

# Unbundling the complexity of performance management of healthcare providers in the Middle East

Healthcare providers

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## Abstract

**Purpose** – Previous research provides adequate evidence on performance management (PM) for hospitals and healthcare providers; however, less is known about their individual and PM appraisal process. Additionally, there is limited research exploring PM in the Middle Eastern context. This study investigates PM practices in the Middle Eastern healthcare industry.

**Design/methodology/approach** – This study adopts the qualitative research methodology through semi-structured interviews of healthcare professionals in Kingdom of Saudi Arabia and the United Arab Emirates. Thematic analysis was adopted for analyzing this qualitative data.

**Findings** – The main findings have uncovered different facets of appraisal challenges for both the appraiser (i.e. manager) and the appraisee (i.e. employee). These challenges include communication deficits, lack of goal setting standards and regular meeting updates in order to ensure employee satisfaction and motivation in the workplace.

**Research limitations/implications** – This study has significant implications for policymakers in Middle Eastern hospitals in terms of implementing PM for their staff. Moreover, future studies can conduct in-depth analysis and provide comparison between public and private sectors in the Gulf countries.

**Originality/value** – This study is one of the first to portray challenges involved in conducting PM in the Middle East healthcare sector specifically in the UAE and Kingdom of Saudi Arabia (KSA), both from the perspectives of the appraiser and appraisee.

**Keywords** Performance management, Healthcare, Medical sector, Key performance indicator (KPI), Healthcare providers (HCP), Middle East

**Paper type** Research paper

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**Erratum:** It has come to the attention of the publisher Vaz, D., Qureshi, W., Temouri, Y. and Pereira, V. (2023), “Unbundling the complexity of performance management of healthcare providers in the Middle East”, *IIM Ranchi Journal of Management Studies*, Vol. ahead-of-print No. ahead-of-print. <https://doi.org/10.1108/IRJMS-03-2023-0026>, that the affiliation of Wardah Qureshi has been incorrectly listed as “ISM University of Management and Economics, Kaunas, Lithuania”. This error was introduced during the typesetting process and has been corrected to “ISM University of Management and Economics, Vilnius, Lithuania” in the online version. The publisher would like to sincerely apologize for any inconvenience caused.



## 1. Introduction

“Performance management is essentially about measuring, monitoring and enhancing the performance of staff, as a contributor to overall organizational performance” (Martinez, 2003, p. 208). Performance management (PM) systems are a crucial way of gauging employee performance and suitably rewarding them for good work. This system is followed in every industry but is being performed differently. Ample research has been done on PM of hospitals and healthcare institutions (Mesabbah and Arisha, 2016; Vainieri, Noto, Ferre, & Rosella, 2020), but not much attention is given to PM system of healthcare workers, i.e. doctors, nurses and other staff employed for administrative roles in these institutions. The primary purpose of having performance appraisals in hospitals and medical industry is to improve such healthcare service (Choudhary and Puranik, 2014) by motivating healthcare staff to serve better (Choudhary and Puranik, 2014). Performance in healthcare sector basically depends on employee motivation and job satisfaction since their role is mainly focused toward patient care. Reward systems are a way of driving these employees to do better be it through intrinsic rewards, extrinsic rewards or by total reward systems (Pereira, Neal, Temouri, & Qureshi, 2020). Speaking about how human capital can be enhanced in the UAE, Pereira, Neal, Temouri, and Qureshi (2020) further highlight the need for trainings to develop required skills.

A quick search on PM in the Middle East medical sector shows very limited research in this area. One of the studies conducted across Lebanese hospitals showed lack of PM practices (El-Jardali, Tchaghchagian, & Jamal, 2009), and the need for better performance appraisal system was gathered from a survey conducted in Iran (Moradi, Mehraban & Moeini, 2017). Nikpeyma, Abed\_Saeedi, Azargashb, and Alavi\_Majd (2014) further argued that lack of fairness and appropriate feedback in appraisal system in addition to untrained managers resulted in poor efficiency of nurses in Iran. This points us toward the lack of best practices in PM in this industry across the Middle East. To bring this complexity to light, we give evidence from healthcare institutions from two Middle Eastern countries, i.e. UAE and KSA and aim to find the following:

- (1) How is PM conducted in the Middle East medical industry? What are the results in comparison to PM in the world?
- (2) What are the challenges faced by the appraiser and the appraisee in conducting performance appraisals in the Middle Eastern hospitals?
- (3) How can these challenges in implementing and conducting performance appraisals in the Middle Eastern hospitals be overcome?

We use the attribution theory to understand how a healthcare worker perceives performance appraisal while playing the role of an appraisee and appraiser. To find answers to our research questions, we use the qualitative approach of semi-structured interviews. Based on the data collected from health workers (specialist doctors and nurses) of public and private sectors, we compare the PM systems implemented in UAE and KSA. Further, we look at the differences of PM in the Middle East in comparison to the PM in healthcare in other parts of the world.

In the next sections, we elaborate on past literature and research, both specific to PM in healthcare sector and generally in other sectors. We then move to the methodology adopted in this study and elaborate on the qualitative method of research with semi-structured interviews carried out in the UAE and KSA and further conduct thematic analysis to highlight emerging themes. In the sections to follow, we discuss our findings in detail and provide answers to our research questions and list out implications for practice with future research directions.

## 2. Literature review

### 2.1 Early history of performance management in healthcare sector

A century ago, Dr Ernest Amory Codman, a surgeon from Harvard Medical School and the Massachusetts General Hospital criticized the healthcare system for not having measurement

tool or indicator to analyze and monitor the outcomes of the clinical care provided to patients (Donabedian, 1989; Melnyk and Fineout-Overhold, 2022). Codman further highlighted the issue to the hospital management by showing a picture of an ostrich who is burying its head under the sand and laying golden eggs (Wrege, 1983). The ostrich represented the surgeons and hospital administrators who are not willing to study or audit the outcomes of the care delivered to the patients but were delighted to receive the financial benefits (Jackson, Paterson, Pong, & Scarparo, 2013).

With the advent of twenty first century, hospitals in United states and Europe began to focus on performance indicators under the umbrella of Quality in healthcare. In 1952, the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association collectively established the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (Roberts, Coale, & Redman, 1987). The purpose of the Joint Commission was to endorse and implement a set of rigorous accreditation standards.

During late 1980s, JCAHO further emphasized on the clinical outcomes. This compelled the pressing need for implementing performance management system (PMS) for evaluation of the performance of the physicians and surgeons through a system for monitoring and improving their work leading to enhancement of the quality of care. The Joint commission endorsed a set of standards and indicators for “performance improvement.” These Joint Commission International (JCI) standards not only suffice as an evaluation tool to facilitate the process of measuring, assessing and improving performance of the healthcare providers (HCPs) and organizations but also aid in the establishment of key performance indicators (KPIs) for the accredited organizations (JCI, 2020), leading to development of the PM system in healthcare institutions.

In healthcare, the PM particularly relates to care outcomes that is why the term “outcome management” is used. The outcome management encompasses the patient, the care team, the care process and the outcomes (Walburg, Bevan, Wilderspin, & Lemmens, 2006). With outcome management, healthcare is focused on continuous improvement. The PM system will involve measuring progress against a series of clinical performance indicators (Borگونovi, Anessi-Pessina, & Bianchi, 2018).

The introduction of standards and indicators in healthcare has driven the development of multidimensional performance measurement systems and during the last half century has undergone many evolutionary phases. Continuously changing dynamics and emerging challenges are demanding evolution of PM systems of healthcare (Vainieri, Noto, Ferre, & Rosella, 2020). Healthcare systems are dynamic, demanding and continuously evolving. With coronavirus disease 2019 (COVID-19) pandemic, HCPs and systems are under great pressure and this is causing a new shift in healthcare PM, which is leading more toward resilience at work (Whelehan, Algeo, & Brown, 2021) to cope up with “burnout,” a widely discussed topic in healthcare even before the COVID-19 pandemic (Shanafelt *et al.*, 2015).

Generally, PM is a continuous process which is aligned with organizational goal and mission (Aguinis, 2013). Continuous process refers to an individual’s performance review and feedback provided on weekly or even daily basis through frequent interactions apart from annual evaluation (Varma and Budhwar, 2019). According to Varma and Budhwar (2019), these interactions are required in any organization due to the dynamic work nature wherein goals keep changing weekly or monthly and so goals set at the beginning of the year may not be the same until the year end. Moreover, such an approach will help in better collaboration within teams, retain talent and help them develop at fast pace.

Healthcare in the Middle East is continuously growing and by next year in 2023. A compound annual growth rate (CAGR) of 11.7% from \$185.5bn in 2019 to \$243.6bn is predicted (Zawya, 2022b). The healthcare industry is a combination of public and private hospitals which are being governed by the healthcare regulators. In Saudi Arabia, the Ministry of Health (MOH) is the governing body. Whereas in UAE, the Department of Health

(DOH) is the regulatory authority for Abu Dhabi and Al Ain, and the Dubai Health Authority (DHA) governs the emirate of Dubai. However, five northern emirates Sharjah, Ras al Khaimah, Fujairah, Umm al Quwain and Ajman are regulated by the United Arab Emirates Ministry of Health and Prevention (MOHAP).

It is interesting to know that in healthcare, a standard approach to PM is embedded into standards of accreditation, but a fixed criterion is nonexistent globally. Not only healthcare system is unique, each and every healthcare organization is unique too. The PM in a healthcare organization will vary, depending on the number of the beds, specialties and services offered. In addition, based on evidence-based practices and complexity of care, the PM system will differ from one specialty to another. Every healthcare organization is responsible for identifying and assessing the sources of KPIs and benchmarks, based on the operational capacity, regulator's requirement and accrediting body.

Generally, in healthcare industry and particularly in Middle East health care industry, views of medical doctors toward PM remain underexplored. [Trebbele \*et al.\* \(2015\)](#) studied the attitudes of doctors toward PM system and concluded that such approaches are poorly defined in healthcare. Additionally, in healthcare, HCPs work collaboratively and collectively, sometimes in interdisciplinary team, toward the common goal of patient safety and quality of care, hence, directly and indirectly affecting and impacting each other's performance ([Rosen \*et al.\*, 2018](#)). Thus, the concept of individual PM poses a challenge and PM systems should be able to address such dimensions of performance.

Previous studies have shown that PM in hospitals have not been very well established. Although healthcare workers risk their lives and serve the society, their job is not much appreciated. A survey conducted in three Australian medical and surgical nursing units by [Dawson, Stasa, Roche, Homer, and Duffield \(2014\)](#) showed that turnover of nurses was mainly due to lack of support and work recognition and that career opportunities were also limited ([Dawson, Stasa, Roche, Homer, & Duffield, 2014](#); [Manafa \*et al.\*, 2009](#)). Another study conducted in Malawi (country in East Africa) showed the inadequacy of performance appraisals and supervisor feedback ([Manafa \*et al.\*, 2009](#)). These situations highlight that there are loopholes in PM system and fail to recognize the work of healthcare staff. Research by [Lutwama, Roos, and Dolamo \(2013\)](#) in Kumi, Mbale, Sironko and Tororo districts of Uganda further showed that PM was still not in place in relation to setting performance targets and management planning. Performance indicators were not clearly communicated to all healthcare workers in addition to mismanagement of performance assessment schedule and performance rewards ([Lutwama, Roos, & Dolamo, 2013](#); [Lutwama, 2011](#)). Performance evaluation is one of the predictors of motivation for health workers as per a survey conducted by [Weldegebriel, Ejigu, Weldegebreal, and Woldie \(2016\)](#) in Ethiopia. Also, proactively indulging healthcare staff in finding solutions to problems, creating a sense of belonging ([Dieleman, Gerretsen, & van der Wilt, 2009](#)) augments their enthusiasm to continue as a healthcare worker. In St. Theresa's hospital at Ghana, healthcare staff raised concerns about their performance feedback not being communicated to them by their managers ([Adinkagre, 2012](#)).

Healthcare facilities, work environment and Human Resource Management (HRM) differ from public to private sectors. With regard to PM in public sector, [Arnaboldi, Lapsley, and Steccolini \(2015\)](#) state that the remuneration and performance reward system needs to be incorporated. Moreover, [Arnaboldi \*et al.\* \(2015\)](#) also speaks about the higher complexity in public sector than a private or non-profit organization. In the case of a public hospital at Cyprus, performance achievement, remuneration, co-workers and job attributes were main contributors to job satisfaction of healthcare staff ([Lambrou, Kontodimopoulos, & Niakas, 2010](#)), but it is important to note that remuneration varied as per gender, emergency and outpatient departments ([Lambrou \*et al.\*, 2010](#)). According to [Silva and Ferreira \(2010\)](#), Health Sub-Region (HSR) of Porto, Portugal lacked reward systems, performance planning and target setting. In a public hospital of Czech Republic, it was learnt that PM was conducted for

operational requirement and not in the interest of the employees (Krupicka, 2021). In the UK, balanced scorecard is not used as much as KPI in the case of the National Health Services (NHS) (Arnaboldi, Lapsley, & Steccolini, 2015). Smith (2002) had earlier highlighted that alignment in terms of management and managerial resources is required for effective PM at NHS, UK.

Given that the Middle East and North Africa (MENA) region is culturally unique and diverse with high inflow of expatriates, challenges faced here in implementing PM may differ. Yahiaoui, Nakhle, and Fardale (2021) conducted a study on French MNEs (Multi National Enterprises) that have successfully implemented PM in Lebanon and Tunisia taking socio-cultural values into consideration. Morley, Murphy, Cleveland, Heraty, and McCarthy (2021) additionally suggest that political and economic contexts might further influence PM implementation and this has implications for the MENA region given the fact that the region experiences high influx of expatriates. Yet another study conducted in the MENA region in banking sector showed that profit sharing also improved team performance and team cohesiveness (Serhan, Salloum, & Abdo, 2021).

### *2.2 Current practices of performance appraisals in the healthcare sector*

In general, considering that all healthcare workers strive to achieve a common cause of improving healthcare services, appraisals in a hospital are conducted by peers for one another. This means that nurses and physicians will be evaluated by others who share similar responsibilities (Choudhary and Puranik, 2014). Pay-for-Performance (P4P) (rewarded based on performance), Balanced Scorecard (links business strategies to target actions), 360-degree Feedback (evaluated by peers and supervisors) and Management by Objectives (objectives and targets set for employees in advance) (Abujbara & Worley, 2019) are common methods of evaluating performance in hospitals. In Australia, nurses, junior doctors and associated staff were managed through behavioral control, i.e. to follow operating procedures and regulations. But a mix of behavior, input (skill set) and output (goal setting) control was adopted for senior physicians. At the executive level, appraisals included KPIs that aligned with the strategic business plan of the hospital (Cogin, Ng, & Lee, 2016). The performance-based financing (PBF) was started in healthcare sector in Burundi (country in South Africa) to improve the quality of healthcare services. This scheme improved quality and relationship between patients and healthcare workers (Rudasingwa and Uwizeye, 2017). In Hubei, China, healthcare staff showed high levels of job satisfaction due to hospital management, performance appraisal system and compensation. The change in the healthcare system was implemented by the government of China in 2009 and focusses on improving healthcare facilities for general public and administrative changes for hospitals (Fang, Luo, & Fang, 2015).

Osman, Berbarly, Sidani, Al-Ayoubi, and Emrouznejad (2011) have developed a data envelopment analysis model for PM of nurses working in the Intensive Care Unit. This model includes training and development needs and clearly communicates targets for promotion. A survey conducted in Irish hospitals by McDermott, Conway, Cafferkey, Bosak, and Flood (2019) unearthed that relational coordination helped in better performance of cross functional teams and boosted employee outcome and also partially helped in patient care. It is also interesting to note that Mthatha general hospital at Mthatha Eastern Cape, South Africa uses PM and development system (PMDS) as a tool for performance appraisal (Adejoka and Bayat, 2014).

## **3. Research design**

To better understand how the process of PM in medical industry especially in the Middle East is conducted, we chose two countries, i.e. Saudi Arabia and UAE. These two countries are quite advanced in terms of medical facilities and technology adoption (Arabian Business, 2022, Zawya, 2022a) and would therefore make sense to understand if PM is also done at an

advanced level in these countries and if the medical staff and doctors working in these institutions are rewarded for their service.

We chose to adopt the qualitative research method for our study since we were interested in getting answers to open ended questions. It was important for us to understand how the PM system takes place even at the basic level. Since one of our research questions focuses on comparing PM in the gulf with other countries worldwide, we chose to seek this answer from our respondent's past global experience. Moreover, if we chose to go by quantitative method and adopt surveys, we would not be able to get rich information regarding the challenges faced by both the appraiser and the appraisee. Since we are using the attribution lens and look at the PM process both through the standpoint of appraiser and appraisee, it is most prudent to explore our research questions through one on one interviews, either physically or via online platforms.

The authors therefore decided to have interactive interviews with some of the medical staff working for prestigious hospitals in the UAE and Saudi Arabia. The respondents are all medical doctors, currently working in these two countries with a good mix of specialties like Internal medicine, Anesthesiology, Emergency medicine, Pediatrics, radiology, Family Medicine, Obstetrics and Gynecology. They are working as Specialists, Registrars and Consultants in their particular specialties. On average, they have 5 years of tenure in the current hospitals with 2 years as minimum and 13 years as maximum. All respondent doctors were intentionally hired from other counties into Saudi and UAE healthcare and most of them were trained in Europe and United Kingdom after completing their medical education (graduation) in their countries of origin. Their overall experience in healthcare as medical doctor is averaged at 18.5 years, where 28 years were the highest and 9 years were the minimum clinical experience of respondent medical doctors. Please see below [Table 1](#) for details about respondents.

[Bernard and Ryan \(1998\)](#) explain the different forms of data and objects of analysis. One of the options stated by them is analysis of a conversation carried out over a video interaction which has been adopted by us. We managed to conduct 10 interviews (6 in Saudi Arabia and 4 in the UAE) and saw a repetitive pattern in the answers obtained and data saturation was almost reached by the end of tenth interview. The interview questionnaire was designed based on the three research questions put together by the authors. This questionnaire is presented in Appendix 1. The interviews with our respondents were conducted virtually

Respondent	Gender	Location	Total work experience (years)	Tenure in current hospital (years)	Department
R1	M	Saudi Arabia	18	9	Nephrology
R2	F	UAE	18	3	Family Medicine
R3	F	UAE	17	4	Family & emergency medicine
R4	M	Saudi Arabia	20	3	Internal Medicine
R5	F	UAE	9	4	Registrar, Pediatric department
R6	F	UAE	18	3	Family Medicine
R7	M	Saudi Arabia	20	3	Internal Medicine/ Endocrinology
R8	F	Saudi Arabia	28	13	Obs & Gyn
R9	M	Saudi Arabia	25	2	Radiology
R10	F	Saudi Arabia	20	6	Internal Medicine and Rheumatology

**Table 1.** Details of respondents **Source(s):** Authors' compilation

through zoom application by one of the authors and was recorded with consent from respondents for transcription and analysis by other authors. Upon completion of the interview, the transcription of the recording was immediately completed by using an online software called Trint. The author conducting the interview was not involved in the analysis phase in order to eliminate any bias.

Thematic analysis was used for the analysis of this qualitative data. As stated by [Lochmiller \(2021, p. 2030\)](#), “The aim of thematic analysis is, then, to consider how the reported information addresses a specific research question or invites a new conceptual or theoretical understanding.” So, the transcribed interviews were read multiple times by the team and thematic coding was conducted under the supervision of the senior researcher and carried out as per [Clarke, Braun, and Hayfield \(2015\)](#) following steps of familiarization, coding, searching for themes and reviewing and defining themes and then drawing meaningful conclusions. As suggested by [Guest, MacQueen, and Namey \(2011, p. 10\)](#) that “Thematic analyses move beyond counting explicit words or phrases and focus on identifying and describing both implicit and explicit ideas within the data, that is, themes,” transcribed data were coded with color and third order themes were drawn. These themes were agreed upon by all researchers and are elaborated in the findings section below.

#### 4. Findings

The finding section is divided into subdivisions of current experiences, challenges faced and recommendations of the respondents. As discussed earlier in the literature review that healthcare is outcome based, it is not only about the number of patients treated and the revenue generated, but it is focused more on the care outcomes, patient safety and quality of clinical practice. Hence, these aspects should be kept in the scope while conducting PM.

Here below, we elaborate on the different themes that emerged from the data analysis. We further categorized the themes as “Appraisal experiences,” “Appraisal challenges” and “Appraisal recommendations.” We bring out the various issues experienced by both the appraisee and the appraiser and an overall view of how PM is conducted in these hospitals.

##### 4.1 Appraisal experiences

*4.1.1 Lack of face-to-face discussion.* Most of the respondents mentioned that the appraisal is conducted annually only and happens just on the paper. The Head of Department (HOD), appraiser, will complete the appraisal form in silos and the appraisee will be asked by the human resource department (HRD) to come and sign the document. The opportunity of face-to-face discussion to identify the areas of improvement and to confer the plan for skill enhancement will not be provided. It was mentioned by one of the doctors that there is no experience of PM since he has started working in the current role. Goals and targets are not discussed openly and formal discussion of Physician Professional Development (PPD) does not happen.

##### Quotes:

- (1) “The official frequency of the official evaluation is like after every year or after two years” – R5
- (2) “HOD is the one who’s evaluating us” – R2
- (3) “Actually, evaluation is a secret process which is going on. But in the end of the year, we have to share this with the employer and with the administration.” – R9
- (4) “So, it’s actually pretty nonspecific and quite vague. Like we don’t really have a formal appraisal or like any directly observe the sort of scenario for getting our performance evaluated” – R10

- (5) “My main concern for my own evaluation is that it is not actually done in real time, i.e. sitting face to face with your real waiter or appraiser. If I’m see and go through the various components of the appraisal process face to face, discussing each and giving feedback on it, or to discuss the challenges of each component” – R4

*4.1.2 Shortage of staff and unequal workload distribution.* The interviewees have mentioned that both in private and government hospitals, there is shortage of clinical staff and unequal distribution of the workload. While conducting the PM, the HOD and management does not take this factor into consideration. Also, it was mentioned that evaluation is very generic and not specific to the appraisee’s clinical duties and academic participation. Thus, not providing the true picture of one’s work and dedication. Due to this imbalance in workload, the time constraint becomes a challenge to arrange and plan on-on-one meetings between appraiser and appraisee.

Quotes:

- (1) “And one of the major challenges which I came across while doing that was to have time to discuss various elements of the feedback or the performance face to face and go through in more of a customized way rather than a generic answer” – R4
- (2) “So, first of all, is the time that we are working in a very busy clinic. So, we don’t have time to really like, you know, do a proper evaluation for the other colleagues or to observe their practice or so on” – R10
- (3) “But there’s really kind of lack of like an overall or holistic opportunity for the evaluation of the colleagues and maybe it might apply to them as well, that they are quite busy and they might not observe our like work directly” – R10
- (4) “So, I think the system is the not really very organized in a way of like giving you enough time or really the opportunity to either be evaluated or evaluate others”- R10
- (5) “We are in acute shortage. One person is doing the work for four or five” – R9

*4.1.3 Favoritism and fear of disagreement.* Particularly doctors from public sector have shared that the outcome of PM depends on the relationship with the appraiser. If one is in the good books of the appraiser, the outcomes will be positive, regardless of the clinical performance and quality of care delivered. In addition, if given an opportunity of face-to-face discussion, then there is a fear of disagreeing with the appraiser.

Quotes:

- (1) “So, if you disagree, for example, what will happen? Make you feel like that you cannot disagree, although you are disagreeing in your understanding, but you cannot openly disagree with them” – R1
- (2) “I cannot be verbal. It cannot be a handwritten note and just try to be I mean, try to notice the point, and not try to notice down those points, which I disagree and keep in my mind how I can improve it. And why, why, why the other person thinks like that? So, yes, just I mean, keeping silent and knowing your weaknesses so that you can improve yourself and others” – R1
- (3) “So, at this point, sometimes I feel that the true level of my work is not being acknowledged. So, and usually I sometimes I raise this issue and sometimes keep quiet if the things are going smoothly”- R9
- (4) “So I think there’s a little bit of bias and then you have appraisals, appraiser is working with you” – R6



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## 4.2 Appraisal challenges

### 4.2.1 Lack of performance management training: Quotes:

- (1) "Maybe the appraisers should be trained to do better. Qualified, should be neutral, should not be in the same organization"-R6
- (2) "So you know that they don't have enough time to evaluate me and they don't have the robust processes of appraisals" - R1

4.2.2 *Lack of transparency.* Most of the respondents believe that there is a lack of transparency in PM process. Either they receive a system notification or reminder that evaluation is due and after sometimes they will receive another notification that PM evaluation has been completed by HOD, without any personal discussion or meeting. In some cases, they simply receive a form to be signed. In some instances, doctors have been asked to sign a blank form which will be later filled by the HOD or line manager and the feedback will not be shared with them, nor by HOD neither by HR.

Quotes:

- (1) "I just signed a paper and they said, what is this? So, this is your privileges. Okay, I have given this number. And what is it behind what is in front? Never been discussed, you know" – R2
- (2) "So, most of the time what happens, like the HOD, he will call and he is going to give me the paper to sign and I will just sign it. And then he's putting his remarks and then, but I don't know, I unfortunately, I can't follow up with that a present form" – R7
- (3) "But I mean, we don't have a formal appraisal system, okay? So, every year we do get some notification in the system that your appraisal is due and then we also get a notification that your appraisal has been done." – R10
- (4) "They are just asking to fill this paper even is not showing the full form properly." – R2

4.2.3 *Lack of peer review.* There is a lack of formal peer review during PM evaluation. In some instances, peer review might be done but not from the same specialty. Ideally, peer review should be performed by the specialists of the same specialty who understand the subject and guidelines in the similar fashion. But most of the time it is not done during PM and if done, then might involve physicians from different specialty which does not fully suffice the requirements of clinical quality standards.

Quotes:

- (1) "Oh, no, no. Nobody have approached me even formally, like in the form of any documents or anything. No, I have never done this formally." – R7
- (2) "Yeah, there is no peer review" – R10
- (3) "We are discussing amongst the colleagues and if necessary, we are conveying to that specifically as well. But for the moment. You know, it's informal."- R7
- (4) "There I mean; everybody will not portray the same image of your colleagues. So, you have to observe, and you have to I mean, it's by looking by your eyes and observing certain person and seeing them clinically or seeing them like I am in in behaviour wise or conduct wise or attitude wise. And, and so it's said basically what I feel that we have issues on and this sometimes and then as a supervisor or as a as evaluator of your colleagues, of your someone that you have to be very vigilant so that you are not deceived or cheated by somebody. So, I mean, you have to keep your eyes open." – R1

- (5) “They can include apart from the other senior colleagues in a book of late. And they can include these like nursing department as well that probably that will also help us in our evaluation” – R5

#### 4.3 *Appraisal recommendations*

4.3.1 *Link of performance management reviews to pay, reward and incentives.* Many respondents raised concerns of having appraisal and PM being conducted regularly but with no reflection of performance rewards in salary hikes or increments. This seemed to be a demotivator for most well performing doctors. While conducting appraisals and providing feedback for further improvement is helpful, salary increments can be a bigger motivation to do better.

Quotes:

- (1) “If you if you give them more and some financial benefit, they can perform better than this.” – R1

4.3.2 *Physicians as managers.* In the current scenario, top management board is comprised of non-medical officials who do not clearly understand the problems faced by doctors and medical staff in providing best service to patients. Some respondents raised issues that the top officials take opinion from patients and pass it on to doctors as an improvement area without really understanding why such feedback was given by patients and what are the hurdles in implementing them. Therefore, the general opinion of respondents was that the management must include doctors and medical personnel to improve the healthcare service quality.

Quotes:

- (1) “The second thing is that in the management site or in the administration, there are some of the seats or the some of the positions they are filled by the people who are not capable for their seats. For example, the in the higher level, the directors of the hospital directors. At the end it should be a doctor each. Then he can really understand the medical issues well.” – R9
- (2) “There are three different people who are sort of on board which makes this very unbiased and neutral as well.” – R6
- (3) “The people who are controlling the doctors, they don’t know anything about the medical field. This really it’s not understandable for me because you really have to go deep into the medical field. You should know what limitations be, how this is the problem. The non-medical people, they will not understand the limitations we have, you know.” – R7

4.3.3 *Usage of digital platforms.* Most respondents quoted that their evaluation was done on paper and some were even asked to sign unfilled evaluation forms. This created issues in transparency. On the other hand, 360 evaluation system was followed in few hospitals where appraisees received clear feedback. However, some faced technical issues in 360 evaluation which delayed the process. Also, not all appraisers were well versed with digital platforms. This issue was highlighted by respondents as a training need. Also, digital systems provide the option of reviewing and tracking your own targets and improving performance.

Few respondents also stressed on the importance of using technology for improving efficiency and overall hospital performance. They stressed on the need to be well versed with modern technology apart from just medical knowledge. One respondent also spoke about

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using AI and modern technology for remote analysis of patient reports thereby sharing workload of staff physically present in the hospital. By sharing workload, performance of the team can be improved significantly.

Quotes:

- (1) “If you’re starting work in a modern hospital these days, it’s not enough to come in with a degree and with a bit of practice in your head. You have to be fluent in in your in your computer skills as well as you have to be fluent in your computer linguistic language.” – R8
- (2) “Health care is something that has changed drastically in the last decade with the with the incoming artificial intelligence, with the incoming paperless systems, with the incoming I.T. integration into essential I.T. integration into healthcare, that none of the hospitals can now essentially function without having a proper I.T. system.” – R8
- (3) “If I’m sitting in my home by using the technology, I need not to work physically. I’m going to have to report the images and I have to report the at the X-rays or the future scans which are conducted by my technologies. So if I am, for example, working in my hospital, I can work in places I can work if I use properly the technology.” – R9

## 5. Discussion

The three research questions were developed to receive an insight into the PM in the healthcare of Middle East. There is scarcity in available literature about PM in healthcare in general and in the Middle East in particular. The research questions are also developed to explore the challenges of the appraiser and appraisee for PM and also to understand hindrances faced while effort is being done to improve PM in the department or health facility. Through these research questions, perceptivity of the respondents is also gathered to explore their experiences as appraiser and appraisee, in addition to collecting their recommendations to improve the current PM in healthcare.

Our first research question on how PM is being conducted in the Middle East medical industry and how is it different in comparison to PM in the world. From our findings, it appears that in healthcare a standard PM approach is not visible. Health institutes have developed their own PM standards, criteria and frequency based on their feasibility. Although, JCI endorses standards and frequency of PM in a healthcare organization, but not all entities are following those guidelines and meeting the standards. Overall, the practice of PM and appraisal is not followed to expected standards. It is still in preliminary stages of implementation.

Our second research question explores the challenges faced by the appraiser and the appraisee. Though this study, we highlight the fact that managers are not trained on how PM and are not aware of the process. In a few institutions where the PM process is enforced, appraisees are asked to sign the form which maybe in some cases pre-filled or blank in other cases which only fills an obligation of conducting PM. But appraisees are not given an opportunity to discuss and agree upon the ratings given by the appraiser. Moreover, since there is no face to face discussion, individual feedback is not provided to appraisees and there exists a gap between appraiser’s expectations and appraisee’s performance. Peer review also does not exist in most hospitals and so a formal system of is missing largely in these hospitals.

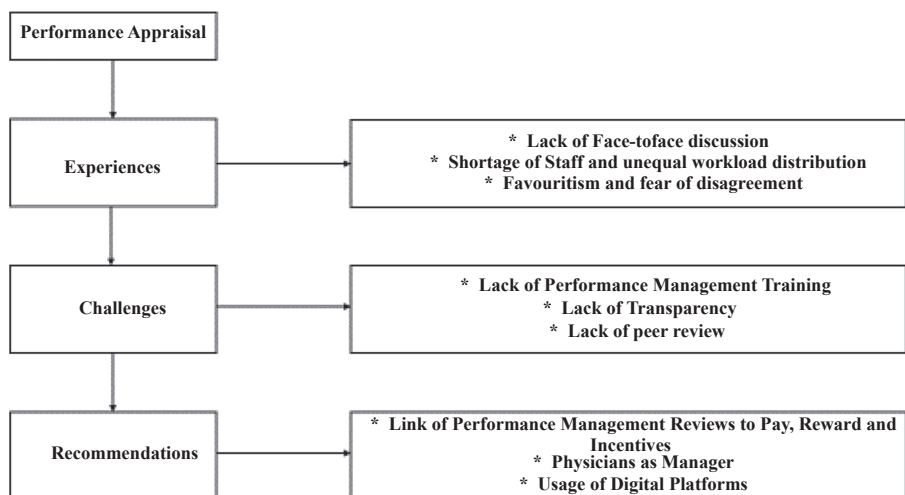
Our third research question focuses on how these challenges can be overcome. First of all, there must be a digital platform to enter KPIs and a yearly plan which can be reviewed mid yearly and annually to track one’s progress. Individuals who achieve their targets and perform exceptionally must be rewarded with bonus and increment to keep up their interest in performing better every year. It is also surprising that, in few hospitals, the top

management comprises executives with non-medical background and are key policymakers. They take feedback from patients and enforce certain rules on doctors which are not implementable. This has direct effect on doctor's performance when not achievable. And yet another major issue that came to forefront was shortage in staff which hauls down individual and team performance. These are some of the suggestions that the top management must take into consideration to improve the overall performance of their medical institutions. Based on the above discussion we develop following model (Figure 1) in the context of the PM in the Middle East medical industry, based on evidence from our respondent's experiences, challenges and recommendations.

### 6. Conclusion, implications and future research

The importance of continuous, credible and bona fide PM cannot be denied. PM not only helps in boosting the employee engagement but also directly affects the employee productivity. The culture of continuous PM creates an atmosphere of responsibility, trust, clarity of expectations and obligations. It also supports in developing a positive relationship between the employee and the organization. This periodic dialogue and exchange of feedback allows the employee to establish clarity of goals and personal development strategies.

The findings of this study conclude that in the Middle East region, the PM in healthcare requires modifications and improvements. The process should be periodic, with clearly defined timelines like quarterly, semi-annually, annually along with weekly or daily interactions as suggested by Varma and Budhwar (2019), which accelerate team collaboration and development and aid in attracting new talent and retaining existing talent. It further helps teams to keep up with changing work goals to stay ahead of the race in global competition. A great emphasis should be placed on transparent, face-to-face and authentic communication. Goal setting should be practiced by, both the management and the clinicians, which will guide the employee and will support the organizational strategy. Direct managers must be involved candidly in the process and should be able to understand the daily operations and patient safety measures in addition to clinical practice. Managers must be trained for conducting the PM. Healthcare should be managed and supervised by the



**Figure 1.** Performance management in the Middle East medical industry experiences, challenges and recommendations

Source(s): Authors' compilation

clinicians or HCPs because they are better able to understand the healthcare system's dynamics and the interdisciplinary complex networks.

Open dialogues during PM should be encouraged and fear of disagreement must be curtailed. PM should be practiced authentically and not just as a formality because it has a direct impact on the delivery of care to the patients. During the PM, emphasis should be more placed on the bigger picture and positive feedback, or critique should be provided, rather focusing on errors and minor mistakes only. The positive effect of continuous feedback and goal setting has been confirmed by [Tripathi, Thite, Varma, and Mahapatra \(2021\)](#) through a study in IT MNEs in India. HCPs are already under pressure and facing burnout more than ever before; thus PM can be used as a tool of motivation and directing HCP toward personal development goals, which are aligned with the objectives of the healthcare institute. Healthcare institutions can adopt one of the strategies defined by [Bartlett and Ghoshal \(1998\)](#) i.e. global strategy, multidomestic strategy, international strategy or a transnational strategy. During the PM implementation, culture and power distance could play an important role ([DeNisi, Murphy, Varma, & Budhwar, 2021](#)). Moreover, host country nationals might also voice concerns if better performance ratings are given to expatriates ([DeNisi, Murphy, Varma, & Budhwar, 2021](#)). Such sensitive situations must be handled professionally by the management. Studies by [Morley, Murphy, Cleveland, Heraty, and McCarthy et al. \(2021\)](#), and [Bader, Bader, Froese, and Sekiguchi \(2021\)](#) conducted in multinational companies globally provide evidence for influence of cultural, legal/political and economic on performance appraisals.

Like any other industry, PM in healthcare should be performed with the scope of ensuring the achievement of wider organizational objectives by encouraging, motivating and aligning HCP with the goals. This approach will not only enable the organizational growth but will also catalyze the trust of HCPs and patients in the healthcare institute. Moreover, performance must be rewarded with incentives and promotions ([Wayne, 2012](#)) since it provides growth opportunities to employees ([Kryscynski, 2020](#)). Lastly, punitive measures for errors by HCP are not encouraged as per healthcare quality standards, and all such situations should be utilized for the planning purpose to mitigate and prevent errors in the future. However, rewarding good behaviors and acknowledging efforts and achieving patient satisfaction should be exercised. Organizations can follow the study by [Yahiaoui et al. \(2021\)](#) conducted in MENA region, wherein PM system was implemented by taking into consideration the socio-cultural values such as emotional relationships between appraiser and appraisee and higher power distance.

Particularly in Middle East healthcare industry, standards for patient safety and delivery of care are being practiced extensively, but the frontliners, HCPs, must also be directed and encouraged through PM. In addition, there is a huge scope of conducting further research in this area where an in-depth analysis should be performed and compared between public and private sectors. Lack of a standard PM process and criteria also demands further investigations and suggestions.

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### Further reading

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**Questionnaire**

Select as applicable: consultant/specialty doctor/associate specialist

Years in current post:

Department:

Please answer the following as best as you can

- (1) Performance can be described as “what doctors do” and includes their activity and quality of their practice. Quality may include clinical competence (both specific to their specialty and overall) and patients’ satisfaction with their work; activity may include number of patients seen and, with respect to their case mix, the time and resources required.
- (2) How do you think individual doctors’ performance is evaluated and managed in your department?
- (3) Have you noticed any change in attitudes towards evaluating and managing specialists’ performance in the past three years? Please comment.
- (4) What stops specialists’ performance being evaluated and managed effectively?
- (5) Do you consider evaluating and managing specialists’ performance to be part of the clinical directors’/clinical leaders’ role? In what way?
- (6) Would you be, or have you been, prepared to address any perceived underperformance or overperformance issues with your colleagues? What would be your concerns?
- (7) If you have received information on your own performance, did you find it useful and could it make you change your practice?
- (8) Who should own performance data and what is your opinion of sharing the data with your colleagues, with the Trust or with the public?
- (9) What could motivate you to work differently? For example, feedback on your performance, financial incentives, increased autonomy etc.
- (10) Any other comments?

(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6460141/table/ut0001/?report=objectonly>)

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