# WORKPLACE SPIRITUALITY, LEARNING ORGANIZATION PRACTICES AND ORGANIZATIONAL COMMITMENT AMONG MEDICAL DOCTORS IN PAKISTAN

RANA ZEESHAN MUBARAK

05-4506832 pustaka.upsi.edu.my Perpustakaan Tuanku Bainun Kampus Sultan Abdul Jalil Shah PustakaTBainun ptbupsi

THESIS SUBMITTED IN FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

FACULTY OF MANAGEMENT AND ECONOMICS
UNIVERSITI PENDIDIKAN SULTAN IDRIS

2017

05-4506832 pustaka.upsi.edu.my Perpustakaan Tuanku Bainun Kampus Sultan Abdul Jalil Shah PustakaTBainun ptbupsi

## ABSTRACT

The purpose of this study is to explore workplace spirituality, learning organization practices and organizational commitment among medical doctors in Karachi, Pakistan. The study determines the level of these practices with a detailed insight on if the practices differ among medical doctors in public and private sector hospitals. This study further investigates the direct relationship of workplace spirituality and learning organization practices with the affective, continuance and normative forms of organizational commitment. The study entails a non-experimental research design and a quantitative approach towards data collection and analysis. A field survey method was used to collect the primary data from medical doctors working in teaching hospitals in Karachi, Pakistan. A total of 364 questionnaires were equally distributed among public and private sector teaching hospitals. However, a set of 261 was used for final analysis. Data was analyzed by using descriptive statistics, Mann–Whitney U test, correlation and multiple regression analysis. The findings disclosed a moderate to moderately high level of workplace spirituality, learning organization practices and all the three forms of organizational commitment. The medical doctors in private sector hospitals exhibited a relatively higher level of these practices as compared to medical doctors working in public sector hospitals. The results of correlation and multiple regression analysis revealed that the workplace spirituality and learning organization practices would lead to better affective and normative commitment among medical doctors. The results are promising and negate much of the earlier work on the proposed relationships. Previously, less was understood on practical application of workplace spirituality and learning organization practices in medical vocation. Therefore, this empirical study has significantly contributed to the body of knowledge and considered a pioneer work in context of Pakistan. The findings suggest strong managerial implications and new directions to the practices of attracting, developing and retaining medical doctors in Pakistan.

# ABSTRAK

KEROHANIAN TEMPAT KERJA, AMALAN ORGANISASI PEMBELAJARAN DAN KOMITMEN ORGANISASI DALAM KALANGAN DOKTOR PERUBATAN DI PAKISTAN

Kajian ini bertujuan untuk mengkaji kerohanian tempat kerja, amalan organisasi pembelajaran dan komitmen organisasi dalam kalangan doktor perubatan di Pakistan. Kajian ini meneroka hubungan langsung antara kerohanian tempat kerja dan amalan organisasi pembelajaran dengan bentuk-bentuk komitmen afektif, komitmen berterusan dan komitmen normatif dalam kalangan doktor perubatan di hospital awam dan swasta di Karachi, Pakistan. Sejumlah 364 soal selidik diedarkan secara sama rata antara hospital awam dan swasta yang ada menjalankan program latihan. Sejumlah 261 soal selidik digunakan untuk analisis akhir. Pada keseluruhannya, tahap amalan kerohanian tempat kerja, amalan organisasi pembelajaran dan ketiga-tiga kelompok komitmen organisasi dalam kalangan doktor perubatan didapati berada pada tahap sederhana tinggi, dan secara relatif didapati bahawa tahap amalan yang lebih tinggi adalah dalam kalangan doktor perubatan di hospital swasta. Keputusan kajian analisis korelasi dan regresi berganda pula menunjukkan bahawa terdapat perkaitan antara kerohanian tempat kerja dan amalan organisasi pembelajaran yang membawa kepada komitmen afektif dan komitmen normatif. Dapatan kajian ini telah memberi perspektif baharu dalam memahami tentang kerohanian di tempat kerja dan organisasi pembelajaran dalam konteks amalan di hospital-hospital awam dan swasta. Perbincangan dapatan kajian menunjukkan implikasi pengurusan dan hala tuju baharu dalam amalan pengurusan sumber manusia untuk menarik, membangun dan mengekal doktor-doktor perubatan di Pakistan.

# TABLE OF CONTENTS





**CHAPTER 1 INTRODUCTION**

## LIST OF TABLES

05-4506832 pustaka.upsi.edu.my Perpustakaan Tuanku Bainun Kampus Sultan Abdul Jalil Shah PustakaTBainun ptbupsi

## LIST OF FIGURES

05-4506832 pustaka.upsi.edu.my Perpustakaan Tuanku Bainun Kampus Sultan Abdul Jalil Shah PustakaTBainun ptbupsi

## LIST OF ABBREVIATIONS

| | | |
|---|---|---|
| CPD | - | Continuous Professional Development |
| CME | - | Continuous Medical Education |
| HDI | - | Human Development Index |
| HR | - | Human Resource |
| HRM | - | Human Resource Management |
| HRD | - | Human Resource Development |
| IOM | - | International Organization for Migration |
| MPI | - | Multidimensional Poverty Index |
| OECD | - | Organization for Economic Cooperation and Development |
| OPD | - | Out Patients Department |
| PMDC | - | Pakistan Medical and Dental Council |
| UN | - | United Nations |
| UNDP | - | United Nations Development Program |
| WHO | - | World Health Organization |

# CHAPTER ONE

# INTRODUCTION



## 1.1 Overview

Medicine is an exalted and dedicated vocation that deals with restoring human health. The profession engenders a compassionate approach that not only addresses the physical, mental and social aspects of patients health but now encompasses their spiritual concerns for a total care (Dhar, Chaturvedi & Nandan, 2011). Modern practice demands competence in spiritual integration at work (Anandarajah, 2014) and continuous learning for better treatment of injuries and illnesses as well as provision of medicare care to the impaired (Australian Medical Association, 2011).

Nevertheless, provision of a holistic care much depends on commitment and availability of medical doctors (Scheffle, Liu, Kinfu & Dal, 2008). Incase doctors get scarce, less people may avail the health care services, lesser would be time for

patients consultation, higher would be the healthcare cost and diseases may amplify (Bohl, 2008). Inevitably, their sufficient presence is essential for the economic growth of a country (Marry, 2012). Therefore, unlike other professions, a medical practice starts with an oath of commitment. Hereby, for a compassionate care, medical doctors promises to serve humanity with integrity in wherever and whatever situation, avoid medical negligence, consider patient's values and beliefs (religious/non-religious) for quality relations and enhance medical skills through lifelong and continuous learning practices (Loewy, 2007). A good medical practice improves the life expectancy of people and advances the quality of a community life. Medical doctors are thus the icons of health promotion in a society and their demand remains indispensable (Scheffle et al., 2008).



## 1.2 Background of the study

The human capital in health is scarce around the globe. Both the developed and developing nations are facing the shortages of the health workers. On the contrary, the health situation around the globe is deteriorating (WHO, 2016) whereas the population of the world is rising high (United Nations, 2011). Therefore, to meet the health goals, nations keep their gates open for competent health professionals. For better options, many health workers are migrating to other countries. This immigration is largely from developing to developed countries and majority of the skilled migrants are medical doctors (IOM, 2008). Now, developing nations are the biggest source of doctors to developed nations (Khadria, 2010). The denouement of this global movement is an acute crisis of physicians in developing parts of the world.

The rising population and poor economic conditions of low-income nations has further exacerbated this dearth.

The health care facilities around the globe are in desperate need of inspiring a lasting loyalty among medical doctors. Doctors are ought to put utmost efforts even in grueling hours. However, in a state of plight, doctors' affiliation with hospitals is not sanguine. According to a Gallup survey majority of medical doctors are emotionally disengaged with hospitals (Blizzard, 2003). Bullying at workplace is also a growing menace among medical doctors (M. Mistry, Mistry & Latoo, 2009). Moreover, doctors are often on strike in both developing (Pakistan Observer, 2016, July, 16) and developed parts of the world (Kirkup, 2016). Such strikes are often against new laws that restrict their freedom at work, against workplace bullying, violence and for increment in salaries (De Sousa, Shrivastava, Sonavane & Shah, 2015). However, regardless of any conflicting pressure at work, doctors are desired to sustain individual commitment and care via life time practice (Astrow, 2013). Exploring commitment among medical doctors is, therefore, a significant literature gap to fill (Karsh, Beasley & Brown, 2010). Today, it is essential to understand doctors' instance on emotional, obligatory and compulsory attachments with the workplace as the situation demands utmost efforts in re-building trust and organizational commitment among medical doctors (Ibrahim, Yaaba & Shaba, 2016).

Infact, individuals at work respond on analyzing individual and organizational work interactions (Joo & Park, 2010) and develop an attitude to stay when the perceive (i) they like to (ii) they have to or (iii) they are obliged to do so (Allen & Meyer, 1990). Organizational commitment is thus a perception about oneness or

belongingness with the workplace (Bhattacharya, Rao, and Glynn , 1995) which connects individuals with organizations (Mathieu & Zajac, 1990). Thus all work-related psycho-social factors (Meyer & Allen, 1991; Kuusio, Heponiemi, Sinervo & Elovainio, 2010; Elovainio et al., 2013), individual traits (Su, Murdock & Rounds, 2015) work roles and challenges (Azeez & Abimbola, 2016; Bowditch, Buono & Stewart, 2007), competence, job demands and perceived control over assigned task (Kuusio, Heponiemi, Sinervo & Elovainio, 2010) are significant contributors of organizational commitment. Since paradigms of modern medical practice have expanded to embrace new advancements, therefore, a potential way to re-build organizational commitment among medical doctors is to enquire such factors that are now integral to modern medical practice and thereby influencing the nature of work and thus the behavior of the medical workforce.



### 1.2.1 Challenges of a Holistic Medical Care

A holistic medical care is about addressing the social, physical and emotional concerns of patients for complete healing and total care. This encompasses a quality relationship with inpatients, updated modalities of diagnosis and treatment, full commitment and continuous learning of medical staff. Today, a key aspect of total care is its desire to reflect further on spiritual concerns of patients. Therefore, beyond the mental, social and the physical aspects of health, WHO and its associated member nations are actively investigating this fourth dimension and its effect on individual's overall level of health and happiness (Dhar, Chaturvedi & Nandan, 2011). Like never before, a holistic medical treatment demands both the doctors and patients to define

spirituality, explore it and express it in relevance to own thoughts, background and culture, and in quest for meaning (Hassed, 2008). Caring needs calling on inner power of individuals and a doctor's spiritual and religious practice may affect his efficiency (D'Souza, 2007). Spirituality instills meaning to medical care through transcendental obligation aiming for doctor-patient partnership in shared sense of humility (Astrow, 2013). Doctors in this era must know how to tap spiritual-selves and weave it in medical practice. Recent investigations prove that spiritual concerns play a greater part in patients' recovery than ever before and therefore doctors ought to develop spiritual competency (Anandarajah, 2014). Spirituality at work is a growing challenge for medical doctors. However, to what extent the medical doctors integrate spiritual self at work is yet questionable.



Medicine as a discipline is evolving fast and practicing medicine is more demanding, compassionate and arduous than ever before. Now change in diagnostic and treatment methodologies is inevitable for a quality care and calls for doctors' commitment to learn continuously. Developing up to date clinical skills and maintaining a high level of professional conduct is therefore an integral responsibility of medical doctors. A good practice thus encompasses an extensive update of clinical knowledge, mastery in management and health services, a team approach, as well as training and mentoring of junior doctors (Australian Medical Association, 2011).

Nevertheless, medicine is tagged a busy vocation and thus life long learning in medical practice cannot be unhitched from workplace. In clinical settings workplace learning is more viable as it focuses on learning how to do things as compared to academic learning that is focused on learning about things (Sessa & London, 2015).

Relevance is the key when learning is associated with clinical practice (Karim, Irfan, Qureshi, Naeem & Alfaris, 2013) and experiential learning provides a platform for reflection in clinical settings (Sand, Bowers, Wing & Kendrick, 2014). Both experiential and reflective learning experiences exhibit transformation (Sessa & London, 2015). Therefore, when individuals are committed to improve and offered with the opportunities to reflect the individual learning, this actually paves the way towards a learning organization (Serinkan, Kiziloglu,Volkan & Pınar, 2014). A learning organization facilitates individual learning and continuously transforms to adapt with the changes in the external environment. Therefore, learning health-care organizations continuously learn and improve for delivering the very best care each time (Dias & Escoval, 2015). Recent studies on learning in medical vocation strongly argue that, in this era of information and technology, hospitals ought to transform into learning organizations (Soklaridis, 2014). However, this cognizance is still missing in the literature (Ratnapalan & Uleryk, 2014).



.

### 1.2.2 Medical Practice in Pakistan

To be licensed practitioners, all the medical doctors in Pakistan enter a compulsory and obligatory oath with Pakistan Medical and Dental Council (PMDC). Hereby, they declare an informed consent to provide their best services to the patients, whoever and wherever, without any discrimination and in any situation and stage. Medical doctors in Pakistan follow the mandatory codes of conduct by Pakistan Medical and Dental Council (PMDC). These codes are the living documents which are periodically updated to ensure a good medical practice in context of changing global standards of

health. Accordingly, medical doctors are responsible and accountable for their individual actions. These codes bond all the medical doctors in Pakistan to serve the nation as an instrument of "mercy of God". They are required to treat the patients with dignity and provide a compassionate quality care. The bioethics calls them for a duty to heal while acknowledging that the Almighty Allah has the ultimate power of healing. Doctors in Pakistan are ought to address the spiritual attributes of patients illness along with the physical and mental concerns.

The code of competence ensures that doctors sustain an uttermost competence level in particular in diagnostic skills, clinical decisions, planning, implementing, monitoring and evaluation of interventions. To continue medical practice, they are bond to (i) be aware of their capability and level of task they can be assigned to (ii) keep on continuing education (iii) ensure a competent clinical care and updated approach of research, technology and practice with realistic efficacy and sufficient dialogue in patient management (iv) acquire skills/knowledge for better training and supervision (v) Monitor quality care and identify training gaps and (vi) update the flow in history of patients for other physicians and/or future concerns in treatment.

### 1.2.3 Healthcare Crisis in Pakistan

Findings of the human development report 2014 by UNDP shows that Pakistan stands 145$^{th}$ out of 187 countries of the world on Human Development Index (HDI) with a population of 176.7 million and an expected population of 234.4 million by 2030. The Multidimensional Poverty Index (MPI) by UNDP discloses that 61% of the total

population in Pakistan is multidimensional poor or near poverty where health accounts for 32% of the poverty of deprivation. The development of the nation is hindering by poor and insufficient health services (Nizar & Chagani, 2016; Khan, 2008). The country is facing a high maternal and infant mortality rate, twice the problems from diseases, insufficient facilities for health and only 175,223 doctors (Pakistan Economic Survey, 2015) i.e. only one doctor available for the service of 1300 person (Nizar & Chagani, 2016). By the year 2020, Pakistan is expecting to face a shortfall of around 57,900 to 451,102 doctors (Talati & Pappas, 2006). Yet, out of 4000 doctors produced annually, half of them leave the country and mostly do not return (Adkoli, 2006).

According to the World Bank's fact book for the year 2011, Pakistan is the ninth largest source of doctors for other countries (Ratha, Mohapatra, & Silwal, 2011). The report uncovers an emigration of 12,727 (13.3%) of total trained doctors in Pakistan. According to an investigation report by IOM, Pakistan is among top 10 sources of overseas doctors to OECD countries, second largest for UK and Canada, and the third largest source for USA and Australia (Khadria, 2010). The report claims that 12,713 doctors so far have left their services and moved to the respective countries.

A compassionate and efficient medical practice is indispensable in the growing health crisis of Pakistan. However, Pakistan is facing a dearth of medical workforce and hospitals in Pakistan are in greater demand of medical doctors. This demand is particularly higher in public sector hospitals as these are large setups established to serve the mass population. Yet, doctors in public sector hospitals are

often on strikes (Pakistan Observer, 2016). Media has been consistently highlighting this issue. Kazmi (2011) reported that the strike in civil hospitals of Pakistan by Young Doctors Association lasted for thirty-seven days and was the longest strike ever in Pakistan history. As a result, 60% of the public hospitals could not provide services to emergency patients and 500 of them faced death. Doctors in public teaching hospitals in Karachi also supported the strike (Pakistan Today, 2011). The medical doctors postponed the surgeries, left the patients unattended and many of them resigned from work (Zahir, 2011). Doctors in public hospitals in Islamabad also called for a strike against planned scale for health personnel and did not offer medical services (Pakistan Today, 2012). On a strike by Young Doctors Association against doctor's transfer, the Outpatient department (OPD) services were not offered in any of the public and teaching hospitals in Lahore (The News, 2012). Doctors postponed the operations and their unsympathetic attitude resulted in conflicts with patients (Dawn, 2012).

Such strikes are mainly for pay raise, structural change in job and job security (Dawn, 2011); promotion and development policies and care given to doctors (Khan, Nawaz, Aleem, & Hameed, 2012); and against transfers (Daily Times, 2012). The issue of medical negligence among medical doctors in Pakistan is rising as well. Shiwani and Gadit (2010), in a study on growing medical negligence in Pakistan, pointed out that inadequate qualification of doctors for the assigned task and private practices of doctors with public hospital jobs are among top reasons of doctors' medical negligence. The researchers insisted on improving medical trainings and commitment among doctors to resolve this issue.

As a first step towards quality healthcare services the health facilities should be equipped with sufficient, properly trained and motivated human resources for health (Hafeez, Khan, Bile, Jooma, & Sheikh, 2009). An efficient and committed administration, working closely with a dedicated staff can make hospitals an excellent center of health care (Naz, Daraz, Khan, & Hussain, 2012). People at work have different inner motives, varying truths and individual desires that forces them to engage in such roles that yields a higher meaning to their life and fosters a deep connection with people at work (Ashmos & Duchon, 2000) while bringing harmony in individual and organizational values (Milliman, Czaplewski & Ferguson, 2003). Such integration of individuals' spiritual values at work may reinforce the holistic-engagement of people at work and help understanding the behavior of a workforce (Kazemipour, Amin & Pourseidi, 2012; Nasurdin, Nejati & Mei, 2013; Noor & Arif, 2011; Nazir & Malik, 2013). Perceiving an opportunity to control individual actions, relate with others and develop competency at work strengthens the individuals' involvement with organizations (Greguras & Diefendorff, 2009). A medical care unit that facilitates spiritual integration at work may offer greater opportunities of manifesting spiritual self and addressing the spiritual concerns of inpatients. This may yield enriched spiritual experiences at work and provide emotional succor to medical doctors in grueling hours and under poor working conditions. A spiritually invigorated medical workforce may thus exhibit a higher level of organizational commitment (Wah, Ahmed, Ansari & Aafaqi, 2005).

Besides, the improved facilities for learning may be one of the various realistic incentives than financial incentives, which may help retaining and returning of medical professionals in Pakistan (Imran, Azeem, Haider & Bhatti, 2012). However,