Organizational internal environment, role clarity and citizenship behavior at casualty emergency centers

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ABSTRACT

The burden of casualty emergency handling in developing countries is enormous, challenging, and steadily increasing. There is an increasing pressure for health services to address major issues connected with management of emergencies at casualty centers. Early and effective treatment of patients could lead to substantial reduction in hospital costs, mortality, and disability (Sethi et al, 1995). However, the casualty emergency centers in many hospitals in the country are approaching "casualty status", with poor operating climate, limited and disorganized services and facilities. The current study examined the perceived organizational internal environment, role clarity, employee empowerment, commitment, and their impact on organizational citizenship behavior (OCB) at casualty emergency centers in public and private hospitals in Uganda.

The study employed a cross sectional survey design. The target population (540) comprised of casualty emergency employees. A sample size of 120 respondents from two hospitals (public X and private Y hospitals) was used and included employees from surgical unit (52.5%), Medical unit (27.5%), Intensive care unit (15.8%), Investigation unit (3.3%), and records (0.8%). A stratified random sampling design based on categories of doctors, nurses, paramedicals, and support staff was used to select the sample. Data was analyzed using SPSS package, to establish Pearson's correlation coefficient, t-test, and regression analysis level of significance between variables and groups.

Results indicated significant positive correlation between role clarity and OCB ($r = .204$; $p < .05$); role clarity and employee empowerment ($r = .338$; $p < .01$); employee empowerment and organizational commitment ($r = .465$; $p < .01$); employee empowerment and OCB ($r = .436$; $p < .01$); role clarity and organizational commitment ($r = .301$; $p < .01$); organizational commitment and OCB ($r = .809$; $p < .01$). Further, there was a significant difference with regard to organizational internal environment and role clarity between private and public hospital casualty centers. Public Hospital casualty centers had a higher level of organizational internal environment than private hospital casualty center; whereas private hospital casualty center was better than public at clarification of employee roles. Role clarity, organisational commitment, employee empowerment, and supervision had a 66.1% predictive potential on OCB. However, organisational commitment was a highly significant predictor of OCB at both hospitals. Implications for regular organizational internal environment audit, OCB appraisal, empowerment evaluation, and competence profiling at casualty centers are elucidated.

Keywords: Emergency, Role clarity, Empowerment, Commitment, Internal environment, OCB

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INTRODUCTION

The burden of casualty emergency handling in developing countries is enormous, challenging and steadily increasing (Sethi, Zwi, Gilson, fox Makoni, Msika, Levy Murugusampillay, 1995). There is an increasing pressure for health services to address major issues connected with management of emergencies, particularly traumatic injuries, at casualty centres. Early and effective treatment of patients with acute injuries and ailments could lead to substantial reduction in hospitals costs, mortality and disability (Sethi et al 1995).

In Uganda, epidemic and disaster prevention preparedness and response is one of the major areas of focus on the health sector strategic plan. According to the ministry of health hospital strategic plan (Ministry of Health-Hospital Strategic Plan, MOH-HSSP, 2001-2005), the programme is aimed at improving emergency preparedness and response at both national and district level in order to promote health, prevent disease and reduce death among the affected population and to equip casualty emergency centres. The establishment of an effective communication consultation and co-ordination system to ensure efficient information flow constitutes a major component of this programme (MOH-HSSP 2002).

However, in spite of the substantial achievements, the health sector in Uganda still faces many challenges which include; gross under funding that have affected the availability of medical resource inputs, drugs and supplies; severe understaffing at all levels in the hospitals; unsatisfactory morale and attitudes of health workers; and delay of flow of funds to service delivery points (MOH-HSSP 2001-2005). In addition, the casualty care units in many hospitals are dilapidated. The operating conditions are grim. Munene (1995) study findings confirmed that doctors and allied health professionals frequently avoid ward rounds, spend only half the time in hospitals and report late or leave early, while nurses in the more controlled non-government sector get round the controls by applying for compassionate leave.

In addition, the different cadres of staff perform more or less the same roles/ways through history taking, physical examination and investigations. Because of such ambiguous role definitions and procedures, diagnosis and treatment are poor and it is unlikely that diagnosis is accurate (Mwesigye 1995). Further, in most regional hospitals, laboratory requests, X-rays and other investigations take long to produce results (Batega 2004) and when results are got they are rarely accompanied by competent reports. Professionally this is an undesired scenario. The absence of service attitude, commitment or willingness to exert additional effort to achieve hospital care goals is a major complaint of in-charges. For instance, statistics (WB 1994) show that by 1990 doctors in the ministry of Health hospitals saw far fewer patients per day (1.3) than doctors in private voluntary hospitals (6.7). Under use was so prevalent that Uganda would be able to reduce the number of health care personnel by 30% without affecting the quality of service (WB 1994).

In the medical sector, a state of powerlessness especially at making decisions that influence the organizational direction, treatment programme and performance continue to be tied to the Uganda Medical and Dental Practitioners council old statute. The simplest decisions must always be checked before a subordinate at the lower level proceeds with health service delivery. This state of limited empowerment coupled with inability by senior health staff to reach

out and supervise health workers in their duties is demoralizing and has encouraged negative clinical, administrative, and management habits (Mwesigye, 1995).

LITERATURE REVIEW

Role clarity and Organizational citizenship behaviour (OCB)

Podsakoff, Niehoff, MacKenzie, and Williams (1993), reported significant association between leader's clarification and OCB, but found negative links between specification of procedures, altruism and conscientiousness. Podsakoff, Mackenzie, Moorman and Fetter, (1990), reported modest positive corrections between high performance expectations and OCB. A later study by Podsakoff et al (1996) found that a clear vision of the future and high performance expectations (i.e. task/role clarity) were positively linked to citizenship behaviour. Since there is inadequate evidence from literature, new studies should endeavor to assess the association between role clarity and citizenship behaviour at lower levels.

Organisational internal environment and OCB

There are two forms of OCB reflected in prior studies; prosocial extra role behaviours aimed at others in the organisation and extra role behaviours done for the benefit of the organisation. OCB is multidimensional and consisting of distinct altruistic, other directed behaviours, and extra role compliance done for the sake of the organisation (Smith, et al, (1983); Williams & Anderson (1991). Thus extra role behaviours are organizationally desirable and advance the effective operation of the organisation (Organ, 1988; Organ and Konofsky, 1989). Since OCB is not considered in formal job appraisal and reward system, refusal to exhibit these behaviours cannot be formally punished (Van Dyne, Cummings & Park 1995).

There is therefore, need to focus on assessing the strength of associations between perceptions of organisational internal climate (supervisor support, amount of bureaucracy, satisfaction with rewards, recognition of good work) and OCB. According to Turnipseed and Markison (2002), OCB is linked to the work environment suggesting that these behaviours may be manageable. A good social climate with involvement, fair and competent management, good communication, satisfaction with the organisation and good planning have been found to correlate to OCB (Turnipseed & Markison 2000).

Empowerment and organisational commitment

Krammer, Siebert and Liden (1999), found a significant association between psychological empowerment and organizational commitment both in nursing and non- nursing environment. In addition, Kanter (1993) maintains that there is a positive link between empowering work environments and organizational commitment. Employees in empowering environments are more committed to the organization, are more likely to engage in positive organizational activities and experience less strain. Access to empowering structures at casualty emergency centers could be facilitated by formal job characteristics. Having access to these

casualty structures results into feelings of autonomy, higher levels of self-efficacy and greater commitment to the organization.

Problem statement

The casualty emergency care units in many Uganda hospitals are approaching 'worst casualty status" with 30-40 minutes patient waiting time. The levels of role clarity, hospital internal environment, employee empowerment and commitment have progressively deteriorated. The emergency operating climate is grim, facilities disorganized and often limited. There is a high rate of employee absenteeism, neglect of duty, poor handling of equipment and patients and persistent shortage of staff especially in government aided hospitals (WB 1998, 2004). This situation, if not corrected, could lead to a continued decline in work performance and a rise in mortality rates at the casualty emergency centres.

Purpose of the study

The study assessed the organizational internal environment, role clarity, employee empowerment, commitment and their predictive potential on citizenship behavior at public and private hospital casualty centers in Uganda.

The study was guided by the following specific hypotheses:

1. There is a significant relationship between role clarity and OCB.
2. There is a significant relationship between role clarity and employee empowerment.
3. There is a significant relationship between organisational internal environment and OCB.
4. There is no significant relationship between employee empowerment and commitment.
5. Organisational internal environment, role clarity, organisational commitment, and employee empowerment ill significantly predict OCB in public and private hospitals.

METHODS

The study employed a cross sectional survey design. The target population (540) comprised of casualty emergency employees. A sample size of 120 respondents from two hospitals (public X and private Y hospitals) was selected using a disproportionate stratified random sampling design and included employees from surgical unit (52.5%), Medical unit (27.5%), Intensive care unit (15.8%), Investigation unit (3.3%), and records (0.8%). In terms of professional diversity, the sample consisted of doctors (8.3%), nurses (68.3%), paramedicals (10.8%) and support staff (12.5%). Data was collected using self administered questionnaires consisting of adopted operationalised scales.

Instrument/scale reliability analysis indicated that Cronbach alpha values for work performance (.819), Organisational internal environment (.891), Employee empowerment (.813), Organisational commitment (.780) and Role clarity (.706) were higher than 0.7 and therefore considered satisfactory for this study.

Questionnaires for primary data were administered to respondents, collected after three days and labeled to help in identifying the respondents without their knowledge. This helped in matching respondents' filled questionnaires and the OCB scale rated by the immediate supervisors. Subsequently, data was analyzed using special package for social scientists (SPSS)

to establish Pearson's correlation coefficient, t-test, and regression analysis level of significance between variables and groups under study.

FINDINGS

The results of data analysis are presented in table 1, 2 and 3 in appendix (showing correlations, means, standard deviations and regression analysis findings)

Role clarity

There was significant positive correlation between role clarity and perceived employee empowerment ($r = .338$; $p < .01$); role clarity and organisational commitment ($r = .301$, $p < .01$); role clarity and OCB ($r = .204$, $p < .05$); role clarity and coping with information/consultation related problems ($r = .187$, $p < .05$). See appendix 1.

Organisational internal environment

Perceived organisational internal environment had a significant positive association with coping with reward related problems ($r = .584$, $p < .01$) and coping with information/consultation related problems ($r = .498$; $p < .01$). However, there was no significant association between organisation internal environment and organisation commitment ($r = .098$, $p > .05$); employee empowerment ($r = .111$, $p > .05$) and OCB ($r = .006$, $p > .05$). See appendix 1.

Employee empowerment

Results indicated a significant positive correlation between employee empowerment and coping with information/consultation related problems ($r = .166$, $p < .05$); organisational commitment ($r = .465$, $p < .01$) and OCB ($r = .436$, $p < .01$). See appendix 1

Organisational commitment and OCB

There was a significant positive relationship between organisational commitment and OCB ($r = .809$, $p < .01$)

Regression analysis on OCB

Regression analysis results indicated that role clarity, organisational commitment, employee empowerment and supervision have a 66.1% prediction potential on OCB. However, organisational commitment is a highly significant predictor of OCB both at public and private casualty emergency centers ($t = 12.682$; $p < .01$). See appendix 3.

DISCUSSION OF FINDINGS

The results indicated a significant positive correlation between role clarity and organizational behavior ($r = .204p< 0.05$). High levels of role clarity generate high OCB. Organizational citizenship behavior has been linked to task/role clarity and good planning. The

above results agree with findings of Podsakoff et al (1996) who reported significant positive corrections between leader role clarification and OCB. Organizational citizenship behavior has been linked to casualty emergency management effort to provide task clarification for doctors, nurses, allied health professionals and support staff. This lessens the burden of casualty emergency handling in order to save life, reduce mortality and disabilities and also to cut down on associated hospitals costs/expenses.

Role clarity positively associated with employee empowerment at the casualty emergency centres ($r = .338$; $p < 0.010$). Higher levels of role clarity are associated with increased psychological empowerment of employees. This is in agreement with Wellins, Byham and Wilson (1991) findings that linked psychological empowerment to a sense of ownership and control over tasks (roles). Employee empowerment and the energy that comes with feelings of ownership are necessary pre-requisites for continuous improvement. Employees who tend to have control over their work and work context; have the competence to perform their work. Thus, empowerment could be conceived as a positive additive function of perceived control, competence and goal internalization. However, there was no significant difference between X and Y casualty emergency centres with regard to employee empowerment ($t = 187$; $p > 0.01$).

The results indicated no significant association between organizational internal environment (supportive supervision, rewards, information, consultation and coping) and organizational citizenship behavior at the casualty emergency centres ($t = .006$; $p > 0.05$). The above findings are in disagreement with Turnispseed and Murkison (2000) research results; are also in disagreement with Bateman and Organ (1983) who reported a positive correlation between supervisory relations and OCB

Further, there was no significant relationship between perception of rewards and OCB ($r = .004$; $p > 0.05$). This finding is in agreement with Morrison (1994) who found non- significant links between pay/reward and OCB: but is in conflict with Bateman and Organ (1983) research results that showed a positive correlation between OCB and pay/rewards.

In addition, the study results indicated no significant association between organizational internal environment and employee empowerment ($r = .11$; $p > 0.05$); and differs from Kanter (1977, 1993, 2003) findings that maintain that work environments that provide access to information, resources, support and opportunity to learn and develop are empowering and enable employees to accomplish their work. In private hospital casualty, most nurses interviewed reported that the simplest decisions must always be checked before a subordinate at the lower level proceeds with health service delivery. This state of limited empowerment coupled with inability by senior health staff to reach out and supervise casualty emergency health workers in their duties has led to negative clinical and management habits (Mwesigye 1995). Yet Laschinger, Wrong, McMilion and Kaufman (1999) found out that nurses felt more empowered in their work setting when leaders encouraged autonomy, facilitated participative decision making and expressed confidence in employee competence.

Further, employee empowerment positively associated with organizational commitment ($r = .465$; $p < 0.01$). The findings are consistent with Krammer, Siebert and Liden (1999) who found a significant association between psychological empowerment and organizational commitment both in nursing and non- nursing environment. The findings are also in agreement with Kanter (1993) who maintains that there is a positive link between empowering work environments and organizational commitment. Employees in empowering environments are more committed to the organization, are more likely to engage in positive organizational activities and experience less strain. Access to empowering structures at casualty emergency

centres could be facilitated by formal job characteristics. Having access to these casualty structures results into feelings of autonomy, higher levels of self-efficacy and greater commitment to the organization. Autonomy and self-efficacy are components of what Speitzer (1995) labeled psychological empowerment. As a consequence of higher levels of empowerment, casualty emergency employees tend to experience positive feelings about their work and are more productive and effective in meeting casualty emergency organizational goals.

Health care professional often perceive having little or no control over extensive changes and stressors in industry, including an increasingly regulated environment, complex health care, equipment and demands for higher standards of medical care, better patient-provider interaction and quicker response times particularly during emergency.

Organizational commitment was positively linked to OCB ($r = .809$; $p < .01$). High levels of organizational commitment elicit OCB. This is supported by O'Relly and Chatman (1986) and Morman, Nichoff and Organ (1993) findings that also indicated a positive link between organizational commitment and OCB. Many modern hospitals management approaches attempt to indirectly control employees by fostering organizational commitment (Muller et al, 1994) since organizationally committed employees are reported to be better performers (Jauch et al 1978); are more aligned with enterprise goals and are less likely than their uncommitted counterparts to seek employment elsewhere (Mowday, Steers and Porter 1979).

Findings indicated a significant difference between public and private hospital casualty emergency centres with regard to overall organizational internal environment ($t = 2.504$; $p < 0.05$). Public casualty Centres had higher levels on managing the organizational internal environment (Mean = 100.2840) than private ones (Mean = 90.0000). This finding has been re-enforced by a significant difference on level of supervision between public and private casualty emergency centres ($t = 33.073$; $p < .01$). Public casualty center had a higher mean value (45.3086) of supervision compared to private centers (38.8718) and therefore was better at supervising workers who handle emergency cases.

In addition, there was a significant difference with regard to role clarity between public and private Hospital casualty centers ($r = 3.392$; $p < 0.01$). Private casualty emergency centre was better at clarifying work roles (Mean =18.2821) compared to public one (Mean=16.6914). Private hospital casualty center endeavors to give sufficiently clear instructions for casualty emergency work and health workers know their roles, key result areas and performance output to sustain service delivery.

There was a significant difference in coping with reward related problems between public and private casualty centers ($r = 2.277$; $p < 0.05$). Public casualty center was better at coping with reward related issues (17.6687) than private center (15.7436)). The Public hospital management had negotiated a loan scheme with commercial banks, and hire purchase with Tonakopesha and Zain (U) Limited. These schemes were intended to make good the salary/rewards and maximize benefit (Ministry of Health, financial year, 2000/2001). This has helped staff including those at casualty emergency centres out of difficult financial situation.

In addition, results showed no significant difference between public and private hospital casualty centers with regard to perception of information/consultation bureaucracy ($t = 1,750$, $p > 0.01$). However, there was a significant difference at coping with information consultation related problems ($t = 3.097$, $p < 0.01$). Public casualty center respondents were better at coping with information/consultation bureaucracy related problems (mean = 56.4198); compared to private hospital casualty centers (Mean = 51.5263).

Lastly, the t-group test statistical findings showed no significant difference between public and private casualty emergency centres with regard to employee empowerment ($t = .187$; $p > .01$); organizational commitment ($r = 1.624$; $p > .01$) and OCB ($t=0.031$; $p>0.01$). This finding was inconsistent with Moos (1994) and Seiter (1984) assertion that the work internal environment characterized by quality interpersonal relations between supervisors and subordinates improves employee commitment.

Implications

Management should enhance efficient handling of casualty emergency cases by empowering health workers through specialized training, team building, revising compensations systems upwards, improving leadership climate and role clarity. These avenues could then generate high organisational commitment and citizenship behaviour at the casualty centers. Training health workers for empowerment must prepare the employee for the integrative and collaborative role at casualty centers.

The Ministry of health should put in place strategies for improving supportive supervision, information exchange among departments and reducing the red tape. Further, employees should be fairly represented on hospital committees to participate in decision making to improve commitment, and enhance individual and team performance.

The casualty emergency centers should be restructured in order to improve service delivery. In this line there should be a regular audit of the organisational internal environment to monitor and evaluate the level of supervision, reward related issues, knowledge sharing, consultation, coping strategies, occupational attitudes, and physical climate. This is aimed at enhancing employee psychological empowerment and performance. Competence based performance appraisals should be introduced and implemented expeditiously. Employees should be sensitized about their roles, key result areas, competences and expected performance output.

Guidelines for referral of patients from peripheral public and private hospitals to national referral hospital casualty centers should be drawn up in order to achieve a more effective referral pattern and improve service delivery. Further, curative service sector financial vote should be increased at national and district level to equip the casualty centers with adequate drugs, sundries, medical first aid appliances, and other treatment requirements.

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APPENDIX

Table 1. Showing Pearson's correlation between research variables under study

Variable	S	R	CRP	ICR	CIC	RC	OC	EE	OIE	*OCB*
Supervision (S)	**1.000 120**									
Rewards (R)	**.572** * .000**	**1.000 .120**								
Coping with reward problems (CRP)	**.534** .000**	**.342 .000**	**1.000**							
Information Consultation and Response (ICR)	**.618** .000**	**.529** * .000**	**.587** * .000**	**1.000**						
Coping Information Consultation (CIC)	**.437** .000**	**.256** * .002**	**.528** * .000**	**.551** * .000**	**1.000**					
Role Clarity (RC)	**.033 .359**	**.032 .364**	**.096 .149**	**.119 .100**	**.187* .021**	**1.000**				
Organisational Commitment	**.028 .380**	**.102 .135**	**.057 .259**	**.139 .068**	**.084 183**	**.301** * .000**	**1.000**			
Employee empowerment (EE)	**.144 .058**	**.031 .368**	**.015 .435**	**.082 .190**	**.166* .036**	**.338** * .000**	**.465** * .000**	**1.00**		
Organisational internal Environment (O.I.E)	**.911** .000**	**.784** * .000**	**.584** * .000**	**.827** * .000**	**.498** * .000**	**.057 .271**	**.098 .147**	**.111 .116**	**1.00 0**	
Organisational Citizenship Behaviour (OCB)	**.039 .334**	**.004 .483**	**.043 .319**	**.071 .223**	**.073 .215**	**.204** * .013**	**.809** * .000**	**.436** * .000**	**.006 .476**	*1.00 0*

Table 2. T-group test for Public and Private Casualty Emergency Centers in Uganda

Variables	Hospitals	N	Mean	Standard deviation	T	Df	Sig p (2 d) tailed
Supervision	**Public** **Private**	**81** **39**	**45.3086** **38.8718**	**10.1114** **11.9806**	**3.073** **2.895**	**118** **64.908**	**.003***
reward	**Public** **Private**	**81** **39**	**24.333** **22.7179**	**6.4846** **6.0522**	**1.306** **1.336**	**118** **80.007**	**.194**
Coping with reward related problems	**Public** **Private**	**81** **38**	**17.6667** **15.7436**	**4.4074** **4.1721**	**2.277** **2.322**	**188** **78.977**	**.025****
Perceived information/knowl consultation	**Public** **Private**	**81** **37**	**30.6420** **28.1622**	**7.4587** **6.3836**	**1.750** **1.854**	**116** **80.766**	**.083**
Coping with information/knowl related problems	**Public** **Private**	**81** **39**	**56.4198** **51.6263**	**8.4733** **7.0299**	**3.094** **3.310**	**117** **86.143**	**.002***
Role clarity	**Public** **Private**	**80** **39**	**16.6914** **18.2821**	**2.6108** **1.9050**	**-3.392** **-3.779**	**118** **99.252**	**.000***
Organisational commitment	**Public** **Private**	**81** **39**	**51.0375** **53.8974**	**9.0769** **8.8905**	**-1.624** **-1.636**	**177** **76.883**	**.107**
Employee empowerment	**Public** **Private**	**81** **39**	**89.2222** **89.6154**	**11.2550** **9.7946**	**-.187** **-196**	**118** **85.539**	**.852**
Internal environment	**Public** **Private**	**81** **37**	**100.2840** **90.0000**	**20.5227** **21.0805**	**2.504** **2.479**	**116** **68.169**	**.014****
Organisational Citizenship Behaviour	**Public** **Private**	**81** **37**	**80.1235** **80.0256**	**16.1658** **16.1774**	**.031** **.31**	**118** **75.080**	**.975**

Table 3. Showing Regression of Organsational Citizenship Behaviour on Role Clarity, Organizational Commitment, Employee Empowerment and Supervision

Model	**Unstandardised coefficients**		**Standardized coefficient**	**T**	**Sig**	**R2**	**R adjusted**	F	**sig**
	B	**Std error**	**Beta**						
C**onstant**	**7.060**	**8.490**		***.802***	**.407**	**.680**			
Role clarity	**-.518**	**.369**	**-.081**	**-.1.402**	**.163**				
Organizational commitment	**1.374**	**.108**	**.780**	**12.682**	**.000***	**.672**	**.661**	**58.503**	**.000***
Employee empowerment	**.176**	**.093**	**.119**	**1.886**	**.062**				
Supervision	**-126**	**.078**	**-.088**	**-1.628**	**.107**				