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# Can organizational justice help the retention of general practitioners?

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ABSTRACT

In many countries, public sector has major difficulties in recruiting and retaining physicians to work as general practitioners (GPs). We examined the effects of taking up a public sector GP position and leaving public sector GP work on the changes of job satisfaction, job involvement and turnover intentions. In addition, we examined whether organizational justice in the new position would moderate these associations. This was a four-year prospective questionnaire study including two measurements among 1581 (948 women, 60%) Finnish physicians. A change to work as a public GP was associated with a substantial decrease in job satisfaction and job involvement when new GPs experienced that their primary care organization was unfair. However, high organizational justice was able to buffer against these negative effects. Those who changed to work as public GPs had 2.8 times and those who stayed as public GPs had 1.6 times higher likelihood of having turnover intentions compared to those who worked in other positions. Organizational justice was not able to buffer against this effect. Primary care organizations should pay more attention to their GPs – especially to newcomers – and to the fairness how management behaves towards employees, how processes are determined, and how rewards are distributed.



## 1. Introduction

In many countries, public sector has major difficulties in recruiting and retaining physicians to work as general practitioners (GPs). For example, in Finland 11 percent of the vacancies in public health care centers were not filled in 2008 [1]. In 2001, a fifth of English GPs intended to quit direct patient care within five years [2]. Increased need to recruit and train new GPs due to high GP turnover may lead to decreased productivity, be costly, and affect health outcomes [3,4]. In the US, it has been estimated that the minimum cost of turnover may represent a loss of over five percent of the total annual operating budget due to hiring and training costs and productivity loss [5]. In addition, patient care suffers from physician turnover because the continuity of care is undermined and patient satisfaction is impaired [4]. Moreover, turnover and turnover intentions may lower GPs work morale [4] and lead to absenteeism and lowered performance [6].

The high stressfulness of GP's work may underlie the unpopularity of GP work. Approximately 30–50 percent of GPs report high levels of psychological distress in the UK [7] and 10 percent have been found to report very high levels in New Zealand [8]. The combination of low job satisfaction, poor mental health, and poor subjective physical health is a common experience for many GPs [7]. In the UK, researchers have found that male GPs score higher on anxiety and depression than the general population

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[9]. Burnout has been found to be more common among GPs than among other physicians [10]. In Finland GPs are reported to be less committed to their organizations than other physicians [11]. Public sector physicians have also been found to have lower levels of job satisfaction and organizational commitment and higher levels of psychological distress, sleeping problems, and problems in connecting work and family life than private sector physicians [12,13]. Lower commitment and job satisfaction among GPs is a concern since earlier research suggests that GPs that are dissatisfied with their jobs are more willing to change from the public sector to the private sector [14].

A factor that shows promise as a possible buffer in negative work environments is justice of the organizational procedures and leadership. The term 'organizational justice' refers to the extent to which employees are treated with justice in their workplace [15]. Organizational justice can further be divided into procedural, interactional, and distributive components. Procedural justice can be defined as the justice of the processes by which organizational outcomes are determined [16]. Interactional justice refers to the nature of the interpersonal treatment towards the employees, especially from the leaders [17,18]. Distributive justice is known as the justice of resource distributions, such as pay, rewards, and promotions [19].

Organizational injustice has been associated with retaliation, turnover, lower job satisfaction, and lower organizational commitment [15,20–22]. Studies involving Finnish hospital personnel have shown organizational injustice to be associated with increased rates of mental distress, psychiatric disorders, sickness absence, and poor self-rated health status [23–25]. It has also been shown that organizational injustice is associated with a lower quality of care [26] and decreased productivity [27] in long-term care for the elderly.

Previous studies have shown that especially among health care sector employees, perceptions of organizational justice are important for two reasons: (a) they are directly related to the well-being, attitudes, and performance of employees; and (b) they seem to act as a buffer for the negative impact of a number of detrimental factors. For example, it has been shown that high levels of organizational justice are able to mitigate work-family conflict associated with working with fixed-term employment contract [28]. In addition, organizational justice has been shown to buffer against the negative effects of employer that is experienced as insecure [29] and low staffing levels [30]. The theoretical rationale for the strong buffering effect of organizational justice comes from the fairness heuristic theory which assumes that because ceding authority to another person provides an opportunity for exploitation, people may feel uncertain about their relationship with the authority [see e.g., 16,31]. In other words, if one chooses to co-operate with others, sacrifice for the common good, and allocate a lot of time and energy to work, there is always a possibility that this high effort will be exploited. Therefore, it is important for people to know whether the authority will treat them in an honest and nonbiased way [18]. One way to resolve the fear of exploitation is to use impressions of fair treatment as a heuristic device [32]. Thus, when the procedures, pay and leadership are considered to be fair, employees can assume that working with a high work load and under a lot of stress, for example as a GP, is profitable also for them and would not lead to exploitation. Therefore, one might expect that working as a GP when organization is considered as fair might not lead to such negative consequences.

A concept that is of importance in health care sector but still only little researched among GPs is job involvement which refers to a cognitive belief state of psychological identification with one's job [33]. Job involvement has been associated negatively with turnover intentions [34] and among physicians it has been associated positively with job satisfaction [35].

Even though previous studies show that GP's work is stressful, little is known of the effects of taking up a GP work and leaving the GP work. Moreover, it has not been studied yet whether organizational justice could buffer against the possible negative effects of these work changes. Thus, the present four-year prospective study among Finnish physicians aimed to examine the effects of leaving public sector GP work and taking up a public sector GP position on the changes of job satisfaction, job involvement and turnover intentions. In addition, we examined whether organizational justice in the new position would moderate these associations. Based on previous studies, we expected that taking up a GP position would be associated with negative changes in the outcomes, whereas the reverse was expected for leaving the GP position. Moreover, we expected that high levels of organizational justice could buffer against these negative changes of taking up a GP position.

## 2. Methods

### 2.1. Study sample

The present work and Wellbeing of Finnish Doctors data is a part of an ongoing Finnish Health Care Professionals Study, in which we drew a random sample of 5000 physicians in Finland (30% of the whole physician population) from the 2006 database of physicians maintained by the Finnish Medical Association. The register covers all licensed physicians in Finland. Phase 1 data were gathered with postal questionnaires in 2006. Non-respondents were sent a reminder and copy of the questionnaire up to two times. Responses were received from 2841 physicians (response rate 57%). The sample is representative of the eligible population in terms of age, gender, and employment sector [36].

Four years later, at phase 2 in 2010 the data were gathered by using either a web-based or a traditional postal survey. At phase 1 the respondents were asked their permission to follow-up surveys and 2206 agreed to participate in future surveys. Those who had died or had incorrect address information were excluded ($N = 37$), thus, at phase 2 the survey was sent to 2169 physicians. First, an e-mail invitation to participate in the web-based survey was sent followed by two reminders. For those who did not respond to these, also a postal questionnaire was sent once. E-mail and postal addresses were obtained from the Finnish Medical Association. The total number of respondents was