NEAR EAST UNIVERSITY
INSTITUTE OF GRADUATE STUDIES
BUSINESS ADMINISTRATION PROGRAM

THE EFFECT OF HOUSING SERVICES IN THE RELATIONSHIP BETWEEN LEADERSHIP STYLES AND PATIENT SATISFACTION AND SERVICE QUALITY

SERKAN TURGUTOĞULLARI

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THESIS ADVISOR

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ACCEPTANCE AND APROVAL

The study titled as **"The Effect Of Housing Services In The Relationship Between Leadership Styles and Patient Satisfaction and Service Quality"** by SERKAN TURGUTOĞULLARI Being Successful as a Result of the Defense Exam on 27/12/2021 It has been accepted by our Jury as a Doctoral Thesis.

Thesis defence was held online. The Jury members declared their acceptance verbally which is recorded.

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DECLARATION

I hereby undertake that this thesis study is completely my own work and that I indicated sources for each citation. I accept that I consent for my thesis to be kept in the archives of Near East University Institute of Social Sciences in the forms of hardcopy and electronic copy under following.

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Signiture

SERKAN TURGUTOĞULLARI

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Very valuable people have provided support in the creation of this study. First of all, I would like to express my gratitude to my thesis advisor, Professor Doctor Tülen Saner, who supported the work with great patience and tolerance with her valuable thoughts and feedback at every stage of the thesis, and whose understanding and help I always felt. I would like to thank my family for showing me the financial and moral support I needed throughout my entire education life, especially my family, for which I am happy to exist in my life.I would also like to thank all the people who contributed to my thesis work.

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ÖZ

LİDERLİK TARZLARI İLE HASTA TATMİNİ VE HİZMET KALİTESİ İLİŞKİSİNDE OTELCİLİK HİZMETLERİNİN ARACI ETKİSİ

Bu araştırmanın amacı, Muğla ili Fethiye ilçesinde faaliyetlerini sürdürmekte olan Fethiye Devlet Hastanesi, Özel Lokman Hekim Esnaf Hastanesi ve Özel Letoon Hospital hastaneleri sağlık yöneticilerinin ortaya koydukları liderlik tarzları ile hastaların tatmin düzeyleri ve sağlık çalışanları tarafından sunumu yapılan hizmet kalitesi ilişkisinde hastane otelcilik hizmetlerinin aracı etkisinin incelenmesidir.

Araştırmaya 31 sağlık yöneticisi, 341 sağlık çalışanı ve 200 ayakta ve yatarak tedavi olan hasta olmak üzere toplamda 572 kişi katılmıştır. Katılımcılara sosyo-demografik veri formu, hastane otelcilik hizmetleri ölçeği, toplam kalite yönetimi ölçeği, liderlik davranışları ölçeği, hasta memnuniyeti verilmiştir.

Sağlık yöneticilerinin katılımcı liderlik özellikleri gösterdikleri, liderlik tarzları ile sağlık çalışanlarının hastane otelcilik hizmetleri sunumlarının toplam kalite yönetimi üzerine yine liderlik tarzlarının hastane otelcilik hizmetleri üzerinde doğrudan etkisi bulunmuştur. Hasta tatmini ile toplam kalite yönetimi aracı değişken hastane otelcilik hizmetleri birlikte modele girdiğinde kurulan modelin istatistiksel açıdan uygun olduğu ve hastane otelcilik hizmetlerinin aracı rolünün bulunduğu belirlenmiştir.

Sonuç olarak örneklemin küçük olması nedeni ile sonuçların genellenmesi mümkün değildir ve daha büyük bir örneklem ve nitel araştırma yöntemleri ile yeni çalışmalar yapılması önerilir.

Anahtar Kelimeler: Liderlik, Hasta Tatmini, Hizmet Kalitesi, Hastane Otelcilik Hizmetleri

ABSTRACT

THE EFFECT OF HOUSING SERVICES IN THE RELATIONSHIP BETWEEN LEADERSHIP STYLES AND PATIENT SATISFACTION AND SERVICE QUALITY

The aim of this study is to determine the relationship between the leadership styles of the health care managers of Fethiye State Hospital, Private Lokman Hekim Artisan Hospital and Private Letoon Hospital, and the satisfaction levels of outpatient and inpatient patients and the quality of service offered by health professionals. and the mediation effect of hotel services.

A total of 572 people, including 31 health managers, 341 health workers and 200 outpatients and inpatients, participated in the study. The participants were given a socio-demographic data form, hospital hotel services scale, total quality management scale, leadership behavior scale, patient satisfaction.

It was found that the leadership styles of the health managers showed participatory leadership characteristics, and the hospital hotel services presentations of the health workers had a direct effect on the total quality management and the leadership styles on the hospital hotel services. When patient satisfaction and total quality management tool variable hospital hotel services entered the model together, it was determined that the established model was statistically appropriate and hospital hotel services had a mediating role.

As a result, it is not possible to generalize the results due to the small sample size and it is recommended to conduct new studies with a larger sample and qualitative research methods.

Keywords: Leadership, Patient Satisfaction, Service Quality, Hospital Hotel Services

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TABLE OF CONTENTS

LIST OF TABLES

Page Number

LIST OF FIGURES

Page Number

ABBREVIATIONS

OPSS : Outpatient Patient Satisfaction Scale

HHMS : Hospital Hotel Management Scale

SDDF : Socio-Demographic Data Form

TQMS : Total Quality Management Scale

LSSM : Leadership Styles Scale of Managers

ISS : Inpatient Satisfaction Scale

CHAPTER 1

INTRODUCTION

Chief Physician of Fethiye State Hospital, which has a hierarchical structure, Deputy Chief Physician, Administrative Financial Affairs Manager, Assistant Manager of Administrative Financial Affairs, Health Care Services Manager and Deputy Director of Health Care Services, Private Letoon Hospital and Private Lokman Hekim Esnaf hospitals health workers, The main purpose of this research is to determine the mediating effect of hotel management services on the effect of leadership styles put forward in hospitals on patient satisfaction and service quality within the framework of the opinions of outpatient and inpatient treatment.

Leadership is a concept that has received attention for a long time, and scientific research on leadership can be traced back to the early twentieth century. There is no common and universal definition of leadership. This is because those who read leadership define leadership by focusing on different aspects and fundamentals. Definitions related to leadership are defined in terms of the interests of scientists who conduct leadership research (Yukl, 2002: 4). Whitney's (1989) study is one of the earliest studies on leadership styles. In his research, Whitney (1989) concluded that experienced and knowledgeable employees express their views on the future of the organization when they listen to their supervisors and believe that they will protect themselves from ideas even if their views disrupt the status quo of the company.

It is observed that there is no complete consensus on which factors affect patient satisfaction, which is a multidimensional concept. Important criteria in relationships in the evaluation of patient satisfaction; Patient-other hospital personnel relationship, patient-doctor relationship, patient-nurse relationship, information, nutritional services, physical and environmental conditions, bureaucracy, trust and wages (Devebakan, 2005:8).

The concept of quality in health services, according to classical judgments; It can be defined as the degree of compliance or excellence of the elements that make up the health care system. In fact, these elements are a range of primary, secondary and tertiary and continuing services, from the prevention and strengthening of health services, to public health services, to ensuring the health of people in the community

before they get sick. The main purpose here is to ensure that the individuals who make up the society maintain their healthy state, and in case of illness, to ensure that they regain their old health by providing quality health services as soon as possible. The provision of quality health services in the protection and maintenance of health is the responsibility of the health professionals who provide the service, and the right of the people who finance the system. (http://www.canaktan.org/politika/kamudakalite/asuna.pdf).

When a general evaluation is to be made, the concept of service quality has an abstract content. In addition, it has a complex structure in terms of application, concept and control (Koçoğlu ve Aksoy, 2012:15). All these are expressed as difficulties in explaining service quality. This difficulty in explaining service quality seems to be reflected in the definitions made in this section. While a service provided may satisfy some individuals, it may not satisfy others. This is the main difficulty in explaining service quality. Since people's expectations and needs are different, differences in the explanation of the concept of service quality are inevitable. The fact that there is a consensus on the definitions of service quality and the difference in the definitions in this section has gained meaning through these expressions. Since the researchers explaining the concept of service quality tend to explain through the variables specific to their research, differences in the definitions of service quality such as focus, quality of quality and expectation make themselves felt.

Hospitals are one of the oldest organizations in history. Although the advances in medical science and technology are followed by hospitals, the way to become a modern hospital is to provide hotel services in accordance with the needs and expectations of the patients and current standards. The development of health care services, protection and fight against infections began in the years of Semmelweis and Florence Nightingale in 1818-1865. Nightingale, by sensitizing the state administrations with her work, and by contributing financially herself, pioneered the establishment of a hospital with clean patient beds, diet kitchen, laundry, material warehouse and complying with hygiene rules. At the same time, he laid the foundation of the Home Administration Services, or the current name of the Hotel Services, provided in the hospitals (Aktaş, 2007:11).

The adequacy and quality of accommodation services in hospitals have a very important place in the treatment process of the patient and patient satisfaction, as

well as in the satisfaction and motivation of the working personnel. Patients have to spend the entire time they stay in the hospital in their rooms, therefore, patient rooms should be suitable for hospital functions and meet all expectations for the patient and accompanying persons in terms of accommodation comfort. When the accommodation services in hospitals are well organized, medical personnel will have the opportunity to work more effectively and efficiently in their field of expertise. During and after diagnosis and treatments, many complications and even patient deaths occur due to lack of hygiene and sanitation and inappropriate room conditions. Prevention of these situations can only be achieved by professional accommodation services management.

The research consists of six parts. In the introduction, which is the first part of the research, the problem situation of the research, the purpose of the study, the importance of the study and its definitions are presented. In the second part, under the title of conceptual framework and related research, leadership, manager and leadership, leadership approaches and leadership behaviors, general quality management, general quality management in the health sector, the positive role of quality management in the organization and the basic elements of general quality management will be discussed. The expectations from the healthcare provider, the importance of patient satisfaction in health, the factors affecting patient satisfaction and the measurement and evaluation techniques of patient satisfaction are mentioned. In the third part, the method, the model, universe and sample of the research, the question and hypotheses of the research, the limitations of the research, data collection and statistical analysis of the data are explained.

In the fourth part of the study, the findings part is included. In the fifth part of the research, the subject is discussed according to the findings in the literature.

As a result of the analyzes made in the conclusion part of the sixth part of the study, it was analyzed whether the mediating effect of hotel services on the relationship between leadership styles, patient satisfaction and service quality differs according to sociodemographic variables.

1.1. Definition of the Problem

Below are the definitions of the main subjects that form the basis of our thesis. On the basis of these definitions, the problem of the research is explained.

The type of service used by almost everyone and necessary to repair damage caused by accident or illness is expressed as medical service (Yaylalı et al., 2012: 563).

Service quality is related to satisfaction but not synonymous with satisfaction. It is obtained by comparing the quality of service received with the expected value. Service quality exceeds customer expectations (Hacıefendioğlu and Koç, 2009: 146).

Internal Customer: Persons and groups working in the health institution or having an organic relationship with the health institution.

External Customer: Persons and institutions that directly or indirectly benefit from the services of the health institution.

Hotel Businesses: They are tourism enterprises that are established for economic purposes and that examine all functions such as the management, organization and similar functions of the units that carry out production and marketing activities to meet the needs of people in tourism (Barutçugil, 1989: 11).

Patient Satisfaction: It is meeting the wishes and expectations of the patients or providing service above these requests and expectations.

Leadership: It is the responsibility and privilege of directing the actions of others, while working towards the objectives of the relevant sector, at different levels of authority and responsibility. (Uysal, 2001: 21).

This study contributed for the first time to the academic literature. The structure of this research was used to model strategic human resource management, service quality and business performance. Numerous studies have been conducted in the relevant literature. There is no other study examining the impact of hotel management activities on improving hotel quality. This research aims to determine the effect of strategic human resource management and service quality innovation on the performance of hotel businesses. However, modeling this issue is considered to be an extremely important contribution.

1.2. Purpose of the Research

The main purpose of this research is; Fethiye State Hospital Chief Physician, Deputy Chief Physician, Administrative Financial Affairs Manager, Administrative Financial Affairs Assistant Manager, Health Care Services Manager and Health Care Services Assistant Manager, Private Letoon Hospital and the aim of this study is to reveal the mediating effect of hotel management services on the effect of leadership styles in hospitals on patient satisfaction and service quality, within the framework of the views of private Lokman Hekim Esnaf hospitals health workers and outpatient and inpatient treatment.

1.3. Importance of the Research

Scope of analysis of this research Chief Physician of Fethiye State Hospital, Deputy Chief Physician, Administrative Financial Affairs Manager, Assistant Manager of Administrative Financial Affairs, Health Care Services Manager and Deputy Director of Health Care Services, Private Letoon Hospital and Private Lokman Hekim Esnaf Hospitals are the outpatients and inpatients of healthcare professionals.

The leadership styles of the Chief Physician, Deputy Chief Physician, Administrative Financial Affairs Manager, Administrative Financial Affairs Manager, Health Care Services Manager and Health Care Services Deputy Manager participating in the research, patient satisfaction and service quality of outpatients and inpatients are the basis of the study. In this context, the differences in the views of hospital administrators and health workers, outpatient and inpatient treatment on the subject within the framework of demographic information were also investigated.

The concept of quality in health services, according to classical judgments; It can be defined as the degree of compliance or excellence of the elements that make up the health care system. In fact, these elements are a range of primary, secondary and tertiary and continuing services, from the prevention and strengthening of health services, to public health services, to ensuring the health of people in the community before they get sick. The main purpose here is to ensure that the individuals who make up the society maintain their healthy state, and in case of illness, to ensure that they regain their old health by providing quality health services as soon as possible.

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It is aimed that this study will contribute significantly to the literature on leadership styles, total quality management, patient satisfaction with outpatient and inpatient treatment and hotel services, which have become an important problem in our country as well as in the world. In this research, unlike the studies on hospital hotel services, it is aimed to contribute to the field by creating an important sample with a significant sample in terms of leadership styles, total quality management, outpatient and inpatient patient satisfaction for the first time.

1.4. Methodology of the Research

The sample of the study consisted of 31 volunteer health managers, 341 health workers, 200 outpatients and inpatients selected by easy sampling method from state and private hospitals operating in Fethiye district of Muğla province. The questionnaire form consisted of 8 items for managers and employees, 5 items for inpatients, 13 questions, leadership styles of managers 34, outpatient satisfaction 19, inpatient satisfaction 17, total quality management scale 47, hospital hotel services scale 33 questions. It consists of 158 statements in 5 scales. Except for demographic variables, other scales were evaluated using 5-point Likert type scales. Opinions on the mediating effect of hotel services on patient satisfaction and service quality of leadership styles in hospitals within the framework of the views of health managers, health workers, outpatients and inpatients of public and private hospitals, t-test, Anova test, Scheffe test as post-hoc analysis, tested with pearson correlation and regression analysis.

1.5. Limitations of the Research

In the study, the difficulty in collecting data due to the nature of the service provided by the administrators and health workers of public and private hospitals, and patients receiving outpatient and inpatient treatment changed the sample size of the study. The variables discussed in the study are limited to the reliability dimension of the applied questionnaire. The fact that some of the administrators, healthcare professionals, and outpatients and inpatients who were surveyed did not want to participate in the survey created difficulties in collecting data. Therefore, allowing partial research in hospitals reduced the sample size.

CHAPTER 2

CONCEPTUAL FRAMEWORK AND RELATED RESEARCH

In this section, leadership styles, total quality management, patient satisfaction concepts will be explained and leadership approaches, leadership behavior styles, total quality management in the health sector, and the basic elements of total quality management will be defined.

2.1. Leadership Concept and Definition

The words leader and leader entered English three or four centuries ago. It comes from the Latin word manus and means 'hand' (Adaır, 2005:11).

Leadership is about influencing and directing the work of others to achieve personal or group goals (Ceylan, Keskin and Eren, 2005:33).

Leadership is associated with the ability and process of influencing people to achieve a specific vision and goals (Robbins, 2013:9). It includes all functions of influencing, motivating, leading, directing and activating (Certo and Certo, 2009:15).

Different groups formed by individuals, unique interaction patterns, different goals and means, external and internal pressures on groups create different leaders. Leadership arises from the behavior of the individual in the organization. An individual's leadership in a group depends on the group's perception of him. Leadership is granted by group members to members of the group who are perceived as competent to play a particular leadership role. Change and leadership are closely related. The need for a leader diminishes with change, yet the leader seeks change (Adaır, 2005:12).

Leaders are also people who can draw new horizons for their institutions. Leaders are very effective in taking people beyond the horizons they open. The foundation of effective leadership is to think, define and reveal the mission of the organization. Managers set goals and priorities, set and follow standards (Özden, 2005:18).

The 21 indisputable leadership traits are: character, charisma, loyalty, communication, talent, courage, sensitivity, attention, generosity, initiative, listening,

passion, positive attitude, problem solving, relationships, responsibility, trust, service, discipline, being able to learn, and vision (Maxwell, 2000:12).

In addition to these 21 leadership skills, there are some leadership elements.

The elements of leadership can be listed as follows: evaluating people, vision (seeing), supporting, passion, power, influence, communication skills, management skills, conflict resolution skills, and having a strong spirit (Yiğit, 2002:18).

There have been various definitions of leadership since the early 1900s. These are presented in Table 2.1.

Table 2.1: Evolutionary development of leadership

1902 C.H. Cooley	Leadership is to be at the center of social movements.
1911 F.W. Blackmar	Leadership is the ability to reveal the strength of the group in their own efforts.
1921 E.L. Munson	Leadership is the ability to lead people to success with the least conflict and the strongest cooperation.
1924	Leadership is the ability to give special meaning to group cooperation.
1927	Leadership is to recognize the energies and wishes of group members and ensure that they are met.
1930 C.M. Bundel	Leadership is the art of getting people to do what they want with the ability to persuade.
1942 N. Copeland	Leadership is the art of influencing people mentally, physically, emotionally and socially.
1950 R.M. Stogdil	Leadership is the process of influencing the group to set and achieve goals.
1968 R. Dubin	Leadership is the ability to make decisions using authority.
1978 D.Katz & R.L. Kahn	Leadership is to have a motivating effect on the performance of the members of the organization outside the routine orientations of the organization, to contribute to the institutional transformation.
1986 R.R. Krausz	Leadership is the power used to influence the activities of followers.
1994 R. Heifetz	Leadership is to attribute different meanings to behaviors in the face of different situations
1997 K. Gallagher	Leadership is influencing people by transforming all potentials into efforts to reach the goal, getting people to give more of themselves.

Source: Seyda, (2013:9)

2.1.2. Manager and Leader

Leadership does not stem from the mystical nature of the leaders or their personality traits. Leadership is a job that requires different actions from management. The problem with many companies is over-management but insufficient leadership. A manager manages complexity by setting future goals, planning and budgeting. The leader sets a direction for the company, creates a vision and determines the necessary change strategies (Baltaş, 2005:129).

The leader and his followers represent the oldest and most natural of all human relations, as well as the most effective. The manager and the people he manages are the next stage that does not have the same place in history. Leadership is the soul unity of personality and vision, and its application is a separate art. Management, on the other hand, requires concentrating on fine calculations, methods, time tables and

work schedules related to statistics and its application is scientific. Managers are necessary, leaders are essential (Adaır, 2005:13).

The goals of collective leaders are to meet needs, and managers are adept at spreading the word. The leader, on the other hand, accepts personal and influential views on goals, inspires subordinates, and establishes close relationships with employees and colleagues (Zaleznık, 2004:16).

The differences between a manager and a leader can be listed as follows;

- Defines and implements the goals, objectives and values of the governing body. Leadership defines a direction and encourages employees to act in that direction.
- The concept of leadership is future-oriented; management is static, only linked to today
- Leadership requires recognition of organizational values and beliefs and analysis of their significance for the future; There is no need to analyze beliefs and values in management (Baltaş, 2005: 130).
- The manager serves the goals set by someone else. The leader sets the goals himself.
- The manager derives his power from a formal structure such as laws, regulations and regulations. The leader, on the other hand, takes his power from his personal characteristics and position (Sabuncuoğlu, 2003:10).

Şahin (2003:7) divided the emergence of leadership theories into four groups. The main idea it defends and the theories shaped according to the period in which it was put forward can be summarized as follows:

Table 2.2: Emergence of leadership theories

Years	Leadership Theory	Main Idea of the Theory
Until the 1940s	Features Theory	Leadership is an innate trait.
1940-1960	Behavioral Theories	The effectiveness of the leader is related to how the leader behaves.
1960-1980	Situational Theories	The effective leader is affected by the situation.
After the 1980s	New Approaches	Leader has vision

Source: Güney, (2012:8)

2.1.3. Leadership Approaches

With the change of conditions, there has been a change in management practices and different approaches have been developed. These can be divided into three groups: trait approach, behavioral approach and contingency approach (Sabuncuoğlu, 2003:11).

2.1.3.1. Feature Approach

The most important thing about this approach is the qualities of the leader; The importance of the leader's physical characteristics such as height, weight, strength, age, health status, appearance and intelligence, speech, personal relationships and communication skills, confidence or self-confidence, entrepreneurship and risk taking and courage were discussed. However, due to the lack of registration of other members of the group and their followers, like-minded people could not reach complete agreement on the matter. Changes and uncertainties in the leader's environment, the interaction of the leader and team members are key factors in the leader's success (Eren, 2004:18).

As a result of this approach, it has been determined that the leader has four types of personality traits (Table 2.3).

Table 2.3: Leadership characteristics

Age	Ability to form personal relationships
Size	Having the initiative
Intelligence	Speaking clearly
Maturity	Emotional maturity
Truth	Honesty
Stability	Confidence
Information	Good speaking ability
Seeing Forward	Ability to trust others
Gender	To be sincere

Source: Güney, (2012:9).

2.1.3.2. Behavioral Approach

In the behavioral approach, the behavior of the leader gains importance instead of the individual characteristics. There are basically two types of leaders; task oriented leader type and people oriented leader type. According to this approach, except for exceptional cases, the human-oriented type of leader is more successful (Sabuncuoğlu, 2003:12).

The assumptions that people-oriented leadership is more successful have been confirmed in research, but no concrete results have been found (Dereli, 1981:16).

Blake and Mouton's Management Style Matrix

Five types of leadership-based leadership factors are important for production and organization. These (Blake and Mouton, 1985:9):

1. Poor Leadership: The leader does not pay attention to the people in the organization or industry. The leader does his best to stay in the organization, shows little interest and involvement in his work, and avoids taking responsibility.
2. City Club Leadership: The leader demonstrates that he puts a lot of effort into creating an environment among his subordinates and is less concerned with production.
3. Task Leadership: The leader sees his subordinates as robots, specifies and directs their strikes in detail.
4. Middle Way Leadership: The leader cares about both the business and the people, but aims to protect himself by pleasing both parties.
5. Team Leadership: Thinks that people need to work efficiently and hardworking, therefore encourages employees to participate in decisions (Üçok, 1992:20).

Mc Gregor's Theories X and Y

According to Mc Gregor, one of the most important factors determining the behavior of managers is their assumptions about human behavior. The assumptions of theory X are (Eren, 1993:11):

- The average person does not like work and seeks to avoid work as much as possible. For this reason, the management should take preventive measures and give importance to discipline,
- It is wrong to expect people to do their own work and take responsibility.
- The most important force that will enable people to take action is financially in line,
- People are very reactive to change. Therefore, they do not like change and continue their habits,
- People are selfish and prefer their own desires to organizational goals.

McGregor's Theory Y:

- Natural like work or rest,

- Excessive supervision and control is not the only way to manage people. People work with self-management if they are committed to their organization and like to work.
- One does not learn to escape from innate responsibility. He learns to avoid responsibility for his bad experiences in organizations.

Based on these assumptions, the manager should do; is to help people realize themselves by creating a suitable environment. Accordingly, while the managers adopting the X theory exhibit more authoritarian leadership style, the managers adopting the assumptions of the Y theory; will demonstrate a more democratic and participatory leadership style (Koçel, 1996:25).

Table 2.4 shows the assumptions of theories X and Y, which show two contrasting leadership styles:

Table 2.4: Features of X and Y theories

THEORY X	**THEORY Y**
Such people should be forced to work.	The leader tries to help his followers discover their creativity.
They do not like to take responsibility.	He wants to take more responsibility.
They do not like to work.	He knows how to handle himself at school.

Source: Güney, (2012:10).

Likert's System 4 Model

Likert, in his work between 1947-1961, oil, paper, railway, electronics, etc. has written on it. At the end of the surveys and interviews, he received information from thousands of people in different positions working in many sectors and finally determined a personnel and business-oriented manager (Likert, 1961:13):

Leaders who exhibit a business-oriented management style;

- They divide the work into small simple sections and problems,
- They find the best way to deal with every problem,
- The employee is trained to provide the skills to best perform these tasks,
- This function of the employee is closely monitored,

Managers who show management style to employees:

- They deal with the problems of those under their care,
- They focus on building a team to achieve productivity goals.

Table 2.5: Leadership styles according to Likert

Leadership variable	System 1 Abuser	System 2 Helpful	System 3 Participants	System 4 Democratic
Trust in subordinates	He does not trust his subordinates.	There is Servant-Master trust.	Trust is limited. Decision control is in the leader.	There is full confidence in all matters
The feeling of freedom felt by subordinates	Subordinates do not feel free to discuss work issues with their superiors.	In business matters, subordinates do not feel very free.	Subordinates feel free enough.	Subordinates feel completely free.
The superior's relationship with the subordinate	Gets very little of the subordinate's opinion on business matters.	He occasionally asks for the subordinate's opinion.	In general, he takes the opinion of subordinates and takes advantage of them.	He always gets the opinion of subordinates.

Source: Erdal, (2007:16).

Ohio State University Leadership Studies

The aim of this study, which was carried out by many military and civilian leaders in 1945, is to determine how the leader is defined, that is, a leader who establishes friendly and sincere relations with members and creates respect and trust in individuals. Secondly, those with high entrepreneurial spirit; in other words, he is a successful leader in establishing positive relationships among members, facilitating communication, and effectively planning and organizing work. The most effective leader is the one who exhibits his behavior in two dimensions (Eren, 2004:15).

University of Michigan Leadership Studies

The aim of this research program is to find the difference between effective and ineffective leaders. As a result of the research, the behaviors of the management were determined in two areas as work-oriented and employee-oriented. The leader, who exhibits a leadership-oriented structure, is interested in the work and success of his subordinates. The goal is to deal with the problem effectively. The manager, who reveals the leadership character of the employee, is interested in the satisfaction of the employee. The aim is to make employees feel good (Sabuncuoğlu, 2003:13).

Table 2.6: University of Michigan's leadership classification

Business-centric Leader	Individual-Centered Leader
It focuses on the work that needs to be done.	He focused on the characteristics of the social system that made up his personal achievements and part of his work.
He pressures his subordinate to fulfill his duty.	Defines high performance targets for business units and informs subordinates about performance expectations.
He constantly supervises the employees as he does not believe that they can fulfill their duties on their own.	Much of his work focuses on improving employee behavior and business reasons, and personal relationships between himself and his subordinates.

Relationships with those under his care are poor.
It focuses on specific principles of action.

Source: http://www.slideshare.net/mustafadegerli/mustafa-degerli-2014-liderlik, 22.10.2017.

2.1.3.3. Contingency Approach

In this approach, it is important to know how authoritative (problem oriented) and how democratic (people oriented) the leader should be. There is no single universal leadership style that can be used in circumstantial situations, and the conditions for choosing a leadership style must be considered. (Aydın, 2000:26).

Fred Fiedler's Model of Effective Leadership

According to Fiedler's situational leadership model, the most ideal leadership attitude can be achieved with the high performance exhibited by the organization, which emerges by providing two factors together, the conditions in which the group members work and the behavior they expect from the leader. Fiedler, who accepts that there are two leadership styles as task-oriented and relationship-oriented, bases the leader's effectiveness on 3 situation variables: leader-subordinate relations, task structure and the power that the leader derives from his position (Taşkıran, 2011:20).

Purpose-Path Theory

It focuses on how the leader influences followers, how business goals are perceived, and ways to achieve the goal. The basic assumption is that managers are effective in achieving organizational goals, job satisfaction in the workplace, and motivating their subordinates (Eren, 2004:16).

Vroom and Yetton's Normative Theory

According to this model, a leader may show another leadership model from time to time. While evaluating the decisions taken, the leader should compare the alternatives and consider the number of decision makers in the decision making process.

Hersey and Blanchard's Contingency Approach

This model focuses on two main dimensions: the behavior of the problem and the behavior of the relationship. As the case progresses, the manager tells his members what, where, when and by whom. Due to the nature of the relationship, the leader has a close personal relationship with the members (Özkalp and Kırel, 2007:13).

Reddin's Three-Dimensional Leadership Theory

The theory is based on the control scale concept of Reddin, Blake and Mount and writes the following four main dimensions in these two dimensions (Can, 1991:9).

A leader's level of effectiveness depends on the situation, not the behavior. Reddin's basic typology has four effective and four ineffective leadership methods (Tabak, 2005:3).

- Basic Approach: 1 Circulating, 2. Associated, 3. Unifying, 4. Dedicated
- Ineffective approach: 5. Abandoned, 6. Incumbent, 7. Negotiable, 8. Authoritarian
- Effective Approach: 9. Bureaucrat, 10. Developer, 11. Manager, 12. Babacan-Authoritarian

Efforts to change the Turkish education system are outdated. The new organizational structures aim to raise people who are interested in management, argumentative, questioning, innovative, creative, knowing how to use information systems and using time well. From a management perspective, assigning more than one unit or person to a job causes the job to fail. Doing the same job with limited resources by different departments prolongs operations in our country due to consumption of material and human resources, complexity of obligations, delays in service and even non-fulfillment. It is assumed that the desired success can be achieved when the changes are made in a planned way.

2.1.4. Leader Behaviors

Different researchers have different interpretations of the behavior styles of managers. They can be divided into humanistic, caring, authoritarian, charismatic, natural, free, democratic, collective, transformational, and interactive leaders.

2.1.4.1. Humanist Leader

He is a leader with a fatherly attitude and a protective role. This is usually authorized on behalf of the administrator when the decision is made. Use emotion-focused incentives and use reward systems. No fines are applied when not required (Sabuncuoğlu, 2003:14).

2.1.4.2. Supporting Leader

It accepts the opinions and suggestions of team members and makes decisions, implements the participation and compensation system, negotiates with the members of the organization, sets organizational goals, communicates with the members and gives instructions (Sabuncuoğlu, 2003:15).

2.1.4.3. Authoritarian Leader

At all stages of management, the authority belongs to the leader. This type of leadership is more applicable to societies with autocratic and bureaucratic management. The autocratic leader is only authorized at all stages of management and does not delegate authority. Motivation of group members is usually based on the use of the leader's previous power (Sargut, 2001:4).

2.1.4.4. Charismatic Leader

Leader; have unusual traits and strong personality traits that often emerge in times of crisis. In this type of leadership, the leader is generally admired by his employees, has courage, has very strong persuasiveness, high self-confidence, and is quite successful in motivating (Çelik and Sünbül, 2008:17). Atatürk can be given as the best example of a charismatic leader in our country.

2.1.4.5. Natural Leader

He is a leader who is not chosen by a manager, but created by a group of people. It has no formal authority, but its power over the group is higher than that of the legal leader (Sabuncuoğlu, 2003:16).

2.1.4.6. Liberal Leader

Liberal leaders completely liberate their group members. They adopt the principle of let them do, let them pass. It is up to the members to set goals and make decisions. The job of providing information and resources from outside the organization is your leader (Sabuncuoğlu, 2003:17).

2.1.4.7. Democratic and Participatory Leader

Organizational objectives are determined according to the group's decisions, excluding crisis periods. The leader encourages his subordinates to participate in planning, decision making and organizing activities. There is a reward system, no

penalty; The organization is open to all kinds of communication (Sabuncuoğlu, 2003:18).

The absence of communication problems in the organization increases the participation of subordinates. Democratic leaders make and evaluate performance-based participatory decisions. They pay attention to the distribution of power (Kurt, 2005: 166).

In institutions with democratic leaders, management authority is shared with the audience. The leader shows leadership behavior in line with the ideas he receives from his subordinates in the determination of goals, plans and policies, in the division of work and in the creation of work orders (Eren, 2004:17).

2.1.4.8. Transformational Leadership

Transformational leadership is the process of creating commitment to organizational goals and objectives, motivating followers to those goals and objectives, and making them believe that they will achieve great things (Baltacı et al., 2014: 353).

Thus, viewers are motivated to try harder than expected. In another way, according to Ataman, transformational leaders; they bring out all the talents and skills of their subordinates, making them self-confident, highly motivated and more productive. That is, the leader builds the followers' confidence in achieving their goals, sets an example for the followers, and increases their level of dedication to work (Ataman, 2009: 14)

Avolio and Bass consider the transformational leadership style in 4 sub-dimensions in the multi-factor leadership scale they developed (Bass, Waldman, Avolio and Bebb, 1987: 73):

1. Individual Care: The leader coaches or teaches his employees, sharing their concerns and understanding their needs.
2. Intrinsic Motivation: The leader inspires his employees, motivates them and instills team spirit.
3. Intellectual Encouragement: The leader encourages his employees to generate new ideas and creativity.
4. Charisma (Ideal Effect): The leader becomes a role model in the eyes of his employees

2.1.4.9. Interactive Leadership

Transactional leadership; It is the rewarding of the follower by the leader in line with the lower level needs such as acceptance, recognition and security, and a higher performance in return. In other words, the leader and the follower are in constant interaction with a cycle in this structure (Peachey et al., 2015: 570). Transactional leader behaviors include the skills and competencies that groups and individuals possess in order to perform more efficiently and effectively. Behaviors such as giving feedback, giving direction to employees, evaluating performance and setting goals are among the things that a leader with an interactionist attitude should do (Kakabadse, Bank and Vinnicombe, 2004: 19).

In the multi-factor leadership scale developed by Bass and Avolio, transactional leadership is discussed in 4 sub-dimensions (Bass, Avolio and Bebb, 1987: 74):

- Management by Exceptions (active): The leader finds and corrects deviations and errors in the work of his employees.
- Management by Exception (passive): The leader only intervenes when the work of his employees does not go well.
- Conditional Award: The leader rewards his employees in direct proportion to their performance.
- Freedom: The leader leaves his employees free in their work and avoids work.

When we look at the sub-dimensions, it is clearly seen that; Unlike the transformational leader, the transactional leader is the one who supports and encourages his employees to maximize the performance expected from them instead of changing their beliefs. At the same time, such leaders think that rewarding employees must be done in return for a high performance and they act in this direction.

2.2 The Concept of Customer (Patient) in Health.

According to the classical view, health services are among the basic public services that the state has to provide to its people, along with services such as justice, security and education. Evaluation of these and similar services from this point of view; The fact that the citizens do not have the opportunity to obtain these services from other places or that they are limited, even if they are provided, is due to the fact that they

are among the services that require state control and intervention due to their characteristics. For this reason, these public services must be given and controlled by the state.

Today, due to the changing world dynamics, the sharing brought by globalization, the increasing quality demands of the people in need of service, various legal regulations and the inadequacy of the economic opportunities of the states (Somunoğlu et al., 2012: 19), many services, which are basically public services, are only provided with public facilities. In addition to the public, various types of service delivery such as the private sector and public-private partnerships have emerged. Thus, the classical public administration understanding has left its place to the new public administration approach. The new public management approach reveals some principles that business management has adopted.

With the downsizing in public administration, there is a tendency towards a more effective state, faster delivery of public services, and a customer-oriented approach in public services. The new public management approach adopts total quality management and a customer-oriented approach, which is an important part of it (Sezer, 2008:147).

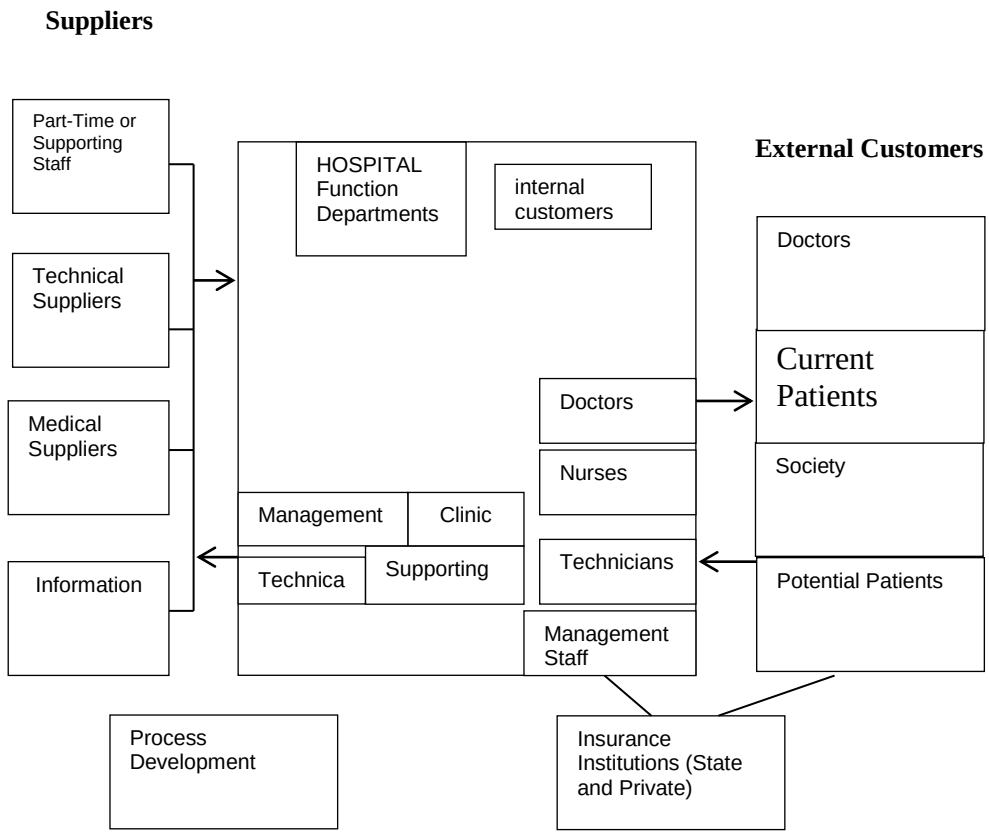
The fact that some services, which are seen as basic public services, especially Health Services, are started to be provided outside of public institutions and the change in service understanding forces the transformation of the concept of patient in health into the concept of customer gradually. Although the use of the concept of customer in public services, especially in the field of health, was very strange in the past and it is said that this concept describes the buyer of goods and services belonging to the private sector, today it is a psychological basis for providing a fast, effective, efficient and friendly public service to the public. this concept is welcome (Çukurçayır, 2002: 155).

When the customers of health institutions are mentioned, only those who receive service, that is, patients, come to mind, but today this view has lost its validity to a great extent. Now, when the customer is mentioned in healthcare, all individuals and institutions participating in the production of healthcare services are considered as customers. With this understanding, the customers of health institutions can be grouped into two main groups as internal and external customers. While internal customer refers to the individuals and groups working in the healthcare institution or

having an organic relationship with the healthcare institution, external customer refers to the individuals and institutions that directly or indirectly benefit from the services of the healthcare institution (Kavuncubaşı and Kısa, 2002:9).

In addition to patients, who are defined as primary customers and make up the majority of the external customer group, patient relatives, companions, visitors, other health care companies, contracted institutions, pharmacies, insurance companies, medical equipment and pharmaceutical companies, construction companies, state and community health companies' external customers can be shown as an example; The personnel, managers, shareholders (partners) and consultants of the health establishments are the internal customers of the health establishments (Sevimli, 2006: 10).

Apart from the scope of internal and external customers determined in accordance with the general evaluation and acceptance, there are also customer relations in terms of functionality in health institutions. Units can be customers of each other due to functional relationships. For example, the nursing service may be the customer of the pharmacy due to drug use, and the customer of the nutrition unit because it deals with the diet of the patients. Likewise, doctors are also customers of the units (laboratory, x-ray, etc.) that they want to test for diagnosis. While the intensive care service can be the customer of the emergency service, the insurance companies can be the customers of the billing units, all the departments of the health business can be the customers of the management (Bakır, 2006:9).



Source: *Rakich et al (2004:15).*

Figure 2.1: Internal and external customers of a healthcare business

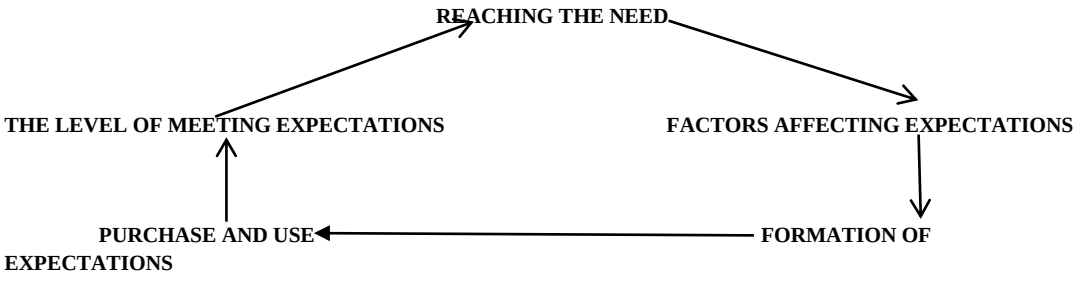
In Figure 2.1 above, the relationships between the internal and external customers of the health business, which has been tried to be explained so far, and the various units of the institution, which are included in the Concept of Customer in Health, are seen collectively.

2.2.1. Expectations of Health Service Users from Service Providers

For a health institution, it is of great importance for customer satisfaction that the quality level and quality of the service it provides to the audience it serves can meet the expectations of those who receive this service and channel their perceptions about the service correctly. For this reason, the institution should know the expectations of the society to which it is addressing, organize the service flow processes accordingly, analyze the way the health service is perceived by the customer and make the necessary arrangements. It means meeting customer requests

and expectations and even providing a service above it; It means optimizing the scientific, managerial and behavioral characteristics that those who request the service want to see, which differ according to the age, gender, education level, socio-cultural characteristics of the customers and their past experiences with health services and institutions. When a customer's expectations are met (that is, his perception is equal to or greater than his expectation), he will be satisfied with the service he received, otherwise (Perception level < Expectation level) he will be counted as an unsatisfied customer because his expectations are not fully met (Kavuncubaşı and Kısa, 2002:10).

When looked at as a dictionary meaning, it is seen that the concept of expectation is defined as what is expected to happen at the end of an action. Customer expectations are; It is defined as the features that the customer demands or expects from the product or service they want to buy. The customer's expectations are not only related to the product they buy. These expectations include how the product will be reached, under what conditions it can be purchased, the attitudes and behaviors shown to it during the purchase, how to eliminate the dissatisfaction that will occur after the purchase, and even how the waste will be disposed of as a result of the consumption of the product. The process of shaping customer expectations begins with the emergence of the need, it is shaped by the factors affecting the expectations, and as a result of purchasing and consuming the product, whether the need is met or not is revealed. As a result of this experience, expectations and the factors affecting them are re-evaluated and a comparison is made. With the re-emergence of the need, the cycle of expectations is reactivated (Bostan, 2006:20).



Source: *Bostan (2006:20).*

Figure 2.2: The process of forming and meeting customer expectations

The process of forming and meeting the expectations of the customers is shown in Figure 2.2. The expectations of the patient applying with a health service request can be examined in two groups: The patient's expectations for the health service they need: These expectations are the first and foremost expectations of the person. When a person gets sick, he expects to receive the health care service that is of the highest quality in terms of medicine and technique, in the fastest and best way, and in accordance with the requirements of medicine. Although he cannot fully evaluate the accuracy and quality of the health service provided, it is a measure for him to regain his health quickly and in a way that does not look old. Only experts decide on the necessity and correctness of the applied medical intervention. Expectations about the process of receiving health care: While patients are in the medical intervention process, they expect to be given sufficient information, to participate in the decisions to be made in the procedures to be done, to use their right to choose and to be in comfort and security within human values. These expectations are about perceived quality. Therefore, it is possible to classify expectations about perceived quality as information, participation in decisions and exercising the right to choose, and administrative services (Bostan, 2006:21).

2.2.2. The Importance of Patient Satisfaction in Health

The main function of health institutions is patient care and treatment, its potential customer is the whole society. “Customer satisfaction, on the other hand, can be defined as the opinion that the customer has reached as a result of the customer's decision to purchase a good or service, as a result of comparing the events experienced during the processes of researching, finding, purchasing, using, repairing, maintaining and consuming the goods or services, and comparing the benefits obtained with their expectations” (Bostan et al., 2005: 10).

Today, different parameters are used in the health sector to evaluate and measure the service quality and delivery, and the most important of these parameters is Patient Satisfaction. Although evaluation, measurement and control are made by using internationally accepted standards to evaluate the necessity, accuracy and quality of the health care applied to the patient, these alone cannot reveal the effect of the health care applied and the health service provided on the service area in all its aspects. A fairly good audit can be achieved only by comparing the compliance of the procedures used in the diagnosis and treatment stages with the medical

requirements and the results with those that should be. However, monitoring and measuring patient satisfaction gives us important data that can reveal the quality of the service in all its aspects. It is not enough for health care institutions to apply a good treatment procedure and heal their patients alone. Many factors directly or indirectly affect customer (patient) satisfaction during the healthcare service delivery, from the patient's admission to the hospital through the door, to his/her recovery and discharge. Among these factors, we can list the first ones that come to mind as follows:

- Behaviors of patient registration-admission, welcome, orientation and security personnel with their knowledge and skills while doing their jobs,
- Knowledge and competence of healthcare personnel involved in patient care,
- Domination and competence of other personnel involved in health care,
- The general physical structure of the health institution, the social areas such as waiting areas and the design of health care areas such as clinics, inpatient units, laboratories, operating rooms, imaging centers,
- General hygiene conditions of the health institution,
- Availability of opportunities to meet the humanitarian needs of patients and their relatives,
- Communication skills, attitudes and behaviors and friendliness of all personnel,
- Arrangements made by the administrative units that take responsibility for the management and administration of the institution in terms of accessibility to all services provided, crisis management skills, and the value they give to patients and their relatives,
- The level of patient expectations,
- The patient's demographic characteristics, culture, environment, education level and social status

These and many other factors that we have mentioned affect customer satisfaction. As a result, the customer, who makes a comparison between his expectations and what he finds, reaches a level of satisfaction and satisfaction depending on his perception of the health service provided. When this level is combined with the diagnosis and treatment services offered by the institution, the perception of quality

leads to the preference and recommendability of the institution by the masses, or vice versa.

2.2.3. Factors Affecting Patient Satisfaction

The effect of quality studies and practices on patient satisfaction is an indisputable fact accepted by all circles. In the light of this fact, while organizing all medical care processes, health institutions should first know the factors affecting patient satisfaction and make their plans within the framework of these factors. According to Altunışık et al. (2002), “highly satisfied customers tend to purchase the same product again, have lower price flexibility, remain customers for longer periods, and make positive propaganda for that product or business. Customer satisfaction is also closely related to factors such as the image of the business, sense of professionalism, speed of transaction and personality of the customer. (Tanrıverdi and Erdem, 2010:101; Altunışık et al, 2002:9).

As the satisfaction of the patients and their satisfaction with the service increase, the ratio defined as patient loyalty increases accordingly. The results of the research show that patient loyalty is closely related to patient satisfaction as well as being affected by factors such as demographic and psychological characteristics of patients, their health status and service delivery (Tanrıverdi and Erdem, 2010:102).

In order to provide patient satisfaction, which is a very important factor in patient loyalty, first of all, it is necessary to know the factors that directly affect it. "It should be noted that there is no consensus on the factors affecting patient satisfaction. This is a multidimensional concept." According to the researches, the factors affecting patient satisfaction are: doctor-patient interaction (doctor-patient relationship, nurse-patient relationship, relationship, health personnel and patient relationship), service environment (material and ecological nutrition services, comfort), bureaucracy, salary, knowledge, trust (Kavuncubaşı and Kısa, 2002:11; Tanrıverdi and Erdem, 2010:103).

The factors mentioned above are the factors arising from the institutional characteristics and the personnel serving. Apart from these important factors that affect patient satisfaction, there are also factors arising from the service recipient group, namely the patient and their relatives. In this context, it is well known that the social, cultural and psychological characteristics of patients will affect their

expectations and satisfaction from health services. These factors include the most important personality traits, perceptions, motivations, attitudes, behaviors and beliefs, degree of novelty, social status, education, culture and family relationships (Tanrıverdi and Erdem, 2010:104).

To briefly mention the factors that affect patient satisfaction in the health sector and mentioned above, the following can be said: When staff-patient interaction is mentioned, the interaction of physicians, nurses and other health personnel working in health care with the patient they serve is understood. The doctor-patient relationship is the most important determinant of patient satisfaction, as it plays an important role in these interactions in the delivery of health services. The elements of this factor are choice, ability, communication, compassion, continuity, and conflict (Tatarlı, 2007:16).

The service environment factor (physical and environmental nutrition services, comfort) is also very important.

During the period of service in health institutions, patients and their relatives want adequate comfort and quality for their other needs, especially hotel services, as well as medical service quality, and they are happy to the extent that they meet their expectations. This resulting satisfaction increases the number of loyal customers of the institution. It is very important for patients and their relatives to be informed about their health status by a doctor or nurse while receiving services from health institutions, and that this information is provided through an appropriate communication channel, for a better understanding and acceptance of their situation. Patients are especially worried and worried about the current state of their disease, the procedures to be performed, the treatment processes and the recovery time. In addition to patient satisfaction, the level of effectiveness of the health services provided can be increased with information. Thus, patients' compliance and adherence to treatment increases. For this reason, healthcare personnel should inform patients about their condition in plain, non-technical and patient-understandable terms (Tanrıverdi and Erdem, 2010:105).

Bureaucratic procedures and the time spent on these processes also affect satisfaction. While patients and their relatives are waiting for their health problems to be resolved as soon as possible, they do not want to waste time with complex and long bureaucratic procedures and do not want to be stressed in the meantime. Health

services are a service group that gains meaning with the concept of trust. Patients receiving this service want to know that the services they provide are adequate, effective and accurate and that the hospital management can provide services if the patient has confidence in the hospital (Kavuncubaşı and Kısa, 2002:12).

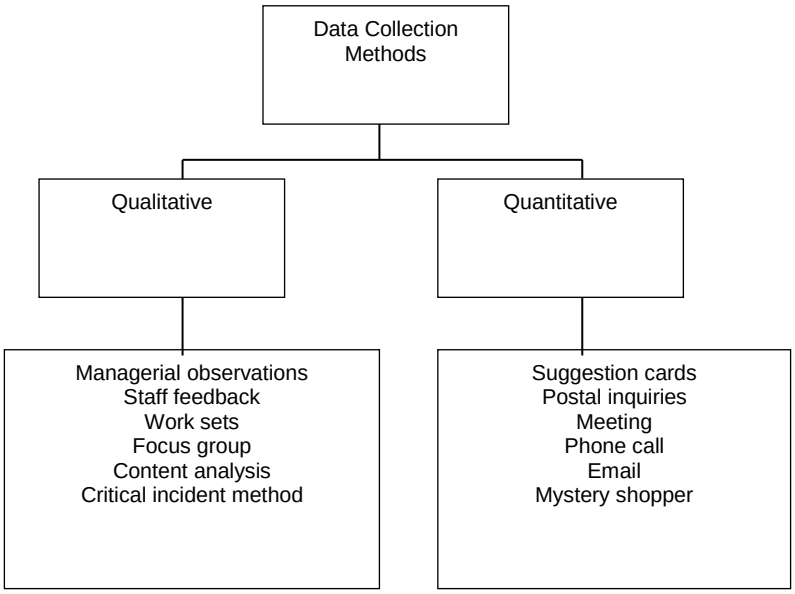
Patients want the best and quality service to be offered to them at the most affordable price possible. Although price flexibility in healthcare is low, no patient wants to face high bills. As for the factors that originate from the patients themselves and affect the level of satisfaction; The socio-cultural and psychological characteristics of patients such as personality traits, perception, motivation, beliefs and attitudes, social class, culture, education level, family relations affect service expectations and satisfaction levels (Tanrıverdi and Erdem, 2010: 106).

2.2.4. Patient Satisfaction Measurement and Evaluation Techniques

The multidimensional and complementary design of the methods used in the measurement and monitoring process in such a way as to enable access to different quality data sources eliminates the disadvantages of the techniques and helps to create a rich data source. The solution of the problems that cause problems in patient satisfaction and the corrective and preventive activities designed with an integrated approach and coordinated with measurement and monitoring methods increase the speed of improvement of service quality. Patient satisfaction measurement and evaluation methods can be grouped in two ways as direct and indirect. direct method; It is the method revealed by applying the level of satisfaction in the form of questionnaires and face-to-face interviews prepared in the light of predetermined criteria. If the indirect method is; Unlike the direct method, it is a method in which values such as "number of nurses per patient" are obtained, which the patient is not aware of but affects him or her, with the feedback given by the patient himself (Bakır, 2006: 10).

While the first of these methods has advantages such as enabling the patient's thoughts to be learned directly, guiding the issues related to the problems, and providing purposeful questions and answers, the advantages of the second method include; It can be considered as an objective, spontaneous, undirected and non-irritating method. These two methods, which are used for measurement and evaluation purposes shown in Figure 3, provide us with different types of data as

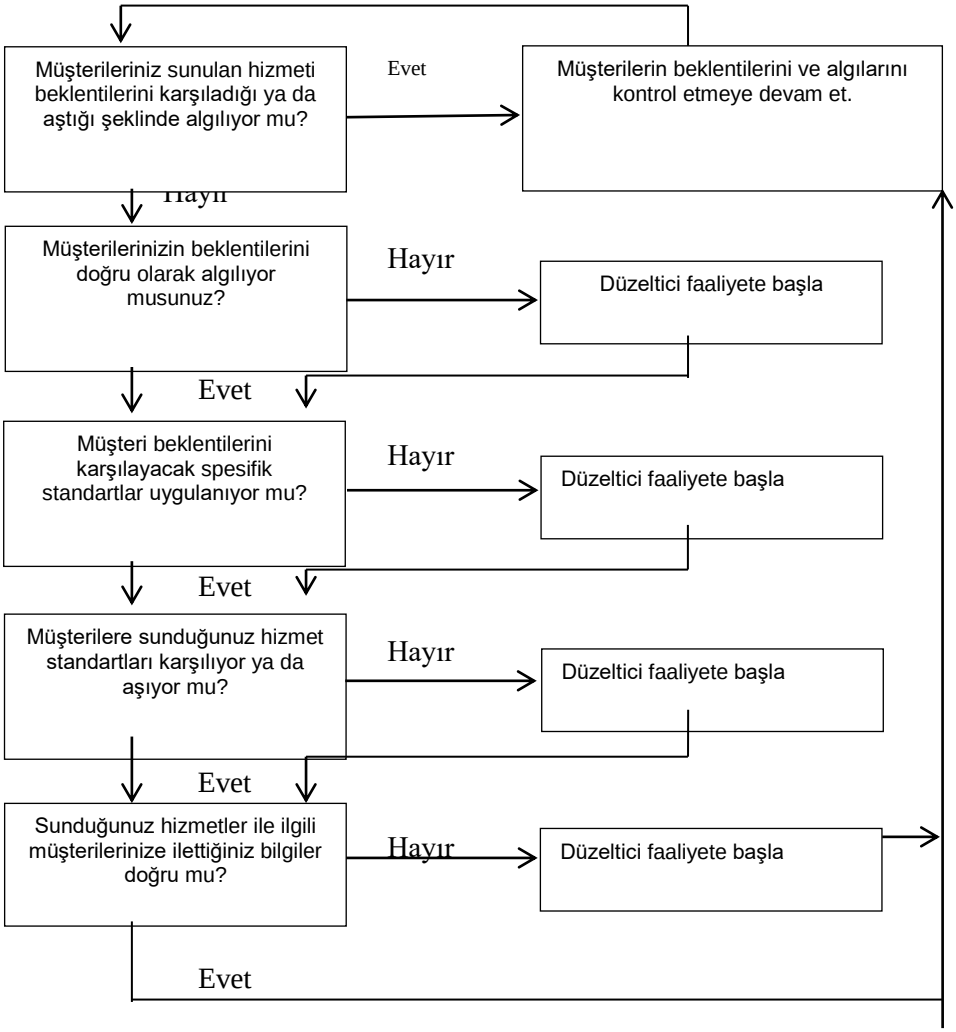
qualitative (qualitative) and quantitative (quantitative). Quantitative data, which are numerical and statistical data, are generally obtained as a result of measuring the level of patient satisfaction with measurement tools whose validity and reliability can be tested, or by monitoring measurable quality indicators, which are considered as indirect indicators of patient satisfaction. Qualitative data can be accessed through methods such as face-to-face bilateral interviews, telephone interviews, focus group interviews and observation. Both data types have advantages and disadvantages over the other. Considering these advantages and disadvantages, it is possible to say that the most reliable data can be reached by establishing an integrated measurement system in which all methods and data types are used together (Türköz, 1999: 15).



Source: *Bakır, (2006: 10).*

Figure 2.3: Patient satisfaction measurement approaches

The process model in which the health care provider can be used to continuously measure and improve the service quality that provides patient satisfaction can be designed as follows.



Source: *Zeithaml et al., (1990:20).*

Figure 2.4: Process model for continuous measurement and improvement of service quality

2.3. Total quality Management

Increasing competition conditions in the world market leave all companies that want to survive before providing customer satisfaction. This is reflected in the delivery of quality, cheap and short time goods or services that customers need (Demirdöğen, 2001: 184).

In today's market, competition is becoming more fierce and more and more international from a national perspective, the concept of quality from a commercial perspective is also changing. The content of the concept of quality is more about general excellence and perfection than the friendliness and stability of the product

under physical conditions. Appreciation, trust, meeting needs, first-class performance and satisfaction, in short, being a qualified person. Represents the main purpose of the philosophy of quality (Kanbur and Kanbur, 2008: 52).

Quality is the most economical production of products and services that can fully and consistently meet the needs and reasonable expectations of customers (Kovancı, 2003:9).

In a modern world where factors of production (resources) are limited and costs continue to increase, these framework conditions will be possible with efficient use of resources and meeting demand (Şale, 2001:13).

When it comes to quality, a product or service should have some of the features listed below (Küçük, 2004:5). Fair distribution of resources will prevent waste. Preventing waste and conscious consumption is the best solution.

- Excellence in design,
- Excellence in use
- Price excellence,
- Perfection at the time of delivery,
- Excellence in sales

As can be understood from the above elements, the concept of quality depends not only on performance, but also on the process of achieving this performance. The widespread use of the concept of quality has led to the need to modernize quality efforts, and quality efforts within the organization have become a management and organizational philosophy under the name of Total Quality Management. Total quality management, performance management, zero defect management and a management approach for 100% customer satisfaction and full involvement in the company. (Kalder, http://www.kalder.org/). It is necessary to have enormous potential to make the best use of resources using a holistic quality management philosophy.

Overall quality needs to be determined at the workplace level and its functions. Total quality management aims to outperform the quality efforts made within the organization and to place quality within the organizational culture. Although quality assurance efforts are carried out in individual parts of the organization, overall

quality management is carried out throughout the organization. For example, in addition to the medical services provided in the hospital, special attention is paid to improving the quality of hotel services. The main features of total quality management are shown below (Çatalca, 2003:9);

- The change depends on customer preferences.
- In addition to inputs and outputs, processes are focused and strong statistical analyzes are made.
- The flexible management style required in total quality management is often contrary to the management style established in the firm.
- The source of the problems in total quality management is not in the individual but in the system. In general quality management, the customer is not just the end user or buyer of the product.
- Various departments and employees in the organization or other stakeholders in the company are also customers of each other.

2.3.1. Total Quality Management in the Health Sector

Healthcare is the work done to diagnose, treat, cure or prevent diseases and improve the health of individuals and communities (Aydın and Hatırlı, 2003:2). After the 1980s, general quality management has spread rapidly in the health sector, especially in hospital services. The rapid increase in health care costs is to improve the quality and care of patients, such as excessive x-ray and imaging, cesarean section, hysterectomy, coronary transplantation and hospitalization seen in some treatment facilities (Diken, 1995:30).

Total quality management practices must be applied in health services, which are primarily related to people within the service sectors. In addition to the differences in the service sector, there are some differences in health services compared to other service types. Unlike other healthcare providers, healthcare providers have adopted social goals such as putting income behind and protecting the health of the population. Hospitals are more complex with more interest groups. There is an extreme division of labor and occupation. Coordinating working groups with different characteristics and structures is difficult. Technology is constantly evolving and changing. It is available 24 hours a day and employees often have to be more

hardworking and responsible than in other industries (Çatalca, 2003:10). All these features indicate the need for higher quality programs in the industry.

All these differences lead to some differences in total quality management practices in health services. Having a full understanding of planning and implementation makes it difficult to deal with diagnosis and treatment flexibly within the physician's personal abilities and responsibilities (Ayaz and Soykan, 2003:11). Aligning TQM with the roles of healthcare providers can eliminate real differences in healthcare.

The difference between health services and other sectors is that they are affected by morality and certain ethical values. A wide variety of customers will be met who may be older, messy, restless and vulnerable in different ways (Mohanty, Santhi and Haripriya, 1996:6). Due to this customer characteristic, the overall quality of health services becomes more important.

Tıbbi bakımın toplam kalite yönetiminin uygulanmasını etkileyen ana faktörler şunlardır: örgütsel faktörler, kişilerarası faktörler, çevresel faktörler, hedef faktörler ve ekonomik faktörler (Mohanty, Santhi and Haripriya, 1996:7). The active application of the influence of these factors will bring success.

- Organizational Factors: The number, diversity and level of people are varied; low-skilled workers and high-quality workers work together to provide services.
- Interpersonal Factors: The patient may display an irrational attitude or have low tolerance. In these cases, care should be taken to communicate with patients, their views on services and institutions should be positive, and they should be as close and relevant as possible.
- Environmental Factors: As with open systems, hospitals also have an impact on the environment. There are many groups and stakeholders.
- Facility Factors: Service facilities and equipment constitute non-human factors in health care. It has an important role in providing satisfaction as well as treatment services.
- Economic factors: Health services should be economical. The expected quality of health care can only be achieved in public hospitals when limited resources and financial resources are used effectively.

2.3.2. Positive Effects of Total Quality Management on the Organization

General quality management is a multidimensional and more comprehensive tool in addition to the tools, methods and standards used to control quality (Ortiz, Benito and Galende, 2006:28). A holistic view of the organization and the pursuit of the whole is an important feature of the overall philosophy of quality, and the results will come in the form of some positive developments that will affect the entire organization. To accept TQM operations within the organization, starting from the top management; It will increase the investment in human resources, which is the key of the organization, will prioritize time and cost quality, and will ensure that quality is understood as a fundamental goal for everyone in the organization (Ahire and O'Shaughnessy, 1998:13). The overall quality management philosophy realizes quality management experience from the enterprise level to the strategic level (Prajogo and Sohal, 2006:1). Total quality management should be taken from the top management to the lowest employee of the enterprises, which are the main part of the sectors.

2.3.2.1. Non-Financial Effects of Total Quality Management on the Organization

By understanding the overall management of quality, the concept of quality refuses to be just a definitive result or control mechanism, and becomes a management philosophy that encompasses the entire organization. With this feature, Total Quality Management makes its impact felt in a wide range from organizational structure to work. Small and medium-sized companies, especially those starting to implement TQM, will experience more change and growth than large companies (Hendricks and Singhal, 2000:10). If the changes in businesses start to show positive, this method should continue to be used more effectively.

Since TQM requires the involvement and support of senior managers, it acts as a tool to develop senior managers' leadership qualities and management skills. When TQM is implemented, senior managers will gain employee engagement through leadership, training, and self-acceptance so that organizational goals, job satisfaction, and employee self-implementation needs will be met through TQM (Snape et al, 1995: 9). The aim in their work is to achieve the goals of the Group Key Strategy under the guidance of leadership leaders.

Bringing together employees at different hierarchical levels and focusing on common goals during training and guidance activities will make a significant contribution to removing communication barriers between levels and improving quality work (Ahire and O'Shaughnessy, 1998:14). The support of management and teamwork will also have a positive effect on employee satisfaction. (Oosi et al, 2007:41). As a result of quality research, the satisfaction of the employees will increase.

Organizational culture includes a set of values and beliefs shared by the members of an organization, and these elements together with the members of the organization shape the behavior of the organization. By supporting and applying the concept of innovation embedded in total quality management, new values will be embraced within the organization such as open communication channels, risk aversion and delegation of authority (Moura and Abrunhosa, 2007:37). The ability of organizations to strengthen their unique features with a common quality depends on the efficiency of communication between businesses.

As a result of TQM operations, organizations will be flexible and self-assessed (Geraedts, Montenarie and Rijk, 2001:23). In addition to its positive impact on the organizational structure, TQM also has a positive impact on the production process with its statistical monitoring systems. Reducing the level of error in operations and products, saving time and resources, shortening the shipping time, thereby increasing the quality of a product or service, and customer satisfaction are the main positive effects that will result from improving the production process (Bayazit, 2003:34). The positive change in the organizational structure of the enterprises with the help of Total Quality Management will make the organizations more positive due to self-criticism.

2.3.2.2. Financial Effects of Total Quality Management on The Organization

Statistical application controls, which constitute the technical dimension of TQM operations, have a significant impact on reducing error rates and improving financial performance with regular planning. Efficient allocation of resources and efficient use of data are beneficial in reducing costs in an effort to improve quality (Ahire and O'Shaughnessy, 1998:15). The outlook for TQM predicts that customer satisfaction is the beginning of increased market share and profitabilit (Hendricks and Singhal, 2000:11). The highest level of decision making tools used in total quality management operations are the best way to meet human needs.

With the interest of the customer, the companies will get ahead of their competitors with their special products and prices and they will have a higher market share (Prajogo and Sohal, 2006:1). Quality is the most widely used among differentiation strategies. Because it provides competitive and financial advantage by reducing the price sensitivity of quality customers (Prajogo and Sohal, 2006:2). The products produced as a result of human-oriented research should be made in accordance with the general quality management.

Total quality Management; It will also prefer long-term and good supply relationships and financial performance. With effective supplier management, organizational costs are reduced, production cycles are shortened and raw material quality is reflected in product quality. With extensive and long-term supplier relationships, raw material and exploration costs can be reduced (Das, Paul, Swierczek and Laosirihongthong, 2006:25). The most appropriate balance between customer and supplier relations is provided by total quality management. The impact of TQM on financial performance varies depending on the characteristics of the companies.

Effects such as firm size, capital structure, product diversity, maturity of TQM operations and timing of TQM implementation will distinguish the impact of TQM on financial performance (Hendricks and Singhal, 2000:12). Continuous productivity measurements will increase the impact of practical methods on businesses.

2.3.3. Basic Elements of Total Quality Management

Although the principles of total quality management are adopted differently by each researcher, the generally emphasized principles are the same. These;

- Top management support
- Customer interest
- Leadership
- Employee engagement
- Innovation concept
- Training and development activities
- Supplier Quality Management
- Continuous improvement
- Evaluation

- Product quality
- Reward and gratitude (Şimşek and Nursoy, 2002: 2).

2.3.3.1. Top Management Support

The development of systems is the responsibility of those performing management duties; other employees work within a system defined by management. The higher the level of governance, the greater the prestige and responsibility for the development of the system. Quality is with organizations that believe, accept and obey it, and quality employees. Quality management is carried out with a sense of responsibility. Quality is an effective management style and to achieve this, organizations need leaders who accept quality and make quality a philosophy of life (Şimşek, 2001:9). As long as the management believes in quality, the attitudes of the employees towards quality will also change.

Management should not isolate itself from quality management research, on the contrary, by participating in these surveys, it should set an example for other employees of the company and encourage them to participate in these surveys. The general approach to quality management, especially the approach of senior managers to employees, plays an important role. All approaches that enable employees who value their employees' ideas and personalities to see themselves as family members form the infrastructure of the system (Swensson, 2005:2). The support of top management, which is the most important step in general quality management research, will enable employees to achieve superior scores in the production process.

Training of technical personnel, technical authorization and provision of necessary resources are elements that can and should be implemented by senior managers (Çatalca, 2003:11). Recognition of the importance of training for employees depends on the support of senior management.

2.3.3.2. Customer Focus

Customer attention is one of the most important elements of overall quality. It means doing the necessary research to understand the expectations and needs of the customer and to offer a product or service that meets these requirements. To be a leading organization in a dynamic and competitive environment, you need to be better positioned than a business competitor. Better product or service, better prices and easier product. The key to Japan's success lies in customer preferences in terms

of business strategy (Lagrosen, 2001:2). The human focus, which forms the basis of total quality management, ensures that the needs of the customers are met in the best way possible.

2.3.3.3. Leadership

Leadership is about influencing people who unite for common goals under certain conditions to achieve goals. Leaders have a role to play in bringing new values to the organization. Developing the effectiveness and skills of individuals in groups depends on leaders who motivate and guide them (Ören, 2002:9). In overall quality management, senior managers should best fulfill their leadership roles and motivate employees as organizers in teamwork (Chiu, 1999:2). Leaders have a large role to play in adopting overall quality management for organizations.

2.3.3.4. Employee Engagement

The aim of total participation is to achieve the highest synergy by creating an environment conducive to teamwork. Business is a large system of people and organizations. The overall connectivity of people working in the organization is determined by planning. Each team prepares its own plans according to the aims and objectives of the study. People can create opportunities to produce more effective solutions with different perspectives and teamwork. One of the most important issues in teamwork is flexibility. An agreement is reached when a group of people decide to support the work together. Teams should work together to reach a common conclusion and support the decision they see fit (Lagrosen, 2001:3). Participation will increase the effectiveness of ideas or experiences that need to be embedded in organizations.

2.3.3.5. The Concept of Innovation in Total Quality Management

To innovate in the organization; Supplier compliance, organizational flexibility, presence of key innovation drivers, business teams, a well-functioning communication system and a tight data flow are key factors (Ortiz, Benito and Galende, 2006:29). These factors work as a result of innovative thinking embedded in organizations.

2.3.3.6. Training and Development Activities

The tuition fee is low when combined with the positive results and benefits (Das, Paul, Swierczek and Laosirihongthong, 2006:26). In addition to enabling employees

to learn and learn from quality experiences, their satisfaction level from training activities can also increase. Therefore, training and development activities should be seen as an investment in the employees of the companies (Yaman, Moussa and Ergün, 2005:6). Seeing cost effectiveness as a disadvantage will reduce the effectiveness of training activities.

2.3.3.7. Supplier Quality Management

Another important factor related to the concept of quality in total quality management is the technical imperfection of the products or services offered and the fixed cost of maintaining financial performance. The materials and equipment to be used in the production process are the main components of the product or service offered and are directly related to the quality of the product. The criteria for choosing a supplier depend not only on prices, but also on production costs, quality, use of time and technology. These criteria may include after-service support, continuity and transaction costs (Swinehart and Green, 1995:3). Choosing a supplier according to the structure of the business will both reduce costs and save time.

2.3.3.8. Continuous improvement

According to the philosophy of continuous improvement, all employees from top to bottom play an important role in quality assurance. Misunderstandings and problems are caused by the system, not the personnel. Therefore, the overall system needs to be reviewed, improved and reviewed (Çatalca, 2003:12). The future and efficiency of systems depend on the consistent tracking and integration of innovations.

2.3.3.9. Benchmarking

Benchmarking is a quality improvement strategy that aims to identify and adapt the best practices, organizational structures and behaviors of top performing companies (London and Higgot, 1997:2). Although this system may seem like one of the easiest, training is a must. Educational work should be intensified.

2.3.3.10. Product Quality

The quality of the product is not only the product of the final product, but also an element that must be monitored in all the activities of the company. Every process, high quality product or service within the organization must be transferred to the next job. In this way, quality continuity will be ensured within the organization and efforts to improve product quality will be effective in reducing production costs by

eliminating operational errors. The quality of the manufacturing process will also lead to the quality of the product. Four basic product quality criteria are used to prevent possible errors and to determine the quality of the product before proceeding to the next step; durability, reliability, productivity, convenience (Das, Paul, Swierczek and Laosirihongthong, 2006:27). Consistent application of total quality management methods improves the quality of the product.

2.3.3.11. Reward and Gratitude

One of the conditions that will motivate employees and reflect on customer satisfaction during general quality management activities is rewarding and recognition (Das, Paul, Swierczek and Laosirihongthong, 2006:28). Increasing patient satisfaction and rewarding service quality requires general quality management in the health sector.

2.4. Scope of Hospitality Services in Health Institutions

Today's health institutions have tried to make a difference by raising the quality of health services in order to increase patient / customer satisfaction, by making an effort to provide a good hotel service by applying different practices in service delivery. Considering the health policies, the competitive element has been revealed by aiming to develop the health hotel management in a forward-looking way. With the emerging competition, it is seen that in 2012, one of the aims of the health transformation project, comfortable, peaceful and various services in the hotels are also applied in the health facilities and it is desired to increase the patient/customer satisfaction to the highest levels. The services provided by health institutions for the purpose of meeting personal and social needs, as well as treatment, fall within the scope of the service sector.

In the study conducted by Akdu et al. in 2016, it was aimed to add a new perspective to health hotel management in health institutions by considering the services that guests will need to use personally. This study aims to increase patient/customer satisfaction by reaching the information that the rooms where patients/customers stay should be arranged in the comfort of a hotel room, and the materials kept for use in the room should be evaluated and determined in terms of functionality (Kozak and Gülenç, 2017: 2).

In the age we live in, that is, the hotel services offered in healthcare establishments that are suitable for today require an efficient, effective and good experience. Considering the structural formations of health institutions, it is formed by bringing together and managing constantly functioning systems. An important point to be considered in health institutions is that services such as equipment, maintenance and medical techniques are carried out by experts in order to increase satisfaction. This will make a difference in terms of increasing satisfaction with the service offered and providing quality service.

Since health institutions are structures formed by the combination of more than one system, the activities of each department may vary according to smaller enterprises in terms of forming an effective and efficient management style, considering their size and bed capacity (Kozak and Gülenç, 2017:15).

With the health transformation project, the foundation of which was laid in 2012, the general secretariats, which were renewed and revealed in all provinces of the country, were connected to the administration of the Public Hospitals Union, and the management of the enterprises affiliated to the Ministry of Health were gathered under a single organizational structure. With this management style, it is seen that the organizational structure of the enterprises is arranged in such a way that the medical care services and administrative financial affairs directorate will be replaced by the hotel services and quality directorate. The hotel services directorate, which seems to be the beginning of the new era, has made arrangements to make its patients/customers feel comfortable and at home, and to increase patient/customer satisfaction by providing the comfortable service that a hotel offers to its guests. In order to organize the management of these services, people with experience in hotel management in the private and public sectors were employed (Karahan, 2008:155).

2.4.1. Front Office Services

Front office services in health institutions are known as welcome and consultation, and it is an important area where you get information and carry out your transactions, starting from the moment you step into the institution and during the service process, if you are going to spend your treatment process in the inpatient category, during your accommodation and until you leave the institution. It is the front of the health institution. It is the section that is seen as the central area where all procedures

including hospitalization and discharge of the patient to be treated are carried out, information gathering and sharing this information with the necessary persons and units. It is the area where patients and their relatives, who receive front desk service, are in first contact when they come to the health institution. In general, services such as assisting the patient/customer to settle into the clinic and room where they will be examined are provided, together with the process of getting the information of all the needs of the patients and their relatives, by providing an accompanying person to the departments they want to receive service with (Erdem et al, 2008:95).

2.4.2. Food and Beverage Services

One of the most important service areas offered within the scope of hotel management services in health institutions is food/beverage services. Nutrition is an indispensable basic requirement for every living thing during their lifetime. Adequate and balanced nutrition is one of the basic needs and conditions for people to stay healthy, protect and improve their health, and develop socially. Food/beverage services are of great importance not only for the patients and their companions treated in the health institution, but also for the personnel working in the institution. Creating food menus and delivering the quality of the food served on time and to the required places is an extremely important service delivery stage. All health institutions are obliged to provide quality services to the patients and their relatives, and to the personnel who provide service (Karahan, 2008:156).

2.4.3. Housekeeping

Due to the high expectations of patients and their relatives in the field of health sector in our age, it has emerged that there is a need for professional housekeeping services for quality service delivery. The housekeeping department, especially offered in health institutions, is considered a very important unit. The reason for this is that the length of stay of the patient and patient relatives in the health institution varies depending on the health status of the patient, and the patient spends time in his room during the time he stays in the health institution. The relatives of the patient also spend time in the room of the patient receiving treatment and in other areas of the health institution. In addition to the cleanliness of the patient/customer rooms and the furniture in the rooms, the general areas such as the inside of the waiting rooms, corridors and elevators in the health institutions of the housekeeping department, in

the businesses that offer medical services with beds, the beds and sheets of the patients and their relatives are clean, It is an important service section that covers all of the services that provide the healthy service in the environment, such as the creation of the necessary order and the decoration of the health institution (Tunç and Sevin, 2000:2).

2.4.4. Cleaning services

Cleaning is the removal of substances such as dust and dirt that will endanger people's health from the environment. It is one of the most important issues for health institutions. Cleaning service operation should be well planned, managed and executed. Cleaning services are of great importance in terms of protecting patients and their relatives, service providers from infections that may arise in the health institution, ensuring the quality of the service and ensuring the continuity of the quality. It has been demonstrated by many studies that cleaning services are effective and increase satisfaction in the preferences of health institutions depending on the best level and quality of the cleaning service offered to patients and their relatives who come to health institutions and are described as customers. For this reason, it is possible to say that the opposite situation, that is, insufficient cleaning service delivery, causes dissatisfaction in terms of patients and their relatives (Tengilimoğlu, 2013: 91).

2.4.5. Security services

Society wants to be able to live fearlessly and peacefully, in other words to feel safe. After the physical needs of life, one of the most desired emotional impulses is trust. Since health institutions offer public services, they are easily accessible to everyone, and although they have a complex structure, they have many personnel working in different fields. However, this feature of health institutions, where everyone can easily reach, also increases the possibility of people who are intentionally or inclined to commit crimes to reach the institutions and harm the people around them. One of the most important requirements is to ensure the safety of patients and their relatives, working personnel, served in health institutions. Ensuring the complete building security of the institution should be ensured that the patients and their relatives, health institution employees are in a safe environment (Tengilimoğlu, 2013:107).

2.4.6. Other Support Services

Restaurants and canteens are areas that contribute to increasing satisfaction in providing quality service. These areas, located in the garden or inside the building of health institutions, are the sections where the relatives of the patients rest, meet their food/drink needs and socialize. Since private health institutions have luxurious architectural structures, they provide quality service to patients' relatives and institution employees by providing a relaxing environment with a pleasant design. This department, which provides service 24 hours a day, 7 days a week, provides domestic and international calls to the personnel working in the health institution. They help to establish contact with the necessary units in order to transfer information to patients and their relatives calling from outside. In addition, they facilitate the operation by enabling the employees in the health institution to communicate with the places they need to meet while providing health services. Parking areas in health institutions are offered to patients, health institution employees, patients and visitors of institution employees. Employees providing this service should act in harmony with the employees of the health institution providing security services. Because it is necessary to prevent the accumulation of vehicles at the emergency entrances and main entrances of the health institution (Tengilimoğlu, 2013:98).

CHAPTER 3
METHOD

In this section, the aim and scope of the research, its question and model, its rationale and level of analysis and research method will be given.

3.1. Research Model and Hypotheses

This research is a descriptive research. In the research, the relational screening model was preferred to examine the mediator effect of hotel services on the relationship between leadership styles in hospitals and patient satisfaction and service quality, within the framework of the views of health managers, health workers, outpatients and inpatients of public and private hospitals, which have a hierarchical structure. Relational screening model; It is generally used to determine the presence and amount of interaction between multiple variables. These relationships can be determined with the help of statistical methods such as correlation, t-test, analysis of variance and multiple regression (Büyüköztürk, 2016:12).

Detailed research questions regarding the stated research are expressed as follows.

Do hotel services have a mediating role in the leadership styles, patient satisfaction and service quality in hospitals within the framework of the views of health leaders, employees, outpatients and inpatients?

Within the framework of the views of health leaders, employees, outpatients and inpatients, are the leadership styles and patient satisfaction and service quality in hospitals affected by sociodemographic variables?

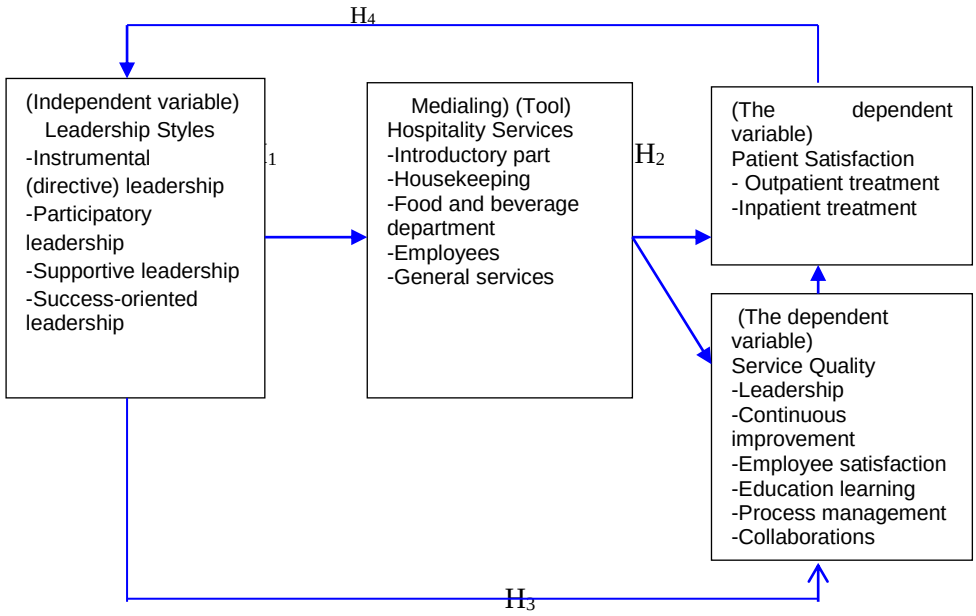


Figure 3.5: Dependent and independent variables with the design of the study

Based on our research model shown in Figure 3.5, the following hypotheses have been developed to determine whether the leadership styles and patient satisfaction and service quality of hotel services will differ according to sociodemographic variables within the framework of the views of health leaders, employees, outpatients and inpatients (Annex 2).

The basic hypothesis: Hospitality services have a mediating role in the leadership styles and patient satisfaction and service quality in hospitals within the framework of the views of health leaders, employees, outpatients and inpatients, and they differ according to socio-demographic variables.

3.2. Universe, Sampling and Selection

The numbers related to the population and sample between 09 April and 09 May 2018, when the research was conducted, are given in Table 3.7 and Table 3.8.

Table 3.7: Number of employees participating in the research

Number of participants between 09 April – 09 May 2018						
Hospital name	**Manager**	**Employee**	**Total**	**Research Participating Manager**	**Employee Participating in the Research**	**Total**
Fethiye State Hospital	60	700	760	15	95	110
Private Lokman Hekim Esnaf Hospital	12	345	367	12	176	188

Private Letoon Hospital	10	237	247	4	70	74
Total	**82**	**1282**	**1374**	**31**	**341**	**372**

Table 3.7 shows the number of managers and employees of Fethiye State Hospital, Private Lokman Hekim Esnaf Hospital and Private Letoon Hospital in Fethiye district of Muğla province, where the research was conducted, between 09 April - 09 May 2018, and the number of participants in the research. According to this;

The total number of employees of Fethiye State Hospital is 760. There are 60 managers and 700 employees. A total of 110 people, 15 from managers and 95 from employees, participated in the research.

The total number of employees of Private Lokman Hekim Esnaf Hospital is 367. There are 12 managers and 345 employees. A total of 188 people, 12 from managers and 176 from employees, participated in the research.

The total number of employees of Private Letoon Hospital is 247. There are 10 managers and 237 employees. 74 people, 4 from the managers and 70 from the employees, participated in the research.

The total number of employees in the hospitals where the research was conducted is 1374. There are 82 managers and 1282 employees. A total of 372 people, 31 from the managers and 241 from the employees, participated in the research.

Table 3.8: Number of patients participating in the study

	Outpatient Patient	**Patient with Inpatient Treatment**	**Total Patient**	**Participating Outpatient Patient**	**Participating Yatan Hasta**	**Participating Toplam**
Hospital name						
Fethiye State Hospital	63.627	1.291	64.918	51	64	115
Private Lokman Hekim Esnaf Hospital	26.593	1.089	27.682	28	17	45
Private Letoon Hospital	11.465	432	11.897	21	19	40
Total	**101.685**	**2.812**	**104.497**	**100**	**100**	**200**

Table 3.8 shows the number of patients who applied to Fethiye State Hospital, Private Lokman Hekim Esnaf Hospital and Private Letoon Hospital in Fethiye district of Muğla province, where the research was conducted, between 09 April - 09 May 2018, and the number of participants in the research. According to this;

Fethiye Devlet Hastanesi toplam hasta sayısı 64.918'dir. 63.627 hasta ayakta, 1.291 hasta ise yatarak tedavi görmüştür. Araştırmaya ayakta tedavi gören hastalardan 51, yatarak tedavi gören hastalardan 64 kişi olmak üzere 115 hasta katılmıştır.

The total number of patients at Private Lokman Hekim Esnaf Hospital is 27,682. 26,593 patients received outpatient treatment and 1,089 patients received inpatient treatment. A total of 45 patients, 28 from outpatients and 17 from inpatients, participated in the study.

The total number of patients at Private Letoon Hospital is 11,897. 11,465 patients received outpatient treatment and 432 patients received inpatient treatment. Forty patients, 21 from outpatients and 19 from inpatients, participated in the study.

The total number of patients in the hospitals where the research was conducted was 104,497. 101,685 patients received outpatient treatment and 2,812 patients received inpatient treatment. 200 patients, 100 from outpatients and 100 from inpatients, participated in the study.

Among these patients, 372 people, 31 of the managers and 241 of the employees, in the hospitals where the research was conducted, due to the tourism intensity experienced between **09 April and 09 May 2018**, the excessive workload of health workers and the unwillingness of patients to participate in the study, and they did not volunteer with the easy sampling method. 200 patients, 100 from patients receiving treatment and 100 from patients receiving inpatient treatment, participated in the study.

3.3. Data Collection Tools of the Research

Obtaining research data; Socio-Demographic Data Form, Leadership Behaviors Scale, Patient Satisfaction Questionnaire (Outstanding) and Patient Satisfaction Questionnaire (Inpatient), Total Quality Management Scale, Hospital Hotel Management Scale provided using.

3.3.1. Socio-Demographic Data Form

In the Socio-Demographic Data Form developed by the researcher, health managers and employees gender, age, marital status, educational status, services it runs, duties, working hours in their positions, total professional experience, outpatients and inpatients gender, age, educational status, professions and social security is asked.

3.3.2. Leadership Behaviors Scale

As a result of the Factor Analysis conducted in the article titled "A Field Study to Determine the Effect of Leadership Behaviors in Hospitals on Employee Job Satisfaction" by Tengilimoğlu and Yiğit (2005: 382-390) on the Leadership Behaviors Scale, the leadership styles of managers can be gathered in four main dimensions.

These are: (1) the "instrumental (directive) leadership" style, which focuses on work, (2) the "participatory leadership" style, which trusts the knowledge and experience of subordinates and allows them to participate in decisions, and (3) the "participatory leadership" style, which constantly helps their subordinates and takes care of their well-being and happiness. “supportive leadership” style (4) was determined as “achievement-oriented leadership” style that encourages subordinates to grow, is open to innovations and allows performance improvement.

These identified leadership styles are consistent with those identified by House and Mitchell (1982), Umstot (1984) and Randolph (1985). Leadership behaviors were examined in four dimensions by House and Mitchell (1982), Umstot (1984) and Randolph (1985). It consists of 34 expressions in total. Questions in this scale were measured with a five-point Likert scale. The scale means "1-never", "2-rarely", "3-sometimes", "4-often", "5-constantly". These four leadership styles are taken from the previous study and the variables are given below.

Variables in the supportive leadership dimension:

1. It provides order,
2. It is consistent,
3. encourages new ideas,
4. Open to criticism
5. Does not avoid taking risks while making decisions,
6. He has an open and honest method,
7. It is reassuring,
8. Enjoys discussing new ideas
9. He is friendly,
10. He always knows who is responsible for what,
11. He makes plans for the future.

Variables in the directive leadership dimension:

1. Gives clear instructions
2. Respects subordinates as individuals
3. Examines events and does not take decisions without thinking
4. Introduces new and different ideas in the implementation of works
5. Creates opportunities to eliminate conflicts
6. Flexible and open to change
7. Treats his subordinates fairly
8. The work is meticulous in the supervision
9. Makes quick decisions when needed
10. Gives subordinates a say in decision making
11. Gives importance to complying with rules and principles
12. Makes plans carefully.

Variables in the achievement-oriented leadership dimension:

1. Encourages growth
2. Their purpose is clear
3. Appreciates good work
4. Gives importance to the opinions of others
5. Generates new projects
6. It is open to innovations.

Variables in the participatory leadership dimension:

1. Trusts his subordinates
2. Defends his subordinates
3. Creates a friendly atmosphere away from arguments
4. Meticulously dwells on the plans being implemented
5. Listens to the ideas and suggestions of others.

3.3.3. Patient Satisfaction Questionnaire (Outstanding and Inpatient)

Outpatient and inpatient satisfaction surveys were prepared using the study of Tokul (2014: 20). T.R. The original patient satisfaction questionnaire of the Ministry of Health was used in the preparation of this questionnaire. Outpatient satisfaction surveys consist of 19 questions and inpatient satisfaction surveys consist of 17 questions.

3.3.4. Total Quality Management Scale

There is the TQM scale, which was developed by Grandzol and Gershon (1998) and adapted into Turkish by Çetin and Özçakar (2014:351) and aims to measure the activities related to TQM. It consists of 39 questions in total. Scale; leadership (5 items), continuous improvement (4 items), employee satisfaction (5 items), training-learning (5 items), process management (8 items), collaborations (8 items) and customer orientation (4 items) sub-dimensions. Questions in this scale were measured with a five-point Likert scale. In the scale: 1: strongly disagree, 2: disagree, 3: neither agree nor disagree, 4: agree, 5: strongly agree.

3.3.5. Hospital Hotel Management Scale

Similar studies were used to develop the hospital hotel services survey form (Koçbek, 2005:9; Emir, 2007:45; Murat and Çelik, 2007:20; Tayfun and Kara 2007:273; Yılmaz et al., 2007:234; Keskin, 2008: 23). ; Sandıkçı, 2008: 42; Karakaya, 2009:16; Shengelbayeva, 2009: 46). The scale consists of 33 questions in total.

3.4. Data Analysis

The data related to the research subject were obtained from primary sources.

The scales of this study were applied to health managers, health workers, outpatient and inpatient patients. Participants were informed with the Voluntary Participation Form and their consent was obtained. No application was made to the participants who did not give their consent. There are 158 statements in the questionnaires consisting of 5 scales in total. It takes approximately 20 minutes to complete the questionnaire. The data were obtained by the researcher as a result of face-to-face interviews with health managers, health workers, outpatients and inpatients between 09.04 and 09.05.2018.

The data obtained in this study were analyzed in the Statistical Package for Social Sciences (SPSS) 19.0 program.

Before the statistical analyzes were passed, Leadership Behaviors Scale, Patient Satisfaction Questionnaire (Outstanding) and Patient Satisfaction Questionnaire (Inpatient), Total Quality Management Scale, Hospital Hotel Management Scale Cronbach's Alpha values were determined.

Frequency analysis was used to determine the socio-demographic characteristics of health managers, health workers, outpatients and inpatients included in the study.

Mean, standard deviation, lower and upper values, which are descriptive statistics for Leadership Behaviors Scale, Patient Satisfaction Questionnaire (Outstanding) and Patient Satisfaction Questionnaire (Inpatient), Total Quality Management Scale, Hospital Hotel Management Scale scores are shown.

Parametric hypothesis tests were used to statistically compare the difference between the scores of the Leadership Behaviors Scale, Patient Satisfaction Questionnaire (Outstanding) and Patient Satisfaction Questionnaire (Inpatient), Total Quality Management Scale, Hospital Hotel Management Scale according to the socio-demographic characteristics of healthcare professionals, outpatients and inpatients.

During the decision to use parametric hypothesis tests in these comparisons, the normal distribution of the scores obtained from the scales was examined with the Kolmogorov-Smirnov test and the skewness-kurtosis coefficients, and it was found that they showed normal distribution. In the comparisons, if the number of categories of the independent variables is two, the independent sample t-test was used, while ANOVA was used to compare the scale scores according to the independent variables consisting of more than two categories. Tukey test was preferred as a post-hoc test to determine which of the different categories were. Relationships between Leadership Behaviors Scale, Patient Satisfaction Questionnaire (Outstanding) and Patient Satisfaction Questionnaire (Inpatient), Total Quality Management Scale, Hospital Hotel Management Scale scores were tested with Pearson correlation analysis since the data set showed a normal distribution, and the prediction status was examined with linear regression.

CHAPTER 4
FINDINGS

The findings regarding the mediating effect of hotel management services on the effect of leadership styles put forward in hospitals on patient satisfaction and service quality within the framework of the opinions of health managers, health workers, outpatients and inpatients are given below.

4.1. Findings Related to Socio-Demographic Characteristics

4.1.1. Health Managers

The tables regarding the socio-demographic characteristics of the health managers of Fethiye State Hospital, Private Letoon Hospital and Private Lokman Hekim Esnaf Hospital are given below.

Table 4.9: Distribution of health administrators by demographic status (n=31)

	Number (n)	Percent (%)
Hospital name		
Fethiye State Hospital	15	48,4
Private Lokman Hekim Esnaf Hospital	12	38,7
Private Letoon Hospital	4	12,9
Gender		
Woman	17	54,8
Male	14	45,2
Age		
17-24	10	32,3
25-34	16	51,6
35 and above	5	16,1
Marital status		
Married	10	32,3
Single	21	67,7
Educational status		
Health vocational high School	8	25,8
Associate degree	4	12,9
Licence	5	16,1
Degree	8	25,8
Doctorate	6	19,4
Total	**31**	**100,0**

When Table 4.9 is examined, according to the hospitals where the health managers included in the research work; 48.4% Fethiye State Hospital, 38.7% Private Lokman Hekim Esnaf Hospital and 12.9% Private Letoon Hospital, according to their gender; 54.8% (n=17) were woman, 45.2% (n=14) were male, according to their age; 32.3% (n=10) are between 17-24 years old, 51.6% (n=16) were between the ages of 25-34, 16.1% (n=5) were aged 35 and over, according to their marital status; 32.3% (n=10) were married, 67.7% (n=21) were single, according to their educational status; 25.8% (n=8) of them were Health Vocational High School, 12.9% (n=4) associate

degree, 16.1% (n=5) undergraduate, 25.8% (n=8) of them are graduates, 19.4% (n=6) had a doctorate.

Table 4.10: Distribution of health administrators by demographic status (n=31) (Continue)

	Number (n)	**Percent (%)**
Service running		
Internal medicine	7	22,6
Other	24	77,4
Duty		
Specialist doctor	10	32,3
Chief Physician	3	9,7
Assistant chief physician	3	9,7
Administrative Financial Affairs Manager	3	9,7
Assistant Manager of Administrative Financial Affairs	2	6,5
Other	10	32,3
Management task		
Manager	16	51,6
Chief Physician	3	9,7
Deputy chief physician	3	9,7
Administrative Financial Affairs Manager	3	9,7
Health Care Services Manager	2	6,5
Assistant Manager of Administrative Financial Affairs	2	6,5
Deputy Director of Health Care Services	2	6,5
Total	**31**	**100,0**

When Table 4.10 is examined, it is seen that the health administrators included in the research according to the services they work for; 22.6% (n=7) Internal Medicine and 77.4% (n=24) other services, according to their duties; 32.3% (n=10) were specialist doctors, 9.7% (n=3) Chief Physician, 9.7% (n=3) Deputy Chief Physician, 9.7% (n=3) Administrative Financial Affairs Manager, 6.5% (n=2) Assistant Administrative Financial Affairs Manager, 32.3% (n=10) are other managers. According to management duties; 51,6 of them (n= 16) were Managers, 9.7% (n=3) Chief Physician, 9.7% (n=3) Deputy Chief Physician, 9.7% (n=3) Administrative Financial Affairs Manager, 6.5% (n=2) Health Care Services Manager, 6.5% (n=2) Assistant Administrative Financial Affairs Manager and 6.5% (n=2) are Deputy Health Care Services Managers.

Table 4.11: Distribution of health administrators by demographic status (n=31) (Continue)

	Number (n)	Percent (%)
Working time in current position		
0-5 years	24	77.4
6-10 years	5	16.1
11-15 years	2	6.5
Total professional experience period		
0-5 years	18	58.1
6-10 years	8	25.8
11-15 years	2	6.5
16-20 years	3	9.7
Total	**31**	**100,0**

When Table 4.11 is examined, according to the working hours of the health managers included in the research; 77.4% (n=24) 0-5 years, 16.1% (n=5) are between 6-10 years, 6.5% (n=2) between 11-15 years, according to their total professional experience; 58.1% (n=18) were between 0-5 years, 25.8% (n=8) are between 6-10 years, 6.5% (n=2) between 11-15 years, 9.7% (n=3) are between 16-20 years.

4.1.2. Health workers

The tables regarding the socio-demographic characteristics of the health workers of Fethiye State Hospital, Private Letoon Hospital and Private Lokman Hekim Esnaf Hospital are given below.

Table 4.12: Distribution of health workers by demographic status (n=341)

	Number (n)	Percent (%)
Hospital name		
Fethiye State Hospital	95	27,9
Private Lokman Hekim Esnaf Hospital	176	51,6
Private Letoon Hospital	70	20,5
Gender		
Woman	229	67,2
Male	122	32,8
Age		
17-24	93	27,3
25-34	164	48,1
35 and above	84	24,6
Marital status		
Married	191	56,0
Single	150	44,0
Educational status		
Health vocational high School	142	41,6
Associate degree	102	29,9
Licence	84	24,6
Degree	7	2,1
Doctorate	6	1,8
Total	**341**	**100,0**

When Table 4.12 is examined, it is seen that the health workers included in the research according to the hospitals where they work; 27.9% of Fethiye State Hospital, 51.6% of them are Private Lokman Hekim Esnaf Hospital and
20.5% Private Letoon Hospital, according to their gender; 67.2% (n=229) were woman, 32.8% (n=122) were male, according to their age; 27.3% (n=93) were between the ages of 17-24, 48.1% (n=164) were between the ages of 25-34, 24.6% (n=84) were aged 35 and over, according to their marital status; 56.0% (n=191) were married, 44.0% (n=150) were single, according to their educational status; 41.6% (n=142) of them were Health Vocational High School, 29.9% (n=102) associate degree, 24.6% (n=84) undergraduate, 2.1% (n=7) of them are graduates 1.8% (n=6) had a doctorate.

Table 4.13: Distribution of health workers by demographic status (n=341) (Continue)

Service running	**Number (n)**	**Percent (%)**
Anesthesia	30	8,8
Urology	3	0,9
Dermis	8	2,3
Pediatry	9	2,6
Internal medicine	67	19,6
Infectious Diseases	6	1,8
Physical therapy and rehabilitation	6	1,8
General Surgery	36	10,6
Thoracic Surgery	6	1,8
Eye diseases	6	1,8
First and Emergency Aid	36	10,6
Gynecology and Obstetrics	4	1,2
Cardiology	3	0,9
ENT	9	2,6
Neurology	20	5,9
Neurosurgery	23	6,7
Radiology	19	5,6
Orthopedics and Traumatology	6	1,8
Other	44	12,9
Duty		
Nurse	126	37,0
Midwife	18	5,3
Lab Technician	11	3,2
Health Officer	6	1,8
Specialist Doctor	72	21,1
Emergency medical technician	57	16,7
Physiotherapist	14	4,1
Anesthesia Technician	15	4,4
General practitioner	13	3,8
Other	9	2,6

When Table 4.13 is examined, it is seen that the health workers included in the research according to the services they work for; 8.8% (n=30) Anesthesia, 0.9% (n=3) Urology, 2.3% (n=8) Dermatitis, 2.6% (n=9) Pediatric Diseases, 19.6% (n=71) Internal Medicine, 1.8% (n=6) Infectious Diseases, 1.8% (n=6) Physical Therapy and

Rehabilitation, 10.6% (n=36) General Surgery, 1.8% (n=6) Thoracic Surgery, 1.8% (n=6) Eye Diseases, 10.6% (n=36) First and Emergency Aid, 1.2% (n=4) Gynecology and Obstetrics, 0.9% (n=3) Cardiology, 2.6% (n=9) ENT, 5.9% (n=20) Neurology, 6.7% (n=23) Neurosurgery, 5.6% (n=19) Radiology, 1.8% (n=6) Orthopedics and Traumatology, 12.9% (n=44) Other Services, according to their duties; 37.0% (n=126) Nurses, 5.3% (n=18) Midwives, 3.2% (n=11) Laboratory Technician, 1.8% (n=6) Medical Officers, 21.1% (n=72) Specialist Doctor, 16.7% (n=57) of them had ATT, 4.1% (n=14) Physiotherapists, 4.4% (n=15) Anesthesia Technician, 3.8% (n=13) Practitioners and 2.6% (n=9) are other tasks.

Table 4.14: Distribution of health workers by demographic status (n=341) (Continue)

	Number (n)	**Percent (%)**
Working time in position		
0-5 year	190	55,7
6-10 year	90	26,4
11-15 year	39	11,4
16-20 year	9	2,6
21 year and above	13	3,8
Total period of professional experience		
0-5 year	141	41,3
6-10 year	115	33,7
11-15 year	28	8,2
16-20 year	34	10,0
21 year and above	23	6,7
Total	**341**	**100,0**

When Table 4.14 is examined, according to the working hours of the health workers included in the research; 55.7% (n=190) 0-5 years, 26.4% (n=90) were between 6-10 years, 11.4% (n=39) were between 11-15 years, 2.6% (n=9) 16-20 years and 3.8% (n=13) were 21 years and over, according to their total professional experience; 41.3% (n=141) were between 0-5 years, 33.7% (n=115) are between 6-10 years, 8.2% (n=28) between 11-15 years, 10.0% (n=34) 16-20 years and 6.7 (n=23) of them are 21 years and over.

4.1.3. Outpatient and Inpatient Treatment

Table 4.15: Demographic distribution of patients (n=200)

	in outpatient		**inpatient treatment**	
	Number (n)	**Percent (%)**	**Number (n)**	**Percent (%)**
Hospital name				
Fethiye State Hospital	51	51,0	64	64,0

Private Lokman Hekim Esnaf Hospital	28	28,0	17	17,0
Private Letoon Hospital	21	21,0	19	19,0
Gender				
Woman	56	56,0	44	44,0
Male	44	44,0	56	56,0
Age				
18-25	29	29,0	18	18,0
26-40	30	30,0	38	38,0
41-50	21	21,0	9	9,0
51-65	12	12,0	13	13,0
66 and above	8	8,0	22	22,0
Education level				
Illiterate	13	13,0	12	12,0
Primary school	20	20,0	29	29,0
Middle School	8	8,0	6	6,0
High School and Equivalent School	30	30,0	25	25,0
University and above	29	29,0	28	28,0
Profession				
Self Employed (Other)	34	34,0	21	21,0
Employee	23	23,0	32	32,0
Officer	21	21,0	19	19,0
Retired	7	7,0	6	6,0
Housewife	8	8,0	12	12,0
Unemployed	7	7,0	10	10,0
Social security				
Employees subject to SSI	82	82,0	48	48,0
Retired subject to SSI	10	10,0	23	23,0
Green card	2	2,0	6	6,0
No social security	4	4,0	1	1,0
Other (Private, Bağ-Kur, Abroad)	2	2,0	22	22,0

When Table 4.15 is examined, among the hospitals that are the subject of the research, 51.1% for outpatient treatment, 64.0% for inpatient treatment to Fethiye State Hospital. Private Lokman Hekim Esnaf Hospital 28.0% for outpatient treatment, 17.0% for inpatient treatment, It was determined that 21.0% for outpatient treatment and 19.0% for inpatient treatment were paid to the Private Letoon Hospital Hospital. Outpatients; 56.0% are women, 44.0% are male, 29.0% of them are between the ages of 18-25, 30.0% of them are between the ages of 26-40, 21.0% of them are between the ages of 41-50, 12.0% of them are between 51-65 years old, 8.0% are 66 years and over, 13.0% are illiterate, 20.0% of them are primary school graduates, 8.0% are secondary school graduates, 30.0% of them are high school or equivalent school graduates, 29.0% of them graduated from university and above, 34.0% are self-employed (other), 23.0% are workers, 21.0% are civil servants, 7.0% are retired, 8.0% are housewives, 7.0% are unemployed, SSI employees of 82.0%, 10.0% of them are retired from SSI, 2.0% green card, It was found that 4.0% had no social security and 2.0% had other (Private, Bağ-Kur, abroad) social security.

Patients treated in bed; 44.0% are women, 56.0% are male, 18.0% is between the ages of 18-25, 38.0% are between the ages of 26-40, 9.0% of them are between the ages of 41-50, 13.0% of them are between 51-65 years old, 22.0% of them are 66

years and over, 12.0% is illiterate, 29.0% of them are primary school graduates, 6.0% are secondary school graduates, 25.0% graduated from high school or its equivalent, 28.0% graduated from university or higher, 21.0% was self-employed (other), 32.0% are workers, 19.0% are civil servants, 6.0% are retired, 12.0% are housewives, 10.0% are unemployed, 48.0% are SSI employees, 23.0% of them are SSI retired, green card of 6.0%, 1.0% do not have social security, It was found that 22.0% had other (Private, Bağ-Kur, abroad) social security.

4.2. Reliability Analysis

Reliability analysis was performed for the survey questions used in the research. Cronbach's Alpha test statistics were used for the reliability of the questionnaire questions. The evaluation criterion used in the evaluation of the Cronbach Alpha coefficient; If $0.00 \leq \alpha < 0.40$, the scale is unreliable. If $0.40 \leq \alpha < 0.60$, the scale has low reliability. If $0.60 \leq \alpha < 0.80$, the scale is quite reliable. If $0.80 \leq \alpha < 1.00$, the scale was evaluated as highly reliable. It can be said that the reliability values of the four scales used in this study are at an acceptable level for social sciences.

Table 4.16: Scale reliability analyzes

Scales	Cronbach's Alpha	N of Items
Leadership Behaviors Scale	,973	34
Patient Satisfaction Scale	,831	25
Total Quality Management Scale	,892	39
Hospital Hospitality Services Scale	,920	33

The internal consistency coefficients of the Leadership Behaviors, Patient Satisfaction, Total Quality Management and Hospital Hospitality Services scales were calculated. Cronbach's Alpha values of the scales; Leadership Behavior Scale, .973, Patient Satisfaction Scale, .831, Total Quality Management, .892 and Hospital Hotel Management Services has been determined as ,920.

4.3. Mean and Standard Deviation

4.3.1. Leadership Behaviors Scale

Table 4.17: Mean and standard deviations of leadership behavior scale items

Scale Item Statistics			
	N	**x̄**	**Ss**
I maintain order in my work.	64	41,25	6,04
There is a consistent production.	64	46,25	4,87
I encourage new ideas.	64	43,75	4,87
I am open to criticism.	64	41,25	6,04
I do not hesitate to take risks when making a decision.	64	40,00	5,03
I have an open and honest method.	**64**	**48,75**	**3,33**
I am reliable.	64	45,00	7,12
I like to discuss new ideas.	64	46,25	4,87
There is a friendly production.	64	45,00	5,03
I always know who is responsible for what.	**64**	**38,75**	**7,86**
I make plans for the future.	64	40,00	10,07
I give my instructions clearly.	64	43,75	4,87
I respect my subordinates as individuals.	64	43,75	4,87
I examine the events and make decisions by thinking.	64	42,50	4,36
I put forward new and different ideas in the implementation of works.	64	41,25	7,86
I create opportunities to eliminate conflicts.	64	42,50	6,66
I am open to change.	64	45,00	5,03
I treat my subordinates fairly.	64	46,25	4,87
I am meticulous in controlling my work.	64	42,50	4,36
I make quick decisions when needed.	64	43,75	7,01
I give my subordinates a say when making a decision.	64	46,25	4,87
I care about obeying the rules and principles.	64	46,25	4,87
I make plans carefully.	64	43,75	4,87
I encourage growth and development.	64	46,25	4,87
My goals are clear.	64	43,75	4,87
I appreciate the good work.	64	46,25	4,87
I care about the opinions of others.	64	45,00	5,03
I produce new projects.	64	43,75	8,63
I am open to innovations.	64	46,25	4,87
I trust my subordinates.	64	43,75	4,87
I defend my subordinates.	64	45,00	5,03
I provide a friendly environment away from arguments.	64	47,50	4,36
I meticulously focus on the plans being implemented.	64	45,00	5,03
I listen to the ideas and suggestions of others.	64	47,50	4,36

One of the Leadership Behaviors scale expressions is “I have an open and honest method.” While the average of the item (48.75±3.33) was the highest, “I always know who is responsible for what.” the mean of the item (38.75±7.86) is the lowest

4.3.2. Patient Satisfaction Scale

Table 4.18: Mean and standard deviations of patient satisfaction scale items

Scale Item Statistics			
	N	**x̄**	**Ss**
I did not wait long during the patient registration process for outpatient treatment.	100	16,60	7,68
The staff in the patient registration department for outpatient treatment were friendly and interested.	100	14,70	7,44
I chose the doctor I will be examined for outpatient treatment.	100	11,70	4,03

My questions, which I think are important for outpatient treatment, were answered by my doctor in a way I could understand.	100	13,90	6,01
I had sufficient confidence in my doctor who undertook my examination for outpatient treatment, I received the necessary attention and care.	100	13,20	5,10
For outpatient treatment, sufficient information was given about the course of my disease and the treatment applied to me.	100	14,00	5,31
I think that the required examination time is allocated during my examination for outpatient treatment.	100	14,00	6,51
Adequate privacy was maintained while being examined for outpatient treatment.	100	12,10	5,55
I did not wait long for the analysis and examination performed on me for outpatient treatment.	100	14,70	6,42
General cleanliness and orderliness of outpatient clinics, waiting areas and examination rooms were sufficient for outpatient treatment.	100	16,20	8,26
I would recommend this hospital to others for outpatient treatment.	100	12,00	4,02
Outpatient hospital services were generally good	100	11,80	3,86
If I have to go to the hospital again for outpatient treatment, I would prefer this hospital.	**100**	**11,60**	**3,68**
Is it your first time to apply to the hospital for inpatient treatment?	100	14,80	5,02
The room I was in for inpatient treatment was clean and warm.	100	15,70	5,55
I found the patient meals sufficient in terms of cleanliness, taste and presentation for inpatient treatment.	**100**	**19,60**	**7,51**
During my treatment for inpatient treatment, I had sufficient confidence in my nurses responsible for my treatment, and received the necessary attention and care.	100	14,50	6,41
The nurses who took care of my treatment for inpatient treatment gave explanations in every procedure they did.	100	14,70	6,58
The questions that I thought were important for inpatient treatment were answered by my doctor in a way that I could understand.	100	14,20	5,89
I had sufficient confidence in my doctor who undertook my treatment for inpatient treatment, and I received the necessary attention and care.	100	13,50	5,75
All staff working for inpatient treatment paid due attention to my privacy.	100	14,60	5,93
I would recommend this hospital to others for inpatient treatment.	100	12,40	4,29
This hospital is safe for inpatient treatment.	100	13,00	4,60
Hospital services for inpatient treatment were generally good.	100	13,00	4,60
When I have to go to the hospital again for inpatient treatment, I would prefer this hospital again.	100	13,00	4,60

From the statements of the Patient Satisfaction scale, “I found the patient meals sufficient for inpatient treatment in terms of cleanliness, taste and presentation.” While the average of the item (19.60±7.51) was the highest, the average of the item “If I had to go to the hospital again for outpatient treatment, I would prefer this hospital” (11.60±7.51) was the lowest.

4.3.3. Total Quality Management Scale

Table 4.19: Mean and standard deviations of total quality management scale items

Scale Item Statistics			
	N	**x̄**	**Ss**
Those in top management are of similar opinion about the future of the organization.	372	28,60	13,08
Activities and investments that yield long-term results receive little support from senior management.	372	30,00	9,74
Employees have the opportunity to participate in management and are encouraged to implement change in the organization.	372	32,04	12,00
When necessary, middle and lower level managers do not allow employees to make decisions on their own. (Middle and lower level managers do not allow employees to make decisions on their own when necessary.)	372	31,45	11,63
Top managers anticipate change and plan accordingly.	372	33,36	12,27

This organization encourages employees to continuously improve its processes and services.	372	32,95	12,83
Employees do not have the chance to make suggestions that will change the current situation / operation. This is not well received or encouraged.	372	29,40	12,02
Most of our services have been improved compared to the recent past.	372	33,89	12,31
This organization has a good reputation and recognition for improving its services and processes.	372	33,46	12,99
My job duties and responsibilities do not help me provide quality service.	**372**	**28,25**	**12,77**
I love my job because I do what I want to do.	372	35,59	12,58
Employees in this organization are dedicated to their work.	372	34,97	11,62
Managers want to see employees strive for excellence.	**372**	**35,61**	**11,94**
Managers create a working environment where employees can show their talents in the best way.	372	31,80	11,19
Employees are given training to better understand what the organization does or how it does it.	372	34,16	12,26
Most of the employees do not have enough knowledge about the sector in which we work.	372	28,79	11,53
Few of our employees are aware of the processes that produce our services.	372	31,07	12,52
Top management has created an environment that supports continuing education.	372	29,54	10,61
Top management receives training on relations with employees and customers.	372	30,64	9,57
It is the common attitude of this organization to prevent the occurrence of faulty services.	372	33,49	9,72
There are no in-process control measures in the processes in this organization.	372	30,05	11,67
Quality is the most fundamental feature when designing new services.	372	33,03	11,64
Employees know how to use statistical process control tools.	372	33,52	10,67

Total Quality Management scale is one of the expressions “My duties and responsibilities related to my job do not help me to provide quality service.” While the average of the item (28.25±12.77) is the highest, “Managers want to see the efforts of their employees for excellence.” the mean of the item (35.61±11.94) is the lowest

4.3.4. Hospital Hospitality Services Scale

Table 4.20: Mean and standard deviations of hospital hotel services scale items

Scale Item Statistics			
	N	**$\bar{x}$**	**Ss**
Warm and friendly welcome upon arrival at the hospital	372	34,38	15,57
Fast and error-free hospital admission and registration	372	34,22	13,91
Giving a room according to the patient's request at the entrance to the hospital	372	34,67	11,54
Providing sufficient information to the patients about the departments of the hospital and the services offered at the entrance to the hospital.	372	34,54	12,13
Giving information about the times of breakfast, meals and other activities at the entrance to the hospital	372	34,62	13,68
Timely preparation of the room	372	33,65	13,60
Cozy and comfortable rooms	372	35,86	12,28
The cleanliness and orderliness of the room is provided as required	372	35,69	12,51
The furnishings in the room and the technical equipment of the room are at a level to meet the needs	372	35,48	12,90

Providing room service services in line with the wishes of the patients without any problems	372	34,67	13,40
The decoration and design of the food and beverage department should reflect the quality of the hospital.	**372**	**39,03**	**14,37**
The quality and deliciousness of the food and beverages served	372	38,25	13,98
Including diet and vegetarian food/drinks in the menus	372	34,00	13,04
The quality and cleanliness of the tools and equipment used in the food and beverage department	372	35,10	11,02
Adequate cleanliness and ventilation of the food and beverage section	372	37,58	13,17
Quality and fast service	372	27,31	16,04
Finding halls/halls suitable for organizations	372	25,05	15,92
Employees are friendly and courteous	372	22,09	14,49
Employees give importance to cleanliness and hygiene	372	28,33	15,67
Employees have the necessary knowledge and skills related to their jobs	372	28,84	16,00
Employees should take the necessary care to establish good relations with patients	372	28,57	15,32
Employees to do their jobs accurately and quickly	372	30,99	16,39
Employees' knowledge of first aid	372	26,42	16,93
The general physical equipment and furnishing of the hospital is sufficient	372	26,12	15,86
Availability of sports and entertainment opportunities for children and adults	372	20,94	14,40
Clean and well-maintained common areas of the hospital	372	23,01	15,35
Timely and accurate delivery of all services provided in the hospital	372	25,51	17,15
Taking the necessary level of fire, health and safety precautions	372	22,04	15,33
Adequate and good placement of directional signs and signs within the hospital	372	23,84	15,57
Quick resolution of patient wishes and complaints	**372**	**20,83**	**14,92**
Patients can easily communicate with officials and employees in all departments of the hospital.	372	24,16	16,82
Patients feel in a peaceful and safe environment in the hospital.	372	24,19	17,08
The suitability of hospital hotel prices compared to the quality of the service provided	372	25,02	16,91

While the average of the item "The decoration and design of the food and beverage department should reflect the quality of the hospital" was the highest (39.03±14.37) among the hospital hotel services scale expressions, the average of the item "Quick resolution of the patient's wishes and complaints" (20, 83±14.92) is the lowest.

4.4. T-Test and Anova Analysis

4.4.1. Health Managers

4.4.1.1. Leadership Behaviors Scale

Table 4.21: Comparison of the scores of health managers from the leadership scale and its subscales according to the hospitals they work in (n=31)

Scales	Hospital name	n	x̄	s	Min	Max	F	p
Leadership Behaviors Scale	Fethiye State Hospital	15	44,21	4,36	37	48		
	Private Lokman Hekim Esnaf Hospital	12	43,57	4,68	37	48	0,082	0,922
	Private Letoon Hospital	4	43,45	5,49	37	48		
– Supportive Leadership	Fethiye State Hospital	15	43,33	4,98	33	48		
	Private Lokman Hekim Esnaf Hospital	12	42,34	5,79	33	48	0,128	0,881
	Private Letoon Hospital	4	42,27	6,82	33	48		
– Instrumental (Directive) Leadership	Fethiye State Hospital	15	43,88	3,99	38	49		
	Private Lokman Hekim Esnaf Hospital	12	43,33	4,03	38	47	0,071	0,932
	Private Letoon Hospital	4	43,33	4,85	38	47		

– Achievement Oriented Leadership	Fethiye State Hospital	15	45,00	4,83	38	50		
	Private Lokman Hekim Esnaf Hospital	12	44,44	4,94	38	50	0,113	0,893
	Private Letoon Hospital	4	43,75	5,50	38	50		
– Participatory Leadership	Fethiye State Hospital	15	46,00	4,27	40	50		
	Private Lokman Hekim Esnaf Hospital	12	45,83	4,46	40	50	0,005	0,995
	Private Letoon Hospital	4	46,00	4,61	42	50		

When Table 4.21 is examined, it has been determined that there is no statistically significant difference between the scores of the health administrators included in the study according to the hospitals they work in, the leadership behavior scale and its sub-dimensions (p>0.05).

Table 4.22: Comparison of the scores of health administrators from the leadership scale and its subscales according to their gender (n=31)

Scales	Gender	n	$\bar{x}$	s	t	p
Leadership Behaviors Scale	Woman	17	43,47	4,37	-0,533	0,598
	Male	14	44,34	4,72		
– Supportive Leadership	Woman	17	42,51	5,20	0,340	0,736
	Male	14	43,18	5,73		
– Instrumental (Directive) Leadership	Woman	17	43,23	3,92	-0,559	0,581
	Male	14	44,04	4,14		
– Achievement Oriented Leadership	Woman	17	43,92	4,56	-0,893	0,379
	Male	14	45,47	5,12		
– Participatory Leadership	Woman	17	45,64	4,31	-0,411	0,684
	Male	14	46,28	4,28		

When Table 4.22 was examined, it was determined that there was no statistically significant difference between the scores of health administrators from the leadership behavior scale and its sub-dimensions according to their gender (p>0.05).

Table 4.23: Comparison of the scores of health administrators from the leadership scale and its subscales according to their age (n=31)

Scales	Age	n	$\bar{x}$	s	Min	Max	F	p
Leadership Behaviors Scale	between the ages of 17-24	10	43,35	5,20	37	48		
	between the ages of 25-34	6	43,98	4,65	37	48	0,119	0,888
	35 years old and over	5	44,52	2,64	40	46		
– Supportive Leadership	between the ages of 17-24	10	41,90	6,47	33	48		
	between the ages of 25-34	6	43,06	5,53	33	48	0,235	0,792
	35 years old and over	5	43,81	1,86	40	45		
– Instrumental (Directive) Leadership	between the ages of 17-24	10	43,41	4,72	38	49		
	between the ages of 25-34	6	43,69	4,09	38	47	0,015	0,985
	35 years old and over	5	43,66	2,40	40	45		
– Achievement Oriented Leadership	between the ages of 17-24	10	43,83	5,27	38	50		
	between the ages of 25-34	6	44,47	4,89	38	50	0,578	0,568
	35 years old and over	5	46,66	3,72	40	48		
– Participatory Leadership	between the ages of 17-24	10	45,80	4,04	48	42		
	between the ages of 25-34	6	46,12	4,58	48	40	0,034	0,966
	35 years old and over	5	45,60	4,33	50	40		

When Table 4.23 is examined, it has been determined that there is no statistically significant difference between the scores of health administrators from the leadership scale and its subscales according to age groups (p>0.05).

Table 2.24: Comparison of the scores of health administrators from the leadership scale and its subscales according to their marital status (n=31)

Scales	Marital status	n	$\bar{x}$	s	t	p
Leadership Behaviors Scale	Married	10	42,64	4,04	-1,052	0,302
	Single	21	44,45	4,64		
– Supportive Leadership	Married	10	41,54	4,84	-0,906	0,372
	Single	21	43,42	5,61		
– Instrumental (Directive) Leadership	Married	10	42,25	3,35	-1,321	0,197
	Single	21	44,24	4,16		
– Achievement Oriented Leadership	Married	10	44,00	4,98	-0,492	0,626
	Single	21	44,92	4,81		
– Participatory Leadership	Married	10	44,40	4,80	-1,414	0,168
	Single	21	46,66	4,21		

When Table 4.24 was examined, it was determined that there was no statistically significant difference between the scores of health administrators from the leadership scale and its subscales according to their marital status (p>0.05).

Table 4.25: Comparison of the scores of health administrators from the leadership scale and its subscales according to their Educational status (n=31)

Scales	Educational status	N	$\bar{x}$	s	Min	Max	F	p
Leadership Behaviors Scale	Health vocational high School	8	42,86	5,22	37	48	0,197	0,938
	Associate degree	4	45,07	5,19	37	48		
	Licence	5	44,70	4,07	40	48		
	Degree	8	43,67	3,83	40	48		
	Doctorate	6	43,97	5,34	37	48		
– Supportive Leadership	Health vocational high School	8	41,25	6,67	33	48	0,322	0,860
	Associate degree	4	43,63	6,76	33	48		
	Licence	5	44,54	3,46	40	48		
	Degree	8	43,29	3,60	40	48		
	Doctorate	6	42,27	6,86	33	48		
– Instrumental (Directive) Leadership rlik	Health vocational high School	8	42,91	4,52	38	47	0,209	0,931
	Associate degree	4	44,79	4,37	38	47		
	Licence	5	44,16	3,86	40	47		
	Degree	8	43,02	3,47	40	47		
	Doctorate	6	44,02	4,81	38	49		
– Achievement Oriented Leadership	Health vocational high School	8	43,33	5,03	38	50	0,218	0,926
	Associate degree	4	45,83	5,18	38	50		
	Licence	5	45,00	4,71	40	50		
	Degree	8	44,58	4,94	40	50		
	Doctorate	6	45,27	5,51	38	50		
– Participatory Leadership	Health vocational high School	8	45,75	4,59	40	50	0,307	0,870
	Associate degree	4	48,00	4,00	42	50		
	Licence	5	46,00	5,47	40	50		
	Degree	8	45,00	4,27	40	50		
	Doctorate	6	46,00	3,79	42	50		

When Table 4.25 was examined, it was determined that there was no statistically significant difference between the scores of health administrators from the leadership scale and its sub-scales according to their educational status (p>0.05).

Table 4.26: Comparison of the scores of health administrators from the leadership scale and its subscales according to their Service running (n=31)

Scales	Service running	n	x̄	s	F	p
Leadership Behaviors Scale	Internal medicine	7	44,62	5,17	0,248	0,622
	Other	24	43,65	4,35		
– Supportive Leadership	Internal medicine	7	43,11	6,65	0,028	0,869
	Other	24	42,72	5,10		
– Instrumental (Directive) Leadership	Internal medicine	7	44,52	4,58	0,476	0,496
	Other	24	43,33	3,85		
– Achievement Oriented Leadership	Internal medicine	7	45,95	5,34	0,684	0,415
	Other	24	44,23	4,68		
– Participatory Leadership	Internal medicine	7	46,57	3,77	0,198	0,660
	Other	24	45,75	4,42		

When Table 4.26 is examined, it has been determined that there is no statistically significant difference between the scores of the leadership scale and its subscales according to the services they work for (p>0.05).

Table 4.27: Comparison of the scores of health administrators from the leadership scale and its subscales according to their Duty (n=31)

Scales	Duty	N	x̄	s	Min	Max	F	p
Leadership Behaviors Scale	Specialist doctor	10	44,11	4,69	37	48	0,039	0,999
	Chief Physician	3	43,43	5,65	37	48		
	Assistant chief physician	3	44,51	6,21	37	48		
	Administrative Financial Affairs Manager	3	43,82	3,27	40	46		
	Assistant Manager of Administrative Financial Affairs	2	44,41	5,82	40	48		
	Other	10	43,47	47,38	37	48		
Supportive Leadership	Specialist doctor	10	43,09	5,63	33	48	0,066	0,997
	Chief Physician	3	41,81	7,44	33	48		
	Assistant chief physician	3	42,72	7,87	33	47		
	Administrative Financial Affairs Manager	3	43,06	2,77	40	45		
	Assistant Manager of Administrative Financial Affairs	2	44,54	5,14	40	48		
	Other	10	42,45	5,68	33	48		
Instrumental (Directive) Leadership	Specialist doctor	10	43,83	4,10	38	47	0,102	0,991
	Chief Physician	3	43,05	4,58	38	47		
	Assistant chief physician	3	45,00	5,83	38	49		
	Administrative Financial Affairs Manager	3	43,05	2,92	40	45		
	Assistant Manager of Administrative Financial Affairs	2	43,75	5,30	40	47		
	Other	10	43,25	4,20	38	47		
Achievement Oriented Leadership	Specialist doctor	10	44,66	4,89	38	50	0,089	0,993
	Chief Physician	3	45,55	6,30	38	50		
	Assistant chief physician	3	45,00	6,00	38	50		
	Administrative Financial Affairs Manager	3	45,55	4,81	40	48		
	Assistant Manager of Administrative Financial Affairs	2	45,00	7,07	40	50		
	Other	10	43,83	4,90	38	50		
Participatory Leadership	Specialist doctor	10	46,40	4,69	40	50	0,074	0,996
	Chief Physician	3	45,33	4,16	42	50		
	Assistant chief physician	3	46,66	4,16	42	50		
	Administrative Financial Affairs Manager	3	45,33	4,16	42	50		
	Assistant Manager of Administrative Financial Affairs	2	45,00	7,07	40	50		

	Other	10	45,80	4,46	40	50		

When Table 4.27 is examined, it has been determined that there is no statistically significant difference between the scores of the leadership scale and its subscales according to the duties of health administrators (p>0.05).

Table 4.28: Comparison of the scores of health administrators from the leadership scale and its subscales according to their Management task (n=31)

Scales	Management task	N	$\bar{x}$	s	Min	Max	F	p
Leadership Behaviors Scale	Manager	16	44,33	4,54	37	48	0,422	0,857
	Chief Physician	3	43,43	5,65	37	48		
	Deputy chief physician	3	44,51	6,21	37	48		
	Administrative Financial Affairs Manager	3	43,82	3,27	40	46		
	Health Care Services Manager	2	38,82	2,07	37	40		
	Assistant Manager of Administrative Financial Affairs	2	44,41	5,82	40	48		
	Deputy Director of Health Care Services	2	44,41	5,82	40	48		
Supportive Leadership	Manager	16	43,35	5,45	33	48	0,458	0,832
	Chief Physician	3	41,81	7,44	33	48		
	Deputy chief physician	3	42,72	7,87	33	47		
	Administrative Financial Affairs Manager	3	43,03	2,77	40	45		
	Health Care Services Manager	2	36,81	4,49	33	40		
	Assistant Manager of Administrative Financial Affairs	2	44,54	5,14	40	48		
	Deputy Director of Health Care Services	2	44,09	5,78	40	48		
Instrumental (Directive) Leadership	Manager	16	44,06	4,00	38	47	0,475	0,820
	Chief Physician	3	43,05	4,58	38	47		
	Deputy chief physician	3	45,00	5,83	38	49		
	Administrative Financial Affairs Manager	3	43,05	2,92	40	45		
	Health Care Services Manager	2	39,16	1,17	38	40		
	Assistant Manager of Administrative Financial Affairs	2	43,75	5,30	40	47		
	Deputy Director of Health Care Services	2	43,75	5,30	40	47		
Achievement Oriented Leadership	Manager	16	44,79	4,66	38	50	0,423	0,857
	Chief Physician	3	45,55	6,30	38	50		
	Deputy chief physician	3	45,00	6,00	38	50		
	Administrative Financial Affairs Manager	3	45,55	4,81	40	48		
	Health Care Services Manager	2	39,16	1,17	38	40		
	Assistant Manager of Administrative Financial Affairs	2	45,00	7,07	40	50		
	Deputy Director of Health Care Services	2	45,00	7,07	40	50		
Participatory Leadership	Manager	16	46,62	4,54	40	50	0,356	0,899
	Chief Physician	3	45,33	4,16	42	50		
	Deputy chief physician	3	46,66	4,16	42	50		
	Administrative Financial Affairs Manager	3	45,33	4,16	42	50		
	Health Care Services Manager	2	42,00	0,00	42	42		
	Assistant Manager of Administrative Financial Affairs	2	45,00	7,07	40	50		
	Deputy Director of Health Care Services	2	46,00	5,65	42	50		

When Table 4.28 was examined, it was determined that there was no statistically significant difference between the scores that health administrators received from the leadership scale and its sub-scales according to their management duties (p>0.05).

Table 4.29: Comparison of the scores of health administrators from the leadership scale and its subscales according to their working time in current position (n=31)

Scales	Working time in current position	N	x̄	s	Min	Max	F	p
Leadership Behaviors Scale	0-5 years	24	43,86	4,49	37	48	0,017	0,983
	6-10 years	5	43,70	5,84	37	48		
	11-15 years	2	44,41	0,00	44	44		
Supportive Leadership	0-5 years	24	42,95	5,23	33	48	0,111	0,896
	6-10 years	5	41,81	7,55	33	48		
	11-15 years	2	43,63	0,00	43	43		
Instrumental (Directive) Leadership	0-5 years	24	43,64	4,08	38	49	0,007	0,993
	6-10 years	5	43,50	4,76	38	47		
	11-15 years	2	43,33	0,00	43	43		
Achievement Oriented Leadership	0-5 years	24	44,23	4,71	38	50	0,674	0,518
	6-10 years	5	45,00	6,12	38	50		
	11-15 years	2	48,33	0,00	48	48		
Participatory Leadership	0-5 years	24	45,91	4,43	40	50	0,298	0,745
	6-10 years	5	46,80	4,38	42	50		
	11-15 years	2	44,00	0,00	44	44		

When Table 4.29 was examined, it was determined that there was no statistically significant difference between the scores of the leadership scale and its subscales according to the working hours of the health managers in their positions (p>0.05).

Table 4.30: Comparison of the scores of health administrators from the leadership scale and its subscales according to their total professional experience period (n=31)

Scales	Total professional experience period	N	x̄	s	Min	Max	F	p
Leadership Behaviors Scale	0-5 years	18	43,82	4,73	37	48	0,095	0,962
	6-10 years	8	43,56	5,19	37	48		
	11-15 years	2	43,52	4,57	40	46		
	16-20 years	3	45,19	1,35	44	46		
Supportive Leadership	0-5 years	18	42,67	5,73	33	48	0,079	0,971
	6-10 years	8	42,50	6,38	33	48		
	11-15 years	2	43,18	3,21	40	45		
	16-20 years	3	44,24	1,04	43	45		
Instrumental (Directive) Leadership	0-5 years	18	43,70	4,27	38	49	0,051	0,985
	6-10 years	8	43,33	4,49	38	47		
	11-15 years	2	42,91	4,12	40	45		
	16-20 years	3	44,16	1,44	43	45		
Achievement Oriented Leadership	0-5 years	18	44,25	4,85	38	50	0,637	0,598
	6-10 years	8	44,16	5,49	38	50		
	11-15 years	2	44,16	5,89	40	48		
	16-20 years	3	48,33	0,00	48	48		
Participatory Leadership	0-5 years	18	46,11	4,30	40	50	0,043	0,988
	6-10 years	8	45,75	4,59	40	50		
	11-15 years	2	45,00	7,07	40	50		
	16-20 years	3	46,00	3,46	44	50		

When Table 4.30 was examined, it was determined that there was no statistically significant difference between the scores of the leadership scale and its subscales according to the total professional experience of the health managers (p>0.05).

4.4.2. Health workers

4.4.2.1. Total Quality Management Scale

Table 4.31: Comparison of the scores obtained from the total quality management scale and its subscales according to the hospitals where healthcare professionals work (n=341)

Scale	Hospital name	n	x̄	s	Min	Max	F	p	Fark
Total Quality Management Scale	Fethiye State Hospital	95	34,38	5,39	13	44	13,292	,000*	1-3
	Private Lokman Hekim Esnaf Hospital	176	31,34	4,96	13	43			
	Private Letoon Hospital	70	30,83	5,01	13	43			
Leadership	Fethiye State Hospital	95	32,75	6,77	10	46	3,891	0,021*	1-3
	Private Lokman Hekim Esnaf Hospital	176	30,31	7,49	10	46			
	Private Letoon Hospital	70	30,20	7,69	10	46			
Continuous Development	Fethiye State Hospital	95	34,57	7,86	10	47	4,753	0,009*	1-2
	Private Lokman Hekim Esnaf Hospital	176	31,54	8,04	10	45			
	Private Letoon Hospital	70	31,78	7,94	10	45			
Employee satisfaction	Fethiye State Hospital	95	35,76	6,65	16	48	8,486	0,000*	1-3
	Private Lokman Hekim Esnaf Hospital	176	32,29	7,13	16	44			
	Private Letoon Hospital	70	32,25	7,11	16	44			
Training learning	Fethiye State Hospital	95	32,90	6,91	14	50	6,299	0,000*	1-3
	Private Lokman Hekim Esnaf Hospital	176	30,28	6,48	14	44			
	Private Letoon Hospital	70	29,68	6,54	14	44			
Process management	Fethiye State Hospital	95	34,26	6,17	13	43	11,931	0,000*	1-3
	Private Lokman Hekim Esnaf Hospital	176	30,94	5,88	13	41			
	Private Letoon Hospital	70	30,33	5,93	13	41			
Collaborations	Fethiye State Hospital	95	34,94	6,91	12	47	7,755	0,001*	1-3
	Private Lokman Hekim Esnaf Hospital	176	32,38	6,16	12	50			
	Private Letoon Hospital	70	31,17	6,65	12	50			
customer orientation	Fethiye State Hospital	95	35,10	7,59	12	50	10,330	0,000*	1-3
	Private Lokman Hekim Esnaf Hospital	176	31,29	7,19	12	50			
	Private Letoon Hospital	70	30,67	7,27	12	50			

**p<0,05*

When Table 4.31 is examined, it has been determined that there is a statistically significant difference between the scores of the healthcare professionals included in the study, according to the hospitals they work in, from the total quality management scale and its sub-scales ($p<0.05$). Total Quality Management Scale scores of Fethiye State Hospital healthcare professionals were found to be significantly higher than those of Private Lokman Hekim Esnaf Hospital and Private Letoon Hospital healthcare professionals.

Table 4.32: Comparison of the scores obtained from the total quality management scale and its subscales according to gender (n=341)

Scales	Gender	n	x̄	s	t	p
Total Quality Management Scale	Woman	229	32,42	4,94	1,711	0,088
	Male	112	31,38	5,87		
- Leadership	Woman	229	31,36	6,82	1,388	0,166
	Male	112	30,17	8,45		
- Continuous Development	Woman	229	33,65	6,99	4,072	0,000*
	Male	112	29,95	9,44		
- Employee satisfaction	Woman	229	34,07	6,48	3,044	0,000*
	Male	112	31,58	8,14		
- Training learning	Woman	229	30,78	6,64	-0,414	0,679
	Male	112	31,10	6,90		
- Process management	Woman	229	32,31	5,46	2,455	0,015*
	Male	112	30,58	7,30		
- Collaborations	Woman	229	32,70	6,39	-0,599	0,550
	Male	112	33,15	7,03		
- Customer orientation	Woman	229	32,12	7,46	-0,350	0,726
	Male	112	32,43	7,67		

**p<0,05*

When Table 4.32 is examined, it has been determined that there is a statistically significant difference between the scores of the health care workers included in the study from the total quality management scale continuous improvement, employee satisfaction and process management subscales ($p<0.05$). Total quality management scale continuous improvement, employee satisfaction and process management subscale scores of female healthcare professionals were found to be significantly higher than male healthcare professionals. There was no statistically significant difference between the scores they got from the overall total quality management scale, leadership, education learning, collaborations and customer focus subscales ($p>0.05$).

Table 4.33: Comparison of the scores obtained from the total quality management scale and its subscales according to ages (n=341)

Scales	Age	n	$\bar{x}$	s	Min	Max	F	p	Diff
Total Quality Management Scale	between the ages of 17-24	93	31,93	2,99	27	43			
	between the ages of 25-34	164	32,91	3,64	23	44	5,436	0,005*	2-3
	35 years old and over	84	30,61	5,28	13	43			
- Leadership	between the ages of 17-24	93	33,05	4,41	26	42			
	between the ages of 25-34	164	31,17	5,94	20	44	9,728	0,000*	1-3
	35 years old and over	84	28,28	11,02	10	46			
- Continuous Development	between the ages of 17-24	93	31,66	7,11	20	47			
	between the ages of 25-34	164	34,19	5,80	17	47	8,930	0,000*	2-3
	35 years old and over	84	29,88	11,42	10	45			
- Employee satisfaction	between the ages of 17-24	93	30,28	7,25	24	48			
	between the ages of 25-34	164	36,14	4,43	26	48	30,478	0,000*	2-1
	35 years old and over	84	30,90	8,98	16	46			
- Training learning	between the ages of 17-24	93	30,90	6,46	14	40			
	between the ages of 25-34	164	31,43	5,10	18	50	1,639	0,196	
	35 years old and over	84	29,81	9,25	14	46			
- Process management	between the ages of 17-24	93	32,04	4,41	25	42			
	between the ages of 25-34	164	32,83	4,44	22	43	9,827	0,000*	2-1
	35 years old and over	84	29,28	9,32	13	43			
- Collaborations	between the ages of 17-24	93	32,15	3,61	25	43			
	between the ages of 25-34	164	33,18	5,70	17	46	0,747	0,474	
	35 years old and over	84	32,97	9,98	12	50			
- Customer orientation	between the ages of 17-24	93	33,52	5,35	20	50			
	between the ages of 25-34	164	31,18	6,47	15	50	3,248	0,040*	1-2
	35 years old and over	84	32,82	10,64	12	50			

**p<0,05*

When Table 4.33 is examined, it has been determined that there is a statistically significant difference between the scores of the total quality management scale, leadership, continuous improvement, employee satisfaction, process management and customer orientation subscales according to the age of the healthcare professionals included in the study ($p<0.05$). The general total quality management scale, continuous improvement, employee satisfaction, process management and customer focus subscales, and leadership and customer focus subscales between the ages of 17-24 were found to be significantly higher than the other age groups of healthcare professionals aged 25-34. There was no statistically significant difference between the scores they got from the Education, Learning and Cooperation subscales ($p>0.05$).

Table 4.34: Comparison of the scores obtained from the total quality management scale and its subscales according to marital status (n=341)

Scales	Marital status	n	$\bar{x}$	s	t	p
Total Quality Management Scale	Married	191	31,80	6,32	-1,082	0,280
	Single	150	32,42	3,51		
- Leadership	Married	191	30,74	8,33	-0,647	0,518
	Single	150	31,26	6,04		
- Continuous Development	Married	191	31,80	9,22	-1,646	0,101
	Single	150	33,25	6,21		
- Employee satisfaction	Married	191	32,41	7,94	-2,454	0,015*
	Single	150	34,32	5,85		
- Training learning	Married	150	30,74	7,12	-0,458	0,647
	Single	191	31,08	6,18		
- Process management	Married	150	31,80	7,10	0,207	0,836
	Single	191	31,66	4,74		
- Collaborations	Married	150	32,94	7,64	0,293	0,770
	Single	191	32,73	4,99		
- Customer orientation	Married	150	31,40	8,50	-2,309	0,022*
	Single	191	33,28	5,90		

**p<0,05*

When Table 4.34 is examined, it has been determined that there is a statistically significant difference between the scores obtained from the total quality management scale employee satisfaction and customer orientation subscales according to the marital status of the healthcare professionals included in the study ($p<0.05$). The scores of single health care workers on the total quality management scale employee satisfaction and customer orientation subscales were found to be significantly higher than those of married health workers. There was no statistically significant difference between the scores they got from the overall total quality management scale, leadership, continuous improvement, training learning, process management and cooperation subscales ($p>0.05$).

Table 4.35: Comparison of the scores obtained from the total quality management scale and its subscales according to educational status (n=341)

Scales	Educational status	N	$\bar{x}$	s	Min	Max	F	p	Diff.
Total Quality Management Scale	Health vocational high School	142	30,76	4,28	18	41	6,353	0,000*	2-1
	Associate degree	102	34,08	4,33	23	43			
	Licence	84	31,98	6,92	13	44			
	Degree	7	31,61	7,51	24	42			
	Doctorate	6	30,89	1,12	29	32			
Leadership	Health vocational high School	142	29,94	7,11	10	42	3,954	0,004*	4-5
	Associate degree	102	33,17	6,37	20	46			
	Licence	84	29,88	8,70	10	46			
	Degree	7	34,28	5,46	30	42			
	Doctorate	6	29,33	4,84	24	38			
Continuous Development	Health vocational high School	142	30,65	8,46	10	47	6,560	0,000*	4-1
	Associate degree	102	35,19	5,93	17	47			
	Licence	84	31,45	8,82	15	45			
	Degree	7	38,57	5,92	27	45			
	Doctorate	6	34,58	5,79	27	40			
Employee satisfaction	Health vocational high School	142	30,84	7,57	16	42	9,169	0,000*	2-1
	Associate degree	102	36,11	5,90	24	48			
	Licence	84	33,76	6,88	16	48			
	Degree	7	35,14	2,54	30	38			
	Doctorate	6	32,33	4,27	26	38			
Training learning	Health vocational high School	142	30,21	7,10	14	44	2,402	0,050*	5-4
	Associate degree	102	32,17	5,58	18	48			
	Licence	84	30,97	6,93	14	50			
	Degree	7	25,71	9,75	16	40			
	Doctorate	6	30,00	4,56	26	38			
Process management	Health vocational high School	142	30,07	6,43	13	42	5,313	0,000*	2-1
	Associate degree	102	33,43	4,60	22	43			
	Licence	84	32,64	6,52	16	43			
	Degree	7	30,17	9,80	20	42			
	Doctorate	6	31,66	3,76	25	36			
Collaborations	Health vocational high School	142	32,23	4,48	20	42	2,716	0,030*	2-4
	Associate degree	102	34,27	6,78	17	50			
	Licence	84	32,76	8,28	12	46			
	Degree	7	28,39	13,32	15	45			
	Doctorate	6	29,58	5,16	20	35			
Customer orientation	Health vocational high School	142	30,91	7,00	20	50	5,024	0,001*	2-5
	Associate degree	102	34,87	6,19	15	50			
	Licence	84	31,31	8,98	12	50			
	Degree	7	33,57	8,88	27	47			
	Doctorate	6	29,58	6,00	20	37			

**p<0,05*

When Table 4.35 is examined, it has been determined that there is a statistically significant difference between the scores obtained from the overall quality management scale, leadership, continuous improvement, employee satisfaction,

training learning, process management, collaborations and customer orientation sub-scales according to the educational status of the healthcare professionals included in the study (p<0.05). The overall quality management scale, employee satisfaction, process management, collaboration and customer focus subscales of associate degree graduate health workers, and the scores of postgraduate health workers from leadership, continuous improvement, and education learning subscales of doctoral health workers are significantly higher than those of health workers with other education levels. level was found to be high.

Table 4.36: Comparison of the scores obtained from the total quality management scale and its subscales according to Service running (n=341)

Scales	Service running	N	x̄	s	Mi	Ma	F	p	Diff
Total Quality Management Scale	Anesthesia	30	32,96	2,04	30	41	20,326	0,000*	18-6
	Urology	3	32,56	0,00	32	32			
	Dermis	8	28,39	1,63	24	29			
	Pediatry	9	29,45	6,44	13	32			
	Internal medicine	67	35,13	4,47	26	44			
	Infectious Diseases	6	16,62	6,80	13	30			
	Physical therapy and rehabilitation	6	32,69	1,57	29	33			
	General Surgery	36	33,29	2,76	30	37			
	Thoracic Surgery	6	31,28	1,25	30	33			
	Eye diseases	6	34,74	2,82	29	35			
	First and Emergency Aid	36	33,22	4,26	23	43			
	Gynecology and Obstetrics	4	24,48	3,84	18	26			
	Cardiology	3	27,35	5,18	24	33			
	ENT	9	20,14	4,27	18	31			
	Neurology	20	31,80	4,00	24	35			
	Neurosurgery	23	33,74	5,30	30	43			
	Radiology	19	31,36	2,50	28	35			
	Orthopedics and Traumatology	6	42,65	1,67	39	43			
	Other	44	29,40	1,88	23	33			
- Leader ship	Anesthesia	30	34,66	5,12	26	42	12,207	0,000*	18-14
	Urology	3	34,00	0,00	34	34			
	Dermis	8	30,00	0,00	30	30			
	Pediatry	9	25,55	7,33	10	30			
	Internal medicine	67	33,31	6,10	24	46			
	Infectious Diseases	6	14,00	9,79	10	34			
	Physical therapy and rehabilitation	6	31,00	2,44	26	32			
	General Surgery	36	31,11	5,22	22	38			
	Thoracic Surgery	6	28,33	0,81	28	30			
	Eye diseases	6	26,66	1,63	26	30			
	First and Emergency Aid	36	32,16	6,24	20	42			
	Gynecology and Obstetrics	4	20,50	7,00	10	24			
	Cardiology	3	31,33	2,30	30	34			
	ENT	9	13,11	9,33	10	38			
	Neurology	20	29,10	6,43	18	34			
	Neurosurgery	23	35,13	5,87	32	46			
	Radiology	19	33,57	6,05	28	42			
	Orthopedics and Traumatology	6	40,00	0,00	40	40			
	Other	44	29,04	5,96	20	40			

Table 4.37: Comparison of the scores obtained from the total quality management scale and its subscales according to Service running (n=341) (Continue)

Scales	Service running	N	x̄	s	Mi	Ma	F	p	Diff
- Continuous Development	Anesthesia	30	36,33	5,56	17	45	12,415	0,000*	18-14
	Urology	3	30,00	0,00	30	30			
	Dermis	8	26,56	4,41	25	37			
	Pediatry	9	25,27	6,05	15	32			
	Internal medicine	67	35,89	6,61	17	47			
	Infectious Diseases	6	18,33	8,16	15	35			
	Physical therapy and	6	30,00	0,00	30	30			
	General Surgery	36	35,90	4,47	27	40			
	Thoracic Surgery	6	27,08	5,10	25	37			
	Eye diseases	6	33,33	4,08	25	35			
	First and Emergency Aid	36	35,00	6,43	20	45			
	Gynecology and	4	30,62	13,75	10	37			
	Cardiology	3	38,33	1,44	37	40			
	ENT	9	13,33	10,00	10	40			
	Neurology	20	32,50	8,07	15	40			
	Neurosurgery	23	29,56	8,38	25	45			
	Radiology	19	31,18	5,55	22	37			
	Orthopedics and	6	44,58	10,02	42	45			
	Other	44	29,20	5,75	20	40			
- Employee satisfaction	Anesthesia	30	34,86	2,50	32	38	16,236	0,000*	18-14
	Urology	3	30,00	0,00	30	30			
	Dermis	8	25,50	4,24	24	36			
	Pediatry	9	29,33	5,65	16	38			
	Internal medicine	67	36,00	6,15	22	48			
	Infectious Diseases	6	18,33	5,71	16	30			
	Physical therapy and	6	32,66	3,26	26	34			
	General Surgery	36	36,88	3,15	32	42			
	Thoracic Surgery	6	36,33	0,81	36	38			
	Eye diseases	6	34,00	4,89	24	36			
	First and Emergency Aid	36	36,94	5,68	26	48			
	Gynecology and	4	20,50	3,00	16	22			
	Cardiology	3	38,66	4,61	36	44			
	ENT	9	18,44	7,33	16	38			
	Neurology	20	36,30	6,65	28	44			
	Neurosurgery	23	27,47	6,74	24	40			
	Radiology	19	32,94	7,09	24	40			
	Orthopedics and	6	43,33	1,63	40	44			
	Other	44	30,22	4,74	24	40			

Table 4.38: Comparison of the scores obtained from the total quality management scale and its subscales according to Service running (n=341) (Continue)

Scales		Service running	N	X̄	s	Min	Ma	F	p	Diff
		Anesthesia	30	32,80	4,02	26	42			
		Urology	3	28,00	0,00	28	28			
		Dermis	8	26,50	4,24	16	28			
		Pediatry	9	29,77	5,95	14	32			
		Internal medicine	67	33,70	6,01	14	50			
		Infectious Diseases	6	17,66	8,98	14	36			
		Physical therapy and	6	28,66	1,63	28	32			
		General Surgery	36	31,00	3,86	26	38			
		Thoracic Surgery	6	28,33	0,81	28	30			
-	Training learning	Eye diseases	6	33,00	2,44	28	34	11,323	0,000*	18-6
		First and Emergency Aid	36	28,22	9,28	14	48			
		Gynecology and Obstetrics	4	23,50	5,00	16	26			
		Cardiology	3	20,00	6,92	16	28			
		ENT	9	18,44	7,33	16	38			
		Neurology	20	30,80	3,45	28	44			
		Neurosurgery	23	37,39	2,51	36	42			
		Radiology	19	30,84	3,48	26	34			
		Orthopedics and Traumatology	6	42,00	4,89	32	44			
		Other	44	29,90	4,43	18	38			
		Anesthesia	30	33,16	3,03	28	42			
		Urology	3	36,25	0,00	36	36			
		Dermis	8	28,75	3,53	20	30			
		Pediatry	9	32,36	7,11	16	36			
		Internal medicine	67	34,77	5,44	22	43			
		Infectious Diseases	6	16,66	1,02	16	18			
		Physical therapy and	6	35,20	2,55	30	36			
		General Surgery	36	33,99	3,65	30	41			
		Thoracic Surgery	6	31,04	2,55	30	36			
-	Process management	Eye diseases	6	36,25	3,06	30	37	18,969	0,000*	2-14
		First and Emergency Aid	36	31,70	5,90	22	42			
		Gynecology and Obstetrics	4	20,31	4,37	13	22			
		Cardiology	3	24,16	7,21	20	32			
		ENT	9	15,83	6,25	13	32			
		Neurology	20	31,62	3,46	25	35			
		Neurosurgery	23	36,14	2,94	30	41			
		Radiology	19	31,05	3,70	26	35			
		Orthopedics and Traumatology	6	34,79	2,55	33	40			
		Other	44	27,98	3,68	18	36			

Table 4.39: Comparison of the scores obtained from the total quality management scale and its subscales according to Service running (n=341) (Continue)

Scales	Service running	N	x̄	s	Min	Ma	F	p	Diff
	Anesthesia	30	30,54	5,46	20	42			
	Urology	3	33,75	0,00	33	33			
	Dermis	8	29,21	5,74	15	31			
	Pediatry	9	30,97	8,28	12	35			
	Internal medicine	67	36,02	6,01	20	47			
	Infectious Diseases	6	16,04	8,67	12	33			
	Physical therapy and	6	35,00	3,06	28	36			
	General Surgery	36	33,47	3,40	27	37			
	Thoracic Surgery	6	32,29	2,55	31	37			
- Collaborations	Eye diseases	6	38,54	3,57	31	40	11,957	0,000*	18-6
	First and Emergency Aid	36	34,13	5,54	17	46			
	Gynecology and Obstetrics	4	24,06	8,12	20	36			
	Cardiology	3	19,16	7,21	15	27			
	ENT	9	34,44	5,41	20	36			
	Neurology	20	31,50	5,84	21	37			
	Neurosurgery	23	35,32	5,23	32	45			
	Radiology	19	30,26	3,26	26	35			
	Orthopedics and	6	48,33	4,08	40	50			
	Other	44	30,05	4,31	17	35			
	Anesthesia	30	29,75	6,13	20	47			
	Urology	3	32,50	0,00	32	32			
	Dermis	8	31,87	1,76	27	32			
	Pediatry	9	29,44	6,82	12	32			
	Internal medicine	67	36,26	6,67	15	50			
	Infectious Diseases	6	15,83	8,16	12	32			
	Physical therapy and	6	32,91	1,02	32	35			
	General Surgery	36	30,06	6,31	22	40			
	Thoracic Surgery	6	35,00	6,12	22	37			
- Customer orientation	Eye diseases	6	38,75	3,06	32	40	10,933	0,000*	18-6
	First and Emergency Aid	36	35,62	6,19	25	50			
	Gynecology and Obstetrics	4	38,75	12,50	20	45			
	Cardiology	3	29,16	2,88	27	32			
	ENT	9	20,00	0,00	20	20			
	Neurology	20	31,12	5,93	22	37			
	Neurosurgery	23	31,52	8,74	20	47			
	Radiology	19	30,26	5,12	25	35			
	Orthopedics and	6	48,33	4,08	40	50			
	Other	44	29,88	4,34	20	35			

**p<0,05*

When Table 4.36, Table 4.37, Table 4.38 and Table 4.39 are examined, it is seen that the scores obtained from the overall total quality management scale, leadership, continuous improvement, employee satisfaction, training learning, process management, collaborations and customer orientation subscales according to the services they work for. a statistically significant difference was found ($p<0.05$). Orthopedics and Traumatology service health workers' overall quality management scale, leadership, continuous improvement, employee satisfaction, training learning, cooperation and customer orientation sub-scales, Bevliye (Urology) service health workers' process management sub-scale scores are significant compared to health workers working in other services. level was found to be high.

Table 4.40: Comparison of the scores obtained from the total quality management scale and its subscales according to duty (n=341)

Scales	Duty	N	x̄	s	Min	Max	F	p	Diff
Total Quality Management Scale	Nurse	126	33,08	4,79	13	44	2,839	0,003*	3-5
	Midwife	18	33,03	4,33	26	43			
	Lab Technician	11	35,33	4,33	30	42			
	Health Officer	6	28,93	7,61	13	34			
	Specialist Doctor	72	30,00	4,79	13	39			
	Emergency medical technician	57	31,88	5,68	13	43			
	Physiotherapist	14	31,06	5,70	18	36			
	Anesthesia Technician	15	31,98	4,74	18	41			
	General practitioner	13	33,59	8,79	13	43			
	Other	9	31,48	1,70	29	33			
- Leadership	Nurse	126	31,81	6,62	10	46	1,207	0,290	
	Midwife	18	30,44	5,11	24	40			
	Lab Technician	11	34,90	5,61	26	44			
	Health Officer	6	28,66	10,40	10	38			
	Specialist Doctor	72	28,97	7,58	10	42			
	Emergency medical technician	57	31,01	7,99	10	46			
	Physiotherapist	14	31,00	10,06	10	40			
	Anesthesia Technician	15	31,60	8,21	10	42			
	General practitioner	13	31,07	10,02	10	46			
	Other	9	31,55	4,44	26	38			
- Continuous Development	Nurse	126	33,57	7,51	10	47	1,450	0,166	
	Midwife	18	33,05	6,33	20	40			
	Lab Technician	11	35,90	8,23	17	45			
	Health Officer	6	30,00	9,61	15	40			
	Specialist Doctor	72	31,00	8,06	10	42			
	Emergency medical technician	57	32,19	8,58	10	45			
	Physiotherapist	14	28,92	9,18	10	40			
	Anesthesia Technician	15	29,66	9,05	10	45			
	General practitioner	13	34,61	9,28	15	45			
	Other	9	32,77	6,54	25	40			
- Employee satisfaction	Nurse	126	33,77	7,04	16	48	0,931	0,498	
	Midwife	18	34,33	7,00	22	44			
	Lab Technician	11	36,00	4,28	30	44			
	Health Officer	6	30,66	9,60	16	40			
	Specialist Doctor	72	32,16	6,82	16	44			
	Emergency medical technician	57	33,71	7,84	16	48			
	Physiotherapist	14	31,57	8,88	16	44			
	Anesthesia Technician	15	32,13	5,87	16	40			
	General practitioner	13	34,61	7,63	16	44			
	Other	9	30,44	6,30	24	38			
- Training learning	Nurse	126	31,66	6,43	14	50	0,787	0,629	
	Midwife	18	30,33	4,40	26	46			
	Lab Technician	11	31,27	9,43	14	40			
	Health Officer	6	30,00	8,67	14	38			
	Specialist Doctor	72	29,25	6,53	14	44			
	Emergency medical technician	57	30,91	7,25	14	48			
	Physiotherapist	14	30,57	6,48	16	36			
	Anesthesia Technician	15	31,46	5,87	16	42			
	General practitioner	13	31,84	9,71	14	44			
	Other	9	32,44	3,97	28	38			

Table 4.41: Comparison of the scores obtained from the total quality management scale and its subscales according to duty (n=341) (Continue)

Scales	Duty	N	x̄	s	Mi	Ma	F	p	Dif
- Process management	Nurse	126	32,89	5,53	13	43	2,544	0,008	3-5
	Midwife	18	33,61	5,10	22	41			
	Lab Technician	11	34,54	5,65	26	42			
	Health Officer	6	30,41	7,93	16	37			
	Specialist Doctor	72	29,35	6,18	13	40			
	Emergency medical technician	57	31,25	6,47	13	42			
	Physiotherapist	14	29,73	7,64	13	38			
	Anesthesia Technician	15	32,58	6,72	13	42			
	General practitioner	13	31,82	7,59	16	41			
	Other	9	33,19	2,65	30	36			
- Collaborations	Nurse	126	34,19	5,54	12	50	3,457	0,000*	3-4
	Midwife	18	33,88	5,81	20	47			
	Lab Technician	11	36,81	5,79	27	45			
	Health Officer	6	27,70	9,33	12	36			
	Specialist Doctor	72	30,08	6,61	12	40			
	Emergency medical technician	57	32,21	7,15	12	50			
	Physiotherapist	14	33,66	5,10	25	43			
	Anesthesia Technician	15	33,08	4,03	26	42			
	General practitioner	13	35,48	11,67	12	50			
	Other	9	31,25	5,03	20	37			
- Customer orientation	Nurse	126	33,27	7,20	12	50	4,302	0,000*	3-4
	Midwife	18	35,13	5,65	27	50			
	Lab Technician	11	38,18	6,52	27	47			
	Health Officer	6	24,16	6,64	12	30			
	Specialist Doctor	72	29,68	6,66	12	45			
	Emergency medical technician	57	32,23	7,88	12	50			
	Physiotherapist	14	30,71	6,31	20	42			
	Anesthesia Technician	15	31,83	6,44	20	47			
	General practitioner	13	36,34	11,48	12	50			
	Other	9	27,22	5,51	20	35			

**p<0,05*

When Table 4.40 and Table 4.41 are examined, it has been determined that there is a statistically significant difference between the scores of the health professionals included in the study from the overall total quality management scale, process management, collaborations and customer orientation subscales according to their duties ($p<0.05$). The scores of laboratory technicians on the overall total quality management scale, process management, collaborations and customer focus subscales were found to be significantly higher than those of healthcare workers who were in other duties.

There was no statistically significant difference between the scores obtained from the sub-scales of leadership, continuous improvement, employee satisfaction, education learning ($p>0.05$).

Table 4.42: Comparison of the scores obtained from the total quality management scale and its subscales according to working time in position (n=341)

Scales		Working time in position	N	x̄	s	Min	Max	F	p	Diff
Total Quality Management Scale		0-5 year	190	31,74	4,77	18	43	12,777	0,000*	3-5
		6-10 year	90	32,63	4,11	24	44			
		11-15 year	39	34,82	4,38	29	43			
		16-20 year	9	33,67	4,58	30	42			
		21 year and above	13	23,82	11,22	13	41			
-	Leadership	0-5 year	190	31,28	7,54	10	44	4,626	0,001*	4-5
		6-10 year	90	30,57	5,47	18	40			
		11-15 year	39	32,61	6,90	24	46			
		16-20 year	9	32,66	5,65	28	40			
		21 year and above	13	23,07	13,53	10	44			
-	Continuous Development	0-5 year	190	32,92	8,37	10	47	4,029	0,003*	3-5
		6-10 year	90	30,66	6,53	15	45			
		11-15 year	39	35,89	6,10	27	45			
		16-20 year	9	30,55	7,26	25	40			
		21 year and above	13	28,65	13,52	15	45			
-	Employee satisfaction	0-5 year	190	32,84	7,42	16	48	4,561	0,001*	4-5
		6-10 year	90	33,84	6,12	24	44			
		11-15 year	39	34,92	5,52	28	48			
		16-20 year	9	38,00	4,24	34	48			
		21 year and above	13	26,92	10,97	16	42			
-	Training learning	0-5 year	190	29,98	6,63	14	48	12,741	0,000*	2-5
		6-10 year	90	33,17	5,20	26	50			
		11-15 year	39	33,02	4,89	28	42			
		16-20 year	9	31,77	6,59	28	46			
		21 year and above	13	21,23	10,56	14	42			
-	Process management	0-5 year	190	30,85	6,14	13	42	13,298	0,000*	3-5
		6-10 year	90	32,66	4,65	18	43			
		11-15 year	39	36,34	3,75	30	43			
		16-20 year	9	32,08	4,41	26	40			
		21 year and above	13	24,32	10,85	16	43			
-	Collaborations	0-5 year	190	32,07	5,84	17	47	19,796	0,000*	3-5
		6-10 year	90	34,34	5,75	21	50			
		11-15 year	39	36,89	4,14	26	45			
		16-20 year	9	34,02	4,54	30	41			
		21 year and above	13	20,86	12,24	12	42			
-	Customer orientation	0-5 year	190	33,03	6,77	20	50	5,987	0,000*	4-5
		6-10 year	90	31,47	6,94	15	50			
		11-15 year	39	31,47	8,84	22	47			
		16-20 year	9	37,50	3,75	32	45			
		21 year and above	13	24,23	12,59	12	45			

**p<0,05*

When Table 4.42 is examined, it has been determined that there is a statistically significant difference between the scores of the total quality management scale, leadership, continuous improvement, employee satisfaction, training learning, process management, collaborations and customer focus subscales according to the working hours of the health care workers included in the research. ($p<0.05$). The general quality management scale, continuous improvement, process management and collaborations of those with a working period of 11-15 years among the healthcare professionals, the leadership, employee satisfaction and customer focus of

those between 16-20 years, and the education-learning subscales of those between 6-10 years. scores were found to be significantly higher than the health workers who were working in other positions.

Table 4.43: Comparison of the scores obtained from the total quality management scale and its subscales according to total period of professional experience (n=341)

Scales	Total period of professional	N	x̄	s	Min	Max	F	p	Diff
Total Quality Management Scale	0-5 year	141	32,62	3,90	23	43			
	6-10 year	115	31,42	5,18	18	43			
	11-15 year	28	35,68	5,77	29	44	8,577	0,000*	3-5
	16-20 year	34	31,94	2,66	29	39			
	21 year and above	23	27,79	10,16	13	42			
- Leadership	0-5 year	141	32,01	6,13	20	44			
	6-10 year	115	29,67	7,88	10	42			
	11-15 year	28	34,71	8,38	24	46	6,042	0,000*	3-5
	16-20 year	34	31,17	3,11	26	40			
	21 year and above	23	26,26	11,35	10	44			
- Continuous Development	0-5 year	141	34,71	6,55	17	47			
	6-10 year	115	29,73	8,68	10	45			
	11-15 year	28	36,60	7,76	22	45	10,149	0,000*	3-4
	16-20 year	34	29,48	5,25	25	45			
	21 year and above	23	31,30	10,81	15	45			
- Employee satisfaction	0-5 year	141	34,38	6,79	22	48			
	6-10 year	115	32,71	7,23	16	44			
	11-15 year	28	35,78	6,26	28	48	4,678	0,001*	3-5
	16-20 year	34	30,94	5,33	24	44			
	21 year and above	23	29,39	9,67	16	48			
- Training learning	0-5 year	141	30,85	6,32	14	46			
	6-10 year	115	30,90	6,59	16	48			
	11-15 year	28	34,35	6,20	26	50	4,263	0,002*	3-5
	16-20 year	34	31,00	3,62	28	42			
	21 year and above	23	26,69	10,84	14	46			
- Process management	0-5 year	141	31,82	5,08	22	42			
	6-10 year	115	31,46	6,15	13	42			
	11-15 year	28	35,80	5,04	30	43	6,985	0,000*	3-5
	16-20 year	34	32,20	6,15	18	43			
	21 year and above	23	27,01	9,70	16	43			
- Collaborations	0-5 year	141	31,80	6,38	17	47			
	6-10 year	115	33,91	5,18	21	50			
	11-15 year	28	37,23	5,85	26	46	9,792	0,000*	3-5
	16-20 year	34	33,75	3,35	26	43			
	21 year and above	23	27,33	12,09	12	43			
- Customer orientation	0-5 year	141	34,55	6,19	20	50			
	6-10 year	115	29,30	6,86	20	50			
	11-15 year	28	34,19	10,56	15	50	11,573	0,000*	3-5
	16-20 year	34	33,67	2,62	27	40			
	21 year and above	23	28,04	11,52	12	47			

**p<0,05*

When Table 4.43 is examined, it has been determined that there is a statistically significant difference between the scores of the total quality management scale, leadership, continuous improvement, employee satisfaction, training learning, process management, collaborations and customer focus subscales according to the total professional experience of the healthcare professionals included in the study.

(p<0.05). The scores of healthcare professionals with a total professional experience of 11-15 years in the overall total quality management scale, leadership, continuous improvement, employee satisfaction, training learning, process management, collaborations and customer focus subscales were found to be significantly higher than the other total professional experience periods.

4.4.2.2. Hospital Hospitality Services Scale

Table 4.44: Comparison of the scores of the hospital hotel management services scale and sub-scales according to the hospitals where healthcare professionals work (n=341)

Scale	Hospital name	n	x̄	s	Min	Max	F	p
Hospital Hospitality Services Scale	Fethiye State Hospital	95	29,65	6,62	10	49	0,049	0,953
	Private Lokman Hekim Esnaf Hospital	176	29,93	7,92	10	48		
	Private Letoon Hospital	70	29,70	7,94	10	48		
- Entrance	Fethiye State Hospital	95	34,00	9,28	10	50	0,193	0,825
	Private Lokman Hekim Esnaf Hospital	176	34,38	11,31	10	50		
	Private Letoon Hospital	70	35,05	11,59	10	50		
- Housekeeping department	Fethiye State Hospital	95	34,29	9,41	10	50	0,402	0,669
	Private Lokman Hekim Esnaf Hospital	176	35,09	10,44	10	50		
	Private Letoon Hospital	70	35,71	10,81	10	50		
- Food and beverage department	Fethiye State Hospital	95	33,50	8,98	10	50	0,128	0,880
	Private Lokman Hekim Esnaf Hospital	176	33,73	8,36	10	50		
	Private Letoon Hospital	70	34,18	8,56	10	50		
- Employees	Fethiye State Hospital	95	28,93	9,41	10	50	1,497	0,225
	Private Lokman Hekim Esnaf Hospital	176	27,29	10,89	10	50		
	Private Letoon Hospital	70	26,11	11,27	10	50		
- General services	Fethiye State Hospital	95	22,91	10,35	10	50	0,440	0,645
	Private Lokman Hekim Esnaf Hospital	176	24,05	10,80	10	45		
	Private Letoon Hospital	70	23,04	10,77	10	45		

**p<0,05*

When Table 4.44 is examined, no statistically significant difference was found between the scores of the healthcare professionals included in the study, according to the hospitals they work in, from the hospital hotel services scale and its sub-scales (p>0.05). Although the hospitals where healthcare professionals work are different, their views on hospital hotel services are similar.

Table 4.45: Comparison of the scores of the hospital hotel management services scale and sub-scales according to gender (n=341)

Scales	Gender	n	$\bar{x}$	s	t	p
Hospital Hospitality Services Scale	Woman	229	27,97	6,92	-6,830	0,000*
	Male	112	33,56	7,47		
- Entrance	Woman	229	32,97	11,03	-3,569	0,000*
	Male	112	37,35	9,79		
- Housekeeping department	Woman	229	33,52	10,68	-3,892	0,000*
	Male	112	38,01	8,50		
- Food and beverage department	Woman	229	32,02	8,45	-5,605	0,000*
	Male	112	37,32	7,64		
- Employees	Woman	229	24,57	9,83	-7,960	0,000*
	Male	112	33,51	9,55		
- General services	Woman	229	21,90	9,90	-4,128	0,000*
	Male	112	26,85	11,38		

**p<0,05*

When Table 4.45 is examined, it was determined that there was a statistically significant difference between the scores of the hospital hotel services scale, entrance section, housekeeping department, food and beverage section, employees and general services sub-scales according to the gender of the healthcare professionals included in the study ($p<0.05$).). Hospital hotel services scale, entrance section, housekeeping department, food and beverage section, employees and general services subscale scores of male healthcare professionals were found to be significantly higher than female healthcare professionals.

Table 4.46: Comparison of the scores of the hospital hotel management services scale and sub-scales according to age (n=341)

Scales	Age	n	$\bar{x}$	s	Min	Max	F	p	Diff
Hospital Hospitality Services Scale	between the ages of 17-24	93	29,66	9,33	10	47			
	between the ages of 25-34	164	30,85	7,21	10	49	4,280	0,015*	2-3
	35 years old and over	84	27,92	5,48	10	43			
- Entrance	between the ages of 17-24	93	35,33	11,04	10	50			
	between the ages of 25-34	164	37,25	9,60	10	50	24,340	0,000*	2-3
	35 years old and over	84	27,85	10,14	10	50			
- Housekeeping department	between the ages of 17-24	93	35,07	11,29	10	50			
	between the ages of 25-34	164	37,61	9,45	10	50	17,738	0,000*	2-3
	35 years old and over	84	29,81	8,42	10	50			
- Food and beverage department	between the ages of 17-24	93	33,87	9,50	11	50			
	between the ages of 25-34	164	35,25	8,27	10	50	8,081	0,000*	2-3
	35 years old and over	84	30,73	7,21	10	47			
- Employees	between the ages of 17-24	93	28,49	12,05	10	50			
	between the ages of 25-34	164	26,55	10,88	10	50	1,288	0,277	
	35 years old and over	84	28,27	7,92	10	50			
- General services	between the ages of 17-24	93	21,89	12,27	10	46	1,781	0,170	

	between the ages of 25-34	164	23,78	11,24	10	50
	35 years old and over	84	24,83	6,72	10	40

**p<0,05*

When Table 4.46 is examined, it has been determined that there is a statistically significant difference between the scores of the hospital hotel services scale, entrance section, housekeeping department and food and beverage department sub-scales according to the age of the healthcare professionals included in the study (p<0.05). Hospital hotel services scale, entrance section, housekeeping department and food and beverage department subscale scores of healthcare professionals aged 25-34 were found to be significantly higher than those of healthcare professionals in other age groups.

There was no statistically significant difference between the scores of the employees and general services sub-scales of the healthcare workers aged 17-24 and 35 years and older (p>0.05). Healthcare professionals in the aforementioned age groups expressed similar opinions about the hospital hotel management services regarding the employees and general services.

Table 4.47: Comparison of the scores of the hospital hotel management services scale and sub-scales according to marital status (n=341)

Scales	Marital status	n	x̄	s	t	p
Hospital Hospitality Services Scale	Married	191	30,79	6,63	2,746	0,006*
	Single	150	28,55	8,47		
- Entrance	Married	191	33,84	10,43	-1,104	0,270
	Single	150	35,14	11,28		
- Housekeeping department	Married	191	34,77	9,74	-0,452	0,652
	Single	150	35,28	10,84		
- Food and beverage department	Married	191	34,73	7,50	2,383	0,018*
	Single	150	32,52	9,62		
- Employees	Married	150	28,21	10,30	1,386	0,167
	Single	191	26,61	10,93		
- General services	Married	150	26,08	10,33	5,183	0,000*
	Single	191	20,27	10,19		

**p<0,05*

When Table 4.47 is examined, it has been determined that there is a statistically significant difference between the scores of the hospital hotel services scale, food and beverage department and general services sub-scales according to the marital status of the healthcare professionals included in the study (p<0.05). The scores of the hospital hotel services scale, food and beverage department and general services

subscales of the married health workers were found to be significantly higher than those of the single health workers.

There was no statistically significant difference between the scores of the single health workers in the entrance department, housekeeping department and the employees subscales (p>0.05). Single healthcare professionals expressed similar opinions about the entrance part of the hospital hotel services, the housekeeping department and the issues related to the employees.

Table 4.48: Comparison of the scores of the hospital hotel management services scale and sub-scales according to educational status (n=341)

Scales	Educational status	N	x̄	s	Mi	Ma	F	p	Diff
Hospital Hospitality Services Scale	Health vocational high	14	31,8	8,53	10	49	5,080	0,001*	1-4
	Associate degree	10	28,9	5,08	21	47			
	Licence	84	27,6	8,03	10	43			
	Degree	7	27,4	3,44	25	35			
	Doctorate	6	28,8	3,37	25	33			
- Entrance	Health vocational high	14	38,0	9,94	10	50	12,370	0,000*	1-3
	Associate degree	10	34,6	9,92	10	50			
	Licence	84	28,3	10,7	10	50			
	Degree	7	29,1	10,8	20	48			
	Doctorate	6	36,6	9,52	20	48			
- Housekeeping department	Health vocational high	14	37,6	9,77	10	50	9,682	0,000*	1-3
	Associate degree	10	35,8	9,00	18	50			
	Licence	84	29,3	10,4	10	50			
	Degree	7	34,5	10,7	20	50			
	Doctorate	6	36,3	9,24	20	46			
- Food and beverage department	Health vocational high	14	36,6	9,03	10	50	10,806	0,000*	5-3
	Associate degree	10	33,1	6,01	20	50			
	Licence	84	29,6	8,79	10	47			
	Degree	7	30,6	7,46	24	44			
	Doctorate	6	37,6	5,61	31	44			
- Employees	Health vocational high	14	28,8	11,3	10	50	1,304	0,268	
	Associate degree	10	26,8	10,7	10	50			
	Licence	84	26,6	8,70	10	43			
	Degree	7	25,0	12,5	10	50			
	Doctorate	6	22,2	7,93	10	28			
- General services	Health vocational high	14	24,3	11,9	10	50	2,741	0,029	3-1
	Associate degree	10	21,0	9,46	10	46			
	Licence	84	25,6	9,62	10	44			
	Degree	7	22,2	9,12	10	30			
	Doctorate	6	19,1	5,41	13	26			

**p<0,05*

When Table 4.48 is examined, it has been determined that there is a statistically significant difference between the scores of the hospital hotel management services scale, entrance section, housekeeping department, food and beverage section and general services sub-scales according to the education levels of the healthcare professionals included in the study (p<0.05). . The scores of the Health Vocational

High School health workers on the hospital hotel services scale, entrance department and housekeeping department, and the general services sub-scales of the undergraduate graduates were found to be significantly higher than the health workers with other education levels.

There was no statistically significant difference between the scores of the employees of the hospital and hotel management services scale according to the education level of the healthcare professionals (p>0.05).

Table 4.49: Comparison of the scores of the hospital hotel management services scale and sub-scales according to Service running (n=341)

Scales	Service running	N	x̄	s	Mi	Max	F	p	Diff
Hospital Hospitality Services Scale	Anesthesia	30	31,28	5,44	26	49	8,724	0,00*	17-10
	Urology	3	29,09	0,00	29	29			
	Dermis	8	26,02	0,10	25	26			
	Pediatry	9	24,14	5,31	10	27			
	Internal medicine	67	28,91	5,13	13	40			
	Infectious Diseases	6	26,56	1,97	25	30			
	Physical therapy and	6	25,96	1,97	25	30			
	General Surgery	36	24,25	12,64	10	41			
	Thoracic Surgery	6	26,61	7,29	23	41			
	Eye diseases	6	22,78	1,60	21	26			
	First and Emergency Aid	36	29,72	5,04	10	43			
	Gynecology and Obstetrics	4	33,48	0,90	33	34			
	Cardiology	3	30,20	7,69	25	39			
	ENT	9	34,71	0,40	33	34			
	Neurology	20	31,51	5,03	26	39			
	Neurosurgery	23	37,73	7,60	45	45			
	Radiology	19	40,47	7,44	32	48			
	Orthopedics and Traumatology	6	22,92	2,72	21	28			
	Other	44	29,09	3,59	23	34			
- Entrance	Anesthesia	30	40,60	6,54	26	48	9,226	0,00*	17-18
	Urology	3	26,00	0,00	26	26			
	Dermis	8	39,50	7,07	22	42			
	Pediatry	9	19,33	3,74	10	24			
	Internal medicine	67	33,64	7,78	12	50			
	Infectious Diseases	6	25,00	12,24	20	50			
	Physical therapy and	6	31,33	3,26	30	38			
	General Surgery	36	29,55	17,89	10	48			
	Thoracic Surgery	6	26,00	9,79	22	46			
	Eye diseases	6	23,66	8,98	20	42			
	First and Emergency Aid	36	39,72	6,62	10	48			
	Gynecology and Obstetrics	4	39,00	2,00	36	40			
	Cardiology	3	25,33	5,77	22	32			
	ENT	9	36,00	0,00	36	36			
	Neurology	20	28,50	4,93	22	36			
	Neurosurgery	23	39,04	5,96	28	44			
	Radiology	19	46,10	4,34	40	50			
	Orthopedics and Traumatology	6	15,66	13,88	10	44			
	Other	44	35,72	9,04	20	50			
- Housekeeping department	Anesthesia	30	40,53	6,80	24	50	9,645	0,00*	17-4
	Urology	3	30,00	0,00	30	30			
	Dermis	8	38,75	3,53	30	40			
	Pediatry	9	20,22	5,51	10	32			
	Internal medicine	67	33,61	8,49	12	50			
	Infectious Diseases	6	22,66	6,53	20	36			
	Physical therapy and	6	21,33	8,16	18	38			
	General Surgery	36	27,83	17,02	10	48			
	Thoracic Surgery	6	27,66	8,98	24	46			
	Eye diseases	6	35,00	2,44	34	40			
	First and Emergency Aid	36	39,27	6,19	10	48			
	Gynecology and Obstetrics	4	39,00	2,00	38	42			
	Cardiology	3	34,66	8,08	30	44			
	ENT	9	41,77	0,66	40	42			
	Neurology	20	33,70	6,49	28	44			
	Neurosurgery	23	40,95	5,90	30	44			
	Radiology	19	46,10	4,34	40	50			
	Orthopedics and Traumatology	6	24,00	9,79	20	44			
	Other	44	35,36	6,26	20	48			

Table 4.50: Comparison of the scores of the hospital hotel management services scale and sub-scales according to Service running (n=341) (Continuos)

Scales	Service running	N	x̄	s	Min	Max	F	p	Diff
- Food and beverage department	Anesthesia	30	37,19	5,39	24	50	7,415	0,00*	17-9
	Urology	3	37,14	0,00	37	37			
	Dermis	8	35,53	4,54	24	37			
	Pediatry	9	29,20	7,28	10	34			
	Internal medicine	67	32,62	8,35	10	50			
	Infectious Diseases	6	33,81	1,16	31	34			
	Physical therapy and rehabilitation	6	31,19	6,41	28	44			
	General Surgery	36	27,06	11,89	10	42			
	Thoracic Surgery	6	22,61	6,41	20	35			
	Eye diseases	6	25,23	5,83	22	37			
	First and Emergency Aid	36	34,36	6,55	10	47			
	Gynecology and Obstetrics	4	40,71	4,28	34	42			
	Cardiology	3	29,04	8,24	24	38			
	ENT	9	35,39	3,33	34	44			
	Neurology	20	36,00	6,01	28	45			
	Neurosurgery	23	39,44	6,04	28	42			
	Radiology	19	44,81	6,53	35	50			
	Orthopedics and Traumatology	6	26,67	2,33	25	31			
	Other	44	33,11	6,78	24	45			
- Employees	Anesthesia	30	24,44	10,08	10	50	10,911	0,00*	17-3
	Urology	3	15,00	0,00	15	15			
	Dermis	8	11,25	3,53	10	20			
	Pediatry	9	26,11	6,06	10	28			
	Internal medicine	67	28,50	8,02	10	50			
	Infectious Diseases	6	26,94	0,68	26	28			
	Physical therapy and rehabilitation	6	25,00	4,08	23	33			
	General Surgery	36	19,30	12,52	10	40			
	Thoracic Surgery	6	24,72	7,48	21	40			
	Eye diseases	6	22,50	6,12	10	25			
	First and Emergency Aid	36	26,89	10,36	10	45			
	Gynecology and Obstetrics	4	38,33	3,33	33	40			
	Cardiology	3	25,55	9,62	20	36			
	ENT	9	32,77	1,66	28	33			
	Neurology	20	34,41	4,33	28	40			
	Neurosurgery	23	35,50	7,84	21	40			
	Radiology	19	44,03	9,81	23	50			
	Orthopedics and Traumatology	6	20,27	4,76	18	30			
	Other	44	25,45	7,67	10	43			
- General services	Anesthesia	30	21,96	9,43	10	50	4,985	0,00*	16-10
	Urology	3	33,00	0,00	33	33			
	Dermis	8	15,12	6,01	13	30			
	Pediatry	9	23,77	5,26	10	26			
	Internal medicine	67	21,83	8,60	10	46			
	Infectious Diseases	6	24,00	2,44	19	25			
	Physical therapy and rehabilitation	6	22,50	6,12	10	25			
	General Surgery	36	20,83	13,60	10	42			
	Thoracic Surgery	6	30,33	5,71	28	42			
	Eye diseases	6	14,66	0,81	13	15			
	First and Emergency Aid	36	18,38	9,27	10	44			
	Gynecology and Obstetrics	4	20,00	0,80	16	32			
	Cardiology	3	34,00	6,92	30	42			
	ENT	9	31,22	2,33	25	32			
	Neurology	20	27,05	9,33	10	42			
	Neurosurgery	23	35,60	11,13	10	42			
	Radiology	19	29,68	15,32	14	45			
	Orthopedics and Traumatology	6	25,00	7,,34	10	28			
	Other	44	22,02	8,58	10	38			

**p<0,05*

When Table 4.49 and Table 4.50 are examined, it has been determined that there is a statistically significant difference between the scores of the hospital hotel services scale, entrance section, housekeeping department, food and beverage section and general services sub-scales according to the educational status of the healthcare professionals included in the study (p<0). .05). The scores of the radiology service health workers on the hospital hotel services scale, entrance department and housekeeping department, and the neurosurgery (Neurosurgery) service health

workers on the general services sub-scales were found to be significantly higher than the health workers of other services.

Table 4.51: Comparison of the scores of the hospital hotel management services scale and sub-scales according to duty (n=341)

Scales		Duty	N	x̄	s	Min	Ma	F	p	Diff
Hospital Scale	**Hospitality Services**	Nurse	126	29,38	8,18	10	48	2,412	0,012	8-9
		Midwife	18	28,63	4,23	17	33			
		Lab Technician	11	26,11	7,97	10	38			
		Health Officer	6	31,76	7,49	23	42			
		Specialist Doctor	72	30,02	7,59	10	48			
		Emergency medical	57	30,22	7,51	10	48			
		Physiotherapist	14	33,20	5,17	25	42			
		Anesthesia Technician	15	34,80	7,04	26	49			
		General practitioner	13	24,21	2,13	21	29			
		Other	9	31,41	6,36	25	42			
-	Entrance	Nurse	126	33,01	10,76	10	50	4,187	0,000*	8-9
		Midwife	18	34,33	6,55	20	48			
		Lab Technician	11	30,72	12,56	10	48			
		Health Officer	6	34,33	11,75	20	48			
		Specialist Doctor	72	36,47	11,49	10	50			
		Emergency medical	57	35,61	10,89	10	50			
		Physiotherapist	14	38,57	7,45	26	50			
		Anesthesia Technician	15	39,86	6,47	26	48			
		General practitioner	13	20,76	5,57	10	28			
		Other	9	38,88	8,43	20	48			
-	Housekeeping department	Nurse	126	33,27	10,43	10	50	3,527	0,000*	7-9
		Midwife	18	30,44	8,87	12	46			
		Lab Technician	11	32,18	13,34	10	50			
		Health Officer	6	36,33	10,91	20	48			
		Specialist Doctor	72	37,00	10,08	10	50			
		Emergency medical	57	36,59	10,20	10	50			
		Physiotherapist	14	40,71	6,20	30	50			
		Anesthesia Technician	15	40,00	7,09	24	50			
		General practitioner	13	26,92	5,00	20	34			
		Other	9	39,11	8,60	20	48			
-	Food and beverage department	Nurse	126	32,52	8,62	10	50	2,663	0,005*	10-9
		Midwife	18	33,17	8,40	10	42			
		Lab Technician	11	30,90	9,58	11	47			
		Health Officer	6	35,95	6,84	25	44			
		Specialist Doctor	72	34,98	9,00	10	50			
		Emergency medical	57	34,66	8,55	10	50			
		Physiotherapist	14	36,83	6,93	24	50			
		Anesthesia Technician	15	37,61	6,75	24	50			
		General practitioner	13	26,48	5,03	20	37			
		Other	9	38,09	4,57	31	44			
-	Employees	Nurse	126	27,87	10,98	10	50	0,892	0,533	
		Midwife	18	28,24	8,77	10	41			
		Lab Technician	11	26,36	10,32	10	46			
		Health Officer	6	26,66	12,42	10	40			
		Specialist Doctor	72	26,59	10,92	10	50			
		Emergency medical	57	27,92	10,54	10	50			
		Physiotherapist	14	28,69	8,14	10	40			
		Anesthesia Technician	15	32,00	12,77	10	50			
		General practitioner	13	21,53	4,38	15	30			
		Other	9	26,85	11,03	10	40			

Table 4.52: Comparison of the scores of the hospital hotel management services scale and sub-scales according to duty (n=341) (Continuos)

Scales	Duty	N	x̄	s	Min	Max	F	p
- General services	Nurse	126	24,34	10,78	10	46	1,645	0,101
	Midwife	18	21,94	7,13	10	38		
	Lab Technician	11	17,27	7,15	10	31		
	Health Officer	6	28,33	11,67	10	42		
	Specialist Doctor	72	21,90	10,89	10	45		
	Emergency medical technician	57	22,61	11,09	10	45		
	Physiotherapist	14	26,92	10,08	14	42		
	Anesthesia Technician	15	29,40	11,87	10	50		
	General practitioner	13	24,61	5,81	15	33		
	Other	9	21,88	12,97	10	42		

**p<0,05*

When Table 4.51 and Table 4.52 were examined, it was found that there was a statistically significant difference between the scores of the healthcare professionals included in the study from the sub-scales of the hospital hotel services scale, entrance section, housekeeping department, and food and beverage section ($p<0.05$). The scores of the hospital hotel services scale and entrance section of the employees as anesthesia technicians, the housekeeping department of the employees as physiotherapists, and the food and beverage department sub-scales of the employees in other duties were found to be significantly higher than those of the healthcare professionals working in other duties.

There was no statistically significant difference between the scores of the hospital and hotel management services scale Employees and general services subscales according to the duties of the healthcare professionals ($p>0.05$).

Table 4.53: Comparison of the scores of the hospital hotel management services scale and sub-scales according to working time in position süreleri (n=341) (Continuos)

Scales	Working time in position	N	x̄	s	Mi	Ma	F	p	Dif
Hospital Hospitality Services Scale	0-5 year	19	29,2	5,47	12	47			
	6-10 year	90	31,1	11,0	10	48			
	11-15 year	39	30,7	7,38	24	49	1,716	0,146	
	16-20 year	9	28,7	6,60	23	40			
	21 year and above	13	26,4	2,68	24	35			
- Entrance	0-5 year	19	36,2	8,66	10	50			
	6-10 year	90	34,1	13,8	10	50			
	11-15 year	39	30,9	10,7	20	48	6,400	0,000*	1-4
	16-20 year	9	29,7	10,1	22	50			
	21 year and above	13	23,5	6,11	20	40			
- Housekeeping department	0-5 year	19	37,3	8,06	10	50			
	6-10 year	90	33,6	13,1	10	50			
	11-15 year	39	31,5	9,61	20	48	8,668	0,000*	1-4
	16-20 year	9	27,1	3,88	24	34			
	21 year and above	13	25,8	8,99	16	50			
- Food and beverage department	0-5 year	19	34,0	7,16	10	50			
	6-10 year	90	34,8	11,8	10	50			
	11-15 year	39	32,0	4,90	20	48	2,054	0,087	
	16-20 year	9	28,2	10,4	20	42			
	21 year and above	13	31,2	5,97	24	44			
- Employees	0-5 year	19	26,4	9,75	10	50			
	6-10 year	90	28,8	13,4	10	50			
	11-15 year	39	29,9	8,10	15	50	1,378	0,241	
	16-20 year	9	26,6	6,61	21	36			
	21 year and above	13	27,3	7,74	20	50			
- General services	0-5 year	19	20,1	9,14	10	46			
	6-10 year	90	27,0	12,4	10	45			
	11-15 year	39	29,7	9,23	19	50	13,361	0,000*	4-1
	16-20 year	9	30,7	4,63	28	42			
	21 year and above	13	24,4	5,44	10	30			

**p<0,05*

When Table 4.53 is examined, it has been determined that there is a statistically significant difference between the scores of the health workers included in the study, according to their working hours in the entrance section, housekeeping department and general services sub-scales ($p<0.05$). The scores obtained from the sub-scales of the entrance department and housekeeping department of the employees with a working period of 0-5 years in their positions were found to be significantly higher than the health workers who had worked in other positions.

There was no statistically significant difference between the scores of the hospital hotel management services scale, food and beverage department and employees sub-scales according to the working hours of the health workers in their positions ($p>0.05$).

Table 4.54: Comparison of the scores of the hospital hotel management services scale and sub-scales according to total period of professional experience (n=341)

Ölçekler	Total period of professional	N	x̄	s	Min	Max	F	p	Diff
Hospital Hospitality Services Scale	0-5 year	141	29,37	5,76	12	47			
	6-10 year	115	32,04	10,03	10	48			
	11-15 year	28	30,34	6,73	23	49	6,464	0,000*	2-5
	16-20 year	34	25,75	3,69	13	30			
	21 year and above	23	26,66	3,68	23	35			
- Entrance	0-5 year	141	35,12	7,96	10	50			
	6-10 year	115	37,23	12,99	10	50			
	11-15 year	28	32,57	9,15	22	50	9,225	0,000*	2-5
	16-20 year	34	30,17	11,68	12	50			
	21 year and above	23	24,52	6,77	20	40			
- Housekeeping department	0-5 year	141	36,09	7,86	10	50			
	6-10 year	115	37,79	12,55	10	50			
	11-15 year	28	32,57	6,32	20	48	11,310	0,000*	2-5
	16-20 year	34	28,64	8,92	12	40			
	21 year and above	23	26,60	6,83	16	50			
- Food and beverage department	0-5 year	141	34,10	7,20	20	50			
	6-10 year	115	35,32	10,22	10	50			
	11-15 year	28	33,16	7,74	17	48	3,880	0,004*	2-4
	16-20 year	34	29,79	8,19	10	40			
	21 year and above	23	30,43	5,97	24	44			
- Employees	0-5 year	141	28,52	8,92	10	50			
	6-10 year	115	27,52	12,97	10	50			
	11-15 year	28	31,60	7,66	21	50	4,490	0,002*	3-4
	16-20 year	34	21,66	8,97	10	41			
	21 year and above	23	24,85	8,70	15	50			
- General services	0-5 year	141	20.34	9,38	10	46			
	6-10 year	115	26,97	12,55	10	45			
	11-15 year	28	25,39	9,83	13	50	7,513	0,000*	2-1
	16-20 year	34	21,73	7,78	10	38			
	21 year and above	23	26,21	4,88	10	33			

**p<0,05*

When Table 4.54 is examined, it has been determined that there is a statistically significant difference between the scores of the hospital hotel services scale, entrance section, housekeeping department, food and beverage section, employees and general services sub-scales according to the total professional experience of the healthcare professionals included in the study (p<0). .05). The scores of the hospital hotel services scale, entrance section, housekeeping department, food and beverage department and general services of the employees with a total professional experience of 6-10 years, and the sub-scales of employees with a total of 11-15 years are significantly more significant than the other healthcare professionals with total professional experience. level was found to be high.

4.4.3. Outpatient and Inpatient Treatment

4.4.3.1. Patient Satisfaction Scale

Table 4.55: Comparison of the scores of the patients according to the hospitals (n=200)

Scale	Hospital name	n	x̄	s	Min	Max	F	p
Outpatient scales	Fethiye State Hospital	51	14,34	4,22	10	25	1,842	0,164
	Private Lokman Hekim Esnaf Hospital	28	13,02	3,32	10	20		
	Private Letoon Hospital	21	12,74	3,11	10	20		
Inpatient scales	Fethiye State Hospital	64	14,42	3,73	10	25	0,090	0,914
	Private Lokman Hekim Esnaf Hospital	17	14,11	3,59	10	25		
	Private Letoon Hospital	19	14,69	3,98	10	25		

When Table 4.55 was examined, it was determined that there was no statistically significant difference between the scores of outpatients and inpatients in outpatient and inpatient scales compared to hospitals (p>0.05).

Table 4.56: Comparison of the scores of the patients according to ages (n=200)

Scales	Ages	n	x̄	s	Min	Max	F	p	Diff
Outpatient scales	between the ages of 18-25	29	13,82	3,80	10	20	1,962	0,107	-
	between the ages of 26-40	30	14,38	2,88	10	20			
	between the ages of 41-50	21	11,72	3,50	10	23			
	between the ages of 51-65	12	13,78	5,14	10	25			
	66 age and above	8	15,00	4,56	10	20			
Inpatient scales	between the ages of 18-25	18	14,72	2,55	11	17	**5,024**	**,001***	**4-5**
	between the ages of 26-40	38	14,40	3,71	10	21			
	between the ages of 41-50	9	14,72	2,46	10	20			
	between the ages of 51-65	13	17,56	6,18	12	25			
	66 age and above	22	12,19	0,48	10	12			

**p<0,05*

When Table 4.56 is examined, it has been determined that there is no statistically significant difference between the scores of the patients participating from the outpatient hospitals according to their ages from the outpatient scale (p>0.05). It was determined that there was a statistically significant difference between the scores of the inpatients received from the inpatient scale according to their age (p<0.05). The scores of inpatients between the ages of 51-65 who received inpatient treatment from the inpatient scale were found to be significantly higher than inpatients in other age groups.

Table 4.57: Comparison of the scores of the patients according to educational level (n=200)

Scales	educational level	n	x̄	s	Min	Max	F	p	Diff
	Illiterate	13	13,19	5,05	10	25			
	Primary school	20	12,26	3,13	10	20			
Outpatient scales	Middle School	8	13,07	3,67	10	19	**4,102**	**0,004***	**2-4**
	High School and Equivalent School	30	15,82	3,65	10	23			
	University and above	29	12,67	3,01	10	20			
	Illiterate	12	12,15	1,25	11	15			
	Primary school	29	11,98	1,07	10	14			
Inpatient scales	Middle School	6	14,58	1,02	12	15	**19,210**	**0,000***	**2-5**
	High School and Equivalent School	25	14,16	3,00	10	20			
	University and above	28	18,09	4,24	10	25			

**p<0,05*

When Table 4.57 is examined, it has been determined that there is a statistically significant difference between the scores of the patients attending outpatient hospitals according to their education levels ($p<0.05$). The scores of the outpatients who were high school or equivalent school graduates from the outpatient scale were found to be significantly higher than the patients with other education levels who were treated for an attack. It was determined that there was a statistically significant difference between the scores of inpatients receiving treatment from the inpatient scale ($p<0.05$). The scores of inpatients with university or higher education level from the inpatient scale were found to be significantly higher than the inpatients with other education levels.

Table 4.58: Comparison of the scores of the patients according to gender (n=200)

Scales	Gender	n	x̄	s	t	p
Outpatient scales	Woman	56	14,02	4,25	1,144	0,255
	Male	44	13,14	3,14		
Inpatient scales	Woman	44	14,92	3,27	1,211	0,229
	Male	56	14,01	4,02		

Table 4.58 shows the results of the independent sample t-test, which was made for the purpose of comparing the scores obtained from the scales according to the gender of the patients attending from outpatient and inpatient hospitals. When Table 4.32 was examined, it was determined that there was no statistically significant difference between the scores of the patients participating from the outpatient and inpatient hospitals ($p>0.05$).

Table 4.59: Comparison of the scores of the patients according to profession (n=200)

Scales	Profession	n	x̄	s	Min	Max	F	p	Diff
Outpatient scales	Self Employed (Other)	34	12,37	3,11	10	25	1,572	0,176	-
	Employee	23	15,01	3,68	10	20			
	Officer	21	14,39	3,89	10	20			
	Retired	7	13,29	5,78	10	23			
	Housewife	8	13,46	2,66	10	17			
	Unemployed	7	13,51	5,08	10	20			
Inpatient scales	Self Employed (Other)	21	12,57	0,82	10	15	**7,217**	**0,000***	**4-5**
	Employee	32	16,04	3,24	10	21			
	Officer	19	12,58	2,60	10	15			
	Retired	6	11,94	0,68	11	13			
	Housewife	12	17,63	6,50	11	25			
	Unemployed	10	14,16	2,63	11	16			

**p<0,05*

When Table 4.59 was examined, it was determined that there was no statistically significant difference between the scores of the outpatients according to their occupations from the outpatient scale (p>0.05). It was determined that there was a statistically significant difference between the scores of the inpatients received from the inpatient scale according to their occupations (p<0.05). The scores of the patients who were housewives from the inpatient scale were found to be significantly higher than the patients who were hospitalized with other occupations.

Table 4.60: Comparison of the scores of the patients according to Social security (n=200)

Ölçekler	Social security	n	x̄	s	Min	Max	F	p	Diff
Outpatient scales	Employees subject to SSI	82	13,51	3,77	10	25	2,159	0,080	-
	Retired subject to SSI	10	16,00	4,24	10	20			
	Green card	2	15,76	1,63	14	16			
	No social security	4	10,57	0,38	10	10			
	Other (Private, Bağ-Kur, Abroad)	2	10,76	0,00	10	10			
Inpatient scales	Employees subject to SSI	48	14,93	3,22	10	21	**25,763**	**0,000***	**3-4**
	Retired subject to SSI	23	11,66	1,00	10	12			
	Green card	6	23,61	3,40	16	25			
	No social security	1	10,83	0,00	10	10			
	Other (Private, Bağ-Kur, Abroad)	22	13,82	2,05	10	16			

**p<0,05*

When Table 4.59 was examined, it was determined that there was no statistically significant difference between the scores of the outpatients according to their occupations from the outpatient scale (p>0.05). It was determined that there was a statistically significant difference between the scores of the inpatients received from the inpatient scale according to their occupations (p<0.05). The scores of the patients who were housewives from the inpatient scale were found to be significantly higher than the patients who were hospitalized with other occupations.

4.5. Correlation Analysis

Table 4.61: Mean and standard deviations of research scales and subscales

Scales	N	x̄	Ss
Leadership Behaviors Scale	**31**	**43,87**	**4,47**
– Supportive Leadership	31	42,81	5,36
– Instrumental (Directive) Leadership	31	43,60	3,98
– Achievement Oriented Leadership	31	44,62	4,80
– Participatory Leadership	31	45,93	4,24
Total Quality Management Scale	**341**	**32,07**	**5,28**
– Leadership	341	30,97	7,40
– Continuous Development	341	32,44	8,06
– Employee satisfaction	341	33,25	7,15
– Training learning	341	30,89	6,72
– Process management	341	31,74	6,16
– Collaborations	341	32,85	6,60
– Customer orientation	341	32,22	7,52
Hospital Hospitality Services Scale	**341**	**29,81**	**7,56**
- Entrance	341	34,41	10,82
- Housekeeping department	341	34,99	10,23
- Food and beverage department	341	33,76	8,56
- Employees	341	27,50	10,59
- General services	341	23,52	10,65
Patient Satisfaction Scale	**200**	**14,03**	**2,55**
- Outpatient scales	100	13,63	3,81
- Inpatient scales	100	14,41	3,72

While the average of the participatory leadership subscale (45.93±4.24) of the leadership behaviors scale used in the research was the highest, the average of the supportive leadership sub-scale (42.81±5.36) was the lowest.

While the mean of the total quality management employee satisfaction subscale (33.25±7.15) is the highest, the mean of the education-learning subscale (30.89±6.72) is the lowest.

While the average of the hospital hotel services housekeeping department subscale (34.99±10.23) is the highest, the average of the general services subscale (23.52±10.65) is the lowest.

While the mean of the hospital satisfaction scale inpatient scale (14.41±3.72) was the highest, the mean of the outpatient subscale (13.63±3.81) was the lowest.

Table 4.62: Correlation Table

		Leadership Behaviors Scale	Supportive Leadership	Instrumental (Directive) Leadership	Achievement Oriented Leadership	Participatory Leadership	**Toplam Kalite Yönetimi Ölçeği**	Leadership	Continuous Development	Employee satisfaction	Training learning	Process management	Collaborations	Customer orientation	**Hospital Hospitality Services Scale**	Entrance	Housekeeping department	Food and beverage department	Employees	General services	**Patient Satisfaction Scale**	Outpatient scales	Inpatient scales
Leadership Behaviors Scale	r	1																					
	p																						
Supportive Leadership	r	**,974**	1																				
	p	**,000****																					
Instrumental (Directive) Leadership	r	**,991**	**,949**	1																			
	p	**,000****	**,000****																				
Achievement Oriented Leadership	r	**,964**	**,915**	**,944**	1																		
	p	**,000****	**,000****	**,000****																			
Participatory Leadership	r	**,923**	**,828**	**,939**	**,887**	1																	
	p	**,000****	**,000****	**,000****	**,000****																		
Total Quality Management Scale	r	-,044	-,046	-,048	-,008	-,071	1																
	p	,812	,804	,798	,965	,705																	
Leadership	r	-,014	,022	-,039	,028	-,115	,798	1															
	p	,940	,905	,837	,881	,538	,000**																
Continuous Development	r	-,080	-,070	-,081	-,048	-,133	,768	**,666**	1														
	p	,668	,708	,664	,796	,476	,000**	**,000****															
Employee satisfaction	r	-,088	-,108	-,087	-,078	-,030	,732	**,550**	**,635**	1													
	p	,637	,562	,643	,676	,872	,000**	**,000****	**,000****														
Training learning	r	-,091	-,070	-,097	-,071	-,145	,717	**,549**	**,424**	**,339**	1												
	p	,626	,708	,604	,705	,437	,000**	**,000****	**,000****	**,000****													
Process management	r	-,026	-,039	-,023	,024	,005	,845	**,635**	**,553**	**,573**	**,656**	1											
	p	,890	,837	,904	,898	,977	,000**	**,000****	**,000****	**,000****	**,000****												
Collaborations	r	-,060	-,073	-,071	,002	-,072	,730	**,389**	**,408**	**,386**	**,452**	**,523**	1										
	p	,749	,698	,706	,991	,702	,000**	**,000****	**,000****	**,000****	**,000****	**,000****											
Customer orientation	r	,193	,169	,222	,187	,158	**,699**	**,526**	**,510**	**,466**	**,391**	**,435**	**,506**	1									
	p	,298	,363	,229	,313	,395	**,000****	**,000****	**,000****	**,000****	**,000****	**,000****	**,000****										
Hospital Hospitality Services Scale	r	**,396**	**,408**	**,363**	**,396**	,350	-,060	,018	-,075	-,064	-,018	,007	-,018	**-,232**	1								
	p	**,028***	**,028***	**,045***	**,027***	,054	,273	,746	,165	,236	,735	,901	,745	**,000****									
Entrance	r	,059	,047	,071	,059	,056	-,052	,096	-,013	-,041	-,097	-,018	-,051	**-,180**	**,723**	1							
	p	,751	,803	,703	,751	,765	,343	,077	,813	,446	,072	,736	,351	**,001****	**,000****								
Housekeeping department	r	,004	,008	,010	-,012	,004	-,071	,032	-,013	-,080	-,079	-,051	-,032	**-,187**	**,767**	**,875**	1						
	p	,982	,967	,958	,948	,984	,192	,556	,811	,140	,145	,347	,560	**,001****	**,000****	**,000****							
Food and beverage department	r	,289	,312	,273	,271	,223	-,068	,054	-,019	**-,137**	,030	-,006	**-,106**	**-,184**	**,811**	**,711**	**,735**	1					
	p	,115	,087	,138	,141	,227	,211	,323	,729	**,011***	,584	,919	**,049***	**,001****	**,000****	**,000****	**,000****						
Employees	r	,265	,288	,224	,285	,209	,032	**,110**	-,037	-,050	,047	,049	,033	-,009	**,735**	**,328**	**,377**	**512**	1				
	p	,149	,116	,225	,120	,259	,557	**,042***	,496	,356	,391	,364	,545	876	**,000****	**,000****	**,000*****	**,000****					
General services	r	**,459**	**,463**	**,416**	**,466**	**,436**	-,060	**-,119***	**-,131**	,016	,000	,023	,040	**-,253**	**,714**	**,172**	**,236**	**,318**	**,491**	1			
	p	**,009****	**,009****	**,020***	**,008****	**,014***	,267	**,028**	**,015***	,770	,999	,668	,464	**,000****	**,000****	**,001****	**,000****	**,000****	**,000****				
Patient Satisfaction Scale	r	-,251	-,242	-242	-,207	-,302	,114	,093	,074	,004	**,204**	,063	,140	,013	-,142	-,007	-,156	,005	-,077	-,182	1		
	p	,173	,190	,189	,264	,099	,260	,358	,467	,966	**,042***	,531	,165	,895	,159	,945	,122	,964	,446	,069			
Outpatient scales	r	-,182	-,187	-,167	-,124	-,236	,077	,054	,051	-,017	,161	,052	,073	,041	-,170	-,092	-,136	-,011	-,004	**-,243**	**,747**	1	
	p	,328	,313	,368	,506	,201	,444	,595	,613	,863	,109	,606	,470	,686	,091	,361	,178	,917	970	**,015***	**,000****		
Inpatient scales	r	-,188	-,158	-,198	-,197	,193	,051	,056	,037	,008	,090	,010	,096	-,048	-,016	,097	-,073	,014	-,109	,008	**,608**	-,067	1
	p	,312	,396	,287	,288	,298	,612	,579	,715	,936	,374	,920	,341	,633	,873	,339	,472	,887	,280	,941	**,000****	,508	

*. Correlation is significant at the 0.05 level (2-tailed). **. Correlation is significant at the 0.01 level (2-tailed).

When Table 4.62 is examined; Between general leadership behaviors and hospital hotel services (r=396, p<.05), hospital hotel services between general services dimension (r=459, p<.05), between supportive leadership style of leadership behaviors and hospital hotel services (r= 408, p<.05), among hospital hotel management general services dimension (r=463, p<.05), between instrumental (Director) leadership style of leadership behaviors and hospital hotel services (r=363, p<.05), hospital among general hospitality services (r=416, p<.05), between achievement-oriented leadership style and hospital hotel services (r=396, p<.05), among hospital hotel general services (r=466, p<.05) Statistically significant and positive correlations were found between participatory leadership and hospital hotel management general services (r=436, p<.05). Accordingly, as the leadership behavior scores increase, there is an increase in hospital hotel services and general services.

Statistically significant and positive (r=110, p<.05) between total quality management leadership dimension and hospital hotel services employees dimension, statistically significant and negative direction (r=-119, p<.05) between hospital hotel services scale general services dimension scores. p<.05), statistically significant and negative correlations (r=-131, p<.05) were found between hospital hotel management services scale continuous improvement sub-dimension scores. Accordingly, as the total quality management leadership scores increase, the scores of the hospital and hotel services employees increase and the general services scores decrease.

Statistically significant and negative direction (r=-137, p<.05) between total quality management employee satisfaction dimension and hospital hotel services food and beverage department.

Statistically significant and positive (r=204, p<.05) between total quality management education learning dimension and hospital satisfaction.

Statistically significant and negative direction (r=-106, p<.05) between total quality management collaborations dimension and hospital hotel services food and beverage department.

Statistically significant and negative direction (r=-232, p<.05) between total quality management customer orientation dimension and hospital hotel services.

Statistically significant and negative direction (r=-180, p<.05) between total quality management customer orientation dimension and hospital hotel services introductory section.

Statistically significant and negative direction (r=-187, p<.05) between total quality management customer orientation dimension and hospital hotel services housekeeping department.

Statistically significant and negative direction (r=-184, p<.05) between total quality management customer orientation dimension and hospital hotel services food and beverage department.

Statistically significant and negative direction (r=-253, p<.05) between total quality management customer orientation dimension and hospital hotel services general services.

4.6. Regression Analysis

Thanks to these data, it is appropriate to test the main hypotheses. Data on the relationship between variables are obtained by performing correlation and regression analyzes. These two structures are related to each other; While correlation examines the causality context of the relationship between variables, regression examines the effect between variables in the context of cause and effect.

Starting from the established model, first of all, the effect of leadership styles on hotel services should be found. Then, the mediating effect of hotel management services on the relationship between leadership styles and patient satisfaction and service quality was analyzed and interpreted. Baron and Kenney (1986) mediator variable analysis model was used. In order to accept the model established according to this approach, the hypotheses were tested in four stages. The four stages are as follows: “The independent variable must have an effect on the mediating variable; the mediating variable must have an effect on the dependent variable; the effect of the independent variable on the dependent variable together with the mediating variable should decrease or disappear completely” (Baron & Kenney, 1986).

In this context, the variables in the research are; The effect of leadership styles on hotel services, leadership styles and patient satisfaction was examined as the effect of hotel services on patient satisfaction.

In these conditions, in the examination of the main hypotheses, the effect of the leadership styles stated in the H1 hypothesis on the hotel services was tested in the first place, and then the mediating role of the leadership styles of the hotel services, which is the reason for the research, in the relationship between patient satisfaction and service quality was tested.

In the regression analysis, the effects of the mediator variable were analyzed and interpreted in the form of a model summary, anova table, coefficients table.

Here, in the model summary table, it is aimed to show the effect between variables. The effect between the variables is decided by looking at this table. Durbin-Watson value is also an element of this table. Interpretations were made about whether there was an autocorrelation between the Durbin-Watson value and the variables. The desired value range for this element of the table is between 1.5 and 2.5. The fact that the values of the variables are in this medium means that there is no autocorrelation (Kalaycı, 2010).

The significance level of the hypotheses regarding the model is determined in the Anova table. In order for the established model to be statistically significant, the 95% confidence interval and the significance value must be less than 0.05.

H0: The established model is completely meaningless.

H1: The established model has complete meaning.

If hypothesis H1 is accepted, it is possible to proceed with the interpretation of the coefficients table.

The significance level of the variables within the scope of the model was examined from the coefficients table. This is how the hypotheses for the coefficients are set up.

H0: The coefficients of the variables are not statistically significant

H1: The coefficients of the variables have statistical significance.

Here, too, the values must be within the 95% confidence interval and less than 0.05 for the hypotheses to be accepted. The coefficient providing these values is meaningful and must be kept in the model. Another important element of this table is the tolerance and VIF values for multicollinearity. In order to avoid a multicollinearity problem, the values should be greater than 0.2 for tolerance and less than 10 for VIF (Can, 2017). It is useful to reemphasize the main hypothesis of the research.

Basic hypothesis: Leadership styles have a mediating effect on the relationship between patient satisfaction and service quality.

In the coefficients table tested with the Baron and Kenney (1986) approach, the model summary table should give a meaningful relationship result at first, then it should be found that the model is significant with the Anova table, and finally the coefficients of the variables related to the model should be significant in the coefficients table. In this process, after the supportive results in the tables tested with regression analysis were obtained, other tables were examined. Throughout the study, the "Entre" method was used.

Table 4.63: Regression analysis between leadership behaviors and hospital hotel services

Model Summary

Model	Correlation	Correlation Square	Corrected Correlation Square	Standard Error of Estimation	Durbin-Watson
1	,396[a]	,157	,128	,60138	1,221

a. Predictors: (Constant), Leadership Behaviors
b. Dependent variable: Hospital Hospitality Services

ANOVA[a]

Model		Sum of Squares	Degrees of Freedom	Mean Squares	F	Sig.
1	Regression	1,948	1	1,948	5,387	,028[b]
	Error	10,488	29	,362		
	Total	12,436	30			

a. Dependent variable: Hospital Hospitality Services
b. Predictors: (Fixed), Leadership Behaviors

Coefficients [a]

Model		Non-Standardized Coefficients		Standardized Coefficients			Multi-Linearity	
		B	Std. Error	Beta	t	Sig.	Tol	VIF
1	(Constant)	,463	1,081		,428	,672		
	Leadership Behaviors	,569	,245	,396	2,321	,028	1,000	1,000

a. Dependent variable: Hospital Hospitality Services

In the first stage, the relationship between leadership behaviors and hospital hotel services was examined. The test results of the model are given in Table 4.63. At this stage, the H_1 hypothesis, which is one of our main hypotheses, has been tested. As seen in Table 4.63, there is a 39.6% relationship between leadership behaviors and hospital hotel services, according to the correlation value in the model summary. It is understood that leadership behaviors explain hospital hotel services at the level of 15.7%. When we look at the Anova table, it was accepted that the model was significant since the 0.00 significance value of the established model was found to be less than 0.05 (***H_1 was supported***). Durbin-Watson value of 1.221 indicates autocorrelation. The first of the main hypotheses (***H_1 hypothesis is supported***) as the results are supported in all three stages. You can move on to the next stage.

Table 4.64: Regression analysis between hospital hotel services and patient satisfaction

Model Summary

Model	Correlation	Correlation Square	Corrected Correlation Square	Standard Error of Estimation	Durbin-Watson
1	,142[a]	,020	,010	,25468	1,301

a. Predictors: (Constant), Hospital Hospitality Services
b. Dependent variable: Patient Satisfaction

ANOVA[a]

Model		Sum of Squares	Degrees of Freedom	Mean Squares	F	Sig.
1	Regression	,130	1	,130	2,009	,159[b]
	Error	,6356	98	,065		
	Total	,6487	99			

a. Dependent variable: Patient Satisfaction
b. Predictors: (Fixed), Hospital Hospitality Services

Coefficients [a]

Model		Non-Standardized Coefficients		Standardized Coefficients			Multi-Linearity	
		B	Std. Error	Beta	t	Sig.	Tol	VIF
1	(Constant)	1,569	,119		13,140	,000		
	Hospital Hospitality Services	-,056	,039	-,142	-1,418	,159	1,000	1,000

a. Dependent variable: Patient Satisfaction

In the second stage, the relationship between hospital hotel management services and patient satisfaction was examined. The test results of the model are given in Table 4.64. At this stage, the H_2 hypothesis, which is one of our main hypotheses, has been tested. As seen in Table 4.64, there is a 2.0% relationship between hospital hotel management services and patient satisfaction, according to the correlation value in the model summary. It is understood that hospital hotel services explain patient satisfaction at the level of 14.2%. When we look at the Anova table, the model was not considered to be significant since the 0.00 significance value of the established model was found to be greater than 0.05 (***H_2 was not supported***). A Durbin-Watson value of 1.301 indicates autocorrelation. The second of the main hypotheses (***H_2 hypothesis is not supported***) as the results were not supported in all three stages. You can move on to the next stage.

Table 4.65: Regression analysis between leadership behaviors and total quality management

Model Summary

Model	Correlation	Correlation Square	Corrected Correlation Square	Standard Error of Estimation	Durbin-Watson
1	,044[a]	,002	-,032	,51731	1,615

a. Predictors: (Constant), Leadership Behaviors
b. Dependent variable: Total Quality Management

ANOVA[a]

Model		Sum of Squares	Degrees of Freedom	Mean Squares	F	Sig.
1	Regression	,015	1	,015	,057	,812[b]
	Error	7,761	29	,268		
	Total	7,776	30			

a Dependent variable: Total Quality Management
b. Predictors: (Constant), Leadership Behaviors

Coefficients [a]

Model		Non-Standardized Coefficients		Standardized Coefficients			Multi-Linearity	
		B	Std. Error	Beta	t	Sig.	Tol	VIF
1	(Constant)	3,232	,930		3,476	,002		
	Leadership Behaviors	-,051	,211	-,044	-,240	,812	1,000	1,000

a. Dependent variable: Total Quality Management

In the third stage, the relationship between leadership behaviors and total quality management was examined. The test results of the model are given in Table 4.65. At this stage, the H_3 hypothesis, which is one of our main hypotheses, has been tested. As seen in Table 4.65, there is a 4.0% relationship between leadership behaviors and total quality management according to the correlation value in the model summary. It is understood that leadership behaviors explain the total quality management at the level of 0.2%. When we look at the Anova table, the model was not considered to be significant because the 0.00 significance value of the established model was found to be greater than 0.05 (***H_3 was not supported***). The Durbin-Watson value of 1.615 indicates that there is no autocorrelation. The third of the main hypotheses (***H_3 hypothesis is not supported***) as the results were not supported in all three stages. The next, final stage can be passed.

Table 4.66: Regression analysis between leadership behaviors and patient satisfaction

Model Summary

Model	Correlation	Correlation Square	Corrected Correlation Square	Standard Error of Estimation	Durbin-Watson
1	,251[a]	,063	,031	,29222	,951

a. Predictors: (Constant), Leadership Behaviors
b. Dependent variable: Patient Satisfaction

ANOVA[a]

Model		Sum of Squares	Degrees of Freedom	Mean Squares	F	Sig.
1	Regression	,167	1	,167	1,952	,173[b]
	Error	2,476	29	,085		
	Total	2,643	30			

a. Dependent variable: Patient Satisfaction
b. Predictors: (Constant), Leadership Behaviors

Coefficients [a]

Model		Non-Standardized Coefficients		Standardized Coefficients			Multi-Linearity	
		B	Std. Error	Beta	t	Sig.	Tol	VIF
1	(Constant)	2,141	,525		4,076	,000		
	Leadership Behaviors	-,166	,119	-,251	-1,397	,173	1,000	1,000

a. Dependent variable: Patient Satisfaction

In the fourth stage, the relationship between leadership behaviors and patient satisfaction was examined. The test results of the model are given in Table 4.66. At this stage, the H_4 hypothesis, which is one of our main hypotheses, has been tested. As seen in Table 4.66, there is a 2.5% relationship between leadership behaviors and patient satisfaction, according to the correlation value in the model summary. It is understood that leadership behaviors explain patient satisfaction at the level of 0.6%. When we look at the Anova table, the model was not considered to be significant since the 0.00 significance value of the established

model was found to be greater than 0.05 (***H₄ was not supported***). Durbin-Watson value of .951 indicates that there is no autocorrelation. The fourth of the main hypotheses (***H₄ hypothesis is not supported***) as the results were not supported in all three stages.

Table 4.67: Regression analysis between leadership behaviors, patient satisfaction and total quality management

Model Summary

Model	Correlation	Correlation Square	Corrected Correlation Square	Standard Error of Estimation	Durbin-Watson
1	,485[a]	,235	,150	,59366	1,164

a. Predictors: (Constant), Patient Satisfaction, Total Quality Management and Leadership Behaviors
b. Dependent variable: Hospital Hospitality Services

ANOVA[a]

Model		Sum of Squares	Degrees of Freedom	Mean Squares	F	Sig.
1	Regression	2,920	3	,973	2,762	,061[b]
	Error	9,516	27	,352		
	Total	12,436	30			

A Dependent variable: Hospital Hospitality Services
b. Predictors: (Constant), Patient Satisfaction, Total Quality Management and Leadership Behaviors

Coefficients [a]

Model		Non-Standardized Coefficients		Standardized Coefficients			Multi-Linearity	
		B	Std. Error	Beta	t	Sig.	Tol	VIF
1	(Constant)	,840	1,438		,584	0,564		
	Leadership Behaviors	,490	,250	,341	1,959	0,061	,937	1,067
	Total Quality Management	,248	,218	,196	1,138	0.265	,951	1,051
	Patient Satisfaction	-,552	,386	-,254	-1,427	0.165	,893	1,120

b. Dependent variable: Hospital Hospitality Services

In the last stage, the mediating effect of hotel services on the relationship between leadership styles, patient satisfaction and service quality, which is the main hypothesis, was tested. Findings related to the analysis results of this test are given in Table 4.67. According to the results of the analysis, there is a 48.5% relationship between leadership styles, patient satisfaction and service quality. In parallel, the mediator role of hotel services in the relationship between leadership styles, patient satisfaction and service quality explains 23.5%.

When we look at the results in the Anova table, this model is meaningful because the significance level has a value less than 0.05 (0.00). A Durbin-Watson value of 1.164 means that there is autocorrelation. However, in order for there to be no multicollinearity problem, the values must be greater than 0.2 for tolerance and less than 10 for VIF. Since the linearity values in Table 4.28 (tolerance 0.893; VİF 1.120) also meet the necessary criteria, there is no problem here either.

When we examined the coefficients in the last stage, it was concluded that the coefficient for leadership styles (0.61), the coefficient for service quality (0.265), and the coefficient for patient satisfaction (0.165).

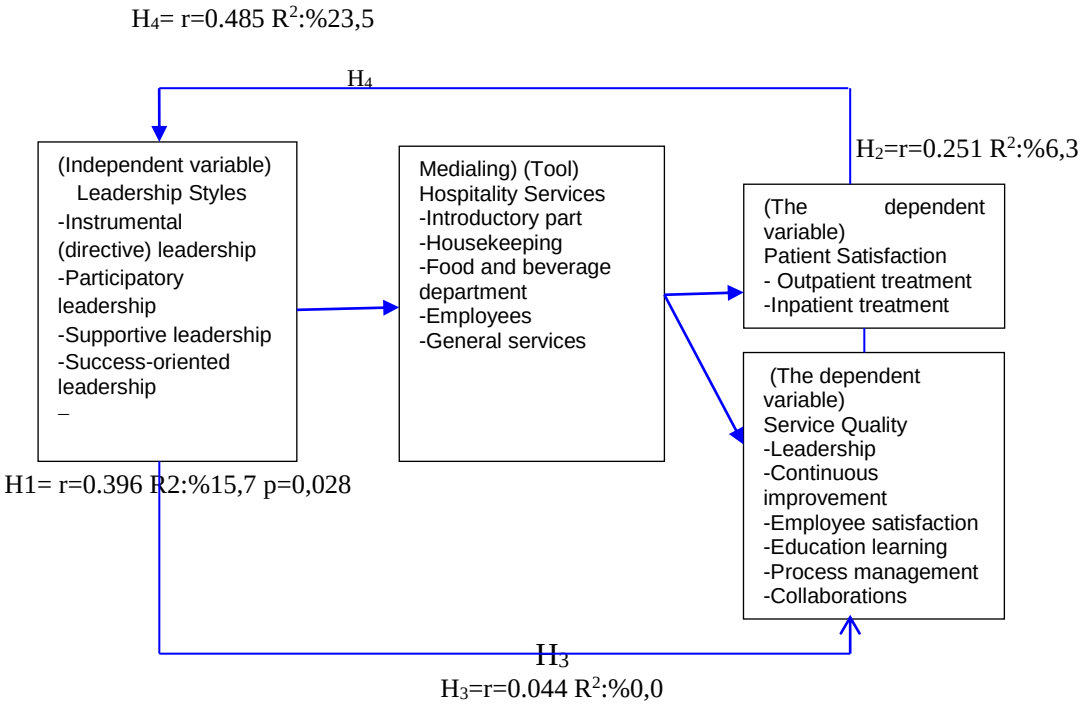


Figure 4.6: Testing the main hypothesis of the research through the model

Although the coefficient regarding leadership styles in the independent variable role shows a meaningless stance, hotel services have a role in the mediating variable effect. When the mediating effect of hotel services in the relationship between leadership styles, patient satisfaction and service quality is added, the rate increased from 15.7% to 23.5% and a low increase was observed. (***The main hypothesis is partially supported***).

CHAPTER 5

DISCUSSION

The main purpose of this research is to determine the mediating effect of hotel management services on the effect of leadership styles in hospitals on patient satisfaction and service quality, within the framework of the views of health managers, health workers, outpatients and inpatients.

Discussing the findings about the leadership behaviors of health administrators

It has been determined that there is no statistically significant difference between the scores of the managers from the leadership style scale according to the hospitals they work for, their gender, age, marital status, educational status, the services they work, their duties, the length of time they work in their positions and their total professional experience.

Türeli (2003: 39) tried to measure the effect of task and human-oriented leadership behaviors on the subordinates' perception of themselves as a team on 300 blue-collar employees. He found that leadership behaviors towards people and tasks create differences in the perceptions of leadership style of employees in different departments. In the study of Taşkıran (2011: 16), he investigated whether the leadership orientations of 164 senior managers working in 5-star hotels in Istanbul change according to demographic factors; It was seen that the tendency towards the task in the managers participating in the research was higher than the tendency towards people.

As a result of the research conducted by Uzun (2005: 46) with 68 managers working in private banks in Adana, "There was no difference between male and female managers in terms of leadership skills. As a result of the examination conducted by Taşkıran (2011: 16) in terms of gender, the tendency of leadership behavior towards the task was found to be higher in male managers than in female managers.

In the research conducted by Alkın (2006: 25) with 283 managers working in the paper and chemistry sector in Yalova, it was seen that leadership behaviors differ according to age, education and working time.

In the studies conducted, nurses stated that their managers mainly exhibited a task-oriented leadership style (Göktepe and Baykal, 2006: 37).

By examining 11 studies (nurse, leadership and Turkey concepts) conducted in Turkey between 2006-2016, it was determined that task-oriented leadership behavior was exhibited (Yılmaz & Kantek, 2016: 110).

In the study of Cowden (2011:2), it is revealed that the leadership behaviors applied positively affect the intention to stay at work.

In another study, it was determined that there is a positive relationship between perceived leadership and organizational commitment (Karahan, 2008: 171).

Vural et al. (1999:14) stated that the transformational leadership approaches of hospital managers, to increase productivity, performance and quality through teamwork, to increase personnel productivity, to improve personnel job satisfaction, to minimize personnel dissatisfaction, to create a much more positive and strong organizational climate, It is stated that it is effective on issues such as the solution of different management problems.

Keklik (2012:2) revealed in his study that managers in managerial positions are expected to be adaptable and open to change and innovation, to be fast and determined to adapt to changing conditions. Transformational leadership is very important in terms of creating an environment.

Göktepe and Baykal (2006:38), Arabacı (2012:9), Kelez (2008:23), Ergün and Çelik (2015:203) and Gür and Baykal (2016:152) In his studies with nurses, it was determined that the leadership style perceived by nurses in their managers is task-oriented. According to the research results of Erkan and Abaan (2006:13), it was found that the nurses in charge of the service exhibited task-oriented leadership behavior. Akyurt et al. (2015:50) and Gelmez and Ürtürk (2019:51) in their studies with healthcare professionals, it was determined that they exhibited the transactional/instrumental (task-oriented) leadership style more.

Ozturk et al. (2012:7), Demirtaş and Bahçecik (2006:51), Karayılmaz (2006:13) and Sayın (2008:15) revealed that managers are change-oriented.

In the study of Vesterinen et al. (2013:8) in which they investigated the leadership styles of executive nurses in Finland, contrary to this study, it was determined that

the executive nurses exhibited the most visionary/transformational leadership behaviors.

In the study of Koç and Altuntaş (2018:100), it was stated that nurses perceive themselves as change-oriented.

Discussing the findings of healthcare professionals on total quality management

It was determined that there was a statistically significant difference between the scores they got from the Total Quality Management scale according to the hospitals they worked in ($p<0.05$).

In the study of Doğan and Kaya (2004: 2), it was seen that among the hospitals affiliated to the Ministry of Health, the most important obstacles in the implementation of the TQM process are the lack of education and, in parallel, the lack of personnel and financial inadequacy. In the current study, nurses show similar reasons in parallel with the findings in the study of Doğan and Kaya (2004: 2); nurses stated that lack of education (61.3%) and lack of personnel (60.5%) are among the reasons why TQM could not be applied.

It was determined that there was a statistically significant difference between the scores they got from the Total Quality Management scale according to their age ($p<0.05$). Total Quality Management scores of healthcare professionals aged 25-34 were found to be significantly higher than those of healthcare workers aged 17-24 and over 35. While Alp (2014: 30), Sezer (2009: 10) and Şarbak (2009: 40) found that quality perception did not differ according to age, in Yazgan's (2009:30) study, quality perception was highest in the 41-50 age group, and lowest in the age group. He concluded that he belonged to the group aged 20 and under. This result is partially compatible with our research finding.

It was determined that there was a statistically significant difference between the scores they got from the Total Quality Management scale according to their educational status ($p<0.05$). Total Quality Management scores of associate degree graduate health workers were found to be significantly higher than those of health workers with other education levels. In the study of Akar et al. (2015:77), there was no relationship between education and TQM perception. However, in the study of Şarbak (2009:41), a relationship was determined between the level of education and the perception of quality, and it was observed that the perception of quality decreased

as the level of education increased. Yazgan (2009:31) found a positive relationship between education level and quality perception in his study. According to these results, the relationship between the perception of quality and the education variable differs in the literature. In the research conducted by Pirhan (2014:30), when the answers given by the participants in the Ahi Evran Research and Training Hospital were examined, there was a significant difference only in the adequacy of the tools and equipment for the hospital according to their education level.

In the study of Doğan and Kaya (2004: 2), the education level of the majority of the participants was found to be associate degree (32.4%), Ulusoy et al. (2011:17), the education level of the majority of the participants was undergraduate (39.6%) and Akar et al. (2015:78) reported that nearly half of the participants (41.8%) had a bachelor's degree.

It was determined that there was a statistically significant difference between the scores they got from the Total Quality Management scale according to the services they worked for ($p<0.05$). Total Quality Management scores of the employees in the Orthopedics and Traumatology service were found to be significantly higher than those working in other services.

It was determined that there was a statistically significant difference between the scores they received from the Total Quality Management scale according to their duties ($p<0.05$). Total Quality Management scores of those working as laboratory technicians were found to be significantly higher than those working in other positions. Sezer (2009:12) study results also support the research results. According to this, there is a significant difference between the TQM perception levels of the hospital staff and their positions. However, in Sarbak's (2009:42) study, doctors' perceptions of quality were high, and in Kayhan's (2015:9) study, midwives' perceptions of quality were high. It is consistent with our study results.

Ulusoy et al. (2011:18) evaluated the views of hospital administrators on TQM, 52.9% of the head physician and his assistants, 50% of the hospital managers and assistants; It was observed that 86.7% of the head nurses and assistant head nurses received training on TQM. Akar et al. (2015:79), on the other hand, 53.3% of health managers received training on TQM.

It was determined that there was a statistically significant difference between the scores they got from the Total Quality Management scale according to the working hours in their positions ($p<0.05$). The Total Quality Management scores of the health workers who have worked in their positions for 11-15 years were found to be significantly higher than those of the health workers with other working periods. In the study of Şarbak (2009: 43), the quality perceptions of those who work for 6-20 years are found to be higher than those who work for 21 years or more. This finding is consistent with our study results. In the research conducted by Pirhan (2014:31) in Ahi Evran Training and Research Hospital, there was no significant difference according to the duration of duty.

It was determined that there was a statistically significant difference between the scores they got from the Total Quality Management scale according to their total professional experience ($p<0.05$). Total Quality Management scores of healthcare professionals with a total professional experience of 11-15 years were found to be significantly higher than those of healthcare professionals with other total professional experience periods.

It was determined that there was no statistically significant difference between the scores they got from the Total Quality Management scale according to their gender and marital status ($p>0.05$).

In the studies of Sezer (2009:13) and Şarbak (2009:44), no significant difference was found between gender and TQM perception level. In the study of Alp (2014:31), it is seen that the perception level of TQM in women is lower than in men, but this result is not statistically significant. Akar et al. (2015:30) evaluated the perceptions of TQM of health administrators and no significant relationship was found between gender and perception of TQM.

Kayhan (2015:26) found in his study that the quality perceptions of married people are higher than those of single people. In the study of Yardan and Arslan (2014:103), no significant relationship was found between marital status and perception.

In the study conducted by Mosadeghrad and Moraes (2009:51), the lowest satisfaction scores were found for benefits, rewards, communication, salaries, working conditions and promotion. Studies conducted on healthcare professionals in Turkey (Orhaner and Mutlu, 2018: 74; Nal and Nal, 2018: 131) revealed that

employees' satisfaction levels in external dimensions (working conditions, management style, wages, etc.) are lower.

Oktizulvia et al. (2017:1) examined the relationship between nurses' job satisfaction factors and IAN in Type C hospitals, including private, state and military hospitals in Indonesia. In the study, nurses reported high satisfaction with their colleagues, communication and nature of work.

Oktizulvia et al. (2017:2), job satisfaction levels in private, public and military hospitals were compared, and a significant difference was found between hospitals. In the study, it was concluded that the most IT was in the military and the least IT was in the public hospital.

Kaddourah et al. The results of the study conducted by (2018:2) on nurses show that the participants are not satisfied with their working life (54.7%), and almost 94% of them intend to leave their current hospitals.

It is seen that the TQM perception levels of the hospital staff are at a moderate level (Kayhan, 2015:27; Alp, 2014:32; Yazgan, 2009:32; Şarbak, 2009:45; Sezer, 2009:14).

Discussing the findings of healthcare professionals about hospital hotel services

It was determined that there was a statistically significant difference between the scores they received from the Hospital Hospitality Services scale according to their gender. ($p<0.05$). The scores of male healthcare professionals from the hospital hotel services scale were found to be higher than female employees.

It was determined that there was a statistically significant difference between the scores they got from the Hospital Hospitality Services scale according to their age ($p<0.05$). Hospital Hospitality Services scores of healthcare professionals aged 25-34 were found to be significantly higher than those of healthcare workers aged 17-24 and over 35.

It was determined that there was a statistically significant difference between the scores they received from the Hospital Hospitality Services scale according to their marital status. ($p<0.05$). The scores of the married healthcare professionals from the

hospital hotel services scale were found to be higher than those of the single employees.

It was determined that there was a statistically significant difference between the scores they got from the Hospital Hospitality Services scale according to their educational status ($p<0.05$). Hospital Hospitality Services scores of health professionals who graduated from Health Vocational High School were found to be significantly higher than those of health workers with other education levels.

It was determined that there was a statistically significant difference between the scores they got from the Hospital Hospitality Services scale according to the services they worked for ($p<0.05$). Hospital Hospitality Services scores of those working in the radiology service were found to be significantly higher than those working in other services.

It was determined that there was a statistically significant difference between the scores they got from the Hospital Hospitality Services scale according to their duties ($p<0.05$). Hospital Hospitality Services scores of those working as Administrative and Financial Affairs Assistant Managers were found to be significantly higher than those working in other positions.

It was determined that there was a statistically significant difference between the scores they got from the Hospital Hospitality Services scale according to their total professional experience ($p<0.05$). Hospital Hospitality Services scores of healthcare professionals with a total professional experience of 6-10 years were found to be significantly higher than those of healthcare professionals with other total professional experience periods.

It was determined that there was no statistically significant difference between the scores they got from the Hospital Hospitality Services scale according to the hospitals they worked at and the working hours in their positions ($p>0.05$).

Yagli (2009:36) found in his study that there was no statistically significant difference between the satisfaction levels of the patients according to their gender.

Şişe (2012:213) revealed in his study that there was no significant difference between the genders of hospitalized patients and their satisfaction level scores.

Ercan et al. (2004:151) found a significant relationship between age, education level, income, social security status and satisfaction level score.

Hekkert et al. (2009:68) stated in their study that there is a significant relationship between age, gender, and satisfaction level.

Quintana et al. (2006:205) found a significant relationship between patient satisfaction and age, gender, and educational status in their study.

When we look at the studies on this subject, the rate of patients to re-prefer the institution they receive service from and to recommend it to others is 76.7% in the study of Önsüz et al. (2008:34); While it was found to be 93.4% in the study of Aytar and Yeşildal (2004:10), and 99% in the study of Konca et al. (2006:160), there was a statistically significant difference between the groups when the satisfaction levels were examined according to whether the patients chose the same hospital again or not and whether they recommended it to others. It is stated that there is no difference and it is important in measuring patient satisfaction.

Roof et al.(2002:46) stated in their study that different gender and education level are effective in determining the satisfaction levels of patients in terms of patient satisfaction. In the study, they reported that women's satisfaction levels were higher than men's. Onsuz et al. (2008:35) in their study, when the effect of the age of the patients on the general satisfaction was evaluated, a statistically significant difference was found between the ages of the patients and the general satisfaction.

When we look at the study of Türkuğur et al.(2016: 170), it was determined that although the satisfaction levels of the married patients were higher than the single patients, there was no significant relationship between their satisfaction scores and their marital status. Bottle et al. (2012:214) reported that married patients were more satisfied with hospital services than singles, according to their study.

Tezcan et al. (2014:57) it is seen that the education level of the patients participating in their study is high, but there is no significant difference between the education levels of the patients and their satisfaction level scores. Erdem et al. (2008:96) examined whether demographic variables make a difference in patient satisfaction and showed that education level and gender cause differences in some patient satisfaction dimensions. In the study conducted by Sarp and Tükel (1999), it was

reported that as the education level of the patients increased, their dissatisfaction with the hospital services also increased.

In the study of Ercan et al (2004: 152), the relationship between the social security status and occupation of the patients within the scope of the study and their general satisfaction was found to be significant. Önsuz, et al. (2008:36) in his study, the group with the lowest level of satisfaction was found to be patients with Bag-Kur and no statistically significant relationship was found between the social security and occupation of the patients and their general satisfaction levels (p=0.173).

When we look at the literature reviews on patient satisfaction in health services, it is seen that there are many studies on this subject, and the process improvement of these studies also provides important benefits to health operations (Hekimoğlu et al., 2015: 5).

Discussing the findings about the satisfaction of the patients

It was determined that there was a statistically significant difference between the scores of the inpatients received from the inpatient scale according to their age ($p<0.05$). The scores of inpatients between the ages of 51-65 who received inpatient treatment from the inpatient scale were found to be significantly higher than inpatients in other age groups.

It was determined that there was a statistically significant difference between the scores of the outpatients and inpatients received from the outpatient scale and the inpatient scale, according to their education levels ($p<0.05$). The scores of the outpatients who were high school or equivalent school graduates from the outpatient scale were found to be significantly higher than the patients with other education levels who were treated for an attack. On the other hand, the scores of inpatients with university or higher education level from the inpatient scale were found to be significantly higher than the inpatient treatment patients with other education levels.

It was determined that there was a statistically significant difference between the scores of the inpatients received from the inpatient scale according to their occupations ($p<0.05$). The scores of the patients who were housewives from the inpatient scale were found to be significantly higher than the patients who were hospitalized with other occupations.

It was determined that there was a statistically significant difference between the scores of the inpatients received from the inpatient scale according to their social security ($p<0.05$). The scores of the patients with social security green card from the inpatient scale were found to be significantly higher than the inpatient treatment patients with other social security.

There is a statistically significant difference between the scores of outpatients and inpatients in the outpatient and inpatient scales according to the hospitals they are treated and their gender, and the scores of the outpatients in the outpatient scale according to their age, social security and occupation. was found to be absent ($p>0.05$).

In the patient satisfaction research conducted by Genç (2011: 20) in Sivas State Hospital, no difference was observed in terms of gender.

In the study of Küçük (2009: 40) in Diyarbakır State Hospital, the subject of evaluating the general cleanliness of the hospital differed according to gender.

In the study of Küçük (2009:41), the satisfaction level of those with a low level of education was found to be higher than those with a high level of education, however, in the study of Genç (2011:20), no difference was found in terms of educational status.

In the study of Zerenler and Öğüt (2007:501) in Konya, “Considering the evaluations of the patients participating in the research about the personnel in the hospitals; respectively, "Nurses' medication distribution patterns (3.53)", "Staff's being well, cleanly dressed and well-appeared (3,34)", "Ease of access to nurses (3,26)" and "Nurses' respect, courtesy and understanding (3,3)" ,07) “They are more satisfied with their activities than others”. In a study conducted by Büber and Başer (2012:265) in a private university hospital, "propositions regarding courtesy, informing and guidance behaviors were asked about the group consisting of nurses, secretaries, health technicians, advisors and security guards. It was observed that the seven statements formed had a high mean of 4.16.

In the study conducted by Zerenler and Öğüt (2007: 502) in Konya, "the activities that the patients participating in the research are most satisfied with about the doctors they receive service from are "doctor checks (4.27)", "trust in doctors (4,19)", " They found that doctors have respect, courtesy and understanding (4,13)" and "ease of

meeting with doctors (4,06)". Büber and Başer (2012:266) in their study conducted in a private university hospital, “The interpersonal relationship skills of doctors are the most important factor affecting patient satisfaction.

Büber and Başer (2012:267) in their study conducted in a private university hospital, “The physical conditions of the hospital and the room in the hospital emerge as one of the satisfaction dimensions that individuals focus on and attach importance to.

Genç (2011:22) in the study he carried out in Sivas State Hospital; “Patients hospitalized in all wards were satisfied with the kindness of the personnel who performed the hospitalization procedure. They found that they were most satisfied with the 4.65 ratio in pediatric surgery, neurosurgery and orthopedics services, that is, the patients hospitalized in the same department”.

In the study conducted by Önsüz et al. (2006:33) in a university hospital in Istanbul, “When the effect of the age of the participants on general satisfaction was evaluated, the mean age of the group who stated that they were generally satisfied with the hospital (45.72±20.82) was higher than the group that was not satisfied (37.51±20.88). found. A statistically significant difference was found between the ages of the patients and their general satisfaction (p=0.038)”.

In the study of cute (2006:11), it was determined that the perceived service quality did not change significantly according to gender and income status. In the study conducted by Papatya et al. (2012), it was concluded that patients' perception of service quality and patient satisfaction did not show a significant difference according to the gender factor. Therefore, the results obtained in this study are in line with the findings obtained in the literature.

According to the findings obtained in the study of Kapak (2006:12), it was observed that there was a statistically significant difference between the education level and the perception of service quality.

Discussing the findings on the relationships between the leadership behaviors of health managers, the total quality management of health workers and hospital hotel services, and the satisfaction of patients.

Statistically significant and positive correlations were found between Hospital Hospitality Services Scale and Outpatient Satisfaction Scale scores (r=233, p<.05) (p<0.05).

Statistically significant and positive correlations were found between Hospital Hospitality Services Scale and Inpatient Satisfaction Scale scores (r=327, p<.05) (p<0.05).

Yağcı and Duman (2011:218) examined the relationship between perceived service quality and patient satisfaction in their study and found a statistically significant and positive strong relationship between the two variables. In addition, Bilgin and Göral (2008: 151) also examined the relationship between service quality and patient satisfaction in the health sector and found a statistically significant relationship. In this study, a significant relationship was found between service quality and patient satisfaction. Therefore, it can be said that the findings obtained in this study are compatible with the literature.

Discussing the findings about the mediating effect of hospital hotel management services on the relationships between the leadership behaviors of health managers, the total quality management of health workers and the satisfaction of patients.

Leadership styles of managers have a significant direct effect on total quality management (β= -1.157, p<.001), Hospital Hospitality Services (β=1,208, p<.001) and Hospital Hospitality Services have a significant direct effect on total quality management (β=1,208, p<0.001).

Outpatient (β=0.501, p<.001) and inpatient (β=0.684, p<.001) patient satisfaction scores were found to positively predict hospital hotel services. If outpatients and inpatients receive 1 point more, hospital hotel services scores increase by 0.50 and 0.68 points.

According to the findings obtained in the studies of Boudeh (2011:141), Aksaraylı and Kıdak (2008:87), Xesfingi and Vozikis (2016:94), and Abbas (2010:50), it is seen that the quality of health care affects patient satisfaction. The findings obtained in this study are also in line with the literature in question.

In the study conducted by Şişe (2012:215) to determine the factors affecting the perception of nursing care and satisfaction levels of hospitalized patients in Kocatepe University Hospital, it was seen that the satisfaction level of the patients from the nursing services was generally good.

CHAPTER 6
CONCLUSION and RECOMMENDATIONS

6.1.Conclusion

The following results were obtained in our research, in which we evaluated the opinions of the participants in order to examine the mediator effect of hotel services on the relationship between patient satisfaction and service quality within the framework of the views of outpatients and inpatients within the framework of the views of health managers, according to socio-demographic variables.

In this study, the effect of leadership behaviors on patient satisfaction and service quality of hotel services was investigated. Four scales were used to investigate these relationships, and the scores obtained from these scales were compared with the results of studies using similar scales in the literature. Four basic variables (leadership behaviors, patient satisfaction, total quality management and hospital hotel services) were used in the study. Relationships between these variables were investigated with the help of independent samples t-test, Anova, Pearson correlation analysis and linear regression and discussed by comparing with other studies. Then, whether the scale scores differ according to socio-demographic variables was discussed by examining the studies in the literature. In this section, the results obtained from this study are included and suggestions are made based on this.

It was observed that the scale scores obtained in this study were generally similar to similar studies in the literature. However, considering that most of the studies were carried out in different sectors and most of them with low-level employees, it was understood that there was a need for studies conducted at different management levels in the health sector in order to make a better evaluation. In addition, although there was no significant difference between the groups in terms of leadership behaviors in this study, it was observed that the scores obtained from other scales were affected by the other socio-demographic characteristics of the individual. From this point of view, employees at lower levels of management; it can be said that their perceptions of their managers' leadership characteristics, their institutions' total quality management and patient satisfaction may be at a moderate level. For this reason, it is necessary to consider how the total quality management and patient

satisfaction in hospitals are reflected on the employees according to the leadership characteristics of the managers.

Among the four variables used in the research, there is a positive and significant relationship between leadership behaviors and hospital hotel services, and these relationships are also supported by the literature. These relationships are based on cause and effect relationships. It can be said that a manager who exhibits leadership behaviors ensures the implementation of hospital hotel services.

In the study, it is seen that general leadership behaviors, supportive leadership, instrumental or directive leadership, achievement-oriented leadership and participatory leadership are related to hospital hotel services, and participatory leadership affects hospital hotel services.

As mentioned before, it is now accepted that leadership characteristics are not only dependent on innate characteristics, but leadership potential is developed with some acquired characteristics. For this reason, it is recommended that health managers develop participatory leadership characteristics and display them in the business environment. Thus, managers can be more effective on organizational results. In addition, since hospital hotel services and leadership behaviors are related, it becomes clear how necessary it is to establish hospital hotel services in hospitals.

When the scores obtained from the scales were compared according to various socio-demographic variables, it was seen that there was a statistically significant difference between the groups in terms of some variables, but no significant difference in terms of some variables. The first of these variables is the hospital variable. In terms of the hospital variable, there was a significant difference between the groups in other scales, except for the leadership behavior scale. Although there are results in the literature showing that there is no significant relationship between the hospital variable and leadership behaviors, it has also been found in a study that patient satisfaction, total quality management and hospital hotel services vary depending on the hospital variable. For this reason, it can be said that the hospital variable has a significant effect on the perceptions of the participants, except for the health managers.

When it was investigated whether the gender variable was effective on the perceptions of the participants in the study, it was found that it had no effect on

leadership behaviors, women's perceptions of total quality management and patient satisfaction were higher than men, and men's perceptions of hospital hotel services and patient satisfaction were higher than women's. This finding is partially consistent with the literature findings. It has been concluded that the perceptions of women and men regarding leadership behaviors are similar due to the fact that there is a state hospital among the hospitals they work in, men's perceptions of total quality management are lower than women's, and women's perceptions of hospital hotel services and patient satisfaction are lower than men's. When leaders are given different leadership behaviors training, ensuring that male health workers are trained on total quality management, increasing the knowledge of women about hospital hotel services, and increasing the satisfaction of female patients can increase positive perceptions.

In this study, it was investigated whether there was a difference between the groups according to the education/academic status of the participants, and it was concluded that regardless of the school level they graduated from, their perceptions of leadership behaviors were similar, and the perceptions of healthcare professionals regarding total quality management and hospital hotel services, and satisfaction of patients were affected by the education variable. The reason for this result in leadership behaviors is that those with higher education levels mostly work at higher levels in the state hospital. As a result, the education variable affected the total quality management and hospital hotel services of the healthcare professionals and the satisfaction of the patients.

There was a significant difference between the groups in terms of age variable, except for the leadership behavior scale. In the literature, there are results indicating that there is no significant relationship between age and leadership behaviors of health managers, and there is a significant relationship between total quality management and hospital hotel services of health care workers, and satisfaction of patients. For this reason, it can be said that the age variable does not have a significant effect on the perceptions of leadership behaviors of health managers, but it has a significant effect on the total quality management and hospital hotel services of health workers, and the satisfaction of patients.

There was a significant difference between the groups in terms of marital status variable, except for leadership behaviors and patient satisfaction scales. There is a

significant relationship between the total quality management of single healthcare professionals and hospital hotel services of married healthcare professionals. From this point of view, it can be said that the leadership styles of married or single managers have a similar effect on the satisfaction of the patients, and that they have different effects on the total quality management and hospital hotel services of the healthcare professionals.

The task variable of health managers and employees was examined in this study. There was a significant difference between the groups in terms of the task variable, except for the leadership behaviors and patient satisfaction scales.

In this study, the variable of working time in the task the participant is in was also examined. There is a significant relationship between total quality management and hospital hotel services between those who have worked for a longer period of time in their position and those who have worked for a shorter period of time. Except for the leadership behaviors and patient satisfaction scales, there was a significant difference between the groups in other scales.

6.2. Recommendations

In this section, suggestions are made for practitioners and researchers according to the results obtained in the research.

6.2.1 Recommendations for Practitioners

Patients between the ages of 51-65 who received inpatient treatment, High school or equivalent school graduates who received outpatient treatment, University and higher education level inpatient treatment, Housewife patients inpatient treatment, Social security green card patients inpatient treatment Considering the patients, larger studies can be done in the population and sample.

Health administrators should exhibit more supportive leadership characteristics, in other words, maintain order in relationships, be consistent, encourage new ideas, be open to criticism, not avoid taking risks while making decisions, adopt an open and honest method, give confidence, discuss new ideas with liking, be friendly. It is recommended that they always know who is responsible for what, and make plans for the future.

6.2.2 Recommendations for Researchers

In the literature, it is seen that there are very limited studies on the mediating effect of hotel services on the effect of leadership behaviors in public and private hospitals on patient satisfaction and service quality. For this reason, researchers' in-depth studies on public and private hospitals' health managers, health workers, and outpatients and inpatients will increase awareness.

In order for public and private hospitals to have a more efficient structure, leadership behaviors, patient satisfaction, total quality management and hospital hotel services training programs should be established for health managers, health workers and outpatient and inpatient patients.

In addition to quantitative research, qualitative research will be able to produce clearer results on leadership behaviors, patient satisfaction, total quality management and hospital hotel services.

In addition to its contribution to the management of public and private hospitals, its contributions to leadership behaviors, patient satisfaction, total quality management and hospital hotel services resources can be investigated.

Research can be conducted to reveal the effects of leadership behaviors, patient satisfaction, total quality management and hospital hotel services perceptions of managers, employees and patients of public and private hospitals on their problem solving skills.

This study was carried out on Fethiye State Hospital, Private Letoon Hospital and Private Lokman Hekim Esnaf Hospitals health managers and employees, outpatients and inpatients. Which factors affect the leadership behaviors of health managers in hospitals, which are not included in the scope of this study, and the total quality management of employees, hospital hotel management services, and patient satisfaction can be investigated in future studies.

It is important to carry out theoretical research in order to further expand the existing literature by considering the Turkish health system.

6.2.3 Contribution to Current Literature

Based on the opinions of health managers, health workers and patients, a new academic research model was carried out to increase the mediation effect of hospital

hotel management services on the relationship between leadership behaviors, patient satisfaction and service quality.

The ideas and discussion methods expressed in the previous scientific researches in the literature were taken into consideration in our research. In our academic research, previous research on this research topic was reviewed and it was seen that this research was the first in the Turkish literature. Within the scope of the literature review process in the academic research, researches such as examining, discovering, analyzing, reading, classifying, summarizing and synthesizing previous studies related to the research topic were carried out. In the literature review and analysis, the views of the previous literature on the research topic were determined, the deficiencies in the literature were revealed and the place where our own research would fit with the previous literature was revealed. Considering that the literature review is an indispensable requirement for academic research, 170 types of literature have been reached.

In academic study; purpose, research questions, problem situations, hypotheses, methods, findings and results are based on the results of the literature review. A literature review was conducted with scientific depth and originality in accordance with the requirements of academic research.

The contribution of academic research to the humanities is also valuable, and it also places great emphasis on literary criticism. Considering the previous researches on the subject, it can be thought that the research will eliminate the important deficiencies of the subject such as originality, ability, responding to the needs of the target audience, and contribution to science. Almost all technologies, equipment, systems, ideas and trends that are a part of daily life have been fully evaluated in scientific research through literature reviews. In book and article research, university students, master's and doctoral theses, project and thesis proposals and even homework, literary research in different shapes and details have been made. The literature review, thesis proposals, and the thesis are discussed as a separate section and mainly in the introduction part of the article. Literature review, reading and synthesizing the information found were not easy, especially during the publication phase of the article, and the process was followed carefully and systematically.

As a result of the realization of the thesis, it is thought to contribute to the scientific knowledge and benefits of leadership behaviors, patient satisfaction, total quality

management and hospital hotel management services. From the results obtained, it is thought that with the adoption of hospital hotel services, leadership behaviors will be implemented, patient satisfaction will be ensured, total quality will increase, thus the performance of public and private hospitals will increase.

This research was conducted for the first time in Turkish literature. It can be thought that this study is the first review and will contribute to the literature. The empirical, theoretical or methodological contribution of the research to the literature can be increased by turning it into accessible publications.

In this study, in contrast to the Turkish and foreign literature, the mediating effect of hospital hotel management services on the relationship between leadership behaviors, patient satisfaction and service quality was examined within the framework of the views of health managers, health workers and patients.

It is thought that this study was carried out on 31 health managers, 342 health workers, 200 patients receiving outpatient and inpatient treatment of state and private hospitals operating in the Fethiye district of Muğla province, and it will provide very important support to the health documentation of Muğla and help the health management of the country.

In the first stage of the implementation of the research results, taking into account the pandemic process, leadership behaviors, patient satisfaction and service quality and hospital hotel services training should be given to public and private hospital employees.

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APPENDICES

Annex 1: Questionnaire Form

SURVEY FORMS

NEAR EAST UNIVERSITY
SOCIAL SCIENCES INSTITUTE
DEPARTMENT OF BUSINESS

HOSPITAL HOTEL SERVICES SURVEY FORM

Dear participant,

The following survey was conducted by Prof. Near East University Institute of Social Sciences, Department of Business Administration. Dr. It is about the research part of the doctoral thesis titled "The Mediator Effect of Hospitality Services on the Leadership Styles of Health Leaders and Patient Satisfaction and Service Quality" conducted under the consultancy of Tülen Saner. In the research, it was aimed to examine the hospital hotel services according to the opinions and knowledge of the healthcare professionals. The survey was designed for purely scientific purposes. Your information will be kept strictly confidential. The data obtained from the study will only be used as statistical data. Providing your answers honestly and accurately will ensure that these survey results are used as useful information for the society. We recommend that you also participate in this study. However, participation in research is based on voluntary law.

Thank you for supporting our work by participating in our research and wish you a successful and healthy working life. Kind regards,

Serkan TURGUTOĞULLARI

Near East University
Social Sciences Institute
Department of Business Administration

1. Gender:

☐Woman ☐Male

2. Age:

☐ 17-24 ☐ 25-34 ☐ 35 and above

3. Marital status:

☐Married ☐Single

4. Educational status:

☐Health vocational high School ☐Associate degree ☐ Degree

☐Master ☐Phd

5. Service running

☐Anesthesia ☐Urology ☐Biochemistry

☐ Dermis ☐Pediatry ☐Internal medicine

☐Endocrinology ☐Infectious Diseases

☐Physical therapy and rehabilitation

☐Gastroenterology ☐General Surgery ☐Geriatrics

☐Thoracic Surgery ☐Eye diseases

☐First and Emergency Aid

☐Gynecology and Obstetrics ☐Cardiovascular surgery ☐Cardiology

☐ENT ☐Microbiology ☐Nephrology

☐ Nöroloji ☐Nöroşirurji (Beyin Cer.) ☐ Radyoloji

☐Orthopedics and Traumatology ☐General practitioner ☐Psychiatry

☐Rheumatology ☐Sports Physician

☐Other ……..(Please specify.)

6. Duty:…….. (Please specify.)

7. Working time in your current position:

☐0-5 year ☐6-10 year ☐11-15 year

☐16-20 year ☐21 year and above

8. Your total professional experience:

☐0-5 year ☐6-10 year ☐11-15 year

☐16-20 year ☐21 year and above

Please rank the following statements regarding the evaluation of Hospital Hotel Management services in order of importance.	**( )**
INTRODUCTION SECTION (List from 1 to 5 in order of importance)	
Warm and friendly welcome upon arrival at the hospital	( )
Fast and error-free hospital admission and registration	( )
Giving a room according to the patient's request	( )
Providing sufficient information to patients about the departments of the hospital and the services provided	( )
Giving information about the times of breakfast, meals and other activities	( )
HOUSEKEEPING (Rank from 1 to 5 in order of importance)	
Timely preparation of the room	( )

Cozy and comfortable rooms	( )
The cleanliness and orderliness of the room is provided as required	( )
The furnishings in the room and the technical equipment of the room are at a level to meet the needs	( )
Providing room service services in line with the wishes of the patients without any problems	( )
FOOD AND BEVERAGE SECTION (Rank from 1 to 7 in order of importance)	
The decoration and design of the food and beverage department should reflect the quality of the hospital.	( )
The quality and deliciousness of the food and beverages served	( )
Including diet and vegetarian food/drinks in the menus	( )
The quality and cleanliness of the tools and equipment used in the food and beverage department	( )
Adequate cleanliness and ventilation of the food and beverage section	( )
Quality and fast service	( )
Finding halls/halls suitable for organizations	( )
EMPLOYERS (Rank from 1 to 6 in order of importance)	
Employees are friendly and courteous	( )
Employees give importance to cleanliness and hygiene	( )
Employees have the necessary knowledge and skills related to their jobs	( )
Employees should take due care to establish good relations with patients	( )
Employees to do their jobs accurately and quickly	( )
Employees' knowledge of first aid	( )
GENERAL SERVICES (Rank from 1 to 10 in order of importance)	( )
The general physical equipment and furnishing of the hospital is sufficient	( )
Availability of sports and entertainment opportunities for children and adults	( )
Clean and well-maintained common areas of the hospital	( )
Timely and accurate delivery of all services provided in the hospital	( )
Taking the necessary level of fire, health and safety precautions	( )
Adequate and good placement of directional signs and signs within the hospital	( )
Quick resolution of patient wishes and complaints	( )

Patients can easily communicate with officials and employees in all departments of the hospital.	( )
Patients feel in a peaceful and safe environment in the hospital.	( )
The suitability of hospital hotel prices compared to the quality of the service provided	( )

TOTAL QUALITY MANAGEMENT SCALE

	Please indicate your level of agreement (between 1 and 5) with the following statements 1= Strongly Disagree, 2=I do not agree, 3=Undecided, 4=Agree, 5=Strongly Agree	**I strongly disagree**	I do not agree	Undecided	Agree	**Strongly Agree**
1	Those in top management are of similar opinion about the future of the organization.	**1**	**2**	**3**	**4**	**5**
2	Activities and investments that yield long-term results receive little support from senior management.	**1**	**2**	**3**	**4**	**5**
3	Employees have the opportunity to participate in management and are encouraged to implement change in the organization.	**1**	**2**	**3**	**4**	**5**
4	When necessary, middle and lower level managers do not allow employees to make decisions on their own. (Middle and lower level managers do not allow employees to make decisions on their own when necessary.)	**1**	**2**	**3**	**4**	**5**
5	Top managers anticipate change and plan accordingly.	**1**	**2**	**3**	**4**	**5**
6	This organization encourages employees to continuously improve its processes and services.	**1**	**2**	**3**	**4**	**5**
7	Employees do not have the chance to make suggestions that will change the current situation / operation. This is not well received or encouraged.	**1**	**2**	**3**	**4**	**5**
8	Most of our services have been improved compared to the recent past.	**1**	**2**	**3**	**4**	**5**
9	This organization has a good reputation and recognition for improving its services and processes.	**1**	**2**	**3**	**4**	**5**
10	My job duties and responsibilities do not help me provide quality service.	**1**	**2**	**3**	**4**	**5**
11	I love my job because I do what I want to do.	**1**	**2**	**3**	**4**	**5**
12	Employees in this organization are dedicated to their work.	**1**	**2**	**3**	**4**	**5**
13	Managers want to see employees strive for excellence.	**1**	**2**	**3**	**4**	**5**
14	Managers create a working environment where employees can show their talents in the best way.	**1**	**2**	**3**	**4**	**5**
15	Employees are provided with training to better understand what the organization does or how it does it.	**1**	**2**	**3**	**4**	**5**
16	Most of the employees do not have enough knowledge about the sector in which we work.	**1**	**2**	**3**	**4**	**5**
17	Few of our employees are aware of the processes that produce our services.	**1**	**2**	**3**	**4**	**5**
18	Top management has created an environment that supports continuing education.					
19	Top management receives training on relations with employees and customers.					
20	It is the common attitude of this organization to prevent the occurrence of faulty services.					

21	There are no in-process control measures in the processes in this organization.					
22	Quality is the most fundamental feature when designing new services.					
23	Employees know how to use statistical process control tools.					
24	Explaining the variation in processes is not used as an analysis technique in the business.					
25	Quantitative quotas are not the only criteria in measuring employee performance in the organization, and this criterion is not an important criterion.					
26	Managers know how to motivate employees to perform at their best.					
27	Managers consider the total cost of the service.					
28	Management focuses on the miscommunications between suppliers and our company and tries to improve them.					
29	Management encourages the use of few suppliers.					
30	The criterion in supplier selection is not cost alone, but quality is also an important criterion.					
31	Teamwork is a common working method.					
32	Each employee contributes to the improvement of processes and services.					
33	When making decisions, managers look at the big picture, the whole picture.					
34	Employees are reluctant to offer suggestions and express their opinions.					
35	Managers insist that all information flow within the organization is accurate and reliable.					
36	Our focus in our processes and activities is the satisfaction of our customers.					
37	Managers promote activities that improve customer satisfaction.					
38	The most important thing we do is to satisfy our customers and meet their expectations.					
39	Our managers do not care about customer satisfaction.					

Leadership Traits of Managers (Managers)

	According to the following judgments, the one you feel closest to you "1-never", "2-very few", "3-sometimes", "4-often","5-continuous" Answer by ticking one of the options	Never	Very few	Sometimes	Often	Continuous
1	I keep order in my work	1	2	3	4	5
2	There is a consistent production	1	2	3	4	5
3	I encourage new ideas	1	2	3	4	5
4	I am open to criticism	1	2	3	4	5
5	I don't mind taking risks when making a decision.	1	2	3	4	5
6	I have an open and honest method	1	2	3	4	5
7	I am trustworthy	1	2	3	4	5
8	I like to discuss new ideas	1	2	3	4	5
9	There is a friendly production	1	2	3	4	5
10	I always know who is responsible for what	1	2	3	4	5
11	I make plans for the future	1	2	3	4	5
12	I give my instructions clearly	1	2	3	4	5
13	I respect my subordinates as individuals	1	2	3	4	5
14	I examine the events and make decisions by thinking.	1	2	3	4	5
15	I introduce new and different ideas in the implementation of works	1	2	3	4	5
16	I create 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 am meticulous in the control of my work.	1	2	3	4	5
20	I make quick decisions when needed	1	2	3	4	5
21	I give my subordinates a say when making a decision	1	2	3	4	5
22	I care about obeying 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 clear	1	2	3	4	5
26	I appreciate the good work	1	2	3	4	5
27	I care about the opinions 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 arguments	1	2	3	4	5
33	I meticulously focus on the plans being implemented.	1	2	3	4	5
34	I listen to the ideas and suggestions of others	1	2	3	4	5

OUTDOOR SATISFACTION SURVEY FORM

1. Your age group;

a) 18–25 b) 26–40 c) 41–50 d) 51–65 e) 66 and above

2. Your Educational Status;

a) Illiterate b) Primary School c) Secondary School d) High School and Equivalent School

e) University and above

3. What is your gender?

a) Female b) Male

4. Your profession;

a) Self Employed (Other) b) Worker c) Civil Servant d) Retired e) Housewife f) Unemployed

5. Your Social Security;

a) SGK employee b) SGK retired c) Green card d) Private health insurance

e) No social security f) Other…..

6. Is it your first application to our hospital?

a) Yes b) No

7. I did not wait long during the patient registration process.

a) Yes b) A little c) No

8. The staff in the patient registration department were friendly and interested.

a) Yes b) A little c) No

9. I chose the doctor I would be examined by myself.

a) Yes b) No

10. My questions, which I consider important, were answered by my doctor in a way that I could understand.

a) Yes b) Partially c) No

11. I had sufficient confidence in my doctor who undertook my examination, I received the necessary attention and care

a) Yes b) Partially c) No

12.Adequate information was given about the course of my disease and the treatment applied to me.

a) Yes b) Partially c) No

13. During my examination, I think that the required examination time is allocated.

a) Yes b) Partially c) No

14. Adequate privacy was provided while being examined.

a) Yes b) Partially c) No

15. I did not wait long for the analysis and examination performed on me.

a) Yes b) Partially c) No

16. The general cleanliness and order of the polyclinics, waiting areas and examination rooms were sufficient.

a) Yes b) Partially c) No

17. I would recommend this hospital to others.

a) Yes b) No

18. The services provided at the hospital were generally good.

a) Yes b) No

19. If I have to go to the hospital again, I would prefer this hospital.

a) Yes b) No

INSTALLED PATIENT SATISFACTION SURVEY FORM

1. Your age group;

a) 18–25 b) 26–40 c) 41–50 d) 51–65 e) 66 and above

2. Your Educational Status;

a) Illiterate b) Primary School c) Secondary School d) High School and Equivalent School

e) University and above

3. What is your gender?

a) Female b) Male

4. Your profession;

a) Self Employed (Other) b) Worker c) Civil Servant d) Retired e) Housewife

f) Unemployed

5. Your Social Security;

a) SGK employee b) SGK retired c) Green card d) No social security

e) Other (Private, Bağkur, Abroad)

6. Is it your first application to our hospital?

a) Yes b) No

7. The room I slept in was clean and warm.

a) Yes b) Partially c) No

8. I found patient meals sufficient in terms of cleanliness, taste and presentation.

a) Yes b) Partially c) No

9. During my treatment, I had sufficient confidence in my nurses responsible for my treatment, and received the necessary attention and care.

a) Yes b) Partially c) No

10. The nurses who took care of my treatment gave explanations in every procedure they did.

a) Yes b) Partially c) No

11. The questions that I thought were important were answered by my doctor in a way that I could understand.

a) Yes b) Partially c) No

12. I had sufficient confidence in my doctor who undertook my treatment, and I received the necessary attention and care.

a) Yes b) Partially c) No

13. All the staff showed due care to my privacy.

a) Yes b) Partially c) No

14. I would recommend this hospital to others.

a) Yes b) No

15. This hospital is safe.

a) Yes b) No

16. The services provided at the hospital were generally good.

a) Yes b) No

17. When I have to go to the hospital again, I would prefer this hospital again.

a) Yes b) No

Annex 2: Hypothesis Tables

Sub-hypotheses	Supported	Not supported
H1: Leadership styles have an impact on hotel services.	+	
H2: Hospitality services have an impact on patient satisfaction.		-
H3: Leadership styles have an effect on patient satisfaction.		-
H4: Leadership styles have an effect on service quality.		-

Leadership Behaviors Sub-hypotheses	Supported	Not supported
$H1_1$ hypothesis was not supported since the statistical significance value was $p>0.05$ between the hospitals where the health managers work and their leadership behaviors.		-
$H1_2$ hypothesis was not supported, since the statistical significance value of $p>0.05$ between the genders of health administrators and their leadership behaviors.		-
$H1_3$ hypothesis was not supported since the statistical significance value between the ages of health managers and their leadership behaviors was $p>0.05$.		-
$H1_4$ hypothesis was not supported, since the statistical significance value of $p>0.05$ between marital status and leadership behaviors of health administrators.		-
$H1_5$ hypothesis was not supported, since the statistical significance value of $p>0.05$ between the education levels of health administrators and their leadership behaviors.		-
$H1_6$ hypothesis was not supported, since the statistical significance value of $p>0.05$ between the services that health managers work and their leadership behaviors.		-
$H1_7$ hypothesis was not supported, since the statistical significance value of $p>0.05$ between the duties of health administrators and their leadership behaviors.		-
$H1_8$ hypothesis was not supported since the statistical significance value of $p>0.05$ between the management duties and leadership behaviors of health administrators.		-
$H1_9$ hypothesis was not supported, since the statistical significance value of $p>0.05$ between the working hours of health managers in their positions and their leadership behaviors.		-
$H1_{10}$ hypothesis was not supported since the statistical significance value of $p>0.05$ between the total professional experience of health administrators and their leadership behaviors.		-

Total Quality Management Sub-hypotheses	Supported	Partially supported	Not supported
$H1_1$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the hospitals where the healthcare professionals work and the total quality management.		+	
$H1_2$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the genders of healthcare workers and total quality management.		+	
$H1_3$ hypothesis was partially supported, since the statistical significance value of $p<0.05$ between the ages of healthcare professionals and total quality management.		+	
$H1_4$ hypothesis was partially supported, since the statistical significance value of $p<0.05$ between the marital status of healthcare workers and total quality management.		+	
$H1_5$ hypothesis was supported since the statistical significance value of $p<0.05$ between the education levels of healthcare professionals and total quality management.	+		
$H1_6$ hypothesis was supported, since the statistical significance value of $p<0.05$ between the services of health care workers and total quality management.	+		
$H1_7$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the duties of healthcare professionals and total quality management.		+	
$H1_8$ hypothesis was partially supported, since the statistical significance value of $p<0.05$ between the working hours of health workers in their positions and total quality management.	+		
$H1_9$ hypothesis was supported since the statistical significance value of $p<0.05$ between the total professional experience of healthcare professionals and total quality management.	+		

Hospital Hospitality Services Sub-hypotheses	Supported	Partially supported	Not supported
$H1_1$ hypothesis was not supported since the statistical significance value was $p>0.05$ between the hospitals where the healthcare professionals work and the hospital hotel services.			-
$H1_2$ hypothesis was supported since the statistical significance value of $p<0.05$ between the genders of healthcare workers and hospital hotel services.	+		
$H1_3$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the ages of healthcare professionals and hospital hotel services.		+	
$H1_4$ hypothesis was partially supported since the statistical significance value was $p<0.05$ between the marital status of healthcare workers and hospital hotel services.		+	
$H1_5$ hypothesis was supported since the statistical significance value was $p<0.05$ between the education levels of healthcare professionals and hospital hotel services.		+	
$H1_6$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the services where healthcare professionals work and hospital hotel services.	+		
$H1_7$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the duties of healthcare professionals and hospital hotel services.		+	
$H1_8$ hypothesis was partially supported, since the statistical significance value of $p<0.05$ between the working hours of health workers in their positions and hospital hotel services.		+	
$H1_9$ hypothesis was supported, since the statistical significance value of $p<0.05$ between the total professional experience of healthcare professionals and hospital hotel services.	+		

Patient Satisfaction Sub-hypotheses	Supported	Partially supported	Not supported
$H1_1$ hypothesis was not supported since the statistical significance value was $p>0.05$ between the hospitals where the patients received healthcare services and patient satisfaction.			-
$H1_2$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the ages of the patients and patient satisfaction.		+	
$H1_3$ hypothesis was supported since the statistical significance value was $p<0.05$ between the education levels of the patients and patient satisfaction.	+		
$H1_4$ hypothesis was not supported since the statistical significance value was $p>0.05$ between the gender of the patients and patient satisfaction.			-
$H1_5$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the occupations of the patients and patient satisfaction.		+	
$H1_6$ hypothesis was partially supported, since the statistical significance value was $p<0.05$ between the patients' social security and patient satisfaction.		+	

PLAGIARISM REPORT

LİDERLİK TARZLARI İLE HASTA TATMİNİ VE HİZMET KALİTESİ İLİŞKİSİNDE OTELCİLİK HİZMETLERİNİN ARACI ETKİSİ

ORİJİNALLİK RAPORU

%14	%11	%3	%7
BENZERLİK ENDEKSİ	İNTERNET KAYNAKLARI	YAYINLAR	ÖĞRENCİ ÖDEVLERİ

BİRİNCİL KAYNAKLAR

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ETHICS COMMITTEE REPORT

YAKIN DOĞU ÜNİVERSİTESİ

BİLİMSEL ARAŞTIRMALAR ETİK KURULU

30.03.2018

Sayın Serkan Turgutoğulları

Bilimsel Araştırmalar Etik Kurulu'na yapmış olduğunuz YDÜ/SB/2018/95 proje numaralı ve **"Liderlik Tarzları ile Hasta Tatmini ve Hizmet Kalitesi İlişkisinde Otelcilik Hizmetlerinin Aracı Etkisi"** 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.