DISCUSSION AND DEBATE

Work Mistreatment and Hospital Administrative Staff: Policy Implications for Healthier Workplaces

Harcèlement professionnel et administrateurs en milieu hospitalier : répercussions politiques pour des milieux de travail plus sains

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Abstract

Research on work life quality in hospitals has focused on how nurses and physicians perceive or react to work conditions. We extend this focus to another major professional group – healthcare administrators – to learn more about how these employees experience the work environment. Administrators merit such attention given their key roles in sustaining the financial health of the hospital and in fulfilling management functions efficiently to support consistent, high-quality care. Specifically, we examined

mistreatment in the workplace experienced by administrative staff from a hospital in a large Canadian city. Three dimensions of mistreatment – verbal abuse, work obstruction and emotional neglect – have been associated with diminished well-being, work satisfaction and organizational commitment, along with stronger intent to leave. In this paper, we provide additional support for interpreting these three dimensions as mistreatment and report on their frequencies in our sample. We then consider implications for policy development (e.g., communication and conflict resolution skills training, mentoring programs, respect-at-work policies) to make workplaces healthier for these neglected but important healthcare professionals.

Résumé

Les recherches sur la qualité de vie au travail dans les hôpitaux ont porté sur la perception et la réaction des infirmières et des médecins face à leurs conditions de travail. Nous nous intéressons à un autre groupe professionnel important – les administrateurs des services de santé – afin de connaître l'expérience des ces employés face à leur environnement de travail. Une telle attention à l'égard des administrateurs est nécessaire étant donné le rôle important qu'ils jouent dans la viabilité financière de l'hôpital et dans l'accomplissement efficace des fonctions de gestion pour assurer des soins cohérents et de haute qualité. Plus précisément, nous avons étudié le harcèlement professionnel éprouvé par les administrateurs d'un hôpital d'une grande ville canadienne. Trois aspects du harcèlement professionnel – la violence verbale, l'entrave au travail et la négligence psychologique – sont associés à une diminution du bien-être, de la satisfaction au travail et de l'engagement organisationnel, de même qu'à une plus forte intention de quitter le milieu de travail. Dans l'article, nous proposons des moyens additionnels d'interpréter ces trois aspects du harcèlement, et nous faisons rapport de leur fréquence dans notre échantillon. Ensuite, nous abordons certaines répercussions pour l'élaboration de politiques (par exemple, la formation en communication ou en résolution de différends, les programmes de mentorat ou les politiques de respect au travail) afin de faire des milieux de travail un endroit plus sain pour ces professionnels de la santé importants, mais négligés.

In Canada and elsewhere, concern is mounting about the well-being of healthcare organizations and their employees (Cox and Leiter 1992; Lowe 2002). Conditions such as work overload, poor interpersonal relations and unsupportive climates are commonplace, contributing to staff burnout, low morale and voluntary turnover (Shamian and El-Jardali 2007). The last is particularly troubling in light of persistent workforce shortages and under-funding, which strain health systems already stretched to capacity. Costs of turnover are escalating in part because of high

rates of departure by health professionals, especially nurses (Gray et al. 1996) and administrators (Castle 2006). Surprisingly, the fact that turnover costs due to working conditions are largely avoidable (Abelson 1987) has not been given the attention it deserves from health system executives, policy makers and managers.

Emerging data confirm that healthcare workplaces can benefit from improved retention by strategic planning to sustain a healthy and satisfied workforce (Yassi et al. 2002). In this vein, research on work life quality offers insights into sources of unhealthy work conditions as well as levers for improvements. In Canada, several initiatives illustrate the growing interest in advancing the healthy workplace agenda across sectors, including healthcare, using evidence-informed policy. For example, the Quality Worklife–Quality Healthcare Collaborative (QWQHC), a multidisciplinary coalition of health leaders and partners, has formulated an action strategy for Canada's healthcare providers following a comprehensive review of literatures and practices (QWQHC 2007). More broadly, the National Quality Institute, working with Health Canada, has developed pan-industry criteria for organizational policy to support employee health. Managing workplaces in accordance with such policy should yield more stable staffing levels by providing healthcare employees with the organizational resources, social support and respect they need to work productively and effectively.

In hospital contexts, most research on work life quality has focused on how nurses and physicians perceive or react to work conditions. This work has been invaluable in identifying deficits in practices that adversely affect these professionals and the care they can provide for patients. However, researchers also need to examine how other health professions experience the work environment. In particular, administrative staff merit such attention given their key role in ensuring the financial health of the hospital and fulfilling management functions efficiently to support continuous, high-quality care (Garman et al. 2006). Importantly, the costs of productivity loss from turnover of health administrators appear second only to those of physicians (Waldman et al. 2004).

In this paper, we follow up on a study (Harlos and Axelrod 2005) of mistreatment experienced by hospital administrators, which revealed that many who were verbally abused, prevented from getting their work done or neglected emotionally were planning to quit. Past research has shown that the intent to leave is the most immediate antecedent to, and best predictor of, voluntary turnover (Griffeth et al. 2000). The earlier study showed that verbal abuse, work obstruction and emotional neglect influence other work outcomes, with the result that these administrators tended not to feel good about themselves at work, unsatisfied with their jobs and detached from the hospital.

We go on to determine the frequencies of mistreatment dimensions. We also provide empirical support for interpreting these experiences as mistreatment. From this evidence base, we consider implications for policy development to make workplaces healthier for this neglected but important healthcare profession.

Workplace Mistreatment

People who believe they have been mistreated at work perceive that interpersonal interactions or organizational practices have violated a moral or legal contract for resources, opportunities or treatment (Harlos and Pinder 1999; Sheppard et al. 1992). Mistreatment makes employees feel distressed, less satisfied with their job and less committed to the organization; they are also less productive and more likely to quit (Bowling and Beehr 2006). Interpersonal mistreatment related to verbal interactions warrants investigation for at least three reasons. First, although more prevalent than violations that are physical or sexual in nature, they have received far less research attention in workplace studies. Second, consequences are serious. Even incivility or rudeness lowers individual productivity and organizational returns (Cortina et al. 2001). Third, in industrialized nations employment litigation related to verbal behaviours is on the rise. Increasingly, court decisions hold that yelling or swearing at employees, threats of firing and destructive criticism violate the employment contract. At the same time, legislated protection against such treatment is increasing. Canada, along with Sweden, Belgium and France, is taking a leadership role in this regard. In 2004, Quebec became the first North American jurisdiction to enact legislation against harassment that encompasses verbal exchanges, followed by Saskatchewan in 2007.

Because administrative work requires high levels of contact with people (England and Kilbourne 1988), we suspected that hospital administrators – just like nurses and physicians – experience mistreatment related to verbal interactions. We also wondered whether they experience mistreatment from organizational practices, as do administrators and managers in other industries (e.g., Baron and Neuman 1998; Harlos and Pinder 1999).

Overview of Our Study and Findings

We conducted a study of employees whose positions were excluded from union membership at a large urban hospital in western Canada. Because the positions represented administrative functions that deliver hospital services across management, professional and support ranks from 42 departments, we refer to these employees as administrators. Our data provide only a sketch of administrator experience, given that they are from a single hospital. Additionally, the sample is somewhat heterogeneous because we combined administrative ranks. This prevents us from drawing conclusions about the role of rank (position) in relation to mistreatment. However, the implications for policy are minor because the standard in emerging legislation and preventive policies – at least in terms of verbal mistreatment – is zero tolerance. Nevertheless, these data are a useful starting point for understanding the work realities of healthcare leaders and staff who struggle behind the scenes to ensure that services are well managed and cost-effective, and meet quality expectations. Our results provide an initial platform

for policy development that takes working conditions of this population into account.

The earlier study (Harlos and Axelrod 2005) describes the development of a scale of workplace mistreatment, including our use of in-depth research accounts to generate items. Factor analysis of the items revealed three underlying factors, or dimensions: verbal abuse, work obstruction and emotional neglect. Verbal abuse (measured by eight items) reflects spoken behaviours that denigrate people. Items include being yelled at, blamed for others' mistakes and spoken to in a harsh, cold tone of voice. Work obstruction (four items) involves encountering various blocks in getting work done. Sample items include failing to get needed resources or support and having requests for information ignored. Emotional neglect (five items) refers to a sense of abandonment engendered when employee needs for socio-emotional support and recognition are ignored. Component items include not being given constructive feedback and not being told that one is valued or appreciated. Overall, this scale contributes to the literature on healthy work environments (Kelloway and Day 2005) by introducing a reliable and valid means of measuring the kinds of interactions and practices that provoke perceptions of mistreatment.

For the purpose of this paper, we examined whether associations exist between dimensions of mistreatment and workplace (un)fairness. Respondents rated how fair each of five aspects of the workplace (supervisors, co-workers, subordinates, patients/clients/residents/visitors and the organization) was to them using a single item (e.g., "Overall, my organization treats me fairly") on a 1- to 5-point scale from "strongly disagree" to "strongly agree." This approach conforms to the standard in organizational research, which regards injustice, unfairness or mistreatment as having occurred when targets or victims so label it (Folger and Cropanzano 1998). Specifically, Pearson correlation coefficients revealed that verbal abuse was significantly associated with perceptions of unfairness concerning supervisors (r=–.50, $p<0.001$), co-workers (r=–0.29, $p\leq0.001$) and the organization (r=–0.30, $p\leq0.001$). Work obstruction was significantly associated with unfair supervisors (r=–0.55, $p<0.001$), co-workers (r=–0.36, $p<0.001$), subordinates (r=–0.24, $p<0.01$) and the organization (r=–0.46, $p<0.001$). Emotional neglect was significantly associated with unfair co-workers (r=–0.25, $p<0.01$) and the organization (r=–0.28, $p\leq0.001$). The number of significant correlations at the organizational level implies that authorities beyond co-worker and supervisory levels were seen as sources of mistreatment. No significant relationships were seen involving unfair treatment by patients/clients/residents/visitors.

To assess how often respondents had experienced mistreatment dimensions, we analyzed frequencies (never, once, monthly, weekly, daily) as rated by respondents from the previous 12 months for each item. We report here the monthly, weekly and daily occurrences of mistreatment dimensions (see Table 1). To index verbal abuse, we determined the percentage of respondents for the three frequency categories who reported one or more items that define the dimension. This approach is consistent

with Canadian legislation, which permits single (along with repeated) behaviours to define such mistreatment. Table 1 shows that the majority of respondents (70%) experienced some measure of verbal abuse on a monthly basis. Of particular importance is the finding that about 10% reported such abuse on a daily basis. The fact that respondents represented over 40 departments suggests that verbal abuse is endemic in this hospital. Correlational results (described above) indicate that supervisors and co-workers were the main perpetrators of verbal abuse. Surprisingly, we found that even administrators in leadership positions experienced such mistreatment.

TABLE 1. Percentages of respondents reporting behaviours in last 12 months (N=125)

	Reported (%)		
Factor	**Monthly**	**Weekly**	**Daily**
Verbal abuse[a]	69.6	32.0	9.6
Work obstruction[b]	56.8	29.6	10.4
Emotional neglect[c]	80.8	52.0	37.6

[a] Indexed by minimum of 1 of 8 items.
[b] Indexed by minimum of 1 of 4 items.
[c] Indexed by minimum of 1 of 5 items.

We used a similar approach – determining the percentage of administrative personnel reporting at least one dimension item according to frequency category – to index work obstruction and emotional neglect (Table 1). Again, the daily frequencies are striking: 38% of respondents reported some measure of emotional neglect, and 10% felt obstructed in some aspect of their work every day. These results, along with correlations noted earlier, suggest an emotionally barren culture in which the needs to be recognized and to feel connected to others are routinely overlooked by co-workers and the organization. To illustrate, a patient services manager frustrated by the lack of action – despite much talk – about patient safety exclaimed, "We don't need swimming lessons, we need life preservers. It doesn't feel good to be ignored when you're going down for the third time!" A security supervisor provided an example of work obstruction when he was neither consulted nor informed when a new access control system was installed in the hospital, impeding his ability to carry out his duties. The number of significant correlations between work obstruction and unfairness (reported above) suggest problems with procedures at multiple levels of administrative management. The results support the argument by Cropanzano and Byrne (2001) that organizational policies themselves can be a source of unjust treatment when they are poorly designed or rigidly implemented.

To summarize, our data provide a novel look at the work life of hospital adminis-

trators. Further studies are needed to confirm results on the nature and prevalence of work mistreatment in this population. Such research can support healthcare reform through insights that address work environment issues and strengthen health human resources (Lowe 2002). For example, West et al. (2006) reported a strong association between human resource management systems that emphasize employee engagement and reduced patient mortality following a study across 52 hospitals in England. This finding supports Deber's (2005) contention that small changes, parlayed in this instance across a region, can yield big advances in healthcare outcomes. In her commentary, Deber (2005) also recommends reform by providing the basics of satisfying employment experiences – individual respect, job security and good working conditions. Our findings reaffirm the importance of these basics and echo the need to focus on the fundamentals of management systems in hospitals.

If we accept that the basics of work life quality are important, then developing policy for a healthy workplace through improved interpersonal relations, socio-emotional support and work functioning becomes a key strategic goal. What formalized processes might reduce the prevalence of work mistreatment and lower costs (individual, organizational and societal) of unhealthy conditions in an industry that can ill afford to pay?

Implications for Health Policy: Back to Basics

The take-home message from this research stream is clear: workplace mistreatment makes it harder for hospitals to retain administrative personnel and harder for administrators who do stay to work effectively. In addition, the costs to hospitals, in terms of deficits in recruitment, training and productivity, from administrators who quit (or intend to) because they believe they have been mistreated are largely unnecessary, because the bulk of such turnover is avoidable. As Abelson (1987) points out, departure related to reasons such as "better working conditions elsewhere" or "better organization to work for elsewhere" is under an organization's control. The latter reason is relevant given that an organization can develop a reputation as an abusive place to work (Powell 1998). A hospital with such a reputation suffers the strategic disadvantage of being less able to attract skilled staff compared to a hospital known for its high-quality, healthy work environment.

In healthcare organizations, policy development for healthier workplaces can only benefit from knowledge about working conditions across the range of key professional groups, including administrators. This approach is consistent with the recommendation that policy makers include views from diverse interests for effective policies (Cropanzano and Byrne 2001). These authors also recommend that, along with learning about policy implementation, managers become critical thinkers and skilled communicators who practise fairness and foster organizational justice.

Effective interpersonal skills may be more critical for administrators than for any

other professional group in hospital service positions. Oftentimes, they report both to higher-ranking managers and clinical heads, creating potential ambiguity as well as conflict. In terms of the latter, Garman et al. (2006) observe that hospital administrators typically have strong reward power, which can pit them against other professionals when they must deny requests for resources or revoke resources already allocated. We caution that administrators promoted on the basis of technical rather than management or leadership skills will be especially challenged in navigating the complex and competing accountabilities, interests and alliances in hospital systems.

Healthcare organizations can adopt several strategies to address these issues. For example, they can prepare written guidelines and formal procedures concerning interpersonal conduct. Codifying respect-at-work policies can prevent complaints to regulatory agencies or courts, according to analyses of over 6,000 complaints following the introduction of Quebec's anti-harassment legislation ("Quebec Finds" 2007). Promoting respectful conduct through information sessions and campaigns, for example, signals the organization's commitment and helps all employees appreciate the importance of the issue. Hospitalwide training to teach all employees effective communication and conflict resolution reinforces the organization's support to make a demanding workplace less difficult. Periodic review of procedures and policies (Cropanzano and Byrne 2001) to minimize bottlenecks in getting work done and assess whether employee needs are being addressed will help ensure that policies serve as remedies rather than a source of complaints.

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Policies that reinforce positive social relationships and recognize emotional needs of employees can counter the lonely and demoralizing work environments that some healthcare professionals experience (Harlos and Axelrod 2005; Lavoie-Tremblay et al. 2005). Psychosocial support is a key component of healthy workplaces (Kelloway and Day 2005), and its generally low levels in healthcare are a source of concern to provincial governments and regional health authorities (e.g., British Columbia 2004/2005). Mentoring programs and other sanctioned opportunities for interprofessional collaboration are initiatives that foster a sense of recognition and support.

More broadly, Kelloway and Day (2005) suggest a national strategy to address workplace health issues through assessment, intervention, education and training. In this vein, reducing the prevalence of work mistreatment poses particular challenges because it requires both that employees speak up and that organizations listen. Because employ-

ers tend not to act when employees complain, Namie (2003) recommends that policies to counter verbal abuse and bullying include enforcement processes and restorative interventions. Yet, some employees are reticent to speak up, no matter how troubling the problem or how powerful the policy. Silenced complaints prevent organizations from identifying problems and implementing solutions. For this reason, leading organizations in healthcare and elsewhere are implementing accountability or "whistle-blower" policies to protect individuals who report wrongdoing. More broadly, research-informed models and criteria for healthy workplaces offer rich sources for policy innovations that can be customized to reflect goals and missions of specific healthcare organizations.

… improving the work environment for administrators also will improve the quality and sustainability of hospital services …

Conclusion

Our findings imply that improving the work environment for administrators also will improve the quality and sustainability of hospital services. To effect this change, we suggest a basic but underused approach: look, listen and learn to develop coordinated policies for respectful workplaces that provide all employees with what they need – emotionally and functionally – to feel satisfied and to succeed in their work. If we manage healthcare organizations as if administrative work truly mattered, we might be rewarded with a ready supply of skilled administrators willing to meet challenges with focus, enthusiasm and perseverance.

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