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Behavioural indicators of perceived managerial and leadership effectiveness within Romanian and British public sector hospitals

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Abstract

Purpose – This paper aims to report the results of a replication study of perceived managerial and leadership effectiveness within a Romanian public sector hospital, and to discuss the extent to which they are similar to and different from findings from equivalent studies carried out in two British NHS Trust hospitals.

Design/methodology/approach – Concrete examples (critical incidents) of effective and ineffective managerial behaviour were collected using Flanagan's critical incident technique (CIT). The critical incidents were content analyzed to identify a smaller number of behavioural statements (BSs). These were then compared and contrasted against two British BS data sets using realist qualitative analytic methods, and deductively coded and sorted into extant behavioural categories.

Findings – A total of 57 BSs were identified of which 30 were examples of effective and 27 of least effective/ineffective managerial behaviour. The multi-case/cross-nation comparative analysis revealed high degrees of commonality and relative generalization between the Romanian and British findings.

Research limitations/implications – Data saturation may not have been achieved during the CIT collection phase of the study. The relevance and transferability of the findings to other public sector hospitals in Romania have yet to be demonstrated empirically. The results have potential as "best evidence" to inform and shape "evidence-based HRD" initiatives designed to train and develop effective managers and leaders within the health services sector of Romania and the United Kingdom.

Originality/value – The study is a rare example of indigenous managerial behaviour research in a non-Anglo country. The results lend strong empirical support for universalistic explanations of the nature of perceived managerial and leadership effectiveness.

Keywords Managerial/leadership effectiveness, Behavioural indicators, Cross-nation research, Managers, Leadership, Hospitals, Romania, United Kingdom, Public sector organizations

Paper type Research paper

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Introduction

When searching for evidence in support of empirically-grounded management practice within medicine and the health services sector, Braithwaite (2004) found that although the amount written on management was voluminous, a great deal of its corpus was anecdotal and opinion-based, and few of the reported empirical studies could be translated to hospital clinician-management. He concluded that more grounded behavioural descriptions of the *in situ* world inhabited by clinician-managers were required in order to clarify empirically, and interpret conceptually, how they behave and practice as managers. In examining the concept of managerial effectiveness within the British National Health Service (NHS), Flanagan and Spurgeon (1996) found little reported in the management literature that was relevant, and they called for empirical research to find out what managers believe constitutes effective managerial behaviour. Their call has become even more compelling now that management in the health services sector is not so much about good directing, but more about: exercising effective developmental and influence skills; effectively building trust; ensuring efficient processes, and maintaining quality through rough organizational transitions, all of which require new management and leadership competencies (Dye, 2000; Hartley and Allison, 2000; Zairi and Jarrar, 2001). Yet despite the long established evidence that good leadership and management produce good healthcare, and poor leadership and management generate poor healthcare (Borill *et al.*, 2004; Flowers *et al.*, 2004; Michie and West, 2002), little research has been done to explore effective and ineffective manager/leader behaviour within the NHS (Zairi and Jarrar, 2001).

This is surprising bearing mind "evidence-based medicine" and "evidence-based healthcare" are concepts that are now firmly established and institutionalized in healthcare organizations worldwide (Hamlin, 2010); and considering the numerous calls in the literature for "evidence-based healthcare management" (Axelsson, 1998; Kovner and Rundall, 2005; Stewart, 1998), "evidence-based management" (Pfeffer and Sutton, 2006; Rousseau, 2006) and "evidence-based HRD" (Hamlin, 2002a; Holton, 2004). It is also surprising bearing in mind:

- the rise of evidence-based clinical practice which has led to people questioning how clinician managers and other healthcare managers make decisions and what role evidence plays in the process; and
- the call for a "marriage" between "evidence-based medicine" and "evidence-based management" to achieve sustainable improvement in the delivery, quality, cost and outcomes of healthcare (see Grazier, 2004).

As evidence-based practice becomes further institutionalized within medicine and healthcare, it is likely that HRD professionals operating in the health services sector will increasingly be questioned about how they make their decisions, and what role that evidence plays in the training and development of managers and leaders. Indeed, as Hamlin (2002a) suggested, trainers and developers who fail to use "best evidence" to inform and shape the content of management and leadership development programmes or initiatives, could find themselves severely challenged by healthcare professionals who are themselves strong advocates of evidence-based practice.

In the United Kingdom only a few researchers have conducted managerial behaviour and managerial effectiveness studies within the health services sector (see Alban-Metcalfe and Alimo-Metcalfe, 2000; Barker, 2000; Gaughan, 2001; Hamlin,

2002b; Hamlin and Cooper, 2007; Willcocks, 1997). A similar dearth of studies exists in North America where even fewer researchers have explored managerial and leadership effectiveness within healthcare organizations (see Shipper *et al.*, 1998; Shipper and White, 1999). The only other non-UK managerial behaviour studies in the health services sector that we know of are those of Hamlin *et al.* (2010) and of Hamlin *et al.* (2011). These researchers replicated within an Egyptian and a Mexican public sector hospital Hamlin and Cooper's (2007) study, which replicated in part Hamlin's (2002b) previous healthcare related study. Our inquiry extends this line of replication research into Romania, and for two reasons. First, Romania is an Eastern European country that has gone through several transitions since the fall of communism in 1989: to our knowledge no comparable contemporary indigenous managerial behaviour research has been conducted in that country. Second, Romania is a new entrant to the European Union (EU), and consequently it is desirable to know whether people's perceptions of managerial and leadership effectiveness are the same or different to those in other EU countries. Our inquiry has three aims. The first is to identify what it is that people within the Romanian public health services sector perceive as effective and ineffective managerial behaviour. The second aim is to compare and contrast these findings against Hamlin's (2002b) and Hamlin and Cooper's (2007) findings, and to identify similarities and differences across the three organizations and two countries. In so doing, our article is responding to various calls for more empirical research on the behavioural determinants of managerial and leadership effectiveness (see Barker, 2000; Cammock *et al.*, 1995; Noordegraaf and Stewart, 2000; Yukl *et al.*, 2002), and also to Tsui's (2004) call for single country indigenous research in non-North American and non-Western European countries to expand global management knowledge. The third aim of our study is to extend the small extant body of general knowledge and "best evidence" relating to managerial and leadership effectiveness in support of "evidence-based management" and "evidence-based HRD" within the field of medicine and healthcare.

Our article is structured as follows. Following a brief introduction to the literature on past managerial and leadership behaviour research, we outline our theoretical approach and the research questions. We then discuss our methodology, including the data collection and analysis methods, and the approach used to ensure the trustworthiness of our findings. Following the presentation of our results, we discuss their implications for research and practice, before concluding with the limitations and directions for further research.

Review of the literature

Past managerial and leadership behaviour studies

Many researchers from the 1950s through to the mid-1980s conducted managerial behaviour studies, but few attempted to differentiate between what Hales (1986) refers to as "good" and "bad" management. Instead, most explored the frequencies and duration of managerial activities (Martinko and Gardner, 1985), and used different types of definitions, predictors and measurement criteria of managerial effectiveness (Goodman *et al.*, 1983). This led to Stewart (1989) complaining about the lack of comparability between such studies, which she concluded was caused by the haphazard and arbitrary coding of managerial behaviours and the use of unclear and confusing mixes of coding categories. Consequently, she argued researchers should

free their minds of existing categories and adopt other approaches. But with the exception of Borman and Brush (1993) who produced a "taxonomy of managerial performance requirements" based on dimensions derived from critical incidents and job activity statements reported in 19 unpublished and seven published studies, few other researchers have followed Stewart's suggestion. Consequently, the issue of managerial effectiveness remains a substantially neglected area of management research (Flanagan and Spurgeon, 1996; Noordegraaf and Stewart, 2000; Willcocks, 1992), and there continues to be little agreement about what constitutes and is meant by managerial effectiveness (see Barker, 2000; Cammock *et al.*, 1995; Kim and Yukl, 1995).

A similar situation exists in the area of leadership behaviour research. Most past studies have been focused on a single level of analysis using pre-determined behavioural dimensions and survey instruments; and more often than not these have measured attitudes about leader behaviour rather than actual observed behaviour and their effectiveness (Conger, 1998). Furthermore, as Conger claimed, typically the questionnaire items have been generalized across a variety of contexts, and expressed in such broad terms that a useful richness of detail has often been missing: researchers have then ended up measuring the presence and frequency of static terms and have failed to advance understanding of the deeper structures of leadership. Other writers have bemoaned the fact that little effort has been made to confirm the results of evaluation studies of leader behaviour with alternative approaches to survey-based methods, and have complained about the positivist bias and predominant use of survey tools (see Alvesson, 2002; Avolio *et al.*, 1999; Den Hartog *et al.*, 1997). Thus, despite the large amount of empirical research on effective leadership behaviour, there is still a lack of agreement about which behaviour categories are relevant and meaningful for leaders (Yukl *et al.*, 2002). Our study goes some way towards addressing these concerns and criticisms of past managerial and leadership behaviour research.

Theoretical framework

Two theories have provided the theoretical framework guiding our study, namely Implicit Leadership Theory (ILT) and the Multiple-Constituency Model (MC) of organizational effectiveness.

Implicit Leadership Theory (ILT). According to ILT, individuals have beliefs, convictions and assumptions about the attributes and behaviours that distinguish effective managers/leaders from ineffective managers/leaders (Eden and Leviatan, 1975). And they use these implicit theories to encode, process, and recall specific events and behaviour (Shaw, 1990). Phillips and Lord (1981) have demonstrated that ILT can best be understood in terms of cognitive categorization processes. These processes involve the classification of non-identical perceived stimuli into categories or groups based on similarities with stimuli in the same category, and on differences with stimuli in other categories (Rosch, 1978). The classification of a large number of stimuli into a smaller number of categories permits symbolic representation of the world in terms of the labels given to the categories, and allows for communication and exchange of information about the categorized entities (Cantor and Mischel, 1979) Resulting from such cognitive categorization processes subordinates/followers hold implicit cognitive prototypes of managers/leaders; and managerial and leadership behaviours are perceived and judged in terms of their fit with these implicit prototypes (Cantor and

Mischel, 1979; Cronshaw and Lord, 1987; Foti and Luch, 1992). The better the fit between managerial/leader behaviour and the internal managerial/leadership prototypes held by subordinates/followers (the perceivers), the more the likelihood of the concerned behaviour being seen as effective. Additionally, subordinates/followers' perceptions of managerial and leadership behaviours and cognitive prototypes are thought to be developed and influenced by the organizational environment and situation (Gerstner and Day, 1994), and by the national culture (Helgstrand and Stuhlmacher, 1999). This implies that subordinates/followers from different cultural backgrounds may perceive different levels of managerial and leadership effectiveness from the same manager/leader, because of the different prototypes that are guiding their expectations (Chong and Thomas, 1997). Any discrepancy between subordinates/followers' implicit leadership theories and those of their respective managers/leaders may result in dissatisfaction, disengagement, and increased employee turnover (Engle and Lord, 1997).

Multiple Constituency Model (MC). According to Tsui (1990) the central tenet across all variants of MC is that an organization is effective to the extent it satisfies the interests of one or more constituencies/stakeholders associated with the organization. Furthermore, she argued that the social/behavioural test of effectiveness at the unit level is comparable to the MC approach at the organizational level. Similarly, we argue that the social/behavioural test at the level of individual managers/leaders is comparable to the MC approach at the subunit level. Using the MC approach in the context of managerial behaviour research, managers/leaders are perceived as operating within a social structure consisting of multiple constituencies/stakeholders (e.g. superiors, peers, subordinates), each of whom has his or her own expectations of and reactions to the manager/leader (Tsui, 1984). These perceptions and judgments are influenced by their respective implicit leadership theories and implicit cognitive prototypes of effective and ineffective behaviour. Hall *et al.* (2004) have claimed that employees' perceptions of and satisfaction with their respective managers/leaders can affect positively or negatively their attitude, which in turn can determine how they perform and affectively engage with the organization. Indeed, numerous studies have shown that managerial success is defined in terms of either employees' attitudes, or managerial performance, or both (see Shipper and Davy, 2002), and that the level of satisfaction with the manager/leader is a critical factor. For example, from their review of 147 studies of the determinants of "managerial success", Eagly *et al.* (1992) demonstrated that "satisfaction with the manager" was the dependent variable in 74 per cent of the studies and "managerial performance" in 58 per cent of them. These findings support Tsui and Ashford's (1994) contention that how managers/leaders are perceived to behave cause subordinates either to follow or ignore their leadership, and cause their superiors, peers and other key stakeholders to give or withhold important resources such as information and co-operation. Clearly, least effective or ineffective managerial and leadership behaviours which lead to dissatisfaction on the part of key stakeholders, and lack of engagement on the part of employees, can severely damage a manager/leader's reputational effectiveness, which in turn can lead to a perception of managerial failure. According to Tsui (1984), specific managerial behaviours that are instrumental for gaining [or losing] reputational effectiveness will vary by a manager/leader's constituencies/stakeholders. And, therefore, they will be idiosyncratic and contingent depending on the specific organizational context.

However, the aforementioned replication studies of perceived managerial and leadership effectiveness within public sector hospitals by Hamlin and his various co-researchers in the United Kingdom and in various other countries, suggest that the managerial behaviours manifested in these different organizational settings and societies are far more "generic" than "context-specific".

Purpose and research questions

Our brief review of the extant literature suggests that there remains a lack of clarity and agreement as to what behaviourally differentiates effective managers/leaders from ineffective managers/leaders. Thus, more empirical research is warranted to find out what people within and across managerial levels, organizations, organizational sectors and countries perceive as effective and as ineffective managerial behaviour. In the absence of clear and unequivocal dimensions of managerial performance, including behavioural effectiveness criteria against which managerial performance can be measured, managers/leaders will operate and behave on the basis of their own individual personal preferences. As Flanagan and Spurgeon (1996) argued within the context of the British NHS, "we need to find out the criteria, dimensions, and characteristics they [managers/leaders] use that influence both their own behaviour and lead them to view others as effective or otherwise" (pp. 44-45). Thus, within the organizational context of the public health services sector in Romania, our study addressed two research questions as follows:

RQ1. How are the behavioural indications and contra-indications of perceived managerial and leadership effectiveness manifested within the collaborating Romanian hospital?

RQ2. How do the behavioural indicators resulting from *RQ1* compare against equivalent findings from past replication studies carried out in two British NHS Trust hospitals?

Methodology

This section describes the methods used for conducting our research, and the approaches we deployed for ensuring the trustworthiness of our findings.

Research methods

We assumed a post-positivist ontology and realist epistemology (Madill *et al.*, 2000; Ponterotto, 2005), and we conducted the study in three stages as follows:

(1) *Collecting critical incidents*. Following the example of Hamlin (2002b) and Hamlin and Cooper (2007) in the United Kingdom, Flanagan's (1954) critical incident technique (CIT) was used for the collection of concrete examples (critical incidents) of effective and ineffective managerial behaviour, as observed and so judged by managers and non-managerial staff within the collaborating public sector hospital. Hamlin (1988) selected CIT for his first and subsequent behavioural studies of managerial and leadership effectiveness because it was regarded by experts to be one of the best methods for focusing on the more important effectiveness and performance aspects of managerial behaviour (see Campbell *et al.*, 1970; Latham and Wexley, 1981). Other experts have gone further by claiming CIT is perhaps the best technique for sampling

important performance-related managerial behaviour (Borman and Brush, 1993), and for conducting multiple-case/cross-nation studies in search of evidence of commonalities in themes ("incidents") in order to increase the generalizability of research findings (Chell, 1999).

(2) For this first stage of our study the critical incidents were collected by a native Romanian student of Author 2 as part of her studies for an MA in International Business degree at a French business school. Prior to collecting the CIT data the student was introduced and trained in the use of the technique by Author 2, and received additional guidance and support from Author 1 regarding her application of the common CIT protocol used by Hamlin and Cooper (2007). All of her CIT interviews were conducted in the Romanian language, mostly face-to-face, but a few by telephonic means and/or via emails. Prior to each interview the participant was told the purpose of the research, the potential benefit to the hospital; what was hoped to be achieved through the CIT interview; what was meant by certain key terms that would be used-namely "critical", "incident" and "critical incident"; what the participant would be asked at the interview and how to prepare for it; and the academic code of ethics that would be applied. Participants were also briefed on the following two definitions:

> Effective managerial performance is: "behaviour which you wish all managers would adopt if and when faced with a similar circumstance"
>
> Ineffective managerial performance is: "behaviour which, if it occurred repeatedly, or was seen once in certain circumstances, might cause you to begin to question or doubt the ability of that particular manager in that instance".

(3) Typically the CIT interviews lasted between one and one-and-a-half hours. During this time each participant was invited to offer up to ten critical incidents (CIs) of managerial behaviour that they had personally observed during the previous six months or so. However, participants who were in managerial positions were not allowed to offer examples describing their own practice as managers/leaders. Furthermore, a strict code of anonymity was applied so that the identity of the particular managers/leaders, whose behaviours were the focus of the critical incidents being described, were not revealed to the researcher. In most CIT interviews a roughly equal number of positive (effective) and negative (ineffective) CIs were collected from each interviewee. In total 346 CIs were obtained from the 36 participants. Of these CIs, 33 were considered unsuitable for analysis because of insufficient development, unclear meaning, or because they were focused on non-behavioural factors. The remaining 313 CIs were translated from Romanian into English by the student/researcher who was fluent in both languages.

(4) *Deriving behavioural statements*. This second stage was carried out predominantly in the United Kingdom by Author 1 who is a native English speaker. The "unit of analysis" was the critical incident. The 313 translated CIs were first checked for accuracy/clarity of meaning. Where doubts occurred they were resolved through critical examination and discussion with Author 2 whose first language is English, and through her with the Romanian student/researcher. This resulted in certain refinements being made to

improve the quality of the English describing various CIs whilst retaining the same substantive meaning. It also led to 61 CIs being set aside because of a perceived ambiguity in the English translation, or lack of transparency regarding the causal link between specific managerial behaviours and the described consequences and outcomes. Of the remaining 252 usable CIs, 127 were examples of positive (effective) managerial behaviour, and 125 of negative (least effective/ineffective) managerial behaviour. These CIs were then subjected to inductive thematic analysis (Braun and Clarke, 2006). Open coding and a form of "summarizing" and "structuring" content analysis were used at the semantic level (Flick, 2002) to search for evidence of "sameness", "similarity" or "congruence of meaning". *Sameness* existed when the sentences or phrases used to describe two or more CIs were identical or near identical. Similarity existed when the CI sentences and/or phrases were different, but the kind of meaning was the same. Congruence existed where there was an element of sameness or similarity in the meaning of certain phrases and/or key words. When such commonality of meaning was found, the CIs were clustered accordingly. In accordance with the research procedure used by Hamlin and his previous co-researchers, each cluster was comprised of a minimum of three and a maximum of around ten critical incidents. Each cluster or sub-cluster was then subjected to analysis and interpretation so that a behavioural statement (BS) could be devised which reflected the meaning held in common to all of its constituent critical incidents. A total 57 BSs emerged from this process, of which 30 related to effective and 27 to least effective/ineffective management/leadership.

(5) *Multiple cross-case/cross-nation comparative analysis.* This third stage was conducted jointly by Author 1 and Author 2. The derived Romanian BSs were compared and contrasted against equivalent sets of British BSs identified by Hamlin (2002b) and Hamlin and Cooper (2007) respectively. Hamlin's (2002b) study, which had been carried out in an "acute" NHS Trust hospital, had resulted in 405 usable CIs being collected from 57 CIT informants. From these CIs a total of 67 BSs were identified, of which 30 were examples of positive (effective) and 37 of negative (least effective/ineffective) managerial behaviour. In contrast, Hamlin and Cooper's (2007) study, which had taken place within a "specialist" NHS Trust hospital, had resulted in 467 usable CIs being obtained from 60 CIT informants. From these CIs a total of 49 BSs were identified, of which 25 were examples of positive (effective) and 24 of negative (least effective/ineffective) managerial behaviour. The analytic method used for this stage of the study was "realist qualitative [comparative] analysis" (Madill *et al.*, 2000, p. 9): a variant of open coding which we applied inductively and deductively within a grounded theory mindset (Flick, 2002; Miles and Huberman, 1994; Strauss and Corbin, 1990).

Ensuring the trustworthiness of findings

Whenever the student/researcher had doubts during a face-to-face or telephone interview she clarified these with the CIT interviewee right there and then in order to ensure the internal validity (credibility) of her collected CIT data. The BSs derived by Author 1 from the set of translated Romanian CIs were checked by Author 2. Where

differences of judgment occurred regarding the group of CIs underpinning a particular BS, these were resolved through a process of joint analysis and discussion. For the multiple cross-case/cross-nation comparative analysis, a form of investigator triangulation (Easterby-Smith *et al.*, 1991) was used to ensure internal validity (credibility) and reliability (dependability). Initially, Author 1 independently conducted the comparative analysis whereby the BSs of the two British data sets were coded, sorted, and mapped against the identified Romanian BSs. This analysis was then checked by Author 2 to verify the consistency of meaning across the compared, contrasted and juxtaposed BSs (Madill *et al.*, 2000). Where disagreement with Author 1's judgments occurred, consensus was reached after critical examination and in-depth discussion. Issues of plausibility (confirmability) and external validity (transferability) were addressed through the use of multiple data sources and multiple cross-case processes. The result was mutual validation of the compared replication studies, and an empirical demonstration of the generalizability of findings across the three cases.

Results and findings

Thirty positive (effective) behavioural statements (BSs) resulted from the analysis of the collected CIT data. These are listed in the left hand column of Table I. They can be regarded as the behavioural indications of perceived managerial and leadership effectiveness applying within the Romanian hospital. As can be seen, they have been juxtaposed against equivalent British BSs that are the same, similar, or somewhat congruent in meaning, and thus convergent to a greater or lesser extent. High Convergence was deemed to exist when the sentences or phrases used to describe the BSs were the same or near identical in meaning. Moderate Convergence was deemed to exist when the BS sentences and/or phrases were different but the kind of meaning was similar. Low Convergence was deemed to exist where there was just an element of congruent meaning in certain phrases and/or key words describing the behavioural statements. And No Convergence was deemed to exist where there was insufficient evidence of congruent meaning across any of the Romanian and British behavioural statements. To distinguish between the two British studies, the "specialist" NHS Trust hospital data has been typed in *italics*. The British BSs that are underlined are those that converge in meaning with more than one Romanian behavioural statement. As can also be seen in Table I, the juxtaposed Romanian and British BSs have been thematically grouped into behavioural categories. This was achieved deductively using coding categories derived from the descriptive labels of the behavioural criteria and criterion components constituting Hamlin's (2004) public sector related "generic model" of managerial and leadership effectiveness. Adopting this procedure was deemed appropriate because the "generic model" had been derived in part from the findings of one of the two British studies that we have used for our research, namely Hamlin's (2002b) acute NHS Trust hospital study.

A total 18 of the 30 (60.0 per cent) positive Romanian BSs are at least the same as one BS from either one or more positive BSs resulting from the Hamlin (2002b) and/or Hamlin and Cooper (2007) studies. Four of the 30 (13.3 per cent) are quite similar in meaning, and another 2 (6.7 per cent) contain a single element of congruent meaning. Overall 80.0 per cent ($n = 24$) of the positive Romanian BSs overlap with equivalent British behavioural statements. Conversely, 90.0 per cent ($n = 27$) of the "acute" NHS Trust hospital BSs, and 92.0 per cent ($n = 23$) of the "specialist" NHS Trust hospital

Romanian study	British studies
	Acute NHS Trust Hospital BSs ($n = 30$)
Public Sector Hospital BSs ($n = 30$)	Specialist NHS Trust Hospital BSs ($n = 25$)
Effective organization and planning/Proactive management	
High convergence	*High convergence*
(1) Reacts quickly and calmly to changing and/or stressful situations, and to staff problems, and is quick to take action and/or provide answers	Responds quickly and appropriately to staff/work problems. Takes control of difficult situations and deals with them quickly and appropriately. Recognizes problems and takes the necessary action. *Responds quickly and appropriately to staff work problems. When problems occur he/she deals with them quickly and fairly*
	Moderate convergence
	When staff are in conflict with one another, encourages them to reconcile their personal differences and work through problems with each other.
	Low convergence
	When faced with urgent or difficult problems/ situations is good at making decisions and following them through and keeping promises. *Deals with personal and difficult situations with sensitivity*.
High convergence	*High convergence*
(2) Anticipates trends and potential problems, and introduces preventive measures or innovations as appropriate	*Recognizes and acts appropriately when things are going wrong*
	Moderate convergence
	Thinks ahead and ensures things are done in good time, prepares well for situations and contingencies
High convergence	High convergence
(3) Recognises and finds solutions to problems, and takes the necessary action to reduce or eliminate them	Recognizes problems and takes the necessary action. *Recognizes and acts appropriately when things are going wrong*
High convergence	*High convergence*
(4) Sets and agrees priorities/objectives for/with staff, and gives them clear future direction for their daily work	*Develops a long-term strategy with his/her team members and communicates objectives to staff*. Develops a long term departmental strategy and plan which provides clarity regarding the overall purpose, the roles, goals and targets of all individuals in the department
High convergence	High convergence
(5) Demonstrates good planning, organization, and control of work/projects for self and staff; establishes work priorities, deadlines and priority resource needs, and monitors progress	Develops a long term departmental strategy and plan, which provides clarity regarding the overall purpose, the roles, goals and targets of all individuals in the department. Thinks ahead and ensures things are done in good time, prepares well for situations and contingencies. *Plans ahead so that work can be carried out effectively*

(*continued*)

Table I.
Comparison of the Romanian and British positive (effective) behavioural statements

Romanian study	British studies
	Moderate convergence Uses resources well to aid decision making (e.g. drawing in different disciplines and expertise; hand picks best person for the role; uses research evidence to aid decisions) *Low convergence* *Uses resources well (e.g. brings in people to assist in times of pressure; chooses the best person for the job)*
High convergence (6) Convenes and chairs meetings with staff that are well prepared and organized; ensures all important agenda items are discussed in a time efficient manner, and facilitates very direct and easy exchanges of view between those attending *No convergence* (7) Invests in new equipment and materials that can lead to better staff/organisational performance and improvement in the service delivered to patients	*High convergence* Prepares and organizes well for meetings. Runs meetings efficiently and effectively. *Prepares well for meetings so that his/her meting is run effectively and efficiently* No convergence When making decisions or presenting an argument/case gathers and assesses all the relevant facts and judges things on their merits
Participative and supportive leadership *High convergence* (8) Encourages staff to achieve high performance, and congratulates and gives encouragement when they deliver good results or their best efforts	*High convergence* Thanks people and gives praise for a job well done. *Values the work of his/her team and acknowledges work completed to a high standard*
High convergence (9) Shows appreciation and says "thank you" when members of staff perform well	*High convergence* Thanks people and gives praise for a job well done. *Values the work of his/her team and acknowledges work completed to a high standard*
Moderate convergence (10) Reacts quickly and gives help (answers) to staff experiencing problems	*Moderate convergence* When staff are under particular pressure, or confronted with particularly difficult situations and/ or decisions, is willing to "muck in" and provide both practical and emotional support *Assists other staff at busy times*
Low convergence (11) Ensures all staff are treated fairly and equitably *No convergence* (12) Rewards staff when they perform well, deliver better results, and/or achieve excellent results (13) Arranges periodic performance review meetings with every member of staff (or sends them a written progress report) in order for them to receive useful feedback (14) Exhibits personal credibility, charisma and competence (15) Proactively collaborates and/or develops partnerships with the hospital's suppliers [on projects]	*Low convergence* *When problems occur he/she deals with them quickly and fairly*

Table I.

(*continued*)

Romanian study	British studies
Empowerment and delegation	
High convergence	*High convergence*
(16) Empowers staff by giving them freedom to make their own decisions, to use their own initiative and to innovate, and by giving them more important or challenging tasks	Gives staff the freedom and support to perform their own work in the way they see fit and to address their own problems in their own area. *Gives staff freedom and flexibility in performing their duties*
High convergence	High convergence
(17) Readily delegates to staff important tasks/ projects that require high degrees of responsibility, and shows confidence and trust in their capabilities	He/she delegates; is effective when delegating roles and responsibilities. *Positively delegates work to staff (e.g. is fair in delegating work, not just the "dirty" work)*
Genuine concern for people	
High convergence	*High convergence*
(18) Gives help and support to staff confronted with difficult situations	Gives time to listen to staff with problems or worries relative to work or personal issues *Listens to staff when they are overworked and helps to provide solutions Assists other staff at busy times Listens to staff on personal issues and acts to support the member of staff* *Low Convergence Deals with personal and difficult situations with sensitivity* Deals with difficult and personal issues with sensitivity
Moderate convergence	*Moderate convergence*
(19) Adopts a flexible/adaptable approach to dealing with changing situations and/or staff with different motivational drivers	*Works with staff to support flexible working practice (e.g. permits the rearrangement of workload/pattern in line with staff members' personal circumstances)*
Looks after the interests and development needs of staff	
High convergence	*High convergence*
(20) Encourages and supports staff in their learning, training and self-development, and takes action to address their specific needs	Gives support to staff in developing and progressing their careers (e.g. facilitates and supports career development and progression of staff; ensures staff get adequate time to update their knowledge; gives support in projects and encourages managers to learn and develop). *Supports staff in identifying and finding development opportunities. Ensures staff have the confidence and ability to perform required tasks (e.g. supports staff who require additional skills)*
Moderate convergence	*Moderate convergence*
(21) Organizes induction training for new starters and/or ensures it takes place	Gives support to staff in developing or progressing their careers (e.g. facilitates and supports career development/progression of staff; ensures staff get adequate time to update their knowledge; gives support in projects and encourages managers to learn and develop) *No convergence*

(*continued*)

Table I.

Romanian study	British studies
	Promotes the importance and needs of his/her own department *Publicizes and promotes good news stories to the rest of the NHS Trust staff. Actively promotes the [good] work of his/her staff and department*
Open and personal management approach *High convergence* (22) Is open to staff, listens to their suggestions, and encourages them to make suggestions	*High convergence* Is approachable and makes him/her self readily available to staff (e.g. adopts open door policy; always got time to listen). Exhibits willingness to listen to the ideas of staff, and gives backing and support. *Makes time to talk to staff (e.g. engenders a feeling of value in staff by showing an interest in their work)* *Low convergence* Develops a sense of trust with staff (e.g. ensures staff can talk to him/her on matters of confidentiality; does not break confidences). *Listens to staff when they are overworked and helps to provide solutions*
Low convergence (23) Gives honest and immediate feedback to staff on their work, performance, and/or on problematic issues confronting them, and exhibits honesty and integrity in all other dealings with people	*Low convergence* Develops a sense of trust with staff (e.g. ensures staff can talk to him/her on matters of confidentiality; does not break confidences)
	Uses a personal approach to leadership (e.g. develops a sense of trust) Develops trusting relationships with his/her staff (e.g. does not break confidences of staff) *No convergence* Uses a personal approach to leadership and takes the time to get to know staff on a personal level
Inclusive decision making *High convergence* (24) Responds/gives consideration to and takes into account the suggestions of their staff; additionally, implements these suggestions as appropriate	*High convergence* Exhibits willingness to listen to the ideas of staff and gives backing and support
	Moderate convergence *Makes time to talk to staff (e.g. engenders a feeling of value in staff by showing an interest in their work). When making decisions, gathers the facts and considers the views from other members of staff*

Table I.

(*continued*)

Romanian study	British studies
High convergence (25) Involves staff in decision making	*High convergence* Involves staff in decision making wherever possible. Adopts a team approach to problem solving and decision making (e.g. involves all staff including support staff). In the planning of change he/she involves staff in discussions and decision making. Consults with relevant staff and actively finds out their opinions before making or implementing a decision. *Involves staff in decision making where appropriate Develops a long term strategy with his/her team members and communicates objectives to staff*
High convergence (26) When planning a change or deciding matters that affect staff, collaborates with them to arrive at the most effective decision	*High convergence* In the planning of change he/she involves staff in discussions and decision making. In change situations he/she proactively canvasses and listens to the opinions of his/her staff, seeks their ideas/suggestions and invites them to voice any concerns or fears they may have. *When making decisions, gathers the facts and considers the views from other members of staff* *Moderate convergence* Consults with relevant staff and actively finds out their opinions before making or implementing a decision
Communicates and consults widely/Keeps people informed	
High convergence (27) Keeps staff up-to-date and informed on new hospital policies, procedures, rules and objectives, and any other organizational changes that might affect them at work	*High convergence* Keeping staff and colleagues regularly informed and up to date on what is happening and on matters directly affecting them. *Keeps staff informed of the NHS Trust business*
High convergence (28) Holds periodic meetings with team and individuals to clarify or discuss issues needing attention or solution and to exchange views	*High convergence* Holds regular meetings and/or team briefings with his/her team
Moderate convergence (29) Communicates very clearly and openly with staff	*Moderate convergence* Keeping staff and colleagues regularly informed and up to date on what is happening and on matters directly affecting them *Low convergence* Holds regular meetings and/or team briefings with his/her team
No convergence (30) Organizes and/or actively participates in weekly inter-service meetings to share/-exchange ideas and suggestions with colleague managers on making service quality improvements, and improving inter-departmental collaboration	

Table I.

BSs converge in meaning to a greater or lesser extent with the Romanian behavioural statements. Although 20.0 per cent ($n = 6$) of the positive Romanian BSs appear at a semantic level not to overlap sufficiently in meaning with any of the British BSs to be considered convergent, they all describe managerial behaviour indicative of managers giving necessary technical/personal support to staff, or taking action that leads to employees performing to standard. None of the key words and phrases of these six divergent ("no-convergence") BSs suggest they are specific to the Romanian hospital context or culture.

Twenty-seven negative (least effective/ineffective) BSs emerged from the analysis of the collected Romanian CIT data. These are listed in the left hand column of Table II. They can be regarded as the behavioural contra-indications of perceived managerial and leadership effectiveness applying within the Romanian hospital. As can be seen, they have been juxtaposed against equivalent British BSs and thematically grouped into behavioural categories. The same procedures were adopted as for the positive behavioural statements.

Of the 27 (62.96 per cent) negative Romanian BSs, 17 are the same or near identical in meaning, and six (22.22 per cent) are similar in meaning with at least one of the negative (ineffective) BSs from one or both of the British studies. The other four (14.81 per cent) do not converge in meaning with any of the British negative BSs. Overall, 85.19 per cent ($n = 23$) of the Romanian negative BSs are to a greater or lesser extent held in common with the equivalent British findings. Conversely, 86.49 per cent ($n = 32$) of the "acute" NHS Trust hospital BSs, and 79.17 per cent (n = 19) of the "specialist" NHS Trust hospital BSs overlap with the Romanian behavioural statements. Of the four Romanian negative BSs that are divergent ("no convergence") only one of them appears to be context-specific to the collaborating Romanian public sector hospital, namely the behavioural statement: "Exhibits reluctance or fails to develop or enhance a long term relationship with the [hospital's] suppliers". The reason for this BS being perceived and judged an example of least effective or ineffective managerial behaviour may be because of the government funding constraints or other factors pertaining within the Romanian national context at the time the CIT data were collected. Nothing in the descriptive labels of the other three "divergent" negative BSs suggest they are culture-specific, and thus likely to be observed within Romanian organizations only.

In summary, we found very high degrees of sameness and similarity between peoples' definitions of perceived managerial and leadership effectiveness within the Romanian and British public sector hospitals. Of the overall number ($n = 57$) of Romanian positive and negative BSs, 82.46 per cent ($n = 47$) appear to be convergent with the British BS data. Conversely, of the overall number ($n = 116$) of British positive and negative BSs, 87.07 per cent ($n = 101$) appear to be convergent with the Romanian BS data. Overall, our research findings suggest that in both Romanian and British hospital settings managers are perceived effective by their superiors, peers and subordinates when they "exhibit good organization and planning; proactively manage performance" and "solve problems quickly; lead their staff in an actively supportive manner; delegate well" and "empower their staff"; and "show genuine care and concern for staff when faced with personal difficulties". Additionally, managers are perceived effective when they "look after the interests and development needs of their staff; involve them in decision making; adopt an open, personal and trusting approach"; and

Romanian study	British studies
Public Sector Hospital BSs ($n = 27$)	Acute NHS Trust Hospital BSs ($n = 37$) Specialist NHS Trust Hospital BSs ($n = 24$)
Shows lack of consideration or concern for staff	
High convergence (1) Shows a lack of care, concern and consideration for the well being of their staff	*High convergence* Places unrealistic workloads/expectations on self and his/her staff (e.g. setting unreachable targets and objectives; allowing work overload). When staff are off sick or are away from the unit for several days he/she fails to ensure adequate staff cover *Gives [staff] insufficient time to complete jobs (e.g. sits on [allocating] a job until it is critical and then demands the job to be completed in a rush)* *Moderate convergence* *Does not consult when giving out additional work (e.g. just expects individual [staff member] to "drop everything" in order to complete the particular [extra] task)* *Low convergence* *Criticizes members of staff in front of other members of staff. In meetings criticizes or acts in a negative way towards staff. In staff meetings humiliates members of staff (e.g. breaks confidential news)*
Moderate convergence (2) Fails to give sufficient advance notice of meetings he/she convenes	*Moderate convergence* Fails to inform or notify the right people at the right time
No convergence (3) Cancels/postpones planned meetings at last minute arrangements	
Ineffective autocratic or dictatorial style of management	
High convergence (4) Exhibits autocratic/authoritarian/ – distant behaviour and/or is reluctant to delegate	*High convergence* Forces or imposes change upon people without collaboration or consultation. Adopts an authoritarian, autocratic or dictatorial style of management. Makes and implements decisions regarding changes that affect staff without any discussion with them *Moderate convergence* Does not consult with staff regarding planned changes in staffing, structure, systems and/or working environment *Low convergence* *Overrules decisions made by staff (e.g. humiliates the member of staff who has made the decision* (*continued*)

Table II.
Comparison of the Romanian and British negative (least effective/ineffective) behavioural statements

Romanian study	British studies
High convergence (5) Fails to explain and given reasons to staff regarding changes that affect them in the workplace	*High convergence* Neglects to inform own and/or other staff of things that are going to happen in or around their workspace or elsewhere on site that might affect them personally. Fails to give advance notice and forewarn staff of activities that potentially disrupt the running of the department/unit. *Does not inform staff of changes that are to be made*
Uncaring self serving management *High convergence* (6) Treats staff unfairly, unequally and/or with favouritism regarding such matters as the granting of wages and bonuses, approving requests, providing training/ promotion opportunities, and/ or making judgments about people	*High convergence* Is inconsistent and/or unfair in his/her dealings or handling of people *Does not treat staff equally (e.g. unfairly praises staff when not deserved)*
High convergence (7) Exhibits an inability to admit his/her own mistakes, or when he/she is wrong	*High convergence* Refuses to admit to their own mistakes or errors in judgment and instead blames others. *Refuses to admit mistakes or failings*
High convergence (8) Exhibits selfish or self-serving behaviour at the expense of his/her staff	*High convergence* Exhibits manipulative, politicking and undermining behaviour (e.g. saying one thing but doing another; using delaying tactics; playing one person/group off against another) *Moderate convergence* Failing to be open, honest, forthright, or up-front in their communications and dealings with people. Ignores hospital policies/rules and attempts to by-pass the system. *Asks a member of staff to stay late to complete a task to meet a deadline but is not prepared to stay over and help. Disregards policy (e.g. makes decisions to meet own needs) Fails to follow policies and procedures Fails to be open and honest with staff and "plays one member of staff off against another"* *Low convergence* Fails to follow correct and/or appropriate procedures. Overrides colleague managers, goes behind the back of or over the heads of other managers, and/or omits to use the proper lines of management communication
Undermining, depriving and/or intimidating behaviour *High convergence* (9) Fails to communicate and inform or share with staff essential information or details relating to external/internal driven changes in working practices that they need to know about to perform their jobs effectively	*High convergence* Fails to impart or supply accurate, reliable, consistent, up to date information. Failing to pass on or share information with staff or colleagues and/or keeping them abreast of important news. *Does not inform staff of changes that are to be made*

(*continued*)

Table II.

Romanian study	British studies
	Moderate convergence Neglects to inform own and/or other staff of things that are going to happen in or around their workspace or elsewhere on site that might affect them personally. Fails to give advance notice and forewarn staff of activities that potentially disrupt the running of the department/unit. Fails to inform or notify the right people at the right time
High convergence (10) Fails to support or guide staff when they need help on and/ or require key information for new tasks or projects	*High convergence* Gives little or no support/instruction/training to staff in change situations. *Gives little or no support to staff Does not support staff in difficult positions [situations] (e.g. would not back up staff member who was being harassed by a member of the public) Fails to recognize when staff member is struggling with his/her tasks*
High convergence (11) Takes little or no interest or action in inducting, training and developing his staff/team	*High convergence* Does not give staff the opportunity or sufficient time to train and/or develop themselves. Gives little or no support, instruction, or training to staff in change situations
High convergence (12) Meets insufficiently with staff and/or is not readily available to them to discuss matters either relating to their work or personal issues/problems	*High convergence* In designing/planning for the relocation of departments/services to other buildings/locations fails to consult with staff (and/or with support staff) and take into account their views/needs *Moderate convergence* Does not consult with staff regarding planned changes in staffing, structure, systems and/or working environment
Moderate convergence (13) In giving staff feedback focuses solely or too much on their weaknesses and negative performance	*Moderate convergence* Undermines or dismisses the efforts of staff (e.g. dismissive in dealing with staff ideas, makes cutting remarks; appears uninterested, does not give adequate feedback to the individual). *In meetings criticizes or acts in a negative way towards staff*
Moderate convergence (14) When a member of staff asks for help on a task/problem he/she is struggling with, the manager steps in and does the task or resolves the problem himself, rather than acting as a mentor (e.g. giving guidance, instruction or training)	*Moderate convergence* Gives little or no support/instruction/training to staff in change situations. Does not give staff the opportunity or sufficient time to train and/or develop themselves
Moderate convergence (15) Exhibits no confidence or trust in his staff	*Moderate convergence* Undermines or dismisses the efforts of staff (e.g. dismissive in dealing with staff ideas, makes cutting remarks; appears uninterested, does not give adequate feedback to the individual)

(*continued*)

Table II.

Romanian study	British studies
No convergence (16) Tolerates a situation where his/her staff lack adequate office space and/or conducive working conditions, and takes no action to improve matters	*No convergence* Exhibits threatening behaviour and/or a threatening style of management. Engages in bullying and/or behaviour that humiliates his/her staff. Raises voice to staff and chastises them in front of others/in public. During meetings makes inappropriate/off hand remarks or inappropriately voices disagreements in public. *Does not praise or give credit when it is due*
Tolerance of poor performance and low standards *High convergence* (17) Poor planning and organisation which interferes with the efficient and effective working of the hospital and the quality of service to patients (e.g. of work timetables/visiting schedules and laundry/medical supplies)	*High convergence* Acts without thinking through the implications and consequences of his/her actions
	Moderate convergence Takes action before obtaining or checking the necessary information. (e.g. acts quickly without information; fails to obtain the facts; gets involved without full knowledge; omits to check (data) for relevancy and suitability) *Low convergence* Gives insufficient time to and/or is insufficiently organized when handling paperwork and the administrative aspects of the job. Adopts a short-term view, makes rushed decisions and exhibits poor long term forward planning *No convergence* *Runs meetings ineffectively (e.g. allows certain staff to dominate the meeting) Does not control meetings effectively. Makes poor decisions (e.g. applies blanket rule which disadvantages all staff instead of dealing with the member of staff who is abusing the system). Engages in bullying or harassing behaviour* Fails to fully understand the problems within his/her department/unit or the real issues, or the complexities and complications of situations at the ground level
Ignoring and avoidance *High convergence* (18) Allows misunderstandings and personal conflict between self and other managers to persist at the expense of full effectiveness and efficiency	High convergence Fails to monitor or take control of difficult situations (e.g. dealing with troublesome staff; monitoring staff absenteeism or use of time)
High convergence (19) Ignores, or does not listen/respond to the complaints/concerns of his/her staff or from other sources	*High convergence* Is unwilling to discuss or answer questions regarding staff concerns or queries. *Is unwilling to listen to staff or is unprepared to sort out staff problems*

(*continued*)

Table II.

Romanian study	British studies
High convergence (20) Takes no action to resolve the problem of his/her staff constantly being disturbed/interrupted by misdirected phone calls, or visitors/patients knocking on the wrong doors due to a lack of directions	*High convergence* *Does not support staff in difficult positions [situations] (e.g. would not back up staff member who was being harassed by a member of the public)*
High convergence (21) Ignores/fails to react to actual or potential problems/situations confronted by staff, and takes no action to resolve them	*High convergence* Fails to recognize when staff member is struggling with his/her tasks
	Moderate convergence Is unwilling to discuss or answer questions regarding staff concerns or queries. Refuses to recognize problems or deadlines and avoids making decisions or taking necessary action. *Refuses to recognize problems or deadlines (e.g. leaves tasks to last minute)*
High convergence (22) Fails to produce plans with sufficient detail and/or to set clear workload priorities/objectives for staff	*High convergence* Fails to recognize the roles and tasks that need to be given high priority and to give them priority
Moderate convergence (23) Ignores/fails to take notice of suggestions for improvement and innovation from staff, and/or to implement change previously agreed in meetings	*Moderate convergence* In designing/planning for the relocation of departments/services to other buildings/locations fails to consult with staff (and/or with support staff) and take into account their views/needs. *Is unwilling to listen to staff or is unprepared to sort out staff problems*
Abdicating roles and responsibilities *High convergence* (24) Procrastinates and is very slow at making or implementing decisions, and misses critical decision deadlines	*High convergence* Refuses to recognize problems or deadlines and avoids making decisions or taking necessary action. *Refuses to recognize problems or deadlines (e.g. leaves tasks to last minute)* *Low convergence* Avoids or abdicates from his/her responsibilities (e.g. passes the buck, uses others to sort out problems he/she should address themselves). *Avoids making decisions (e.g. uses others to make decisions for them)*
No convergence (25) Fails to attend internal or inter-service meetings where his/her participation is required (26) Exhibits a reluctance or fails to develop or enhance a long term relationship with the [hospital's] suppliers	
Resistant to new ideas and change/Negative approach *Moderate convergence* (27) Is closed to change and innovation	*Moderate convergence* When in meetings tends to parade or over emphasize the negative views rather than the positive

Table II.

also when they "regularly communicate and consult with their staff and keep them well informed on organizational matters that affect them". Conversely, managers in both Romanian and British hospitals are likely to be perceived least effective or ineffective by their superiors, peers and subordinates, not just when they fail to exhibit the type of positive (effective) managerial behaviours indicated above, but also when they exhibit a "lack of consideration for staff"; are "inappropriately autocratic and non consultative"; are "unfair, uncaring, selfish and self-serving"; and when they "deprive" and/or "withhold from staff key information, clear instructions, guidance, constructive feedback, trust"; and actively or negligently exhibit "undermining behaviour". Furthermore, managers are perceived least effective/ineffective when they are "poor in planning and thinking ahead", or when they "procrastinate" and "ignore or avoid or abdicate from their responsibilities", and are "closed to ideas, change and innovation".

Discussion

The most significant finding of our study is that people within the collaborating Romanian public sector hospital have perceived, judged, and defined managerial and leadership effectiveness in much the same way, and in much the same terms as people in British NHS hospitals. The identified high degrees of sameness and similarity are striking, and challenge current predominant discourse which asserts that manager/leader behaviour and styles of management/leadership are dominantly contingent on the cultural aspects of specific countries (House *et al.*, 2004; Wendt *et al.*, 2009). Indeed, our findings raise questions about the validity of claims made by various past researchers who suggest national specificities, including national culture, have a major impact on how employees perceive the behaviour of their managers/leaders, which in turn determines whether or not they will accept and follow the leadership of their managers (Alas *et al.*, 2007; Brodbeck *et al.*, 2000; Morrison, 2000). Additionally, our findings provide little support for Flanagan and Spurgeon's (1996) assertion that managerial effectiveness in the health services sector is situationally dependent and varies from one organization to another. Furthermore, they lend little support for Tsui's (1984) assertion that behaviours which determine managers' reputational effectiveness vary according to their respective constituencies/stakeholders, and are idiosyncratic, context-specific, and contingent. On the contrary, as can be seen from Table I and Table II, the vast majority of managerial behaviours observed in the two countries are more or less convergent (universal) rather than divergent (contingent) in meaning. This finding provides empirical support for the proponents of universal leader behaviours and universal management/leadership styles (see Bass, 1997; Bennis, 1999; House and Aditya, 1997; Woodruffe, 1992); and suggests the concept of perceived managerial and leadership effectiveness is far more universal across different countries than previously claimed in the literature. Another significant and distinctive contribution of our study is the generation of insights and understanding of effective and ineffective manager/leader behaviour within Romania based on findings from indigenous emic qualitative research, rather than from imposed etic quantitative studies that use survey instruments derived from US or Western European research.

As reported earlier, over 82 per cent of the Romanian BSs and over 87 per cent of the British BSs were found to be convergent in meaning. These high levels of overlap and convergence are of the same order of magnitude to those identified by Hamlin *et al.* (2010) and Hamlin *et al.* (2011) who, as previously mentioned, conducted equivalent

replication studies within Egyptian and Mexican public sector hospitals respectively. These researchers compared their respective findings against those obtained from the same two British hospital studies that we have used for our multiple cross-case/cross-nation comparative study. They found that the vast majority of the compared Egyptian versus British BSs and Mexican versus British BSs were strikingly and significantly similar. The extent of these respective similarities of cross-national findings lend support for Hamlin's (2009) assertion that his emergent UK related cross-sectoral "generic framework" of perceived managerial and leadership effectiveness, which in part was deduced from the empirical findings of Hamlin's (2002b) and Hamlin and Cooper's (2007) NHS Trust hospital studies, is likely to be translatable and transferable across national boundaries.

Implications for HRD practice

The fact that little difference has been found between the findings of our Romanian replication study and the two compared British studies, challenges a number of long held and taken for granted assumptions about the context-specific, culture-specific, and contingent nature of effective and ineffective managerial behaviour. Indeed, it suggests the behavioural determinants of perceived managerial and leadership effectiveness are far more "universalistic" than has previously been reported in the literature. The cross-national commonalities and differences that we have identified in Romania, which mirror those similarly identified by Hamlin *et al.* (2010) and Hamlin *et al.* (2011) in Egypt and Mexico respectively, could be helpful for HRD practitioners in their preparation for expatriate managers who work across borders, and equally useful for the training of indigenous managers and leaders in other hospitals within these countries. Additionally, the cumulative body of "general knowledge" that has emerged from these studies could be used as "best evidence" in support of "evidence-based HRD" and "evidence-based management" practice within and beyond British, Romanian, Egyptian and Mexican hospitals. For example, it has the potential to be used by HRD professionals to:

- critically review existing behavioural management competency frameworks;
- develop management and leadership development programmes that have international relevance and utility; and/or
- inform HRD/OD intervention strategies to improve the way managers behave and to bring about strategic change in the management culture of an organization.

Limitations and directions for future research

The study has three potential limitations: First, it is likely that the CIT data collection stage of the Romanian replication study fell short of reaching data saturation. Furthermore, although 313 CIs were collected in Romania only 252 were usable for the CIT data analysis, as compared to the 405 and 467 usable CIs collected for the "acute" and "specialist" NHS Trust hospitals in the United Kingdom. Consequently, there may be other behavioural indicators of perceived managerial and leadership effectiveness applying within the Romanian hospital that have yet to be identified. Second, there was considerable imbalance in the empirical data used for the cross-case/cross-nation comparative analysis whereby 57 Romanian BSs were compared against a total of

122 British behavioural statements. Hence, we suggest further research should be undertaken within other public sector hospitals in Romania, not only to obtain a more comprehensive understanding and insight of how people in the Romanian health services sector perceive and define managerial and leadership effectiveness, but also to achieve a more robust outcome from any future multi-case cross-nation comparative analysis. And third, although logic suggests the vast majority of the Romanian BSs are likely to be translatable and transferable to other public sector hospitals in Romania, this has yet to be demonstrated empirically.

Conclusion

Our study has addressed in part the concerns of writers such as Braithwaite (2004), Hartley and Allison (2000), Mullally (2001), Porter O'Grady (2003) and Zairi and Jarrar (2001) regarding the paucity of research into the issue of what behaviourally differentiates effective managers/leaders from ineffective managers/leaders in the health services sector. The result of our multiple cross-case/cross-nation comparison mutually validates the findings from the three compared replication studies carried out within public sector hospitals in Romania and the United Kingdom. Furthermore, we suggest our deduced behavioural indicators of perceived managerial and leadership effectiveness are sufficiently translatable and transferable for use by HRD practitioners to improve the performance and effectiveness of healthcare managers/leaders within the three hospitals that we have studied.

Although these deduced behavioural indicators are most likely to be translatable and transferable to other public sector hospitals in Romania, as already implied, more indigenous replication studies should be undertaken in other Romanian public sector hospitals. In addition, more studies in Egypt and Mexico, and in various other countries, should be carried out to shed further light on the extent to which the emergent healthcare related "generic" behavioural indicators revealed by the present and parallel studies are "universalistic" or "near universal". Various other directions for further research are possible. We suggest indigenous replication studies of perceived managerial and leadership effectiveness should also be carried out in a wide range of public sector, private (for-profit) sector, and third (non-profit) sector organizations in a diverse range of countries around the globe. The goal would be to search for evidence of commonalities and relative generalizations across organizations, organizational sectors and nations, and of the possible emergence of a "universal taxonomy of perceived managerial and leadership effectiveness".

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