***Organisational Internal Environment, Role Clarity and Citizenship Behavior
At Casualty Emergency Centers in Uganda.
(by Kibedi Henry)***

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 analysed 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 hospital X and Y casualty centers. Hospital X had a higher level of organizational environment than hospital Y; whereas hospital Y was better than X at clarification of employee roles. Role clarity, organisational commitment, employee empowerment, and supervision had a 66.1% predictive potential on OCB. However, organisational commitment is a highly significant predictor at both hospitals. Implications for regular organizational internal environment audit, OCB appraisal, empowerment evaluation, and competence profiling at casualty centers are elucidated.

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 (MOH-HSSP, 2002), 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, inspite 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 2004). In addition, the casualty

care units in many hospitals are dilapidated. The operating conditions are grim. Munene

(1995, 2004) 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 most simple 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 demolishing and has encouraged negative clinical, administrative, and management habits (Mwesigye 1995).;

Problem statement

The casualty emergency care units in many hospitals are approaching 'casualty status'. The levels of role clarity, hospital internal environment, employee empowerment and commitment have progressively deteriorated. The emergency operating climate is grim, facilities disorganised 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 and methods

The study examined the organizational internal environment , role clarity, employee empowerment, commitment and their effect on citizenship behavior at hospital X and Y casualty centers

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 analysed using SPSS package, to establish pearson's correlation coefficient, t-test, and regression analysis level of significance between variables and groups.

Findings and discussion

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.

However, there was a significant difference with regard to role clarity between X and Y Hospital casualty centers (r = 3.392; p < 0.01). Y casualty emergency centre was better at clarifying work roles (Mean =18.2821) compared to X (Mean=16.6914). Hospital Y endeavours 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.

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, ther was no significant relationship between perception of rewards and OCB (r = .004; p > 0.05). This findings 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 opportuntity to learn and develop are empowering and enable employees to accomplish their work. In hospital Y, 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 Labchinger, 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.

However, T-test group statistical findings showed no significant difference between Mulago and Rubaga casualty Emergency centres with regards to employee empowerment (t = .187; p >.01); organizational internal environment and organizational commitment (r = .098; p > .05). This finding is inconsistent with Moos (1994) and Seiter (1984) assertion that the work interval environment characterized by quality interpersonal relations between supervisors and subordinates improves employee commitment.

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 finding 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 facilited 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) labelled 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 standars 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 elicits 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 hospital X and Y

casualty emergency centres with regard to overall organizational internal environment (t

= 2.504; p < 0.05). X casualty Centre had higher levels on managing the organizational

internal environment (Mean = 100.2840) than Y (Mean = 90.0000). This finding has

been re-enforced by a significant difference on level of supervision between X and Y

casualty emergency centres (t = 33.073; p < .01). X casualty center had a higher mean

value (45.3086) of supervision compared to Y (38.8718) and therefore was better at

supervising workers who handle emergency cases.

However, there was a significant difference in coping with reward related

problems between X and Y casualty centers (r = 2.277; p < 0.05). X casualty center was

better at coping with reward related issues (17.6687) than Y center (15.7436)). X

hospital had negotiated a loan scheme with Commercial Banks, and hire purchase with

Musicraft, Tonakopesha and Celtel (U) Limited. These schemes were intended to make

good the salary/rewards and maximize benefit (MHB FY 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 hospital X and Y

casualty centers with regard to perception of information/consultation bureaucracy ($t =$

1,750, p >0.01). Howeve, there was a significant difference at coping with information

consultation related problems ($t = 3.097$, p <0.01). X casualty center respondents are

better at coping with information/consultation bureaucracy related problems (mean =

56.4198); compared to hospital Y casualty centers (Mean = 51.5263).

Implications

Management should enhance efficient handling of casualty emergency cases

by empowering health workers through specialised 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 commitees 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 periphera public and privatel 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.

References

Batman,T.,& Organ,D. (1983). Job satisfaction and the good soldier;The

relation between affect and employee" citzenship". *Academy of Management Journal*.26 ,

578-596.

Ezati, A.I.(2000). Patterns of emergency admissions in Kampala. *Mulago*

hospital bulletin, Vol. 3 ,No. 1 Kampala.

Kanter, R.M . (1977). *Men and women of the corporation*. New York

Kanter, R.M. (1993). *Men and women of the corporation* (2nd ed). New York.

Basic books.

Kramer, M.L., Sicbert, S.E.,& Liden, R.C. (1999). Antecedents and outcomes of

empowerment as a multidimensional construct; A test of construct validity; *Educational*

and Psychological measurement, 59. 127-142.

Lashinger, H.K.S., & Wrong, C., McMahon.,L., & Kaufmann, C. (1999). Leader behaviour impact on staff nurse empowerment, job tension and work effectiveness. *Journal of Nursing Administration,* 29(5), 28-39.

M.O.H, *Health Sector Strategic Plan*. (2001-2005). Kampala, Uganda.

Mohan, D.,& Tawan, G. (2000). *Ed. Injury prevention and control*. London.

Moorman, R.,Niehoff, B., & Organ, D. (1993). Treating employees fairly and organisational citzenship behaviour; sorting the effects of job satisfaction, organisational commitment and procedural justice. *Academy of management journal*, 37. 1543-1567.

Mueller, C,W., Boyer, E.M., Price, J.L.,& Iverson, R.D.(1994) Employee attachment and Noncoercive conditions of work; The case of dental hygienists, Work and Occupations. 21(21); 179-212.

Munene, C.J. (1995). Not on Seat; An investigation of correlations of organisational citzenship behaviour in Nigeria. *Internatioal Association of Applied Psychology.*. Vol. 44,pp 111-122.

Mwesigye, G. (1995). *Effect of user charges on quality of curative services in district hospitals*. An analysis-Uganda.

O'Reilly I.C., & Chatman, J. (1986). Organisational commitment and Psychological attachment; The effects of compliance, identification, intrenalisation, absenteeism, on prosocial behaviour. *Journal of Applied Psychology*, 71, 492-499.

Podsakoff, P., MacKenzie, S.,& Boomer, W. (1996). Transformational leader behaviours substitutes for leadership as determinants of employee satisfaction, commitment, trust, and organisational citizenship behaviour. *Journal of Management*, 22, 259-298.

Podsakoff, P., Niehoff, B., MacKenzie, S., & Williams, M. (1993). Do sudstitutes for leadership really substitute for leadership? An empirical examination of Kerr & Jermier's situational leadership model. *Organisational behaviour and Human decisions processes*.54, 1-44.

Seiter,S. (1984). *The relationship between leader behaviour and the work environment* (Doctoral dessertation, University of Nebraska, 1982). Dessertation Abstracts International, 43.

Seth, D., Zwi, A., Gilson, I., Fox, J.R., Makon, C., Msika, D., Levy, L.,& Manigusampillay, S. (1995). *A rapid assessment of accident and traumatic Emergencies in Zimbabwe.*

Wellins, R.S., Byham,W.C., Wilson, J.M. (1991). *Empowerment of teams, creating self-directed work groups that improve quality, productivity, and participation.* Jossey Bass Publisher. San Francisco

WHO (1999). *Injury. A leading cause of the global burden of disease.* Geneva.