UNIVERSITI PUTRA MALAYSIA

INFLUENCES OF SUPERVISORY STYLES ON TALENT DEVELOPMENT, TURNOVER INTENTION AND MEDIATING ROLE OF CLINICAL LEARNING ENVIRONMENT AMONG TRAINEE DOCTORS IN MALAYSIA

ANUSUIYA A/P SUBRAMANIAM

FPP 2015 60
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By

ANUSUIYA A/P SUBRAMANIAM

Thesis Submitted to the School of Graduate Studies, Universiti Putra Malaysia, in Fulfilment of the Requirements for the Degree of Doctor of Philosophy

December 2014
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DEDICATION

This thesis is dedicated with deepest gratitude to all my family members, for instilling in me the determination and strength to believe in my dreams and for making this dream a reality. Because of your never-ending love and support, I have been able to spread my wings and soar!
INFLUENCES OF SUPERVISORY STYLES ON TALENT DEVELOPMENT, TURNOVER INTENTION AND MEDIATING ROLE OF CLINICAL LEARNING ENVIRONMENT AMONG TRAINEE DOCTORS IN MALAYSIA

By

ANUSUIYA A/P SUBRAMANIAM

DECEMBER 2014

Chair: Professor Abu Daud Silong, PhD

Faculty: Educational Studies

Examination on the literature indicated that no empirical research has integrated the concepts of supervisory styles (coaching, mentoring, participative and abusive supervision), clinical learning environment, talent development (development of professional and medical competencies) and turnover intention. In addition, there were less talent development studies in testing the mediating role of clinical learning environment. Thus, the main objective of this study is to examine the influences of supervisory styles on talent development, turnover intention and the mediating role of clinical learning environment among trainee doctors in Malaysian public hospitals.

A survey questionnaire was administered on trainee doctors undergoing housemanship training at public hospitals in Klang Valley, Malaysia, and the survey yielded 355 responses. They were chosen using a systematic sampling procedure. Trainee doctors’ talent development was conceptualized using the evidence-based management theory. The theory highlights that doctors possess the craft that can be learned or developed through practice and experience with appropriate supervision.

The findings indicate the following: high level of talent development and low level of turnover intention; high preference for coaching supervision, moderate preference for mentoring supervision, high preference for participative supervision and low preference for abusive supervision; coaching, mentoring,
participative and abusive supervision influences clinical learning environment, coaching and mentoring supervision facilitates talent development, participative supervision and abusive supervision influences turnover intention and clinical learning environment influences talent development. In addition, the findings reveal that clinical learning environment mediates the relationship between supervisory styles (participative and abusive supervision) and talent development. However, contrary to expectation, coaching and mentoring supervision is not linked to turnover intention; there is no direct effect between supervisory styles (participative and abusive supervision) and talent development; and clinical learning environment is not linked to turnover intention, respectively.

As a whole, this study has shed some light on the supervisory styles that can facilitate talent development and influence turnover intention, as well as the influence of clinical learning environment among trainee doctors in Malaysian public hospitals. This study can be a stepping stone for other researchers as this is one of the first few empirical studies done on human resource development, talent development and talent retention among medical practitioners.
Abstrak tesis yang dikemukakan kepada Senat Universiti Putra Malaysia sebagai memenuhi keperluan untuk ijazah Doktor Falsafah

PENGARUH CORAK PENYELIAAN TERHADAP PEMBANGUNAN KEMahirAN, KECENDERUNGAN MENINGGALKAN BIDANG PERUBATAN DAN PERANAN PENGANTIARAN PERSEKITARAN PEMBELAJARAN KLINIKAL DI KALANGAN DOKTOR PELATIH DI MALAYSIA

Oleh

ANUSUIYA A/P SUBRAMANIAM

DISEMBER 2014

Pengerusi: Profesor Abu Daud Silong, PhD

Fakulti: Pengajian Pendidikan

Pemerhatian terhadap literatur menunjukkan bahawa tiada kajian empirikal yang menggabungkan konsep gaya penyeliaan (bimbingan, pementoran, penyertaan dan kasar), persekitaran pembelajaran klinikal, pembangunan kemahiran (pembangunan kompetensi profesional dan perubatan) dan kecenderungan meninggalkan bidang perubatan. Tambahan pula, terdapat kurang kajian berkenaan pembangunan kemahiran dalam mengkaji peranan persekitaran pembelajaran klinikal sebagai pengantara. Maka, objektif utama kajian ini adalah untuk mengkaji pengaruh corak penyeliaan terhadap, pembangunan kemahiran dan kecenderungan meninggalkan bidang perubatan dan peranan pengantara persekitaran pembelajaran klinikal di kalangan doktor pelatih di hospital awam di Malaysia.

Hasil kajian ini menunjukkan bahawa: tahap pembangunan kemahiran adalah tinggi dan kecenderungan meninggalkan bidang perubatan adalah sederhana; keutamaan terhahap penyeliaan bercorak bimbingan adalah tinggi, keutamaan terhahap penyeliaan bercorak pementoran adalah sederhana, keutamaan terhahap penyeliaan bercorak penyertaan adalah tinggi, keutamaan terhahap penyeliaan bercorak kasar adalah rendah dan tahap persekitaran pembelajaran klinikal adalah sederhana; penyeliaan bercorak bimbingan, pementoran, penyertaan dan kasar mempengaruhi persekitaran pembelajaran klinikal; penyeliaan bercorak bimbingan dan pementoran membantu pembangunan kemahiran; penyeliaan bercorak penyertaan dan kasar mempengaruhi kecenderungan meninggalkan bidang perubatan serta persekitaran pembelajaran klinikal mempengaruhi pembangunan kemahiran. Selain itu, kajian ini juga menunjukkan persekitaran pembelajaran klinikal mempengaruhi hubungan di antara gaya penyeliaan (penyertaan dan kasar) dan pembangunan kemahiran.

Bercanggah dengan jangkaan, penyeliaan bercorak bimbingan dan pementoran tidak berkaitan dengan kecenderungan meninggalkan bidang perubatan; tiada kesan secara langsung di antara gaya penyeliaan (penyertaan dan kasar) dan pembangunan kemahiran; dan persekitaran pembelajaran tidak berkaitan dengan kecenderungan meninggalkan bidang perubatan.

Secara keseluruhan, kajian ini memberikan harapan bahawa gaya penyeliaan dapat membantu dalam pembangunan kemahiran dan mempengaruhi kecenderungan doktor pelatih meninggalkan bidang perubatan serta mempengaruhi persekitaran pembelajaran klinikal di kalangan doktor pelatih di hospital awam di Malaysia. Kajian ini juga dapat dijadikan sebagai batu loncatan oleh pengkaji lain memandangkan ia merupakan antara kajian empirikal yang membuat kajian tentang pembangunan sumber manusia, pembangunan kemahiran dan pengekalan kemahiran di kalangan pengamal perubatan.
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Fifth, I thank Prof. Dr. Murali Sambasivan for his beneficial assistance and coaching throughout my journey. Your critiques, "good cheer" and positive affirmation were most appreciated.

Sixth, my sincere appreciation and gratitude to my dearest family members for their tender love and great emotional support which make me stronger and more persistent in thesis writing.

To so many others, as the list of names continue….. From the bottom of my heart, thank you!
I certify that a Thesis Examination Committee has met on **2 December, 2014** to conduct the final examination of **Anusuiya A/P Subramaniam** on her thesis entitled "**Influences of Supervisory Styles on Talent Development, Turnover Intention and Mediating Role of Clinical Learning Environment among Trainee Doctors in Malaysia**" in accordance with the Universities and University Colleges Act 1971 and the Constitution of the Universiti Putra Malaysia [P.U.(A) 106] 15 March 1998. The Committee recommends that the student be awarded the Doctor of Philosophy.

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Date: 19 March 2015

ix
This thesis was submitted to the Senate of Universiti Putra Malaysia and has been accepted as fulfilment of the requirement for the degree of Doctor of Philosophy. The members of the Supervisory Committee were as follows:

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This is to confirm that:

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- supervision responsibilities as stated in the Universiti Putra Malaysia (Graduate Studies) Rules 2003 (Revision 2012-2013) are adhered to.

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iv</td>
</tr>
<tr>
<td>ABSTRAK</td>
<td>vi</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>viii</td>
</tr>
<tr>
<td>APPROVAL</td>
<td>ix</td>
</tr>
<tr>
<td>DECLARATION</td>
<td>xi</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xvii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xix</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>xx</td>
</tr>
<tr>
<td>LIST OF APPENDICES</td>
<td>xxi</td>
</tr>
</tbody>
</table>

## CHAPTER

### 1 INTRODUCTION
1.1 Background
1.2 Statement of Problem
1.3 Objectives of Study
1.4 Significance of Study
1.5 Scope of Study
1.6 Limitation of Study
1.7 Assumptions of Study
1.8 Definition of Terms

### 2 LITERATURE REVIEW
2.1 Introduction
2.2 Conceptions of Talent Development
  2.2.1 Talent
  2.2.2 Talent Management
  2.2.3 Transitions from Talent Management
  2.2.4 Previous research related to Talent Development among Medical Practitioners
2.3 Conceptions of Turnover Intention
  2.3.1 Turnover
  2.3.2 Turnover Intention
  2.3.3 Previous research related to Turnover Intention among Medical Practitioners
2.4 Integration of Theories and Models to Develop a Theoretical Framework
  2.4.1 Relevant Theories
  2.4.2 Relevant Models
  2.4.3 Theoretical Framework
2.5 Conceptualisation and Operational Definition of Research Constructs
   2.5.1 Supervisory Styles 30
   2.5.2 Clinical learning environment 33
   2.5.3 Talent Development 34
   2.5.4 Turnover Intention 34
2.6 Relationship between constructs 35
   2.6.1 Coaching Supervision and Clinical Learning Environment 35
   2.6.2 Coaching Supervision and Talent Development 36
   2.6.3 Coaching Supervision and Turnover Intention 37
   2.6.4 Mentoring Supervision and Clinical Learning Environment 37
   2.6.5 Mentoring Supervision and Talent Development 38
   2.6.6 Mentoring Supervision and Turnover Intention 39
   2.6.7 Participative Supervision and Clinical Learning Environment 40
   2.6.8 Participative Supervision and Talent Development 40
   2.6.9 Participative Supervision and Turnover Intention 41
   2.6.10 Abusive Supervision and Clinical Learning Environment 42
   2.6.11 Abusive Supervision and Talent Development 42
   2.6.12 Abusive Supervision and Turnover Intention 43
   2.6.13 Clinical Learning Environment and Talent Development 44
   2.6.14 Clinical Learning Environment and Turnover Intention 45
2.7 The Mediating Construct 45
   2.7.1 Clinical Learning Environment as a Mediator 46
2.8 Chapter Summary 48

3 METHODOLOGY 49
   3.1 Introduction 49
   3.2 Research Design 49
   3.3 Sample Design 50
      3.3.1 Location and Focus of the Study 50
      3.3.2 Population, Sampling Frame and Unit of Analysis 50
      3.3.3 Sample Size 51
      3.3.4 Sampling Procedure 54
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Expenditure for housemanship training in Malaysia</td>
<td>5</td>
</tr>
<tr>
<td>1.2</td>
<td>Number of house officers whose housemanship extended according to Reasons, 2007-2010</td>
<td>5</td>
</tr>
<tr>
<td>3.1</td>
<td>Total trainee doctors assigned in selected public hospitals in Klang Valley, Malaysia</td>
<td>51</td>
</tr>
<tr>
<td>3.2</td>
<td>Responses to the survey based on the hospitals</td>
<td>61</td>
</tr>
<tr>
<td>3.3</td>
<td>Reliability Analysis (Pre-Validity)</td>
<td>62</td>
</tr>
<tr>
<td>3.4</td>
<td>Testing for Normality using Skewness and Kurtosis</td>
<td>64</td>
</tr>
<tr>
<td>3.5</td>
<td>Analysis for Multicolinearity</td>
<td>64</td>
</tr>
<tr>
<td>3.6</td>
<td>CFA Diagram for First Order Model for CS, PS, AS and TI constructs</td>
<td>67</td>
</tr>
<tr>
<td>3.7</td>
<td>CFA Output for Second Order Model for MS construct</td>
<td>69</td>
</tr>
<tr>
<td>3.8</td>
<td>CFA Output for Second Order Model for CLE construct</td>
<td>69</td>
</tr>
<tr>
<td>3.9</td>
<td>CFA Output for Second Order Model for TDEV construct</td>
<td>70</td>
</tr>
<tr>
<td>3.10</td>
<td>CFA Output of Measurement Model</td>
<td>71</td>
</tr>
<tr>
<td>3.11</td>
<td>Index Category, Level of Acceptance for each Index</td>
<td>73</td>
</tr>
<tr>
<td>3.12</td>
<td>Measurement Model Evaluation</td>
<td>74</td>
</tr>
<tr>
<td>3.13</td>
<td>The Discriminant Validity Index Summary</td>
<td>75</td>
</tr>
<tr>
<td>4.1</td>
<td>Frequency and Percentage Distribution of Respondents by Demographic Profiles</td>
<td>80</td>
</tr>
<tr>
<td>4.2</td>
<td>Descriptive Statistics of Talent Development (N=355)</td>
<td>82</td>
</tr>
<tr>
<td>4.3</td>
<td>Overall Talent Development Levels (N=355)</td>
<td>83</td>
</tr>
<tr>
<td>4.4</td>
<td>Talent Development Levels according to Dimensions (N=355)</td>
<td>83</td>
</tr>
<tr>
<td>4.5</td>
<td>Descriptive Statistics of Turnover Intention (N=355)</td>
<td>84</td>
</tr>
<tr>
<td>4.6</td>
<td>Overall Turnover Intention Levels (N=355)</td>
<td>84</td>
</tr>
<tr>
<td>4.7</td>
<td>Descriptive Statistics of Coaching Supervision (N=355)</td>
<td>85</td>
</tr>
<tr>
<td>4.8</td>
<td>Overall Coaching Supervision Levels (N=355)</td>
<td>85</td>
</tr>
<tr>
<td>4.9</td>
<td>Descriptive Statistics of Mentoring Supervision (N=355)</td>
<td>86</td>
</tr>
<tr>
<td>4.10</td>
<td>Overall Mentoring Supervision Levels (N=355)</td>
<td>86</td>
</tr>
<tr>
<td>4.11</td>
<td>Descriptive Statistics of Participative Supervision (N=355)</td>
<td>87</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>4.12</td>
<td>Overall Participative Supervision Levels (N=355)</td>
<td>87</td>
</tr>
<tr>
<td>4.13</td>
<td>Descriptive Statistics of Abusive Supervision (N=355)</td>
<td>88</td>
</tr>
<tr>
<td>4.14</td>
<td>Overall Abusive Supervision Levels (N=355)</td>
<td>88</td>
</tr>
<tr>
<td>4.15</td>
<td>Descriptive Statistics of Clinical Learning Environment (N=355)</td>
<td>89</td>
</tr>
<tr>
<td>4.16</td>
<td>Overall Clinical Learning Environment Levels (N=355)</td>
<td>89</td>
</tr>
<tr>
<td>4.17</td>
<td>Output for Full Fledged Structural Model</td>
<td>90</td>
</tr>
<tr>
<td>4.18</td>
<td>Results of direct paths</td>
<td>93</td>
</tr>
<tr>
<td>4.19</td>
<td>Summary of Analysis of Significance of Mediation of Clinical Learning Environment in the Path PS-CLE-TDEV</td>
<td>94</td>
</tr>
<tr>
<td>4.20</td>
<td>Summary of Analysis of Significance of Mediation of Clinical Learning Environment in the Path AS-CLE-TDEV</td>
<td>95</td>
</tr>
<tr>
<td>4.21</td>
<td>Summary of Hypotheses Results</td>
<td>96</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>A preliminary model of clinical learning environment and supervision by staff nurses</td>
<td>25</td>
</tr>
<tr>
<td>2.2</td>
<td>Hypothesized model for the development of clinical competence</td>
<td>26</td>
</tr>
<tr>
<td>2.3</td>
<td>Employee turnover model</td>
<td>27</td>
</tr>
<tr>
<td>2.4</td>
<td>Proposed Theoretical Framework of the Study</td>
<td>29</td>
</tr>
<tr>
<td>3.1</td>
<td>Determination of sample size using Sample Size Calculator</td>
<td>52</td>
</tr>
<tr>
<td>3.2</td>
<td>Determination of sample size using G*Power Analysis</td>
<td>53</td>
</tr>
<tr>
<td>3.3</td>
<td>CFA Diagram for First Order Model for CS, PS, AS and TI constructs</td>
<td>67</td>
</tr>
<tr>
<td>3.4</td>
<td>CFA Diagram for Second Order for MS Construct</td>
<td>68</td>
</tr>
<tr>
<td>3.5</td>
<td>CFA Diagram for Second Order Model for CLE Construct</td>
<td>69</td>
</tr>
<tr>
<td>3.6</td>
<td>CFA Diagram for Second Order Model for TDEV Construct</td>
<td>70</td>
</tr>
<tr>
<td>3.7</td>
<td>CFA Diagram for Measurement Model</td>
<td>71</td>
</tr>
<tr>
<td>4.1</td>
<td>Full Fledged Structural Model</td>
<td>91</td>
</tr>
<tr>
<td>5.1</td>
<td>Final Model (with significant relationships)</td>
<td>114</td>
</tr>
</tbody>
</table>
### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRD</td>
<td>Human Resource Development</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOHE</td>
<td>Ministry of Higher Education</td>
</tr>
<tr>
<td>HRM</td>
<td>Human Resource Management</td>
</tr>
<tr>
<td>NIH</td>
<td>National Institute of Health</td>
</tr>
<tr>
<td>NMRR</td>
<td>National Medical Research Register</td>
</tr>
<tr>
<td>IA-HOD-IA</td>
<td>Investigator’s Agreement, Head of Department’s and Institutional Approval</td>
</tr>
<tr>
<td>MREC</td>
<td>Medical Review &amp; Ethics Committee</td>
</tr>
<tr>
<td>VIF</td>
<td>Variance Inflation Factor</td>
</tr>
<tr>
<td>CFA</td>
<td>Confirmatory Factor Analysis</td>
</tr>
<tr>
<td>CR</td>
<td>Composite Reliability</td>
</tr>
<tr>
<td>Chisq</td>
<td>Chisquare</td>
</tr>
<tr>
<td>RMSEA</td>
<td>Root Mean Square Error of Approximation</td>
</tr>
<tr>
<td>GFI</td>
<td>Goodness-of-Fit Index</td>
</tr>
<tr>
<td>AGFI</td>
<td>Adjusted Goodness-of-Fit</td>
</tr>
<tr>
<td>CFI</td>
<td>Comparative Fit Index</td>
</tr>
<tr>
<td>TLI</td>
<td>Tucker-Lewis Index</td>
</tr>
<tr>
<td>Chisq/df</td>
<td>Normed chisquare</td>
</tr>
<tr>
<td>AVE</td>
<td>Average Variance Extracted</td>
</tr>
<tr>
<td>CS</td>
<td>Coaching supervision</td>
</tr>
<tr>
<td>MS</td>
<td>Mentoring Supervision</td>
</tr>
<tr>
<td>PS</td>
<td>Participative Supervision</td>
</tr>
<tr>
<td>AS</td>
<td>Abusive Supervision</td>
</tr>
<tr>
<td>CLE</td>
<td>Clinical learning environment</td>
</tr>
<tr>
<td>TDEV</td>
<td>Talent Development</td>
</tr>
<tr>
<td>TI</td>
<td>Turnover Intention</td>
</tr>
</tbody>
</table>
## LIST OF APPENDICES

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Permission letter towards obtaining information pertaining to housemanship from Ministry of Health Malaysia</td>
<td>155</td>
</tr>
<tr>
<td>B: Number of trainee doctors in approved government hospitals for housemanship training in Malaysia (as at December 2010)</td>
<td>156</td>
</tr>
<tr>
<td>C: Table for Determining Sample Size from a Given Population</td>
<td>158</td>
</tr>
<tr>
<td>D: Questionnaire</td>
<td>159</td>
</tr>
<tr>
<td>E: Letter of approval to conduct survey in Malaysian public hospitals [obtained from Medical Review &amp; Ethics Committee (MREC), Ministry of Health (MOH), Malaysia]</td>
<td>167</td>
</tr>
<tr>
<td>F: Leaflet of survey explanation to the trainee doctors, pertaining to the questionnaire</td>
<td>168</td>
</tr>
<tr>
<td>G: Normal Probability Plots (Normal Q-Q plots)</td>
<td>169</td>
</tr>
<tr>
<td>H: Summary of Factor Analysis for Common Method Bias Test</td>
<td>173</td>
</tr>
</tbody>
</table>
CHAPTER 1

INTRODUCTION

1.1 Background

According to Abdul Hamid and Osman-Ghani (2011), there has been an increase in interest in the development of talent within the workplace. This is due to the reason that human capital is now the core factor of an organization’s success. Moreover, organizations’ main priority is in human resource development (HRD) to ensure high productivity and performance (Abdul Hamid and Osman-Ghani, 2011; Evangalou and Karacapildis, 2007). Thus, there is a need to tap into this pool of promising young talent that can be developed further for performance enhancements in the workforce.

Consequently, the Malaysian government has highlighted the issue of preparing the Malaysian workforce to face the challenges of the dynamic global environment and achieving the objective of 9th Malaysia Plan. The 9th Malaysia Plan focused on HRD by increasing the nation’s capacity for knowledge and innovation, as well as nurturing a ‘first-class mentality’ among the workforce (Zabeda, 2009), whereas the 10th Malaysia Plan can be considered to be focusing on the overall growth and development through partnerships, as well as developing the workforce (The Economic Planning Unit, 2010).

With regards to the 10th Malaysia Plan, there is a requirement for a new economic model in order for Malaysia to become a progressive and a high-income nation. Thus, the 10 key topics presented in the 10th Malaysia Plan are: (i) Internally driven, externally aware; (ii) Leveraging on our diversity internationally; (iii) Transforming to high-income through specialization; (iv) Unleashing productivity-led growth and innovation; (v) Nurturing, attracting and retaining top talent; (vi) Ensuring equality of opportunities and safeguarding the vulnerable; (vii) Concentrated growth, inclusive development; (viii) Supporting effective and smart partnerships; (ix) Valuing our environmental endowments and (x) Government as a competitive corporation (Abdul Hamid and Osman-Gani, 2011).

As per 10th Malaysia Plan, it is evident that Talent Management would be covered under the 5th key theme, which is in nurturing, attracting and retaining top talent. Previously, importance was given towards the attraction of talents;
nevertheless, development issues are becoming highly challenging issues for organizational management (Abdul Hamid and Osman-Gani, 2011).

Precisely, a special type of organization towards helping people is regarded as healthcare (Rubino, 2011). According to Rubino (2011), healthcare is being viewed by numerous individuals as a very special type of work setting towards helping people. In the case of Malaysia, it has a very complete span of health services and is divided into private and public sectors. Healthcare in Malaysia is primarily underneath the responsibility of the government’s Ministry of Health, which bestows quality healthcare through extensive range of countrywide networks of clinics and hospitals (Lee, 2011).

In Malaysia, upon completion of undergraduate studies, graduate medical officers need to undergo housemanship (supervised training) at identified government hospitals for two years (Overworked housemen, 2011). In several countries, undergraduate medical education ends with housemanship. Nevertheless, in Malaysia, housemanship is only imposed upon graduation, which is in accordance to the Medical Act 1971.

The term houseman refers to an advanced student or graduate in medicine obtaining supervised medical practice. In Malaysia, it is essential for doctors to undergo housemanship for two years after accomplishing their medical degree. During the housemanship, trainee doctors need to undergo mandatory rotations of four months in each department: emergency, medical, orthopedic, pediatrics, general surgery, anesthesia and intensive care, as well as obstetrics and gynecology (Bedi and Azizan, 2008).

The purpose of housemanship is to transform these trainee doctors into medical practitioners who are fully conversant with the daily necessities, workload and hasses of the doctors’ tasks. It is regarded as an essential stage in the journey of medical practitioners (Yusoff, Tan and Esa, 2011). In Malaysia, the hospitals of the Ministry of Health (MOH) and Ministry of Higher Education (MOHE) provide housemanship training and employment for trainee doctors upon completion of their undergraduate medical studiesand (Lum, 2012). Lum (2012) posited that presently, there are 41 government hospitals permitted by the Medical Qualifying Board for the aim of houseman training in Malaysia.

According to the Malaysian Medical Council (2012), the main aim of housemanship training is providing fresh graduates with educationally sound experience that professionalizes new medical graduates not only with appropriate knowledge, skills and experience, but above all attitudes. Consequently, the Ministry of Health in Malaysia requires trainee doctors to be excellent in
attaining medical competencies (Ahmad and Ramsay, 2009). Therefore, trainee doctors need to produce and shape their cognitive and highest intellectual concept in order to help them reached the standardized quality necessary while in housemanship teaching (Palmer and Naccarato, 2007). Nevertheless, competence in medicine may also be regarded as a latent talent that can be aroused and developed in an environment that allows the nurturing of such innate talents (Adewale et al., 2012). This indicates that the trainee doctors’ development of professional and medical competencies (talent development) is highly dependent on effective repetitive experiences through exposure to a high volume of cases in clinical learning environment (Sheehan, 2011). Clinical learning environment, as well as the type of organizational system in which the trainee doctors is attached to, can affect the development of their competencies. Learning and competence occur best in environments in which the trainee doctors feel empowered and able to learn freely.

Nevertheless, as revealed by Bedi and Azizan (2008), for those housemen who successfully accomplished their medical degree, the challenge awaits when dealing with the hospital environment, where they are unable to cope with their housemanship. Based on an article from The Star (2012) entitled “System that’s a burden to many housemen”, it was found that the housemen suffered depression and were under psychiatric observation. This is due to the reason that they could not take the bullying from senior doctors, whom constantly shouted and belittled them (System that’s a burden to many housemen, 2012). Besides being bullied, some evidences even revealed that senior doctors ridiculed the housemen in front of patients and visitors, via uncalled-for statements such as: “You do not deserve to be here” and “You are only here because you are a rich man's son/daughter” (Cruel Human Beings, 2012; Parents of housemen want Govt to put an end to the misery, 2012). Besides, it was found that senior doctors also punished housemen by making them stand at a corner and asking them to write repeatedly, for example, the difference between a nerve and a muscle (Parents of housemen want Govt to put an end to the misery, 2012). Consequently, article pertaining to Houseman's work hours, a US perspective (2010) indicated that these stressful situations were found to affect job productivity and led to the incidence of workplace accidents. Besides, these also resulted in housemen quitting from medical profession (Parents of housemen want Govt to put an end to the misery, 2012), while the female housemen ended up as a housewife (Bedi and Azizan, 2008). This is in regards to the reason that they could not tolerate the pressure and the bullying by the senior doctors. Moreover, some of the housemen were also transferred to another hospital or just resigned and even death incidents (D’Cruz, 2012; System that’s a burden to many housemen, 2012).

Thus, senior doctors were found to exhibit bullying supervision when dealing with housemen (Houseman's work hours, a US perspective, 2010). These reveal the existence of bullying aka abusive supervision in the Malaysian healthcare setting. According to Pope (2009), Anon (2001) researched on negative behavior
in the workplace, where it was found that trainee doctors were intimidated and traumatized by the supervisory abusive of their surgical consultants. Furthermore, Pope (2009) exerted the existence of abusive supervision in medical training and disagreed that such supervision should not exist in a caring profession. There are already relatively high levels of supervisory abusive and intimidating behavior within and between different staff groups in healthcare and having these implicitly sanctioned at the highest level is unhelpful (Edwards, 2003). In addition, there is a good evidence that leaders who exhibit supervisory abusive towards their subordinate will lead to low-quality relationships among the staff in a healthcare setting, which seem to produce low staff satisfaction and decrease outcomes for patients (Edwards, 2003).

Public Healthcare Sector in Malaysia

Since independence, there have been tremendous improvements in the healthcare delivery system in Malaysia. Malaysia currently benefits from a complete range of health services provided by both the public and private sectors. Despite this dual system, the government still remains as the main policy maker and regulatory body. This task is entrusted to the Ministry of Health (MOH), which is also responsible for the public healthcare sector.

According to Ghani and Yadav (2008), the public healthcare sector is the backbone of the healthcare system in Malaysia, although private healthcare sector comprises approximately 50% of total healthcare services (Ghani and Yadav, 2008). MOH provides the public healthcare services by means of its network of 131 hospitals and widespread health clinic accommodations, whereas the private sector consists of 217 hospitals and numerous general practitioners’ clinics (Ministry of Health Malaysia, 2011a).

Therefore, with a growing private healthcare sector, some areas of concerns have emerged for the public healthcare sector, which include media reports, where it was claimed by housemen that they are overworked, and there is “bullying” by specialists (Lum, 2012).

Quality of Housemanship Training

According to Yusoff et al., (2011), medical housemanship is the duration of hospital-based service training of new medical graduates through close supervision of attending senior doctors/specialists. The purpose is towards transforming an academic medical student into a medical practitioner who is fully conversant with the daily requirements, workload and pressures of the doctors’ roles. It is regarded as an essential stage in the journey of medical practitioners as they are considered as the first line service providers in a hospital. Thus, a huge
amount of money is being allocated every year for the purpose of housemanship training in Malaysia. Table 1.1 indicates the amount being spent for housemanship training in Malaysia.

Table 1.1. Expenditure for housemanship training in Malaysia

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provisional registration (Housemanship training) in RM</td>
<td>77800.00</td>
<td>51500.00</td>
<td>43840.00</td>
<td>57100.50</td>
<td>64840.00</td>
</tr>
</tbody>
</table>


As revealed by the Malaysian Medical Council Biennial Report (2009-2010), before 2008, medical practitioners were required to undergo housemanship training for a period not less than one year. However, after 2008, a 2-year housemanship period was introduced towards ensuring house officers obtain sufficient clinical training. The Malaysian Medical Council Biennial Report (2009-2010) also states that houseman training can be extended or their full registration is denied for reasons of attitude problem, lack of knowledge, incompetence, insubordination or other disciplinary problems, mental illness or physical disabilities of house officers. For instance, in 2010, the Medical Qualifying Board extended the period of housemanship training for 68 trainee doctors compared to only 20 in the year 2008. As displayed in the Malaysian Medical Council Biennial Report (2006-2007; 2009-2010), statistics on the number of trainee doctors whose training period was extended for the last four years and the corresponding reasons are shown in Table 1.2.

Table 1.2. Number of house officers whose housemanship extended according to Reasons, 2007-2010

<table>
<thead>
<tr>
<th>Reason For Extension</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor work performance</td>
<td>37</td>
<td>103</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Sick leave and exceed leave entitlement</td>
<td>24</td>
<td>35</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Maternity leave</td>
<td>13</td>
<td>27</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Unpaid leave</td>
<td>8</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Others</td>
<td>21</td>
<td>59</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
<td>141</td>
<td>20</td>
<td>68</td>
</tr>
</tbody>
</table>

Based on the statistics on reasons for housemen extension, it can be concluded that poor work performance among trainee doctors was one of the main reasons for an extension of housemanship training. This is towards ensuring trainee doctors obtain the experience required for independent practice. Moreover, medical profession has the responsibility towards ensuring that the healthcare provided is of the highest quality (Merican, 2009).

Through various press release statements (in Malay), Ministry of Health Malaysia in 2009 showed that based on a survey that they conducted, 53% of trainee doctors had high intention of leaving the medical profession (Syed Ali, 2011). These findings were found to be similar to Paice et al.’s (2002) study, which indicated that medical interns who had bad experience during their housemanship resulted in having high intention of leaving the medical profession (Ali Pitchay, n.d.).

**Issues of Medical Professionalism in Public Hospitals**

Lum (2012) stated that learning during housemanship is significantly experiential. Moreover, there has to be sufficient quality supervisors for this aspect of the young doctors’ training. This is due the reason that the supervisors, who are usually specialists, have an important role to play as they are role models for young doctors.

Moreover, as stated by Merican (2009), it is crucial for every doctor to read and understand the requirements and their obligations under the medical profession, specifically “Duties of a Doctor” and “Code of Professional Conduct for Doctors”, which can be obtained from the Malaysian Medical Council’s (MMC) website. According to the Malaysian Medical Council Biennial Report (2009-2010), The Code of Professional Conduct (CPC) supports and promotes medical professionalism and facilitates good medical practice. It serves the profession in its own self-regulation by establishing a set of professionally accepted standards of conduct.

Nevertheless, ignorance and failure to observe the code of ethics have resulted in many complaints against doctors being brought to the MMC. For instance, there is evidence of breaches of professionalism or violation of ethics in public hospitals, where media reports stated that housemen are overworked and there is evidence of abusive supervisory behavior by specialists (Lum, 2012).
1.2 Statement of Problem

Successful healthcare systems worldwide are critically dependent on the development of doctors (Spilg et al., 2012). As per evidence-based management theory, doctors possess the craft that can be learned or developed through practice and experience with appropriate guidance (Pfeffer and Sutton, 2006). Nevertheless, controversy exists on how to develop their professional and medical competencies or widely known as talent development (Spilg et al., 2012). Prior scholars asserted that supervisory styles have significant implications for trainee doctors’ talent development (Akerjordet and Severinsson, 2007). Coaching supervision (Kavanaugh et al., 2006), mentoring supervision (Kavanaugh et al., 2006), participative supervision (Sumrall et al., 2008) and abusive supervision (Ayree et al., 2007) have been utilized to establish the relationship between supervision and talent development in a healthcare setting. Nevertheless, very few studies have provided supporting evidence linking the supervisory styles and talent development (Spilg et al., 2012).

Prior researchers found that coaching supervision (Russell, 1994, Sheehan, 2011; Zainal Abidin, 2006), mentoring supervision (Donaldson and Carter, 2005; Jan, 2010), participative supervision (Boor et al., 2007; Sheehan, 2011) and abusive supervision (Hofmann, 2012) were found to have influence on clinical learning environment. Nevertheless, majority of the previous studies in clinical learning environment used samples of undergraduate medical students (Dornan et al., 2012), postgraduate medical students (Leunis and Varkevisser, 2009; Lucas and Samarage, 2008) and nursing graduates (Baramee and Blegen, 2003). Nevertheless, studies that link the influence of supervisory styles and clinical learning environment among medical practitioners are scarce (Sheehan, 2011; Jan, 2010; Hofmann, 2012).

It was asserted that coaching supervision (Blomjous, 2012; Kavanaugh et al., 2006; Stradling, 2008), mentoring supervision (Kavanaugh et al., 2006; Stradling, 2008) and participative supervision (Gupta and Singh, 1999) leads towards retaining of talents in a healthcare setting, as well as influences supervisees’ intention to leave the organization. Nevertheless, when supervisees encounter mistreatment from abusive supervision, this leads to the decision of turnover intention (Tepper, 2000; Liu et al., 2012). Nevertheless, very few studies have provided supporting evidence linking the supervisory styles (coaching, mentoring, participative and abusive supervision) with turnover intention (Blomjous, 2012; Stradling, 2008; Liu et al., 2012).

Prior literature indicated that the environment in which one works, as well as the type of organizational system in which one works and learns can affect the development of competence (Schroeter, 2008). However, there seems to be limited empirical findings to support the linkage between clinical learning
environment and talent development. Even though an environment in workplace learning is among the most widespread and fastest-growing interventions in HRD practice, turnover intentions could be a result of improper workplace environment (Hughes et al., 2010). Nevertheless, the context of environment in workplace learning associated to its relation with turnover intention has not been explored extensively (Emami et al., 2012; LeeKelley, et al., 2007).

Prior research papers indicate that trainee doctors value a learning environment with participatory supervision that promotes participation and develops the skills needed to be active lifelong learners throughout their medical careers (Sheehan, 2011). Consequently, supervisory abuse during clinical learning environment can affect a supervisee’s sense of competence (Lian et al., 2012). However, to date, lack of empirical research has been conducted pertaining to mediating role of clinical learning environment in the relationship between (1) participative supervision and talent development and (2) abusive supervision and talent development (Lian et al., 2012; Sheehan, 2011).

Majority of the research pertaining to the constructs in this study has been conducted in the Western context. Thus, this study fills in the gap by providing an integrative view of all the concepts of supervisory styles (coaching, mentoring, participative and abusive supervision), clinical learning environment, talent development (development of professional and medical competencies) and turnover intention among public hospital trainee doctors in Malaysia. This study will address three research questions: 1) What is the level of talent development and turnover intention among trainee doctors in Malaysian public hospitals? 2) What is the level of supervisory styles (coaching, mentoring, participative and abusive supervision) and clinical learning environment among trainee doctors in Malaysian public hospitals? 3) Are there interrelationships between coaching supervision, mentoring supervision, participative supervision, abusive supervision, clinical learning environment, talent development and turnover intention? 4) Are participative supervision and abusive supervision mediated by clinical learning environment construct in predicting talent development?

1.3 Objectives of Study

General Objective

Generally, this study attempts to examine the influences of supervisory styles on talent development and turnover intention and the mediating role of clinical learning environment among trainee doctors in public hospitals in Malaysia.
Specific Objectives

Specifically, the study aims:

i. To determine the level of talent development and turnover intention among trainee doctors in public hospitals in Malaysia.

ii. To determine the level of supervisory styles (coaching, mentoring, participative and abusive supervision) and clinical learning environment among trainee doctors in public hospitals in Malaysia.

iii. To examine the relationships between supervisory styles (coaching, mentoring, participative and abusive supervision), clinical learning environment, talent development and turnover intention.

iv. To examine the mediating effect of clinical learning environment on the relationship between supervisory styles (participative and abusive supervision) and talent development.

1.4 Significance of Study

This study is important in terms of theoretical and practical implications. From a theoretical standpoint, the research contributes to talent development and turnover intention literature by identifying the factors that may directly impact trainee doctors’ talent development (development of professional and medical competencies) and turnover intention, as the antecedents of talent development and turnover intention pertaining to healthcare environment tend to focus on conceptual theorizing without much empirical evidence. To be exact, this extends the existing literature by offering a consistent point of view to integrate the concepts of supervisory styles (coaching, mentoring, participative and abusive supervision), clinical learning environment, talent development and turnover intention. Therefore, this study adds to the body of knowledge and extends understanding by providing a foundational base for the academic study pertaining to factors affecting talent development and turnover intention among trainee doctors by providing an integrative view of all the concepts.

As few empirical studies have provided supporting evidence linking supervisory styles (i.e. coaching, mentoring, participative and abusive supervision) with talent development among public hospital trainee doctors, this study contributes to the literature by examining effective supervisory styles (i.e. coaching, mentoring, participative and abusive supervision) that senior medical officers should exhibit when supervising trainee doctors in public hospitals towards enhancing supervisees’ talent development (development of professional and medical competencies). Furthermore, the findings of this study also provide theoretical basis and empirical evidence on supervisory styles (i.e. coaching supervision, mentoring supervision, participative supervision and abusive supervision) that are
essential towards stimulating a clinical learning environment among public hospital trainee doctors. This study also contributes to model building based on HRD and turnover intention literature. Despite the fact that the atmosphere in workplace learning is among the most pervasive and fastest-growing interventions in HRD practice, the environment in workplace learning and its relation to turnover intention has not been examined in an extensive manner. Thus, this study further contributes to the empirical examination of both concepts of clinical learning environment and talent development, as well as clinical learning environment and turnover intention.

This study also contributes to the clinical learning environment literature by examining the mediating effect of clinical learning environment in the relationship between (1) participative supervision and talent development, and (2) abusive supervision and talent development among public hospital trainee doctors. Basically, the examination of the role of clinical learning environment as a mediator may deepen the understanding about a potential underlying mechanism that is responsible for the relationship between supervisory styles (participative and abusive supervision) and talent development among public hospital trainee doctors. So far, based on the researcher’s best knowledge, only one study (Baramee and Blegen, 2003) has examined the mediating effect of clinical learning environment, which is between input variables (i.e. personal background and school characteristics) and clinical competence, as well as input variables (i.e. personal background and school characteristics) and program grade point average (development of professional competence). Thus, this study adds to the body of knowledge by filling the gap on the scarcity of empirical research by examining the mediating effect of clinical learning environment in the relationship supervisory styles (participative and abusive supervision) and talent development (development of professional and medical competencies) among trainee public doctors.

The present study would provide empirical support on the literature in the Asian context. Specific to the case of public hospitals in Malaysia, studies pertaining to the constructs in this study (supervisory styles, clinical learning environment, talent development and turnover intention) have been limited in several ways. Therefore, it is hoped that the findings of this study will help to narrow the gap and will increase and enhance the existing body of knowledge by further contributing to the development and retention of talents in Malaysian public hospitals.

From a practical standpoint, this study helps to identify and understand supervisory styles that should be adopted and cultivated by senior medical officers or immediate supervisors of public trainee doctors. Precisely, the
understanding about the supervisory styles would provide some insight to the immediate supervisors of trainee doctors on the supervisory styles that can stimulate clinical learning environment, and subsequently facilitate talent development (development professional and medical competencies) and reduce turnover intention among public hospital trainee doctors. This study can be used towards assisting HRD professionals in evaluating training programs for trainee doctors and assisting public hospitals to plan HRD interventions to improve its talent development (development professional and medical competencies) programs for trainee doctors based on the understanding of supervisory styles that have been identified as being effective to improve trainee doctors’ level of talent development (development professional and medical competencies), as well as minimizing turnover intention.

1.5 Scope of Study

The study was restricted to trainee doctors between 12 months to 24 months undertaking their housemanship training at six public hospitals in Malaysia, precisely in Klang Valley area. Participants were voluntarily invited from a population of 1388 trainee doctors in each department: emergency, medical, anesthesia and intensive care, pediatrics, general surgery, orthopedic, and obstetrics and gynecology of the hospitals. The main variables of the study were coaching supervision, mentoring supervision, participative supervision, abusive supervision, clinical learning environment, talent development (development of professional and medical competencies) and turnover intention (tendency to quit) among the trainee doctors.

1.6 Limitation of Study

As in any study, this study has its share of limitations. Hence, the following are some of the limitations:

Self-report data

Relying on self-report data has its limitations, precisely pertaining to talent development (development of professional and medical competencies) among trainee doctors, even though the present study is meant to pursue the perceptions of trainee doctors in their talent development. However, gathering data from the superiors pertaining to the assessment of professional and medical competencies of trainee doctors would have provided us with the perception from their senior medical officers or immediate supervisors of trainee doctors. Nevertheless, this could prompt future researchers to look into investigating senior medical officers or immediate supervisors of trainee doctors on the variable of interest.
Cross-sectional research

A methodological limitation of the present study is the use of a cross-sectional research design that prohibits the definitive establishment of cause-and-effect relationships (Gomez and Rosen, 2001). Due to time constraints imposed on a PhD dissertation such as this one, it is impossible for the researcher to carry out a longitudinal research.

Generalization

The sample consists of trainee doctors from public hospitals in Klang Valley, Malaysia. Thus, the generalization of the results is limited to only public hospital trainee doctors in Klang Valley, Malaysia.

Self-administered questionnaire

Like all self-administered questionnaires, once the respondent receives the questionnaire, the questioning process is beyond the researcher’s control. Each respondent will attach a different personal meaning to each question even though the printed stimulus is meant to be the same. There is no interviewer present who can probe for additional information or clarification of an answer and the recorded answer must be assumed to be complete (Zikmund, 1997).

1.7 Assumptions of Study

The assumptions pertaining to the study are as follows: Malaysian public hospitals have the ability to improve trainee doctors’ clinical learning environment, as well as trainee doctors’ talent development (development of professional and medical competencies) by providing adequate supervision; within Malaysian public hospitals, the impression exists that trainee doctors leave the profession because they experience improper supervision; data collection instruments are valid and reliable based upon their previous use; and participants in the field test of the instrument answered truthfully.
1.8 Definition of Terms

Public hospitals

Public hospitals are owned by the government and receive most of their funding from the government. The government funds these hospitals through the financial source gained from taxes on earned income.

Housemen/Junior doctors/Trainee doctors/Medical trainees/House officers

Housemen/Junior doctors/Trainee doctors/Medical trainees/House officers are known as newly graduated medical officers who undergo a structured and supervised hospital-based service training to enable them to consolidate and extend theoretical clinical knowledge and technical skills.

Housemanship

A period of supervised training in medical education.

Coaching Supervision

Coaching supervision is formal practice of professional support, that make certain of trainers/immediate supervisors coaching practice through shared reflection, informative evaluation and the sharing of knowledge among trainee doctors’ towards nurturing the trainee doctors’ professional, academic, or personal development.

Mentoring Supervision

Mentoring supervision is acknowledged as a dyadic, face-to-face, long-term interaction among a senior medical officer and trainee doctors that nurture’s the trainee doctors’ professional, academic, or personal development.

Participative Supervision

Participative supervision involves senior medical officers guiding the trainee doctors on how to use self-monitoring, standard setting, self-evaluation, as well as self-reinforcement procedures towards acquiring new knowledge and skills with minimal involvement of senior medical officers’.
**Abusive Supervision**

Abusive supervision denotes senior medical officers’ hostile verbal and non-verbal behaviors towards trainee doctors’, which include public demonstrations of anger, personal ridicule, and destructive feedback, and does not include physical abuse.

**Clinical Learning Environment**

Clinical learning environment known as the atmosphere that facilitates the transition from novice to expertise among trainee doctors undergoing housemanship in public hospitals.

**Talent Development**

Talent development is acknowledged as developing trainee doctors’ competencies (professional and medical competencies) required towards the accomplishment of housemanship training.

**Turnover Intention**

Turnover intention is defined operationally defined as trainee doctors’ own likelihood that he or she has a deliberate intention to leave public hospitals and their profession permanently in the near future.
REFERENCES


