Voice Bundles: A model to integrate employee and patient-care voice practices and outcomes in Healthcare

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INTRODUCTION

As documented in this volume, and elsewhere (eg Barry, Dundon and Wilkinson 2018) employee voice is a topic of central interest to scholars in HRM, ER and OB. Nevertheless, while starting off with a common understanding built on the work of Hirschman, over time these research disciplines diverged quite significantly in how they conceptualize and study voice. As a result, while research has developed it has done so largely within self-contained siloes (Morrison, 2011, 2014; Pohler and Luchak 2014; Klaas et al 2014; Wilkinson and Fay 2011), notwithstanding recent efforts to integrate the disparate literatures (Kaufman, 2015; Mowbray, Wilkinson and Tse, 2015; Wilkinson, Barry and Morrison, 2019). An unfortunate by-product of these different approaches has been a failure to accept and appreciate what other disciplines have to offer, or to consider different ways of understanding employee voice (Wilkinson et al. 2019).

We believe that voice research stands to benefit from drawing on these different disciplinary perspectives and by incorporating the knowledge gleaned from studies undertaken by scholars outside their own fields. We note that there have been a number of “call to arms”, suggesting a more integrated perspective, a good example being Bashur and Oc (2015:1546) who maintain that we need to move away from the distilling of the voice construct into “smaller and distally related mini-constructs”. One of the limitations associated with some of these calls for greater disciplinary integration, however, is that they tend to rely on an abstract conceptualization of voice—one that lacks the benefits of clear and concrete contextual detail. This chapter calls for a contextualized study of voice as a way to increase disciplinary integration. In doing so, we propose a framework for assessing voice in the healthcare setting. Seeking to better understand voice in a specific and well-defined context highlights the need for more comprehensive frameworks that build on a wide array of disciplinary insights.

Our call for the contextualized study of voice stems from the argument that scholarly integration is likely to be especially fruitful when insights are applied to specific industries and settings where voice is leveraged in unique ways. In this chapter, we sketch out the potential of
integrating some of the disparate literature to examine the issue of employee voice, using the hospital setting and drawing on the healthcare, human resource management (HRM), employment relations (ER), and organisational behaviour (OB) voice research. The healthcare focussed literature is connected, albeit loosely, to a wider management literature on voice. However, it is primarily focused on the role that voice can play in enhancing quality of patient care, and the reduction in medical and medication errors (for examples of voice related to patient care, see Avgar et al. 2016; and Schwappach & Gehring, 2014), rather than employee wellbeing, that is, staff raising concerns about their own welfare (for an exception, see Clark et al. 2001). Put differently, voice is studied primarily as a vehicle for improved performance, rather than for worker wellbeing. From a disciplinary standpoint, one could argue that voice in healthcare has been influenced by an HR or OB approach, where voice is seen as beneficial where is aids measures of unit level or organisational-wide functioning. While the link between voice and quality of patient care is clearly important, we argue for a broader and more comprehensive conceptualization of voice in this context, one that also incorporates an employment relations disciplinary approach. In this chapter, we take a broad and multidisciplinary view to conceptualise employee voice, which refers to all of the ways and means through which employees attempt to have a say about, and influence, issues that affect their work and the functioning of the organisation (Wilkinson and Fay, 2011). Voice can cover a range of different domains and topics (e.g. working conditions, remuneration, policies and procedures, work methods) and can occur through a variety of mechanisms: formal and informal, direct and indirect, individual and collective.

A broader approach to the study of voice in a specific context allows us to highlight missing conceptual linkages. Thus, in the healthcare context, diverse forms of voice are central to the delivery of high-quality patient care, and to employee wellbeing. Nevertheless, the extant literature tends to focus on the former rather than the latter, and rarely on the two together. Furthermore, existing research has, for the most part, focused on individual voice practices with limited attention to the different configurations of multiple voice practices designed to advance different types of organizational outcomes within a particular setting. The study of voice in context might also help in identifying specific bundles of voice that operate in a complementary manner.

In short, we look at the application of voice theory to a specific context—in this case healthcare. While there are insights about voice across different disciplines these often remain abstract and
disconnected from practical applications. In the following sections, we draw on the varied concepts of voice across OB, HRM and ER to develop an fuller understanding of employee voice within a hospital context. We also use the hospital context to explore a new avenue for integration: one that encapsulates employee voice associated with patient care, that tends to be associated with the HRM and OB conceptualisations of voice, and voice associated with working conditions, that is more closely aligned with the ER conceptualisation of voice. We discuss the reciprocal relationship between these two forms of voice, and their influence over employee wellbeing and patient care outcomes.

**VOICE WITHIN THE HEALTHCARE CONTEXT**

Healthcare systems in most developed countries are facing dramatic challenges in providing high quality and error free patient care. While there are many factors contributing to this state of affairs, inadequate and underutilized frontline worker voice is often seen as leading to poor quality of patient care and unacceptably high medical and medication error rates (Avgar et al., 2016; Schwappach and Gehring, 2014). In short, voice (or lack thereof) is critical to the safe delivery of patient care that has real-world life and death implications in the health context. Nevertheless, despite its centrality, healthcare researchers have documented the widespread prevalence of frontline providers’ reluctance to use voice to address behaviours and practices that are inconsistent with the delivery of high-quality patient care (Okuyama et al., 2014).

Frontline employee reluctance to speak up in healthcare has been linked to team-level psychological safety (Nembhard & Edmondson, 2006), which highlights the importance of the organisational climate and context in promoting effective forms of voice and creating an environment that encourages frontline workers to speak up (Bosak et al., 2017). The healthcare literature also points to the importance of voice barriers, posed by status (such as between doctors and nurses) and occupational differences (Nembhard & Edmondson, 2006; Okuyama et al., 2014). For example, in Australia, the Queensland Public Hospitals Commission of Inquiry (QPHCI) was instigated following complaints relating to the actions of Dr Jayant Patel at Bundaberg base hospital in 2004 and early 2005, and the inability of other staff to voice their concerns. At the time before his arrest for the deaths of several patients he operated upon, Dr Patel had been in a senior position as the Director of Surgery,
and attempts by the less senior nurses to raise concerns regarding his medical treatment of patients went ignored by management, indicating a clear hierarchical division between doctors and nurses, whereby nurses were discouraged to speak up on patient concerns (Wilkinson et al., 2015). Similarly, reports in the UK, such as the Francis report (2013), arose following the failings at Mid Staffordshire National Health Foundation Trust, where it was evident that staff concerns over standards of poor care were ignored. The famous *Silence kills* study showed that 85 per cent of nurses were warned about a problem by a safety tool but 58 per cent felt powerless to speak up (Maxfield et al., 2005).

Not surprisingly, there has been a growing interest in how voice can be leveraged to address these persisting challenges. Nevertheless, despite this interest, healthcare research has been primarily focused on employee voice as a vital input that can reduce errors or unsafe clinical practices, actions and behaviour (Schwappach and Gehring 2014), rather than on how employee voice can be used to address concerns that healthcare staff have about their own interests and welfare. This healthcare literature is primarily focused on patient welfare and errors such as health care related infections, incorrect medication or doses and how staff speaking up can contribute to a reduction of errors and quality improvements in general. However, we might see such an approach as short sighted given the link in healthcare between worker outcomes and patient care outcomes (Avgar et al. 2016; Avgar, Givan, Eaton, and Litwin 2018). As documented by employment relations scholars, improved working conditions for frontline healthcare providers is related to improved quality of patient care (for a study examining the link between outsourcing of hospital cleaners and rates of hospital acquired infections see, Litwin, Avgar, and Becker 2017). As such, increased scholarly and practitioner attention to the role that voice can play in affecting worker outcomes is likely to contribute both to enhanced working conditions in a vital industry, and to a more nuanced understanding of how voice can have an indirect effect on patient-care quality.

Thus, for example, the findings of the Standing Committee on Community Affairs: Inquiry into the Medical Complaints Process in Australia found that despite a 'zero tolerance' approach to bullying and harassment, these unacceptable practices were nevertheless a widespread and significant problem across the medical profession, affecting patients and their families, medical
practitioners, students and trainees (2016, p. 41). Similarly, the Australasian College for Emergency Medicine (ACEM) reported that more than a third of those surveyed said they had experienced bullying (see Australian Medical Association, 2017). It is apparent, therefore, that within the healthcare context there are barriers to employees speaking up on both patient and employee related concerns, leading to poor outcomes for patients and employees alike. Consequently, we need to consider how hospitals and other healthcare organisations can more effectively elicit frontline worker voice.

Building on exiting ER, HRM and OB research, we argue for a link between staff wellbeing and patient outcomes, and view voice as a mechanism for this relationship. (Buttigieg et al 2011) First, staff who do not speak up about their own interests and wellbeing, including traditional ER concerns about wages and working conditions, and more serious instances of mistreatment such as bullying, may also be less likely to make suggestions for organisational improvements, as proposed in OB voice research (eg Morrison 2011). Furthermore, and as Hirshman (1970) famously theorised, such workers will be more likely to “exit” rather than voice (see also Forster 2005, Davies 2005). Second, improvements to working conditions associated with worker voice are likely to translate into an improved capacity to provide high quality care. At a time when the inability of hospitals to manage staff successfully is resulting in excessive turnover and a demoralised workforce and leading to other withdrawal behaviours such as high levels of absenteeism, it is more important than ever that voice scholars provide empirical evidence on the link between voice and working conditions in this unique and essential setting. Thus, as Bosak et al (2017 p19) comment, “scholars and managers alike are thus seeking the holy grail in terms of how to engage and succeed in the productivity challenge yet maintain employee motivation and morale”.

PATIENT-CARE AND WORKING CONDITIONS VOICE WITHIN HOSPITALS

Hospitals are complex organisations due to the nature of work that is performed within their boundaries, their large scale, high levels of uncertainty, the consequences associated with poor performance, and the interaction between and across a host of professional groups with varying levels of organisational and occupational status. This combination of complexity, high stakes, uncertainty, and clear status differences poses a particular challenge for eliciting genuine and effective employee voice. With more than 70 per cent of a hospital’s expenditure
being employment costs, this level of “labour intensity” gives impetus to the need to look to workplace practices and relationships for improvements. A review by Lchniowski et al. (1996:299) concluded that, 'innovative workplace practices can increase performance, primarily through the use of systems of related practices that enhance worker participation, make work design less rigid and decentralise managerial tasks'. However, scholars have warned that the piecemeal take-up of novel practices means that many enterprises miss the benefits to be gained from a more integrated approach, and it is thus a challenge for managers to identify and implement sets of integrated voice practices (which we define here as voice “bundles”).

We call for a similar conceptual approach to voice. Specifically, we argue that like other work practices, we should assess worker access to voice as a function of multiple and potentially reinforcing voice enhancing practices that, together, form a voice bundle. Doing so, we maintain, allows for a broader and more complete understanding of different patterns of voice in general and in the healthcare setting in particular. In addition, this approach is also likely to increase disciplinary integration. The siloed approach to the study of voice may, among other factors, be the product of a fragmented focus on the facilitation of voice in organizations through separate processes and practices. In other words, in the absence of an integrated conceptualization of voice, different disciplines may focus on specific practices or pieces of a larger puzzle.

One way to address the healthcare specific voice challenges discussed above is to conceptualize and empirically identify different configurations or bundles of practices. Are there certain voice bundles that are more effective than others? Do voice bundles differ in terms of their ability to encourage different types of voice? Thus, while hospitals are increasingly experimenting with workplace innovations designed to improve the quality of patient care, alleviate financial pressures, and retain staff (Avgar et al 2011), such as high performance work systems (HPWS), which includes employee voice (Weinberg et al., 2013), it clearly makes sense for management to approach employee voice as integral to workplace innovation efforts (Detert and Burris 2007). Scholars, for their part, need to provide more clarity about the different ways in which voice plays out in this critical setting. While we do not yet have clear evidence regarding the range of different voice bundles in healthcare or the relative effectiveness of different configurations, we are convinced that this is an important and fruitful research agenda.
Moreover, evidence regarding this configurational approach in the healthcare context is likely to inform how we think of voice in other settings.

Our definition of voice covers speaking up about such matters as operational errors and patient care, ER interest in ways that employees participate in and challenge management decisions, HR interest in employee access to due process and grievance procedures, and OB interest in employee efforts to offer constructive suggestions and opinions to enhance the overall performance of the organisation. This definition of voice draws on the academic concepts commonly utilised within the OB, HRM and ER literature, including “pro-social voice”, where employees are seen to speak up to improve organisational functioning (Van Dyne and LePine, 1998); “justice-based voice”, where speaking up seeks to correct organisational wrongdoing (Olson-Buchanan and Boswell, 2008); “grievance voice”, where employees seek to correct personal grievances (McCabe and Lewin, 1992); and voicing over “employee rights and interests”, such as improved wages and employment benefits (Bryson, 2004). While we recognise that employee voice can encapsulate each of these dimensions, in reality the content of any given concern or issue a healthcare worker has may relate specifically to patient care or their own well-being and working conditions. An organization’s voice system is made up, we argue, of a bundle of patient care voice practices and a bundle of working conditions voice practices. Identifying the role that voice plays in healthcare requires, therefore, that we conceptualize voice as a system of practices bundled into fundamentally different types of voice. This systems lens is likely, we propose, to facilitate greater voice scholarship integration.

Our theoretical approach, therefore, is to distinguish between voice designed to primarily address patient care concerns and voice that is designed to primarily address working conditions and sources of frontline employee dissatisfaction. Different overall systems of worker voice, we maintain, will differ in their effectiveness in terms of facilitating each type of voice. Some bundles may privilege patient care directed voice over working conditions voice while others may increase availability of the latter over the former. An effective voice system, we argue, is one that is balanced in the availability of both forms of voice.

To that end, we develop the concept (and associate Model, see below) of “voice bundles” in the healthcare context, which represents the integration of different sets of voice practices designed to elicit different types of employee input and involvement. One bundle might
comprise primarily voice enhancing practices, such as upwards employee communication of suggestions and opinions about possible work improvements that will assist to enhance patient care, whereas another set of voice practices, such as dispute resolution practices, employee work groups and information sharing platforms, and formal employee representation through staff associations and unions, will be focused on improving employee outcomes. Within any given hospital setting, we would expect variations in bundles across the organisation and also across and within discrete operational units, such as emergency and surgery units.

Figure 1 Model of patient care voice and working condition voice bundles and outcomes

While they are discrete forms of voice in that their primary focus is different, we also believe patient care voice and working conditions voice to be inextricably linked. Figure 1 graphically depicts our conceptual model illustrating this relationship. A hospital’s voice system includes, we propose, two primary bundles that are designed to elicit very different forms of input from frontline workers. Each of these bundles is comprised of both formal and informal voice mechanisms and are likely to vary in their effectiveness across hospitals and units. As depicted in our model, we expect employee voice to have both a direct and indirect effect on patient care. Staff may speak up directly to improve patient care, while voice can also drive improvements in working conditions, which, in turn, improve patient care. As such, worker wellbeing is the mediator between voice and patient care. This proposed link builds on existing literature cited above, but advances research on the relationship between voice practices and quality of patient care by highlighting a potential mechanism by which this effect is delivered.

In addition, we propose that healthcare workers may use a variety of different voice strategies to express patient care and/or employee related concerns, and that the use of voice to address working conditions is likely to influence and promote voice that targets patient care related shortcomings. Avgar and colleagues (2011) found that employee turnover mediates the link
between organizational innovations around delivery of care and patient care outcomes. They also found that work practices that can be seen as voice enhancing are an important moderating variable in the relationship between patient care delivery models and errors that could harm staff and patients. Therefore, we propose that when voice bundles promote the expression of voice related to both patient care and employee working conditions voice, this will lead to improved wellbeing and patient care outcomes.

To this point, voice has been approached from either an employee benefit or and organisational benefit (such as through improved patient care outcomes) perspective but rarely by considering both together. Our framework sets forth a foundation on which to better understand how voice in one sphere can spill over to the other with significant consequences for multiple stakeholder outcomes. It also points to the need for more complex criteria to be used to evaluate the effectiveness of worker voice. Voice should be assessed based on its ability to advance two distinct objectives—improved working conditions and employee wellbeing, and improved patient care—through the use of different sets of practices.

This research is highly relevant to the debates on both patient welfare and employee welfare, both of which are attracting significant attention. Our conceptual approach points to the need to get inside the 'black box' of voice behaviour and allow us to explore how the voice system works in practice. For example, some pilot data suggests health workers spend considerable effort in informal peer to peer voice but do not always want to express voice through the dedicated formal channels. Furthermore, as noted above, existing research has for the most part focused on individual voice practices with limited attention to the different bundles of multiple voice practices designed to advance different types of organisational outcomes. Instead, our approach is to examine these two separate bundles (patient and worker centred) of voice as being part of one voice system.

**CONCLUSION**

In general, much policy discussion around employee voice in the healthcare context relates to its absence, including the consequences of a lack of voice and efforts by whistle-blowers to raise issues where voice is constrained. However, opportunities for voice occur much further upstream in day to day workplace interactions. As such, whistleblowing is a last resort or a response to the failure of voice systems (Wilkinson 2015 et al.). As Jones and Kell comment
(2017, p709) “the disregard shown by academics, practitioners and policymakers to employee voice strategies, which do not amount to whistleblowing but equally cannot be defined as silence result in signals being ignored that can be effective in preventing and ending wrongdoing by others”. Better employee-voice mechanisms should be able to prevent incidents of 'rogue doctors' continuing to operate in hospitals, and instances of workplace bullying, as well as reducing employee turnover. Moreover, it follows logically that the provision of voice practices that enable hospital staff to identify issues and concerns related to patient care and that provide them with the opportunity to express their suggestions for improvement, should improve patient care outcomes; while practices that provide the opportunity for employees to voice on working conditions issues will improve employee wellbeing outcomes. In our model, explained above, we have proposed that effective bundles of voice practices will contribute to a climate supportive of working conditions voice and that this will encourage employees to speak up on patient care issues, and vice versa. We also proposed that there would be a reciprocal relationship whereby employee wellbeing outcomes and patient care outcomes would be influenced by both forms of voice. To date, voice has been approached from either an employee benefit or organisational benefit perspective but rarely by considering both together.

In this chapter we have also proposed that researchers seek to bridge the voice literatures in the HRM, ER and OB fields to examine the wider employee and organisational benefits of voice, and we propose a model for doing so (applied specifically in this case to healthcare) as a starting point for such integration. We suggest the need to understand how greater coherence and complementarities within a given “voice system” can serve to advance multiple stakeholder outcomes, in this case as it relates both to the delivery of high-quality patient care and the effective management of a complex healthcare workforce. Previous research has primarily focused on individual voice enhancing practices. We call for a broader and more comprehensive conceptualization of voice, and show how in this case it takes into account the various different voice mechanisms operating in tandem that are available to employees and designed to facilitate patient care input, and those that allow for expressions of dissatisfaction around working conditions and employee rights. We term these voice bundles as they are sets of practices integrated in a manner designed to elicit different types of employee input and involvement and advance specific sets of outcomes - patient care and employee wellbeing. Though set here in the healthcare context, we believe the voice bundles model we propose can be applied/adapted
to other contexts to advance our understanding of the relationship between voice practices aimed at enhancing worker as well as customers/client/stakeholder interests.

REFERENCES


