles

One of the main duties of the manager is decision making. The role types related to the decisions are related to the role types that the manager has to choose. These role types often require conceptual abilities as well as human connections. Managers at all levels face an infinite flow of decisions in the business, from how to respond to a customer complaint, to developing a new product group (Draft, 1994). Managers take the roles of entrepreneurship, problem solving, resource allocation and mediation while performing their activities related to decision making.

Informational Roles

Within the scope of the information roles, administrators are obliged to obtain sufficient information for the individuals with whom they work to perform their jobs effectively. Tasks in this category are related to internal and external information processes (Tuncer, et al., 2009). At the same time, all administrators need the right information to make effective decisions and implement them. Administrators have the opportunity to access more information from their employees due to their status in the institution (Lewis et al.,1994).

They obtain an opinion both by consultation with employees in their own unit and by making connections with different unit employees, and by evaluating the information in question. Managers spend most of their time in businesses collecting information from internal and external sources and distributing this information to employees and other stakeholders. The activities related to collecting various information from inside and outside the business and transferring this information to the relevant people constitute the role of the manager to provide information (Kavuncubaşı and Yıldırım, 2012).

3.1.2. The Functions of Management

There are resources on the one hand, and goods and services resulting from the management process on the other. In order for businesses to achieve their organizational goals, they must use these resources effectively and perform certain functions in the management process (Mirze, 2010). These functions

are all of the planning, organizing, directing, coordination, supervision and decision making functions as stated in Figure 3.3 (Tengilimoğlu et al., 2009).

Figure 3.3. Management Process

Resource: Atıgan, (2014)

To briefly explain the management process functions, the planning function is the determination of the mandatory means in terms of determining the objectives of the institution and making these types of objectives. The organizing function includes activities such as determining the ability to issue official orders and obligation links, sharing and designing jobs, dividing into units, acting together, and designing the information system. The guiding function covers all activities related to the individual element along with the sum of the main stages such as communication, motivation and leadership (Kavuncubaşı, 2000).

Coordination function is to achieve compatibility in the units in order to facilitate the work of the organization and increase the probability of success (Şimşek and Çelik, 2011).

The audit function covers the functions of determining the standards regarding the success of the organization, comparing the results with the standards and

introducing compulsory measures by finding deficiencies, if any. Finally, in the decision-making function, the most compatible of the alternatives found is selected (Atıgan, 2014; Ulukan, 2014).

Planning Function

Planning, which is a very important part of every management phase, can be defined as the preference of mandatory policies and procedures in order to achieve organizational goals (Can, 2005). According to the modernist definition, planning can be explained as “the decision of things to be done in advance” or “the process of determining when, where and by whom to do before” (Arkış, 1985). We can also define planning as “the stages of determining the purpose types and the functions that are obligatory in terms of making these purpose types”. (Can et al., 2011).

Managers use the information and findings they obtain to determine the long-term path of the organization through the successive seven-step strategic planning process. (Figure 3.4.) (Tuncer et al., 2009: 200).

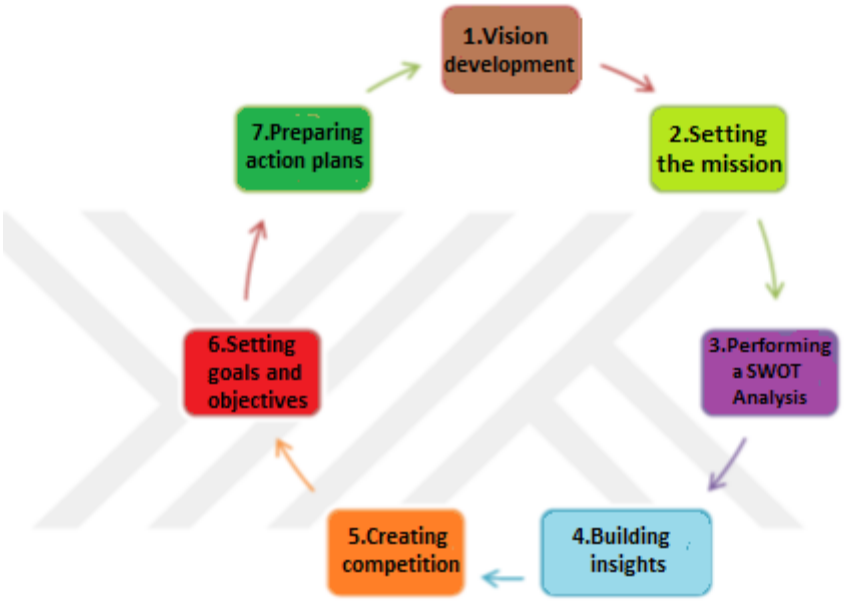

Figure 3.4. Steps of the Strategic Planning Process

Resource: Tuncer et al., (2009)

At the end of these stages, the management activities to be carried out for the purposes of the organization begin. Looking at the stages alone, it is seen that the planning function is a process in itself. Performing the planning correctly step by step increases the strength and efficiency of the management function (Koçel, 2001:).

The planning function has two main attributes. The first is a future-oriented thinking, valuation and investigation. The second feature is the relationship between planning and risk and purpose and assumptions. Planning reveals the existing risks and assumptions about this subject clearly and ensures realistic selection (Can, 2005). After the planning function, organizing function comes in the strategic planning process steps.

Organizing Function

The organization is a structure in which two or more people work together in coordination, in a way that indicates that they are conscious to achieve a predetermined goal (Can, 2005). Organizing is to arrange human, physical and technological possibilities and means in a way that reveals the purpose of the company (Tengilimoğlu et al., 2012). In other words, organizing means to regulate the authority, responsibility and report editing functions and to create the system. During the organization, the works are shared and the tasks are distributed by focusing on the activities that need to be performed. In terms of achieving the objectives, it is determined how the work and activities will be carried out, how the communication functions and information will be shared and how the audits will be carried out. The absence of an effective organization causes confusion in the business (Tengilimoğlu et al., 2009). The basic principles of a good working organization are as follows (Hayran and Sur, 1998; Eren, 2016);

- The principle of unity of purpose: All units that make up the basic structure in a firm should be realized in a way that enables effective and efficient participation in order to achieve similar goals or objectives.
- The division of labor and specialization principle: By dividing the work into small sections, instead of revealing the whole work, an employee reveals a single piece that he/she becomes an expert.

- Control area principle: The number of units that a manager will manage and supervise effectively and efficiently in each enterprise should be limited.
- Hierarchical structure principle: Authority relations connected from top to bottom must be meticulously provided.
- Order control unit principle: Each subordinate must have only one supervisor.
- Authority and responsibility principle: Supervisors of the groups may request to perform the functions determined from their subordinates.
- The principle of the equivalence of authority and responsibility: If the obligation of the person towards her superior is not equal to the authority of that person against his/her superior, it is impossible to perform duties.
- Delegation of authority principle: In order to perform the functions expected from the employees, the superiors should transfer some of their powers to their subordinates.
- The principle of economics: The organization should achieve the company's goals in a low and efficient manner.
- The principle of defining and explaining the activities: While the functions are grouped, they are grouped by analyzing, defining and classifying. Sections, units and sub-units can be grouped in the system, showing functions and activities.
- Management unity principle: It is an executive's functions that serve similar purposes within a certain program.
- Internal balance principle: The organizational system should be in harmony with the place of authority and responsibility transferred to its different levels in the organizational structure of that step.
- The principle of the organization being interchangeable: Since the social, economic, cultural, legal, technological conditions in the external environment that the company is influenced by are not static, the objectives of the company may also differ.
- The principle of facilitating leadership: It is imperative that the organization be in a system that will ease the work of its senior manager.

- Special principles: Specific principles that can ensure the effectiveness of the organization are obtained according to the branches of the companies themselves.
- The principle of simplicity and intelligibility: Every coordinated organization should be open and transparent.

Orientation Function

Orientation is a function that activates an organized structure and encourages employees to perform high in their work (Atıgan, 2014). The main purpose of the orientation situation is to realize the integration of the organization with the person and to achieve the goals of these groups at the top (Can, 2005). With this feature, people and their behavior form the subject of the directing function. After all, the orientation function is a comprehensive function that includes tasks such as leadership (Seagal, 1997). The orientation starts with the notification of what the manager has to do in line with the verbal or written instructions given to the subordinates in the lower ranks. The orientation function consists of the following stages (Kutun, 2011);

- Commending the duties of the employees according to their knowledge, skills and abilities
- Providing in-service training types to guide employees in order to achieve continuity in their work after their assigned duties.
- Imposing discipline in the phase of doing duties, awarding effective and productive employees
- Motivation of the employees.

Auditing (Control) Function

Auditing as a function is one of the four primary functions of management, which are Planning, organizing, directing and auditing. Supervision is the fourth of these functions. With this function, the manager determines the extent to which the desired targets are achieved and investigates the amount and reasons of this situation, if there is a difference between the planned objectives and the realized objectives (Eryılmaz, 1997). Auditing means checking whether initially planned objectives are met or not. This function is not only

related to the planning stages, but also whether it is carried out in a systematic way, which is mandatory at other stages. The control phase reveals what other levels are achieving (Ateş, 2011). The targets determined by planning, which is the first step of the administration, are set as the production standards desired to be reached. Managerialism tends to make these standards with all its other activities. Control activities measure the extent to which these standards are achieved (Mirze, 2010).

Coordination

It is the main goal of management to direct the efforts of the employees in the companies in order to ensure the success of the organization (Budak and Budak, 2016). Coordination is the harmonization of the working personnel and making them harmonious in order to reach the future targets of the business. In other words, coordination is the realization of the collaboration of the employees at the most appropriate time, in the most appropriate way and with the most appropriate tools in order to carry out the work more effectively (Dalay, 2001). In organizations where coordination is successful, the following points are at the forefront (Şimşek and Çelik, 2011);

- The departments are in harmony among each other.
- Continuous control is carried out for cooperation between departments.
- Each department is linked to other departments and knows what relationships exist between its functions and those of other sections.

Decision Making Function

Decision making in its simplest definition is that the person, the manager or the organization prefers one of the available options. Decision refers to the preferred activity or sequence of activities from many options (Can, 2005). According to another definition, decision making is the whole mental, physical and emotional stages associated with showing preference in ways that enable the business to achieve various goals (Eren, 2001). One of the main duties of the managers is to decide. Managers have the authority to decide which work to do, by whom, how, how and when. The important thing here is that every decision taken must be in harmony with the other decisions of the business.

The success of the manager depends on his/her ability to make decisions (Atıgan, 2014).

3.2. The Definition of Health and Hospital

According to the World Health Organization (WHO), health is not only a loss of health or failure of any organ to function properly, however, it has made a similar definition as a state of peace (comfort) in social and psychological terms. This definition made by WHO includes the social, psychological, physical and economic aspects of health (Kavuncubaşı and Yıldırım, 2010). Healthcare services are systems that are provided in terms of preventing the occurrence of diseases, treating patients with early diagnosis, protecting and improving health, and supporting individuals to have a long life and quality (Pala, 2008). In hospitals offering this service, defects and uncertainty are not allowed. Because the smallest defect to occur can directly cause the patient to lose his/her life. (Tengilimoğlu et al., 2009). Hospitals are the institutions where the diseases of the sick people are examined and treated, and all kinds of medical interventions with medical tools and equipment are made (Sur and Pataki, 2013). Hospitals have changed and developed rapidly with the advances in medical science and technology, hospitals have become increasingly important, and hospitals have become healthcare units that make up a substantial part of the health-related costs of governments (Menderes, 1995).

3.3. The Features of Hospitals

Hospital types are institutions that contain different qualifications and are evaluated among large enterprises that are organized to make different purposes arising from these qualities. Although being owned by individuals, governments or foundations or being a research-based university hospital changes some priorities of the hospital, ensuring efficiency in management is the common goal of all hospitals (Akbar and Özgülbaş, 2003).

Since service providers are the basis of hospital types, hospital administrations should take into account the economic principles. Therefore, management science has been accepted in hospital management in terms of all its methods.

The fact that the types of hospitals belonging to the person / individuals that are established as health enterprises established for the purpose of obtaining income are very much related with the amount of income. Providing income in health-related services is related to providing health services in the right place, desired quality and desired expectations (Kurtulmuş, 1998).

Hospital types are first accepted from service delivery organizations that benefit individuals who have lost their health, and the hospitals have various goals. The most important of these goals is to provide health-related services (Yükçü and Yüksel, 2015).

Hospital types continue to exist by targeting sick people to regain their health. Since the basis of establishing the types of hospitals is to provide health services to the patients in order to obtain their health, they are considered as one of the service organizations.

All departments of hospital types within the service sector are of great importance; because the scientific quality produced and the health service provided are similar to the rings of a chain. Therefore, the failure that will occur in one of the rings of this chain will affect the quality of the whole health system (Seçim, 2001).

Hospitals are organizations with a more complex structure than other businesses of similar size. There are different reasons for the confusion of the hospital system. The separation of too much work in the hospital system and the formation of specialization types are among the reasons that cause systemic confusion (Menderes, 1994). Another reason is the complexity in technology that is used. As a result of the development in technology related to medicine, the medical tools and equipment used in the diagnosis and treatment of diseases have gained a quality that can only be used by those who have increased in the form of menstruation and only by specialists (Yıldız, 2008).

The presence of large masses with which hospitals are in contact and the inability to impose a limit on these masses increases the complexity in the hospital structure. Another reason for complexity is the irregular situation in the

application of unhealthy individuals suffering from different types of disease. At the same time, the potential of patients with different cultures and different expectations, sharing too much work and becoming an expert are other reasons for systemic confusion. (Kurtulmuş, 1998).

Hospital organizations are the best examples of matrix organizations. One of the works carried out while organizing the organizational system of a particular institution or organization is to divide the activities to be carried out within the enterprise into groups within the determined bases. The division of the activities into groups such as medical-related service offerings, the services offered by nurses, describes the functional organization. Chief physician who is responsible for the types of services offered in medicine and head nurse who is responsible for the types of services offered by nurses are functional manager types (Beyatlı, 2017).

Organization is carried out on the basis of one or more than one of these separations according to size, field, technological structure and nature of the environment. When the function and property principle are evaluated together in grouping, the system that shows itself is expressed as a matrix system. In other words, matrix organization is a system that shows itself with the addition of the project organization on top of an organization in which the activities are divided into groups according to function basis (Özgen and Öztürk, 1992).

While only a doctor and a nurse are involved in the treatment of a sick individual, the doctor, nurse, operating room, physiotherapy and rehabilitation unit employees can also be present during the treatment of another patient. Since the treatment form being implemented is “customized treatment”, every person who has lost their health is accepted as a project for the doctor. The person responsible for the project is the doctor who treats the sick individual. Other team members who are in the process of treatment are liable to the doctor for the continuation of the service, and to their administrators who are committed to supply and professional matters (Tengilimoğlu, et al., 2009).

3.4. The Classification of Hospitals

The “type of healthcare provided”, “the duration of hospitalization of individuals who have lost their health”, “whether they belong to the private or public sector” and “how many beds are available” re often seen as the basis for the classification of hospitals. The classification of hospitals can also affect the service provided to incoming patients.

3.4.1. The Classification of Hospitals According To the Type of Services They Provide

Hospital types are classified in two groups according to the service they provide. Hospitals in this group are specified as general hospitals and private hospitals (Carson, et al., 1995).

General Hospitals

They are the healthcare establishments where the treatment of the patient types associated with the specialization branches are deemed appropriate, the examination is performed standing, and there is also an inpatient service regardless of the various emergency cases and age and gender changes (Seçim, 1985). Public hospitals are in this group (Okursoy, 2010).

Private Hospitals

They are healthcare establishments where the observations, examinations, diagnoses, treatments and rehabilitations of individuals of a specified age and sex or of a specified type of disease or of individuals with an organ or organ group are carried out (Kavuncubaşı and Yıldırım, 2012). For example, children's hospitals, maternity hospitals, physical therapy hospitals, chest diseases hospitals, oncology and psychiatric hospitals are examples of these hospitals (Tengilimoğlu, et al., 2009).

3.4.2. The Classification of Hospitals by Ownership

Hospital types in Turkey consist of publicly affiliated hospitals associated with the Ministry of Health, medical faculties of universities, hospitals belonging to foreign nationals and minorities, Hospitals belonging to associations and foundations and hospitals of private individuals. Whom the property belongs to, he/she is responsible for the entire administration and organization of the

hospital (Danacı, 2010). The owners of the abovementioned property, to whom the ownership of the hospital types of this type depend, also generally hold the management and control powers of the hospital. Hospitals are grouped in three classes according to their ownership status (Kavuncubaşı and Yıldırım, 2012):

Hospitals Directly Connected to the State

Types of hospitals that have direct connections with the state consist of hospitals affiliated to the Ministry of Health. Most of the hospital in Turkey is connected to the Ministry of Health. In 2005, the hospitals affiliated with the Social Insurance Institution were transferred to the ministry by law (Danacı, 2010). Finally, the Ministry of National Defense hospitals were connected to the Ministry of Health with a Decree Law issued after the coup attempt in 2016.

Hospitals Indirectly Connected to the State

These hospitals are University hospitals and Red Crescent hospitals. University hospitals are tertiary healthcare facilities that serve all social security institutions depending on the university concerned. They provide more unlimited health services than the Red Crescent hospitals. There are more than one function with the health care providers presented at university hospitals. Quantity and speed draw attention in the health services they offer (Kavuncubaşı and Yıldırım, 2012).

University hospitals are expected to perform three important functions. The first of these tasks is to provide health-related services. The second is the training that will enable those who can make presentations about the optimum health that is possible. Thirdly, university hospitals bring the benefit of medical-related examination to all social life and are asked to rehabilitate their diagnosis and treatment procedures in terms of health problems expanding to a very common field. These different tasks or elements meet by representing the triple leg of “service delivery”, “training” and “review” in different places and different organizational systems around the world.

Organizational systems in university hospitals are different in other healthcare businesses due to their different mandatory tasks. The fact that education and

research benefits are expected, along with the provision of health-related services from the university hospitals requires organizational systems be investigated to identify existing problems and develop solution methods to eliminate these problems.

Changes in the systems of university hospital organizations are often regarded as a result of local establishment conditions and the historical process, geographical location, past habits, the competitive environment for healthcare, and the types of strategic decisions that differ by the leaders and the time set forth (Pardes and Pincus, 2010).

University hospital organizational systems differ from other healthcare companies due to the different tasks that they are required to perform. Demanding education and research benefits from university hospitals together with health-related presentations makes it imperative to investigate the organizational systems, identify existing problems and develop solutions to eliminate them.

When the researches between countries are evaluated, it can be stated that the concept of integration is generally used in university hospital organizational systems and that the concept explains the level of connection between academic activities (education and research) and clinical activities (types of hospital and doctor practice).

Although more than one organizational model related to the university hospital organization is mentioned, it is observed that two different organizational models are generally valid (Wartman, 2007):

(1) Fully integrated model: It is the model type in which the common duties of the university hospitals or health service presentations, education and research activities are managed by an executive and the board of directors.

(2) Functional integrated model: In other words, functional adaptation model is a more elastic type of affiliated model in which each of the university academic activities, the practice methods of physicians in the medical faculty and the associated hospital activities are managed by separate and free

boards. The harmony of the elements is more functional than being systematized. It is observed that the three important tasks of education, research and service delivery are the responsibility of a single administrative leader and the person directly reports to the rector of the university in University Health buildings where the fully integrated model type is applied (Phillips and Rubenstein, 2008).

3.4.3 Functional Integrated Model

When the sample models of the Functional Integrated Model are investigated (see Figure 2), it is observed that the University Health Systems are a distributed organizational system. It is believed that the success of each task of university hospitals (giving health service-research-education) is associated with working together. Each element is under the responsibility of different administrators and boards. The conditions (market conditions, budget limitations, difficulties such as reducing costs, increasing access, rehabilitating quality and patient safety) necessitate clinical and academic activities to work together more. Therefore, it can be stated that the main emphasis is more functional than formal organizational harmony. Functional compliance is run at the strategic and operational level. The strategic level includes reconciliation and maintenance of who they are, what to do and how they can help each other. The operational level is linked to functional compliance, creating interdisciplinary teams for agreed goals, and making organizations and leaders accountable for results (Barrett, 2008).

The country's health practice structure and the medical faculty are also trying to support the realization of functional compliance by providing public agreements that achieve substantial increases in the amount of academic development funds transferred from the hospital to the medical faculty. With the aforementioned agreements, which are called “Academic and Quality Support Agreements”, the hospital structure provides financial assistance to the faculty in line with the comparisons made across the country and in relation to rehabilitation in clinical dimensions. These types of compromises provide flexibility in the use of funds available in the dean to invest in types of academic programs, different investigations and biomedical research. Therefore, these

types of reconciliation can be a public and visible example of how the medical school and health structure will help each other to adapt more at the functional level.

There is a type of organizational system implemented by university hospitals. However, it can be stated that they possess various common qualities. The first of these qualifications is the establishment of a research center in the university organization of university hospitals, as explained above. Application centers and research centers are directly connected to the rector. The rectors of these centers are appointed by the rector from the academic staff with the title of the director of the center. University hospitals are also managed by the "chief physicians" appointed by the rectors as top managers. Chief physicians organize research and education activities as well as medical treatment and care services within the hospitals. Although the chief physician is located as the top manager in the hospital, a title is not accepted as a staff or legal administration since the title of the chief physician is not found in the laws that regulate higher education. With this situation, the practice of chief physician is continued based on the organizational system of the Ministry of Health within the body of university hospitals. (Kavuncubaşı and Yıldırı, 2010; Özcan, 1995).

It can be stated that the processes of research and application centers associated with universities are followed in the establishments and organizations of university hospitals. On the other hand, it is seen that the major universities have introduced certain types of regulations belonging to their hospitals. These hospitals carry out their business operations with their own regulations. If there is no such regulation, they are executed by the Ministry of Health, Inpatient Treatment Institutions Business Regulation. The said regulations are implemented in the determination of the administrative system and the realization of the work and services within the university hospitals with operating regulations.

Another common feature is that universities 'medical faculties have a major impact on the management of hospitals' medical services. Although university hospitals are research and application centers affiliated to the rectorate, they are the places where medical faculties are trained by practice. The people

working in the service and laboratories within the university hospitals are accepted as university lecturers and these persons are in the staff of different departments. Although the heads of the department, who are the administrators of the affiliated department, are service or laboratory administrators within the hospital, the deans are the chief of the registry and have responsibilities. Chief physicians are appointed to university hospitals, but their legal authority remains limited; because the staff of the service providers and research assistants are at the deanery. In other words, the links between the administrators of the service and laboratories and the chief physician are not clear, and the uncertainty is further increased by the appointment of chief physicians with an academic title other than the professor (Özcan, 1995; Kavuncubaşı and Yıldırım, 2010; Küçükilhan and Lamba, 2007).

Another common feature in university hospitals is that the current administrative, financial and technical services administration in hospitals is carried out by the general secretary of the university and a chief officer who works in connection with the chief physician. Another legal regulation for the organization of university hospitals is in the “Decree Law on the Administrative and Organization of Higher Education Institutions and Higher Education Institutions”. In this context, the concept of “university hospital chief” was introduced in the university administration organization. The chief of the hospital is authorized in the main administrative functions of the hospital in the form of planning, organizing, coordinating and control in the administrative, financial and technical aspects, and has an obligation to the chief physician and the general secretary.

The stated functions are carried out through the hospital managers associated with the head offices. In the appointment of chief directors, the opinion of the chief physician is ensured and the chief directors are appointed by the rector. It can be stated that the hospital administrative staff is also affiliated to the Rectorate over the chief director (Kavuncubaşı and Yıldırım, 2010; Özcan, 1995).

The last common feature of university hospitals is that they are set up as institutions with added budgets and they have a revolving fund company associated with the services. Therefore, there is an added budget and circulating capital enterprise in the financial institutions of university hospitals. In the system with added budget, the chief of staff is the first degree rectors and the second degree hospital chief physicians. Hospital managers are also available as accrual officers. In the circulating capital enterprise, the chief of disbursement is the rector and can delegate this authority to his assistants, deans and one of the other executive committee members as he sees fit. As the accrual officer, there is a circulating capital operating manager. This system causes the formation of a financial organization with two different structures (Can and İbicioğlu, 2008).

Although there are minor changes in major university hospitals in Turkey, the main organizational systems of university hospitals are similar.

Private Hospitals

Progressing and differentiating life conditions, changing needs and the desire to spend a better life have made it possible to obtain healthcare services at a price. This service has been added to some or all of the price, resulting in high and sufficient quality of health services. Individuals are given the right to choose with private hospital services. Private hospitals can be divided into three groups: individuals, minorities and foreigners. The number of private hospitals, which was 556 in 2014, reached 562 in 2015 (https://www.saglik.gov.tr/).

Classification of Hospitals by Size

Classification of hospitals in terms of size is important for the organization. Hospital types are classified as 25, 50, 100, 200, 400, 600, 800 and above according to the number of beds available (Kavuncubaşı and Yıldırım, 2012).

Attention is paid to the number of beds to classify the hospitals as large and small. Hospitals with less than 150 beds are called small hospitals and the larger ones are called large hospitals (Yılmaz, 1996).

In addition to the number of beds, the number of staff and the number of daily patients are some of the criteria in the classification (Tengilimoğlu et al., 2009).

Classification of Hospitals According to Patients' Length of Stay

In this classification type, the classification was made by taking into consideration the duration of sick individuals staying in the hospital. The hospital types that are left in the shortest time are named as acute care hospitals. State hospitals are examples of the types of hospitals where patients stay for a short time. Health institutions, where more than half of the patients stay for more than a month, are called long-term hospitals. Types of sanatoriums, psychiatric hospital types, geriatric (elderly) hospital types, oncology (cancer) hospital types are the types of hospitals in question (Yıldız, 2008).

In addition, according to the 5th article of the Regulation on Inpatient Treatment Institutions, differentiation is made in the form of hospitals providing and not providing training. Training hospital types are the types of hospitals that provide specialized training. The types of hospitals that do not provide training services are named as hospitals that provide functional services and they are the types of hospitals that do not provide training in a random specialty branch and they just continue their treatment services (Okursoy, 2010).

3.5. The Concept of Affiliation and Affliated Hospitals

While affiliation refers to cooperation between today's institutions, it means "adoption" in Latin. When analyzed as a term, the word affiliation evokes a formal unity such as joining forces and solidarity. This togetherness, formed based on specific common goals, is also called positive commitment. In cases where one institution's human resources are sufficient, and another institution is sufficient in terms of physical and material, it means that the members of the first institution transition to the second institution to serve and receive training there. The universities and the hospitals carry out this type of cooperation in developed countries. Universities have their clinical education only in the hospital of a public, foundation or private institution by having only education

and research staff within the medical faculties. In this case, management reduce the workload of education and research staff (Aydın, 2011).

The word affiliation has come to the fore in Turkey, especially through agreements that express joint use between the Ministry of Health and Medical Faculties today (Anak and Ünalan, 2007).

In the 12th Medical Expertise Congress held in 2006, the word Afiliation was first brought to the agenda and the answer to the question "What Should An Ideal Affiliation Program Be Among Healthcare Institutions?" was sought. In the final declaration of this congress, it was recommended that “Afiliation is a feasible method in specialized education and necessary legal and administrative arrangements should be made for its realization” (Yürümez et al., 2018).

The first legal arrangement was made regarding the application of affiliation as stated in the law numbered 5947 in the Official Gazette dated 30.01.2010 and numbered 27478 and with the addition of the Additional Article 9 of the Health Services Basic Law No. 3359 dated 07.05.1987, "The relevant units of health institutions and organizations and universities under the Ministry of Health can be used together in cooperation with the ministry and universities..." (Official Gazette, 2010).

Later, on 18.02.2011, Regulation on the Management and Principles of Cooperation and Use of Health Facilities and Universities Related to the Ministry of Health was published. The purpose of the said regulation was determined as follows: “This Regulation has been prepared in order to regulate the principles regarding the additional payments to be made from the circulating capital revenues to the personnel within the framework of the legislative provisions regarding the use and cooperation of the relevant units of the health institutions and organizations and universities of the Ministry of Health.” Co-operation and working are two issues that manifest themselves within the regulation. It should be clarified that the resources of the Ministry of Health related institutions and organizations and / or departments of the university should be used together within the scope of the protocol to be signed

between the Ministry of Health and the university related to the Ministry of Health in terms of providing health services, training and research services or providing various common goals and benefits. The fact that the Ministry of Health and / or universities perform their roles and provide their services, the parties concerned behave, support and work together in the fields of education, service, and technique in order to reveal the common goals and benefits is defined as collaboration, that is, affiliation (Official Gazette, 2011).

As stated in the regulation dated 18.02.2011, affiliations are carried out between hospitals affiliated to the Ministry of Health and university hospitals affiliated to the Higher Education Institution within the protocol determined. The principles determined while making the said protocol are as follows:

- To ensure that the balances and rights between the two parties are protected, to ensure the efficient use of resources, to ensure that the affiliated hospitals do not see each other as competitors, to enable cooperation under equal conditions and to ensure the balance between university hospitals and state hospitals.
- To determine the training programs and rotations within the institution,
- To determine the training programs in the hospital for students who have undergraduate and graduate education (But, 2017).

With the protocol signed in question, state hospitals that offer secondary health care transform into a tertiary health research education hospital (Tuman, 2017). Regarding the affiliation, new legal arrangements were made in the following processes on 03.05.2014, 16.06.2016 and 16.06.2017, respectively, and the most appropriate method of affiliation was tried to be introduced. Finally, the last amendment to the application was made and a regulation was issued in the Official Gazette dated 08.05.2018 and numbered 30415.

The regulation on the joint use and cooperation procedures and principles of the health facilities belonging to the Ministry of Health and its affiliated institutions and related units of universities has been published in the Official Gazette No. 29744 on Thursday, 16 June 2016. The said regulation states that in the cities, where the number of people is below 750 thousand, state

hospitals and medical faculties will cooperate and it determines the working principles

According to the relevant regulation, related to the operation of Health Facilities:

> *Article 7 (Item 1) includes the following statement: "Health facilities, which are put into use together, are operated by the Ministry in accordance with the legislation that the Ministry is subject to, provided that the provisions of this regulation are reserved. The managers of the health facility used together are appointed by the Ministry, taking the opinion of the University. Executive appointments are carried out within the framework of the Public Hospitals Association legislation."*
>
> *Article 7 (Item 2) includes the following statement: "All kinds of health and support services in the health facility are under the responsibility of the hospital administrator, including the health service provision of university staff. The hospital manager is authorized to take all kinds of precautions within the framework of the relevant legislation for the smooth and efficient delivery of training and health services and he/she works in cooperation with the Dean in this regard."*
>
> *Article 7 (Item 3) includes the following statement: "Revolving fund accounts of health facilities that are put into use are combined with their assets and liabilities, provided that they are limited only to the units used together."*

Due to the economic difficulties of Medical Faculty hospitals, medical faculties invoiced the medical interventions they carried out in the third stage. Public hospitals invoice similar initiatives from the second stage. For example, public hospitals bill 800 TL to an initiative that is billed as 3 thousand TL by the Faculty of Medicine. Despite the excessive benefit of the resulting medical school, universities are struggling economically. It should be examined why universities are in financial difficulties under conditions where low invoicing is made by public hospitals (Aygün, 2007).

> *Article 9: "Health facilities used jointly are called university hospitals in terms of pricing of the health services they offer. There are many similar provisions in the regulation and they have been published in the Official Gazette."*

Another situation that creates distress is the circulating fund premiums. Today, the circulating fund premium received by the anesthesiologist within the state hospital is around 6 thousand TL. An anesthesiologist receives 10 thousand liras with the monthly fee. An anesthesiologist receives a circulating capital premium of 3 thousand TL within the medical school. With the emergence of this merger situation, employees such as physicians, nurses, and technicians who received a high premium before within the public hospital do not receive high premiums compared to the past. As a result, the circulating capital received by specialist physicians decreased between 3 and 6 thousand TL, and support health personnel decreased between 300 and 500 TL. Compared to the increase in revenues due to the merger event, the decrease in income arising from the supplementary payment regulation caused a decrease in premiums (Bilir and Kaçal, 2018).

Another important point is that, as can be seen in the article 8 below, those who occupy cadres of professors, associate professors, assistant professors, chief assistant staff who have no relation with the state hospital in the past will be able to take office within the state hospital in necessary and compulsory situations.

> *Article 8 (Item 6): "All physicians working in health facilities and related units in cooperation and joint use are obliged to be on duty, work in consultation and health services in case of important and urgent cases, to respond to the invitation made to them, if necessary, medical and scientific counseling, and regulation of seizures in the protocol provided that training activities are not interrupted".*

3.6. The Affliated Hospitals in Turkey

Table 3.1:

The Affiliated Hospitals Connected to the Ministry of Health of Turkey

Serial No	Name of the City	Name of the Hospital
1	Adıyaman	Ministry of Health, Adıyaman University Training and Research Hospital
2	Amasya	Ministry of Health, Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital
3	Ankara	Ministry of Health, Yıldırım Beyazıt University Ankara Atatürk Training and Research Hospital
4	Ankara	Ministry of Health, Yıldırım Beyazıt University Yenimahalle Atatürk Training and Research Hospital
5	Ankara	Ankara Yıldırım Beyazıt University Faculty of Dentistry Tepebaşı Oral and Dental Health Education Hospital
6	Bolu	Ministry of Health, Abant İzzet Baysal University Training and Research Hospital
7	Bolu	Ministry of Health, Abant İzzet Baysal University FTR Training and Research Hospital
8	Bolu	Ministry of Health, Abant Izzet Baysal University Mental Health and Diseases Training and Research Hospital
9	Çorum	Ministry of Health, Hitit University Çorum Training and Research Hospital
10	Erzincan	Erzincan University Mengücek Gazi Training and Research Hospital
11	Erzincan	Erzincan Oral and Dental Health Hospital
12	İstanbul	Ministry of Health, Marmara University Pendik Training and Research Hospital
13	İstanbul	Ministry of Health, Medeniyet University Göztepe Training and Research Hospital
14	İzmir	Ministry of Health, İzmir Katip Çelebi University Training and Research Hospital
15	Karabük	Ministry of Health, Karabük University Karabük Training and Research Hospital
16	Kırşehir	Ministry of Health, Ahi Evran University Training and Research Hospital
17	Kütahya	Ministry of Health, Dumlupınar University Kütahya Evliya Çelebi Training and Research Hospital
18	Muğla	Ministry of Health, Muğla Sıtkı Koçman University Training and Research Hospital
19	Ordu	Ministry of Health, Ordu University Training and Research Hospital
20	Rize	Ministry of Health, Recep Tayyip Erdoğan University Training and Research Hospital
21	Sakarya	Ministry of Health, Sakarya University Training and Research Hospital

The affliated hospitals connected to Ministery of Health in Turkey are given in Table 3.1. The number of hospitals is 21. There is one affiliated hospital in Adıyaman, Amasya, Çorum, İzmir, Karabük, Kırşehir, Kütahya, Muğla, Ordu, Rize and Sakarya. There are two affiliated hospitals in Erzincan and Istanbul. There are three affiliated hospitals in Ankara and Bolu.

3.6.1 The First Applications In Terms of the Concept "Affiliation" in Turkey and in the World

Affiliation is a long-standing cooperation model in the world (USA, EU Countries, Canada, Japan) (Çukurova, 2016). Although the protocols (first protocol 5 June 2009) have already started between Sakarya Training and Research Hospital and Sakarya University Faculty of Medicine, the use of the universities' Medical Faculties and the state hospitals affiliated to the Ministry of Health together, which are stated to be not at the desired level (universal meaning is named as affiliation) and affiliation has been initiated with the "Regulation on the Procedures and Principles of Cooperation and Use of Cooperative Units belonging to the Ministry of Health Facilities and Universities" published in the Official Gazette dated 18/2/2011 and numbered 27850.

The purpose stated in the regulation is as follows:

> *"This Regulation has been prepared in order to ensure the joint use of the health facilities of the institutions and organizations belonging to the Ministry of Health and its affiliated institutions and the relevant units of the universities, and to regulate the procedures and principles regarding the additional payment to be made to the personnel from the cooperation and circulating capital revenues".*

As a result of these legal arrangements, the basis for the implementation of affiliation policies has been provided. One of the important steps has been exceeded with the laws that will enable university hospitals and state hospitals to unite around the same goal (Anak and Ünalan, 2007).

3.6.2. The Affiliation Policies in Ministry of Health

Both the faculty members of the universities and those who are physicians in the public hospitals affiliated with the Ministry of Health have put forth the necessity to benefit from the hospitals of the Ministry of Health in order to eliminate the deficiencies in the practice of students studying in the medical faculty. Educators think that it would be beneficial for medical students to go to public hospitals for training. An affiliation program, which will be implemented for medical students before graduation, is important for students to get acquainted with the business environment and gain practicality. The affiliation program is important for educators working in public hospitals to update their knowledge. Ministry hospitals are structured accordingly (Yürümez et al., 2018).

3.6.3. The Affiliation Parties

The “Regulation on the Procedures and Principles of Cooperation and Use of Health Facilities of the Ministry of Health and Affiliated Institutions and Related Units of Universities” published in the Official Gazette dated 03 May 2014 and numbered 28989 is as follows:

> *According to Article 4, the affiliations parties are address based population registration system, Turkey Public Hospitals Authority, Ministry of Health, second and tertiary care hospitals and affiliated units attached to the Public Hospitals Association, oral and dental health services, and the Higher Education Council.*

3.6.4. The Advantages and The Disadvantages of Affiliation Hospital Application

Due to the advantages of the affiliation hospital application, significant differences between the education and research hospital educators and the academic staff at the university were prevented. to the advantage of those at the university in terms of personal rights. It is ensured that circulating capital distribution is done equally. The sense of loyalty has been strengthened among the education officers, and the feeling of exclusion and worthlessness has been eliminated. The changes in personal rights have been eliminated,

the continuous desire of the educators to be transferred to the Faculty of Medicine and the hierarchical problem of the Secretary General, Hospital Manager, Chief Physician and Dean in the hospitals were eliminated. The training of those who give education in public hospitals has been initiated as well as within the body of Medical Faculties. The trainings of the trainers in the Ministry of Health hospitals are provided, thus, it is possible for the students of the Faculty of Medicine to benefit. Physicians contribute to the education of students of the Faculty of Medicine. The trainers are prepared in accordance with this training, believe in the importance of this training, and have the necessary experience and skills.

From time to time, when the physical facilities are insufficient, students of medical faculties are sent to the hospitals of the Ministry of Health; but no student was satisfied with this situation. This is because the students of medical faculties who were sent to the hospitals of the Ministry of Health were regarded as a drudgery by people. Physicians of the Ministry of Health did not feel obliged to take care of the students as there was no mentioned issue in their job descriptions. Students who went to the hospitals of the Ministry of Health returned without training (Tuman, 2017).

Less reimbursement from the health services provided by the Social Security Institution to the hospitals affiliated to the universities has been prevented. Health Practice notification prices have been updated. For this reason, healthcare services have started to be provided in medical schools at the prices they should have, and the burden on circulating capital has been lifted. University hospitals, which were put under debt burden with the wrong policies, were connected to the Ministry of Health through protocols, and university hospitals were turned into service hospitals.

Protocols have been made between Medical Faculties and Ministry of Health hospitals. During the protocol, the public hospital was transformed into a Training and Research Hospital, although there was no random variation in its infrastructure. Due to the legislation, university hospitals have been started to be managed by the Ministry of Health (http://www.hataytabip.org.tr/hto/index.php/yonetim/57-saglik-bakanliginin-hastane-protokol-uygulamalari-afiliasyon-ve-saglik-bilimleri-universitesi).

3.6.5. Problems and Solution Suggestions in Affiliated Hospital Application

Employees, especially Specialist Physicians, Physicians and assistant Health personnel (Nurse, Lab Technician, Health Officer, etc.) were victimized. In fact, staff working in the General Administrative Services and Auxiliary Services Class cannot receive circulating capital. Although healthcare revenues increased after the merger of hospitals, Healthcare workers are victimized and lost motivation due to problems arising from the supplementary payment regulation (http://www.medimagazin.com.tr/hekim//tr-universite-hastanesi-Affliated-oldu-donerler-dustu-2-50-64622.html)

As the voice of healthcare workers, the problems arising in the supplementary payment regulation should be conveyed by the hospital management and the General Secretariat to the Public Hospitals Union Institution Presidency and the Ministry of Health and solutions should be determined. It is necessary to act urgently to eliminate the grievances of the employees and the unfairness in the circulating capital regulation.

3.7. A Case Study: Affiliation in Japanese Management Style

Japan is at a good level in terms of health workers. Approximately 275,000 doctors serve in the healthcare sectors. There are 210 doctors per 100,000 people. The number of beds in hospitals throughout the country is high. The average length of hospital stay is 56 days. This period is quite a long time. Most beds are often used to serve social goals. Use of beds for medical service is low. It is often private healthcare companies that perform the provision of treatments. The number of public hospitals is 450. The rest are private hospitals. Patients have the right to choose the health institution in which they

want to receive health care. A certain part of the cost of receiving health care is covered by the patient and the remaining part is covered by insurance. Acupuncture, Ying and Yang, Reiki, which is one of the alternative medicine applications in Japan, is widely used in traditional Chinese Medicine. These practices are regulated by law and incentives. The health structure of Japan is very complex. The most important deficiency is that preventive and curative health services are offered separately. This deficiency manifests itself as a problem during the delivery of health services. Another important problem is the financial problem arising from the increase in the elderly population. The population of Japan reveals a profile with the majority of the elderly. In this case, it creates health and social security problems. Most of the social security-related services are for the elderly population. This problem puts a lot of burden on the health structure. However, the future of Japan is in danger for this situation. Japan generally produces all medical devices and materials thanks to its advanced technology. Japan is in the class of states with Welfare Oriented / Insurance type health system (http://www.pasiad.org/).

The health structure of Japan is the best found among the advanced states. The structure contains high-level tools and equipment and performs the distribution of healthcare in the best way. This distribution creates less expense than other advanced states (www.heartland.org/article.cfm?artid=16528).

Within the framework of the World Health Organization (WHO) sequence, Japan is the first place among 191 states in terms of public health, health structure, knowing what their obligations are and fair financial contribution. It is the tenth in terms of the overall performance of the whole health structure (www.oecd.org/country/0,3021,en_33873108_33873539_1_1_1_1_1,00.htm)

The health structure of Japan is the second and first, due to low child and pregnancy mortality rates compared to 28 OECD states. The most important feature of the Japanese health structure is the market conditions and the fact that this situation provides more than one option in terms of both sick individuals and healthcare providers. In Japan, private businesses and government agencies have created markets for service delivery. Sick

individuals are obliged to decide where and when they want to receive the health service. Through the payments to the hospitals per patient and through the bureaucracy which was reduced to a minimum during the said payments, hospitals focus more on their primary care and better service means attracting more patients in hospitals. In the health structure of Japan, a certain part of the service expenses are covered by the sick individuals receiving health care. 20-30% of all healthcare payments are taken from patients. This situation ensures that sick individuals do not overpay service purchases and act more informed. Japan has more opportunities than other states in terms of equipment used in the provision of health-related services. The number of CT and MRI scanning devices of the profession is 10 times that of Canada in terms of per capita rate. (www.heartland.org/article.cfm?artid=16528).

Advances in environmental conditions, developments in medical technology, rehabilitation in healthcare enterprises in recent years have led to significant differentiations in the social life system. While the amount of coincidence of tuberculosis, which is considered as the most important causes of mortality, was 146.2 cases per individual, this amount decreased below 2 in 2019. Brain hemorrhage and stroke, a major cause of mortality, have fallen since 1970, and a slow increase has occurred in cancer cases, another cause of mortality starting in 1980. According to a study conducted by the Ministry of Health, among the causes of mortality, cancer ranks first with 28.5%, brain diseases 15.9%, heart diseases 15.1% and pneumonia 8.6% (http://web-japan.org).

CHAPTER 4

THE LEADERSHIP AND THE ORGANIZATIONAL CULTURE IN AFFILIATED HOSPITALS

4.1 Affiliated Hospital Management

The main thing leaders do in affiliated health institutions is to guide. Leaders guide their followers by improving their knowledge, strategic visions, risk-taking experiences and inspiring their subordinates. It is inevitable that leaders whose main task is guidance should establish a successful communication with their subordinates. The development of the communication skills of today's affiliated healthcare institution leaders can be considered as an opportunity for themselves for their future leadership positions. Affliated healthcare institutions' leaders should be able to predict future fluctuations during planning, analyze current situations and improve their experience, and solve problems in a guiding manner that improves processes. Affiliated health institutions leaders should work in cooperation with their subordinates and with a perspective that will adapt to changing conditions. These solutions should also provide benefits in the long term. There is a need for influential types of intellectuals within Affliated healthcare institutions, believing that the team will succeed, relying and using its authority based on participation. Leadership in affliated healthcare services that have an impact should be made strategically, vision should be determined, goals should be reached, communication should be provided with employees, motivations should be realized, opportunities should be created from innovation, and new and effective solutions should be found. A good leader must have the vision to successfully fulfill his personal and team goals. From this point of view, the leader should manage the inputs

and outputs well and increase the team motivation in order to reach the targeted goals within the process (Uysal et al., 2012).

Leader plays an important role in creating an affiliated hospital culture that can achieve high performance. For this reason, leaders should be relied on and they should create a culture based on a qualified patient treatment using effective means and systematically control this situation (Uysal et al., 2012). Opportunities should be created to increase the participation of individuals in the organization in the service quality and safety process. The leader should create a list of codes that complement acceptable, harmonious and useful movements. The leader should define incompatible and destructive movements and manage the process of getting away from the problems that these movements will give. Training should be provided so that individuals in the organization can focus on quality and safe health care. The leader should be in contact with staff at all levels.

4.2. The Leadership in Affiliated Hospitals

There is a strictly defined step management in affiliated hospital organizations. It is well known which of its employees is the manager of which one. Apart from that, there are more than one tool in which administrators can direct their employees according to their thoughts. In this case, it can be argued that there is no need for leadership status, so that employees do not need to monitor the manager with their initiative. However, a system determined in this way does not fulfill the need for leadership. Being a leader continues its importance for the following reasons (Hayran and Sur, 1997:262):

- It is impossible to instantly monitor the activities within the affiliated hospitals. Therefore, the top manager does not have the authority to ask his/her employees to act in any way they think. For this reason, there is a need for a mechanism that will continuously direct the efforts of the employees to the targets. This mechanism is also the phenomenon of leadership.
- The environment in which affliated hospitals are located is constantly changing. Top executives realize the adaptation and renewal of the business to different environmental conditions with their leader styles.

One of the most important functions of the leadership situation is to emphasize the importance of team work to its employees and to regulate harmonious organizational atmosphere conditions.

For this, top managers need to have some leadership qualities. Increasing efficiency and effectiveness of affliated hospitals and providing continuity of the quality of the services provided in the affiliated hospitals, which have an important place in the provision of health services, are gaining importance today. Increasing quality and continuity can also be achieved through the development of transformational leadership styles of top managers. With the development of leadership styles, the understanding of teamwork of top level affiliated hospital administrators working in relation to the leader has also become more positive and strong.

It can be said that the leadership-related understanding of those working as affiliated hospital managers can be effective in the following topics (Vural et al., 1999:14-15):

:

- Increasing productivity and quality by working with the team,
- Improvement of employee productivity,
- Ensuring that those who are in employment are satisfied with their work,
- Reducing the number of staff dislikes and complaints,
- Making the organizational atmosphere more positive and strong,
- Strong implementation of differentiation programs,
- Resolving different management problems.

Therefore, it is hoped that the administrators who have an impact on team work and efficiency of their subordinates will have good leadership with their managerial skills. Beyond good leadership, it is imperative that top executives have the qualifications required by their leadership understanding in the way they work together to create differentiation, to take into account goals, to inspire, influence, and to take risks.

It will be beneficial for the development of leaders to work on the following topics in Affliated hospitals:

- There is a need for administrators who demonstrate leadership style in affliated hospital managements. In this respect, it should be considered that the leadership styles of the administrators should improve in the affiliated hospital organizations. Therefore, administrators must participate in systematic trainings.
- The most important issue that must be taken into consideration in the management of affiliated hospitals is the communication of those who do business with the upper administration and subordinates. For this reason, affiliate hospital administrators should also be given importance to improve their communication skills and training programs should be organized.
- It is observed that the administrators, who have a duty in affiliated hospitals, do not develop their leadership qualities if their assignments are realized according to their political ideologies without paying attention to their competencies. In addition, employees do not respect their managers for these reasons and do not rely on their decisions and their knowledge. It will be ensured that these administrators are assigned according to certain license and merit. During their tenure, their promotion will be made according to the in-service training and evaluations. At certain times, their subordinates will be asked to evaluate them.
- Elements that negatively affect the leadership styles of administrators should be eliminated. Putting leadership lessons in medical institutions and educational institutions that train health administrators will ensure that managers of all levels in the health structure are trained to show their leadership characteristics (Tengilimoğlu and Cermikli, 2002).

In order to make plans in organizing affiliate, compulsory resources are collected and they work together. During the leadership phase, the manager tries to increase the belonging of his employees to the organization and creates conditions that can use the skills of the subordinates in order to reveal

the predetermined organizational goals. In the last audit stages, it should be checked whether the works are carried out correctly. (İnci, 2001:11).

In order to work as a team in affliated hospitals and to behave together and to be successful in organizational purposes, it is known that the affiliated hospitals' administrators are the factors that bring the organization to the determined goals, make the organization effective, and provide the employees with concrete behavior. For this reason, no matter how advanced the organization possesses the tools and equipment and quality employees, it is obvious that the determined goals cannot be achieved unless they are actively directed (Underwood and Kenner, 1991).

The obligation of a good leader is an accepted consideration, both for the subject of work and for all organizations serving the society. It is understood that the employees of our time are doing activities only according to the behavior of the person in the leader position. A significant part of the traditional leadership data in this sense has become the target of criticism today; because the quality, opportunities and environments of both leaders and followers have become different (Yiğit, 2004).

The concepts expressing leader and leadership are used with the facts of differentiation, vision and risk in today's world. With the definition of "differentiation" as "It requires creating a modern structure and in relation to that, the structure in question generally demands a leader", it is emphasized that the place where the leadership phenomenon is clearly separated from the management phenomenon is to accept the risk and to differentiate the structure (Kılınç, 2002)

Strategic leadership gives importance to the "positive interaction between leaders and followers and the values of the organization" as stages of foreshadowing organizations. Strong adaptation of the values shared in this sense to life will positively affect the loyalty of the employees to the organization (Sullivan and Harper, 1997).

Too many departments and specialties in affliated hospitals cause systemic confusion. In particular, strong developments in medicine and technology have

led to the emergence of different professions and specialization. The fact that these developments reflected on the type of hospital affiliated has led to an increase in the number of employees and units in the hospital (Kavuncubaşı and Malhan, 1999).

For this reason, leadership movements strengthen the efforts of the affiliated hospital administrators to achieve the targets and increasing the organizational loyalty of the affiliated hospital employees becomes more difficult.

4.3. The Problems Faced in the Management of Affiliated Hospitals, Their Positive and Negative Reflections

Affiliated hospital administrative problems are generally classified under three headings. These are as follows (Akoplat, 2009):

- Organizational System Problems
- Functional System Problems
- Employee Oriented Systemic Problems

Based on this approach, when the literature is investigated in the problems faced in affiliated hospital management, the types of services offered within the affiliated hospital are the institutions that are secured by all states as a constitutional right and that produce the types of health-related services that are very difficult to define. The mentioned feature makes the management and activities of affiliated hospital types more complicated. “Affiliated hospitals in Turkey give the appearance of problematic health institutions instead of being healing centers because of the lack of a system in which it can evaluate the difficulties in evaluating the service provided to the patients who are in customer status, and the working forces determined with objective criteria.” (Şahin, 2000).

The reason for the said situation reaching a complex state can be stated as the fact that the health expenses are made more than the plan and the need, and that the state is unable to pay the expenses. “The first of the goals expected from the transfer of health-related service delivery to the private enterprises is to remove the state, which cannot afford the provision of health-related service, from the monetary problems faced by the transfer of affiliated

hospitals to the private enterprises. The second case is that the lack of resources that show itself in the health structure and cause problems to the state is overcome by the method of personal expenses. The third case is that state resources are transferred to preventive healthcare services, other than the healthcare services that are transferred to private businesses. These expectations of the World Bank are considered to be widespread, with scarce resource types and preventive healthcare services, so it is the right choice to meet the actual needs." (Ak, 2001).

It is anticipated that the variations in the field of health and the differentiations made without revealing the estimates will reach the condition that will meet them over time. "It is possible to collect the problems seen in the health structure in three centers, which are politically based, connected with the organizational system, in monetary terms. In terms of political problems, health policies generally have a periodic feature due to the fact that health services are predominantly within the Ministry and political pressures and cooperation with non-governmental organizations cannot be realized as desired. In every change of political power, the Ministry necessarily differs in the bureaucratic system and a long-term, regular health policy and activity cannot be established. In terms of organizational system problems, it is mentioned that there are certain factors arising from problems such as not being able to coordinate the employees arising from central management thought, and not being able to perform job definitions and controls (Balcı).

Thus these forms of contemporary practice in Turkey is taken into effect. In the management of employees, in the management of processes, in the management of data structures, in the management of holistic quality, the negative reflections of administrative and organizational-centered problems and in the affluent hospital types are minimized. With this situation, efforts are made to mobilize the stages in a positive direction. However, the central administration may be the factor that can reduce the positive defects, and the transfer of the affiliated hospitals, another factor of progress efforts, to individuals is another fact. By making affliated hospitals autonomous, it is desired to change their status and turn them into a form of health business. The problems that may be faced in the administration of affliated hospitals on

the positive side are being planned as hospitals that are able to provide services, meet their earnings and expenditures, can be found in the market environment, provide administrative service and financially autonomous and state legal personality based on the foundations of being efficient and effective. . In addition to this situation, lack of motivation, inadequate salary, affiliated hospital approach, lack of control, work ethics and insufficient education etc. problems are followed as negative reflections. Affiliated hospitals are struggling to overcome these problems with in-service training, but the trainings are not at the desired level because their occupational issues are dominant. Another important issue is to create the management conditions caused by the wrong attitudes and behaviors of the employees (Ülgen and Mirze**,** 2010).

In the examinations carried out, it is thought that the physicians' requests to have a laboratory test within the affiliated hospitals increase the affiliated hospital expenses as a result of the factors such as the number of surgeries that are not required. Positive or negative reflections in the problems faced by Affliated hospital administrations include not only the employee but also the patients As a result of the ministry's guidelines on broadcasting in Turkey, parts of patients 'rights and patients' rights boards have formed within Affiliated hospitals. With this situation, differentiations such as outpatient treatments, examinations or treatments, which were not included in the scope of outpatient treatment, were realized during green card applications. In this way, positive reflections affect the quality of service delivery. However, the inability to make plans, such as the fact that patients who have become unemployed temporarily or who have economic problems cannot meet their premiums, are included in the scope of negative reflections (Uğurluoğlu, 2015).

In short, it is observed that the correct and strategic planning of the current problems arising from the administration in the affiliated hospitals, human resources management, quality standards in service, efficiency, process management, risk and crisis management and health service delivery types will positively affect the process. For this reason, in the social life under the responsibility of the ministry, it is obligatory for people to carry out with the right policies, management and organizational practices in order to ensure the

continuity of the life of the social life completely psychologically, physically and socially. At this point, the administrators of affiliate hospitals have great duties.

4.4. The Characteristics of Organizational Culture in Affiliated Hospitals

Organizational culture in affiliated hospitals clarifies the ability of its members to have the same view and act. There are different definitions about organizational culture in Affliated hospitals as well as different features. We can list these features as follows (Vural and Coşkun, 2007);

- Organizational Culture in Affliated Hospitals is a Learned Case or Acquired Case: It manifests and directs in the fields where culture is functional, with the behaviors of those who work in the past and still continue to work. Thus, employees gain and learn organizational culture with value, belief, behavior, attitude, symbol and language.
- Organizational Culture in Affiliated Hospitals Is Not a Written Text: According to Schein (1984), organizational culture is divided into three steps. Each of these steps is a transfer of our culture. The upper step is concrete order and its surroundings. The working principles used in the organization are the work order, daily spoken language, business scheme and briefings. The middle level continues by communicating the values that guide the behavior and respond to the problems. On the other hand, there are behavioral patterns embedded in the structure of the organization. In adopting values and norms, these behaviors must be recognized and applied by the employees of the organization. These take place orally.
- Organizational Culture in Affiliated Hospitals is Behavioral Patterns Repeated or Revealed Regularly: Values such as system, belief, norm and tradition, which are interconnected and integrated, are important in the recognition and transfer of the phenomenon of culture. Because culture is a behavioral pattern formed as a result of these values and united within itself. In addition, organizational culture has a system that is repeated consistently, transferred from past to present and to our future.

- Organizational Culture in Affiliated Hospitals Can Be Shared Among Group Members: Organizational culture in affliated hospitals has distinctive qualities in all organizations that have their own characteristics. Affliated hospital staff should also respect, learn, develop these qualities and convey these qualities to other employees. In this way, Affliated hospital will maintain its continuity by sharing its organizational culture and will have a culture that will be explained to the next generations by its employees.

4.5 The Functions of Organizational Culture in Affiliated Hospitals

In affliated hospitals, organizational culture has various functions that express themselves in different ways and features, forming an identity based on their own traditions, values, behaviors and norms. Together with the affliated hospital organization, the functions it creates for the hospital staff also show differences at this point.

In affiliated hospitals, we can list the functions of organizational culture determined as a result of various studies as follows (Erkmen, 2010);

- Organizational culture in affliated hospitals has the function of providing control and coordination. Affliated hospital organizations, which form a solid Affliated hospital organizational culture structure, can be socially more beneficial than the written principles and rules by reducing the control to the minimum level structurally.
- Organizational culture shapes the behavior of employees by understanding what they can extract and express from events that happen around them.
- Organizational culture creates self in its employees. Corporate identity is obtained. In this way, it strengthens the sense of identification with its employees and strengthens the internal loyalty of the Affliated hospital organization.
- In Affiliated hospital organization, it is proceeded by acting on common values rather than developing emotions individually. Collaborative working methods are developed.

- It is tried to be avoided from the negative effects of change with the mindset and goals owned by the affiliated hospital organization.
- With socialization, cultural values and systems are transferred to future generations and continuity is provided.
- Affliated hospital organization culture is the method used to solve the problems that occur within the Affliated hospital organization. The problems faced by the affliated hospital organization in internal adaptation and external adaptation can be solved.
- It has the function of mobilizing organizational culture members. In the light of some cultural elements, we can say that it occurred as a social synergy.
- It increases organizational efficiency by creating a strong organizational culture for its members. The unity between the elements that make up the structure of organizational culture provides organizational efficiency and effectiveness.

4.6 The Formation of Organizational Culture in Affiliated Hospitals

In the formation of affliated hospital organizational culture, various dimensions have been defined due to the influence of external factors. These cultural explanations are made with elements that directly affect the culture, such as behavior, norms and values. Affliated hospital organization culture can be assumed as a bridge that helps to understand what is right and wrong within the organization, what is the benefit and harm to Affliated hospital organization and facilitates the unity of employees (Sezgin and Bulut, 2013). Economic conditions, the history of Affliated hospital organization, and external factors, such as environmental impacts that are difficult to control, also have a significant impact on the formation of the Affliated hospital organizational culture (Aydınlı, 2003). The organization's structure, managers, founders and the cultural values and beliefs they bring are also reflected in the formation of Affliated hospital organizational culture. (Uslu, 2010).

It is known that affliated hospitals contribute to the formation of organizational cultures. Affliated hospital founders have a great contribution in this formation. It is normal to see that the founders of Affliated hospitals will not be limited to

the ideas and ideologies of the past, and that they will give the Affliated hospital organization its own management approach and vision. In addition to the founders of the Affliated hospital organization, Affliated hospital organization members also contribute to the formation of the Affliated hospital organizational culture. Employees share their unique values and cultures and form the Affliated hospital organizational culture. (Sezgin and Bulut, 2013). As a result, the Affliated hospital organizational culture is formed by the behaviors and mutual interaction gained together with the influence of the common cultural values of their founders and employees and their own experiences.

According to Schein (1988), affiliated hospital organization culture formation consists of the following stages (Çelik, 2008);

• In the first stage, the founder of the Affliated hospital organization has a new idea.

• In the second stage, one or more people who will take risks and support will be brought to the organization for the new idea. Efforts are made to ensure that these individuals agree with the founder of the Affliated hospital organization.

• At the third stage, efforts are made for the necessary equipment for the Affliated hospital organization, such as capital, facility and location, under the leadership of the founder.

• At the last stage, the environment of the Affliated hospital organization is expanded and the foundation of the Affliated hospital organizational culture begins to be established.

Besides creating the affliated hospital organizational culture, it is important to ensure its continuity. Affliated hospital organization founders and employees have important duties at this point. Internal affinity and closeness should be strengthened in the affliated hospital organization. The affliated hospital organizational integrity should be taught to the individuals who are new to the affliated hospital organization.

4.7 Factors Affecting the Formation of Affiliated Hospital Organizational Culture

Many factors such as the environment in which Affliated hospital organization operates, the goals and objectives set within this environment, owners and founders, production type and technology, cultural values and the structure of the society, the structure of the current sector and competitors affect the formation of Affliated hospital organization culture. In the light of these components, we can list the factors affecting Affliated hospital organization culture formation as follows (Güney, 2012);

Social culture

We cannot think of our general culture and organizational culture separately. The culture of our society is the building block of the Affliated hospital organizational culture. Cultural elements are comprehensively seen within the organizational structure. Cultural features acquired by founders and employees are effective in shaping Affliated hospital organizational culture (Hofstede, 2001).

No culture can act independently from its environment and cannot sustain its future. Affliated hospital organizations are in communication and mutual interaction with their external environment. This shows us that when an affliated hospital organization has a relationship with other affliated hospital organizations in the field of services or goods, it is influenced by the cultural values and characteristics of the other party. In some cases, since Affliated hospital organizations are constantly interacting with their environment, they choose their own cultural structure as an example of the structure of other Affliated hospital organizations and make their culture suitable for their values. The resulting cultural interaction can be in the social, economic, physical and technological framework (Mengenci, 2010).

Studies conducted in affliated hospital organizations of various countries show the impact of local and national cultures on organizational and managerial activities of affliated hospitals. From a personal point of view, culture begins in the family, the basic building block of society, and is learned in social life and working life. Here, far or near environment, economic, social and physiological factors contribute to the organization. Affliated hospital organizational culture formed with such environmental factors is not realized in a short time as seen (Karadağ, 2006).

Founders and executives of the organization

Affliated hospital organizational culture founders have important roles in creating, maintaining and maintaining an affliated hospital culture. Founders must carry the values, assumptions and ideas that should be in that organization. Because the formation of affliated hospital organizational culture occurs under the roof of these elements. Different cultural values and ideas in the founders of the organization cause the culture of the affliated hospital organization to be different. As the founders of the organization ultimately make common decisions, the foundations of the affliated hospital organizational culture are beginning to take shape (Tiryaki, 2005).

Besides the founders, managers also have a significant impact in the formation of organizational culture of affiliated hospitals. Managers consider some cultural elements for the organization. Managers have duties and responsibilities in solving the problems facing the organization, determining their goals and making strategic decisions. Many factors such as the fact that managers are open to change and innovation, working principles, acting within the common values of the organization and directing the employees of the organization are the basic elements in the formation of affliated hospital organization culture. Thus, organizational culture is determined by the ideas of the founders and managers, organizational management features and experiences. The biggest contribution to the organization is to have new suggestions and opinions (Güler, 2005).

The aims and objectives of the organization

Due to the variety of areas in which organizations operate, their goals and objectives differ. This difference is reflected in the culture of affliated hospital organizations. Therefore, this variability in organizational goals and objectives leads to the formation of affliated hospital organizational culture. While some organizations are established with the purpose of service, some of them realize their establishment based on the purpose of profit. The success of the organizations established under these thoughts causes them to embark on new quests; because the organization that has succeeded draws its course by revealing new goals and objectives. The emerging goals and objectives change the cultural values of the affliated hospital organization (Erdem, 2007).

The Size of the Organization

Organizational size has both positive and negative effects on the cultural structure in the affliated hospital organization. The size of the organization directly concerns the employees and management of the organization In large-scale enterprises due to its establishment and capacity, the relationship between employees and management protects itself in a more formal and serious level. The control mechanism coming from above determines the limits of this relationship. When we think of the opposite situation, the relationship between employees and management in small-scale businesses is in a warm and friendly atmosphere (Seymen and Bolat 2002).

History of the Organization

The history of the organization, which has a versatile importance for the organization, does not occur in a short time. In this way, the history of the organization must be known in order to have a complete idea about the affliated hospital organizational culture. History, which is the product of the past, does not have a static structure. Affliated hospital organizational culture is accumulated in the historical structure with the influence of many factors such as the diversity of the values brought by the new members of the organization, the change of the goals and objectives in the field in which the organization operates. Affliated hospitals, founded on a solid structure in the

past, have a culturally sound foundation (Bakan, Bedestenci, Büyükbeşe, 2004).

Technology of the Organization

As organizations are open systems, the technological structure updates itself depending on the renewed and changing structure in the formation of affliated hospital organizational culture. As a result, the culture of the affliated hospital organization renews itself. When we consider the chain of changes in the organization, employees also change their mindset. In order to better understand the change in the technological structure of the organization, the structure of ideas and behavior patterns is examined. The technology structure, which constantly interacts with the affliated hospital organizational culture, has a guiding effect in creating new affliated hospital organizational cultural elements (Güney, 2006).

Staff of the Organization

The formation of affiliated hospital organizational culture is not only caused by the founders and managers. The employees' beliefs, their values and norms, different thought and behavior patterns have an important effect on the formation of a family hospital culture. Employees enter the organization with their behavioral patterns. Affiliated hospital organizational culture is created by combining the values of all employees. Affiliated hospital organization culture, which is composed of employees, each with a different value and characteristics, has different characteristics than the values of the employees (Omay, 2009).

CHAPTER 5

5. FINDINGS and COMMENTS

In this section, the purpose and scope of the research, question and model, rationale and analysis level and research method are included.

5.1. Purpose and Scope of the Research

The main aim of this research is to reveal the effects of leadership and organizational structures in Affiliated Hospitals in Turkey on organizational culture. From this point on, it is aimed to reveal, analyze and make recommendations about the relationship of health managers with leadership styles and corporate culture. It is aimed to understand what the effects of health managers in Affiliated hospitals in Turkey are as leaders and managers, and which/which of the structuralist, Human Resource, political and symbolic dimensions emerge as predictors of leadership and management effectiveness. How an organizational culture is formed in Affiliated hospitals in Turkey and the relationship between leadership styles and organizational culture is the main topic of the research.

5.2. Research Question and Model

In this research, the effects of leadership and organizational structures on organizational culture are examined. Leadership dimensions are business-oriented leadership, employee-oriented leadership, and change-oriented leadership. There are 4 basic dimensions in organizational culture, and there are 3 sub-dimensions in each dimension. These are the basic dimension of the participation culture and the sub-dimensions of empowerment, teamwork and talent development, the basic dimension of the coherence culture and the basic values, the compromise and coordination sub-dimensions, the basic

dimension of the adaptation culture and the sub-dimensions of change, customer-orientation and organizational learning, the basic dimension of the mission culture and strategic management is organizational goals and vision. Within the scope of these distinctions, the basic research question has been posed. The effects of leadership and organizational structures on organizational culture have been studied. Depending on the basic research model below, the fiction of this study was made as dependent variable leadership and independent variable as organizational culture. In other words, the effects of leadership and organizational structures on the organizational culture in Afiliated Hospitals, where they work according to the opinions of healthcare professionals, are tried to be emphasized. The formal design of this research is shown below. In addition, research questions are mentioned here.

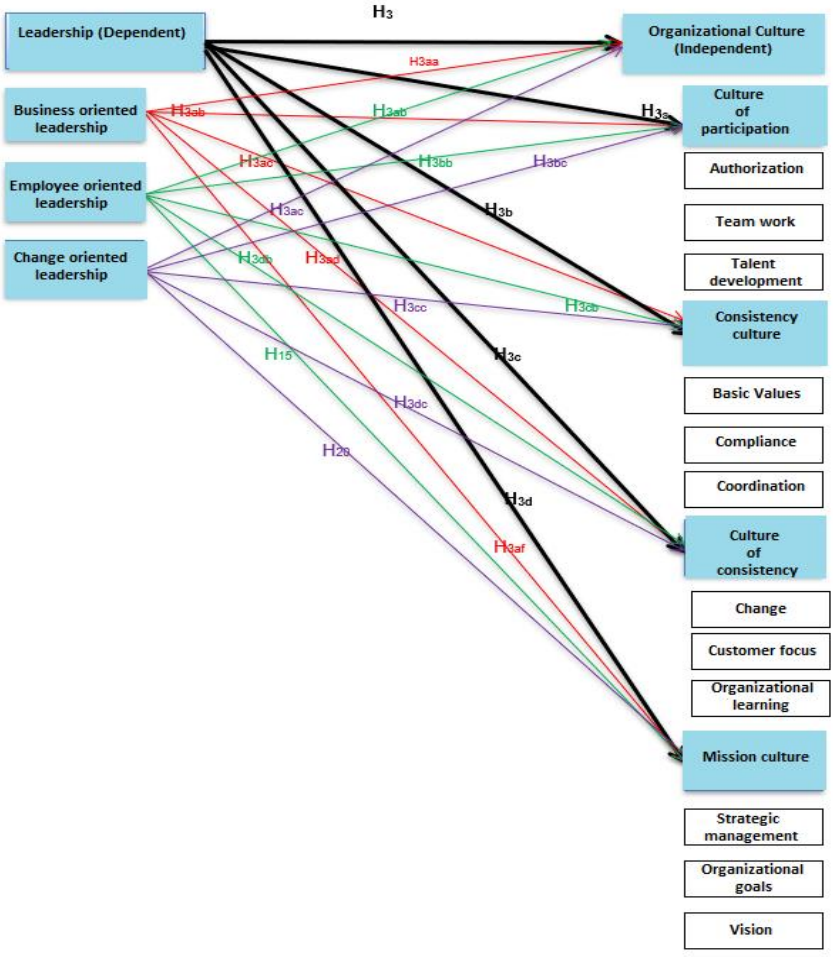

Figure 5.6: The detailed research question regarding the specified research design can be expressed as follows.

- Are there effects on organizational culture, leadership and organizational structure in Affiliated Hospitals in Turkey?

In addition, the study will seek answers to the following questions:

- Is there a relationship between the leadership styles of managers and the organizational structures of Afiliated Hospitals where they work?
- Is there a relationship between managers' leadership styles and organizational culture?
- Is there a relationship between the organizational structures of Afiliated Hospitals where managers work and organizational culture levels?
- Is there a relationship between managers' demographic status and leadership styles, organizational structures and organizational culture levels of Afiliated Hospitals where they work?

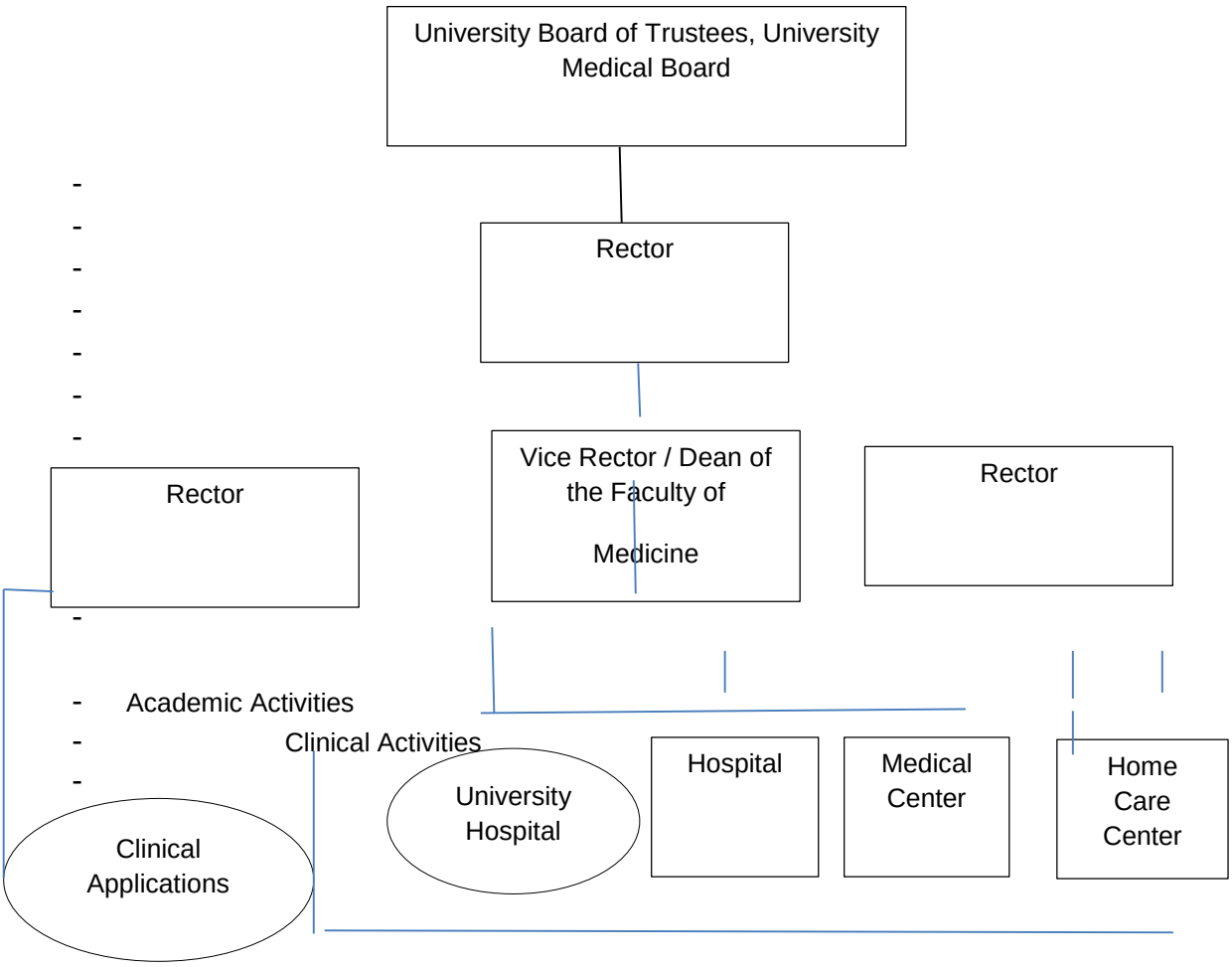

Figure 5.7 Example of Fully Integrated Model

5.3. Research Justification and Level of Analysis

The analysis level of this research is individuals. The questionnaires were made face to face with healthcare professionals working at Adıyaman Training and Research Hospital, İzmir Kâtip Çelebi University Atatürk Training and Research Hospital, Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital, Erzincan Binali Yıldırım University Oral and Dental Health Training and Research Hospital, Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital and Rize Recep Tayyip Erdogan University Training and Research Hospital.

The opinions of healthcare professionals on the effects of leadership and organizational structures of affiliated hospitals on organizational culture form the basis of the study. In this context, it has been investigated whether there is a difference in the effect of leadership on organizational culture according to the variables of leadership and organizational culture within the framework of the demographic information of healthcare workers.

It is not always possible to inspect the activities carried out in affiliated hospitals. Therefore, the top manager cannot do whatever he wants to the employees under all circumstances. For this reason, there is a need for a mechanism that will continuously direct the struggles of the employees towards the targets. This mechanism is expressed as leadership. The managers of affiliated hospitals need to ensure that the organization adapts to the ever-changing environment conditions and renews them with their leadership approach. The organizational culture of affiliated hospitals is formed by the mutual interactions and behaviors that they acquire together with the influence of the common cultural values and their own experiences of both their founders and employees. In this context, the reason why the study was conducted in public affiliation hospitals is to investigate whether the leadership behaviors in affiliated hospitals have an effect on the organizational culture of the hospitals.

5.4. Research Method

In order to determine the effect of leadership behaviors in affiliated hospitals on organizational cultures of hospitals, a questionnaire, one of the primary data collection methods, was prepared first with healthcare professionals working at Adıyaman Training and Research Hospital, İzmir Kâtip Çelebi University Atatürk Training and Research Hospital, Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital, Erzincan Binali Yıldırım University Oral and Dental Health Training and Research Hospital, Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital and Rize Recep Tayyip Erdogan University Training and Research Hospital. The scale prepared for the research consists of three parts. The first part consists of questions about the gender, age, marital status, education status, service, position, working time in the position, and total professional experience of the employees, which determine the demographic characteristics of the employees.

In the second part, the Randolph Leadership Behaviors scale (1985) was used. In the scale, there are 4 leadership characteristics (supportive leadership, directive leadership, success oriented leadership, participatory leadership) that will measure and classify the leadership characteristics of managers. Leadership behaviors were examined in four dimensions by House and Mitchell (1982), Umstot (1984) and Randolph (1985). These four leadership styles are taken from the previous study and the variables are stated below (Tengilimoğlu, 2005). The dimensions of executive leadership behaviors in the scale are named as job-oriented leadership behaviors, employee-oriented leadership behaviors, and change-oriented leadership behaviors (Tengilimoğlu, 2005). The items collected in the first dimension of the leadership behaviors of the scale were named as job-oriented leadership behavior by using their common features. The items collected in the first dimension of the leadership behaviors of the scale were named as job-oriented leadership behavior by using their common features. This dimension consists of 10 (3, 11, 14, 18, 21, 23, 28, 29, 32, 34) items. The second dimension of this part is named as employee-oriented leadership behavior and this dimension consists of 14 (1, 4, 7, 8, 10, 12, 16, 20, 24, 25, 27, 31, 33, 35)

items. The third dimension of the leadership behaviors section of the scale is named as change-oriented leadership behavior and consists of 11 (2, 5, 6, 9, 13, 15, 17, 19, 22, 26, 30) items. The reliability of the scale data was tested with the Cronbach Alpha coefficient. Cronbach Alpha value was found to be 0.98.

In the third part, Denison Organizational Culture scale (1995) was used. The scale was developed by Denison and Mishra in 1995. Denison Organizational Culture Scale consists of 34 statements including 4 basic dimensions and 12 conceptual sub-dimensions. The validity and reliability tests of the scale were conducted by Denison and Mishra and Jae Cho, and it is statistically significant. The reliability coefficient (Cronbach's Alpha) was found to be 0.96, which was adapted to the Denison Organizational Culture Scale by Gökşen (2001) and later by İçin (2002). Yahyagil (2004), on the other hand, created the 36-statement form in which each of the 12 sub-dimensions of the scale is represented by three statements, and made its validity and reliability. Denison measurement tool was developed to measure the cultural profile of organizations. This model is positioned on 4 basic features on which effective organizations are based. These features consist of 4 basic conceptual dimensions: participation, consistency, harmony and mission. Each conceptual dimension consists of 3 sub-conceptual dimensions. These dimensions are as follows:

1. Participation Culture
   - Authorization: 1, 2, 3
   - Team work: 4, 5, 6
   - Developing skills: 7, 8, 9
2. Consistency culture
   - Basic Values: 10, 11, 12
   - Compromise: 13, 14, 15
   - Coordination: 16, 17, 18
3. Compliance Culture
   - Change: 19, 20, 21
   - Customer Orientation: 22, 23, 24

- Organizational learning: 25, 26, 27

4. Mission Culture

- Strategic Management: 28, 29, 30
- Organization Objectives: 31, 32, 33
- Vision: 34, 35, 36

Denison Organizational Culture Scale items are scored with Likert-type 5-point rating. Item ratings are "I strongly disagree, I disagree, I am indecisive, I agree, I strongly agree". Expressions 4, 12, 18, 24, 30, 34 in the scale are negative (negative) items. The reverse scoring was made as "I definitely agree, I agree, I am indecisive, I disagree, I definitely disagree". In the calculation of the concept itself, firstly the average value (arithmetic mean) taken by each conceptual dimension is taken into consideration. Then, the value of the sub-conceptual dimensions is calculated. Then the dimensions are collected three by three (Yahyagil, 2004). The reliability coefficient (Cronbach's Alpha) of the measuring tool, which was finalized with Yahyagil's study and reduced the total number of items to 36, was found to be 0.89. In Kelez's study, the reliability coefficient (Cronbach's Alpha) was found to be 0.94 (Kelez, 2008). In this study, the Cronbach's Alpha value of the scale was calculated as 0.936.

In this study, since it was aimed to reveal the opinions and attitudes of healthcare professionals working in managerial positions in examining the effects of current practices in affiliated hospitals and leadership and organizational structures on organizational culture, a relational design was used. This research design was chosen to explain whether there is a relationship between organizational culture, leadership and hospital organizational structures and what kind of relationship this is.

The research was prepared with the questionnaire application method, one of the quantitative research methods, and the design of the study is the correlational research design. In correlational studies, it was aimed to reveal the relationship of at least two variables with each other without intervention (Karasar, 2016).

In the quantitative research method, numerical results are obtained from the sample that will represent the population related to the researched subject. In the quantitative research method, the direction of the opinion of the research population about the research subject is questioned. That is, it is not an intense analysis about the subject, on the contrary, it is determined more superficially more numerical data. Since numerical representation is in question in quantitative research, it is important to determine the sample that will represent the research population without error and to ask the right questions to this sample (Akman, 2014).

A questionnaire can be defined as a systematic data collection technique by asking the source people who constitute a population or sample depending on the hypotheses or questions determined on a particular subject. Surveys are just one of the tools used in social sciences to standardize observations. Surveys require source people to be literate. Therefore, questionnaires are also defined as written data collection tools. (http://www.bingol.edu.tr/media/226197/sayt-bolum13c-anket-teknigi.pdf)

5.5. Explanatory Variables and Hypotheses

Based on our research model, the following hypotheses have been developed in order to explain the effects of the current practices and leadership and organizational structures of healthcare professionals on the organizational culture of affiliated hospitals.

H1: Leadership behaviors of healthcare professionals vary according to demographic variables.

H2: The organizational culture of healthcare professionals varies according to demographic variables.

H3: There is a relationship between leadership behaviors and organizational culture.

H4: Leadership behaviors have an effect on organizational culture.

The correlations of leadership behaviors and organizational culture variables with socio-demographic data and sub-hypotheses about the effect of leadership behaviors on organizational culture are shown in (Annex: 2). Whether the hypotheses were accepted or rejected are detailed in these tables.

5.6. Limitations of the Research

Transportation difficulties were experienced due to the fact that the surveys were conducted face to face with healthcare professionals working at Adıyaman Training and Research Hospital, İzmir Kâtip Çelebi University Atatürk Training and Research Hospital, Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital, Erzincan Binali Yıldırım University Oral and Dental Health Training and Research Hospital, Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital and Rize Recep Tayyip Erdogan University Training and Research Hospital.

It was impossible to reach some of the healthcare professionals working in hospitals due to unpaid leave, and some because they were sick at the planned date intervals and because of giving births.

Various bureaucratic difficulties were encountered in the process of obtaining permission to conduct surveys in hospitals.

Ensuring the participation of healthcare managers and employees who do not want to participate in the study due to their busy work was considered as a challenge for the purpose of the study.

5.7. Selection of Target Population and Sample

The universe of this research consists of health workers who serve as managers, directors, assistant managers, specialist physicians, dentists, Assistant physicians, general practitioners, nurses, midwives, health officer operators, health officer technicians, dialysis technicians, emergency medical technicians, Laborants, officers and secretaries working in 21 Afiliye hospitals in Turkey.

Table.5.2

Distribution of the participants of the research by the hospitals they work at

	Number(n)	Percentage(%)
Name of the Hospital		
Adıyaman Training and Research Hospital	101	23,2
İzmir Kâtip Çelebi University Atatürk Training and Research Hospital	95	21,8
Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	17,5
Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	8,5
Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	22,5
Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	6,4
Total	435	100,0

When Table 5.1 is analyzed, it was determined that 23.2% of healthcare workers included in the study work at Adıyaman Training and Research Hospital, 21.8% of healthcare workers work at İzmir Kâtip Çelebi University Atatürk Training and Research Hospital, 17.5% of healthcare workers work at Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital, 8.5% of healthcare workers work at Erzincan Binali Yıldırım University Oral and Dental Health Training and Research Hospital, 22.5% of healthcare workers work at Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital and 6.4% of the healthcare professionals work at Rize Recep Tayyip Erdogan University Training and Research Hospital.

According to official records, the number of employees working in the leading positions in the relevant hospitals was 585, including Chief Physician (19), Deputy Chief Physician (80), Manager (47), Assistant Manager (99) and Unit Supervisor Nurse (340).

In the quota sample (all leading positions of 21 Affliated Hospitals), simple random sampling took place. In the calculation of the sample, the dimensions in the population were used as a percentage.

5.8 Collection of Data

The scope of application of the questionnaire to collect the data held in Turkey in the study who serve in the Affiliated Hospital 21 is carried out between 1-30 June 2018. Detailed information about the study was given to the potential participants before the application and their consent to participate in the study was obtained. The questionnaire was applied by using face-to-face interview technique with the healthcare professionals working as Chief Physician, Deputy Chief Physician, Manager, Assistant Manager and Supervisor Unit Supervisor Nurse of 21 Affliated Hospitals who accepted to be included in the study.

5.9. Statistical Evaluation of Data

SPSS 19 statistical software was used to evaluate the data. During the analysis of the data, statistical methods such as variance analysis, t test and anova were applied, and the level of 5% ($p < 0.05$) was accepted as the level of significance. Analyzes were carried out to determine the relationships between various demographic variables, leadership characteristics and organizational culture.

The descriptive qualities of the healthcare professionals working as Chief Physicians, Deputy Chief Physicians, Deputies, Deputy Managers and Supervisors Unit Nurses of the 21 Affliated Hospitals participating in the study were determined by frequency analysis and the findings obtained are given in the next section.

The mean scores, standard deviation and minimum-maximum descriptive findings of the participants' scores from the Denison Organizational Culture and Randolph Leadership Behavior scales are also given in findings section.

According to the descriptive qualities of the participants of the study, the Denison Organizational Culture and Randolph Leadership Behaviors were

analyzed with Kolmogorov-Smirnov and Shapiro-Wilks tests whether the scores they would get from the scale types showed normal distribution. The data set was determined to conform to the normal distribution and it was decided to use the parametric independent sample T-Test and ANOVA. A correlation analysis was conducted to determine the links in Denison Organizational Culture and Randolph Leadership Behavior scale scores, and regression analysis was performed for the prediction of Denison Organizational Culture scores by Randison Leadership Behavior scores.

5.10. Findings

The findings of the studies conducted within the framework of socio-demographic variables to investigate the effects on organizational culture, leadership and organizational structure in Affliated Hospital in Turkey is shown below:

5.10.1. The Findings Related to the Socio-Demographic Characteristics of Healthcare Professionals

The tables of the socio-demographic qualities associated with the effects of leadership and organizational structures in organizational culture in Affliated Hospitals are presented below.

Table 5.3.

Distribution of health professionals by their socio-demographic characteristics

	Number (n)	Percentage (%)
Gender		
Female	281	64,6
Male	154	35,4
Age		
17-24	46	10,6
25-34	208	47,8
35 and above	181	41,6
Marital Status		
Married	291	66,9
Single	144	33,1
Education status		
Health Vocational high School	45	10,3
Associate	106	24,4
License	210	48,3
Master	33	7,6
Doctorate	41	9,4
Working time in his/her position		
0-5 years	148	34,0
6-10 years	150	34,5
11-15 years	59	13,6
16-20 years	31	7,1
21 years and above	47	10,8
Total professional experience time		
0-5 years	94	21,6
6-10 years	146	33,6
11-15 years	73	16,8
16-20 years	44	10,1
21 years and above	78	17,9

Table 6.1 shows the distribution of Affliated hospital employees by their socio-demographic characteristics. When Table 6.1 is analyzed, it is determined that 64.6% of the healthcare professionals participating in the research are women and 35.4% are men. It is understood that 10.6% of the healthcare workers participating in the study belong to 17-24 age groups, 47.8% of healthcare workers belong to 25-34 age groups, and 41.6% of healthcare workers belong to the age groups of 35 and over. It

is seen that 66.9% of the healthcare professionals participating in the research are married and 33.1% are single. It is understood that 10.3% of the participants in the study are Health Vocational High School graduates, 24.4% are associate degree graduates, 48.3% have a bachelor's degree, 7.6% a master's degree and 9.4% a doctorate degree. When the working time in the positions of the participants is examined, it has been observed that 34.0% of the participants worked for 0-5 years, 34.5% worked for 6-10 years, 13.6% worked for 11-15 years, 7.1% of the participants worked for 16-20 years, 10.8% of the participants worked for 21 years and above. Considering the total professional experience of the participants, 21.6% of the participants had 0-5 years of experience, 33.6% had 6-10 years of experience, 116.8% had 11-15 years of experience, 10.1% was found to have 16-20 years of experience, 17.9% had experiences of 21 years and above.

Table 5.4.

Distribution of health professionals by the services they work at

	Number (n)	**Percentage (%)**
Unit		
Anesthesia	14	3,2
Urology	5	1,1
Biochemistry	2	,5
Dermatology	7	1,6
Pediatry	14	3,2
Internal medicine	29	6,7
Endocrinology	2	,5
Infectious Diseases	10	2,3
Physical therapy and rehabilitation	4	,9
General Surgery	11	2,5
Geriatrics	2	,5
Thoracic Surgery	11	2,5
Eye diseases	3	,7
First Aid and Emergency Aid	18	4,1
Gynecology and Obstetrics	6	1,4
Cardiovascular surgery	14	3,2
Cardiology	9	2,1
ENT	14	3,2
Microbiology	5	1,1
Nephrology	5	1,1
Neurology	21	4,8
Neurosurgery	3	,7
Radiology	3	,7
Orthopedics and Traumatology	10	2,3
Psychiatry	4	,9
Other	209	48,2

When Table 6.2 is examined, it is seen that 3.2% of the healthcare professionals work in the anesthesia unit, 1.1% work in the Urology unit, 0.5% work in the Biochemistry unit, 1.6% work in the Dermatology unit, 3.2% of healthcare professionals work in the Department of Pediatrics, 6.7% work in the Internal Medicine unit, 0.5% work in the Endocrinology unit, 2.3% work in the Infectious Diseases unit, 0.9% work in the Physical Therapy and Rehabilitation unit, 2.5% work in the General Surgery unit, 0.5% work in the Geriatrics unit, 2.5% of healthcare professionals worked in the Thoracic Surgery unit, 0.7% worked in the Eye Diseases unit, 4.1% worked in the First Aid and Emergency Department, 1.4% worked in the Obstetrics and Gynecology unit. , 3.2% work in Cardiovascular Surgery unit, 2.1% work in Cardiology unit, 3.2% work in ENT unit, 0.5% work in Microbiology unit, 0.5% work in Nephrology unit, 4.8% work in the Neurology unit, 0.7% work in the Neurosurgery unit, 0.7% work in the Radiology unit, 2.3% work in the Orthopedics and Traumatology unit, 0.9% work in the Psychiatry unit, and 48.2% of the healthcare professionals work in other services (Management, Human Resources, Administrative Affairs, Accounting, etc.).

Table 5.5.

Distribution of health professionals by their duties

	Number (n)	**Percentage (%)**
Position		
Nurse	154	35,4
midwife	13	3,0
Health officer operator	33	7,6
Health officer technician	44	10,1
Specialist physician	12	2,8
Director	**7**	**1,6**
Assistant physician	7	1,6
General practitioner	7	1,6
Officer	97	22,3
Assistant director	6	1,4
Secretary	11	2,5
Dialysis technician	9	2,1
Emergency medical technician	6	1,4
Dentist	16	3,7
Manager	6	1,4
Laboratory Assistant	7	1,6

When Table 6.3 is examined, it is understood that 35.4% of healthcare workers are Nurses, 3.0% are Midwives, 7.6% are Health Officer operators, 10.1% are Health Officer technicians, 2.8% are Specialist Physicians, 1.6% are the Directors, 1.6% are the Assistant physicians, 1.6% are the Practitioners, 22.3% are the Officers, 1.4% are

the Assistant Directors, 2.5% are the Secretaries, 2.1% are the Dialysis technician, 1.4% are the Emergency medical technicians, 3.7% are the Dentists, 1.4% are the Managers and 1.6% are the Laboratory Assistants.

5.10.2. Reliability Analysis Results for Key Dimensions

The items of the scales used in the research were made using Cronbach's Alpha reliability analysis. In the evaluation criteria of Cronbach's Alpha coefficient, the scale is 0.00 0,α <0.40 is not reliable, 0.40≤ α <0.60 has low reliability, 0.60≤ α <0.80 is quite reliable, 0.80≤ α <1, 00 is highly reliable.

5.10.2.1. Leadership Behaviors Scale Reliability Analysis

Table 5.6.

Reliability analysis of leadership behaviors scale

Reliability Analysis	
Cronbach’s Alpha	N of Items
,932	34

Leadership behavior scale internal consistency coefficient was calculated. As a result of the analysis found, Cronbach's Alpha value is 0.93.

Table 5.7.

Reliability analysis results for the leadership behaviors scale items

	Corrected Item-Total Correlation	Cronbach's Alpha value when the item is deleted
I organize my work.	,697	,928
I am consistent.	,735	,928
I encourage new ideas	,646	,929
I'm open to criticism	,593	,929
I do not hesitate to take risks when making a decision	,345	,933
I have a clear and honest way of working	,635	,929
I am reassuring.	,697	,928
I like to discuss new ideas	,682	,928
I am friendly.	,699	,928
I am always aware of the responsibilities of others.	,667	,928
I make plans about the future.	,635	,929
I give my instructions clearly.	,318	,935
I respect my subordinates as an individual	,268	,936
I examine the events and make a logical decision.	,719	,928
I put forward new and different ideas in the implementation of the works	,698	,928
I produce opportunities to eliminate conflicts	,691	,928
I am open to change.	,228	,941
I treat my subordinates fairly.	,714	,928
I'm meticulous under the supervision of things.	,705	,928
I make quick decisions when necessary.	,690	,928
When I make a decision, I give my subordinates the right to speak.	,255	,936
I give importance to follow the rules and principles.	,707	,928
I make plans carefully.	,771	,928
I encourage growth and development.	,724	,928
My goals are evident.	,752	,928
I appreciate good work.	,697	,928
I care about the thoughts of others.	,637	,929
I produce new projects.	,380	,931
I am open to innovations.	,697	,928
I trust my subordinates.	,633	,929
I defend my subordinates.	,649	,929
I provide a friendly environment away from discussions.	,689	,928
I rigorously emphasize the plans that are being implemented.	,688	,929
I listen to other ideas and suggestions.	,685	,928

As seen in Table 5.7, Cronbach's Alpha (α) values were found to be quite reliable in the analysis of the leadership behaviors scale expressions within the survey. Internal consistency analyzes of 34 items (including sub-dimensions) of the leadership behaviors scale were conducted. As a result of the analysis, the Cronbach's Alpha (α) internal consistency coefficient of the leadership behaviors scale was determined as .93. In addition, the correlations of all items with the total score were determined. As seen in Table 5.7, item-total correlations are between .02 and .07.

5.10.2.2. Organizational Culture Scale Reliability Analysis

Table 5.8.

Reliability analysis of organizational culture scale

Reliability Analysis	
Cronbach's Alpha	N of Items
,931	36

The organizational culture scale internal consistency coefficient was calculated. As a result of the analysis found, Cronbach's Alpha value is 0.93.

Table 5.9.

Reliability analysis results for organizational culture scale items

	Corrected Item-Total Correlation	Cronbach's Alpha value when the item is deleted
The majority of employees are integrated into their work.	,500	,929
Since there is a sufficient amount of information sharing among the employees, everyone can access the required information when necessary.	,536	,929
All employees are included in the decision making process to a certain extent when planning work (patient care and treatment planning).	,511	,929
There is no cooperation between different departments (service units).	,133	,933
Team work is based on all our work.	,468	,930
All employees understand the relationship between their duties and the objectives of the organization.	,557	,929
Employees are given the necessary authority to plan their own business.	,353	,932
Employees' capacity to work is constantly improving.	,628	,928
Everything needed to improve the employees' work skills is done.	,645	,928
Managers apply what they say.	,674	,928
We have a clear and consistent system of values that guide our working methods.	,665	,928
There are no (ethical) values that guide our behavior in conducting business and enable us to distinguish between right and wrong.	,170	,932
When a dispute arises in business activities, each employee makes a great effort to find a satisfactory solution.	,557	,929
This workplace has a strong organizational culture.	,657	,928
A consensus can be easily achieved even in problematic issues.	,677	,928
Our employees can share a common perspective in business activities, even if they work in different departments of the organization..	,411	,932
Studies (projects) carried out by different departments of the institution are easily coordinated.	,686	,928
Working with someone from another department is like working with someone from a different institution.	,347	,931
Our working style is very flexible and open to change	,593	,928
Management may develop appropriate strategies depending on other health institutions and changes in the field of business.	,660	,928
Innovations and developments in our business are monitored and implemented by management.	,677	,928
The requests and suggestions of the people we serve can lead to frequent changes in business activities.	,537	,929
All employees take care to understand the wishes and needs of the people served.	,392	,931
The requests of the people we serve are not generally taken into consideration in our business activities.	,384	,931
25. In the event of any failure, this is considered by management as an opportunity for development and learning.	,437	,930
Taking risks in innovation and works is demanded and rewarded by management.	,604	,928
It is an important purpose for the employees to learn about their jobs and to obtain new information.	,303	,934
We have a long-term work program and a specific development plan.	,684	,928
We have a clear and clear corporate mission to guide the work of the employees.	,706	,927
There is no strategic business planning determined for the future of the institution.	,299	,931
There is a complete consensus among employees regarding the operational objectives of the Agency.	,650	,928
Managers can act in line with the main objectives of the institution.	,660	,928
Employees know what needs to be done to ensure the success of the institution in the long run.	,656	,928
Employees are far from sharing the vision of the institution determined for the future.	,317	,931
Our managers have a long-term perspective.	,669	,928
Short-term expectations can be met without compromising our vision.	,714	,927

As seen in Table 5.9, Cronbach's Alpha (α) values were found to be quite reliable in the analysis of the organizational culture scale expressions within the survey. Internal consistency analyzes of 36 items (including sub-dimensions) of the organizational culture scale were conducted. As a result of the analysis, the Cronbach's Alpha (α) internal consistency coefficient of the leadership behaviors scale was determined as .93. In addition, the correlations of all items with the total score were determined. As seen in Table 5.9, item-total correlations are between .01 and .07.

5.10.3. T Test and Variance Analysis

5.10.3.1. Leadership Behavior Scale Analysis

Table 5.10.

Comparison of leadership scale scores of healthcare professionals according to their hospitals

Scales	Hospitals	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Business-oriented leadership	Adıyaman Training and Research Hospital	101	40,28	7,67	10	50	3,302	,006*	4-6
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	43,15	6,26	14	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	41,59	6,30	10	50			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	44,00	4,77	33	50			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	42,35	7,03	10	79			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	39,71	6,01	30	50			
Employee-oriented leadership	Adıyaman Training and Research Hospital	101	40,50	8,17	10	50	2,921	,013*	1-4
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	43,10	5,77	16	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	41,86	6,40	10	49			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	44,57	6,08	36	72			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	42,06	5,76	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	40,76	6,27	30	50			
Change-oriented leadership	Adıyaman Training and Research Hospital	101	40,52	8,33	10	50	2,263	,047*	1-4
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	43,44	5,92	22	69			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	41,55	6,44	10	50			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	43,73	4,53	31	50			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	42,68	7,58	10	75			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	41,88	8,92	30	75			
Leadership scale	Adıyaman Training and Research Hospital	101	40,44	7,94	10	50	2,997	,011*	1-4
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	43,22	5,75	17	56			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	41,68	6,24	10	49			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	44,13	4,54	35	54			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	42,35	5,92	10	52			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	40,81	6,29	30	**51**			

**p<0,05*

In Table 5.10, comparison of leadership scale scores of healthcare workers according to the hospitals they work in is given. It has been observed that there is a statistically significant difference between the mean scores of the leadership scale sub-dimensions of the leadership scale, business-oriented leadership, employee-oriented leadership, change-oriented leadership, and leadership scale overall, according to the hospitals where healthcare professionals work. (p<0,05). According to the hospitals where healthcare workers work, H1a hypothesis was accepted as the significance values of business-oriented leadership, which is a sub-dimension of the leadership scale, was p <0.05. H1b hypothesis was accepted as the significance values of employee-focused leadership, which is a sub-dimension of the leadership scale, was p <0.05. The H1c hypothesis was accepted as the significance values of change-oriented leadership, which is the sub-dimension of the leadership scale, were p <0.05. H1d hypothesis was accepted as the significance values of the overall leadership scale were p <0.05. In other words, the opinions of healthcare professionals on leadership behavior differ significantly according to the hospitals they work in.

Table 5.11.

Comparison of leadership and organizational culture scales scores of healthcare professionals according to their gender

	Gender	**n**	$\bar{x}$	**s**	**t**	**p**
Business-oriented leadership	Female	281	41,99	5,94	,453	,651
	Male	154	41,68	8,07		
Employee-oriented leadership	Female	281	42,15	5,88	,557	,578
	Male	154	41,78	7,85		
Change-oriented leadership	Female	281	42,25	6,59	,249	,803
	Male	154	42,07	8,17		
Leadership scale	Female	281	42,13	5,82	,447	,655

When Table 5.11 is examined, it has been observed that there is no statistically significant difference between the scores of healthcare workers in the sub-dimensions of the leadership scale according to their gender, business-oriented leadership, employee-oriented leadership, change-oriented leadership, and leadership scale. (p>0,05). The H1e hypothesis according to the genders of the healthcare professionals was rejected as the significance values of business-oriented leadership, which is a sub-dimension of the leadership scale, was p> 0.05. H1f hypothesis was rejected because the significance values of employee-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. The H1g hypothesis was rejected because the significance values of change-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. H1h hypothesis was rejected

because the significance values of the overall leadership scale was p> 0.05. In other words, the opinions of healthcare professionals on leadership behaviors according to their gender do not differ significantly.

Table 5.12.

Comparing the scores of leadership and organizational culture scales according to the age of healthcare professionals

Scales	Age		n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Business-oriented leadership	17-24		46	40,71	6,23	18	50			
	25-34		208	41,75	7,28	10	79	1,139	,321	
	35 above	and	181	42,34	6,26	10	50			
Employee-oriented leadership	17-24		46	41,10	6,29	13	50			
	25-34		208	41,73	6,90	10	50	1,308	,271	
	35 above	and	181	42,59	6,40	10	72			
Change-oriented leadership	17-24		46	41,79	8,13	11	75			
	25-34		208	41,98	7,71	10	75	,354	,702	
	35 above	and	181	42,52	6,26	10	69			
Leadership scale	17-24		46	41,21	6,32	14	51			
	25-34		208	41,81	6,84	10	52	,949	,388	
	35 above	and	181	42,49	6,06	10	56			

The comparison of leadership scale scores of healthcare workers according to their ages is given in Table 5.12. It was observed that there was no statistically significant difference between the scores of the healthcare professionals in terms of the sub-dimensions of the leadership scale according to their age, from the business-oriented leadership, employee-oriented leadership, change-oriented leadership, and leadership scale. (p>0,05). H1i hypothesis according to the age of healthcare workers was rejected because the significance value of business-oriented leadership, which is a sub-dimension of the leadership scale, was p> 0.05. H1i hypothesis was rejected as the significance value of employee-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. The H1j hypothesis was rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. H1k hypothesis was rejected because the significance value of the overall leadership scale was p> 0.05. In other words; The views of healthcare professionals on leadership behaviors according to their age do not differ significantly.

Table 5.13.

Comparison of leadership scale scores according to the marital status of healthcare professionals

Scales	Marital status	n	$\bar{x}$	S	t	p
Business-oriented leadership	Married	291	42,18	6,64	1,322	,187
	Single	144	41,27	7,00		
Employee-oriented leadership	Married	291	42,27	6,73	1,106	,269
	Single	144	41,52	6,45		
Change-oriented leadership	Married	291	42,43	7,21	1,013	,312
	Single	144	41,69	7,11		
Leadership scale	Married	291	42,29	6,51	1,204	,229
	Single	144	41,50	6,38		

The comparison of leadership scale scores according to the marital status of healthcare workers is given in Table 5.13. It was observed that there was no statistically significant difference between the scores of the healthcare workers in the sub-dimensions of the leadership scale according to their marital status, business-oriented leadership, employee-oriented leadership, change-oriented leadership, and overall leadership scale (p> 0.05). According to the marital status of the healthcare professionals, the H1l hypothesis was rejected as the significance value of business-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. H1m hypothesis was rejected because the significance value of employee-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. H1n hypothesis was rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. H1o hypothesis was rejected because the significance value of the overall leadership scale was p> 0.05. In other words, the opinions of healthcare professionals on leadership behaviors according to their marital status do not differ significantly.

Table 5.14

Comparison of the scores of leadership and organizational culture scales according to the education levels of healthcare professionals

Scales	Education Level	n	$\bar{x}$	S	Bottom	Top	F	p
Business-oriented leadership	Health vocational high School	45	41,91	6,52	14	50	,055	,994
	Associate	106	41,99	7,02	10	50		
	License	210	41,74	6,67	10	79		
	Master	33	42,24	6,15	25	50		
	Doctorate	41	42,02	7,59	18	50		
Employee-oriented leadership	Health vocational high School	45	42,17	7,43	16	72	,532	,712
	Associate	106	42,70	6,83	10	50		
	License	210	41,58	6,16	10	50		
	Master	33	42,40	6,37	23	50		
	Doctorate	41	42,04	7,90	13	50		
Change-oriented leadership	Health vocational high School	45	42,26	5,53	22	50	1,354	,249
	Associate	106	43,05	8,28	10	75		
	License	210	41,42	6,17	10	50		
	Master	33	42,45	5,97	23	50		
	Doctorate	41	43,54	10,56	11	75		
Leadership scale	Health vocational high School	45	42,12	6,00	17	54	,543	,704
	Associate	106	42,60	6,92	10	52		
	License	210	41,58	6,05	10	51		
	Master	33	42,37	6,09	23	50		
	Doctorate	41	42,52	8,09	14	56		

When Table 5.14 is examined, it has been observed that there is no statistically significant difference between the scores of the healthcare workers in terms of the sub-dimensions of the leadership scale, job-focused leadership, employee-focused leadership, change-oriented leadership, and leadership scale (p> 0.05). Healthcare professionals have similar views on the above-mentioned issues according to their education level. According to the education levels of healthcare workers, the H1ö hypothesis was rejected as the significance value of business-oriented leadership, which is a sub-dimension of the leadership scale, was p> 0.05. H1p hypothesis was rejected because the significance value of employee-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. H1r hypothesis was rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. H1s hypothesis was rejected as the significance value of the overall leadership scale was p> 0.05. In other words, the opinions of healthcare professionals on leadership behaviors according to their education level do not differ significantly.

Table 5.15.

Comparison of leadership scale scores of healthcare professionals according to their places of duty

Scales	Duty place	n	$\bar{x}$	s	Bottom	Top	F	p
Business-oriented leadership	Anesthesia	14	44,92	4,68	38	50	1,350	,123
	Urology	5	42,40	7,23	32	50		
	Biochemistry	2	36,50	2,12	35	38		
	Dermatology	7	37,42	4,35	31	43		
	Pediatry	14	41,64	6,82	26	50		
	Internal medicine	29	38,79	8,49	18	50		
	Endocrinology	2	46,00	0,00	46	46		
	Infectious Diseases	10	40,30	5,18	30	50		
	Physical therapy and rehabilitation	4	45,00	4,54	39	49		
	General Surgery	11	41,36	3,95	36	48		
	Geriatrics	2	43,50	2,12	42	45		
	Thoracic Surgery	11	43,63	8,30	24	50		
	Eye Diseases	3	41,33	2,30	40	44		
	First Aid and Emergency Aid	18	43,88	9,51	37	79		
	Gynecology and Obstetrics	6	43,66	5,04	37	50		
	Cardiovascular surgery	14	43,35	4,60	37	50		
	Cardiology	9	40,88	3,98	38	50		
	ENT	14	37,64	11,01	10	50		
	Microbiology	5	45,20	6,72	36	50		
	Nephrology	5	40,60	4,77	33	46		
	Neurology	21	42,61	3,98	34	50		
	Neurosurgery	3	41,00	3,60	38	45		
	Radiology	3	48,33	2,88	45	50		
	Orthopedics and Traumatology	10	38,00	11,14	10	49		
	Psychiatry	4	44,00	4,08	41	50		
	Other	209	42,17	6,40	10	50		
Employee-oriented leadership	Anesthesia	14	45,27	4,51	35	50	1,083	,359
	Urology	5	43,69	5,68	36	50		
	Biochemistry	2	36,53	5,98	32	40		
	Dermatology	7	39,45	3,46	32	42		
	Pediatry	14	42,30	6,82	25	50		
	Internal medicine	29	38,88	8,99	13	50		
	Endocrinology	2	44,23	1,63	43	45		
	Infectious Diseases	10	40,92	5,68	30	50		
	Physical therapy and rehabilitation	4	43,84	2,17	40	45		
	General Surgery	11	41,60	4,53	31	48		
	Geriatrics	2	42,69	0,54	42	43		
	Thoracic Surgery	11	43,35	9,55	18	50		
	Eye Diseases	3	42,05	4,37	38	46		
	First Aid and Emergency Aid	18	41,79	3,46	36	50		
	Gynecology and Obstetrics	6	44,87	3,49	41	50		
	Cardiovascular surgery	14	42,80	5,43	30	50		
	Cardiology	9	41,79	3,64	38	50		
	ENT	14	38,46	11,97	10	50		
	Microbiology	5	44,30	8,02	33	50		
	Nephrology	5	41,23	5,17	32	45		
	Neurology	21	42,93	3,67	33	49		
	Neurosurgery	3	41,79	5,12	38	47		
	Radiology	3	48,71	2,22	46	50		
	Orthopedics and Traumatology	10	38,38	11,71	10	49		
	Psychiatry	4	43,46	2,84	40	46		
	Other	209	42,32	6,41	10	72		

Table 5.16.

Comparison of leadership scale scores of healthcare professionals according to their place of duty (Continued)

Scales	Duty place	n	$\bar{x}$	s	Bottom	Top	F	p
Change-oriented leadership	Anesthesia	14	46,81	9,28	36	75	1,353	,121
	Urology	5	45,09	4,87	39	50		
	Biochemistry	2	38,18	2,57	36	40		
	Dermatology	7	38,31	4,49	29	43		
	Pediatry	14	43,24	10,63	23	69		
	Internal medicine	29	38,80	9,18	11	50		
	Endocrinology	2	43,18	4,49	40	46		
	Infectious Diseases	10	41,63	5,38	30	50		
	Physical therapy and rehabilitation	4	43,63	3,14	40	46		
	General Surgery	11	41,24	5,03	30	48		
	Geriatrics	2	44,09	3,21	41	46		
	Thoracic Surgery	11	42,64	9,99	16	50		
	Eye Diseases	3	39,69	3,67	36	43		
	First Aid and Emergency Aid	18	41,81	4,07	34	50		
	Gynecology and Obstetrics	6	43,03	4,25	38	50		
	Cardiovascular surgery	14	42,92	5,38	30	50		
	Cardiology	9	42,52	3,07	40	50		
	ENT	14	37,66	11,66	10	50		
	Microbiology	5	45,63	5,35	37	50		
	Nephrology	5	41,09	6,50	30	46		
	Neurology	21	44,67	8,23	31	75		
	Neurosurgery	3	41,51	6,05	36	48		
	Radiology	3	48,48	1,89	46	50		
	Orthopedics and Traumatology	10	37,81	11,24	10	49		
	Psychiatry	4	43,86	2,91	40	46		
	Other	209	42,44	6,37	10	75		
Leadership scale	Anesthesia	14	45,67	4,78	36	52	1,335	,131
	Urology	5	43,76	5,73	36	50		
	Biochemistry	2	37,05	2,07	35	38		
	Dermatology	7	38,48	3,86	30	42		
	Pediatry	14	42,41	7,80	25	56		
	Internal medicine	29	38,83	8,83	14	50		
	Endocrinology	2	44,41	2,07	42	45		
	Infectious Diseases	10	40,97	5,36	30	50		
	Physical therapy and rehabilitation	4	44,11	3,08	40	46		
	General Surgery	11	41,41	4,30	32	48		
	Geriatrics	2	43,38	1,45	42	44		
	Thoracic Surgery	11	43,20	9,26	19	50		
	Eye Diseases	3	41,07	3,50	38	45		
	First Aid and Emergency Aid	18	42,41	4,08	37	51		
	Gynecology and Obstetrics	6	43,92	3,81	40	49		
	Cardiovascular surgery	14	43,00	4,83	33	50		
	Cardiology	9	41,76	3,42	39	50		
	ENT	14	37,96	11,39	10	49		
	Microbiology	5	45,00	6,71	35	50		
	Nephrology	5	41,00	5,36	31	45		
	Neurology	21	43,40	3,98	32	51		
	Neurosurgery	3	41,47	4,94	37	47		
	Radiology	3	48,52	2,29	45	50		
	Orthopedics and Traumatology	10	38,08	11,36	10	49		
	Psychiatry	4	43,75	3,05	41	47		
	Other	209	42,31	6,06	10	54		

In Table 5.15 and Table 5.16, the comparison of leadership scale scores of healthcare workers according to the services they work with is given. It has been observed that there is no statistically significant difference between the scores of the healthcare professionals in the sub-dimensions of the leadership scale, business-oriented leadership, employee-oriented leadership, change-oriented leadership, and leadership scale ($p > 0.05$). Healthcare workers think similarly on the issues listed above according to the services they work. According to the education levels of healthcare professionals, the H1t hypothesis was rejected as the significance value of business-oriented leadership, which is a sub-dimension of the leadership scale,

was p> 0.05. H1u hypothesis was rejected as the significance value of employee-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. H1ü hypothesis was rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. The H1v hypothesis was rejected as the significance value of the overall leadership scale was p> 0.05. In other words, the views of healthcare professionals on leadership behaviors according to the services they work do not differ significantly.

Table 5.17.

Comparison of leadership scale scores of healthcare professionals according to their duties

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	p
Business-oriented leadership	Nurse	154	41,45	7,40	10	79	,534	,921
	midwife	13	43,53	3,77	37	50		
	Health officer operator	33	42,69	4,46	32	50		
	Health officer technician	44	42,63	5,93	30	50		
	Specialist physician	12	42,08	8,12	24	50		
	Director	7	40,71	9,51	25	49		
	Assistant physician	7	41,71	6,52	29	50		
	General practitioner	7	40,71	12,12	18	50		
	Officer	97	41,89	7,16	10	50		
	Assistant director	6	42,83	4,44	37	49		
	Secretary	11	41,00	5,38	32	48		
	Dialysis technician	9	38,55	5,19	31	49		
	Emergency medical technician	6	39,33	4,67	33	47		
	Dentist	16	43,37	5,34	33	50		
	Manager	6	44,50	4,27	38	50		
	Laboratory Assistant	7	43,28	6,44	36	50		
Employee-oriented leadership	Nurse	154	41,31	6,96	10	50	,738	,746
	midwife	13	43,84	3,15	38	50		
	Health officer operator	33	42,79	4,69	33	50		
	Health officer technician	44	43,47	4,88	30	50		
	Specialist physician	12	41,85	8,52	18	50		
	Director	7	40,11	9,84	23	47		
	Assistant physician	7	43,95	5,96	31	50		
	General practitioner	7	39,67	13,54	13	50		
	Officer	97	42,07	7,50	10	72		
	Assistant director	6	43,97	2,97	39	46		
	Secretary	11	41,04	4,18	32	45		
	Dialysis technician	9	39,57	5,52	32	49		
	Emergency medical technician	6	40,51	4,39	35	48		
	Dentist	16	42,93	4,89	33	49		
	Manager	6	44,61	4,37	38	50		
	Laboratory Assistant	7	43,40	6,73	33	50		
Change-oriented leadership	Nurse	154	41,24	6,92	10	50	1,033	,419
	midwife	13	42,72	3,55	36	50		
	Health officer operator	33	42,70	5,01	31	50		
	Health officer technician	44	44,00	6,83	30	75		
	Specialist physician	12	43,71	12,21	16	69		
	Director	7	40,00	9,50	23	49		
	Assistant physician	7	44,02	6,16	31	50		
	General practitioner	7	39,35	13,77	11	50		
	Officer	97	41,91	6,79	10	50		
	Assistant director	6	43,63	2,29	40	46		
	Secretary	11	43,63	11,50	31	75		
	Dialysis technician	9	39,69	6,61	28	48		
	Emergency medical technician	6	40,15	4,92	32	48		
	Dentist	16	45,45	9,24	34	75		
	Manager	6	44,24	3,71	38	48		
	Laboratory Assistant	7	44,67	5,01	37	50		
Leadership scale	Nurse	154	41,33	6,79	10	51	,762	,720
	midwife	13	43,39	3,20	37	49		
	Health officer operator	33	42,73	4,56	32	50		
	Health officer technician	44	43,40	5,20	30	52		
	Specialist physician	12	42,52	9,29	19	56		
	Director	7	40,25	9,60	23	48		

Assistant physician	7	43,31	6,09	30	50
General practitioner	7	39,87	13,16	14	50
Officer	97	41,96	6,91	10	54
Assistant director	6	43,52	3,06	39	47
Secretary	11	41,87	5,31	32	51
Dialysis technician	9	39,31	5,59	31	48
Emergency medical technician	6	40,04	4,61	33	47
Dentist	16	43,87	4,86	34	49
Manager	6	44,46	3,93	38	49
Laboratory Assistant	7	43,78	5,94	35	50

The comparison of the scores of the leadership scale according to the duties of the healthcare workers is given in Table 5.17. It was observed that there was no statistically significant difference between the scores of the healthcare professionals in the sub-dimensions of the leadership scale, business-oriented leadership, employee-oriented leadership, change-oriented leadership, and leadership scale (p> 0.05). Healthcare workers think similarly on the issues listed above according to the services they work. H1y hypothesis according to the duties of the healthcare professionals was rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale of the H1w hypothesis, was p> 0.05 for the employee-focused leadership, which is the H1z hypothesis of job-focused leadership, which is the sub-dimension of the leadership scale. The H1q hypothesis was rejected as the significance value of the overall leadership scale was p> 0.05. In other words; the opinion of healthcare workers on leadership behaviors according to their duties does not differ significantly.

Table 5.18.

Comparison of leadership scale scores of healthcare professionals according to their working time in their position

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	p
Business-oriented leadership	0-5 years	148	42,18	6,14	26	79	1,016	,399
	6-10 years	150	41,12	7,79	10	50		
	11-15 years	59	42,27	6,12	20	50		
	16-20 years	31	43,45	4,85	32	50		
	21 years and above	47	41,87	6,97	20	50		
Employee-oriented leadership	0-5 years	148	42,17	5,07	23	50	1,261	,285
	6-10 years	150	41,26	8,00	10	50		
	11-15 years	59	42,02	6,06	20	50		
	16-20 years	31	43,87	4,56	32	50		
	21 years and above	47	42,76	7,84	20	72		
Change-oriented leadership	0-5 years	148	42,38	5,88	22	75	,929	,447
	6-10 years	150	41,43	8,52	10	75		
	11-15 years	59	42,69	7,25	20	75		
	16-20 years	31	43,84	4,17	32	50		
	21 years and above	47	42,26	7,70	20	69		
Leadership scale	0-5 years	148	42,24	5,11	24	51	1,148	,334
	6-10 years	150	41,27	7,87	10	50		
	11-15 years	59	42,31	6,02	20	52		
	16-20 years	31	43,73	4,34	32	50		
	21 years and above	47	42,34	6,99	20	56		

In Table 5.18, the comparison of leadership scale scores of healthcare workers according to their working time in their position is given. It was observed that there was no statistically significant difference between the scores of the healthcare professionals in the sub-dimensions of the leadership scale, business-oriented leadership, employee-oriented leadership, change-oriented leadership, and leadership scale according to the duration of their employment (p> 0.05). Healthcare professionals have similar views on the above-mentioned issues according to their working time in their position. The H1A hypothesis was rejected as the significance value of business-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05, according to the duration of the healthcare professionals' working time in their position. The H1B hypothesis was rejected as the significance value of employee-focused leadership, which is the sub-dimension of the leadership scale, was p> 0.05. The H1C hypothesis was rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale, was p> 0.05. The H1D hypothesis was rejected as the significance values of the overall leadership scale were p> 0.05. In other words, the views of healthcare professionals on leadership behaviors do not differ significantly according to their working time in their position.

Table 5.19

Comparison of leadership behaviors scale scores of healthcare professionals according to their total professional experience time

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	P
Business-oriented leadership	0-5 years	94	42,14	6,63	26	79	821	512
	6-10 years	146	41,33	7,60	10	50		
	11-15 years	73	41,46	6,95	10	50		
	16-20 years	44	43,20	4,77	32	50		
	21 years and above	78	42,25	6,03	20	50		
Employee-oriented leadership	0-5 years	94	41,79	5,45	23	50	1650	161
	6-10 years	146	41,50	7,72	10	50		
	11-15 years	73	41,30	6,74	10	50		
	16-20 years	44	43,82	4,34	32	50		
	21 years and above	78	42,92	6,60	20	72		
Change-oriented leadership	0-5 years	94	42,14	6,40	22	75	836	503
	6-10 years	146	41,76	8,36	10	75		
	11-15 years	73	41,65	7,82	10	75		
	16-20 years	44	43,78	3,91	32	50		
	21 years and above	78	42,62	6,45	20	69		
Leadership scale	0-5 years	94	42,01	5,40	24	51	1190	314
	6-10 years	146	41,53	7,63	10	50		
	11-15 years	73	41,46	6,82	10	52		
	16-20 years	44	43,63	4,17	32	50		
	21 years and above	78	42,63	5,94	20	56		

In Table 5.19, the comparison of the scores of the leadership scale according to the total professional experience of the healthcare workers is given. It was observed that there was no statistically significant difference between the scores of the healthcare professionals in the sub-dimensions of the leadership scale, business-oriented leadership, employee-oriented leadership, change-oriented leadership, and leadership scale according to their total professional experience time (p> 0.05). Healthcare professionals think similarly on the issues listed above according to their total professional experience. According to the total professional experience of the healthcare professionals, the H1E hypothesis was rejected as the significance values of business-oriented leadership, which is a sub-dimension of the leadership scale, was p> 0.05. The H1F hypothesis was rejected because the significance values of employee-oriented leadership, which is a sub-dimension of the leadership scale, were p> 0.05. The H1G hypothesis was rejected because the significance values of change-oriented leadership, which is the sub-dimension of the leadership scale, were p> 0.05. The H1H hypothesis was rejected because the significance values of the overall leadership scale were p> 0.05. In other words, the opinions of healthcare professionals on leadership behaviors according to their total professional experience time do not differ significantly.

5.10.3.2. Organizational Culture Scale Analysis

Table 5.20.

Comparison of organizational culture scale scores according to the hospitals where healthcare professionals work

Scales	Hospitals	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Authorization	Adıyaman Training and Research Hospital	101	20,95	7,18	10	43	5,146	,000*	1-4
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	24,28	7,47	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	25,04	8,71	10	46			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	26,12	7,00	16	43			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	25,64	7,94	10	43			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	22,38	7,52	10	36			
Teamwork	Adıyaman Training and Research Hospital	101	25,54	8,84	10	40	3,997	,001*	1-3
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	26,10	7,00	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	28,37	6,83	13	46			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	27,02	6,70	13	43			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	27,07	5,92	10	40			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	25,11	5,00	13	33			
Skill development	Adıyaman Training and Research Hospital	101	23,76	9,38	10	43	3,997	,001*	1-3
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	26,35	13,16	10	12,67			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	29,86	7,55	10	43			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	27,74	8,82	10	50			

	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	27,85	7,94	10	43			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	27,50	5,26	20	36			
	Adıyaman Training and Research Hospital	101	23,42	7,07	10	40			
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	25,57	7,31	10	57			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	27,76	6,34	15	44			
Culture of participation	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	26,96	6,59	14	42	6,642	,000*	1-4
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	26,85	6,08	10	40			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	25,00	4,97	14	33			
	Adıyaman Training and Research Hospital	101	27,98	8,31	10	46			
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	28,24	7,76	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	31,53	7,64	10	50			
Basic values	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	30,72	7,12	13	50	3,445	,005*	1-6
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	30,17	7,51	10	43			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	32,38	6,07	20	43			
	Adıyaman Training and Research Hospital	101	24,91	8,59	10	46			
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	28,14	9,28	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	31,57	9,27	10	50			
Compromise	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	28,55	7,79	16	43	5,633	,000*	1-3
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	28,77	8,22	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	30,47	8,09	10	50			
	Adıyaman Training and Research Hospital	101	23,49	7,66	10	40			
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,26	8,13	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	29,91	6,59	13	50			
Coordination	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	31,44	17,83	16	13,00	7,109	,000*	1-4
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	27,38	7,26	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	29,28	5,83	16	40			

**p<0,05*

Table 5.21.
C*omparison of organizational culture scale scores of healthcare professionals according to their hospitals (continued)*

Scales	Hospitals	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Consistency culture	Adıyaman Training and Research Hospital	101	23,49	7,66	10	40	7,109	,000*	1-3
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,26	8,13	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	29,91	6,59	13	50			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	31,44	17,83	16	13,00			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	27,38	7,26	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	29,28	5,83	16	40			
Change	Adıyaman Training and Research Hospital	101	24,02	7,86	10	43	6,881	,000*	1-4
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,08	8,57	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	30,13	7,53	16	50			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	27,29	8,67	10	50			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	29,25	7,88	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	29,76	7,13	20	50			
Customer focus	Adıyaman Training and Research Hospital	101	23,66	8,58	10	40	6,897	,000*	1-6
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,73	8,15	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	30,04	6,67	10	50			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	28,82	7,33	13	50			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	28,33	9,91	10	10,33			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	30,59	6,60	20	50			
Organizational learning	Adıyaman Training and Research Hospital	101	23,86	9,89	10	80	7,368	,000*	1-6
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,93	8,16	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	31,49	7,62	10	50			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	28,37	7,27	13	43			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	29,86	10,03	10	96			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	32,73	18,65	16	12,33			
Compliance culture	Adıyaman Training and Research Hospital	101	23,85	7,17	10	40	8,338	,000*	3-1
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,58	7,59	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	30,55	5,83	12	48			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	28,16	6,59	14	45			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	29,15	6,88	10	55			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	31,03	7,63	20	58			
Strategic management	Adıyaman Training and Research Hospital	101	24,25	8,68	10	40	8,338	,000*	3-1
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,36	8,20	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	30,52	6,25	20	43			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	27,56	6,78	10	40			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	29,55	6,83	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	30,00	4,53	20	36			
Organizational goals	Adıyaman Training and Research Hospital	101	24,05	8,06	10	43	5,495	,000*	3-1
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	26,45	8,94	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	30,52	8,97	10	50			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	27,74	8,78	10	50			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	27,92	8,08	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	27,85	7,32	10	43			

**p<0,05*

Table 5.22

*Comparison of the scores of leadership and organizational culture scales according to the hospitals where the healthcare professionals work (continued***)**

Scales	Hospitals	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Vision	Adıyaman Training and Research Hospital	101	24,98	8,42	10	46	7,700	,000*	3-1
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	28,45	8,68	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	31,57	7,53	10	50			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	28,64	6,73	10	50			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	30,03	7,36	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	30,95	5,50	20	40			
Compliance culture	Adıyaman Training and Research Hospital	101	24,14	6,76	10	40	11,198	,000*	3-1
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,50	7,52	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	30,71	5,88	14	47			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	28,07	6,29	12	42			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	29,16	6,11	10	50			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	30,31	4,58	22	41			
Organization culture	Adıyaman Training and Research Hospital	101	24,29	,6,21	10	37	10,274	,000*	3-1
	İzmir Katip Çelebi University Atatürk Training and Research Hospital	95	27,11	6,46	10	50			
	Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital	76	30,05	5,25	18	45			
	Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital	37	28,34	6,02	13	41			
	Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital	98	28,48	5,51	10	46			
	Rize Recep Tayyip Erdoğan University Training and Research Hospital	28	29,08	3,89	21	36			

**p<0,05*

In Tables 5.20, 5.21 and 5.22, the comparison of the scores of organizational culture scales according to the hospitals where healthcare workers work is given. According to the hospitals where healthcare professionals work, the basic dimension of organizational culture is empowerment, teamwork, talent development, participation culture in general, the basic values of the basic dimensions of coherence culture, consensus, coordination and coherence culture in general, the main dimension of the culture of adaptation It has been observed that there is a statistically significant difference between the sub-dimensions of change, customer-orientation, organizational learning and adaptation culture in general, and the sub-dimensions of the mission culture, which are strategic management, organizational goals, vision,

mission culture and organizational culture scale overall score averages ($p < 0.05$). It is understood that healthcare professionals have different opinions on the above-mentioned issues compared to the hospitals they work in. According to the hospitals where healthcare professionals work, the H2a hypothesis was accepted as the overall scale of the participation culture was $p < 0.05$. The significance value of the H2aa authorization was assumed as $p < 0.05$. The significance value of H2ab teamwork was accepted as $p < 0.05$. H2ac ability development significance value was accepted as $p < 0.05$. H2b consistency culture was accepted as the overall significance value was $p < 0.05$. H2ba baseline values were accepted since the significance value was $p < 0.05$. H2bb consensus significance value was accepted as $p < 0.05$. H2bc coordination significance value was accepted as $p < 0.05$. H2c compatibility culture was accepted as the overall significance value was $p < 0.05$. The change in H2ca was accepted as the significance value was $p < 0.05$. H2cb was accepted as the customer focus significance value was $p < 0.05$. H2cc was accepted as organizational learning significance value was $p < 0.05$. The H2d mission culture was generally accepted as the significance value was $p < 0.05$. Strategic management significance value in H2 was accepted as $p < 0.05$. H2db organizational goals were accepted since the significance value was $p < 0.05$. H2dc vision significance value was accepted as $p < 0.05$. H2e organizational culture scale was accepted as the overall significance values were $p < 0.05$. In other words, the views of the healthcare professionals on the organizational culture differ significantly according to the hospitals they work in.

Table 5.23.

Comparison of organizational culture scale scores of healthcare professionals according to their gender

	Gender	n	$\bar{x}$	s	t	p
Authorization	Female	281	24,04	7,86	,215	,830
	Male	154	23,87	7,98		
Team work	Female	281	26,65	6,87	,195	,846
	Male	154	26,51	7,61		
Skill development	Female	281	27,55	10,00	1,922	,055
	Male	154	25,69	9,04		
Culture of participation	Female	281	26,08	6,53	1,064	,288
	Male	154	25,36	7,19		
Basic values	Female	281	30,53	7,67	3,158	**,002***
	Male	154	28,09	7,74		
Compromise	Female	281	28,79	8,83	1,479	,140
	Male	154	27,46	9,07		
Coordination	Female	281	28,03	9,62	2,083	**,038***
	Male	154	26,14	7,78		
Consistency culture	Female	281	29,11	7,12	2,634	**,009***
	Male	154	27,23	7,12		
Change	Female	281	28,06	7,84	1,639	,102
	Male	154	26,71	8,94		
Customer focus	Female	281	27,88	7,39	,909	,364
	Male	154	27,10	10,42		
Organizational learning	Female	281	28,52	8,72	,382	,703
	Male	154	28,13	12,46		
Culture of harmony	Female	281	28,16	6,67	1,144	,253
	Male	154	27,31	8,46		
Strategic management	Female	281	28,17	7,54	1,080	,281
	Male	154	27,33	8,00		
Organizational goals	Female	281	27,52	8,26	1,232	,218
	Male	154	26,45	9,35		
Vision	Female	281	29,09	8,00	1,289	,198
	Male	154	28,05	8,26		
Mission culture	Female	281	28,26	7,02	1,363	,173
	Male	154	27,28	7,50		
Organization culture	Female	281	27,94	5,79	1,833	,067
	Male	154	26,82	6,62		

**p<0,05*

When Table 5.23 is examined, a statistically significant difference was found between the mean scores obtained by healthcare workers from the sub-dimensions of the basic dimension of the organizational culture scale consistency culture, basic values, coordination and consistency culture, according to their gender (p<0,05). The average score of female health workers is higher than male health workers, and the difference between them is statistically significant. Female healthcare professionals think differently from male employees about basic values, coordination and consistency culture. According to the gender of healthcare workers, H2ga basic values were accepted as significance values were p <0.05. H2gc coordination significance values were accepted as p <0.05. H2g consistency culture significance values were accepted as p <0.05.

It has been observed that there is no statistically significant difference between the scores of healthcare professionals in the overall organizational culture scale basic dimension, participation culture sub-dimension, empowerment, teamwork, and talent

development, the sub-dimension of the basic values basic dimension, the sub-dimensions of the main dimension of consensus, adaptation culture, change, customer focus, organizational learning, mission culture, the sub-dimensions of the main dimension strategic management, organizational goals, and the overall vision, the overall score of the basic dimension of mission culture and the organizational culture scale. (p>0,05). H2f hypothesis was rejected as the significance value of the general participation culture was p> 0.05. H2fa authorization was rejected as the significance value of p> 0.05. H2fb teamwork was rejected as the significance value of p> 0.05. H2fc ability development was rejected as the significance value of p> 0.05. H2gb consensus was rejected as the significance value was p> 0.05. The significance value of the H2h cohesion culture in general was rejected as p> 0.05. The significance value of the H2ha change was rejected as p> 0.05. H2hb was rejected as the significance value of customer focus was p> 0.05. H2hc was rejected as the significance value of organizational learning was p> 0.05. The significance value of the H2ı mission culture in general was rejected as p> 0.05. The significance value of the strategic management of H2ia was rejected as p> 0.05. H2ıb was rejected as the significance value of organizational goals was p> 0.05. H2ic vision was rejected as the significance value of p> 0.05. The significance value of the H2i organizational culture scale was rejected as p> 0.05.

Table 5.24.

Comparison of organizational culture scale scores of healthcare professionals according to their ages

Scales	Age	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Authorization	17-24	46	20,72	6,16	10	33			
	25-34	208	23,83	8,50	10	50			
							5,541	**,004***	**1-3**
	35 and above	181	24,99	7,35	10	43			
Team work	17-24	46	22,97	5,88	10	33			
	25-34	208	26,61	7,82	10	50			
							7,658	**,001***	**1-3**
	35 and above	181	27,51	6,28	10	43			
Talent development	17-24	46	25,43	7,67	10	43			
	25-34	208	26,74	11,39	10	126	,830	,437	
	35 and above	181	27,44	7,87	10	50			
Culture of participation	17-24	46	23,04	5,52	10	33			
	25-34	208	25,73	7,58	10	57			
	35 and above						**5,335**	**,005***	**1-3**
		181	26,64	5,85	10	42			
Basic values	17-24	46	30,65	7,49	10	43			
	25-34	208	29,39	8,78	10	50			
	35 and above						,507	,603	
		181	29,74	6,54	10	50			
Compromise	17-24	46	26,95	9,13	10	50			
	25-34	208	27,43	9,45	10	50			
	35 and above						**3,722**	**,025***	**1-3**
		181	29,68	8,07	10	50			
Coordination	17-24	46	26,15	8,01	10	50			
	25-34	208	27,14	10,89	10	130			
	35 and above						,806	,447	
		181	27,91	6,65	10	43			
Consistency culture	17-24	46	27,92	7,16	11	46			
	25-34	208	27,99	8,05	10	64			
	35 and above						1,332	,265	
		181	29,11	5,99	10	45			
Change	17-24	46	29,34	8,59	10	50			
	25-34	208	26,85	8,85	10	50	2,057	,129	
	35 and above	181	27,94	7,39	10	43			
Customer focus	17-24	46	29,34	7,96	10	50			
	25-34	208	26,59	8,38	10	50	3,051	,048*	1-2
	35 and above	181	28,32	8,85	10	103			
Organizational learning	17-24	46	28,11	8,71	10	50			
	25-34	208	27,27	9,51	10	80	2,878	,057	
	35 and above	181	29,74	11,14	10	123			
Culture of compliance	17-24	46	28,93	7,25	13	50			
	25-34	208	26,91	7,78	10	50			
	35 and above						**3,386**	**,035***	**1-3**
		181	28,68	6,76	10	50			
Strategic management	17-24	46	29,56	8,15	10	50			
	25-34	208	27,11	8,55	10	50			
	35 and above						2,435	,089	
		181	28,32	6,40	10	46			
Organization goals	17-24	46	26,81	9,32	10	50			
	25-34	208	27,01	9,23	10	50			
	35 and above						,114	,892	
		181	27,36	7,82	10	50			
Vision	17-24	46	30,21	9,01	10	50			
	25-34	208	27,69	8,69	10	50			
	35 and above						3,422	,034*	1-2
		181	29,54	6,97	10	50			
Mission culture	17-24	46	28,86	7,83	10	50			
	25-34	208	27,27	8,01	10	50			
							1,650	,193	
	35 and above	181	28,41	5,91	10	44			
Organizational culture	17-24	46	27,19	5,95	11	43			
	25-34	208	26,97	6,87	10	50	2,057	,129	
	35 and above	181	28,21	5,12	10	41			

In Table 5.24, the comparison of organizational culture scale scores according to the ages of healthcare workers is given. A statistically significant difference was found between the mean scores of healthcare workers in terms of their age, the sub-dimensions of the organizational culture scale, the basic height of participation culture, authorization and teamwork. A statistically significant difference was found between the mean scores of the sub-dimension of the consistency culture basic dimension. A statistically significant difference was found between the average scores of the sub-dimension of adaptation culture, customer focus. A statistically significant difference was found between the mean scores they got from vision, sub-dimension of the mission culture basic dimension. ($p<0,05$). The mean scores obtained by the healthcare workers aged 35 and over from the dimensions of empowerment, teamwork and reconciliation, and the healthcare professionals between the ages of 17-24 on customer focus and vision dimensions are higher, and the difference between them is statistically significant. Accordingly, healthcare professionals between the ages of 17-24 and those aged 35 and over think differently than other healthcare professionals on the issues mentioned above. The significance value of H2ja authorization was accepted since $p <0.05$ according to the ages of healthcare professionals. H2jb was accepted as the significance value of teamwork was $p <0.05$. The consensus significance value of H2kb was accepted as $p <0.05$. H2lb was accepted as the customer focus significance value was $p <0.05$. H2mc was accepted as the vision significance value was $p <0.05$.

It was observed that there was no statistically significant difference between the scores obtained by the healthcare professionals from the sub-dimension of the basic dimension of the organizational culture scale participation culture according to their age, talent development and the basic dimension of participation culture. It was observed that there was no statistically significant difference between the sub-dimensions of the consistency culture basic dimension, core values and the scores they got from coordination. It was observed that there was no statistically significant difference between the scores of the sub-dimensions of the basic dimension of adaptation culture, change and organizational learning. It was observed that there was no statistically significant difference between the scores of the sub-dimensions of the mission culture basic dimension, strategic management and organizational goals. It was observed that there was no statistically significant difference between the points they got from the mission culture general dimension and the organizational culture scale ($p>0,05$). The H2j hypothesis was rejected as the significance value of the general participation culture was $p> 0.05$. H2jc ability development was rejected

because its significance value was p> 0.05. H2k consistency culture is rejected as the significance value of the overall culture is p> 0.05. H2ka is rejected as the significance value of the basic values is p> 0.05. The significance value of H2kc coordination was rejected as p> 0.05. H2l compliance culture was generally rejected as the significance value was p> 0.05. The significance value of the change with H2 is rejected as p> 0.05. H2lc is rejected because the significance value of organizational learning is p> 0.05. The significance value of H2m mission culture in general is rejected as p> 0.05. H2ma is rejected because the significance value of strategic management is p> 0.05. H2mb is rejected because the significance value of organizational goals is p> 0.05. H2n organizational culture scale was rejected as the overall significance value was p> 0.05.

Table 5.25.

Comparison of organizational culture scale scores according to the marital status of healthcare professionals

Scales	Marital Status	n	$\bar{x}$	S	t	p
Authorization	Married	291	24,44	8,01	1,730	,084
	Single	144	23,05	7,59		
Team Work	Married	291	26,88	7,02	1,159	,247
	Single	144	26,04	7,34		
Talent development	Married	291	27,21	10,17	,978	,329
	Single	144	26,25	8,68		
Culture of participation	Married	291	26,18	6,79	1,551	,122
	Single	144	25,11	6,71		
Basic values	Married	291	29,69	7,66	,077	,939
	Single	144	29,63	8,03		
Compromise	Married	291	28,95	8,88	**2,119**	**,035***
	Single	144	27,03	8,92		
Coordination	Married	291	27,89	7,53	1,734	,084
	Single	144	26,29	11,48		
Consistency Culture	Married	291	28,84	6,96	1,635	,103
	Single	144	27,65	7,54		
Change	Married	291	27,96	8,08	1,345	,179
	Single	144	26,82	8,61		
Customer focus	Married	291	28,19	8,58	**2,047**	**,041***
	Single	144	26,41	8,49		
Organizational learning	Married	291	29,06	10,48	1,955	,051
	Single	144	27,03	9,45		
Culture of compliance	Married	291	28,40	7,22	**2,207**	**,028***
	Single	144	26,75	7,51		
Strategic management	Married	291	28,41	7,64	**2,091**	**,037***
	Single	144	26,78	7,76		
Organization goals	Married	291	27,48	8,69	1,157	,248
	Single	144	26,45	8,61		
Vision	Married	291	29,06	7,83	1,218	,224
	Single	144	28,05	8,61		
Mission culture	Married	291	28,32	7,08	1,666	,096
	Single	144	27,09	7,39		
Organizational culture	Married	291	27,93	5,98	**2,063**	**,040***
	Single	144	26,65	6,32		

**p<0,05*

In Table 5.25, the comparison of organizational culture scale scores according to the marital status of healthcare workers is given. According to the marital status of the

healthcare workers, a statistically significant difference was found between the average scores they got from the sub-dimension of the basic dimension of the organizational culture scale consistency culture. A statistically significant difference was found between the average scores of the sub-dimension of the basic dimension of adaptation culture, customer focus and the general dimension of adaptation culture. A statistically significant difference was found between the average scores they got from the sub-dimension of mission culture, strategic management and organizational culture ($p<0,05$). The mean scores of the married healthcare workers are higher than the singles and the difference between them is statistically significant. Married healthcare professionals think differently than single healthcare professionals on the above-mentioned issues. According to the marital status of the healthcare workers, H2kb consensus, H2lb customer focus, H2l compliance culture in general, H2ma strategic management, H2n organizational culture scale in general were accepted since significance values are $p <0.05$.

It was observed that there was no statistically significant difference between the scores of the healthcare professionals in the sub-dimensions of the basic dimension of the organizational culture scale participation culture, empowerment, teamwork, talent development and participation culture sub-dimension according to their marital status. It was observed that there was no statistically significant difference between the overall scores of the consistency culture basic dimension, basic values, coordination sub-dimensions and consistency culture sub-dimension. It was observed that there was no statistically significant difference between the scores of the basic dimension of adaptation culture, the organizational goals and vision sub-dimensions of change and organizational learning, and mission culture. ($p>0,05$). H2j hypothesis participation culture, H2ja empowerment, H2jb teamwork, H2jc ability development, H2k consistency culture overall, H2ka basic values, H2kc coordination, H2la change, H2lc organizational learning, H2m mission culture overall, H2mb organizational goals, H2mc vision, H2n organization culture scales of were not accepted since significance values are $p> 0.05$

Table 5.26.

Comparison of organizational culture scale scores according to the education level of healthcare professionals

Scales	Educational level	n	$\bar{x}$	S	Bottom	Top	F	p
Authorization	Health vocational high School	45	24,59	9,05	10	43	,579	,678
	Associate	106	24,08	8,33	10	50		
	License	210	23,60	7,44	10	43		
	Master	33	25,65	7,74	10	40		
	Doctorate	41	23,65	7,95	10	43		
Team work	Health vocational high School	45	24,51	6,85	10	46	1,297	,270
	Associate	106	26,76	8,17	10	50		
	License	210	27,11	6,64	10	43		
	Master	33	26,16	6,82	10	40		
	Doctorate	41	26,26	7,15	10	43		
Talent development	Health vocational high School	45	27,03	8,56	10	43	,175	,951
	Associate	106	27,10	13,63	10	126		
	License	210	27,06	8,08	10	50		
	Master	33	25,96	7,39	10	40		
	Doctorate	41	26,09	8,12	10	43		
Culture of participation	Health vocational high School	45	25,38	6,75	10	44	,127	,973
	Associate	106	25,98	8,19	10	57		
	License	210	25,92	6,15	10	42		
	Master	33	25,92	5,94	10	35		
	Doctorate	41	25,33	6,71	10	41		
Basic values	Health vocational high School	45	29,70	6,77	16	46	,360	,837
	Associate	106	28,89	9,04	10	50		
	License	210	29,98	7,46	10	50		
	Master	33	30,00	7,35	10	46		
	Doctorate	41	29,75	7,43	10	40		
Compliance	Health vocational high School	45	28,14	9,14	10	50	,280	,891
	Associate	106	27,64	9,73	10	50		
	License	210	28,52	8,70	10	50		
	Master	33	28,38	8,12	10	50		
	Doctorate	41	29,18	8,55	10	50		
Coordination	Health vocational high School	45	27,63	6,65	16	50	1,465	,212
	Associate	106	27,04	8,78	10	50		
	License	210	26,77	7,10	10	50		
	Master	33	27,98	7,49	10	43		
	Doctorate	41	30,40	17,82	10	130		
Consistency Culture	Health vocational high School	45	28,49	6,35	16	46	,549	,700
	Associate	106	27,86	8,22	10	50		
	License	210	28,42	6,56	10	46		
	Master	33	28,78	6,65	10	46		
	Doctorate	41	29,78	8,53	12	64		

Table 5.27.

Comparison of organizational culture scale scores according to the education level of healthcare professionals (Continued)

Scales	Educational level	n	$\bar{x}$	S	Bottom	Top	F	p
Change	Health vocational high School	45	28,59	8,21	10	50	,290	,885
	Associate	106	27,17	8,89	10	50		
	License	210	27,44	8,11	10	50		
	Master	33	27,87	6,76	10	36		
	Doctorate	41	28,04	8,81	10	50		
Customer focus	Health vocational high School	45	27,70	7,24	10	50	,164	,956
	Associate	106	27,17	8,67	10	50		
	License	210	27,76	9,19	10	103		
	Master	33	28,33	6,92	10	36		
	Doctorate	41	27,23	7,95	10	40		
Organizational learning	Health vocational high School	45	29,33	7,57	10	50	,596	,666
	Associate	106	28,55	11,43	10	96		
	License	210	28,34	10,70	10	123		
	Master	33	29,39	7,33	10	40		
	Doctorate	41	26,34	8,52	10	40		
Culture of Compliance	Health vocational high School	45	28,54	6,14	12	50	,272	,896
	Associate	106	27,63	8,48	10	55		
	License	210	27,85	7,24	10	58		
	Master	33	28,54	5,87	10	36		
	Doctorate	41	27,20	7,32	10	40		
Strategically management	Health vocational high School	45	29,70	6,77	20	50	2,162	,072
	Associate	106	27,01	9,01	10	50		
	License	210	27,47	7,04	10	50		
	Master	33	30,60	7,23	10	46		
	Doctorate	41	27,96	8,26	10	40		
Organizational goals	Health vocational high School	45	27,33	7,70	10	50	,032	,998
	Associate	106	27,17	9,92	10	50		
	License	210	27,01	8,42	10	50		
	Master	33	27,17	7,07	10	40		
	Doctorate	41	27,48	8,96	10	50		
Vision	Health vocational high School	45	28,74	7,08	10	50	,303	,876
	Associate	106	28,61	9,89	10	50		
	License	210	28,47	7,45	10	50		
	Master	33	30,00	7,63	10	40		
	Doctorate	41	29,26	7,80	10	40		
Mission culture	Health vocational high School	45	28,59	6,27	16	50	,523	,719
	Associate	106	27,60	8,79	10	50		
	License	210	27,65	6,48	10	50		
	Master	33	29,25	6,55	10	41		
	Doctorate	41	28,23	7,76	10	43		
Organizational culture	Health vocational high School	45	27,75	4,72	18	44	,159	,959
	Associate	106	27,30	7,62	10	50		
	License	210	27,50	5,62	10	46		
	Master	33	28,21	5,48	10	38		
	Doctorate	41	27,67	6,21	14	40		

When Tables 5.26 and 5.27 are examined, it has been observed that there is no statistically significant difference between the scores of healthcare workers in terms of the sub-dimensions of the basic dimension of the participation culture according to their education levels in terms of authorization, teamwork, talent development and participation culture. It was observed that there was no statistically significant

difference between the scores they got from the sub-dimensions of the consistency culture basic dimension, basic values, reconciliation, coordination and consistency culture. It was observed that there was no statistically significant difference between the scores of the basic dimension of compliance culture in general change, customer focus, organizational learning and adaptation culture, sub-dimensions of mission culture in general, strategic management, organizational goals, vision and mission culture, and organizational culture in general (p>0,05). Healthcare professionals have similar views on the above-mentioned issues according to their education level. According to the education levels of healthcare professionals, H2j hypothesis is based on the overall culture of participation, H2ja authorization, H2jb teamwork, H2jc ability development, H2k consistency culture overall, H2ka basic values, H2kb compliance, H2kc coordination, H2l compliance culture overall, H2la change, H2lb customer focus, H2lc Organizational learning, H2m mission culture in general, H2ma strategic management, H2mb organizational goals, H2mc vision, H2n organizational culture scale are generally rejected since significance values are p> 0.05.

Table 5.28.

Comparison of the organizational culture scale scores of healthcare professionals according to their place of duty

Scales	Unit	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Leadership Scale	Anesthesia	14	45,67	4,78	36	52	1,335	,131	
	Urology	5	43,76	5,73	36	50			
	Biochemistry	2	37,05	2,07	35	38			
	Dermatology	7	38,48	3,86	30	42			
	Pediatry	14	42,41	7,80	25	56			
	Internal medicine	29	38,83	8,83	14	50			
	Endocrinology	2	44,41	2,07	42	45			
	Infectious Diseases	10	40,97	5,36	30	50			
	Physical therapy and rehabilitation	4	44,11	3,08	40	46			
	General Surgery	11	41,41	4,30	32	48			
	Geriatrics	2	43,38	1,45	42	44			
	Thoracic Surgery	11	43,20	9,26	19	50			
	Eye Diseases	3	41,07	3,50	38	45			
	First Aid and Emergency Aid	18	42,41	4,08	37	51			
	Gynecology and Obstetrics	6	43,92	3,81	40	49			
	Cardiovascular surgery	14	43,00	4,83	33	50			
	Cardiology	9	41,76	3,42	39	50			
	ENT	14	37,96	11,39	10	49			
	Microbiology	5	45,00	6,71	35	50			
	Nephrology	5	41,00	5,36	31	45			
	Neurology	21	43,40	3,98	32	51			
	Neurosurgery	3	41,47	4,94	37	47			
	Radiology	3	48,52	2,29	45	50			
	Orthopedics and Traumatology	10	38,08	11,36	10	49			
	Psychiatry	4	43,75	3,05	41	47			
	Other	209	42,31	6,06	10	54			
Authorization	Anesthesia	14	26,66	10,37	10	43	**2,110**	**,002***	**7-25**
	Urology	5	24,66	6,49	20	33			
	Biochemistry	2	20,00	0,00	20	20			
	Dermatology	7	20,95	3,17	16	23			
	Pediatry	14	20,23	3,80	13	26			
	Internal medicine	29	26,55	8,13	13	50			
	Endocrinology	2	15,00	7,07	10	20			
	Infectious Diseases	10	19,66	8,67	10	36			
	Physical therapy and rehabilitation	4	18,33	1,92	16	20			
	General Surgery	11	20,00	4,21	10	26			
	Geriatrics	2	15,00	7,07	10	20			
	Thoracic Surgery	11	18,48	5,64	10	30			
	Eye Diseases	3	23,33	3,33	20	26			
	First Aid and Emergency Aid	18	27,22	10,55	10	46			
	Gynecology and Obstetrics	6	20,55	9,98	13	40			
	Cardiovascular surgery	14	23,09	4,22	16	33			
	Cardiology	9	21,48	5,55	10	30			
	ENT	14	20,47	7,14	10	30			
	Microbiology	5	30,00	6,23	20	36			
	Nephrology	5	17,33	5,47	10	23			
	Neurology	21	24,28	9,13	10	40			
	Neurosurgery	3	21,11	3,84	16	23			
	Radiology	3	20,00	10,00	10	30			
	Orthopedics and Traumatology	10	26,66	9,16	13	43			
	Psychiatry	4	30,00	2,72	26	33			
	Other	209	24,88	7,75	10	43			

Table 5.29.

Comparison of the organizational culture scale scores of healthcare professionals according to their place of duty (continued)

Scales	Unit	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Team work	Anesthesia	14	26,42	8,51	10	40	1,343	,127	
	Urology	5	28,00	6,05	20	36			
	Biochemistry	2	23,33	4,71	20	26			
	Dermatology	7	26,19	8,03	13	40			
	Pediatry	14	29,04	6,32	20	40			
	Internal medicine	29	28,04	6,81	13	50			
	Endocrinology	2	15,00	7,07	10	20			
	Infectious Diseases	10	28,00	8,49	10	36			
	Physical therapy and rehabilitation	4	31,66	9,62	23	40			
	General Surgery	11	25,15	9,58	10	40			
	Geriatrics	2	16,66	9,42	10	23			
	Thoracic Surgery	11	26,66	8,69	10	36			
	Eye Diseases	3	30,00	3,33	26	33			
	First Aid and Emergency Aid	18	29,07	8,69	10	46			
	Gynecology and Obstetrics	6	28,33	8,09	20	40			
	Cardiovascular surgery	14	25,23	5,01	13	30			
	Cardiology	9	25,55	8,66	10	40			
	ENT	14	25,47	6,99	10	36			
	Microbiology	5	32,66	3,65	30	36			
	Nephrology	5	24,00	2,78	20	26			
	Neurology	21	25,07	8,27	10	40			
	Neurosurgery	3	28,88	1,92	26	30			
	Radiology	3	22,22	10,71	10	30			
	Orthopedics and Traumatology	10	27,66	5,22	20	36			
	Psychiatry	4	35,00	3,33	33	40			
	Other	209	26,17	6,65	10	43			
Skill development	Anesthesia	14	33,81	6,90	23	43	1,438	,081	
	Urology	5	25,33	5,05	20	30			
	Biochemistry	2	23,33	4,71	20	26			
	Dermatology	7	26,66	8,60	20	43			
	Pediatry	14	26,90	5,46	20	40			
	Internal medicine	29	27,47	8,52	10	50			
	Endocrinology	2	18,33	2,35	16	20			
	Infectious Diseases	10	23,66	6,93	10	30			
	Physical therapy and rehabilitation	4	16,66	4,71	10	20			
	General Surgery	11	20,90	5,97	10	30			
	Geriatrics	2	21,66	16,49	10	33			
	Thoracic Surgery	11	24,54	14,31	10	43			
	Eye Diseases	3	24,44	3,84	20	26			
	First Aid and Emergency Aid	18	27,59	8,38	13	43			
	Gynecology and Obstetrics	6	18,88	8,60	10	33			
	Cardiovascular surgery	14	27,14	7,49	13	36			
	Cardiology	9	24,81	8,01	10	33			
	ENT	14	22,85	7,60	10	33			
	Microbiology	5	30,66	3,65	26	36			
	Nephrology	5	22,00	7,30	10	30			
	Neurology	21	28,88	10,66	10	43			
	Neurosurgery	3	27,77	5,09	23	33			
	Radiology	3	22,22	10,71	10	30			
	Orthopedics and Traumatology	10	30,00	8,46	20	40			
	Psychiatry	4	34,16	3,19	30	36			
	Other	209	27,49	10,66	10	126			
Culture of participation	Anesthesia	14	28,93	7,58	14	40	**1,609**	**,033***	**7-25**
	Urology	5	26,00	5,18	20	33			
	Biochemistry	2	22,22	0,00	22	22			
	Dermatology	7	24,60	2,67	22	30			
	Pediatry	14	25,39	3,50	20	31			
	Internal medicine	29	27,35	7,44	12	50			
	Endocrinology	2	16,11	5,49	12	20			
	Infectious Diseases	10	23,77	6,87	10	30			
	Physical therapy and rehabilitation	4	22,22	3,51	18	26			
	General Surgery	11	22,02	5,52	10	28			
	Geriatrics	2	17,77	10,99	10	25			
	Thoracic Surgery	11	23,23	8,82	10	35			
	Eye Diseases	3	25,92	2,31	23	27			
	First Aid and Emergency Aid	18	27,96	7,87	11	44			
	Gynecology and Obstetrics	6	22,59	8,12	16	37			
	Cardiovascular surgery	14	25,15	4,66	15	33			
	Cardiology	9	23,95	6,23	10	30			
	ENT	14	22,93	6,48	10	31			
	Microbiology	5	31,11	4,15	25	36			
	Nephrology	5	21,11	3,92	15	25			
	Neurology	21	26,08	7,82	10	40			
	Neurosurgery	3	25,92	0,64	25	26			
	Radiology	3	21,48	10,32	10	30			
	Orthopedics and Traumatology	10	28,11	6,85	17	40			
	Psychiatry	4	33,05	1,89	31	35			
	Other	209	26,18	6,68	10	57			

Table 5.30.

Comparison of the organizational culture scale scores of healthcare professionals according to their place of duty (continued)

Scales	Unit	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Basic Values	Anesthesia	14	31,19	9,92	13	43	1,130	,305	
	Urology	5	28,66	8,02	20	40			
	Biochemistry	2	23,33	4,71	20	26			
	Dermatology	7	30,00	5,44	23	40			
	Pediatry	14	30,95	8,10	20	43			
	Internal medicine	29	30,34	7,14	10	50			
	Endocrinology	2	25,00	7,07	20	30			
	Infectious Diseases	10	28,33	9,06	10	40			
	Physical therapy and rehabilitation	4	26,66	0,00	26	26			
	General Surgery	11	24,54	8,46	10	40			
	Geriatrics	2	21,66	16,49	10	33			
	Thoracic Surgery	11	27,57	11,36	10	40			
	Eye Diseases	3	28,88	3,84	26	33			
	First Aid and Emergency Aid	18	28,70	9,50	10	46			
	Gynecology and Obstetrics	6	23,88	9,98	10	40			
	Cardiovascular surgery	14	32,85	4,30	26	40			
	Cardiology	9	27,40	8,46	10	40			
	ENT	14	27,61	8,71	10	46			
	Microbiology	5	29,33	4,94	23	36			
	Nephrology	5	29,33	1,49	26	30			
	Neurology	21	32,69	6,20	20	46			
	Neurosurgery	3	36,66	3,33	33	40			
	Radiology	3	23,33	11,54	10	30			
	Orthopedics and Traumatology	10	31,00	5,45	23	40			
	Psychiatry	4	31,66	6,38	23	36			
	Other	209	29,96	7,61	10	50			
Compliance	Anesthesia	14	30,47	11,53	10	50	**1,674**	**,023***	**7-25**
	Urology	5	29,33	6,41	20	36			
	Biochemistry	2	23,33	4,71	20	26			
	Dermatology	7	24,28	4,17	20	30			
	Pediatry	14	25,95	7,75	20	40			
	Internal medicine	29	30,11	9,23	10	50			
	Endocrinology	2	23,33	9,42	16	30			
	Infectious Diseases	10	24,33	7,70	10	36			
	Physical therapy and rehabilitation	4	21,66	3,33	20	26			
	General Surgery	11	21,81	7,93	10	36			
	Geriatrics	2	23,33	18,85	10	36			
	Thoracic Surgery	11	27,87	12,04	10	40			
	Eye Diseases	3	27,77	6,93	20	33			
	First Aid and Emergency Aid	18	28,33	9,78	10	46			
	Gynecology and Obstetrics	6	20,00	8,43	10	30			
	Cardiovascular surgery	14	28,57	9,49	13	50			
	Cardiology	9	27,03	8,40	10	33			
	ENT	14	24,28	7,67	10	36			
	Microbiology	5	29,33	3,65	23	33			
	Nephrology	5	21,33	5,57	16	30			
	Neurology	21	33,17	8,06	20	50			
	Neurosurgery	3	30,00	3,33	26	33			
	Radiology	3	21,11	10,18	10	30			
	Orthopedics and Traumatology	10	30,00	8,74	13	40			
	Psychiatry	4	35,00	4,30	30	40			
	Other	209	29,10	8,79	10	50			
Coordination	Anesthesia	14	27,61	11,72	10	50	,996	,471	
	Urology	5	28,00	5,57	23	36			
	Biochemistry	2	26,66	4,71	23	30			
	Dermatology	7	23,81	6,50	16	33			
	Pediatry	14	25,00	7,36	20	40			
	Internal medicine	29	29,42	8,68	13	50			
	Endocrinology	2	21,66	16,49	10	33			
	Infectious Diseases	10	24,00	8,43	10	40			
	Physical therapy and rehabilitation	4	21,66	1,92	20	23			
	General Surgery	11	21,51	5,44	13	30			
	Geriatrics	2	25,00	11,78	16	33			
	Thoracic Surgery	11	26,36	9,24	16	40			
	Eye Diseases	3	26,66	3,33	23	30			
	First Aid and Emergency Aid	18	29,44	7,94	16	50			
	Gynecology and Obstetrics	6	18,33	4,59	10	23			
	Cardiovascular surgery	14	27,38	6,68	16	36			
	Cardiology	9	24,81	8,35	10	36			
	ENT	14	26,42	9,47	10	46			
	Microbiology	5	28,66	3,80	23	33			
	Nephrology	5	25,33	3,80	20	30			
	Neurology	21	28,73	9,33	10	50			
	Neurosurgery	3	32,22	6,93	26	40			
	Radiology	3	23,33	8,81	13	30			
	Orthopedics and Traumatology	10	29,00	3,86	23	33			
	Psychiatry	4	32,50	4,19	26	36			
	Other	209	27,99	9,93	10	130			

Table 5.31.

Comparison of the organizational culture scale scores of healthcare professionals according to their place of duty (continued)

Scales	Unit	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Consistency culture	Anesthesia	14	29,76	10,44	11	46	1,564	,043*	7-25
	Urology	5	28,66	5,40	23	35			
	Biochemistry	2	24,44	1,57	23	25			
	Dermatology	7	26,03	2,38	23	28			
	Pediatry	14	27,30	6,12	20	40			
	Internal medicine	29	29,96	7,55	12	50			
	Endocrinology	2	23,33	6,28	18	27			
	Infectious Diseases	10	25,55	7,94	10	38			
	Physical therapy and rehabilitation	4	23,33	0,90	22	24			
	General Surgery	11	22,62	5,56	11	30			
	Geriatrics	2	23,33	15,71	12	34			
	Thoracic Surgery	11	27,27	9,99	12	40			
	Eye Diseases	3	27,77	4,44	23	32			
	First Aid and Emergency Aid	18	28,82	7,77	12	46			
	Gynecology and Obstetrics	6	20,74	5,56	10	25			
	Cardiovascular surgery	14	29,60	6,30	18	41			
	Cardiology	9	26,42	6,70	10	32			
	ENT	14	26,11	6,67	10	35			
	Microbiology	5	29,11	3,08	25	33			
	Nephrology	5	25,33	2,13	23	28			
	Neurology	21	31,53	6,66	20	46			
	Neurosurgery	3	32,96	4,20	30	37			
	Radiology	3	22,59	10,08	11	30			
	Orthopedics and Traumatology	10	30,00	4,25	23	35			
	Psychiatry	4	33,05	4,38	26	36			
	Other	209	29,02	7,09	10	64			
Change	Anesthesia	14	30,71	9,79	10	50	1,207	,227	
	Urology	5	27,33	7,22	20	36			
	Biochemistry	2	25,00	7,07	20	30			
	Dermatology	7	24,76	3,77	20	30			
	Pediatry	14	27,14	6,64	16	40			
	Internal medicine	29	29,42	8,77	10	50			
	Endocrinology	2	18,33	11,78	10	26			
	Infectious Diseases	10	26,00	7,82	10	36			
	Physical therapy and rehabilitation	4	21,66	1,92	20	23			
	General Surgery	11	22,72	7,27	13	40			
	Geriatrics	2	18,33	7,07	13	23			
	Thoracic Surgery	11	24,84	7,04	10	33			
	Eye Diseases	3	31,11	1,92	30	33			
	First Aid and Emergency Aid	18	28,70	7,15	16	43			
	Gynecology and Obstetrics	6	21,11	9,58	13	40			
	Cardiovascular surgery	14	29,04	9,09	16	50			
	Cardiology	9	26,66	7,99	10	36			
	ENT	14	25,00	8,03	10	43			
	Microbiology	5	31,33	3,80	26	36			
	Nephrology	5	27,33	4,34	23	33			
	Neurology	21	29,36	11,52	10	50			
	Neurosurgery	3	34,44	1,92	33	36			
	Radiology	3	22,22	8,38	13	30			
	Orthopedics and Traumatology	10	29,33	6,99	16	40			
	Psychiatry	4	25,00	1,92	23	26			
	Other	209	27,87	8,31	10	50			
Customer focus	Anesthesia	14	32,14	9,02	16	50	**1,618**	**,032***	**15-25**
	Urology	5	26,00	4,34	20	30			
	Biochemistry	2	28,33	7,07	23	33			
	Dermatology	7	26,66	9,02	10	36			
	Pediatry	14	27,14	7,37	16	40			
	Internal medicine	29	31,14	15,76	16	103			
	Endocrinology	2	23,33	18,85	10	36			
	Infectious Diseases	10	26,33	8,52	10	40			
	Physical therapy and rehabilitation	4	18,33	3,33	13	20			
	General Surgery	11	24,84	7,50	16	40			
	Geriatrics	2	21,66	16,49	10	33			
	Thoracic Surgery	11	22,12	9,80	10	40			
	Eye Diseases	3	28,88	1,92	26	30			
	First Aid and Emergency Aid	18	30,18	8,43	13	50			
	Gynecology and Obstetrics	6	16,11	7,12	10	26			
	Cardiovascular surgery	14	28,81	7,69	10	36			
	Cardiology	9	27,77	8,16	10	36			
	ENT	14	26,19	5,36	16	33			
	Microbiology	5	32,00	2,98	30	36			
	Nephrology	5	27,33	5,47	23	36			
	Neurology	21	26,50	10,35	10	50			
	Neurosurgery	3	26,66	3,33	23	30			
	Radiology	3	21,11	10,18	10	30			
	Orthopedics and Traumatology	10	27,33	5,62	20	36			
	Psychiatry	4	32,50	5,69	26	40			
	Other	209	27,80	7,23	10	50			

Table 5.32.

Comparison of the organizational culture scale scores of healthcare professionals according to their place of duty (continued)

Scales	Unit	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
Organizational learning	Anesthesia	14	31,42	10,51	10	50	**1,793**	**,012***	**15-22**
	Urology	5	33,33	4,71	26	36			
	Biochemistry	2	23,33	0,00	23	23			
	Dermatology	7	24,28	5,68	16	30			
	Pediatry	14	23,09	7,67	10	40			
	Internal medicine	29	29,19	7,27	20	50			
	Endocrinology	2	28,33	11,78	20	36			
	Infectious Diseases	10	27,00	8,38	10	40			
	Physical therapy and rehabilitation	4	21,66	6,38	13	26			
	General Surgery	11	22,42	8,04	10	40			
	Geriatrics	2	20,00	14,14	10	30			
	Thoracic Surgery	11	21,81	10,15	10	40			
	Eye Diseases	3	25,55	5,09	20	30			
	First Aid and Emergency Aid	18	31,85	19,24	10	96			
	Gynecology and Obstetrics	6	18,88	9,58	10	33			
	Cardiovascular surgery	14	31,90	8,02	20	50			
	Cardiology	9	22,96	6,33	10	30			
	ENT	14	23,57	7,21	10	36			
	Microbiology	5	32,00	2,98	30	36			
	Nephrology	5	29,33	8,62	20	43			
	Neurology	21	32,06	13,96	16	80			
	Neurosurgery	3	35,55	6,93	30	43			
	Radiology	3	22,22	10,71	10	30			
	Orthopedics and Traumatology	10	32,00	4,76	26	40			
	Psychiatry	4	30,83	6,87	23	40			
	Other	209	29,05	9,88	10	123			
Compliance culture	Anesthesia	14	31,42	9,30	12	50	**1,946**	**,005***	**7-25**
	Urology	5	28,88	4,00	23	34			
	Biochemistry	2	25,55	0,00	25	25			
	Dermatology	7	25,23	4,99	15	31			
	Pediatry	14	25,79	5,99	17	40			
	Internal medicine	29	29,92	8,30	16	52			
	Endocrinology	2	23,33	14,14	13	33			
	Infectious Diseases	10	26,44	7,38	10	34			
	Physical therapy and rehabilitation	4	20,55	3,68	15	23			
	General Surgery	11	23,33	6,83	14	40			
	Geriatrics	2	20,00	12,57	11	28			
	Thoracic Surgery	11	22,92	7,04	10	32			
	Eye Diseases	3	28,51	2,31	26	31			
	First Aid and Emergency Aid	18	30,24	9,76	16	55			
	Gynecology and Obstetrics	6	18,70	8,05	12	33			
	Cardiovascular surgery	14	29,92	7,33	16	45			
	Cardiology	9	25,80	6,40	14	31			
	ENT	14	24,92	6,03	14	34			
	Microbiology	5	31,77	3,00	28	35			
	Nephrology	5	28,00	4,47	23	33			
	Neurology	21	29,31	9,31	12	48			
	Neurosurgery	3	32,22	2,22	30	34			
	Radiology	3	21,85	9,70	11	30			
	Orthopedics and Traumatology	10	29,55	3,89	22	35			
	Psychiatry	4	29,44	1,11	28	31			
	Other	209	28,24	6,85	10	58			
Strategic management	Anesthesia	14	31,66	10,91	10	50	1,658	,025*	23-25
	Urology	5	27,33	3,65	23	30			
	Biochemistry	2	26,66	4,71	23	30			
	Dermatology	7	24,28	7,62	16	40			
	Pediatry	14	24,28	8,51	10	40			
	Internal medicine	29	28,62	8,33	10	50			
	Endocrinology	2	30,00	14,14	20	40			
	Infectious Diseases	10	26,00	7,50	10	36			
	Physical therapy and rehabilitation	4	22,50	3,19	20	26			
	General Surgery	11	22,72	8,14	10	40			
	Geriatrics	2	21,66	16,49	10	33			
	Thoracic Surgery	11	23,33	12,47	10	40			
	Eye Diseases	3	31,11	7,69	26	40			
	First Aid and Emergency Aid	18	29,07	8,06	16	43			
	Gynecology and Obstetrics	6	22,77	7,72	10	33			
	Cardiovascular surgery	14	29,28	6,42	20	40			
	Cardiology	9	25,92	7,22	10	33			
	ENT	14	24,52	6,35	10	36			
	Microbiology	5	30,00	6,23	23	40			
	Nephrology	5	25,33	5,05	20	33			
	Neurology	21	29,20	9,06	10	43			
	Neurosurgery	3	32,22	3,84	30	36			
	Radiology	3	20,00	10,00	10	30			
	Orthopedics and Traumatology	10	32,33	4,72	23	40			
	Psychiatry	4	32,50	5,69	26	40			
	Other	209	28,48	6,90	10	50			

Table 5.33.

Comparison of the organizational culture scale scores of healthcare professionals according to their place of duty (continued)

Scales	Unit	n	$\bar{x}$	s	Bottom	Top	F	p	Difference
	Anesthesia	14	34.28	10.07	16	50			
	Urology	5	28.66	6.91	20	36			
	Biochemistry	2	23.33	9.42	16	30			
	Dermatology	7	25.23	4.65	20	30			
	Pediatry	14	24.76	7.12	16	40			
	Internal medicine	29	28.96	8.50	10	50			
	Endocrinology	2	26.66	9.42	20	33			
	Infectious Diseases	10	24.33	7.03	10	33			
	Physical therapy and rehabilitation	4	21.66	3.33	20	26			
	General Surgery	11	22.42	8.17	10	40			
	Geriatrics	2	21.66	16.49	10	33			
	Thoracic Surgery	11	26.06	11.03	10	43			
Organizational goals	Eye Diseases	3	24.44	3.84	20	26	1,308	,149	
	First Aid and Emergency Aid	18	28.70	7.93	13	46			
	Gynecology and Obstetrics	6	22.77	8.00	10	30			
	Cardiovascular surgery	14	30.47	8.45	20	50			
	Cardiology	9	24.07	7.59	10	33			
	ENT	14	23.33	7.84	10	43			
	Microbiology	5	29.33	7.60	16	36			
	Nephrology	5	24.66	9.00	16	40			
	Neurology	21	28.88	11.56	10	50			
	Neurosurgery	3	30.00	6.66	23	36			
	Radiology	3	20.00	10.00	10	30			
	Orthopedics and Traumatology	10	27.00	5.31	16	33			
	Psychiatry	4	29.16	4.19	23	33			
	Other	209	27.28	8.66	10	50			
	Anesthesia	14	33.57	9.19	20	50			
	Urology	5	30.66	4.34	26	36			
	Biochemistry	2	25.00	7.07	20	30			
	Dermatology	7	28.57	6.62	20	40			
	Pediatry	14	26.90	6.46	20	36			
	Internal medicine	29	29.65	8.08	10	50			
	Endocrinology	2	30.00	14.14	20	40			
	Infectious Diseases	10	26.33	9.35	10	40			
	Physical therapy and rehabilitation	4	26.66	6.08	20	33			
	General Surgery	11	21.81	7.50	10	40			
	Geriatrics	2	16.66	9.42	10	23			
	Thoracic Surgery	11	23.03	9.36	10	40			
Vision	Eye Diseases	3	23.33	3.33	20	26	1,965	,004	1-11
	First Aid and Emergency Aid	18	30.74	9.32	16	50			
	Gynecology and Obstetrics	6	18.88	11.86	10	40			
	Cardiovascular surgery	14	29.52	4.68	23	36			
	Cardiology	9	27.03	7.53	10	33			
	ENT	14	25.00	9.67	10	46			
	Microbiology	5	30.00	7.07	20	40			
	Nephrology	5	29.33	6.41	20	36			
	Neurology	21	29.52	9.38	10	46			
	Neurosurgery	3	32.22	1.92	30	33			
	Radiology	3	22.22	10.71	10	30			
	Orthopedics and Traumatology	10	31.00	7.54	13	40			
	Psychiatry	4	30.00	8.16	20	40			
	Other	209	29.55	7.50	10	50			
	Anesthesia	14	33.17	9.22	16	50			
	Urology	5	28.88	3.84	23	32			
	Biochemistry	2	25.00	7.07	20	30			
	Dermatology	7	26.03	5.20	21	36			
	Pediatry	14	25.31	6.69	16	37			
	Internal medicine	29	29.08	7.77	10	50			
	Endocrinology	2	28.88	12.57	20	37			
	Infectious Diseases	10	25.55	7.40	10	35			
	Physical therapy and rehabilitation	4	23.61	2.77	20	26			
	General Surgery	11	22.32	7.55	10	40			
	Geriatrics	2	20.00	14.14	10	30			
	Thoracic Surgery	11	24.14	9.96	10	38			
Mission culture	Eye Diseases	3	26.29	0.64	25	26	1,853	,008*	1-11
	First Aid and Emergency Aid	18	29.50	7.84	15	44			
	Gynecology and Obstetrics	6	21.48	8.09	10	34			
	Cardiovascular surgery	14	29.76	5.71	22	41			
	Cardiology	9	25.67	6.46	10	32			
	ENT	14	24.28	6.31	10	33			
	Microbiology	5	29.77	6.30	21	38			
	Nephrology	5	26.44	6.00	22	36			
	Neurology	21	29.20	9.38	10	46			
	Neurosurgery	3	31.48	2.31	28	33			
	Radiology	3	20.74	10.08	10	30			
	Orthopedics and Traumatology	10	30.11	2.89	23	33			
	Psychiatry	4	30.55	5.55	24	37			
	Other	209	28.44	6.59	10	50			
	Anesthesia	14	30.75	8.17	14	46			
	Urology	5	28.17	3.92	23	34			
	Biochemistry	2	24.28	2.02	22	25			
	Dermatology	7	25.55	2.26	23	29			
	Pediatry	14	25.98	4.46	20	36			
	Internal medicine	29	29.12	6.77	13	50			
	Endocrinology	2	22.85	9.69	16	29			
	Infectious Diseases	10	25.37	6.38	10	32			
	Physical therapy and rehabilitation	4	22.42	0.75	21	23			
	General Surgery	11	22.59	4.86	11	28			
	Geriatrics	2	20.28	13.33	10	29			
	Thoracic Surgery	11	24.41	8.03	13	34			
Organization culture	Eye Diseases	3	27.23	1.28	26	28	2,114	,002*	11-25
	First Aid and Emergency Aid	18	29.12	7.58	14	44			
	Gynecology and Obstetrics	6	20.95	6.54	13	32			
	Cardiovascular surgery	14	28.59	5.35	20	37			
	Cardiology	9	25.52	6.02	11	30			
	ENT	14	24.59	5.72	12	34			
	Microbiology	5	30.51	3.39	27	36			
	Nephrology	5	25.31	2.42	22	29			
	Neurology	21	29.06	7.38	15	45			
	Neurosurgery	3	30.57	1.03	29	31			
	Radiology	3	21.71	10.02	10	30			
	Orthopedics and Traumatology	10	29.54	2.93	25	33			
	Psychiatry	4	31.50	1.58	30	33			
	Other	209	28.02	5.63	10	43			

Table 5.28, Table 29, Table 5.30, Table 5.31, Table 5.32, and Table 5.33 give the comparison of organizational culture scale scores according to the services of healthcare workers. It was observed that there was a statistically significant difference between the scores obtained by healthcare professionals from the sub-dimension of the basic dimension of the participation culture of the organizational culture, authorization and participation culture according to the services they work. It was observed that there was a statistically significant difference between the overall scores of the consistency culture sub-dimension of compliance, the sub-dimension of compliance culture, customer focus, organizational learning and consistency culture. It has been observed that there is a statistically significant difference between the scores of the sub-dimension of the basic dimension of mission culture, strategic management, vision and mission culture and the overall organizational culture. ($p<0,05$). H2y hypothesis, participation culture in general, authorization to H2, H2zb compliance, H2Ab customer orientation, H2Ac organizational learning, H2A compliance culture general, H2B mission culture overall, H2Ba strategic management, H2Bc vision, H2C organizational culture scale overall have been accepted since significance values are $p <0.05$. The average scores of the psychiatry staff in empowerment, reconciliation, participation culture, customer focus, strategic management, and organizational culture are higher and the difference between them is statistically significant. The mean scores of the employees in the neurosurgery (Brain Surgery) service from organizational learning are higher and the difference between them is statistically significant. The average score of the employees in the anesthesia service from vision is higher and the difference between them is statistically significant. The organizational learning scores of the employees in the geriatric service are higher and the difference between them is at a statistically significant level. The average scores of the people working in the anesthesia service from the compliance culture are higher and the difference between them is at a statistically significant level. It has been observed that there is no statistically significant difference between the scores of healthcare workers in terms of teamwork and skill development, sub-dimensions of the basic dimension of participation culture according to the services they work. It was observed that there was no statistically significant difference between the sub-dimensions of the consistency culture basic dimension, core values and the scores they got from coordination. It was observed that there was no statistically significant difference between the scores of the sub-dimension of the adaptation culture basic dimension. It was observed that there was no statistically significant difference between the scores of the sub-dimension of the

basic dimension of mission culture from organizational goals (p>0,05). H2yb teamwork was rejected because the significance values of H2yc skill development, H2z consistency culture in general, H2za basic values, H2zc coordination, H2Aa change, H2Bb organizational goals significance values were p> 0.05.

Table 5.34.

Comparison of organizational culture scale scores according to the duties of healthcare professionals

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	p
Authorization	Nurse	154	23.00	7.75	10	43	1,051	,401
	midwife	13	21.53	9.48	10	40		
	Health officer operator	33	24.64	10.50	10	50		
	Health officer technician	44	24.54	7.71	10	43		
	Specialist physician	12	22.22	9.98	10	43		
	Director	7	25.23	7.16	13	30		
	Assistant physician	7	25.23	6.04	20	36		
	General practitioner	7	22.85	8.48	10	33		
	Officer	97	25.22	7.03	10	40		
	Assistant director	6	20.00	6.66	10	30		
	Secretary	11	25.15	7.65	13	36		
	Dialysis technician	9	20.00	3.33	13	23		
	Emergency medical technician	6	27.22	10.41	16	46		
	Dentist	16	24.79	7.40	10	40		
	Manager	6	25.00	9.60	10	36		
	Laboratory Assistant	7	29.04	5.68	20	36		
Team work	Nurse	154	26.51	7.51	10	46	,515	,933
	midwife	13	28.71	7.26	20	40		
	Health officer operator	33	26.16	8.54	10	50		
	Health officer technician	44	27.57	7.68	10	40		
	Specialist physician	12	26.66	8.16	10	40		
	Director	7	23.33	5.09	16	30		
	Assistant physician	7	26.66	2.72	23	30		
	General practitioner	7	24.28	8.09	10	33		
	Officer	97	26.49	6.53	10	43		
	Assistant director	6	25.00	7.22	16	33		
	Secretary	11	27.57	5.18	20	33		
	Dialysis technician	9	25.55	4.08	20	33		
	Emergency medical technician	6	24.44	6.55	20	36		
	Dentist	16	27.08	7.68	10	43		
	Manager	6	25.55	6.88	13	33		
	Laboratory Assistant	7	30.47	4.87	23	36		

Table 5.35.

Comparison of organizational culture scale scores according to the duties of healthcare professionals (continued)

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	p
Skills development	Nurse	154	26,29	8,99	10	50	,913	,550
	midwife	13	26,41	11,17	10	43		
	Health officer operator	33	26,76	9,94	10	50		
	Health officer technician	44	26,06	8,54	10	43		
	Specialist physician	12	25,27	9,79	10	43		
	Director	7	26,66	8,60	10	36		
	Assistant physician	7	24,28	5,34	13	30		
	General practitioner	7	28,57	9,78	13	40		
	Officer	97	28,59	12,45	10	126		
	Assistant director	6	17,22	3,89	13	23		
	Secretary	11	29,69	6,57	20	36		
	Dialysis technician	9	30,74	7,95	23	43		
	Emergency medical technician	6	26,11	4,43	20	30		
	Dentist	16	26,87	7,35	10	40		
	Manager	6	25,00	6,58	20	33		
	Laboratory Assistant	7	28,57	4,65	23	36		
Participation culture	Nurse	154	25,27	6,94	10	44	,628	,852
	midwife	13	25,55	7,61	16	40		
	Health officer operator	33	25,85	9,01	10	50		
	Health officer technician	44	26,05	6,34	10	40		
	Specialist physician	12	24,72	8,05	12	41		
	Director	7	25,07	5,87	14	32		
	Assistant physician	7	25,39	3,65	18	30		
	General practitioner	7	25,23	7,95	11	35		
	Officer	97	26,77	6,48	10	57		
	Assistant director	6	20,74	5,05	15	26		
	Secretary	11	27,47	5,21	17	34		
	Dialysis technician	9	25,43	3,35	18	30		
	Emergency medical technician	6	25,92	5,42	20	35		
	Dentist	16	26,25	6,72	10	36		
	Manager	6	25,18	6,61	14	32		
	Laboratory Assistant	7	29,36	4,52	24	36		
Basic values	Nurse	154	29,28	7,88	10	50	,846	,626
	midwife	13	32,30	11,73	10	50		
	Health officer operator	33	29,59	8,69	10	50		
	Health officer technician	44	29,92	7,79	10	43		
	Specialist physician	12	31,11	7,15	20	40		

	Director	7	29,52	5,24	20	36		
	Assistant physician	7	30,00	5,09	23	40		
	General practitioner	7	27,14	8,90	10	33		
	Officer	97	29,21	7,48	10	43		
	Assistant director	6	25,00	5,86	16	33		
	Secretary	11	33,03	5,66	23	40		
	Dialysis technician	9	34,81	6,03	26	43		
	Emergency medical technician	6	27,22	10,62	10	40		
	Dentist	16	29,58	7,87	10	40		
	Manager	6	31,66	5,47	26	40		
	Laboratory Assistant	7	30,95	4,98	23	36		
	Nurse	154	27,68	9,53	10	50		
	midwife	13	27,17	11,04	10	50		
	Health officer operator	33	28,58	8,85	10	50		
	Health officer technician	44	27,87	9,56	10	50		
	Specialist physician	12	27,50	9,54	16	43		
	Director	7	23,33	6,66	10	30		
	Assistant physician	7	29,04	4,98	20	36		
Compliance	General practitioner	7	31,90	12,14	10	50	,596	,879
	Officer	97	29,07	7,90	10	50		
	Assistant director	6	26,11	3,89	20	30		
	Secretary	11	32,12	8,20	23	46		
	Dialysis technician	9	28,14	11,56	16	50		
	Emergency medical technician	6	31,66	11,69	20	50		
	Dentist	16	29,79	8,02	20	43		
	Manager	6	28,88	5,44	20	36		
	Laboratory Assistant	7	27,14	4,87	20	33		
	Nurse	154	26,53	7,72	10	50		
	midwife	13	24,61	7,39	10	36		
	Health officer operator	33	26,86	9,75	10	50		
	Health officer technician	44	26,66	7,53	10	50		
	Specialist physician	12	28,61	9,99	10	40		
	Director	7	25,23	7,90	10	33		
	Assistant physician	7	28,09	6,34	20	40		
	General practitioner	7	30,47	7,80	16	43		
Coordination	Officer	97	27,35	6,68	10	50	,833	,641
	Assistant director	6	30,00	7,30	20	40		
	Secretary	11	30,30	5,46	23	40		
	Dialysis technician	9	28,88	9,57	20	50		
	Emergency medical technician	6	31,66	7,22	20	40		
	Dentist	16	32,08	27,07	10	130		
	Manager	6	27,77	7,20	16	36		
	Laboratory Assistant	7	30,00	3,84	23	33		

Table 5.36

Comparison of organizational culture scale scores according to the duties of healthcare professionals (continued)

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	p
	Nurse	154	27,83	7,32	10	46		
	midwife	13	28,03	9,07	10	43		
	Health officer operator	33	28,35	8,38	10	50		
	Health officer technician	44	28,15	7,20	10	46		
	Specialist physician	12	29,07	7,54	18	40		
	Director	7	26,03	6,04	13	30		
	Assistant physician	7	29,04	4,94	23	38		
	General practitioner	7	29,84	9,23	12	42		
Culture of consistency	Officer	97	28,54	6,23	10	45	,512	,934
	Assistant director	6	27,03	5,14	18	32		
	Secretary	11	31,81	5,04	24	41		
	Dialysis technician	9	30,61	8,24	23	46		
	Emergency medical technician	6	30,18	7,24	20	42		
	Dentist	16	30,48	10,56	20	64		
	Manager	6	29,44	4,64	23	36		
	Laboratory Assistant	7	29,36	2,55	25	33		
	Nurse	154	27,42	8,03	10	50		
	midwife	13	26,41	9,47	13	40		
	Health officer operator	33	26,46	9,60	10	50		
	Health officer technician	44	27,19	8,03	10	50		
	Specialist physician	12	27,22	10,42	10	50		
	Director	7	28,09	9,20	10	36		
	Assistant physician	7	25,71	8,32	10	36		
	General practitioner	7	34,28	5,34	26	40		
Change	Officer	97	27,69	8,17	10	50	1,059	,393
	Assistant director	6	22,77	6,11	13	30		
	Secretary	11	28,78	5,82	20	40		
	Dialysis technician	9	34,44	11,42	23	50		
	Emergency medical technician	6	25,00	9,60	16	40		
	Dentist	16	27,29	8,09	10	40		
	Manager	6	28,88	4,03	23	33		
	Laboratory Assistant	7	30,00	4,30	23	36		
C u s	Nurse	154	26,58	7,63	10	50	1,061	,392

	midwife	13	22,82	9,11	10	40		
	Health officer operator	33	27,77	8,19	10	50		
	Health officer technician	44	27,04	9,12	10	50		
	Specialist physician	12	28,33	10,10	10	40		
	Director	7	28,57	9,20	10	36		
	Assistant physician	7	27,61	4,98	16	30		
	General practitioner	7	28,09	8,78	13	40		
	Officer	97	28,96	10,36	10	103		
	Assistant director	6	25,00	8,62	13	36		
	Secretary	11	30,90	3,67	26	40		
	Dialysis technician	9	30,37	11,48	20	50		
	Emergency medical technician	6	29,44	5,74	20	36		
	Dentist	16	26,25	7,29	10	33		
	Manager	6	32,50	2,93	30	36		
	Laboratory Assistant	7	30,95	3,17	26	36		
	Nurse	154	28,29	11,02	10	96		
	midwife	13	28,20	11,67	10	43		
	Health officer operator	33	27,67	8,51	10	50		
	Health officer technician	44	27,95	8,01	10	50		
	Specialist physician	12	23,33	9,32	10	40		
	Director	7	28,09	8,99	10	36		
	Assistant physician	7	27,14	5,58	20	36		
	General practitioner	7	29,52	11,12	10	40		
Organizational learning	Officer	97	28,31	6,89	10	46	,978	,478
	Assistant director	6	40,55	41,70	13	12		
	Secretary	11	28,18	2,73	23	33		
	Dialysis technician	9	30,74	11,39	20	50		
	Emergency medical technician	6	29,44	6,11	20	33		
	Dentist	16	27,50	8,29	10	40		
	Manager	6	33,88	6,11	26	40		
	Laboratory Assistant	7	30,47	4,05	23	36		
	Nurse	154	27,43	7,31	10	55		
	midwife	13	25,81	9,45	12	40		
	Health officer operator	33	27,30	8,20	10	50		
	Health officer technician	44	27,39	7,40	10	50		
	Specialist physician	12	26,29	8,23	13	40		
	Director	7	28,25	8,97	10	35		
	Assistant physician	7	26,82	5,45	16	34		
	General practitioner	7	30,63	7,90	16	40		
Compliance culture	Officer	97	28,32	6,57	10	52	,667	,817
	Assistant director	6	29,44	16,32	14	58		
	Secretary	11	29,29	2,29	25	33		
	Dialysis technician	9	31,85	10,07	22	50		
	Emergency medical technician	6	27,96	5,27	20	34		
	Dentist	16	27,01	7,25	10	35		
	Manager	6	31,78	3,15	27	36		
	Laboratory Assistant	7	30,47	3,44	25	35		

Table 5.37.

Comparison of organizational culture scale scores of healthcare professionals according to their duties (continued)

Scales		**n**	$\bar{x}$	**Ss**	**Bottom**	**Top**	**F**	**p**
	Nurse	154	27,29	8,16	10	50		
	midwife	13	27,43	8,06	10	40		
	Health officer operator	33	27,37	9,08	10	50		
	Health officer technician	44	28,03	8,11	10	50		
	Specialist physician	12	27,22	10,80	10	40		
	Director	7	27,61	10,13	10	40		
	Assistant physician	7	24,76	5,03	16	30		
	General practitioner	7	30,95	7,86	16	40		
Strategic management	Officer	97	27,97	6,28	10	43	,592	,882
	Assistant director	6	27,22	9,04	13	36		
	Secretary	11	31,51	4,79	26	43		
	Dialysis technician	9	28,51	9,44	20	50		
	Emergency medical technician	6	30,00	5,57	20	36		
	Dentist	16	28,54	7,59	10	40		
	Manager	6	32,22	4,03	26	36		
	Laboratory Assistant	7	30,00	5,44	23	40		
	Nurse	154	26,60	8,47	10	50		
	midwife	13	30,00	10,09	10	46		
	Health officer operator	33	27,67	9,87	10	50		
	Health officer technician	44	27,50	8,86	10	50		
	Specialist physician	12	27,22	11,44	10	50		
	Director	7	27,61	9,75	10	36		
	Assistant physician	7	24,76	5,03	16	30		
	General practitioner	7	32,38	9,56	13	40		
Organizational aims	Officer	97	26,90	8,51	10	50	,814	,663
	Assistant director	6	19,44	8,27	10	33		
	Secretary	11	26,66	5,96	20	36		
	Dialysis technician	9	30,37	11,23	16	50		
	Emergency medical technician	6	30,00	5,57	20	36		
	Dentist	16	27,29	8,36	10	40		
	Manager	6	27,77	5,01	23	36		
	Laboratory Assistant	7	28,57	6,62	16	36		
	Nurse	154	27,68	8,10	10	50		
Vision	midwife	13	28,71	13,77	10	46	,639	,843
	Health officer operator	33	28,99	8,71	10	50		
	Health officer technician	44	29,77	8,54	10	50		

	Specialist physician	12	29,16	9,86	10	40		
	Director	7	30,95	10,49	10	40		
	Assistant physician	7	26,66	3,84	20	30		
	General practitioner	7	32,38	8,09	16	40		
	Officer	97	29,14	7,15	10	50		
	Assistant director	6	25,55	9,81	10	40		
	Secretary	11	28,48	5,24	20	36		
	Dialysis technician	9	32,59	9,68	20	50		
	Emergency medical technician	6	29,44	5,74	20	36		
	Dentist	16	28,33	7,50	10	40		
	Manager	6	30,55	4,43	26	36		
	Laboratory Assistant	7	30,47	5,90	20	40		
	Nurse	154	27,19	7,36	10	50		
	midwife	13	28,71	9,70	10	41		
	Health officer operator	33	28,01	8,21	10	50		
	Health officer technician	44	28,43	7,60	10	50		
	Specialist physician	12	27,87	9,64	10	43		
Mission culture	Director	7	28,73	9,75	10	38		
	Assistant physician	7	25,39	4,41	18	30		
	General practitioner	7	31,90	8,30	15	40	,628	,852
	Officer	97	28,00	6,11	10	46		
	Assistant director	6	24,07	7,90	13	35		
	Secretary	11	28,88	3,54	24	34		
	Dialysis technician	9	30,49	8,97	22	50		
	Emergency medical technician	6	29,81	5,23	20	34		
	Dentist	16	28,05	7,29	10	40		
	Manager	6	30,18	3,25	25	33		
	Laboratory Assistant	7	29,68	5,39	21	38		
	Nurse	154	26,97	6,19	10	44		
	midwife	13	27,03	8,22	13	40		
	Health officer operator	33	27,38	7,97	10	50		
	Health officer technician	44	27,52	6,31	10	46		
	Specialist physician	12	27,00	7,54	16	40		
	Director	7	27,06	7,32	12	32		
	Assistant physician	7	26,77	4,03	20	32		
	General practitioner	7	29,34	7,72	14	39		
Organizational culture	Officer	97	27,97	5,30	10	45	,475	,953
	Assistant director	6	25,42	7,14	16	35		
	Secretary	11	29,42	3,11	25	34		
	Dialysis technician	9	29,61	6,69	22	43		
	Emergency medical technician	6	28,28	4,35	20	32		
	Dentist	16	28,00	5,65	20	37		
	Manager	6	29,34	3,65	25	33		
	Laboratory Assistant	7	29,79	3,10	26	36		

In Table 5.34, Table 5.35, Table 5.36 and Table 5.37, the comparison of the organizational culture scale scores according to the duties of the health workers is given. It has been observed that there is no statistically significant difference between the overall scores of the healthcare professionals in the overall scale of the basic dimension of organizational culture, the sub-dimensions of participation culture, empowerment, teamwork, talent development and participation culture (p>0,05). It was observed that there was no statistically significant difference between the scores they got from the sub-dimensions of the consistency culture basic dimension, core values, reconciliation, coordination and consistency culture scale (p>0,05). It was observed that there was no statistically significant difference between the overall scores of the sub-dimensions of the basic dimension of adaptation culture, change, customer focus, organizational learning and adaptation culture (p>0,05). It has been observed that there is no statistically significant difference between the scores of the basic dimension of mission culture in strategic management, organizational goals, vision and mission culture scale in general, and organizational culture (p>0,05). According to the roles of healthcare professionals, the H2D hypothesis is that the overall culture of participation, H2Da authorization, H2Db teamwork, H2Dc talent development, H2E consistency culture overall, H2Ea basic values, H2Eb compliance, H2Ec coordination, H2F compliance culture overall, H2Fa change, H2Fb customer

focus, H2Fc organizational learning, H2G mission culture overall, H2Ga strategic management, H2Gb organizational goals, H2Gc vision, H2H organizational culture scale are generally rejected since significance values are p> 0.05

Table 5.38.

Comparison of organizational culture scale scores according to the duration of work of healthcare professionals in their positions

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	p
Authorization	0-5 years	148	24,48	7,97	10	50	,831	,506
	6-10 years	150	23,26	8,36	10	46		
	11-15 years	59	25,02	6,67	10	43		
	16-20 years	31	23,01	7,61	10	40		
	21 years and above	47	24,04	7,73	10	43		
Team work	0-5 years	148	26,26	6,64	10	50	,209	,933
	6-10 years	150	26,55	8,16	10	46		
	11-15 years	59	27,06	6,66	10	40		
	16-20 years	31	26,98	5,39	20	40		
	21 years and above	47	27,02	6,88	10	43		
Talent development	0-5 years	148	27,05	8,41	10	50	,554	,696
	6-10 years	150	26,20	12,28	10	126		
	11-15 years	59	26,78	7,37	10	43		
	16-20 years	31	28,81	7,77	10	43		
	21 years and above	47	27,51	7,78	10	43		
Participation culture	0-5 years	148	25,93	6,44	10	50	,339	,852
	6-10 years	150	25,33	7,78	10	57		
	11-15 years	59	26,29	5,88	10	40		
	16-20 years	31	26,27	5,98	13	40		
	21 years and above	47	26,19	6,00	13	42		
Basic values	0-5 years	148	30,02	7,65	10	50	,778	,540
	6-10 years	150	29,00	8,63	10	46		
	11-15 years	59	30,67	7,42	10	50		
	16-20 years	31	30,43	5,94	20	40		
	21 years and above	47	28,93	6,77	13	46		
Compliance	0-5 years	148	28,53	9,28	10	50	1,228	,298
	6-10 years	150	27,28	8,67	10	50		
	11-15 years	59	29,15	7,74	10	50		
	16-20 years	31	30,75	9,76	16	50		
	21 years and above	47	28,29	9,32	10	50		
Coordination	0-5 years	148	27,50	11,44	10	130	,797	,528
	6-10 years	150	26,48	7,81	10	50		
	11-15 years	59	28,24	7,38	10	50		
	16-20 years	31	29,14	7,04	16	50		
	21 years and above	47	27,44	7,06	13	40		
Consistency culture	0-5 years	148	28,68	7,67	10	64	1,241	,293
	6-10 years	150	27,59	7,19	10	46		
	11-15 years	59	29,36	6,44	10	46		
	16-20 years	31	30,10	6,34	17	45		
	21 years and above	47	28,22	6,74	14	43		
Change	0-5 years	148	27,86	8,56	10	50	,729	,572
	6-10 years	150	27,08	8,72	10	50		
	11-15 years	59	27,06	7,50	10	50		
	16-20 years	31	29,67	7,21	20	50		
	21 years and above	47	27,58	7,41	10	43		
Customer focus	0-5 years	148	27,66	7,46	10	50	,513	,726
	6-10 years	150	27,40	10,38	10	103		
	11-15 years	59	26,94	7,83	10	50		
	16-20 years	31	29,57	6,97	10	50		
	21 years and above	47	27,58	7,47	10	40		
Organizational learning	0-5 years	148	28,40	9,17	10	80	,764	,549
	6-10 years	150	27,55	10,18	10	96		
	11-15 years	59	29,66	14,36	10	123		
	16-20 years	31	30,32	8,22	16	46		
	21 years and above	47	28,15	7,97	10	43		
Compliance culture	0-5 years	148	27,97	7,01	10	50	,761	,551
	6-10 years	150	27,34	8,10	10	55		
	11-15 years	59	27,89	7,76	10	58		
	16-20 years	31	29,85	6,25	15	48		
	21 years and above	47	27,77	5,99	10	40		
Strategic management	0-5 years	148	27,81	7,58	10	50	,533	,712
	6-10 years	150	27,48	8,37	10	50		
	11-15 years	59	27,85	6,74	10	50		
	16-20 years	31	29,67	7,37	10	43		
	21 years and above	47	28,15	7,41	10	40		

Table 5.39.

Comparison of organizational culture scale scores according to the duration of work of healthcare professionals in their positions (continued)

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	p
	0-5 years	148	27,18	8,65	10	50		
	6-10 years	150	26,73	8,96	10	50		
Organizational goals	11-15 years	59	26,72	8,22	10	50	,726	,574
	16-20 years	31	29,57	8,50	16	50		
	21 years and above	47	27,23	8,49	10	46		
	0-5 years	148	29,30	7,98	10	50		
	6-10 years	150	27,86	8,80	10	50		
Vision	11-15 years	59	28,47	7,63	10	50	,969	,424
	16-20 years	31	30,43	6,59	20	46		
	21 years and above	47	28,86	7,59	10	43		
	0-5 years	148	28,10	7,09	10	50		
	6-10 years	150	27,36	7,80	10	50		
Mission culture	11-15 years	59	27,68	6,55	10	50	,848	,495
	16-20 years	31	29,89	6,44	17	46		
	21 years and above	47	28,08	6,82	10	41		
	0-5 years	148	27,71	5,98	11	50		
	6-10 years	150	26,93	6,67	10	44		
Organizational culture	11-15 years	59	27,83	5,80	10	46	,919	,453
	16-20 years	31	29,07	5,51	18	45		
	21 years and above	47	27,63	5,35	15	38		

In Table 5.38 and Table 5.39, the comparison of the organizational culture scale scores according to the working time of the healthcare workers in their position is given. It is seen that there was no statistically significant difference among the scores that healthcare professionals get from authorization, teamwork, talent development, basic values, reconciliation, coordination, participation culture, change, customer focus, organizational learning, strategic management, organizational goals, vision, compliance culture, organizational culture, according to their working time in their position (p>0,05). According to the working time of the healthcare professionals in their position, H2I hypothesis, overall participation culture, H2Ia empowerment, H2Ib teamwork, H2Ic ability development, H2İ consistency culture overall, H2İa core values, H2İb consensus, H2İc coordination, H2J compliance culture overall, H2Ja change, H2Jb customer focus , H2Jc organizational learning, H2K mission culture overall, H2Ka strategic management, H2Kb organizational goals, H2Kc vision, H2L organizational culture scale are generally rejected since significance values are p> 0.05.

Table 5.40.

Comparison of organizational culture scale scores according to the total professional experience of healthcare professionals

Scales		n	$\bar{x}$	Ss	Bottom	Top	F	P
Authorization	0-5 years	94	23,68	8,05	10	50	607	658
	6-10 years	146	23,69	8,57	10	46		
	11-15 years	73	24,97	7,20	10	43		
	16-20 years	44	23,03	7,11	10	40		
	21 years and above	78	24,48	7,47	10	43		
Team work	0-5 years	94	25,92	7,10	10	50	948	436
	6-10 years	146	26,14	7,90	10	46		
	11-15 years	73	27,35	7,02	10	40		
	16-20 years	44	27,87	6,51	16	40		
	21 years and above	78	26,88	6,01	10	43		
Talent development	0-5 years	94	26,41	8,28	10	50	352	843
	6-10 years	146	26,43	12,61	10	126		
	11-15 years	73	27,80	7,11	10	43		
	16-20 years	44	27,50	8,26	10	43		
	21 years and above	78	27,13	7,81	10	50		
Participation culture	0-5 years	94	25,34	6,51	10	50	631	641
	6-10 years	146	25,42	7,83	10	57		
	11-15 years	73	26,71	6,13	10	40		
	16-20 years	44	26,13	6,35	13	40		
	21 years and above	78	26,16	5,72	13	42		

Table 5.41.

Comparison of organizational culture scale scores according to the total professional experience of healthcare professionals (continued)

Scales		n	$\bar{x}$	Ss	Alt	Bottom	F	P
	0-5 years	94	29,43	7,96	10	50		
	6-10 years	146	29,42	8,68	10	46		
Basic values	11-15 years	73	31,32	6,88	10	50	1155	330
	16-20 years	44	29,84	7,29	10	43		
	21 years and above	78	28,76	6,69	10	50		
	0-5 years	94	27,51	9,06	10	50		
	6-10 years	146	27,44	9,27	10	50		
Compliance	11-15 years	73	29,54	8,66	10	50	1236	295
	16-20 years	44	29,47	8,71	10	46		
	21 years and above	78	29,14	8,39	10	50		
	0-5 years	94	27,34	13,23	10	130		
	6-10 years	146	26,30	7,92	10	50		
Coordination	11-15 years	73	28,21	7,28	10	50	978	419
	16-20 years	44	28,78	7,19	10	50		
	21 years and above	78	27,77	7,01	10	43		
	0-5 years	94	28,09	7,96	11	64		
	6-10 years	146	27,72	7,45	10	46		
Consistency culture	11-15 years	73	29,69	6,64	10	46	1168	324
	16-20 years	44	29,36	6,82	10	45		
	21 years and above	78	28,56	6,18	14	45		
	0-5 years	94	28,01	8,72	10	50		
	6-10 years	146	26,84	9,12	10	50		
Change	11-15 years	73	28,67	7,61	10	50	924	450
	16-20 years	44	28,48	7,20	13	50		
	21 years and above	78	26,92	7,10	10	40		
	0-5 years	94	27,57	8,24	10	50		
	6-10 years	146	27,23	10,44	10	103		
Customer focus	11-15 years	73	27,44	7,68	10	50	342	850
	16-20 years	44	28,93	7,49	10	50		
	21 years and above	78	27,73	6,32	10	40		
	0-5 years	94	28,40	10,01	10	80		
	6-10 years	146	27,07	8,75	10	50		
Organizational learning	11-15 years	73	30,59	15,48	10	123	1545	188
	16-20 years	44	29,24	8,31	10	46		
	21 years and above	78	28,29	6,97	10	43		
	0-5 years	94	27,99	7,68	10	50		
	6-10 years	146	27,05	7,89	10	52		
Compliance culture	11-15 years	73	28,90	8,17	10	58	1044	384
	16-20 years	44	28,88	6,52	14	48		
	21 years and above	78	27,65	5,21	10	40		
	0-5 years	94	27,87	8,23	10	50		
	6-10 years	146	27,30	8,28	10	50		
Strategic management	11-15 years	73	27,94	7,32	10	50	448	774
	16-20 years	44	28,18	8,05	10	46		
	21 years and above	78	28,71	6,03	10	40		
	0-5 years	94	26,84	8,70	10	50		
	6-10 years	146	26,78	9,48	10	50		
Organisational goals	11-15 years	73	27,03	7,70	10	50	393	814
	16-20 years	44	28,48	9,10	10	50		
	21 years and above	78	27,52	7,68	10	46		
	0-5 years	94	29,07	8,37	10	50		
	6-10 years	146	27,94	8,98	10	50		
Vision	11-15 years	73	29,08	7,66	10	50	535	710
	16-20 years	44	29,47	7,97	10	46		
	21 years and above	78	29,01	6,40	10	43		
	0-5 years	94	27,93	7,58	10	50		
	6-10 years	146	27,34	7,90	10	50		
Mission culture	11-15 years	73	28,02	6,79	10	50	461	765
	16-20 years	44	28,71	7,31	10	46		
	21 years and above	78	28,41	5,59	10	41		
	0-5 years	94	27,38	6,26	11	50		
	6-10 years	146	26,91	6,69	10	44		
Organizational culture	11-15 years	73	28,38	6,09	10	46	942	440
	16-20 years	44	28,29	6,04	13	45		
	21 years and above	78	27,75	4,68	15	39		

In Table 5.40 and Table 5.41, it has been observed that there is no statistically significant difference between the scores of healthcare workers in general sub-dimensions of the basic dimension of organizational culture, authorization, teamwork, talent development and participation culture. (p>0,05). It was observed that there was

no statistically significant difference between the scores of the sub-dimensions of the consistency basic dimension, basic values, compliance, coordination and consistency culture (p>0,05). It was observed that there was no statistically significant difference between the scores of the sub-dimensions of the basic dimension of adaptation culture, change, customer orientation, organizational learning and adaptation culture (p>0,05). It has been observed that there is no statistically significant difference between the scores of the sub-dimensions of the basic dimension of mission culture, strategic management, organizational goals, vision and mission culture in general, and organizational culture (p>0,05). According to the total professional experience of healthcare professionals, the H2M hypothesis the overall participation culture, H2Ma authorization, H2Mb teamwork, H2Mc talent development, H2N consistency culture overall, H2Na basic values, H2Nb compromise, H2Nc coordination, H2O compliance culture overall, H2Oa change, H2Ob customer focus , H2Oc organizational learning, H2Ö mission culture in general, H2Öa strategic management, H2Öb organizational goals, H2Öc vision, H2P organizational culture scale are generally rejected since significance values are p> 0.05.

5.10.4. Leadership Behaviors and Organizational Culture Scales Correlation Analysis

In this section, the means, standard deviations and correlation analyzes of the scales of the research are shown.

Table 5.42.

Healthcare professionals' scores on Leadership and Organizational Culture Scales

	n	$\bar{x}$	ss	Min	Max
Business Oriented Leadership	435	41,88	6,77	10	79
Employee Oriented Leadership	435	42,02	6,64	10	72
Change Oriented Leadership	435	42,18	7,18	10	75
Leadership Scale	435	42,03	6,47	10	56
Authorization	435	23,98	7,89	10	50
Team work	435	26,60	7,13	10	50
Talent Development	435	26,89	9,70	10	126
Culture of Participation	435	25,82	6,77	10	57
Basic values	435	29,67	7,78	10	50
Compromise	435	28,32	8,92	10	50
Coordination	435	27,36	9,05	10	130
Consistency Culture	435	28,45	7,17	10	64
Change	435	27,58	8,26	10	50
Customer Focus	435	27,60	8,58	10	103
Organizational Learning	435	28,39	10,19	10	123
Culture of Compliance	435	27,86	7,35	10	58
Strategic Management	435	27,87	7,71	10	50
Organization Objectives	435	27,14	8,66	10	50
Vision	435	28,72	8,10	10	50
Mission Culture	435	27,91	7,20	10	50
Organization culture	435	27,51	6,11	10	50

In Table 5.42, the scores that healthcare workers got from leadership and organizational culture scales are given. When Table 5.43 is analyzed, the sub-dimensions of the leadership scale of healthcare workers included in the study, the business-focused leadership score average is 41.88 ± 6.77, the employee-focused leadership point average is 42.02 ± 6.64, the change-oriented leadership average score is 42.18 ± 7. , 18, the overall leadership scale mean score was 42.03 ± 6.47 minimum 10, maximum 56 points. Accordingly, the leadership of change with the highest average was preferred by healthcare professionals.

The basic dimension of the organizational culture scale of healthcare workers was calculated as 23.98 ± 7.89, the teamwork sub-dimension mean score was 23.98 ± 7.89, the teamwork sub-dimension mean score was 26.89 ± 9.70. The mean score of the basic values sub-dimension of the consistency culture basic dimension was calculated as 29.67 ± 7.78, the mean score for the reconciliation sub-dimension was 28.32 ± 8.92, and the coordination sub-dimension mean score was 27.36 ± 9.05. The mean score of the change sub-dimension of the basic dimension of adaptation culture was 27.58 ± 8.26, the customer-orientation sub-dimension mean score was 27.60 ± 8.58, and the organizational learning sub-dimension mean score was 28.39 ± 10.19. The mean score of the strategic management sub-dimension of the basic dimension of mission culture was 27.87 ± 7.71, the organizational goals sub-dimension mean score was 27.14 ± 8.66, and the vision sub-dimension mean score was 28.72 ± 8.10. The overall score average of the organizational culture scale was determined as 27.51 ± 6.12, minimum 10, maximum 50 points. Accordingly, the basic dimension of the organizational culture scale is the basic values sub-dimension of the coherence culture is taken into consideration by healthcare professionals more.

Table 5.43.

Correlations between healthcare professionals' scores on leadership and organizational culture scales

		Business oriented leadership	**Employee-oriented leadership**	**Change-oriented leadership**	**Leadership scale**
Business Oriented Leadership	r p	1			
Employee Oriented Leadership					
Change Oriented Leadership	r p	**,869**	1		
Leadership Scale		**,000****			
Authorization	r p	**,794**	**,842**	1	
Team work		**,000****	**,000****		

Talent Development	r	**,934**	**,962**	**,934**	1
	p				
Business Oriented Leadership		**,000****	**,000****	**,000****	
Employee Oriented Leadership	r	,058	,000	,020	,025
	p				
Change Oriented Leadership		,228	,997	,672	,602
Leadership Scale	r	,034	,012	,009	,018
	p				
Authorization		,479	,809	,845	,702
Team work	r	,063	,067	,073	,072
	p	,187	,165	,131	,135
Culture of Participation	r	,065	,036	,046	,050
	p				
Basic values		,179	,459	,342	,296
Compromise	r	,002	,016	,048	,024
	p				
Coordination		,973	,741	,319	,619
Consistency Culture	r	,024	-,015	,028	,012
	p				
Change		,613	,762	,558	,805
Customer Focus	r	-,016	-,027	,010	-,012
	p				
Organizational Learning		,745	,574	,841	,804
Culture of Compliance	r	,004	-,012	,033	,009
	p				
Strategic Management		,932	,808	,491	,859
Organization Objectives	r	**,099**	**,109**	-,066	**,097**
	p				
Vision		**-,039***	**-,023***	,169	**-,043***
Mission Culture	r	,014	-,017	,022	,006
	p	,767	,718	,643	,908
Culture of Participation	r	,003	-,022	,021	,000
	p				
Basic values		,946	,646	,659	,999
Compromise	r	-,030	-,058	-,006	-,034
	p				
Coordination		,533	,229	,897	,478
Consistency Culture	r	,000	-,035	,029	-,003
	p				
Change		,997	,468	,546	,945
Customer Focus	r	-,037	-,061	-,032	-,047
	p				
Organizational Learning		,443	,208	,506	,332
Culture of Compliance	r	-,002	-,048	,009	-,016
	p				
Strategic Management		,968	,316	,858	,733
Organization Objectives	r	-,016	-,055	,001	-,026
	p				
Vision		,746	,254	,987	,589
Mission Culture	r	,008	-,024	,023	,001
	p	,870	,613	,628	,979

**p<0,05,*

As can be seen from the table, there is a negative and significant relationship at the level of 0.05 between business-oriented leadership, employee-oriented leadership

and leadership behaviors in general and adaptation to change in organizational culture. It has been found that there are low-level relationships between the sub-dimension of leadership behaviors, work-oriented leadership and the sub-dimension of organizational culture adaptation culture (r = 0.099, p = -0.039). Low-level relationships were found between employee-oriented leadership (r = 0.109, p = -0.023) and leadership behaviors overall (r = 0.097, p = -0.043). Since the significance values were found to be p <0.05 smaller, the relationship between leadership and organizational culture was considered to be significant. (H1 is supported).

5.10.5. The Effect of Leadership Behaviors on Organizational Culture Regression Analysis

Due to the determined results in our study, H2 hypothesis is appropriate to test the with.

Table 5.44.

Healthcare professionals' prediction of leadership and organizational culture scales scores

R	R^2	Independent variable	The dependent variable	Standardized Non-Coefficients		Standardized Coefficients	t	p
				B	S.H.	Beta		
			(Dependent)	2,264	,249		9,095	,000
,118	**,014**	**Business Oriented Leadership**	Authorization	**,471**	**,196**	**,404**	**2,403**	**,017***
			(Dependent)	2,976	,232		12,805	,000
,100	**,010**	Change-oriented leadership	Culture of compliance	**,339**	**,173**	**,331**	**1,965**	**,050***
			(Dependent)	2,840	,243		11,681	,000
,120	**,014**	Change-oriented leadership	Strategic management	**,451**	**,181**	**,420**	**2,494**	**,013***
			(Dependent)	2,986	,255		11,695	,000
		Business Oriented Leadership	Vision	**,413**	**,201**	**,346**	**2,055**	**,040***
,120	**,014**	Change-oriented leadership	Vision	**,448**	**,190**	**,397**	**2,359**	**,019***
		Leadership scale overall	Vision	**-,888**	**,357**	**-,710**	**-2,485**	**,013***
			(Dependent)	2,939	,227		12,927	,000
,113	**,013**	Change-oriented leadership	**Mission culture**	**,377**	**,169**	**,375**	**2,230**	**,026***
		Leadership scale overall	**Mission culture**	**-,727**	**,318**	**-,653**	**-2,284**	**,023***

**p<0,05,*

The results of the linear regression analysis regarding the prediction of the organizational culture scores of the healthcare workers' leadership scale scores given in Table 5.44.

There is a relationship at the level of 11.8% between the job-oriented leadership sub-dimension of leadership behaviors and the sub-dimension of the basic dimension of the participation culture of the organizational culture. It is understood that the business-oriented leadership sub-dimension of leadership behaviors and the sub-dimension of the basic dimension of the participation culture of organizational culture explain authorization at the level of 01.4%. The model was accepted to be meaningful since it was found that the 0.01 significance value was less than 0.05.

There is a relationship of 10.0% between the change-oriented leadership sub-dimension of leadership behaviors and the basic dimension of adaptation culture of organizational culture. It is understood that change-oriented leadership explains the culture of adaptation at the level of 01.0%. Since the significance value of 0.05 is found to be equal to 0.05, the model is considered to be significant.

A relationship at the level of 12.0% is observed between the change-oriented leadership sub-dimension of leadership behaviors and the strategic management sub-dimension of the basic dimension of mission culture of organizational culture. It is understood that change-oriented leadership explains strategic management at the level of 01.4%. The model was accepted to be meaningful since it was found that the 0.01 significance value was less than 0.05.

There is a relationship at the level of 12.0% between the business-oriented leadership sub-dimension of leadership behaviors and the vision sub-dimension of the basic dimension of mission culture of organizational culture. It is understood that business-oriented leadership explains the vision at the level of 01.4%. The model was accepted to be meaningful since it was found that the 0.04 significance value was less than 0.05.

There is a relationship at the level of 12.0% between the change-oriented leadership sub-dimension of leadership behaviors and the vision sub-dimension of the basic dimension of mission culture of organizational culture. It is understood that change-oriented leadership explains the vision at the level of 01.4%. The model was accepted to be meaningful since it was found that the 0.04 significance value was less than 0.05.

There is a relationship at the level of 12.0% between the leadership behaviors and the vision sub-dimension of the mission culture of the organizational culture. It is understood that leadership behaviors explain the vision at the level of 01.4%. The model was accepted to be meaningful since it was found that the 0.04 significance value was less than 0.05.

There is a relationship at the level of 11.3% between the change-oriented leadership sub-dimension of leadership behaviors and the basic dimension of the mission culture of organizational culture. It is understood that change-oriented leadership explains the mission culture at the level of 01.3%. Since the significance value of 0.02 was found to be less than 0.05, the model was accepted to be significant.

There is a relationship at the level of 11.3% between leadership behaviors and the basic dimension of mission culture of organizational culture. It is understood that leadership behaviors explain the mission culture at the level of 01.3%. Since the significance value of 0.02 was found to be less than 0.05, the model was accepted to be significant.

Since the results are also supported by analysis, the fourth of the main hypotheses (H4 hypothesis) is supported.

Accordingly, the leaders who focus on business activities should be made aware of the fact that they have the opportunity to make decisions that contribute to customer satisfaction and department performance, and it has been determined that they affect answering such questions. “What is our purpose, where do we want to come?" give information about the future goals of the organization.

Change-oriented leaders aim to mobilize people towards change and to identify and manage change in problematic situations that occur within the organization. Based on the emphasis on the importance of change skills necessary for the organization to quickly adapt to environmental changes, the consideration of resources, and the evaluation of the internal and external environments in which the organization operates, it has been understood that these leaders influence the creation and implementation of the main goals and initiatives taken by the senior managers of an organization on behalf of the owners.

DISCUSSION AND CONCLUSION

Discussion

The purpose of this research is to examine the impact of leadership and the organizational structure in the Affliated hospitals in Turkey on organizational culture. In addition, when the health managers working in these hospitals were accepted as a leader and a manager, it was explored what their activities consisted of, and it was tried to determine which of their structuralist, human resource, political and symbolic scales manifest themselves as influencers of leadership and management functionality. Another subject of the research is that the relation between the culture content and leadership behaviors and the organizational culture in affliated hospitals is determined.

In the study of Hoş and Oksay (2015), 89% of the participants in the study were stated to be women. In Kamiloğlu's (2014) study, it was stated that 84.6% of their nurses were women. In Kaya's (2010) study, 79.9% of the nurses were stated to be women. In the study of Mart (2014), it was stated that 86.5% of the nurses were women. When these studies are examined, it is seen that most of the nurses are women and these results are in accordance with our study.

The highest average change-oriented leadership score average among the leadership scale sub-dimensions in the research is 42.18 ± 7.18. This result may show that employees perceive their managers more as change-oriented leaders. As a matter of fact, in studies conducted by Keklik (2012), Yıldız Bağdoğan and Sarpbalkan (2017) and Top et al. (2010), the transformational leadership perceptions of the employees support this research.

In the research conducted by Karakışla (2012) on nurses, it was determined that the highest value was the dimension of participation culture and the lowest value was the dimension of consistency culture. In the research conducted by Özyaman (2010) on administrative and technical personnel and advisory staff in a university hospital, it was determined that the highest value was the

dimension of consistency culture and the lowest value was the vision culture dimension.

In the study conducted by Nurses on Casida (2008), it was determined that the highest value was the culture of participation and the lowest value was the culture of compliance and mission. Similarly to this study, it is seen that the culture of participation is the highest, whereas the culture of compliance and mission is the lowest. The difference here is thought to be due to the fact that the relevant research covers only nurses. In the study of Yahyagil (2004) on the employees of the production sector in order to measure the validity and reliability of the Denison Organization Culture Measurement Tool, it was found that the highest value was the culture of compliance and the lowest value was the culture of consistency. Within the scope of basic dimensions, the culture of adaptation has the highest value and the lowest value is in the participation culture. This result partially complies with the literature.

In this research, a significant difference was found between the employed hospital variable and authorization, talent development, basic values, agreement, coordination, culture of participation, differentiation, customer orientation, organizational learning, strategic management, organizational goals, vision, compliance culture and organizational culture in general which are the sub dimensions of the organizational culture dimension. Within the framework of the said result, it was determined that the scores of Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital employees were statistically high in terms of authorization, participation culture and change; the scores of Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital employees were statistically high in terms of talent development, reconciliation, coordination, strategic management, organizational goals, vision, compliance culture and organizational culture in general; Rize Recep Tayyip Erdogan University Training and Research Hospital employees were found to be statistically high in terms of basic values, customer orientation, and scores obtained from organizational learning.

Discussion of Findings Related to Leadership Behaviors

Participants are mostly women, married, graduate degree, in that Urhan and Etiler (2011) support the distribution of demographic research element of the health sector in Turkey.

The highest average change-oriented leadership score average among the leadership scale sub-dimensions in the research is 42.18 ± 7.18. This result may show that employees perceive their managers more as change-oriented leaders. As a matter of fact, in studies conducted by Keklik (2012), Yıldız Bağdoğan and Sarpbalkan (2017) and Top et al. (2010), the transformational leadership perceptions of the employees support this research.

In this study, a significant difference was found between the leadership scale sub-dimensions, business-oriented leadership, employee-oriented leadership, change-oriented leadership, and the hospital variable in which the duty scale was employed. According to this result, the points that Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital employees received from Business-oriented leadership, Employee-oriented leadership, Change-oriented leadership, and Leadership-wide scales were found to be statistically high.

It has been observed that there is no statistically significant difference between the scores of health workers in terms of leadership scale sub-dimensions according to their gender, age, marital status, education level, service they work, their duties, duration of work in their position and total professional experience in terms of job-oriented leadership, employee-oriented leadership, change-oriented leadership and leadership scale ($p>0,05$).

Jones and Rudd (2008)'s study of higher education institutions in America and in Şirin's (2008) study of physical education and sports colleges of universities in Turkey, it is seen that there is no difference between faculty members' perceptions of the transformational characteristics of top managers. These findings are consistent with our research. Judeh (2010) examined the gender differences in transformational leadership behaviors in higher education institutions in Oman and found significant differences between genders. These

findings are not consistent with our research. In the studies conducted by Turhan (2007), Özdemir (2009) and Aydın (2010), it is seen that the results obtained in terms of gender are consistent with the research. In the studies conducted by Karagöz (2008), Işık (2009), İskele (2009) and Aktoy (2010), it is seen that there were significant differences in terms of marital status. Many studies show that participatory leadership style (Jayasingam & Cheng, 2009; Nicholson-Crotty, 2006; Patel & Buiting, 2013) and transformational leadership style (Mangan, 2016; Appelbaum et al., 2003; Patel & Buiting, 2013) are frequently applied by women. This result does not support our research finding.

Oshagbemi (2004) argued that the leadership behaviors of managers in the 25-35 age group are more energetic than managers over the age of 35 and that they act more courageously and take more risks while making decisions in achieving organizational goals. This result does not support our research findings.

Discussion of Findings Related to Organizational Culture

The most prominent subject in the findings is the gender of the employees. 72% of the respondents are women. However, the amount of employees working 10 years or more in the sector and within the institution is over 50% and raises the reliability of the opinions of the respondents about the culture, learning and innovation status of the workplace where they work (Kendir et al., 2017: 296). 55% of the population employed in the health sector consists of women. 90% of the nurses and midwives, who make up 38% of the assistant health personnel in hospitals, are women (Urhan and Etiler, 2011). 34% of physicians are women (Kuzucu, 2007). In our study, 64.6% of the participants are women. At this point, our findings are compatible with the literature.

Again, the amount of employees working in the sector and the organization over 6 and 10 years is over 50% and it increases the reliability of the opinions of those who respond to this result regarding the organizational culture and leadership status of the workplace they are still working at.

Nearly 58% of the participants are graduates of college and above. Hospitals are institutions where employees have higher education levels than employees in many different sectors. Accordingly, information asymmetry is high between service providers (healthcare professionals) and service recipients (patients). (Mooney & Ryan, 1993).

A statistically significant difference was found between the average scores of the organizational culture scale participation culture sub-dimension of healthcare workers based on their gender, coordination and average of the culture of participation sub-dimension ($p<0,05$). The mean score of female healthcare workers is higher than male healthcare workers, and the difference between them is statistically significant. Women healthcare professionals think differently from male employees in terms of basic values, coordination and participation culture. Similar to the findings of the research, in the study conducted by Karakışla (2012), the mean scores of mission and adaptation culture perceived by nurses working in private hospitals were found higher than men. In the study conducted by Topçu (2014), the average of the harmony and mission culture of female employees was found higher than that of men. Unlike the research, in a study conducted by Öztürk (2015) on the employees of a university hospital, all culture subgroups were examined (participation, consistency, compliance and mission culture) and no statistically significant difference was found in terms of gender. In the study conducted by Pehlivan et al. (2015) on nurses working in the surgical clinics of a university hospital, no significant difference was found between the basic dimensions of organizational culture and gender. Similarly, in a study conducted by Yücel and Koçak (2014) on employees of a service enterprise, no significant difference was found between the basic dimensions of organizational culture and gender.

A statistically significant difference was found between the average scores of the organization culture scale participation culture sub-dimension authorization, teamwork, reconciliation, compliance culture sub-dimension according to the age of the healthcare professionals from the customer orientation and vision dimensions. ($p<0,05$). In the study conducted by Kelez (2008), similar to this study, it was found that there were statistically differences

between the main culture scores of the nurses according to age groups, and the basic dimensions of participation, consistency, harmony and mission culture were compared to other age groups in nurses aged 36 and over. It was found to be significantly high. It has been determined that nurses under 25 years of age perceive the culture of participation more strongly, nurses between the ages of 25-30 perceive the culture of participation weakly in all culture dimensions, while nurses aged 36 and over perceive all culture dimensions very strongly. In the study conducted by Karakışla (2012), a statistically significant difference was found between the age distribution of nurses and the mean scores of participation, consistency, compliance and mission culture, and it was found that nurses aged 25 and under perceived all culture dimensions better than other age groups. In the study conducted by Yazıcı (2006), the overall average score of employees over the age of 44 in the general organizational culture is higher than the other age groups, but statistically highly significant results were found in those who were above the age of 44 compared to other age groups in terms of organizational culture sub-dimensions (structure, responsibility, support, standards, commitment to the organization and conflict). These literature results are consistent with our study findings. Unlike the research findings, in the study conducted by Topçu (2014) for public and private hospital employees, no significant difference was found when public employees were evaluated according to age groups. This result does not match our findings.

According to the marital status of healthcare professionals, there was a statistically significant difference between the organizational culture scale, participation culture sub-dimension consensus, compliance culture sub-dimension, customer orientation, strategic management, compliance culture sub-dimension overall and the average scores received from the organizational culture scale. ($p<0,05$). No significant difference was found between the marital status of the employees participating in the research and the organizational culture basic dimension mean scores. Similar to the research findings, in the studies conducted by Kelez (2008), Sırkültlıoğlu (2011) and Canpolat (2012), no significant difference was found between the

basic dimensions of organizational culture and marital status. These findings do not match our research findings.

It has been observed that there is a statistically significant difference between the scores received by healthcare professionals in terms of empowerment, reconciliation, participation culture, customer orientation, organizational learning, strategic management, vision, compliance culture and organizational culture according to the services they work. ($p<0,05$). In the study conducted by Topçu (2014), it was determined that the mission culture point averages of the public hospital emergency medicine and surgical unit employees were lower than the basic and internal sciences. In the research conducted by Karakışla (2012), significant differences were found in terms of participation, adaptation and mission cultures according to the department where the nurses working in the training and research hospital work. It is compatible with our study data. Unlike the research findings, in the study conducted by Canpolat (2012), no significant difference was found between the units studied and the average scores of organizational culture. This result does not correspond to our study result.

There are studies in domestic and foreign literature that examine the relationship between leadership styles and organizational culture (Masood, Burnsand and Bachouse, 2006; Byrne and Bradley, 2007; Barut and Onay; 2018; Yuan and Lee, 2011; Gül and Aykanat, 2012). In these studies, it was determined that leadership styles have an impact on organizational culture. On the other hand, there are studies examining the relationship between leadership styles and innovation, and leadership styles have been determined to have an effect on innovation (Lee, 2008; Ryan and Tipu, 2013; Bozkurt and Göral, 2013; Chang et al., 2015; Aykanat and Yıldız, 2016).

In the literature, the authorities (Nahavandi, 2014; Daft, 2015 and Schein, 2004), who conducted research on this subject, expressed their views on the existence of a relationship between leadership and organizational culture. Nahavandi (2014) explained with examples that the leader has an effect on the organizational culture. Nahavandi (2014) stated that if the leader is workaholic and control-oriented, the decisions will most likely be taken quickly

and the central management style will be applied. However, according to Nahavandi, if the leader attaches importance to participatory management understanding and teamwork, then decentralization and open communication will dominate the organization. Daft (2015) stated in his study that organizational culture is shaped by the leader's vision, philosophy and business strategy. Schein (2004), who conducted the most serious, most comprehensive and most accepted studies on the relationship between leadership and organizational culture, stated that there is a two-way relationship between leadership and organizational culture, and that leaders have the most impact among the three main sources that have an impact on organizational culture. .

In the study conducted by Koçak (2009) in a mining company operating in the Afşin-Elbistan region, it is seen that the majority of the employees who participated in the survey gave positive answers to the charisma, inspiration, intellectual stimulation and individual support characteristics of transformational leadership. Likewise, it is seen that the results of the survey for measuring organizational culture are also positive. In the “An application on the relationship between charismatic leadership and organizational culture” conducted by Aykanat (2010) at the Governorship of Ardahan, it is seen that the majority of the survey participants responded positively to the characteristics that show sensitivity to the member needs of the charismatic leader and reject the status quo.

As in the studies conducted by Koçak (2009) and Aykanat (2010), it was concluded that transformational leadership in businesses significantly affects organizational culture in this study conducted on employees in the food industry.

According to the studies of Erdem and Dikici (2009), there is a mutual interaction between leadership style and organizational culture. This situation makes it inevitable that both leadership and organizational culture are dynamic processes. The leader has the authority and opportunity to subject the organizational culture to renewal. However, the resistance and pressure of the organizational culture is also an important factor that causes the formation of

leadership style. In their research on travel agencies, Tütüncü and Akgündüz (2012) concluded that those who display leadership style in accordance with the organizational culture can reach the organizational goal more quickly. It has been determined that the relationship between transformational leadership and organizational culture is strong (Barut and Onay, 2018).

The study conducted by Diker (2014) among the five provinces of Turkey operating in the hotel business on 655 people has revealed that there is a significant positive relationship between perceived organizational culture and leadership. In the study conducted by Öztürk (2015) on 502 teachers working in Gaziantep during the 2014-2015 academic year, it was found that there was a positive significant relationship between organizational culture and teacher leadership. In the study conducted by Karcıoğlu and Kaygın (2013) with bank employees in Kars and Rize in order to determine the transformational leadership perceptions of bank employees, it was found that the perceptions of the participants about transformational leadership and its sub-dimensions were high.

In the research of Doğan (2019), it is seen that the managers of two institutions out of four institutions operating in the field of health have the interactive leadership characteristics, the transformative leadership characteristics of one institution and the servant leadership characteristics of another.

It was determined that there were low and significant correlations between the scores they got from the dimension of change, which is a sub-dimension of the adaptation culture sub-dimension of organizational culture ($p<0,05$). Since this correlation is negative, as the scores of healthcare workers in the sub-dimension of change increase, their scores on the leadership scale decrease. Accordingly, the impact of leadership on organizational culture and organizational structure in Affiliated Hospitals in Turkey within the scope of the research is only realized the size of the change in the culture of compliance. When leadership styles and organizational culture characteristics are evaluated, it is seen that the relationship between leader characteristics and organizational culture is compatible. In addition, these results are similar to the

research results of Li (2015), Bassous (2015), Gökçe et al. (2014), Pedraja-Rejas et al. (2006).

There are studies showing that leaders affect organizational culture and this affects the performance of employees (Ogbonna and Haris, 2000; Xenikou and Simosi 2006; Liden, Wayne, Liao, Meuser 2014).

In a study conducted by Üstün and Kılıç (2016) on 437 (Nurse, Technician, Medical Secretary) health personnel of assistant treatment units working in two hospitals in Eskişehir, one of which is public and the other is private, a positive medium correlation was found between organizational culture and organizational trust and self-control.

In a research conducted by Koşar and Yalçınkaya (2013) on 871 teachers in İzmir, it was determined that teachers' organizational trust levels were positively associated with their perceptions of organizational culture, and as their organizational trust levels increased, their perception of organizational culture also increased.

In the linear regression analysis of the healthcare professionals to predict the organizational culture scores of the leadership scale scores, it was found that the variance in leadership scores explained 3.8%, and the skill development sub-dimension in the participation culture scale predicted leadership positively, and the fact that managers took 1 point more than the skill development sub-dimension increased their leadership scale scores by 0.52 points.

In their study with nurses and manager nurses, Afsar and Masood (2017) found that an increase in one unit of transformational leadership style will increase the innovative behavior of nurses by 0.35 units, and it is determined that the relationship between them has reached the strongest and most positive state where there is high avoidance of confidence and uncertainty.

Sönmez and Yıldırım (2019) found that supervisor support explained 14.2% of the variance of nurses 'innovative behaviors, and that a one-unit increase in supervisor support led to an increase of 0,194 in nurses' innovative behaviors.

Wang et al. (2019) found that the inclusive leadership style of executive nurses significantly affected nurses' innovative behavioral scores. These results in the literature show that nurses need a supportive approach to the manager to behave innovatively and to demonstrate innovation.

On the other hand, Aktaş (2018) found that innovative behaviors of nurses who stated that their managers showed democratic and participatory leadership were higher than the nurses who stated that their managers showed autocratic and helpful leadership, but the mean scores did not differ significantly.

Based on this literature, it partially overlaps with the above literature, which states that leadership and organizational structures in Affliated Hospitals have effects on organizational culture in Turkey.

Conclusions

This research has demonstrated effects of leadership and organizational structure on organizational culture in Affliated Hospital in Turkey. In addition, the type of leadership and the culture of the leadership that individuals who are accepted as leaders in the health sector are shown, analyzed and recommendations are made.

The study was attended by Adıyaman Training and Research Hospital with a maximum of 23.2% and from Erzincan Binali Yıldırım University Mengücek Gazi Training and Research Hospital with 22.5% from the Affliated hospitals in Turkey. 64.6% of the participants are women. 47.8% of the participants are between 25-34 years old. 66.9% of the participants are married. 48.3% of the participants are undergraduate graduates. 48.0% of the participants work in other services (Management, Human Resources, Administrative Affairs, Accounting etc.). 35.4% of the participants are nurses. 34.5% of the participants have been working at their workplaces for 6-10 years. 33.6% of the participants have a total professional experience of 6-10 years.

The highest score average among the leadership dimensions of managers' scale was determined as 42.18 ± 7.18 as Change-focused leadership. The highest mean score of the Denison organizational culture sub-dimensions was

found as the participation culture sub-dimension as basic values, and the adaptation culture sub-dimension as vision.

Affliated hospital with the highest average score in business oriented leadership dimension is Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital. Erzincan Binali Yıldırım University Oral and Dental Health Training and Research Hospital, was found with the highest average score in terms of average score in terms of change-oriented leadership sub-dimensions and managers' leadership characteristics among the affliated hospitals in Turkey .

The affliated hospital with the highest average score in Authorization and Coordination dimension was found to be Erzincan Binali Yıldırım University Oral and Dental Health Education and Research Hospital. Amasya University Sabuncuoğlu Şerefeddin Training and Research Hospital was found to be with the highest score in teamwork, talent development, reconciliation, culture of participation, change, strategic management, organizational goals, vision, compliance culture, and organizational culture. Rize Recep Tayyip Erdoğan University Education and Research Hospital was found to be with the highest score in basic values, customer orientation, and organizational learning.

A model that is fully integrated in terms of shape has the identified limitations. In a corporate cascading system, if there is an expectation of loyal teamwork against the principles of being academically autonomous in itself, and when the types of power personality application among academicians and researchers are approached, conflict may occur in institutional and academic cultures. Academics can object to the step management system in the corporate culture. Even in a general organizational system, the strategic emphasis and changes in essential principles between leaders who are primarily doctors and hospital managers should be carefully managed to increase the effectiveness of the organization.

As regards the rehabilitation of the organizational system of university hospitals serving the territory of Turkey, two different solution suggestions can be proposed as long term and short term. As a long-term solution, the need for Affliated systems, where health-related services and educational activities of

hospitals affiliated with universities differ functionally, can be met. The method of this situation is for universities or medical schools to come to an agreement with Affliated hospitals. However, it is absolutely necessary to plan these stages very precisely. For example, in the affiliation phase, educational activities should be under the supervision of medical faculties, the duties of the faculty members of the medical faculty and the clinics of Affliated hospital clinics should be determined well, Care should be taken to ensure that the patient care services in the Affliated hospital do not hinder the education stages of medical students, in summary, the balance of education activities and service delivery should be carefully regulated both systematically and legally.

With these stops, perform certain actions before being able functionally integrated model of service delivery that can be stated that no university hospital in Turkey. In the discussions held in Turkey literature, university hospitals performed in connection with the main emphasis on the organizational system, as I mentioned before the "hierarchy" and "governance gap" of the concept. It is thought that step systematized type of organizations can be adapted to Turkish culture system. Finding a single and strong leader is a desired quality in organizations. It can be considered as an example of hospital management and chief physician duties, which were previously designed as separate administrative stages within the Ministry of Health hospitals, with the arrangements made. All the elements of which is connected to the university hospital in Turkey, is not working as a healthcare structure and the hospital element needs a different personality and brand value that is different from the university. For this reason, the implementation of the more flexible organizational model types, in which more than one state has changed sides, is difficult in our time.

Although conducted in a fully integrated model application Turkey, the powers of the individual, namely the chief physician, whose powers are brought together, are not sufficient to manage the structure. According to the results obtained from the analyzes made in this explanation (See 5.10), within the framework of the correlations of research variables and leadership behaviors affecting the organizational culture in the design of the research (See 5.6), it

can be suggested that the person who will manage the system should be the dean of the medical faculty rather than a chief physician appointed by the rector and experiencing a confusion of authority. The dean's authority under the head of the department, as well as the hospital structure at the top, can eliminate this confusion of authority. Despite the fact that the dean served as the chief physician of the hospital and the model of the system in question was observed in the hospitals of the major universities in our time, these examples are limited in number. This model will necessarily increase the dean's obligations. However, the dean can reduce his/her responsibility by sharing his/her authority types with his/her assistants. Apart from this, the fact that the dean holds the position like the vice-rector may also increase his/her academic competence.

Within the framework of all these results, the advantages and disadvantages considered to be in affiliated hospitals are listed below:

Advantages

- Positive segregation as part of asymmetric competition
- The transformation of hospitals from general purpose hospitals to education and research hospitals,
- Increase in quality and quantity in service delivery and case mix,
- Sharing expenses and costs,
- Affiliation creates synergy with a balanced and appropriate arrangement that observes the law of both parties.
- Having more patient profiles,
- The number of full-time faculty members is much higher,
- Opportunities to benefit from the facilities of both institutions.

Disadvantages

- Transferring the affiliated university hospital to the Public Hospitals Association with its debts,
- Implementation of affiliation procedure without creating an affiliation infrastructure,

- Lack of clear definitions to resolve conflicts regarding duties, powers and responsibilities,
- The current state of affliated hospitals create a climate of chaos for people who are incompatible with different corporate cultures, conflicting tasks, an educational environment and are dissatisfied with affiliation,
- Existence of two different administrative structures within the same institution,
- Current regulations on affiliation reverse the order of importance for education, research and service, and lower the roles of instructors and researchers of faculty members,
- The regulation is mainly left to the Ministry of Health, Higher Education Institution cannot adequately represent the law of the universities,
- Less senior faculty members.

Suggestions

This research was carried out in 6 affliated hospitals. In order for this research to guide future research, when the findings and statistical results of the research are evaluated, the suggestions presented are listed as follows:

Recommendations for Practitioners:

- In order for the research to be particularly useful to managers, time should be allocated to academic studies.
- Physical conditions should be corrected in order to contribute to health workers, and health workers should be provided with space for their education.
- The right to education for university hospital employees should also be given to the staff of the Ministry of Health and thus equal right to education should be provided.
- The quality of service provided to patients should be increased.
- In order to increase the quality of the service, the number of physicians and staff should be increased.

- The university must have a separate financial power from the Ministry of Health.
- The Ministry of Health should also have supervision and evaluation powers for university staff.
- Business segments should be separated by clear boundaries.
- The wage gap between employees of the Ministry of Health and university employees should be balanced. The material loss that occurs in this way should be prevented.
- The double-headedness in management should be eliminated.
- There should be an adaptation process for the managers to adapt to the institution and implementation.
- The current protocol should be updated to ensure satisfaction and equal rights in two affliated hospitals.

Suggestions for Researchers:

- This research is limited to six hospitals with affiliation. In order to apply the results of the study to the general, it can be recommended to conduct studies with more Affliated hospitals and sampling.
- In the research carried out in hospitals affiliated with the Ministry of Health, it may be suggested to be handled in the hospitals that are in the process of affiliation with the University of Health Sciences. Thus, it can be carried out in a wider area in similar studies in the future.

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APPENDIX

Annex 1: SURVEY FORMS

NEAR EAST UNIVERSITY
SOCIAL SCIENCES INSTITUTE
BUSINESS MANAGEMENT DEPARTMENT

ANNEX 1: SURVEY FORM

Dear participant,

The questionnaire below is related to the research of the thesis study titled "Investigation of the Effects of Leadership Styles of Managers on Organizational Culture in Erzincan Health Services" conducted in the Department of Health Management, Near East University, Institute of Social Sciences. The collected data will be evaluated collectively, not personally, and will be used solely for scientific purposes. I would like to thank you for joining our research for supporting our work and wish you a successful and healthy working life. Best regards,

Halil İbrahim İÇOĞLU

1. **Gender:**

☐Female ☐Male

2. **Age:**

☐17-24 ☐25-34 ☐35 and above

3. **Marital Status:**

☐Married ☐Single

4. **Education Status:**

☐Health vocational high School ☐Associate ☐Bachelor

☐Master ☐Doctorate

5. **The unit you work in**

☐Anesthesia ☐Urology ☐Biochemistry

☐Dermatology ☐Pediatry ☐Internal medicine

☐Endocrinology ☐Infectious Diseases ☐Physical therapy and rehabilitation

☐Gastroenterology ☐General Surgery ☐Geriatrics

☐Thoracic Surgery ☐Eye diseases ☐First Aid and Emergency Aid

☐Gynecology and Obstetrics ☐Cardiovascular surgery ☐Cardiology

☐ENT ☐Microbiology ☐Nephrology

☐Neurology ☐Neurosurgery ☐Radiology

☐Orthopedics and Traumatology ☐General practitioner ☐Psychiatry

☐Rheumatology ☐Sports Medicine

☐Other……..(Please mention.)

6. Your Position:……..(Please mention**)**

7. Your term of employment in your current position:

☐0-5 years ☐6-10 years ☐11-15 years

☐16-20 years ☐21 years and above

8. Your total professional experience:

☐0-5 years ☐6-10 years ☐11-15 years

☐16-20 years ☐21 years and above

	Please tick one of these options "1-never", "2-rarely", "3-sometimes", "4-often", "5-always" you feel closest to, according to the judgments below.	Never	Rarely	Sometimes	Often	Always
1	I organize my work.	1	2	3	4	5
2	I am consistent.	1	2	3	4	5
3	I encourage new ideas	1	2	3	4	5
4	I'm open to criticism	1	2	3	4	5
5	I do not hesitate to take risks when making a decision	1	2	3	4	5
6	I have a clear and honest way of working	1	2	3	4	5
7	I am reassuring.	1	2	3	4	5
8	I like to discuss new ideas	1	2	3	4	5
9	I am friendly.	1	2	3	4	5
10	I am always aware of the responsibilities of others.	1	2	3	4	5
11	I make plans about the future.	1	2	3	4	5
12	I give my instructions clearly.	1	2	3	4	5
13	I respect my subordinates as an individual	1	2	3	4	5
14	I examine the events and make a logical decision.	1	2	3	4	5
15	I put forward new and different ideas in the implementation of the works	1	2	3	4	5
16	I produce opportunities to eliminate conflicts	1	2	3	4	5
17	I am open to change.	1	2	3	4	5
18	I treat my subordinates fairly.	1	2	3	4	5
19	I'm meticulous under the supervision of things.	1	2	3	4	5
20	I make quick decisions when necessary.	1	2	3	4	5
21	When I make a decision, I give my subordinates the right to speak.	1	2	3	4	5
22	I give importance to follow the rules and principles.	1	2	3	4	5
23	I make plans carefully.	1	2	3	4	5
24	I encourage growth and development.	1	2	3	4	5
25	My goals are evident.	1	2	3	4	5
26	I appreciate good work.	1	2	3	4	5
27	I care about the thoughts of others.	1	2	3	4	5
28	I produce new projects.	1	2	3	4	5
29	I am open to innovations.	1	2	3	4	5
30	I trust my subordinates.	1	2	3	4	5
31	I defend my subordinates.	1	2	3	4	5
32	I provide a friendly environment away from discussions.	1	2	3	4	5
33	I rigorously emphasize the plans that are being implemented.	1	2	3	4	5
34	I listen to other ideas and suggestions.	1	2	3	4	5

DENISON ORGANIZATIONAL CULTURE SCALE

This section contains statements about organizational culture. Consider the conditions of the department you are working and select the option that shows how much you agree with the statements below.

DENISON ORGANIZATIONAL CULTURE SCALE	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The majority of employees are integrated into their work.					
2. Since there is a sufficient amount of information sharing among the employees, everyone can access the required information when necessary.					
3. All employees are included in the decision making process to a certain extent when planning work (patient care and treatment planning).					
4. There is no cooperation between different departments (service units).					
5. Team work is based on all our work.					
6. All employees understand the relationship between their duties and the objectives of the organization.					
7. Employees are given the necessary authority to plan their own business.					
8. Employees' capacity to work is constantly improving.					
9. Everything needed to improve the employees' work skills is done.					
10. Managers apply what they say.					
11. We have a clear and consistent system of values that guide our working methods.					
12. There are no (ethical) values that guide our behavior in conducting business and enable us to distinguish between right and wrong.					
13. When a dispute arises in business activities, each employee makes a great effort to find a satisfactory solution.					
14. This workplace has a strong organizational culture.					
15. A consensus can be easily achieved even in problematic issues.					
16. Our employees can share a common perspective in business activities, even if they work in different departments of the organization..					
17. Studies (projects) carried out by different departments of the institution are easily coordinated.					

18. Working with someone from another department is like working with someone from a different institution.					
19. Our working style is very flexible and open to change					
20. Management may develop appropriate strategies depending on other health institutions and changes in the field of business.					
21. Innovations and developments in our business are monitored and implemented by management.					
22. The requests and suggestions of the people we serve can lead to frequent changes in business activities.					
23. All employees take care to understand the wishes and needs of the people served.					
24. The requests of the people we serve are not generally taken into consideration in our business activities.					
25. In the event of any failure, this is considered by management as an opportunity for development and learning.					
26. Taking risks in innovation and works is demanded and rewarded by management.					
27. It is an important purpose for the employees to learn about their jobs and to obtain new information.					
28. We have a long-term work program and a specific development plan.					
29. We have a clear and clear corporate mission to guide the work of the employees.					
30. There is no strategic business planning determined for the future of the institution.					
31. There is a complete consensus among employees regarding the operational objectives of the Agency.					
32. Managers can act in line with the main objectives of the institution.					
33. Employees know what needs to be done to ensure the success of the institution in the long run.					
34. Employees are far from sharing the vision of the institution determined for the future.					
35. Our managers have a long-term perspective.					
36.Short-term expectations can be met without compromising our vision.					

Annex 2: HYPOTHESES

Sub-hypotheses of demographic information and leadership behaviors scale comparison

Hypothesis	Accepted	Not accepted
The H1a hypothesis is accepted because the significance value of work-oriented leadership, which is a sub-dimension of the leadership scale according to the hospitals where healthcare	+	
The H1b hypothesis is accepted since the employee-focused leadership significance value, which is the sub-dimension of the leadership scale according to the hospitals where healthcare	+	
The H1c hypothesis is accepted since the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale according to the hospitals where healthcare	+	
The H1d hypothesis is accepted because the significance value of the leadership scale is p <0.05 according to the hospitals where healthcare professionals work	+	
The H1e hypothesis is rejected since the significance value of job-focused leadership, which is the sub-dimension of the leadership scale according to the gender of healthcare professionals, is p> 0.05		+
The H1f hypothesis is rejected since the employee-focused leadership significance value, which is the sub-dimension of the leadership scale according to the genders of healthcare professionals, is p> 0.05		+
The H1g hypothesis is rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale according to the gender of healthcare professionals, is p>		+
The H1h hypothesis is rejected since the significance value of the leadership scale according to the gender of healthcare professionals is p> 0.05		+
The H1ı hypothesis is rejected because the significance value of job-focused leadership, which is the sub-dimension of the leadership scale according to the age of healthcare workers, is p> 0.05		+
The H1i hypothesis is rejected since the employee-focused leadership significance value, which is the sub-dimension of the leadership scale according to the age of healthcare professionals, is p> 0.05		+
The H1j hypothesis is rejected because the change-oriented leadership significance value, which is the sub-dimension of the leadership scale according to the age of healthcare professionals, is p> 0.05		+
The H1k hypothesis is rejected since the significance value of the leadership scale according to the age of healthcare professionals is p> 0.05		+
The H1l hypothesis is rejected because the significance value of job-focused leadership, which is the sub-dimension of the leadership scale according to the marital status of healthcare workers, is p> 0.05		+
The H1m hypothesis is rejected because the employee-focused leadership significance value, which is the sub-dimension of the leadership scale according to the marital status of healthcare workers, is p>		+
The H1n hypothesis is rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale according to the marital status of healthcare professionals, is		+
The H1o hypothesis is rejected since the significance value of the leadership scale according to the marital status of the healthcare professionals is p> 0.05		+
The H1ö hypothesis is rejected because the significance value of job-focused leadership, which is the sub-dimension of the leadership scale according to the education levels of healthcare professionals, is		+
The H1p hypothesis is rejected since the employee-focused leadership significance value, which is the sub-dimension of the leadership scale according to the education levels of healthcare professionals, is		+
The H1r hypothesis is rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale according to the education levels of healthcare professionals		+
The H1s hypothesis is rejected because the significance value of the leadership scale according to the education level of healthcare professionals is p> 0.05		+
The H1t hypothesis is rejected because the significance value of work-oriented leadership, which is the sub-dimension of the leadership scale according to the services that healthcare professionals work with		+
The H1u hypothesis is rejected since the employee-focused leadership significance value, which is the sub-dimension of the leadership scale according to the services that healthcare professionals work with		+
The H1ü hypothesis is rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale, according to the services they work with, p> 0.05		+
The H1v hypothesis is rejected since the significance value of the leadership scale according to the services that healthcare professionals work with is p> 0.05		+
The H1y hypothesis is rejected since the significance value of job-focused leadership, which is the sub-dimension of the leadership scale according to the duties of healthcare professionals, is p> 0.05		+
The H1z hypothesis is rejected because the employee-focused leadership significance value, which is the sub-dimension of the leadership scale according to the duties of healthcare professionals, is p>		+
The H1w hypothesis is rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale according to the duties of healthcare professionals, is p>		+
The H1q hypothesis is rejected since the significance value of the leadership scale according to the duties of healthcare professionals is p> 0.05		+
The H1A hypothesis is rejected since the significance value of job-focused leadership, which is the sub-dimension of the leadership scale, according to the duration of the healthcare staff working in the		+
The H1B hypothesis is rejected because the employee-focused leadership significance value, which is the sub-dimension of the leadership scale, according to the duration of the healthcare professionals		+
The H1C hypothesis is rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale, according to the duration of the healthcare professionals		+
The H1D hypothesis is rejected because the significance value of the leadership scale is p> 0.05 according to the working time of healthcare professionals in the position		+
The H1E hypothesis is rejected because the significance value of job-focused leadership, which is the sub-dimension of the leadership scale, according to the total professional experience duration of		+
The H1F hypothesis is rejected since the employee-focused leadership significance value, which is the sub-dimension of the leadership scale according to the total professional experience of healthcare		+
The H1G hypothesis is rejected because the significance value of change-oriented leadership, which is the sub-dimension of the leadership scale, according to the total professional experience duration of the		+
The H1H hypothesis is rejected since the significance value of the leadership scale according to the total professional experience of healthcare professionals is p> 0.05		+

Hypothesis	Accepted	Not Accepted
The H2a hypothesis is accepted since the significance value of the general participation culture, which is the basic dimension of the organizational culture	+	
The H2aa hypothesis is accepted because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the hospitals where healthcare	+	
The H2ab hypothesis is accepted as the significance value of teamwork sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the hospitals they work in, is p <0.05.	+	
The H2ac hypothesis is accepted since the significance value of the participation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the hospitals where healthcare professionals work, is p <0.05.	+	
The H2b hypothesis is accepted since the significance value of the consistency culture, which is the basic dimension of the organizational culture scale according to the hospitals where healthcare professionals work, is p <0.05	+	
The H2ba hypothesis is accepted because the significance value of the basic values is p <0.05, the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the hospitals where	+	
The H2bb hypothesis is accepted because the significance value of consensus is p <0.05, the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the hospitals where healthcare	+	
The H2bc hypothesis is accepted as the significance value of the coordination coordination sub-dimension of consistency culture, which is the basic dimension of the organizational culture scale according to the hospitals they work in, is p	+	
The H2c hypothesis is accepted since the significance value of the adaptation culture, which is the basic dimension of the organizational culture scale according to the hospitals where healthcare professionals work, is p <0.05.	+	
The H2ca hypothesis is accepted since the significance value of the change is p <0.05, which is the basic dimension of the organizational culture scale according to the hospitals where healthcare professionals work.	+	
The H2cb hypothesis is accepted as the significance value of customer focus, the sub-dimension of compliance culture, which is the basic dimension of the organizational culture scale according to the hospitals where healthcare	+	
The H2cc hypothesis is accepted since the significance value of organizational learning is p <0.05, the sub-dimension of adaptation culture, which is the basic dimension of the organizational culture scale according to the hospitals where	+	
The H2d hypothesis is accepted since the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the hospitals where healthcare professionals work, is p <0.05.	+	
The H2da hypothesis is accepted since the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the scale of organizational culture according to the hospitals where healthcare	+	
The H2db hypothesis is accepted because the significance value of the organizational goals of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the hospitals where	+	
The H2dc hypothesis is accepted because the significance value of the vision is p <0.05, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the hospitals where healthcare	+	
The H2e hypothesis is accepted since the significance value of the overall scale of organizational culture according to the hospitals where healthcare workers work is p <0.05.	+	
The H2f hypothesis is accepted since the significance value of the participation culture, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals, is p <0.05.	+	
The H2fa hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals,		+
The H2fb hypothesis is rejected because the significance value of teamwork, the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals,		+
The H2fc hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals,		+
The H2g hypothesis is accepted since the significance value of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals, is p <0.05.	+	
The H2ga hypothesis is accepted since the significance value of the core values of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals,	+	
The H2gb hypothesis is rejected because the significance value of consensus, which is the sub-dimension of consistency culture, which is the basic dimension of the organizational culture scale according to the gender of healthcare		+

Hypothesis	Accepted	Not Accepted
The H2gc hypothesis is accepted since the significance value of coordination coordination is p <0.05, which is the main dimension of the organizational culture scale according to the gender of	+	
The H2h hypothesis is rejected since the significance value of the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the		+
The H2ha hypothesis is rejected because the significance value of the change is p> 0.05, which is the basic dimension of the organizational culture scale according to the gender of healthcare		+
The H2hb hypothesis is rejected because the significance value of customer focus, the sub-dimension of compliance culture, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals, is p> 0.05.		+
The H2hc hypothesis is rejected since the significance value of organizational learning is p> 0.05, the adaptation culture sub-dimension, which is the basic dimension of the organizational		+
The H2ı hypothesis is rejected since the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the		+
The H2ıa hypothesis is rejected since the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the genders of healthcare professionals, p> 0.05.		+
The H2ib hypothesis is rejected since the significance value of the organizational goals of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals, p> 0.05.		+
The H2ic hypothesis is rejected since the significance value of the vision is p> 0.05, the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the gender of healthcare professionals.		+
The H2i hypothesis is accepted since the significance value of the overall scale of organizational culture according to the gender of healthcare professionals is p <0.05.		
The H2j hypothesis is accepted since the significance value of the participation culture, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals, is p> 0.05.	+	
The H2ja hypothesis is accepted because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the ages of healthcare workers, is p <0.05.	+	
The H2jb hypothesis is accepted because the significance value of teamwork, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals, is the participation culture sub-dimension.	+	
The H2jc hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals, is p> 0.05.		+
The H2k hypothesis is rejected because the significance value of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals, is p> 0.05.		+
The H2ka hypothesis is rejecte since the significance value of the coherence culture sub-dimension, which is the basic dimension of the organizational culture scale according to the ages of healthcare workers, is p> 0.05.		+
The H2kb hypothesis is accepted.since the significance value of consensus is p <0.05, the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals,	+	
The H2kc hypothesis is rejected because the significance value of coordination coordination is p> 0.05, which is the main dimension of the organizational culture scale according to the ages of healthcare professionals.		+
The H2l hypothesis is accepted since the significance value of the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals, is p <0.05.	+	
The H2la hypothesis is rejected because the significance value of change is p> 0.05, which is the		+
The H2lb hypothesis is accepted because the significance value of customer focus, which is the basic dimension of the organizational culture scale according to the age of healthcare professionals, is the significance value of customer focus.	+	
The H2lc hypothesis is rejected because the significance value of organizational learning, which is the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals, is p> 0.05.		+
The H2m hypothesis is rejected since the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the ages of		+
The H2ma hypothesis is rejected because the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals, is p> 0.05.		+
The H2mb hypothesis is rejected because the significance value of the organizational goals, which is the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals, is p> 0.05.		+
The H2mc hypothesis is accepted because the significance value of the vision is p <0.05, which is the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the ages of healthcare professionals.	+	
The H2n hypothesis is rejected because the significance value of the overall scale of organizational culture according to the ages of healthcare professionals is p> 0.05.		+

Hypothesis	Accepted	Not accepted
The H2o hypothesis is rejected because the significance value of the participation culture, which is the basic dimension of the organizational culture scale, according to the marital status of the healthcare workers, is p> 0.05.		+
The H2oa hypothesis is rejected because the significance value of empowerment is p> 0.05, which is the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the marital status of healthcare		+
The H2ob hypothesis is rejected because the significance value of teamwork is p> 0.05, which is the basic dimension of the organizational culture scale according to the marital status of healthcare professionals.		+
The H2oc hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the marital status of healthcare professionals, is p> 0.05		+
The H2ö hypothesis is rejected because the significance value of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the marital status of healthcare workers, is p> 0.05.		+
The H 2a hypothesis is rejected because the significance value of the basic values is p> 0.05, which is the consistency culture sub-dimension of the organizational culture scale according to the marital status of healthcare professionals.		+
The H2öb hypothesis is accepted because the significance value of consensus is p <0.05, which is the main dimension of the organizational culture scale, the consistency culture sub-dimension, according to the marital status of healthcare	+	
The H2öc hypothesis is rejected because the significance value of the coordination coordination sub-dimension of consistency culture, which is the basic dimension of the organizational culture scale, according to the marital status of healthcare professionals.		+
The H2p hypothesis is accepted as the significance value of the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the marital status of healthcare workers, is p <0.05.	+	
The H2pa hypothesis is rejected because the significance value of the change in the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the marital status of healthcare workers, is p> 0.05.		+
The H2pb hypothesis is accepted because the significance value of customer focus, the sub-dimension of adaptation culture, which is the basic dimension of the organizational culture scale, according to the marital status of healthcare	+	
The H2pc hypothesis is rejected because the significance value of organizational learning is p> 0.05, which is the basic dimension of the organizational culture scale according to the marital status of healthcare professionals.		+
The H2r hypothesis is rejected because the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the marital status of healthcare workers, is p> 0.05.		+
The H2ra hypothesis is accepted because the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the marital status of healthcare	+	
The H2rb hypothesis is rejected because the significance value of the organizational goals of the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the marital status of healthcare workers, is p>		+
The H2rc hypothesis is rejected because the significance value of the vision is p> 0.05, which is the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the marital status of healthcare		+
The H2s hypothesis is accepted as the significance value of the overall scale of the organizational culture according to the marital status of the healthcare professionals is p <0.05.	+	
The H2s hypothesis is rejected because the significance value of the participation culture, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p> 0.05.		+
The H2sha hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p> 0.05.		+
H2şb hypothesis is rejected because the significance value of teamwork is p> 0.05, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals.		+
H2şc hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p> 0.05.		+
The H2t hypothesis is rejected since the significance value of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p> 0.05.		+
H2ta hypothesis is rejected because the significance value of the core values is p> 0.05, which is the main dimension of the organizational culture scale according to the education levels of healthcare professionals.		+
Since the significance value of consensus is p> 0.05, the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, the H2tb hypothesis is rejected.		+
The H2tc hypothesis is rejected because the significance value of coordination coordination sub-dimension of consistency culture, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p>		+
The H2u hypothesis is rejected because the significance value of the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p> 0.05.		+
The H2ua hypothesis is rejected because the significance value of the change is p> 0.05, the sub-dimension of adaptation culture, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals.		+
The H2ub hypothesis is rejected because the significance value of customer focus, the sub-dimension of compliance culture, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p>		+
Since the significance value of organizational learning is p> 0.05, the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, the H2uc hypothesis is		+
The H2u hypothesis is rejected because the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p> 0.05.		+
H2üa hypothesis is rejected because the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals, is p> 0.05.		+
H2ub hypothesis is rejected because the significance value of the organizational goals is p> 0.05, which is the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the education levels of healthcare		+
H2p hypothesis is rejected because the significance value of the vision is p> 0.05, which is the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the education levels of healthcare professionals.		+
The H2v hypothesis is accepted since the significance value of the overall scale of organizational culture according to the education level of healthcare professionals is p <0.05.	+	
The H2y hypothesis is rejected because the significance value of the participation culture, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, is p> 0.05.	+	
Since the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, p> 0.05, the H2ya hypothesis is rejected.	+	
The H2yb hypothesis is rejected because the significance value of teamwork is p> 0.05, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals.		+
The H2yc hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, is p> 0.05.		+
The H2z hypothesis is rejected since the significance value of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, is p> 0.05.		+
The H2za hypothesis is rejected because the significance value of the core values is p> 0.05, the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals.		+
Since the significance value of consensus is p> 0.05, the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, the H2zb hypothesis is rejected.	+	
The H2zc hypothesis is rejected because the significance value of coordination is p> 0.05, which is the coherence culture sub-dimension, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals.		+
The H2A hypothesis is rejected since the significance value of the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, is p> 0.05.	+	
H2Aa hypothesis is rejected because the significance value of change is p> 0.05.		+
The H2Ab hypothesis is rejected because the significance value of customer focus, the sub-dimension of compliance culture, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, is p> 0.05.	+	
Since the significance value of organizational learning is p> 0.05, the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, the H2Ac hypothesis is	+	
The H2B hypothesis is rejected since the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, is p> 0.05.	+	

The H2Ba hypothesis is rejected because the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, is p> 0.05.	+	
The H2Bb hypothesis is rejected because the significance value of the organizational goals of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals, is p> 0.05.		+
The H2Bc hypothesis is rejected because the significance value of the vision is p> 0.05, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the workplace of healthcare professionals.	+	
The H2C hypothesis is accepted since the significance value of the overall scale of organizational culture according to the workplace of healthcare professionals is p <0.05.	+	

Hypothesis	Accepted	Not accepted
The H2D hypothesis is rejected because the significance value of the participation culture, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Da hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Db hypothesis is rejected because the significance value of teamwork, the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Dc hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2E hypothesis is rejected because the significance value of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Ea hypothesis is rejected because the significance value of the coherence culture sub-dimension, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Eb hypothesis is rejected because the significance value of consensus is p> 0.05, which is the sub-dimension of consistency culture, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals		+
The H2Ec hypothesis is rejected because the significance value of coordination coordination is p> 0.05, which is the main dimension of the organizational culture scale according to the duties of healthcare professionals		+
The H2F hypothesis is rejected since the significance value of the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Fa hypothesis is rejected because the significance value of the change in the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Fb hypothesis is rejected because the significance value of customer focus, the sub-dimension of compliance culture, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
Since the significance value of organizational learning is p> 0.05, the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, the H2Fc hypothesis is rejected		+
The H2G hypothesis is rejected because the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Ga hypothesis is rejected because the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Gb hypothesis is rejected because the significance value of the organizational goals of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2Gc hypothesis is rejected because the significance value of vision, which is the mission culture sub-dimension, which is the basic dimension of the organizational culture scale according to the duties of healthcare professionals, is p> 0.05		+
The H2H hypothesis is rejected since the significance value of the overall scale of the organizational culture according to the duties of healthcare professionals is p> 0.05		+
The H2I hypothesis is rejected since the significance value of the participation culture, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their position is p> 0.05		+
The H2Ia hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their position is p> 0.05		+
The H2Ib hypothesis is rejected because the significance value of teamwork, the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their position is p> 0.05		+
The H2Ic hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale, is p> 0.05 according to the working time of the healthcare professionals in their position		+
The H2I hypothesis is rejected because the significance value of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their position is p> 0.05		+
The H2IA hypothesis is rejected because the significance value of the basic values of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their position		+
The H2IB hypothesis is rejected because the significance value of consensus is p> 0.05, which is the main dimension of the organizational culture scale, the consistency culture sub-dimension, according to the working time of the healthcare professionals in their		+
The H2Ic hypothesis is rejected because the significance value of coordination, which is the coherence culture sub-dimension, which is the basic dimension of the organizational culture scale, is p> 0.05, according to the working time of the healthcare professionals in their		+
The H2J hypothesis is rejected because the significance value of the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their position is p> 0.05		+
The H2Ja hypothesis is rejected because the significance value of the change is p> 0.05, which is the basic dimension of the organizational culture scale, the adaptation culture sub-dimension, according to the working time of the healthcare professionals in their		+
The H2Jb hypothesis is rejected because the significance value of customer focus, the sub-dimension of compliance culture, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their position		+
The H2Jc hypothesis is rejected because the significance value of organizational learning is p> 0.05, which is the basic dimension of the organizational culture scale, adaptation culture sub-dimension, according to the working time of the healthcare professionals in their		+
The H2K hypothesis is rejected because the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their position is p> 0.05		+
The H2Ka hypothesis is rejected because the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale, is p> 0.05 according to the working time of the healthcare professionals in their		+
The H2Kb hypothesis is rejected because the significance value of the organizational goals, which is the mission culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the working time of the healthcare professionals in their		+
The H2Kc hypothesis is rejected because the significance value of the vision is p> 0.05, which is the mission culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the working hours of the healthcare professionals in their		+
The H2L hypothesis is rejected because the significance value of the overall scale of the organizational culture according to the working time of the healthcare professionals in their position is p> 0.05		+
The H2M hypothesis is rejected because the significance value of the participation culture, which is the basic dimension of the organizational culture scale, according to the total professional experience of healthcare professionals, is p> 0.05		+
The H2Ma hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale, according to the total professional experience of the healthcare professionals, is p> 0.05		+
The H2Mb hypothesis is rejected because the significance value of the participation culture sub-dimension of teamwork, which is the basic dimension of the organizational culture scale, according to the total professional experience of the healthcare professionals, is p>		+
The H2Mc hypothesis is rejected because the significance value of the sub-dimension of participation culture, which is the basic dimension of the organizational culture scale, according to the total professional experience of healthcare professionals, is p> 0.05		+
The H2N hypothesis is rejected because the significance value of the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the total professional experience working time of the healthcare professionals, is p> 0.05		+
The H2Na hypothesis is rejected because the significance value of the core values is p> 0.05, the consistency culture sub-dimension, which is the main dimension of the organizational culture scale, according to the total professional experience of healthcare professionals		+
Since the significance value of consensus is p> 0.05, the consistency culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the total professional experience of healthcare professionals, the H2Nb hypothesis is rejected		+
The H2Nc hypothesis is rejected because the significance value of the coordination coordination sub-dimension of consistency culture, which is the basic dimension of the organizational culture scale, according to the total professional experience of healthcare		+
The H2O hypothesis is rejected because the significance value of the adaptation culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the total professional experience of healthcare professionals, is p> 0.05		+
The H2Oa hypothesis is rejected because the significance value of the change is p> 0.05, which is the basic dimension of the organizational culture scale, adaptation culture sub-dimension according to the total professional experience of healthcare professionals		+
The H2Ob hypothesis is rejected because the significance value of customer focus, the sub-dimension of compliance culture, which is the basic dimension of the organizational culture scale, according to the total professional experience duration of healthcare professionals		+
The H2Oc hypothesis is rejected because the significance value of organizational learning is p> 0.05, which is the basic dimension of the organizational culture scale, adaptation culture sub-dimension according to the total professional experience of healthcare professionals		+
The HWH hypothesis is rejected because the significance value of the mission culture sub-dimension, which is the basic dimension of the organizational culture scale, according to the total professional experience of healthcare professionals, is p> 0.05		+
The H2Öa hypothesis is rejected since the significance value of strategic management, the sub-dimension of mission culture, which is the basic dimension of the organizational culture scale, according to the total professional experience duration of healthcare professionals,		+
H2Öb hypothesis is rejected since the significance value of the organizational goals is p> 0.05, the sub-dimension of mission culture,		+
The H2Öc hypothesis is rejected because the significance value of the vision is p> 0.05, which is the mission culture sub-dimension,		+
The H2P hypothesis is rejected because the significance value of the overall scale of organizational culture according to the total professional experience of healthcare professionals is p> 0.05		+

Correlation sub-hypotheses of leadership behavior and organizational culture

Hypothesis	Accepted	Not accepted
The H3a hypothesis is rejected because the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture, participation culture, is p> 0.05.		+
The H3a1 hypothesis is rejected since the significance value of the relationship between leadership behaviors and the empowerment sub-dimension of the organizational culture is p> 0.05.		+
The H3a2 hypothesis is rejected since the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture and the sub-dimension of participation		+
The H3a3 hypothesis is rejected because the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture is the talent development sub-		+
The H3b hypothesis is rejected since the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture consistency culture is p> 0.05.		+
The H3b hypothesis is rejected because the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture, the sub-dimension of consistency culture,		+
The H3b hypothesis is rejected because the significance value of the relationship between leadership behaviors and organizational culture, the sub-dimension of consistency culture, is p> 0.05.		+
The H3b hypothesis is rejected because the significance value of the relationship between leadership behaviors and organizational culture, the sub-dimension of coherence culture, is p> 0.05.		+
The H3c hypothesis is rejected since the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture is compliance culture.		+
The H3c hypothesis is rejected because the significance value of the relationship between leadership behaviors and organizational culture, the sub-dimension of	+	
The H3c hypothesis is rejected since the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture, the sub-dimension of compliance culture,		+
The H3c hypothesis is rejected since the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture, the sub-dimension of adaptation culture,		+
The H3d hypothesis is rejected because the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture, mission culture, is p> 0.05.		+
The H3d hypothesis is rejected because the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture, mission culture sub-dimension strategic		+
The H3d hypothesis is rejected because the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture, mission culture sub-dimension,		+
The H3d hypothesis is rejected because the significance value of the relationship between leadership behaviors and the basic dimension of organizational culture, mission culture, sub-dimension vision, is		+
The H3aa hypothesis is rejected since the significance value of the relationship between leadership behaviors work-oriented leadership sub-dimension and organizational culture is p> 0.05.		+
The H3aa hypothesis is rejected because the significance value of the relationship between the leadership behaviors work-oriented leadership sub-dimension and the basic dimension of		+
The H3aa hypothesis is rejected because the significance value of the relationship between leadership behaviors work-oriented leadership sub-dimension and organizational culture basic		+
The H3aa hypothesis is rejected because the significance value of the relationship between the leadership behaviors work-oriented leadership sub-dimension and the organizational culture basic		+
The H3aa hypothesis is rejected because the significance value of the relationship between the leadership behaviors job-focused leadership sub-dimension and the organizational culture basic		+
The H3ab hypothesis is rejected because the significance value of the relationship between leadership behaviors work-oriented leadership sub-dimension and organizational culture basic		+
The H3ab hypothesis is rejected because the significance value of the relationship between the leadership behaviors work-oriented leadership sub-dimension and the organizational culture basic		+
The H3ab hypothesis is rejected because the significance value of the relationship between the leadership behaviors job-oriented leadership sub-dimension and the organizational culture basic		+
The H3ab hypothesis is rejected since the significance value of the relationship between leadership behaviors work-oriented leadership sub-dimension and organizational culture basic dimension		+
The H3ac hypothesis is rejected because the significance value of the relationship between leadership behaviors work-oriented leadership sub-dimension and organizational culture basic dimension		+
The H3ac hypothesis is rejected because the significance value of the relationship between leadership behaviors work-oriented leadership sub-dimension and	+	
The H3ac hypothesis is rejected because the significance value of the relationship between the leadership behaviors job-focused leadership sub-dimension and the organizational culture basic		+
The H3ac hypothesis is rejected since the significance value of the relationship between leadership behaviors work-oriented leadership sub-dimension and organizational learning, the basic dimension of		+
The H3ad hypothesis is rejected because the significance value of the relationship between the leadership behaviors job-oriented leadership sub-dimension and the basic dimension of organizational		+
The H3ad hypothesis is rejected because the significance value of the relationship between the leadership behaviors job-oriented leadership sub-dimension and the basic dimension of organizational		+
The H3ad hypothesis is rejected because the significance value of the relationship between the leadership behaviors job-oriented leadership sub-dimension and the organizational culture basic		+
The H3ad hypothesis is rejected because the significance value of the relationship between the leadership behaviors business-oriented leadership sub-dimension and the mission culture sub-		+
The H3aa hypothesis is rejected because the significance value of the relationship between leadership behaviors employee-oriented leadership sub-dimension and organizational culture is p>		+
The H3aa hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3aa hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the organizational culture		+
The H3aa hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3aa hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3ab hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3ab hypothesis is rejected because the significance value of the relationship between the employee-oriented leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3ab hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3ab hypothesis is rejected because the significance value of the relationship between the employee-oriented leadership sub-dimension of leadership behaviors and the coordination sub-		+
The H3ac hypothesis is rejected because the significance value of the relationship between the employee-oriented leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3ac hypothesis is rejected because the significance value of the relationship between the change in leadership behaviors employee-focused leadership sub-dimension and the basic	+	
H3ac hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the compliance culture sub-dimension		+
The H3ac hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the organizational learning		+

The H3ad hypothesis is rejected because the significance value of the relationship between the employee-focused leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3ad hypothesis is rejected because the significance value of the relationship between the employee-oriented leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3ad hypothesis is rejected because the significance value of the relationship between the employee-oriented leadership sub-dimension of leadership behaviors and the basic dimension of		+
The H3ad hypothesis is rejected because the significance value of the relationship between the employee-oriented leadership sub-dimension of leadership behaviors and the mission culture sub-		+

Hypothesis	Accepted	Not accepted
The H3aa hypothesis is rejected because the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture is p> 0.05.		+
The H3aa hypothesis is rejected since the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and the basic dimension of organizational culture is p> 0.05.		+
The H3aa hypothesis is rejected since the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension participation culture sub-dimension authorization is p> 0.05.		+
The H3aa hypothesis is rejected because the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension participation culture sub-dimension teamwork is p> 0.05.		+
The H3aa hypothesis is rejected since the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension participation culture sub-dimension talent development is p> 0.05.		+
The H3ab hypothesis is rejected since the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension consistency culture is p> 0.05.		+
The H3ab hypothesis is rejected because the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture main dimension consistency culture sub-dimension core values is The p> 0.05.		+
The H3ab hypothesis is rejected because the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension consistency culture sub-dimension consensus is p> 0.05.		+
The H3ab hypothesis is rejected since the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension consistency culture sub-dimension coordination is p> 0.05.		+
The H3ac hypothesis is rejected because the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension compliance culture is p> 0.05.		+
The H3ac hypothesis is rejected because the significance value of the relationship between the change-oriented leadership sub-dimension of leadership behaviors and the adjustment culture sub-dimension of organizational culture is p> 0.05.		+
The H3ac hypothesis is rejected because the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension compliance culture sub-dimension customer focus is p> 0.05.		+
The H3ac hypothesis is rejected since the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational learning sub-dimension of organizational culture is p> 0.05.		+
The H3ad hypothesis is rejected because the significance value of the relationship between leadership behaviors, change-oriented leadership sub-dimension and the basic dimension of organizational culture, mission culture is p> 0.05.		+
The H3ad hypothesis is rejected because the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension mission culture sub-dimension strategic management is p> 0.05.		+
The H3ad hypothesis is rejected because the significance value of the relationship between the leadership behaviors change-oriented leadership sub-dimension and the organizational culture basic dimension mission culture sub-dimension organizational goals is p> 0.05.		+
The H3ad hypothesis is rejected because the significance value of the relationship between leadership behaviors change-oriented leadership sub-dimension and organizational culture basic dimension mission culture sub-dimension vision is p> 0.05.		+

Leadership behaviors and organizational culture regression sub-hypotheses

Hypothesis	Accepted	Not accepted
The H3a hypothesis is rejected since the significance value of the effect of leadership behaviors on the		+
The H3a1 hypothesis is rejected since the significance value of the effect of leadership behavior on the		+
The H3a2 hypothesis is rejected since the significance value of the effect of leadership behavior on the sub-		+
The H3a3 hypothesis is rejected since the significance value of the effect of the organizational culture of		+
The H3b hypothesis is rejected since the significance value of the effect of leadership behaviors on		+
The H3b hypothesis is rejected since the significance value of the effect of leadership behaviors' main		+
The H3b hypothesis is rejected since the significance value of the consensus effect is p> 0.05, the main		+
The H3b hypothesis is rejected since the significance value of the coordination effect is p> 0.05, which is the		+
The H3c hypothesis is rejected since the significance value of the effect of leadership behaviors on		+
The H3c hypothesis is rejected since the significance value of the effect of leadership behavior on organizational		+
The H3c hypothesis is rejected since the significance value of the effect of leadership behavior on organizational		+
The H3c hypothesis is rejected since the significance value of the effect of leadership behaviors on		+
The H3d hypothesis is rejected since the significance value of the effect of leadership behaviors on the	+	
The H3d hypothesis is rejected because the significance value of the impact of leadership behaviors on the		+
The H3d hypothesis is rejected because the significance value of the effect of leadership behaviors on		+
The H3d hypothesis is rejected since the significance value of the effect of leadership behaviors'	+	
The H3aa hypothesis is rejected since the significance value of the effect of the business-oriented leadership		+
The H3aa hypothesis is rejected because the significance value of the effect of leadership behaviors' work-		+
The H3aa hypothesis is rejected since the significance value of the effect of leadership behaviors' work-oriented		+
The H3aa hypothesis is rejected since the significance value of the effect of leadership behaviors' work-oriented		+
The H3aa hypothesis is rejected because the significance value of the effect of leadership behaviors' work-		+
The H3ab hypothesis is rejected since the significance value of the effect of leadership behaviors' work-oriented		+
The H3ab hypothesis is rejected since the significance value of the effect of leadership behaviors' work-oriented		+
The H3ab hypothesis is rejected because the significance value of the effect of leadership behaviors' work-		+
The H3ab hypothesis is rejected because the significance value of the effect of leadership behaviors' work-		+
The H3ac hypothesis is rejected since the significance value of the effect of leadership behaviors' work-oriented		+
The H3ac hypothesis is rejected because the significance value of the effect of leadership behaviors' work-		+
The H3ac hypothesis is rejected since the significance value of the effect of leadership behaviors' business-		+
The H3ac hypothesis is rejected since the significance value of the effect of leadership behaviors' work-oriented		+
The H3ad hypothesis is rejected since the significance value of the effect of leadership behaviors' business-		+
The H3ad hypothesis is rejected because the significance value of the effect of leadership behaviors' business-		+
The H3ad hypothesis is rejected because the significance value of the effect of leadership behaviors' business-		+
The H3ad hypothesis is rejected because the significance value of the mission culture sub-dimension of the	+	
The H3aa hypothesis is rejected since the significance value of the effect of employee-focused leadership sub-		+
The H3aa hypothesis is rejected since the significance value of the effect of the employee-focused leadership		+
The H3aa hypothesis is rejected because the significance value of the effect of leadership behaviors' employee-	+	
The H3aa hypothesis is rejected because the significance value of the effect of leadership behaviors' employee-		+
The H3aa hypothesis is rejected since the significance value of the effect of leadership behaviors' employee-		+
The H3ab hypothesis is rejected because the significance value of the effect of the employee-focused		+
The H3ab hypothesis is rejected since the significance value of the effect of leadership behaviors' employee-		+
The H3ab hypothesis is rejected because the significance value of the effect of leadership behaviors on		+
H3ab hypothesis is rejected since the significance value of the effect of leadership behaviors' employee-oriented		+
The H3ac hypothesis is rejected since the significance value of the effect of the employee-focused leadership		+
The H3ac hypothesis is rejected because the significance value of the effect of leadership behaviors' employee-		+
The H3ac hypothesis is rejected since the significance value of the effect of leadership behaviors' employee-		+
The H3ac hypothesis is rejected because the significance value of the effect of leadership behaviors' employee-		+
The H3ad hypothesis is rejected since the significance value of the effect of the employee-oriented leadership		+
The H3ad hypothesis is rejected because the significance value of the impact of leadership behaviors on employee-oriented leadership sub-dimension of organizational culture, mission culture sub-dimension	+	
The H3ad hypothesis is rejected because the significance value of the effect of leadership behaviors' employee-		+
The H3ad hypothesis is rejected because the significance value of the impact of leadership behaviors'		+

Hypothesis	Accepted	Not accepted
The H3aa hypothesis is rejected since the significance value of the effect of change-oriented		+
The H3aa hypothesis is rejected since the significance value of the effect of change-oriented		+
The H3aa hypothesis is rejected since the significance value of the effect of the change-oriented		+
The H3aa hypothesis is rejected because the significance value of the effect of the change-		+
The H3aa hypothesis is rejected because the significance value of the effect of leadership		+
H3ab hypothesis is rejected since the significance value of the effect of change-oriented		+
The H3ab hypothesis is rejected since the significance value of the effect of the change-oriented		+
The H3ab hypothesis is rejected because the significance value of the effect of the change-		+
The H3ab hypothesis is rejected since the significance value of the effect of coordination is p>		+
The H3ac hypothesis is rejected because the significance value of the effect of change-oriented		+
The H3ac hypothesis is rejected because the significance value of the effect of change-oriented		+
The H3ac hypothesis is rejected because the significance value of the effect of the change-		+
The H3ac hypothesis is rejected since the significance value of the effect of change-oriented		+
The H3ad hypothesis is rejected because the significance value of the effect of the change-	+	
H3ad hypothesis is rejected since the significance value of the effect of the change-oriented		+
H3ad hypothesis is rejected since the significance value of the effect of the change-oriented		+
H3ad hypothesis is rejected since the significance value of the effect of the change-oriented		+

CURRICULUM VITAE

I was born on 20.07.1971 in Kemah district of Erzincan. I went to primary school and secondary school in Erzincan. I graduated from Manisa Health Vocational High School. I started working at Erzincan State Hospital as a health officer in 1995. I finished the anesthesia training organized by the Ministry of Health and became an Anesthesia and Reanimation technician. In 2002, I was elected as the provincial representative of a trade union in the health and social service branch. After working as an anesthesia technician at Erzincan Training and Research Hospital for a while, I was appointed as an administrator at the same institution. I graduated from Erzurum Atatürk University Faculty of Health Sciences. I took my master's degree at the University of Turkish Aeronautical Association. I am married. I have 5 children, 3 girls and 2 boys. In 2018, I left my position at the institution and started professional trade unionism.

PLAGIARISM REPORT

ORGANIZATIONAL CULTURE ON THE INVESTIGATION OF THE INFLUENCE OF LEADERSHIP AND ORGANIZATIONAL STRUCTURE IN AFFILIATED HOSPITALS IN TURKEY

HALİL İBRAHİM İÇOĞLU

ORİJİNALLİK RAPORU

%6	%5	%4	%
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ETHICS COMMITEE APPROVAL

YAKIN DOĞU ÜNİVERSİTESİ

BİLİMSEL ARAŞTIRMALAR ETİK KURULU

04.06.2018

Sayın Halil İbrahim İÇOĞLU

Bilimsel Araştırmalar Etik Kurulu'na yapmış olduğunuz YDÜ/SB/2018/151 proje numaralı ve **"Türkiye'de Afiliye Hastanelerdeki Liderlik ve Organizasyon Yapılarının Örgüt Kültürü Üzerine Etkilerinin Araştırılması"** başlıklı proje önerisi kurulumuzca değerlendirilmiş olup, etik olarak uygun bulunmuştur. Bu yazı ile birlikte, başvuru formunuzda belirttiğiniz bilgilerin dışına çıkmamak suretiyle araştırmaya başlayabilirsiniz.

Doçent Doktor Direnç Kanol

Bilimsel Araştırmalar Etik Kurulu Raportörü

Direnç Kanol

Not: Eğer bir kuruma resmi bir kabul yazısı sunmak istiyorsanız, Yakın Doğu Üniversitesi Bilimsel Araştırmalar Etik Kurulu'na bu yazı ile başvurup, kurulun başkanının imzasını taşıyan resmi bir yazı temin edebilirsiniz.