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A PRACTICAL FRAMEWORK FOR HEALTH SYSTEM REVIEW

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Abstract

In order to review a health system we have to understand the context first. For this we need certain information (general background and specific). The general background information pertains to the environment and the people of that country. This information is necessary for understanding the threats to the population health and the challenges the health system has to face and to tackle. The background information pertaining to people is very important because it gives us information about the threats to health associated with people activities, the health needs of the population and the way these are expressed as demand for health care services. Economic activities and occupational patterns can give us information about potential health hazards like pollution (air, water, ground, noise, light), or occupational hazards (occupational diseases). In conclusion all the above goals, functions, factors, methods, elements will be taken into consideration when analyzing the performance of the health system. Relevant indicators ought to be used, and correlations with health outcome indicators have to be made. Not correlated indicators should be avoided.

Keywords:
Framework, Health System, Review

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Introduction

In order to review a health system we have to understand the **context** first. For this we need certain information (general background and specific).The general background information pertains to the environment and the people of that country. This information is necessary for understanding the threats to the population health and the challenges the health system has to face and to tackle.

The environment is about geographical information and climate. There is an ecological dimension of human health pertaining to habitats, natural, built or social environment. We know that many diseases have seasonal outbreaks. Weather is also a factor influencing certain diseases. The landscape is also important both for the human health and for the health system. Certain types of geographical environments favor certain diseases, whereas landscape is an important factor in the functioning of a health system, affecting mainly access to care. There is an environmental exposure to diseases. These in turn, spread over borders; there are well known areas infested with certain pests. The environment encompasses health risk factors concerning natural disasters (earthquakes, floods, fire, hurricanes, tornados, tsunami waves, volcanic eruptions, extreme cold and extreme heat). The geography provides us information about hazardous areas prone to be infested by infectious agents (bacteria, viruses, fungi, other microbes. The air and the water can be the developing environment for infectious agents or can support animal vectors of diseases.

The background information pertaining to people is very important because it gives us information about the threats to health associated with people activities, the health needs of the population and the way these are expressed as demand for health care services. Economic activities and occupational patterns can give us information about potential health hazards like pollution (air, water, ground, noise, light), or occupational hazards (occupational diseases). Furthermore, information about transport and its infrastructure is important in understanding health hazards (accidents), but also the support for the health system. For the same dual purpose we need historic, social and even religious information, because it influences social and gender attitudes. This is useful to understand behavioral patterns of the population pertaining to general hygiene, to food and nutritional habits, to vices (smoking, alcohol and drug consumption) and risky behaviors (promiscuous sex). Also within the useful social information is data about access to firearms and crime. Aside from assessing health challenges, this information is useful for tailoring the health system.

This specific social information should pertain to demographics: population statistical data (population numbers, life expectancy, birth rate, fertility rate, general mortality, infant mortality, mother mortality rate). The information pertaining to the above is very useful in understanding the health challenges, the demand and access to care.

In addition to this we need morbidity data to understand the incidence and prevalence of diseases. It is useful to know which are the main causes of death at certain ages, as well as which are the most prevalent diseases and which are the emerging diseases

Aside from situational snapshot data, it is very important data is displayed over time to see trends.

The health system's has certain goals out of which we mention:

- maintaining and improving the health of the population;
- responsiveness to the health needs of the population, pertaining to persons dignity, individual autonomy and confidentiality as well as addressing the health needs, providing basic amenities, access to family and social support and choice;
- fairness in financial contribution;
- access to care (geographical, financial, time);
- population coverage based on the following factors: meeting the health needs, affordability, access to care including technology and pharmaceuticals, well trained and motivated health professionals; coverage also relies on other sectors performance (transportation, education, local administration);

The health system has to perform 4 main functions: stewardship, resource generation, financing and provision of services

Stewardship

Stewardship pertains to:

- system design;
- integration of data and data analysis;
- policy making, defining a strategy and priority setting;
- creating, implementing and monitoring regulation;
- assuring a clear and fair environment for the actors in the system (patients, purchasers, providers)
- consumer protection;
- performance assessment;
- inter-sectoral advocacy and collaboration with other sectors for the control and management of external factors influencing the health system

In every healthcare system the organization in charge with stewardship the Ministry of Health. In certain cases it can also perform financing and health services providing functions, or even resource generator. As provider it can be owner of facilities and also employer of medical staff. Aside from this any MoH has to have other provider functions like epidemiological surveillance, public health maintenance, health promotion. To fulfil its duties the MoH must have an internal capacity (skilled staff) or to have some of its core functions delegated to competent public agencies. For the same reasoning any MoH must have "branches" subordinated institutions which have same duties in every province of the country. If the MoH does it all we can speak of a centralized system.

Resources

The resource generation pertains to human resource management and education of labor force, as well as managing the introduction in the health system of material resources, such as pharmaceuticals and other medical supplies. In some cases this function is performed by state – sponsored research for the

purpose of developing new medical procedures, and equipment, or accepting pharmaceuticals in the system.

Manpower

The main actors as human resources are: doctors, nurses, dentists, midwives, pharmacists, biologists, chemists and other ancillary personnel, managerial and secretarial staff. Recently, as the health services market shifts from a labor-intensive industry to a more capital- intensive one, new categories of manpower emerged: equipment technicians and IT specialists.

Aside from general numbers of professionals, it is important the educational background of these, positions in the system, career path. It is also important how the labor market is controlled, issues related to diplomas and licensures, staffing policies. Educational institutions can be part of the educational system or can develop within the health system. It is useful to know how many practice independently or hired as an employee.

Materials

Materials pertain to fixed costs / assets, like medical institutions, beds, general medical equipment (sterilizers, operating rooms), diagnostic equipment (lab and imaging), therapeutic equipment (surgical robots, laser and nuclear technology), medical emergency and transportation equipment.

There are also materials linked to variable costs (depending on the volume of activity) like general consumables, food, medical supplies and pharmaceuticals.

For the latter it is important to know how they are introduced onto the market, how prices are set, wholesale arrangements, distribution and retail paths, dispensing rules, (by recipe or OTC), reimbursement lists if any, pharmaceutical studies, advertising.

Financing

Financing pertains to three main functions:

Revenue collection; which is the mobilization of money from primary sources by:

- direct payments
- insurance contributions and medical health accounts
- taxes and excises
- donations and transfers

Fund pooling pertains to accumulation of revenues for the advantage of the individuals. Pooling is done for the purpose of risk-sharing because not all contributors share the same health risks, and not all the participants have the same income

Purchasing is the allocation of the pooled funds to various providers. Purchasing decision has to answer the questions: what is purchased, how is purchased and from whom it is purchased? For any question above there is a specific mechanism: service list or benefit package, bidding or price / volume negotiation, provider licensing / accreditation or program certification. Purchasing the services can range from simple budgeting of health care providers, direct purchasing of certain services and establishing framework contracts. There are several methods of contracting:

- block contracts;

- cost and volume;
- cost per case;
- case mix.

Contracting in a competitive market is associated with certain transaction costs, influenced by factors like resource allocation methodology, complexity of the market, opportunism, uncertainty, bounded rationality, asset specificity, and types of contract.

After contracting, there is the issue of procurement where it is important to define quantity and quality of inputs or services delivered the non-price criteria to consider and the measurement of those.

The provider payment methods are specific to the kind of services or items provided. For services in outpatient these methods include salary, capitation, fee-for-service. For inpatient services these might be cost reimbursement, per case, DRG, fee-for-service.

The pharmaceutical market trades large volumes and requiring significant amounts of money. Usually prices are controlled and payments are made based on commissions and reimbursement.

In the particular case of salary but also from a broader view of income, it is useful to compare the hourly wage of professionals in healthcare with hourly wage in other professions.

Aside from these "official" payments, there might be also "under-the-table" payments.

The flow of money must take into consideration the "money-follows-the-patient" principle.

All health systems evolved from a direct market for health services where the demand was met by a specific supply. However, due to the fact that health services where expensive and price was a barrier for access, systems with third party payer have evolved. In these systems, from financial point of view, the supply does not meet the demand directly. In these systems the third party pays the providers. This third party intermediates the payment of money collected, or collects money from potential beneficiaries while they are healthy and pays for services on behalf of them when they are sick. The third party payer is present when there is the so called purchaser – provider – split; a separation between purchaser and provider. This quasi-market arrangement allows for better efficiency, flexibility, accountability, consumer empowerment. However there might be disadvantages of these markets, competition between providers leading to conspiracy, collusion, cartelization, corporatism, risk selection, market domination, self-contracting, manipulation of disease episodes, biased interpretation, over – treatment, cross – subsidization, segmentation. In the so called "national systems", the MoH is the third party payer. The third party can be also a publicly owned insurance company in so called "social health insurance", or private insurers. When insurers are public there may be a unique or parallel health funds; in this case there is no competition among them, but might exist some inequity in the benefit package. When insurers are private, they might act like a cartel or oligopoly or there might be competition among them; in the latter case, benefit packages vary a lot because private insurers tend to apply segmentation in order to transform direct competition into monopolistic competition.

A better understanding of the money flows within the health sector can be given by a System of Health Accounts which answers three basic questions: what services are consumed, who provides them and what money paid for them?

Provision of services

Provider structures

All the human and material resources are structured into and used by providers of healthcare services. These providers are:

- Primary health care offices / dispensaries; they should be the first contact of the patient with the health system and the medical facility most accessible;
- Specialist outpatient clinics;
- Hospitals; large medical providers whose main function is the treatment of patients who need care under medical supervision;
- Rehabilitation care providers;
- Long term care facilities which are in charge of treatment of chronic illnesses, with limited prospects for recovery;
- Palliative care for patients without recovery prospects but who need maintaining their quality of life;
- Home care and informal care;
- Providers of diagnostic services only, like laboratories and imaging centers.
- Dialysis centers
- Prosthetic providers
- Specific care institutions for treatment of specific diseases who can be inpatient (for mental care, TB, some infectious diseases which need isolation from community) or outpatient, like dental care;
- Ambulance services, in charge with first aid, maintaining vital functions, transportation to a more competent provider (hospital) and specialized referral transport;
- Pharmacies;

There is a growing trend towards getting out from the hospital certain treatments and shifting towards ambulatory, for the purpose of saving costs and increasing access

All these types of providers might exist independently or in various levels of integration. From the economic point of view, providers of healthcare services are also purchasers of materials and other resources. Both in the purchaser or the provider position integration might give an advantage over the competitors due to cost reductions as well as enhancing the market power towards customers by abusing a monopolistic position. There is a specific mechanism of demand creation through the system of referrals.

The providers of healthcare and the beneficiaries of these services (patients) interact within a highly complex system. If there was a free market where supply meets demand directly, due to complexity of services and the numerous imbalances (among which asymmetric information is the main one), this market would have many imperfections, if it wouldn't fail directly in certain areas. Therefore there are certain actors (mainly public) whose job is to regulate and control it, so that as many people as possible (ideally all) have access to, and benefit from these services at an affordable price, correcting the market imperfections.

From the economic point of view, most of the health services are private services (the patient is the only beneficiary) but certain services like vaccinations are public services (the patient and other people too

benefit from the services). This is another reason why public institutions might be involved in delivering the service, and act as providers.

The financial and provision functions of the health system might display vertical and and / or horizontal integration as well as vertical and / or horizontal segmentation.

To attain its goals the health system must consider concepts such as quality, equity and efficiency

Quality of care is a vast realm but its main dimensions are: efficacy, appropriateness, availability, timeliness, safety, effectiveness, and respect for patients. The external quality assurance methods pertain to licensing, certification and accreditation. These methods are based on minimal standards the providers have to comply with.

Equity pertains to the absence of disparities between various groups of population in regard to health care services. There is a horizontal equity regarding equal access to care in terms of geographical and social determinants and vertical equity regarding equal access to care, irrespective of income.

Efficiency pertains to:

- technical efficiency (producing maximum of outputs with a given combination of inputs)
- cost-effectiveness efficiency (producing a given output with minimum combination of inputs)
- allocative efficiency (producing the outputs which satisfy maximum of the demand)

Attention must be paid to how the legal framework defines various structures and how precise are defined the scopes of care of providers. Do they use guidelines?

In conclusion all the above goals, functions, factors, methods, elements will be taken into consideration when analyzing the performance of the health system. Relevant indicators ought to be used, and correlations with health outcome indicators have to be made. Not correlated indicators should be avoided.

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INVESTIGATING THE ROLE OF 5S-KAIZEN-TQM APPROACH IN PATIENT SAFETY IN SAUDI HEALTHCARE INSTITUTIONS

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Abstract

This descriptive study will use a mixed approach (qualitative and quantitative methods) to achieve the aim and objectives of this study. Thus, the population of this study is all the healthcare institutions at the kingdom of Saudi Arabia. The sample of this study will consist of 150 employees worked in Saudi healthcare ,nstitutions to participate in the questionnarie that the researcher will design based on the research issues based on the related previous studies. As well, this study will conduct interviews with 20 the managers of Saudi healthcare institutions, to know more about their views on their experience of applying 5S-KAIZEN-TQM Approach and how it benefits from this approach, in addition to know how its effect on their patient safety.

Keywords:
5S-KAIZEN-TQM, Patient Safety, Saudi Healthcare Institutions

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Introduction

Healthcare is ending up progressively mind-boggling and the cost of medicinal services is expanding because of elements, for example, a maturing populace or choices for new medications (Thies, 2016). From a verifiable viewpoint, the medicinal services framework was intended to manage intense conditions as opposed to continuous ones, which still wins as a method of operation today (Stiernstedt, Zetterberg, & Ingmanson, 2016). Be that as it may, today, incessant conditions win and constitute roughly 70-85% of the costs (Stiernstedt et al., 2016; Thies, 2016).

Continual change and advancement have gotten a noteworthy concentration in broad daylight part associations for quite a while. The fundamental motivation behind the consistent change is to actualize change activities that expansion achievements and reduce disappointments. Raised amounts of value can be accomplished in an association through a procedure of constant search for development and contribution of all levels (Hutchings and Vree, 2017).

To increase in value the significant duty to progress the quality of health of health and social welfare administration and make a commitment to the fulfillment of key health and social welfare markers, the Health Services Inspectorate Unit of the Ministry, began from a modest start of Health administrations examination. It is imperative that the unit's work has been becoming bit by bit finished the previous decade to the point that its degree has extended and as of late it has been moved up to a Health Services Inspectorate and Quality Assurance Section (HSIQA) inside a Health Quality Assurance Department (The Ministry of Health and Social Welfare (MoHSW), 2013).

Amid the preparing time of the previous decade, the leader of the unit helped by a few experts figured out how to pull in promotion activities and particular topical QI extends some with scale-up after pilots [IPC, SBM-R, 5S-CQI (KAIZEN)- TQM, preparing of Tutors in Health Schools, improvement of apparatuses, etc.….]. The unit likewise fashioned community oriented connections with projects, for example, Improvement Collaborative (IC) National Quality Improvement Strategic Plan 2013 – 2018, assistance and support of HIV and AIDS; and working relations with Laboratory QI under the help of CDC (MoHSW, 2013).

Since 2007, JICA (refer to Japan International Cooperation Agency) has executed, a program called "Program of TQM for Better Hospital Services", presenting '5S-KAIZEN-TQM' approach, which presents Japanese-style business technique in stepwise approach, in human services offices in 15 African nations to address this issue (Fujita Planning CO. 2013).

The term 5S is a truncation for five Japanese words, *Seiri, Seiton, Seisou, Seiketsu, and Shitsuke, which to a great extent related to looking after cleanliness. These five words mean English as Sort, Set in Order, Shine, standardize, and Sustain*, separately, and describe an arrangement of practices intended to enhance working environment association and profitability (Kanamori, et al, 2014, P. 1).

The 5S administration strategy (refer to '5S') is known as the establishment of the lean methodologies, which augment an incentive by evacuating inefficient elements. It advanced in the Japanese assembling

part and was acquainted with the West in the 1980s. As of now, 5S is utilized as a part of medicinal services settings to arrange and institutionalize the workplace for lean healthcare. Because of its minimal effort and innovatively undemanding highlights, 5S is viewed as a fitting beginning stage for enhancing healthcare administrations (Imai, 2012).

Utilization of kaizen in medicinal services is a more commonsense contrast with advancement. Kaizen is a little change that is made by healthcare staff. It is a little, minimal effort, low-risk enhancement change that can be effortlessly connected. Kaizen is a progressing system and rationality for testing and approves, everybody in the association to utilize their inventive plans to improve their day to day work (Kaptanoğlu, 2012).

Accordingly, this study will explore the role of 5S-Kaizen-TQM approach and its factors in patient safety in Saudi healthcare institutions.

Problem statement

The development of hospital administration toward a superior nature of care and restorative health began to draw universal consideration as a basic territory for better health in both industrialized and creating nations. This was incompletely activated by repeating occurrences of therapeutic mistakes in developed countries, and it was upgraded by mounting proof demonstrating that better quality and more secure care is probably going to prompt higher usage of healthcare services even by the poor in low-wage nations (Honda, 2012).

Around the world, medicinal services part is the most critical quality pointer of the life of countries (Funk, 2016). There are many issues and difficulties faced the human services benefit for the healing facilities, keeping in mind the end goal to accomplish benefit greatness. The administration must be altered by every individual case while it has trustworthiness qualities which make it troublesome for the patients to precisely evaluate the nature of administration (Hamid, et al., 2016).

As indicated by (Purcărea, et al., 2013), a condition of administration greatness is the point at which the healing facility is satisfying what is guaranteed to the patients, giving individual consideration, putting additional exertion and taking care of issues and inquiries well. Patient's fulfillment has a positive noteworthy association with commitment. As specified by (Abdul Aziz, Neshaminy & Azizan, 2013), a solitary unsatisfied patient can send away more business contrasted with 10 fulfilled patients.

Then again, Haque and others (2012) announced that the patient saw benefit quality is the principal driver to compelling consumer loyalty, and the strong response of the hospitals is urgent in advancing health administrations. The examination was completed at one of the private healing center in Southern Malaysia with the sample size of 200 including staffs and patients. To finish up, the administration perfection will essentially prompt fulfilled patients to return to the hospital in future.

In this way, the present examination endeavor to talk about the role of 5S-Kaizen-TQM approach in patient security in medicinal services establishments, as one of the lean administration rehearses appropriate to be actualized among human services foundations. The created estimation was adjusted from the conventional assembling rehearses with some revised to suit the clinic in around the world.

However, different investigations identified with the execution of 5S-KAIZEN in the hospital; yet, the greater part of the past examinations were led inside the US, UK, Nigeria, Japan and India social insurance setting (Thawesaengskulthai, Wongrukmit & Dahlgaard, 2015; Sarwar, 2014).

But, there are rarely related studies (Ishijima, et al., 2016; Kanamori, et al., 2015; Ishijima, et al., 2014) that talked about the effect of 5S-Kaizen-TQM approach and its factors on the patient safety in healthcare institutions, as well as there is no past study talked about this issue in Saudi Arabia.

Accordingly, this study discusses the following main question **"what is the role of 5S-Kaizen-TQM approach in patient safety in Saudi healthcare institutions?"**

To answer this question, it must discuss the following sub-questions:

1. How can 5S-Kaizen-TQM approach affect and its factors (feedback and information sharing, involvement and commitment, QIT roles and responsibility, 5S knowledge and availability of KAIZEN guideline) on patient safety in Saudi healthcare institutions?
2. What are the main advantages that can be achieved from applying 5S-KAIZEN-TQM Approach in the patient safety at Saudi healthcare institutions
3. What are the most barriers that faced Saudi healthcare institutions in applying 5S-KAIZEN-TQM?

Aims and objectives

This study focuses on 5S-KAIZEN-TQM Approach in healthcare institutions and in what way this approach effect on patient safety.

This study will achieve also the following sub-objectives:

- Determine the effect of 5S-KAIZEN-TQM Approach on patient safety in Saudi healthcare institutions, in terms feedback and information sharing, involvement and commitment, QIT roles and responsibility, 5S knowledge and availability of KAIZEN guideline factors.
- Determine the main improvements that can 5S-KAIZEN-TQM Approach do in the patient safety at Saudi healthcare institutions.
- Determine the obstacles that face Saudi healthcare institutions in applying 5S-KAIZEN-TQM Approach.
- Describing the healthcare institutions around the world that applied 5S-KAIZEN-TQM Approach in it, and show how its effect on patient safety.

Hypothesis of the study

The main null hypothesis of this study is:

H_0: There is no positive significant relation between 5S-KAIZEN-TQM Approach and the patient safety in Saudi healthcare institutions.

The following sub-hypotheses of this study are:

$H_0$1: There is no positive significant relation between 5S-KAIZEN-TQM Approach and the patient safety in Saudi healthcare institutions, in terms feedback and information sharing.

$H_0$1: There is no positive significant relation between 5S-KAIZEN-TQM Approach and the patient safety in Saudi healthcare institutions, in terms involvement and commitment.

$H_0$1: There is no positive significant relation between 5S-KAIZEN-TQM Approach and the patient safety in Saudi healthcare institutions, in terms QIT roles and responsibility.

$H_0$1: There is no positive significant relation between 5S-KAIZEN-TQM Approach and the patient safety in Saudi healthcare institutions, in terms 5S knowledge.

$H_0$1: There is no positive significant relation between 5S-KAIZEN-TQM Approach and the patient safety in Saudi healthcare institutions, in terms availability of KAIZEN guideline.

Significant of the study

Lean is an efficient approach and a blend of a few methods so as to distinguish and take out waste, which prompts consistent change and at last superb execution and upgrade of patient esteem. It is an approach to accomplish cost lessening, quality and productivity change with less exertion. The coveted change can be accomplished by fitting execution of lean devices and strategies, practices and standards. One of the greatest significant lean administration approaches is 5S-KAIZEN-TQM (Chourasia, and Nema, 2016).

Behavioral Health Service Provider (BHSP), a triangular participation program helped by JICA, particularly addresses the difficulties of development of healthcare benefit quality. It intends to share Sri Lankan and Japanese encounters and learning of 5S-KAIZENTQM with fifteen African nations and structures one of the subsequent activities of the Third Tokyo International Conference on Africa's Development (Ishijima, Eliakimu and Mshana, 2016).

The proposed 5S-KAIZENTQM approach depends on the Japanese administration apparatuses initially utilized as a part of the mechanical area like Toyota and different organizations. Be that as it may, it has been established in Japanese customary culture Tea Ceremony or Omotenashi. In 2000, Dr. Wimal Karandagoda, chief of Castle Street Hospital in Sri Lanka, first connected this modern apparatus to health area at the maternity healing center, where he, as the hospital executive, worked for (Hasegawa and Karandagoda, 2011).

Despite the fact that he encountered protection from the workforce in the underlying stage, he effectively introduced the 5S exercises and progressively spread them to the entire healing center. Dr. Wimal Karandagoda imagined the stepwise approach from 5S to KAIZEN at that point to TQM. KAIZEN is the Japanese word for the Continuous Quality Improvement (CQI). This critical thinking procedure can spread to the entire association under the best administration's initiative. TQM arrange, from there on, can be begun (Hasegawa and Karandagoda, 2011).

Moreover, 5S-KAIZEN-TQM is a cross strain administration change approach for medicinal centers. It joins three resolutely steps related however isolate instruments for efficiency and quality change, specifically 5S, KAIZEN, and TQM (Total Quality Management), the following steps are (Honda, 2012):

1. The initial step, 5S, is an arrangement of passage activities towards a further developed phase of KAIZEN-TQM, and it speaks to individually for 5 activities of “Sort, Set, Shine, Standardize, and Sustain” for a superior workplace.
2. The Second step, KAIZEN, is a participatory execution and efficiency change approach through incremental and intelligent gathering activities.
3. The last step, add up to the quality administration or TQM is the approach for system-wide administration in seeking after higher quality in items and administrations.

As appeared in the three resolutely steps of its approach, one of its remarkable highlights is that it places specific significance on the strengthening and mentality changes of clinic staff toward the change of the nature of care as opposed to top-down forthright hierarchical rebuilding. In this manner, the main prescribed activity is to enhance their workplace with the goal that they feel the advantage and the feeling of accomplishment, which at that point give the inspiration and impetuses to the staff to additionally proceed with their base up change activities (Honda, 2012).

5S-KAIZEN-TQM approach empowers the healing centers to diminish misuse of merchandise, workplaces and time for looking and clean work put additionally to bring issues to light of staff, trailed by change of occupation quality and productivity, administration of drugs and equipment and contamination aversion, as well as control and disposal of restorative mishaps through stimulating of ranked limit including staff fulfillment. In this manner, the hospitals can enhance their administration showed by cost lessening and increment in quiet fulfillment (JICA, 2013)

Related works

Several studies reviewing 5S-KAIZEN-TQM Approach and how its effect in healthcare institutions, including disease rates, have decreased, patient's and healthcare staff's satisfaction and nature of care enhanced, for example, lessening of holding up times. While there are a few difficulties that confronted the hospital's administration in applying this approach, consists of low permeability, governmental issues and constrained resources, poor correspondence, and insufficient information (World Health Organization (WHO), 2016; Kanamori, et al., 2016; Chourasia and Nema, 2016).

As, in Bangladesh, the hospitals adjusted "quality improvement Model System" and built up its usage structure, rules and devices under the idea of WHO six building pieces of a healthcare framework and plan-do-check-act cycle alongside 5S-KAIZEN-TQM approach, for maternal and infant healthcare administrations of area and sub-locale level of these hospitals. from that point forward, the national specialists demonstrated that a few key territories of value change found after received and built up the Model QI System of these hospitals, for example, enhance healthcare framework bolster, increment clinical administration conveyance, upgrade between departmental coordination, increment usage of administrations and customer satisfaction (Islam, Rahma, and Halim, 2016).

AS well, Ishijima, et al., (2016) found a positive relation between the applying 5S approach and advance an employed setting through Difference-in-Difference (DID) analysis by comparing of the total waiting time reduction of the patients from 16 hospitals in Northern Tanzania were chosen and divided into treatment and control groups using block randomization.

Additionally, Kanamori, et al., (2015) interviewed with health center staff members in Senegal, he found that regardless of resource requirements and other demotivating factors exhibit at the healthcare focus, the 5S program made changes in the workplace, including reduce undesirable things, enhanced methodicalness, and enhanced marking and directional pointers of administration units. These endeavors induced positive changes in the nature of administrations (e.g. making administrations more productive, quite focused, and safe), and in the demeanor of staff and increase the satisfaction of the patients on these health center.

Furthermore, Ishijima and others (2014) pointed that a significant relationship between the implementation of 5S-KAIZEN-TQM approaches and five explanatory variables (feedback and information sharing, involvement and commitment, QIT roles and responsibility, 5S knowledge and availability of KAIZEN guideline) were found in public hospitals in Tanzania.

Methodology

This descriptive study will use a mixed approach (qualitative and quantitative methods) to achieve the aim and objectives of this study. Thus, the population of this study is all the healthcare institutions at the kingdom of Saudi Arabia.

The sample of this study will consist of 150 employees worked in Saudi healthcare institutions, to participate in the questionnaire that the researcher will design based on the research issues based on the related previous studies.

As well, this study will conduct interviews with 20 the managers of Saudi healthcare institutions, to know more about their views on their experience of applying 5S-KAIZEN-TQM Approach and how it benefits from this approach, in addition, to know how its effect on their patient safety.

Then, the collected data from the questionnaire and interviews will be analyzed using the SPSS program for the data collected by the questionnaire, while the data collected by the interviews will be analyzed through transliterated interview records and prearranged the description data through developing themes by means of thematic analysis using the coding procedure.

The theoretical framework of this study separated into two key portions: independent factors (patient safety) and depended factor (5S-KAIZEN-TQM Approach) which includes five factors according to (Kanamori, et al., 2015; Ishijima and others 2014): feedback and information sharing, involvement and commitment, QIT roles and responsibility, 5S knowledge and availability of KAIZEN guideline factors. Figure 1 shows the theoretical framework of this study.

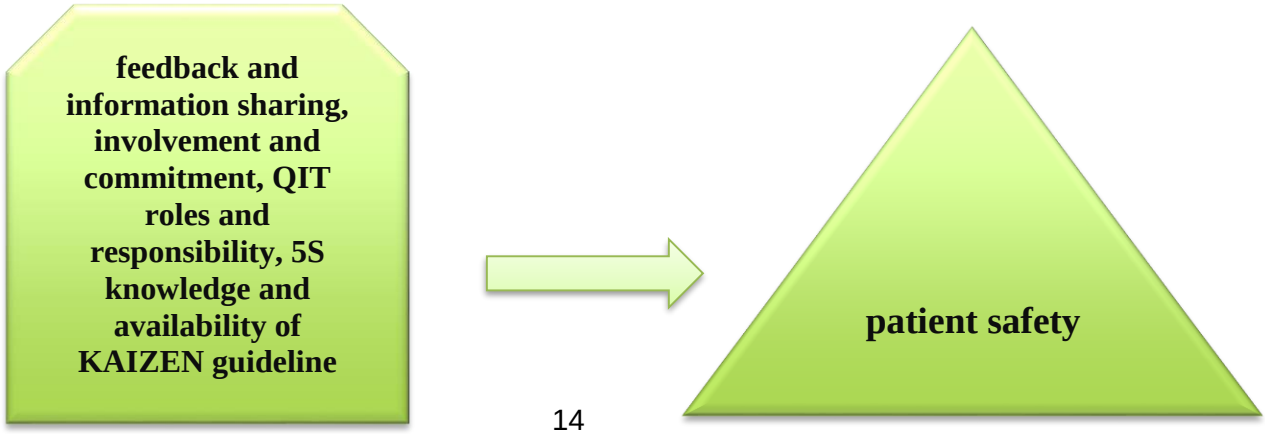

Figure 2 the theoretical framework of this study

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LEISURE TIME AND HEALTH

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Abstract

Introduction: Leisure time is the time when the individual is free of all sorts of obligations and chooses by his own how to use the time left.

Purpose: The aim of this study is to investigate the effect of free time on human health.

Material-Method: An extensive review of the recent literature was performed via Medline database and the Hellenic Academic Libraries Association (HEAL-Link), using the following keywords: leisure time, health, health promotion, and a combination of them.

Results: Leisure time often acts as a remedy in various cases. It has been shown that participation in leisure activities can lead to physical and mental health. Recent studies take into account indicators covering a wide range of social welfare considerations. Dealing with activities that give pleasant emotions to a person suffering from a disease can be beneficial in trying to overcome it.

Conclusions: Leisure is of great importance in human life. An individual, during his spare time, can engage himself in activities resulting in his personal cultivation and his spiritual elevation.

Keywords: leisure time, health, health promotion and a combination of them.

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Introduction

Leisure time is the time when the individual is free of all sorts of duties and chooses by his own how to use the time left. (Karagianni, 2015) It is the time when the person chooses how to allocate himself and during that time he has the opportunity to be himself and participate in activities he prefers. Detachment from work and duty became the definition of leisure time. (Cordes, 2013) In fact, leisure time is the only thing that remains when the person has fulfilled all his duties, such as work, homework or reading and has satisfied all of his basic needs, such as sleeping and eating. (Beliviani, 2013)

However, the distinction between leisure and work is not considered as simple, since in some cases people work without being remunerated (e.g. volunteers) due to the satisfaction they gain from their participation. On the other side, the unpaid household is certainly not a leisure activity, since it includes the element of the obligation. (Goodin, Rice, Bittman, & Saunders, 2005)

Leisure time is also a concept that varies between cultures. It also varies according to social situation, historical period and culture. Some people think that leisure time is freedom from work. Some others see it as a social control tool or a social status symbol, while others believe it is just a state of rest. Furthermore, free time can be considered as a desirable situation rather than a pleasant experience. (Deffer, 2013)

Many times the concept of leisure time is confused with that of entertainment, which aims at relieving and removing the individual from the pressure of everyday life. The concept of recreation also often appears to be confused with the term of leisure. Leisure time is a wider term that includes recreation which along with fun and entertainment are factors contributing to it. (Karagianni, 2015) Leisure time also contributes to the promotion of people's health and good quality of life in general, as it is a factor influencing it and in combination with other factors may have positive or negative effects. (Deffer, 2013 & Psatha, Defner, 2012)

The purpose of this review is to study the literature regarding the contribution of leisure time to the promotion of human health. In particular, the importance of leisure time and some elements of the concept are presented, as well as the activities that can be developed during it and their association with health.

Methods

An extensive review of the recent literature was performed via Medline database and the Hellenic Academic Libraries Association (HEAL-Link), using the following keywords: leisure time, health, health promotion, and a combination of them. Criterion for exclusion of articles was the language except Greek and English.

The importance of leisure time

Leisure is a wider term that includes cultural, touristic, sports and leisure activities. (Deffer, 2013) In antiquity, Aristotle was one of the first who worked and talked freely about leisure time. According to the ancient Greek philosopher, leisure time is the availability of time and the absence of the necessity to be busy. This absence leads to a life of reflection and actual truth. (Vogel, 2001) According to Aristotle, leisure is also achieved in three levels: meditation, recreation and entertainment. (Cordes, 2013)

Another ancient Greek philosopher, Plato, believed that the problem of leisure time was set only for children and young people. The rest of the time was being shared between rituals and work. He believed that people should devote most of their leisure time to the propitiation of gods and the rest of time to games. (Beliviani, 2013)

In England, free time is called 'leisure', which comes from the Latin word licere and means 'to be allowed' or 'to be free'. In France, leisure is called 'loisir', in America ‘non working time', in Germany, 'musse' or 'freizeit', and in Italy free time is given to the term 'tempo libero'.

In Portugal, it is seen as 'lazer' and is replaced by 'folga', which is interpreted as free time or 'horas vagas’ as remaining time. In Spain, free time is called 'ocio' and generally indicates leisure time. (Mihalopoulou, 2006)

The concept of leisure time has to include three basic functions (Oishi, & Lucas, 2003):

• The operation of rest
• The entertainment function
• The function of further development and personality.

The trainee probably, after taking part, needs time to rest, but rest is not entertainment. This raises the issue of the correct allocation of leisure time.

Furthermore, activities that are included in leisure time may be informal and specialized, ie leisure activities, such as game and occupations requiring special skills respectively. (Chatzimanouil, Glynia, & Smernou, 2010) Additionally, leisure time has different dimensions and versions and is categorized according to the activities carried out and the procedure followed, as below (Kouthouris, 2001):

• Criterion 1: How the participant engages in activities
• Criterion 2: Participant's contribution to production or consumption of activity (e.g. gambling)
• Criterion 3: Whether the activities involved are of free choice
• Criterion 4: The control exercised by the participant in the final goal of the activity.

The needs of people for leisure time are divided into 8 (eight) categories depended on the characteristics of the individual. These are (Papanastasiou, 2009):

• Need for rest, relaxation and well-being (recreation)
• Need for balancing, emotional discharging and fun (discharging)
• Need for knowledge, training and instruction (education)
• Need for reasoning, collecting experiences and becoming acquainted with oneself (self-knowledge)
• Need for information, social contacts and sociability (communication)
• Need for grouping, social direction and collective learning experience (integration)
• Need for participation, identification with others and engagement (participation)
• Need for creative development of life, cultural activities and productivity (civilization)

The satisfaction of these needs can be achieved through activities during leisure time, in which the involvement of the stakeholders can be active, ie activities that have to do with physical movement, such

as sport. These activities can take place in gyms and sports facilities. The participation of the individual can also be both interactive and passive, as it happens in cinema. (Beliviani, 2013 & Mihalopoulou, 2006)

Leisure time and health

Leisure time is a component of utmost importance to human health. Recent studies take into account indicators covering a wide range of social welfare considerations. For example, in a study on numerous Spanish provinces, researchers took into account indicators such as health and health services as well as indicators such as cultural and recreational opportunities, coexistence and participation, and citizen's security. (Karagianni, 2015)

Leisure time often acts as a remedy in various cases. More specifically, as mentioned above, it has been shown that participation in leisure activities is quite beneficial to physical and mental health. (Kourkouta, Prokopiou & Iliadis, 2016) Dealing with activities that give pleasant emotions to a person suffering from a disease can be beneficial in trying to overcome it. It is understood, therefore, that "leisure time can be seen as a matter of quality of life and public health". (Syracoulis, 2009)

The allocation of leisure time in various activities seems to have a significant impact on people's lives. Passive activities, such as watching television, have been linked to heart disease. (Burazeri, Goda, & Kark, 2008) On the contrary, active activities seem to prevent or contribute to the treatment of a series of physical and mental illnesses. (Kourkouta, Iliadis & Monios, 2015)

However, despite the obvious benefits, it seems that the participation of people in active leisure activities is problematic. (Azaka, 2009) Thus, despite the proven beneficial effects of exercise on patients suffering from coronary artery disease, only 46% of them is active enough to gain the benefit and those who participate in an exercise program leave it within the first six months. (Thompson &Lim, 2003 & Berger, Pargman & Weinberg, 2002)

However, the necessity of leisure time is understandable, as it allows the individual to escape from everyday life, and to develop his sociality. Leisure is an important parameter of people's health as its benefits can contribute to higher living standards and it can also be a therapeutic tool. (Karagianni, 2015 & Andereck, Valentine, Vogt & Knopf, 2007)

Leisure time, therefore, is an important element of individual’s everyday life, as it contributes, by its activities, to the detachment from everyday duties as well as to physical and mental health, sociability, contact with nature and contact with culture and arts. (Beutell, 2006 & Kourkouta, Rarra, Mavroeidi & Prodromidis, 2014)

In a society where infrastructure affects the daily life and the health of its citizens, negative results, such as urban gaps, can be produced. On the other hand, a properly designed network of public spaces will bring positive results on human's health. (Boley, 2001 & Ziogou, Fradelos & Kourkouta, 2015)

Conclusions

Leisure time is a very important element of human life. It is the time spent away from job and homework. It is a distinct time before or after our basic needs and forced activities, such as eating, sleeping and working. It is the realm of freedom. In his leisure time, an individual can be involved in activities that

result in his personal cultivation and his spiritual elevation through discussion, study, thinking, through the search for knowledge, dialectics, political and cultural enlightenment. (Samaras, Kotsidou, Iliadis, Iakovidis, Prodromidis & Koukourikos, 2015)

An individual can also deal with recreational activities, sports, physical activities, as well as entertainment and play. Common point of all these activities is joy, pleasure and offered satisfaction, necessary feelings in everyday life.

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THE ROLE OF ORGANIZATIONAL CYNICISM FOR THE EFFECT OF EMOTIONAL LABOR ON INDIVIDUAL

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Abstract

This study's aim was to investigate the role of organizational cynicism for the effect of emotional labor on individual work performance. The research, which was planned in order to produce more explanatory results in terms of organizational behavior for managers in health sector. This study was conducted A, B, C type classified private hospitals of İstanbul. The sample of this research consists of 390 nurses who can contact face to face with patients per 130 for each class.

According to results of this research, it could not detect any relation between emotional labor and individual work performance statistically. Yet, there is poor negative relation (p=0,01, r= -0,144) between surface acting and individual work performance. In addition, there is poor positive relation (p=0,05, r= 0,100) between deep acting and individual work performance. The cause of relevant poor relations is that nurses consider themselves competent in the context of individual work performance (4.05 ± 0.77).

Contrary to the expectations, research results indicated that nurses' level in both emotional labor and organizational cynicism were low. The cause why organizational cynicism average (2.45 ± 0.91) was low than expectation, as suitable with literature results, is that health care workers cover up their cynic attitudes in order to not losing their status and income. Emotional labor's average lowness than expected was interpreted as that workers did not internalize the nature of performing job or not including the motivators which work conditions pushing them to display emotional labor.

As a result, this study suggests increasing worker's emotional labor values by keeping them in organizations for long term and in addition, enabling workers to speak about process that affects them directly.

Keywords

Emotional labor, Organizational cynicism, Individual work performance

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Introduction

1. Emotional Labor

Labor is defined the activity of generating the means of supports (Kazgan, 2012). In this regard, labor is a factor of production. However, human production does not just represent endeavoring. From this respect, the most dissimilatory feature of humankind from other living being is that humankind can plan and protect the product process legally (Braverman, 1974). Otherwise, it would be impossible to distinguish humankind efforts from animals. In this regard, humankind have free will on supplying of their labor.

It is known that service sector's volume is so important in context of economic magnitude of developed and developing countries and their developmental level. Although intelligent technology and software, which are in order to eliminate faults, supersede the production based human endeavoring, the dynamic of service sector, which based human endeavoring, sustains its effect still.

Intangible, heterogeneous, simultaneous production-consume features of services give humankind's talent, ability and performance prominence in service sector (Parasuraman et all., 1985). At the same time, personals in service organization have to contact with people that they provide service. In this respect, it is thought that one of the factors that contribute the production of both workers and organizations is emotional labor. Likewise, reciprocal emotional interaction comes about during this communication. This interaction has a big importance that have role on evaluation of enterprises. Because of this condition, it is demanded from workers to be addressed to emotions of customers as part of their job (Rafaeli and Sutton, 1987). From this respect, it is seen that emotions have economical value and they can be exchanged for a fee although they are abstract (Hochschild, 1983).

Emotional labor is a structure that includes suppressing, enforcing and faking it in order to regulate emotional expressions (Grandey, 2000). Emotional labor is also stated as a reflection of emotions and feelings that are needed to collaboration with customer and co-workers, as ability to integrate it with organizational perspective (Meier et all., 2006; Sheih, 2011). In other words, emotional labor is explained as displaying suitable emotional reactions (Ashforth and Humphrey, 1993). Generally, emotional labor is a process of managing feelings and emotions that are expected from workers in compliance with norms decided by organization (Wharton, 2009). If emotional labor is examined as an inward process, it can be said that emotional labor is managing of workers' emotion by striving in case of interaction with others in workplace. In the light of these definitions and approaches to concept of emotional labor, some features of emotional labor can be viewed at figure 1.

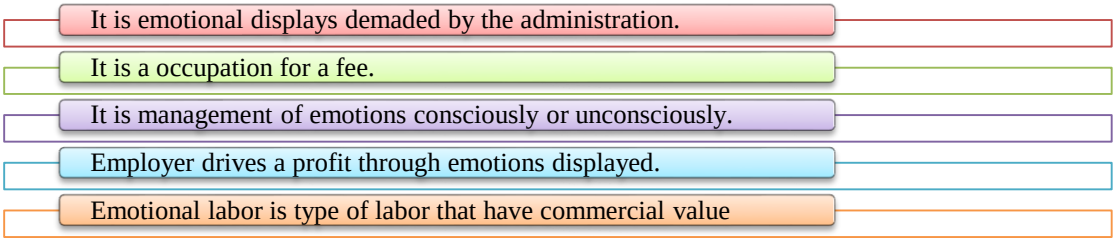

Figure 1: Covalent Elements of Emotional Labor

Resource: Grandey et all., 2013; Hochschild, 1983; Delen, 2017

When examined the concept of emotional labor it is seen that there are its three dimensions as surface acting, deep acting and natural acting. Surface acting is explained with the concept of false self. With reference to it, false self is a defensive behavior that ensures to be gained recognition by concealing true self in order to cover up the empathy failure due to the demand of social environment (Winnicott, 1965). In this regard, emotional expressions are reinvented and controlled in surface acting. While attending to tough customer or while in bad emotional situation, artificial smiling is an example of surface acting (Brotheridge and Grandey, 2002; Ashforth and Humprey, 1993). In this respect, surface acting means is no sincere, but is having an attitude that is far from internalizing. Surface acting which are displayed outwardly is impressionistic phenomenon reflected to other side (Grandey, 2000).

Surface acting which are displayed in the way of not representing yourself can convert to deep acting in the way of playing role of one's psychology of portrayed character (Hochschild, 1983). Worker shows empathy and struggles to act deep acting by perceiving the costumer's emotional situation (Rupp et all., 2008). In this regard, emotional labor have to be viewed as psychological process that workers must regulate their emotional situation by empathize with those who they service (Grandey, 2000).

It have been alleged that one of emotional labor type is also natural acting. It realizes in the way of sympathizing to ones who workers service without any empathy. Said sympathy does not require any role and changing of the self. Emotional concern or humane sentiment of one nurse to crippled child is example for natural acting (Astforth and Humprey, 1993). This emotional reflex, which is sincere, can be also expected by other side. This type of emotional labor is also named as passive deep acting because there is no any manipulation to other side (Prati, 2004).

2. Individual Work Performance

Imperative working conditions like unemployment, low of wages, obligation of working in shift, which economic competition cause, increase the pressure on the worker for increasing individual work performance nowadays (Carneiro ve Novais, 2017). There is no any approach agreed on what individual work performance is. For example, while productivity is important for management sciences; adaptation, satisfaction and selfness come to the forth for organizational psychology (Beaton et all, 2009; Barrick et all.,2001). From this respect, some discussions on whether individual work performance definitions are focused on output or behavioral took place. Therefore, the necessity of differentiate individual work performance from labor productivity came off (Koopmans et all., 2011). In this regard, individual work performance is viewed as suitable set of behaviors for general organizational goals (Murphy and Kroeker, 1988).

According to this approach, there are three essential feature of individual work performance (Koopman et all., 2011):

1. It is a notion related to behaviors than output
2. It encompasses behaviors related to organizational goals
3. It includes a multidimensional structure

Individual work performance is investigated under four top title. These have been depicted at figure 2 (Koopman et all., 2011; Viswesvaran and Ones, 2000)

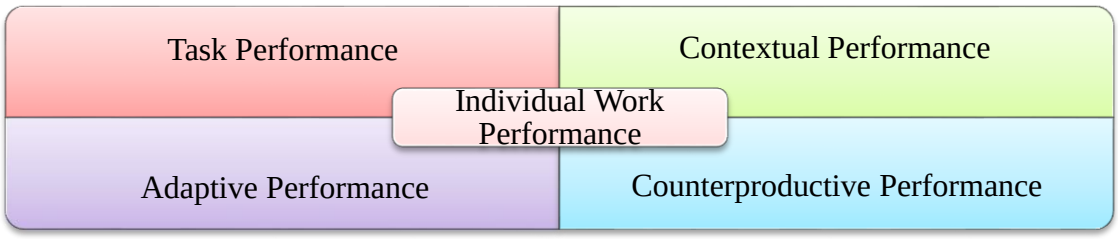

Figure 2: The Dimensions of Individual Work Performance

2.1. Task Performance

Task performance is the first individual work performance coming to mind probably. There are a lot of explanation and describing for task performance in academic literature. However, common point of these is that vocational talent and abilities come to forth in scope of task performance (Bağcı, 2014; Greenslade and Jimmieson, 2007).

Task performance encompasses a lot of mission and duties depended on job (Jawahar and Carr, 2006). In other words, task performance includes essential responsibilities customized the occupation professed that is determined by experience and technical ability (Conway, 1999). In this respect, task performance is defined as individual work performance indicator that contributes to production techs of organization directly (Motowidlo et all., 1997).

Task performance are also separated as routine and creative task performance (Brüggen et all., 2017). While routine task performance means fulfilling work process designated excellently, creative task performance means generating the result demanded by discovering unexperienced methods (Jäder et all., 2017). The need of creative task performance rises because many works got routine due to technological development (Acemoğlu and Autor, 2011). From this point, industries in service sector that product based on knowledge (for example hospitals) have to employ the workers who take in charge of creative duties based on discrete and analytic ability (Acemoğlu and Autor, 2011; Fonseca et all., 2018).

Attitudes and behaviors composing task performance can vary according job or vocation professed as expressed before. Five fundamental individual work performance within task performance for nursing have been ranked as following (Greenslade and Jimmieson, 2007).

Planning patient care,

Fulfilling the demands of patients related to disease and monitoring medical variables,

Informing about health situation and the process of treatment to patients and their relatives,

Providing emotional support for anxious and fears of patients and their relatives,

Co-coordinating with other medical departments for treatment and caring.

2.2. Contextual Performance

Contextual performance can be defined as set of behaviors that include willingness for fulfilling task activities and cooperation with other workers in organization in order to achieve (Borman and Motowidlo, 1997). According to this approach that individual work performance does not consist of task performance, *interpersonal relationship* (Murphy and Kroeker, 1988; Wisecarver et all., 2007), *extra-role performance* for customers and organization (Maxham et all., 2008), *organizational citizenship* (Organ, 1997; Viswesvaran, 1993) and *prosocial behaviors* beyond specifications of task performance (Katz, 1964; Viswesvaran, 1993) compose the contextual performance.

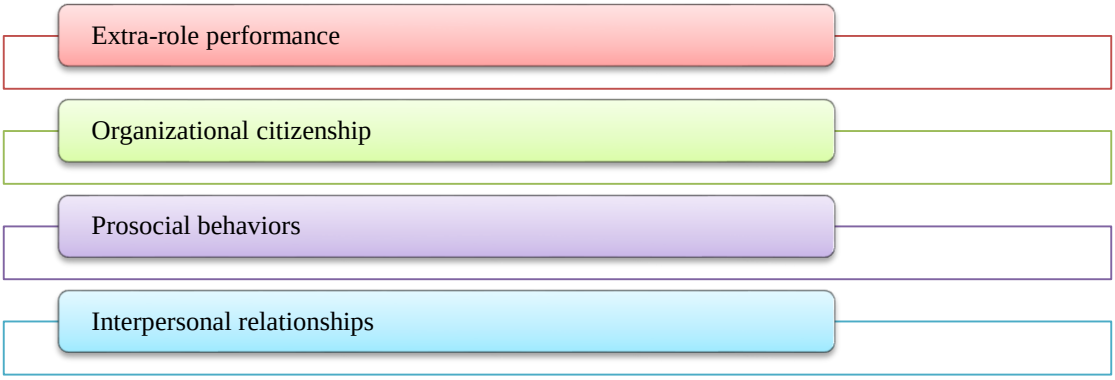

Figure 3: Contextual Performance Labels

If examined heedfully, it is seen that extra-role performance means general a term composed in that way of including organizational citizenship, prosocial behaviors and interpersonal relationship behaviors. For example organizational citizenship behaviors is viewed in context of extra-role performance (Zhu, 2013; Hsu et all., 2017).

Interpersonal relationship generally defines the ability to set up good communication with other side (*co-workers, manager*) (Murphy and Kroeker, 1988). In this regard, it is necessary to set up good communication and collaboration with stakeholder interacted while fulfilling tasks responsibilities. Otherwise, poor interpersonal relationship also decrease general job performance (Murphy and Kroeker, 1988).

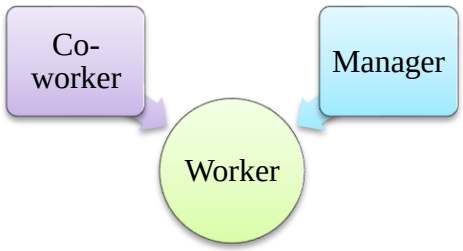

Figure 4: The Way of Interpersonal Relationship

Source: It was adapted from publication of (Murphy and Kroeker, 1988)

Attitudes and behaviors composing interpersonal relationship is a fact experienced subjectively; namely impressively conveyed to other side, and they are explained as a continuous interaction aspect (Reich

and Hershcovis, 2011). Interpersonal relationships in work life is referred as a compound of psycho-social work conditions that are motivated by personality characteristics (Stoetzer, 2010). Set of probable attitudes and behaviors of a workers in context of inter or multi relations in organizations was depicted at figure 5 (https://www.adams.edu/administration/hr/performance%20review.pdf, Accessed Date: 23.04. 2018):

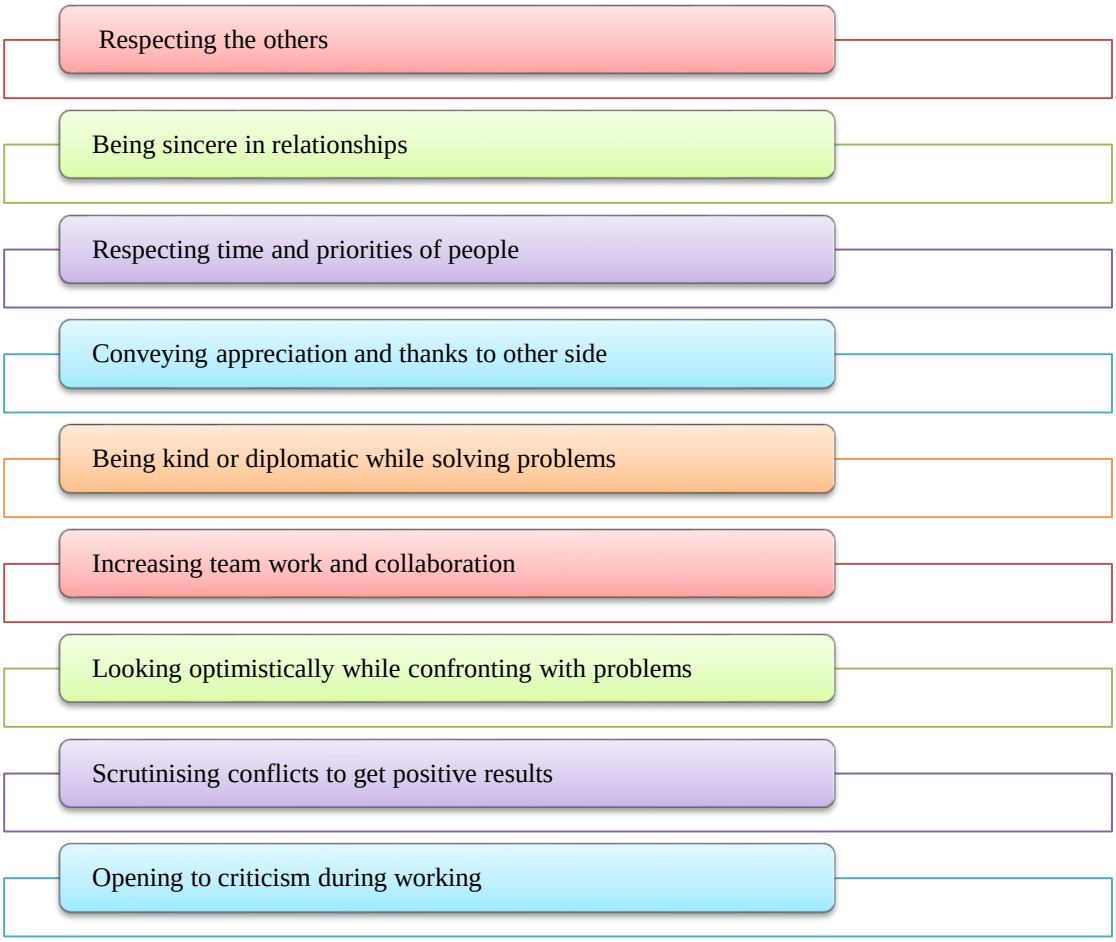

Figure 5: Type of Interpersonal Relationship Behaviors

Interpersonal relationship need to contribute to achievement in production process to view as a performance criterion. For example, while taking care of customers, sincerity and respect of the worker towards them or her/his the ability to communication and collaboration would reach significant providing that they are satisfied. However, although customer satisfaction cannot be got in spite of these behaviors, they even so should consider as criterion of contextual performance because theirs aim is to reach it. As referred before, individual work performance is a notion related to behaviors than output (Koopman et all., 2011).

One of essential indicator of interpersonal relationship is workers' disposition to collaboration. It is asserted that the collaboration with both co-workers and their managers facilitate to reach organizational goals (Schalk and Curşeu, 2010). In order to define a behavior as collaboration, working together and an agent for a general aim require (Chen et all., 1998; Schalk and Curşeu, 2010).

One of the situations where cooperation behavior is important is that situations that working with subordinate personnel for the benefit of third party is compulsory. For example, detecting the cause of any fault committed to customer entails this kind of collaboration. Otherwise, most penalty would paid by the organization by means of being damaged corporate reputation. In this regard, the consent of worker to be directed by his manager can consider as other positive interpersonal relationship performance.

Organizational citizenship is defined a concept that are displayed independently of organizational reward mechanism, namely discretionally (Organ, 1988; Ahmad and Saud, 2016), that includes the approach of giving someone a helping hand by going beyond fundamental job requirement (Zhang, 2011).

Organizational citizenship, which is also considered set of behaviors that increases profitability over the long term (Zhang, 2011), was associated as a part of contextual performance in the way of the approach of being altruistic (Organ, 1997). It is considered that organizational citizenship behaviors or attitudes is associated as conscientiousness, being altruistic, being kind, being virtuous and being gentleman (Singh and Singh, 2008).

Figure 6: Types of Citizenship Behaviors

Source: It was adapted from publication of (Singh and Singh, 2008)

Conscientiousness requires to obey the organizational rules or to participate organizational formations; being altruistic requires to help without expecting a response; being kind requires to consult to others before making decisions even though it is unnecessary; being virtuous requires to get over problems affecting to organization and lastly being gentleman requires to avoid from gossips and rumors or requires to not exaggerate petty issues (Singh and Singh, 2008).

Prosocial behaviors, which are exemplified as helping, sharing, endowing, collaboration and willingness, refers to behaviors like the integration with organization, taking action to provide the organization from hazardous situation, speaking out positive things towards third parts, readiness for more important occupations that requires high responsibility and making suggestion for organizational development lastly (Brief and Motowidlo, 1986).

Said prosocial behaviors that are displayed discretionally (Viswesvaran, 1993) was shown at following figure (Brief and Motowidlo, 1986).

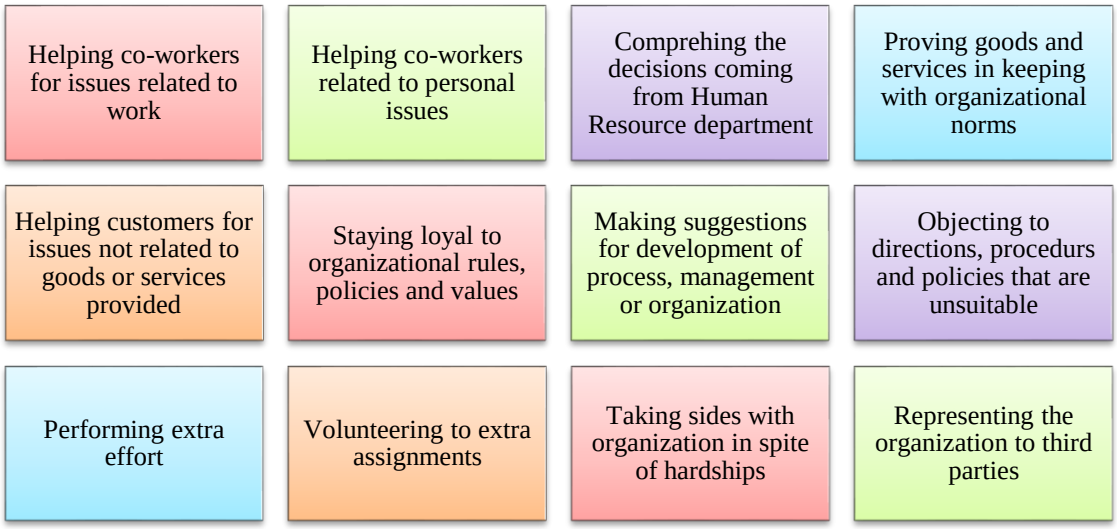

Figure 7: Types of Prosocial Behaviors

Intervening, making suggestions and direction in order to remove the blockage in production process are most common prosocial behaviors in context of helping co-workers. Handling some business of co-worker who is late for job, taking responsibility of co-workers who cannot complete their business because working equipment was broken down, being on night duty in hospital for his/her co-worker who cannot work due to personal causes can asserted as some examples of prosocial behavior in scope of contextual performance.

2.3. Adaptive Performance

Adaptive performance is defined as ability to change workers' behaviors in order to meet demands of changing environment conditions in context of individual work performance (Charbonnier-Voirin and Roussel, 2012). According to other approach, adaptive performance is a notion that have its cognitive and emotional dimensions, which include a disposition to change job requirements, unlike task performance (Allworth and Hesketh, 1999). However, it is considered that adaptive performance affects task performance positively (Shoss et all., 2012).

Many environmental factors like technological change, knowledge-based production, competition due to globalization and the need of controlling costs cause to arise the adaptive performance that needs customizing of workers in terms of consideration, value and behavior (Ployhart and Bliese, 2006). Adaptation areas for future economic system was shown at Figure 8 (Ployhart and Bliese, 2006).

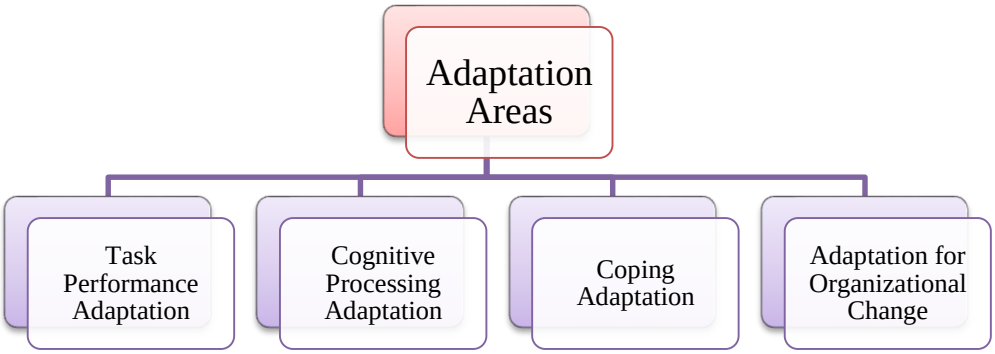

Figure 8: Adaptation Areas in Context of Individual Work

Task performance adaptation refers to attuning of worker in context of talent, ability and knowledge in order to respond environmental change (Ployhart and Bliese, 2006). For example, while it was expected from secretaries to use typewriter before 60 years, it is now expected from them to use computer and software technologies perfectly. In this regard, secretaries who can convey their ability and knowledge to software technologies have stayed on their task. Others have lost their jobs.

Cognitive processing adaptation is referred as ability to choose suitable alternatives correctly by catching marks of changing (Ployhart and Bliese, 2006). Specially, it can be considered this kind of adaptation is more important for manager staff. Applying "A" or "B" plans responsively or specifying proper plan of them should consider as fundamental feature of cognitive processing adaptation.

Copying adaptation is explained as ability to work out in case of one of stress factor (Ployhart and Bliese, 2006). For example, in case of occurring a problem, flexibility to solve fast can be considered as an ability that workers should have in operational level. In this respect, it is necessary to be known of alternatives that fulfill the task.

Adaption for organizational change can be referred as positive reactions in terms of emotional, cognitive, communication and being included of decisions to organizational change carried out to take competitive edge (Witting, 2012). For example, changing of production process, of technology used and of current norms can cause to organizational change. In this regard, low resistance to organizational change and integration of workers to this change should consider as an important adaptive performance in terms of individual work performance.

As long as environment conditions change continuously, importance of adaptive performance comes to forth. In this respect, organizations in this conditions need to organic organization structure that qualifications of workers are more valuable and formality level is low (Koçel, 2011). Specific adaptive performance behaviors or attitudes are shown at figure 9 (Pulakos et all., 2000).

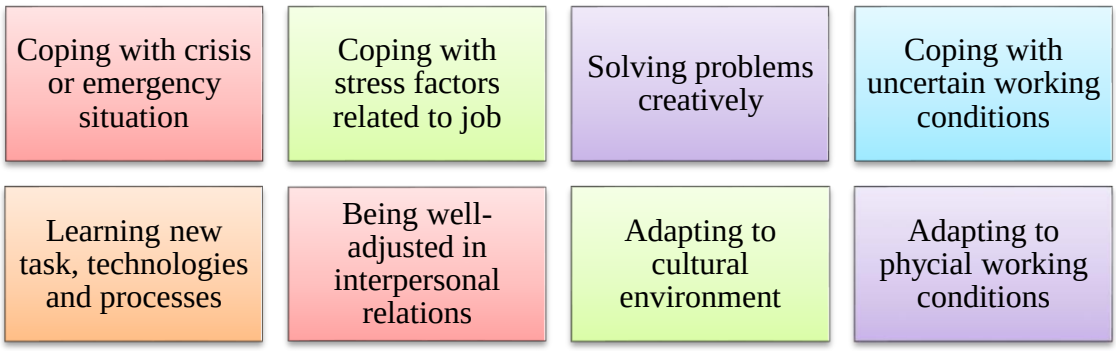

Figure 9: Adaptive Performance Behaviors & Attitudes

Coping with crisis or emergency that can endanger the life is vital for healthcare organizations. For example, in case of fire in hospital, it is expected from workers to control their emotional situation and to take action (Pulakos et all., 2000).

Coping with stress that occurs depend on workload, participation and control, working hours and job content (Leka et all., 2004) is other type of adaptive performance. Having not enough time to complete a project is an example of stressor factors (Pulakos et all., 2002). In this conditions, not blaming of others as source of problem or taking action to accelerate process should be considered expected adaptive performance behaviors (Pulakos et all., 2000; Marques-Quinteiro et all., 2015).

Solving problem creatively is referred as resolving problems that cannot be found easily a remedy (Pulakos et all., 2002). In order to perform it, it is necessary to be creative of workers, to analyze opportunities for solving and to increase quality of production in terms of them (Pulakos et all., 2000; Pukalos et all., 2002). Being created excel calculation table by a personnel in discharge department of hospital in order to accelerate discharge of patient, in terms of health insurance process, should be considered as adaptive performance example.

Coping with uncertain working conditions is also other indicator of adaptive performance. It is expected from worker to react for sudden developments in this individual performance type (Pulakos et all., 2000). Opening new room for an inpatient by night supervisor of hospital by changing hospitalization plan of next day can be asserted as other adaptive performance example.

One of the adaptive performance is learning new task, technologies or processes (Pulakos et all. 2002). It is not possible to work in the same job with same knowledge or ability in the contemporary world where types of working is changing all the time. It can asserted that learning new task, technologies or processes is most demanded performance type from workers by their managers in case of high staff turnover. Most important obstacle in this case is to employ new workers into any department that they did not work before because they do not accept new tasks. Therefore, it should be considered that taking responsibility on accepting new task, which is crucial for organizational interests, is most appreciated adaptive performance.

Being well-adjusted in interpersonal relations is adaptive performance indicator that requires to listen and to be open-minded while dealing with any customer (Pulakos et all., 2000). Compliance in interpersonal relations also requires catching priorities of other side and making cognitive, emotional or

behavioral change in this direction (Pulakos et all., 2000; Pulakos et all., 2002). Being changed alternatives by a sales representative who perceive expectations of customer can be this kind of adaptive performance example.

Adapting to cultural environment is similar with being well-adjusted in interpersonal relations. From this context, being adapted of cultural components like symbol, language, nation, custom, religion and values of other side by workers is expected (Pulakos et all., 2000; Pulakos et all., 2002).

Workers should be more careful while communicating with the patient who have different religion or nationality and should avoid words or behaviors that may cause to conflict. Specially, some situations, which requires different approaches towards patients from nutrition to transfusion depend on their religion, might happens in health organizations. In this regard, that workers respect to changes in service process would be appropriate adaptive performance. Both being well-adjusted in interpersonal relations and adapting to cultural environment depend on social intelligence of workers (Pulakos et all., 2006).

Adapting to physical working conditions includes adjusting to physical environmental conditions like cold, heat, moisture, dryness or to physical specialties like weight, length or muscle force (Pulakos et all., 2000; Pukalos et all., 2002). For example, in aviation sector it is necessary to be suitable in terms of weight and length of any worker. In this respect, it can asserted that losing weight and keeping fit are adaptive performance.

2.4. Counterproductive Performance

Individual work performance is not always concept on behalf of organization benefits. This situation can comprehend when considered individual work performance as workers' behaviors and attitudes clearly. Counterproductive performance is defined as intentional behaviors of worker, which are contrary to legal interest of organization (Sackett, 2002). According to other approach, counterproductive performance is explained as protest behaviors of workers in order to demonstrate their dissatisfactions (Kelloway et all., 2010).

Counterproductive performance have been named with various labels. In this regard, *workplace aggression* as efforts by worker to damage co-workers or organization (Baron and Neuman, 1996), *organizational misbehaviors* as intentional actions that violate organizational norms (Vardi and Wiener, 1996), *protest form* as intentional behaviors of worker in order to emphasize injustice practices (Kelloway et all., 2010), *employee deviance* as voluntary behaviors that endanger the well-being of organization (Robinson and Bennett, 1995), and finally *anti-social* behaviors that is negative for organization (Robinson and O'Leary-Kelly, 1998) are some terms in order to describe counterproductive performance concept.

Workers can commit many counterproductive behavior includes proper-based (theft, vandalism etc.) or production-based (absenteeism, tardiness etc.) deviances that harm both co-workers and organization (Mikulay et all.,2001). The counterproductive work performance is associated with negative emotional attitude, with being on opposition to organization, with making trouble for co-workers and managers, with making mistakes deliberately (Koopmans et all., 2014). Some counterproductive behaviors are shown at figure 10 (Koopmans et all., 2011).

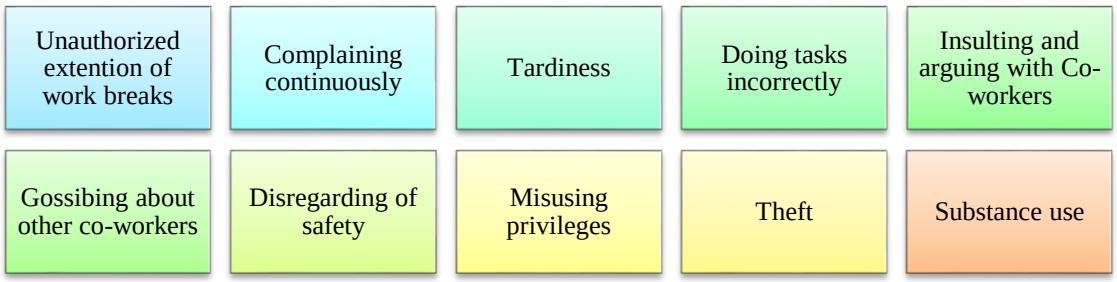

Figure 10: Types of Counterproductive Behaviors

Focus point of counterproductive individual work performance is that these behaviors are performed deliberately. Therefore, for example, a mistake committed by physician unintentionally in surgical operation does not refer to counterproductive performance (Vardi and Wiener, 1996).

3. Organizational Cynicism

3.1. Concept of Cynicism and Its Philosophical Background

Roots of cynicism have been dated back Ancient Greek Philosophy. Cynics were maintained their philosophical reviews that have virtue centered of Socrates school (Luck, 2011; Gökberk, 1993). In this intellection that is equal to have knowledge, cynics who adopted individualistic approach acknowledged avoiding pleasure and being independent from social circle as virtue (Gökberk, 1993). In this regard, there is a near connection between cynicism and stoicism (Luck, 2011).

According to Oxford English Dictionary, cynic is defined as "*one who shows a disposition to disbelieve in sincerity or goodness of human motives and actions, and is wont to express this sneers and sarcasms; a sneering fault-finder*" (Dean et all., 1998).

In other words, cynicism is a general or specific attitude characterized by frustration, hopelessness and disillusionment to any institution, to social custom, to ideology, to social group or people (Andersson and Bateman, 1997). Cynicism is also attitude of being in opposition to motivations behind actions that have skepticism querying the trueness (Turner and Valentine, 2001).

Etymologically, cynicism comes from cynic word. Cynic means "Dog" in Greek language (Luck, 2011). These people named as cynics protested all kind of idea, behavior or emotion in Ancient Greek Civilization by criticizing (Luck, 2011). These protests have been demonstrated in the way of doing the contrary because others are people who lost their virtue. In this regard, they eats if necessary and they have tendency to avoid food giving pleasure. Famous cynic Diogenes presents the standard of being virtue by saying "not needing anything is intrinsic to God, needing few thing is taking after God" (Luck, 2011).

Virtue in cynicism has a disposition to convert to asceticism (Desmond, 2008). For example, *Philon* impressed by cynicism praises asceticism and preaches to avoid any pleasure and superstition (Luck, 2011). Asceticism is rooted from Platonic life style experienced in order to achieve happiness (Dudley, 1937). In this regard, cynic asceticism has contrast with asceticism in Protestant Ethic. Thus, cynic or other ascetic approaches that are output of a sacred belief exclude the individual from daily life because special sacred life is necessary to surpass secular morals (Weber, 2017).

3.2. The Concept of Organizational Cynicism

Organizational cynicism can consider as protest movements that workers do against organization or its administration. However, this concept was defined with different emphasize points. For example, organizational cynicism as belief of not integrating oneself to organization with strong negative emotional reaction, which causes to arise depreciatory and critical behaviors (Abraham, 2000).

Organizational cynicism is also defined as a negative attitude against organization worked (Dean, 1998). According to another approach, organizational cynicism is referred as a concept that arises against unethical behaviors like unfairness, favoritism and deception (O'Leary, 2003).

3.2.1. Types of Organizational Cynicism

Concept of organizational cynicism is an umbrella term for many types of cynicism (Delken, 2004). Thus, there are five organizational cynicism dimensions.

Figure 11: Types of Organizational Cynicism

Source: Abraham, 2000; Dean, 1998; Delken, 2004

Personality cynicism is constant or inherent personal character (Abraham, 2000). These people who have lack of ability to communicate socially think that others are absolutely dishonest and selfish and do not rely on them adamantly (Abraham, 2000). These cynics think, in analogy to Marxist discourse, that they are exploited and alienated from job owing to relations of production (Guastello vd., 1992).

Social cynicism is also one of the five fundamental axiom (Bond et all., 2004). Social axioms is used to refer that beliefs related to mechanism of world constitute general disposition about values in terms of people (Bond et all., 2004). In this regard, social cynicism is defined as thought composition related social world like having adverse opinion towards humankind, causing to unhappiness by life, being exploited someone by powerful people and being practiced double standard on behalf of the rich by social institutions (Leung et all., 2010). From this perspective, feeling of insecurity towards authorities and institutions step forward in social cynicism (Bateman et all., 1992). This situation can also referred as alienation from socio-economic institutions as a result of violating social contract (Abraham, 2000).

It can be said that this negative psychological view occurs due to life experience in social world and it is conveyed to organization by worker. Social cynicism differentiates from personality cynicism in this respect (Bond et all., 2004).

Occupational cynicism can be defined as attitudes or behaviors stemmed from profession executed by the individual. Specially, it may be asserted that occupational cynicism happens due to professional failures. Niederhoffer tries to explain occupational cynicism through policing. According to Niederhoffer, police officers lose both their confidence and reliance to society when they are unsuccessful (Neiderhoffer, 1968a). In these situations, members of profession are offended; hatred and hostility towards society and feeling of weakness against society may take place. Such that, they can say, "I hate civilians", which displays their cynical attitude (Neiderhoffer, 1968b).

Employee cynicism, just as in social cynicism, emerges due to contract violation. This contract violation rises to surface because of breaching psychological contact terms like equity, justice and objectivity between employee and employer (Rousseau, 1989). Psychological contract is perception of reciprocal responsibility between employee and employer (Robinson, 1996). In other words, psychological contract that is related to specific conditions and terms between individual and organizational structure is mutual agreement believed by particularly workers as pledged words (Rousseau, 1989).

In addition, psychological contract have wide structure that encompasses unspoken terms that is assumed (Morrison and Robinson, 1997; Peng et all., 2016). In this regard, psychological contract is feeling of inequity, which occurs in workplace, towards great institutional businesses, top executive managers or similar constitutions (Stanley et all., 2005). Unannounced layoffs, lateral transfer instead of vertical promotions, unfulfilled promises of training or travel (Andersson, 1996), lack of performance-based payment, unfulfilled promises of development (Rousseau, 1990), unfairness on personnel procedures, not supporting with personal and family problems, lack of recognition and feedback on performance (Dainty et all., 2004) are some breaches in context of psychological contract.

Organizational cynicism is investigated in terms of organizational change. Organizational change is referred as finding new methods for organizational schema and its working style (Dawson, 2003). In this context, organizational change cynicism is midrange thought encompassing pessimism about possible unsuccessfulness of organizational change because workers consider that leaders who execute the change is ineligible and lazy (Wanous et all., 1994; Abraham, 2000, Reichers et all., 1997). It is seen that workers have accusatory attitude towards the leaders who conduct organizational change (Brown and Cregan, 2008). It is asserted the fear that working comfortable is removed forcibly causes to develop these attitudes or behaviors (Aslam et all., 2016). From this point of view, it may expressed that organizational change cynicism is a reactional psychological situation.

It is asserted that organization change cynicism is different from skepticism. Thus, although skeptics can guess the unsuccessfulness of organizational change, they may be also hopeful on that some positive developments might take place (Reichers et all., 1997). Organizational change cynicism comes to exist as a belief that new organization change attempts would be fail by regarding unsuccessfulness of previous organization change (Reichers et all., 1997; Ribbers, 2009). Pessimism due to previous failures is example for this circumstance (Rubin et all., 2009; Thompson et all., 2000). Thus, organizational change cynicism is not inherent attitude or behavior ontologically; it arises as a result of experiences (Reichers et all., 1997).

In addition, organizational change cynicism is used as a tool of protecting from negative expressions about that the workers may lose their control on job (Reichers et all., 1997, Barton and Ambrosini, 2013). Therefore, workers do not take responsibilities on the organizational change because they think that reason shown by their current managers is not true and that new manager staff would resolve problems causing organizational change (Reicher et all., 1997). Not taking responsibility on organizational change converts to organizational change resistance in case organizational cynicism is perceived in solidarity (Thompson et all., 2000). The belief that managers pursue hidden or implicit goals, unlike expressed, has role on developing this attitude (Stanley et all., 2005; Grama, 2013). Quality of informing has relation

with this situation (Qian and Daniels, 2008). Therefore, explanatory informing would decrease organizational change cynicism (Grama and Todericiu, 2016).

3.2.2. Dimensions of Organizational Cynicism

Organizational cynicism essentially has three dimensions. These are *cognitive*, *emotional* and *behavioral dimensions* of organizational cynicism

Cognitive dimension of organizational cynicism is referred as ideational approach based on the belief. In this context, worker think that organization do not keeps to fundamental principles like justice, honesty and sincerity in cognitive dimension of organizational cynicism (Dean et all., 1998). In this regard, the belief based on that there is unprincipled practices in organization has role on this cognitive approach (Pelit and Pelit, 2014).

Cognitive organizational cynicism also shape cynical attitudes or behaviors (Delken, 2004). Thus, there is a sceptic position that makes worker think altruistic actions or decisions related job process of organization service to create authority legitimacy and to preserve bureaucratic hierarchy (Dean et all., 1998; Goldner et all., 1977). Indeed, according to workers, manager or co-workers frequently tries to derive benefit via their behaviors seen as altruistic (Kanter and Mirvis, 1989). That is to say, it is quested secret a goal in decisions and actions, which may affect workers negatively. It can seen that some unprincipled practices like injustice, deceit and insincerity, gaining advantage, being unethical are routinized in cognitive organizational cynicism (Işık, 2014).

Emotional organizational cynicism can referred as negative emotions felt towards organization worked. For example, disdain, feeling anger, disgust, feel ashamed for organization are most specific ones. Also, there are emotions like hopeless, disillusionment in this kind of organizational cynicism (Andersson, 1996; Reichers et all., 1997).

These negative emotions develops because of perceiving for superiority in frame of own standards or values that worker demands from organization (Dean et all., 1998). However, these cynical emotions are not disclosed to not lose wage or statue easily (Pelit and Pelit, 2014).

Worker criticizes the approach style of organization by saying snippy words in behavioral organizational cynicism. This critical behavior is performed by estimating the future of organization pessimistically (Dean et all., 1998). To illustrate, the worker in this position can behave cynically by expressing that any investment would be unsuccessful. Main reason of why worker behave like this is that he/she perceives for superiority oneself than organization worked in terms of knowledge and ability. In addition, wry smile or grin are other cynical behaviors wordlessly (Brandes and Das, 2006).

Purpose

The aim of the study is to reveal the role of organizational cynicism for the effect of emotional labor on individual work performance in order to get explanatory results in terms of organizational behavior approaches.

Method

In this study, it was used fieldwork method in order to reveal the role of organizational cynicism for the effect of emotional labor on individual work performance. This study was conducted A, B, C type classified private hospitals of İstanbul. The sample of this research consists of 390 nurses who can contact face to face with patients per 130 for each class under the %5 estimated half width of confidence interval

for unknown universe size. Due to financial and time constraint, stratified sampling was chosen. Fundamental presumption of this sampling method is that human resource capacity, bed numbers, financial structure, technological capability and other substructure potentiality of hospitals is not homogeneous and there is no adequate information about universe of the study.

While including nurses to sampling, those who was not in the hospital did not attach to the fieldwork. In addition, leaving blank of at least one expression, duplicate marking and logical mistakes (*like although he/she is under 20 years, those who marks the service life in the occupation as 20 years and above*) is cause of exclusion from the sample.

For this study, it were used three survey that had been conducted reliability and validity test in Turkish version for emotional labor, organizational cynicism and individual work performance respectively (Basım and Begenirbaş, 2012; Kalağan, 2009 and Çöl, 2008).

In scope of this study, following hypothesizes was composed:

H1: *There is a relation between emotional labor and individual work performance.*

H2: *There is a relation between organizational labor and individual work performance.*

H3: *There is a differentiator effect of organizational labor on the relation between emotional labor and individual work performance.*

H4: *There is a difference between emotional labor and age.*

H5: *There is a difference between emotional labor and marital status.*

H6: *There is a difference between emotional labor and gender.*

H7: *There is a difference between emotional labor and educational level.*

H8: *There is a difference between emotional labor and administrative function.*

H9: *There is a difference between emotional labor and the service life in hospital worked.*

H10: *There is a difference between emotional labor and the service life in occupation.*

H11: *There is a difference between organizational cynicism and age.*

H12: *There is a difference between organizational cynicism and marital status.*

H13: *There is a difference between organizational cynicism and gender.*

H14: *There is a difference between organizational cynicism and educational level.*

H15: *There is a difference between organizational cynicism and administrative function.*

H16: *There is a difference between organizational cynicism and the service life in hospital worked.*

H17: *There is a difference between organizational cynicism and the service life in occupation.*

H18: *There is a difference between emotional labor and hospital classes.*

H19: *There is a difference between organizational cynicism and hospital classes.*

Result

In scope of this study, descriptive statistics of nurses about their age, marital status, gender, educational level, administrative function, service life in hospital worked and service life in occupation were presented in following table 1.

Table 1: Socio-demographic data of nurses in the study

Age	n	%
Under 20	40	10
Range 20-29	194	50
Range 30-39	71	18
Range 40-49	55	14
Range 50-59	21	6
Above 59	9	2
Marital Status		
Single	238	61
Married	152	39
Gender		
Male	124	32
Female	266	68
Educational Level		
High School	141	36
Associate Degree	65	17
Bachelor's Degree	134	34
Post Graduate	50	13
Doctoral	0	0
Administrative Function		
Have	313	80
Have not	77	20

Service Life in Hospital Worked		
Under 1 year	122	31
Range 2-5 years	143	37
Range 6-10 years	64	16
Range 11-15 years	36	9
Range 16-20 years	7	2
Above 20 years	18	5
Service Life in Occupation		
Under 1 year	66	17
Range 2-5 years	143	37
Range 6-10 years	65	17
Range 11-15 years	43	11
Range 16-20 years	29	7
Above 20 years	44	11

For reliability of emotional labor, individual work performance and organizational cynicism, Cronbach alpha values were shown at table 2.

Table 2: Reliability of Variables

Variables	**Cronbach α**
Emotional Labor	,8528
Individual Work Performance	,8664
Organizational Cynicism	,9308

According to table 2, it is seen that all variables in this study is reliable for measurement

Table 3: Validity Test for Emotional Labor

	Surface Acting (Explained Variance = % 33,92)	Deep Acting (Explained Variance = % 22,20)	Natural Acting (Explained Variance = % 19,68)	Cronbach α
EL 1	,846			**0,92**
EL 2	,886			
EL 3	,852			
EL 4	,867			
EL 5	,856			
EL 6	,759			
EL 7		,721		**0,86**
EL 8		,889		
EL 9		,799		
EL 10		,801		
EL 11			,901	**0,90**
EL 12			,887	
EL 13			,865	
Bartlett Test Results		Total Explained Variance (%)	**75,81**	
		Kaiser-Mayer-Olkin (KMO)	**0,863**	
		Degrees of freedom	**78**	
		Ki-kare value	**3581,301**	
		P	**0,00**	

According to explanatory factor analyses, there are there dimension and there is no double item. EL 1, EL 2, EL 3, EL 4, EL 5, EL 6 factors are under the surface acting, EL 7, EL 8, EL 9, EL 10 factors are under the deep acting and EL 11, EL 12, EL 3 are under the natural acting of emotional labor. According to KMO sample test result (0,86), the size of the sample for emotional labor is adequate as “good”. In addition, according to Bartlett test result ($p<0,05$), emotional labor variable is suitable to conduct factor analyses in terms of validity.

Table 4: Validity Test for Individual Work Performance

	Individual Work Performance	Cronbach α
IWP 1	,893	**,86**
IWP 2	,867	
IWP 3	,831	
IWP 4	,792	
Bartlett Test Results	Total Explained Variance (%)	**71,67**
	Kaiser-Mayer-Olkin (KMO)	**,818**
	Degrees of freedom	**6**
	Ki-kare value	**759,824**
	P	**0,00**

For individual work performance, which was scaled as single factor, there is no double item. According to KMO sample test result (0,81), the size of the sample for individual work performance is adequate as "good". In addition, according to Bartlett test result (p<0,05), individual work performance variable is suitable to conduct factor analyses in terms of validity.

Table 5: Validity Test for Organizational Cynicism

	Cognitive Organizational Cynicism (Explained Variance = % 27,29)	Emotional Organizational Cynicism = % 26,85)	Behavioral Organizational Cynicism = % 22,12)	Cronbach α
OC 1	,814			**0,88**
OC 2	,821			
OC 3	,769			
OC 4	,728			
OC 5	,720			
OC 6		,788		**0,93**
OC 7		,862		
OC 8		,846		
OC 9		,770		
OC 10			,905	**0,87**
OC 11			,860	
OC 12			,694	

OC 13			,634	
Bartlett Test Results		Total Explained Variance (%)	**76,27**	
		Kaiser-Mayer-Olkin (KMO)	**,919**	
		Degrees of freedom	**78**	
		Ki-kare value	**3831,775**	
		P	**0,00**	

According to explanatory factor analyses, there are there dimension and there is no double item. OC 1, OC 2, OC 3, OC 4, OC 5, factors are under the cognitive organizational cynicism, OC 6, OC 7, OC 8, OC 9 factors are under the emotional organizational cynicism and OC 10, OC 11, OC 12, OC 13 are under the behavioral organizational cynisim. According to KMO sample test result (0,91), the size of the sample for organizational cynicism is adequate as " very good". In addition, according to Bartlett test result ($p<0,05$), organizational cynicism variable is suitable to conduct factor analyses in terms of validity. As a result, emotional labor, individual work performance and organizational cynicism scales are reliable and valid in context of their original structure.

For hypothesis analyze, dependent and independent variable's mean, median and standard deviation values were shown at following tables.

Table 6: Emotional Labor Factors

Emotional Labor	Mean	Median	St. Deviation
Surface Acting	2,28	2,00	1,06
Deep Acting	3,12	3,00	1,08
Natural Acting	2,45	2,33	1,12
General Point	2,86	2,92	0,76

According to table 6, it is seen that mean of surface acting is 2,28 ± (1,06), mean of deep acting is 3,12 ± (1,08) and mean of natural acting is 2,45 ± (1,12).

Table 7: Individual Work Performance

	Mean	Median	St. Deviation
Individual work performance	4,05	4,00	0,77

According to table 7, it is seen that the mean of individual work performance, which was scaled as single factor, is 4,05 ± (0,77).

Table 8: Organizational Cynicism

Organizational Cynicism	Mean	Median	St. Deviation
Cognitive organizational c.	2,67	2,70	1,00
Emotional organizational c.	2,24	2,00	1,14
Behavioral organizational c.	2,39	2,25	1,07
General Point	2,45	2,38	0,91

According to table 8, it is seen that the mean of cognitive organizational cynicism is 2,67 ± (1,00), the mean of emotional organizational cynicism is 2,24 ± (1,14) and behavioral organizational cynicism is 2,39 ± (1,07).

Table 9: One Sample Kolmogorov-Smirnov test

	Emotional Labor	Individual Work Performance	Organizational Cynicism
Test Statistic	,056	,106	,077
P	,005	,000	,000

When viewed table 6, table 7, table 8 and table 9, it is accepted that variables are non-parametric in terms of mean, median and standard deviation values of variables in this study and Kolmogorov-Smirnov test results.

Table 10: Correlation Test Results (Spearman Correlation)

		Individual Work Performance
Emotional Labor	r	,067
Surface acting	r	**-,144****
Deep acting	r	**,100***
Natural acting	r	-,014
Organizational Cynicism	r	-,098
Cognitive organizational cynicism	r	-,081
Emotional organizational cynicism	r	**-,158***
Behavioral organizational cynicism	r	-,042

** Statistical significance level at p<0,01.
* Statistical significance level at p<0,05 .

According to results of table 10, while there is poor negative positive relation between surface acting and individual work performance, there is poor positive relation between deep acting and individual work performance statistically. In the light of these results, it could not found direct relation between emotional labor and individual work performance. Thus, H_1 hypothesis was rejected.

Also, it was found that there is poor negative relation between emotional organizational cynicism and individual work performance. According to these results, there is no direct relation between organizational cynicism and individual work performance. Thus, H_2 hypothesis was rejected.

Because H_1 and H_2 was rejected, H_3 hypothesis could not tested in terms of research methods. Also, because relation values are poor regression analysis could not tested. Thus, H_3 hypothesis was rejected. In addition; it is presented that other statistical test results to examine other hypothesis at table 11, table 12, table 13 and table 14.

Table 11: Kruskal Wallis Test Results

	Emotional Labor			Organizational Cynicism		
	χ^2	df	P	χ^2	df	P
Age	14,307	5	**0,010***	15,101	5	**0,010***
Educational Level	2,323	3	0,508	15,069	3	**0,002***
Service Life in Hospital Worked	2,821	5	0,728	12,332	5	**0,031***
Service Life in Occupation	16,870	5	**0,005***	4,630	5	0,463
Hospital Class	12,217	2	**0,002***	9,803	2	**0,007***

Research results shows that there is a difference among age's and hospital class's sub groups for both emotional labor and organizational cynicism. In addition, it is found that there is a difference among educational level's and service life in worked hospital's sub groups for organizational cynicism. Finally, it was found that there is a difference among service life occupation's sub groups for emotional labor. According to these results; H_4, H_{10}, H_{11}, H_{14}, H_{16}, H_{18}, H_{19} hypothesis was approved. In addition, Bonferroni correction was done in order to specify the difference among which sub groups are.

Table 12: Bonferroni Corrections (Mann Whithey-U) for Emotional Labor

	Age	N	Mean	St. Deviation	Median	Mean Rank	U	Z	P
Emotional Labor	20-29 age	194	2,91	0,70	2,96	112,50	**1164,00**	**-3,227**	**0,001***
	50-59 age	21	2,37	0,90	2,07	66,43			
	40-49 age	55	3,03	0,75	3,00	43,48	**303,500**	**-3,186**	**0,001***
	50-59 age	21	2,37	0,90	2,07	25,45			
	Service Life in Occupation	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	2-5 years	143	2,94	0,64	2,92	100,97	**2149,00**	**-3,227**	**0,001***
	20 years and above	44	2,53	0,83	2,57	71,34			

	16-20 years 20 years and above	29 44	3,21 2,53	0,94 0,83	3,23 2,57	46,12 30,99	**373,500**	**-2,984**	**0,003***
	Hospital Class	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	A Class B Class	130 130	2,62 2,34	0,86 0,96	2,53 2,11	146,08 114,92	**6425,00**	**-3,342**	**0,001***
	B Class C Class	130 130	2,34 2,94	0,96 0,76	2,11 2,92	118,85 142,15	**6935,00**	**-2,501**	**0,012***

As a result of the Bonferroni correction (under the terms of $p<0,05/\mathbf{6}^{3}=0,008$), it was found that significant difference between "20-29 age range" and "50-59 age range" in favor of those who is in "20-29 age range" and between "40-49 age range" and "50-59 age range" in favor of those who is in "40-49 age range".

Similarly, as s results of Bonferroni correction (under the terms of $p<0,05/6=0,008$) for service life in occupation, it was found that significant difference between "20 years and above" and "2-5 years" and, between "20 years and above" and "16-20 years" against the those who in "20 years and above" for both each comparison.

Finally, as s results of Bonferroni correction (under the terms of $p<0,05/3=0,016$) for hospital class, it was found that significant difference between "A class" and "B class", and between "B class" and "C class" against those who works in "B class" for both each comparison.

[3] It defines the number of sub group for each variable in order to perform Bonferroni correction properly.

Table 13: Bonferroni Corrections (Mann Whithey-U) for Organizational Cynicism

	Age	N	Mean	St. Deviation	Median	Mean Rank	U	Z	P
Organizational Cynicism	Under the 20 age 20-29 age	40 194	2,14 2,49	0,95 0,81	1,84 2,38	112,50 66,43	**2780,50**	**-2,822**	**0,005***
	Under the 20 age 40-49 age	40 55	2,14 2,67	0,95 0,97	1,84 2,53	39,00 54,55	**740,00**	**-2,715**	**0,007***
	Educational Level	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	High school Bachelor's degree	141 134	2,22 2,54	0,84 0,89	2,07 2,53	123,56 153,19	**7411,00**	**-3,091**	**0,002***
	High school grd. Post graduate	141 50	2,22 2,60	0,84 0,87	2,07 2,46	89,54 114,23	**2613,50**	**-2,716**	**0,007***
	Service Life in Hospital Worked	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	0-1 years 6-10 years	112 64	2,33 2,76	0,85 0,90	2,30 2,69	84,83 110,03	**2826,00**	**-3,035**	**0,002***
	2-5 years 6-10 years	143 64	2,37 2,76	0,85 0,90	2,23 2,69	96,21 121,40	**3462,50**	**-2,797**	**0,005***
	Hospital Class	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	A Class B Class	130 130	2,62 2,34	0,86 0,96	2,53 2,11	144,47 116,53	**6634,00**	**-2,997**	**0,003***

As a result of the Bonferroni correction (under the terms of p<0,05/6=0,008), it was found that significant difference between “under the 20 age” and “20-29 age range” and, between “under the 20 age” and “40-49 age” against the those who in under

Similarly, as s results of Bonferroni correction (under the terms of p<0,05/4=0,0125) for educational level, it was found that significant difference between “high school graduate” and “bachelor’s degree” and, between “high school graduate” and “post graduate” against those who in “high school graduate” for both each comparison.

In addition, as s results of Bonferroni correction (under the terms of p<0,05/6=0,008) for service life in hospital worked, it was found that significant difference between “0-1 years” and “6-10 years” and, between “2-5 years” and “6-10 years” in favor of those who in “6-10 years” for both each comparison.

Finally, as s results of Bonferroni correction (under the terms of p<0,05/3=0,016) for hospital class, it was found that significant difference between “A class” and “B class” in favor of those who works in “A class”.

Table 14: Mann Whithey-U test for Organizational Cynicism and Emotional Labor

	Marital Status	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
Emotional Labor	Married Single	152 238	2,89 2,85	0,83 0,71	2,92 2,92	198,44 193,62	**17641,50**	**-0,412**	**,458**
	Gender	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	Male Female	124 266	2,86 2,86	0,78 0,75	2,92 2,92	197,67 194,49	**16222,50**	**-0,261**	**,795**
	Administrative Function	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**

	Have Have not	77 313	2,97 2,84	0,72 0,75	3,00 2,92	209,06 192,16	**11006,00**	**-1,180**	**,238**
Organizational Cynicism	**Marital Status**	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	Married Single	152 238	2,42 2,47	0,95 0,88	2,92 2,92	189,61 199,26	**17192,50**	**-0,825**	**,409**
	Gender	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	Male Female	124 266	2,49 2,44	0,99 0,87	2,34 2,38	197,21 194,70	**16279,50**	**-0,205**	**,838**
	Administrative Function	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	Have Have not	77 313	2,51 2,44	0,84 0,92	2,38 2,38	204,05 193,40	**11392,00**	**-0,743**	**,458**

According table 14, there is no any significant difference between dependent and independent variables. Hence, marital status, gender and administrative function of nurses do not affect their emotional labor and organizational cynicism attitudes. In this regard, H_5, H_6, H_7, H_8, H_9, H_{11}, H_{12}, H_{13}, H_{15} and H_{17} hypothesis were rejected.

Conclusion

Research results shows that there is no relation between emotional labor and individual work performance. However, it is seen that there is a significant poor relation between surface acting and individual work performance negatively. The result that surface acting decreases individual work performance is congruent with other study results (Akhter, 2016; Ghalandari et all., 2012). It can asserted that the necessity to display emotions by putting on false self in emotional labor is a reason of this negative relation between surface acting and individual work performance. Therefore, this kind of emotional labor includes hard and wearing process that workers convert themselves emotionally. In addition, this result can be interpreted as that workers do not perceive surface acting as concern of professionalism.

As congruent with other research results in academic literature, it was found that deep acting increases individual work performance (Akhter, 2016; Ghalandari et all., 2012; Gelderen et all., 2017). In addition, this research result is also parallel with another result that there is relation between deep acting and adaptive performance as part of individual work performance (Wang et all., 2016; Gelderen et all., 2017).

As different from the result of Akhter's (Akhter, 2016), there is no relation between natural acting and individual work performance. This situation can be interpreted as that natural acting is kind of behavior that may be displayed in also other social areas outside working life. Therefore, it should be acknowledged that understanding the difference between natural acting displayed in working life and emotional reflexes displayed in other social areas, and comprehending the probable contribution of natural acting to individual work performance are so hard.

Another prominent concept is organizational cynicism. Research results, as different from some academic results, (Supriadi and Sefnedi, 2017), show that there is no relation between organizational cynicism and individual work performance. Although emotional organizational cynicism was expressed at the least compared with other organizational cynicism types, it has negative effect on individual work performance as different from cognitive and behavioral organizational cynicism. In spite of the negative effect of emotional organizational cynicism on individual work performance, the reason why there is no relation organization cynicism and individual work performance can be interpreted as that having cynical attitudes does not contuse professional and personal liability.

It is known Industry 4.0 (**The Fourth Industrial Revolution) that is dominated by** digitalization, artificial intelligence and robots have **been getting near. In this regard, it is considered that this circumstance will lift its effectiveness in healthcare sector as in every sector. Therefore, it can be thought characteristics of emotional labor in context of being brought the fore of the talents and abilities monopolized by the labor have distinctive** role. Otherwise, being institutionalized of labor knowledge would vulgarize the labor (Braverman, 1974).

Economic system that is on the verge of preferring robots or human, if humankind does not locate their role again with emotional labor behaviors that can be displayed by human only as seen in this study, would choose robots with a high degree of probability. This situation is likely to cause diminishing of the needs for healthcare staff notably nurses. Therefore, this study lays emphasis on the emergency of that nurses should be worked in same organization in long term by increasing their emotional labor values. Decreasing organizational cynicism would be possible by recognizing workers in organizational

decision point and process, which affect to them directly. Therefore, it is not enough to create working culture by declaring the organizational rules and mission for it. In this context, health managers who internalize communication techniques have pivotal role to achieve this aim.

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