

### **Demographic Drivers of Workplace Deviance: A Survey of Clinical and Non-Clinical Hospital Professionals**

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#### **ABSTRACT**

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This paper aims to determine the extent to which employee demographic characteristics (gender, age, tenure and professional group) predict an employee's decision to participate in deviant workplace behavior. We conduct a quantitative field study consisting in a survey of 113 clinical and non-clinical professionals at the three largest hospitals in Brazil. ANOVA and linear regression were used to test the hypothesized model. Our results reveal that those most prone to deviant behavior are the short tenure, young and administrative professionals. Although we found no association between gender and workplace deviance, our results generate specific knowledge on relevant behavioral issues involving clinical and non-clinical hospital professionals. The knowledge of the demographic characteristics that may predict workplace deviance will allow managers to design and implement more accurate control systems and training programs that could reduce this dysfunctional behavior and its negative impact on organizations and society.

#### **KEYWORDS**

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Workplace deviance, Counterproductive work behavior, Hospital, Demographic characteristics, Survey.

## **1. Introduction**

Workplace deviance refers to observable and voluntary employee behavior infringing on organizational rules. This deviance, also known as counterproductive work behavior, includes a wide range of pervasive behaviors (e.g. alcohol/drug consumption, theft, mobbing, bullying and the disclosure of confidential information) in all kinds of organizations across the world. These behaviors represent a hazard to the organization's well-being (organizational deviance) and/or to its workers (interpersonal deviance) (Bennett and Robinson, 2000). Recent healthcare management studies highlight the prevalence of workplace deviance in hospitals and its adverse impact on financial, social and psychological cost as well as on healthcare quality and efficiency (Gallant-Roman, 2008; Christian and Ellis, 2014; Chu, 2014; Fida, Laschinger, and Leiter, 2018). In this respect, the healthcare sector is among the world's top-5 sectors with the highest frequency of deviant work behavior (Association of Certified Fraud Examiners, 2016). In the U.S. alone, over 22,428 disciplinary actions against practicing medical physicians were reported from 2008 to 2012 (Federation of State Medical Boards, 2014).

Existing socioeconomic conditions have made it crucial to analyze the effectiveness and financial sustainability of healthcare institutions (Gonzalez-Sanchez, Lopez-Valeiras, and García-Montero, 2014). In this line, the study of employee deviance predictors in healthcare institutions has made great progress over the past few years (Issel, 2017). Current research mainly focuses on organizational factors (e.g. organizational justice (Faheem, 2015), intention to quit (Christian and Ellis, 2014) or stress) (Chen et al., 2008) and social factors (e.g. the influence of the work group (Dabney, 1995) or the influence of supervisors (Peng, Tseng, and Lee, 2011; Chu, 2014). Although psychology and management literature traditionally recognizes the influence of demographic variables like gender, age, tenure and professional group in explaining employee behavior (Henle, Giacalon, and Jurkiewicz, 2005; Salas-Vallina, Alegre, and Fernández, 2017) little is known about this relationship within a hospital setting.

Expanding knowledge about the impact of individual demographic characteristics<sup>1</sup> on the workplace deviance can be fundamental for its management. For example, younger employees compared to older managers tend to be more determined and aggressive in an effort to succeed in their professional careers (Hambrick and Mason, 1984) or to prove

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<sup>1</sup> Recently upper echelon literature focused of a set of demographic characteristics at team level, such as homogeneity or heterogeneity (Naranjo-Gil, 2016; Wang et al., 2016).

that they are competent (Kor, 2006). Tenure can be another important feature in workplace deviance. In this regard, Michel and Hambrick (1992) suggest that it can be associated with social cohesion and shared cognitive structures, and these attributes can increase socialization, and consequently lead to a better relationship at work. Male employees are overconfident when compared to female employees. In addition, women are more cautious in their decisions, which can be a factor linked with workplace deviance. Particularly in hospitals, the professional group (eg, clinical and administrative) can be another variable associated with workplace deviance.

We have chosen the healthcare sector due to its complex environment with multiple activities, tasks and interdependent processes. In general, hospitals demand professionals with different backgrounds to provide a wide range of services to society, who often present their own views of how activities should be carried out. In addition, these activities require teamwork, which includes frequent interactions and joint decisions. By understanding the characteristics of employees, coordination of activities and the work environment can be improved, which can increase efficiency in the use of resources in hospitals (Naranjo-Gil, 2016).

Moreover, most research addressing the drivers of workplace deviance in hospitals focus on homogeneous groups of clinical professionals (Strandmark and Hallberg, 2007; Chu, 2014; Nicholson, Leiter, and Laschinger, 2014; Zaghini et al., 2016; Fida, Laschinger, and Leiter, 2018; Viotti et al., 2018). So researchers have ignored the complexity of all other professional hospital groups and their link to deviant behavior. Recent research highlights the prevalence of workplace deviance both at non-clinical (Keyvanara, Maracy, and Ziari, 2015) and clinical hospital departments (Chu, 2014). What is more, it shows significant behavioral differences between these two professional groups based on their distinctive individual backgrounds (Pepermans et al., 2001; De Harlez and Malagueño, 2016).

Starting from a previously validated workplace deviance measure in hospitals (Lunkes, Gomez-Conde, and Lopez-Valeiras, 2015), this study aims to identify the determinants of hospital workplace deviance. To this end, it clarifies and complements findings in psychology and management and proposes the following research question: “What type of hospital employees are more likely to participate in deviant behavior?” In response to this question, we use four demographic employee characteristics (gender, age, tenure and professional group) to predict two types of deviant workplace behavior (organizational

deviance and interpersonal deviance) (Aquino, Tripp, and Bies, 2001; Henle, Giacalon, and Jurkiewicz, 2005; Lunkes, Gomez-Conde, and Lopez-Valeiras, 2015). Apart from extending existing literature, our results may also have implications on hospital management by helping practitioners reduce losses due to employee deviance.

## **2. Framework and Conceptual Model**

The Upper Echelon Theory suggests that characteristics such as gender, age, tenure and professional group, are important proxies explaining implicit differences in cognition, perception and value (Carpenter, Geletkanycz, and Sanders, 2004). These variables substantially affect employee decision-making and behavior (Hambrick and Mason, 1984).

First, women and men have different behaviors and perceptions in decision-making. Women are more risk-averse than men and they tend to have superior leadership, communication and listening skills (Eagly and Carli, 2003). For example, male doctors make different decisions than women do when prescribing medication, i.e., female physicians perceive generic medication more negatively than do their male counterparts (Johannesson and Lundin, 2002).

Second, we suggest age is another factor that may predict an employee's decision to participate in workplace deviance. Younger employees are more innovative and aggressive, while older employees are more conservative. Younger employees are more enthusiastic; they are more capable of taking risks and have a greater tendency to do so (Wiseman and Gomez-Mejia, 1998). Younger employees may also be more capable of learning and integrating information into decision-making, and may be more confident about their decisions. They may have superior technological know-how (Bantel and Jackson, 1989), and may be capable of taking risks because they have left their concerns about financial and career security far behind (Barker and Mueller, 2002).

Third, long tenure employees tend to behave differently. Short tenure employees are more likely to take risks to prove their competence to themselves and others (Kor, 2006). Contrarily, long tenure employees may deploy risk aversion of lower pressure on them (Barker and Mueller, 2002; Henderson, Miller, and Hambrick, 2006). In fact, clinicians with tenures over 10 years disagree to given statements more strongly than they do with less time (Tsaprantzi et al., 2016).

Finally, differences in education, background and experience of professionals with clinical and administrative profiles may lead to distinct behavior. For instance, team-

based and cooperative behavior characterize non-clinical backgrounds while autonomous and competitive behavior characterize clinical backgrounds (De Harlez and Malagueño, 2016). In addition, differences in decision-making may be linked to ethical issues and professional standards. Previous studies recognize that clinicians behave or decide based on deontological codes allowing their decisions to be challenged; but these expectations do not apply to administrative employees or managers (Devlin and Magill, 2006).

Following the above discussion, employee demographic characteristics (gender, age, tenure and professional group) predict an employee's decision to participate in workplace deviance.

### **3. Methods**

#### **3.1. Sample and data collection**

We use a five-page survey instrument containing sections on workplace deviance (22 items) (Bennett and Robinson, 2000) and sociodemographics (10 items). To carry out our research question, we use items on employee demographic characteristics (gender, age, tenure, and professional group) and employee workplace deviance (organizational and interpersonal). The survey is widely used to measure behavior in healthcare organizations (Fida, Laschinger, and Leiter, 2018). We pay special attention to the translation of the original scales from English to Portuguese. Moreover, following previous studies (Dillman, Smyth, and Cristian, 2014), we pre-test the survey on six academics and three hospital professionals for the sake of clarity, ambiguity, and face validity (Lopez-Valeiras, Gomez-Conde, and Lunkes, 2018). The procedure yielded valuable suggestions that improved the understandability of the final version of the questionnaire.

Data were collected at the three largest hospitals (Ahmed, 2012; Marx, 2014; Weech-Maldonado et al., 2018) in the State of Santa Catarina (Brazil) between October 2013 and January 2014. One of them was a private hospital (198 beds), another was a state-administered public hospital (329 beds) and the third was a public hospital school managed by the federal government (228 beds). The scientific committees of the hospitals gave ethical approval and authorized the study. The general manager of each hospital scheduled a meeting where researchers and a representative from each of the professional groups (physicians, nurses, pharmacists and administrative employees) discussed data collection (Ahmed, 2012). All of them agreed that a member of the research team would distribute the questionnaires (on paper) personally and randomly to employees within the

hospital premises. The questionnaires, following a letter explaining the research and a note acknowledging participation, were anonymous. Collected questionnaires were put into a box specifically designed for this purpose to ensure respondents would feel free from any external interference, i.e., free of any constraint or pressure.

We received 135 surveys (29.67% of the sample) out of the total of 455 delivered questionnaires; 22 of them were not valid for this study. So the final number of usable questionnaires was 113 (29 physicians, 26 nurses, 7 pharmacists, and 51 administrative employees). Chi-square statistical tests showed no significant differences between the former and latter responses. Table 1 provides the survey demographics including hospital ownership, employee contract type, and human resource outsourcing.

	<i>Number</i>	<i>%</i>
Ownership	113	100
Private	54	47.79
Public	59	52.21
Contract	113	100
Fixed term	84	74.34
Non-fixed term	29	23.66
Human resource outsourcing	113	100
External employee	20	17.70
Own employee	93	82.30

**Table 1.** Sample demographics.

### 3.2. Outcome variables

We follow a previously validated measure of workplace deviance in healthcare organizations (Bennett and Robinson, 2000; Lunkes, Gomez-Conde, and Lopez-Valeiras, 2015) that assess two dimensions: (a) organizational deviance, and (b) interpersonal deviance. On the one hand, organizational deviance refers to deviant behavior directly harmful to the organization (Bennett and Robinson, 2000). We measure this using 11 items rated on a 7-point Likert scale (1-Never; 7-Daily) where respondents were asked about their participation in the following actions at the workplace: (i) Coming in late to work without permission; (ii) Calling in sick when they were not; (iii) Neglecting to follow boss's instructions; (iv) Intentionally working slower than they could have; (v) Discussing confidential company information with an unauthorized person; (vi) Leaving

work ahead of time without permission; (vii) Leaving work for someone else to finish; (viii) Repeating a rumor or gossip about their boss or coworkers; (ix) Making an obscene comment at work; (x) Putting little effort into work; (xi) Intentionally working slowly to obtain overtime.

On the other hand interpersonal deviance includes behavior directly harmful to other individuals within the organization (Bennett and Robinson, 2000). We measured this using 11 items rated on a 7-point Likert scale (1-Never; 7-Daily) where respondents were asked about their participation in the following workplace actions: (i) Acting rudely toward someone at work; (ii) Saying something hurtful to someone at work; (iii) Repeating a rumor or gossip about the company; (iv) Making an ethnic, religious, or racial remark at work; (v) Littering the work environment; (vi) Cursing at someone at work; (vii) Telling someone about the lousy place where they work; (viii) Losing their temper at work; (ix) Making fun of someone at work; (x) Acting rudely with someone at work; (xi) Publicly embarrassing someone at work.

Reliability of both constructs was assessed using Cronbach alpha, with values of 0.807 and 0.847, respectively, above the cut-off value of 0.5.

### 3.3. Explanatory variables

We consider four explanatory variables: (i) gender, (ii) age, (iii) tenure and (iv) professional group. We use a dichotomous variable (1 = female, 0 = male) to measure gender. We measure age in years and tenure (the time the employee has been carrying out a specific job) in months. We also use a dichotomous variable to measure professional group; “1” represents a non-clinical employee (i.e. administrative), and “0” represents a clinical employee (i.e. physician, nurse, or pharmacist) (De Harlez and Malagueño, 2016).

## 4. Results

We use version 22 of SPSS (Statistical Package for the Social Sciences) software to analyze the data; and we use OLS regressions to test the suggested links. Table 2 shows the descriptive statistics for the explanatory variables as well as for the items included in both outcome variables: organizational and interpersonal deviance. Respondents generally reported low levels of workplace deviance. The mean age of employees was 38.21 (SD = 10.54), ranging from 19 to 60 years of age. On average, 62% of the hospital

employees were female and 45% of the hospital employees were administrative. Lastly, the mean number of months (tenure) was 94 (SD = 105), ranging from 0 to 456 months.

	Mean	SD	Range
<b>Organizational deviance</b>			
Coming in late to work without permission	1.826	1.101	1-6
Calling in sick when they were not	1.091	0.367	1-3
Neglecting to follow boss's instructions	1.382	0.744	1-4
Intentionally working slower than they could	1.491	0.904	1-6
Discussing confidential information with an unauthorized person	1.144	0.397	1-3
Leaving work ahead of time without permission	1.468	0.822	1-5
Leaving their work for someone else to finish	1.411	0.797	1-6
Repeating a rumor or gossip about boss or coworkers	1.652	0.988	1-5
Making an obscene comment at work	1.532	1.084	1-6
Putting little effort into work	1.473	0.896	1-6
Intentionally working slowly to obtain overtime	1.143	0.610	1-6
<b>Interpersonal deviance</b>			
Acting rudely toward someone at work	1.596	1.087	1-7
Saying something hurtful to someone at work	1.616	0.984	1-7
Repeating a rumor or gossip about the company	1.910	1.199	1-6
Making an ethnic, religious, or racial remark at work	1.773	1.131	1-6
Littering the work environment	1.327	0.769	1-6
Cursing at someone at work	1.270	0.626	1-4
Telling someone about the lousy place where they work	1.682	0.999	1-5
Losing their temper at work	1.764	1.034	1-7
Making fun of someone at work	1.459	0.799	1-5
Acting rudely with someone at work	1.600	1.054	1-7
Publicly embarrassing someone at work	1.259	0.660	1-4
<b>Gender</b>	0.619	0.488	0-1
<b>Age</b>	38.214	10.548	19-60
<b>Tenure</b>	94.135	105.316	0-456
<b>Professional group</b>	0.451	0.471	0-1

**Table 2.** Descriptive statistics.

Table 3 displays the correlation matrix. Both constructs of workplace deviance, interpersonal and organizational deviance, show a high correlation (0.619,  $p < 0.01$ ).



Tenure and Age also show a high correlation. Concerning correlations between expected explanatory variables and explained variables, tenure and age show significant and negative coefficients on Workplace deviance, while Professional group correlates positively and significantly with deviant behavior. Gender presents no correlation with workplace deviance.

	1	2	3	4	5	6
1. Interpersonal deviance	<b>1.000</b>					
2. Organizational deviance	0.619***	<b>1.000</b>				
3. Gender	-0.066	0.085	<b>1.000</b>			
4. Age	-0.160*	-	-0.119	<b>1.000</b>		
5. Tenure	-0.202**	-0.177*	-0.038	0.574***	<b>1.000</b>	
6. Professional group	0.188**	0.246***	-0.152	-0.002	-0.080	<b>1.000</b>

\* $P < 0.1$ ; \*\* $P < 0.05$ ; \*\*\* $P < 0.01$

**Table 3.** Correlation matrix (Pearson).

Table 4 presents test of differences on workplace deviance among groups of explanatory variables. Gender (male/female), age (categorization based) (Lunkes, Naranjo-Gil, and Lopez-Valeiras, 2018) and tenure (categorization based) (Gould and Hawkins, 1978; Allen and Meyer, 1993) present no significant differences in both dimensions of workplace deviance. Professional group shows significant differences in both organizational and interpersonal deviance. The differences between non-clinical and clinical employees are the main drivers of these results.

<b>Panel A. T-tests on gender</b>				
	<i>Difference</i>	<i>Mean difference</i>	<i>t</i>	<i>P value</i>
Organizational deviance	Female- Male	-0.174	-0.899	0.371
Interpersonal deviance	Female- Male	0.134	0.695	0.489
<b>Panel B. ANOVA and Bonferroni on Professional group</b>				
	<i>F</i>	<i>P value</i>		

Organizational deviance		4.610		0.004
Interpersonal deviance		3.020		0.033
	<i>I</i>	<i>J</i>	<i>Mean difference (I-J)</i>	<i>P value</i>
Organizational deviance	Physician	Nurse	-0.487	0.314
		Pharmacist	-0.824	0.598
		Administrative	-0.720	0.004
	Nurse	Physician	0.487	0.314
		Pharmacist	-0.337	1.000
		Administrative	-0.233	1.000
	Pharmacist	Physician	0.824	0.598
		Nurse	0.337	1.000
		Administrative	0.104	1.000
	Administrative	Physician	0.720	0.004
		Nurse	0.233	1.000
		Pharmacist	-0.104	1.000
Interpersonal deviance	Physician	Nurse	-0.042	1.000
		Pharmacist	-1.084	0.207
		Administrative	-0.479	0.146
	Nurse	Physician	0.042	1.000
		Pharmacist	-1.042	0.315
		Administrative	-0.437	0.612
	Pharmacist	Physician	1.084	0.207
		Nurse	1.042	0.315
		Administrative	0.605	1.000
	Administrative	Physician	0.479	0.146
		Nurse	0.437	0.612
		Pharmacist	-0.605	1.000

**Panel C. ANOVA and Bonferroni on Age (years)**

		<i>F</i>		<i>P value</i>
Organizational deviance		2.846		0.062
Interpersonal deviance		1.457		0.237
	<i>I</i>	<i>J</i>	<i>Mean difference (I-J)</i>	<i>P value</i>
Organizational deviance	Under 30	Between 30 and 50	0.430	0.138
		Over 50	0.616	0.117

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	50	Between 30 and	Under 30	-0.430	0.138
			Over 50	0.187	1.000
	Over 50	Under 30		-0.616	0.117
		Between 30 and 50	30	-0.187	1.000
Interpersonal deviance	Under 30	Between 30 and 50	30	0.359	0.296
			Over 50	0.338	0.780
	50	Between 30 and	Under 30	-0.359	0.296
			Over 50	-0.021	1.000
	Over 50	Under 30		-0.338	0.780
		Between 30 and 50	30	0.021	1.000
<b>Panel D. ANOVA and Bonferroni on Tenure (months)</b>					
				<i>F</i>	<i>P value</i>
				0.263	0.770
				1.719	0.184
Organizational deviance	Under 25	Between 25 and 75	25	0.0176	1.000
			Over 75	0.1472	1.000
	75	Between 25 and	Under 25	-0.0176	1.000
			Over 75	0.1296	1.000
	Over 75	Under 25		-0.1472	1.000
		Between 25 and 75	25	-0.1296	1.000
Interpersonal deviance	Under 25	Between 25 and 75	25	-0.201	1.000
			Over 75	0.250	0.732
	75	Between 25 and	Under 25	0.201	1.000
			Over 75	0.451	0.228
	Over 75	Under 25		-0.250	0.732
		Between 25 and 75	25	-0.451	0.228

**Table 4.** T-tests and ANOVA.

Table 5 displays the regression analysis. The outcome variable is workplace deviance. Column 1 shows a regression of the four explanatory variables on organizational deviance (Model 1). Professional group shows a positive and significant impact on organizational deviance ( $\beta = 0.253$ ;  $p < 0.01$ ) while age shows a negative and significant one ( $\beta = -0.288$ ;  $p < 0.05$ ). Gender and tenure present a non-significant effect on organizational deviance. Thus, young workers and administrative employees are the ones that drive organizational deviance. Tenure explains no organizational deviant behavior.

	Outcome variable	
	Organizational deviance	Interpersonal deviance
Gender	0.084 (0.911)	-0.075 (-0.786)
Age	-0.288** (-2.595)	-0.072 (-0.628)
Tenure	0.015 (0.132)	-0.151 <sup>†</sup> (-1.313)
Professional group	0.253*** (2.754)	0.154 <sup>†</sup> (1.613)
F (sign.)	4.468***	2.135*
R <sup>2</sup>	0.145	0.075
R <sup>2</sup> (adj.)	0.113	0.040
Max. VIF	1.059	1.059

<sup>†</sup> Significant at 0.1 level on one-tailed test; \* $P < 0.1$ ; \*\* $P < 0.05$ ; \*\*\* $P < 0.01$

**Table 5.** Linear regressions of demographic factors on organizational and interpersonal deviance.

Column 2 shows a regression of the four explanatory variables on interpersonal deviance (Model 2). Here we see that professional group has a positive and significant impact on interpersonal deviance ( $\beta = 0.154$ ; significant at one-tailed test) just like it did in the first model. Tenure, however, presents a negative and significant impact ( $\beta = -0.151$ ; significant at one-tailed test). Gender and age reveal non-significant effects on interpersonal deviance. Just like in organizational deviation, employee professional group accounts for interpersonal workplace deviance. That is to say, administrative employees seem to be more potentially predisposed towards this kind of behavior. By contrary, employee tenure reduces interpersonal deviance. The maximum VIF of 1.059 is below the general threshold of 10 (Hair Jr. et al., 2006).

## **5. Discussion and Conclusion**

This study examines the extent to which gender, age, tenure and professional group may predict an employee's decision to participate in organizational deviance and/or interpersonal deviance. Organizational deviance corresponds to behavior harmful to the organization while interpersonal deviance corresponds to behavior harmful to other individuals within the organization.

The study of this phenomenon in healthcare management literature has made great progress over the past few decades. However, a clear interpretation of the underlying mechanisms is essential (Bennett and Robinson, 2003). Much remains to be known about the potential influence of employee demographic characteristics on workplace deviance in hospitals. This study also contributes to previous research in psychology and management literature by identifying the role of demographic characteristics in the decision to adopt deviant behavior within a complex institutional environment with multiple stakeholders and, oftentimes, ambiguous objectives.

Overall, we find that the determination of hospital professionals to participate in workplace deviance varies according to their demographic characteristics. This result falls in line with previous research in psychology and management indicating that demographic variables may predict deviant behavior even though they may represent the lesser part of the variance. Firstly, we find that professional group relates positively with organizational and interpersonal workplace deviance. That is to say, non-clinical personnel are potentially more predisposed than clinical professionals towards deviant actions, harmful to both the organization and its members. Our results therefore clearly suggest that an administrative professional group may be significant in explaining deviant behavior. In light of previous literature suggesting paramount differences in the behaviors of non-clinical and clinical staff based on their different individual backgrounds (De Harlez and Malagueño, 2016).

Studies carried out in several countries have shown that professional groups (clinical and non-clinical) can exhibit different behaviors. For example, Naranjo-Gil (2016) conducted a study in Spanish hospitals and found that management teams with clinical experience influence behavior using more flexible and dialogued controls. De Harlez and Malagueño (2016) researched hospitals in Belgium and found that the interactive use of controls generated greater performance, when managers had clinical experience. Lunkes, Naranjo-

Gil and Lopez-Valeiras (2018) studied large Brazilian hospitals and showed that clinicians do not see any use in adopting horizontal controls. Our results trigger discussion on the complementary role of a few variables linked to predisposition towards deviant actions such as salary level, social norms, relative status within an organization and nature of the job (Bennett and Robinson, 2003; Appelbaum, Iaconi, and Matousek, 2007).

Secondly, there is no consensus in psychology and management literature on the role of age and tenure as drivers of workplace deviance (Peterson, 2002; Henle, Giacalon, and Jurkiewicz, 2005). Our results suggest that both variables are important in predicting workplace deviance. Age correlates negatively and significantly with organizational deviance just like tenure does with interpersonal deviance. That is to say, employees who are young and new to their job are more likely to show deviant behavior. The study by Ertug et al. (2014) in a public hospital and a university hospital in Ankara, Turkey showed that nurses' ethical sensitivity increases with advancing age.

The intrinsic characteristics of a hospital setting pose plausible arguments for discussing this result, i.e. a young and short-tenured professional could experience more frequent situations of frustration, threats to self and perceived injustices than would a long tenure senior professional. Consistent with predictions derived from equity theory, the decision of a young and short tenure professional to participate in deviant behavior may stem as a reaction aiming to restore a state of equity undermined by perceptions of injustice (Fox, Spector, and Miles, 2001; Appelbaum, Deguire, and Lay, 2005).

Employees with less time in the hospital may lack legitimacy in the eyes of other colleagues (Miller, 1993) and are more likely to take risks to prove to themselves that they are competent (Kor, 2006). For example, largest risk zones of mobbing and single cases of harassment related to one occur in the start of professional career (Vveinhardt and Štreimikienė, 2017). Thus, they may be more willing to take more aggressive or improper attitudes in the workplace. On the other hand, longer employees can take a more leadership approach, with openness and negotiation behavior. They can emphasize reputation and stability (Barker and Mueller, 2002) and avoid making decisions that lead to workplace deviance (Kor, 2006).

Like the time in office, younger employees will be more inclined to pursue risky strategies and actions, while older employees tend to be more conservative (Hambrick and Mason, 1984, Barker and Mueller, 2002). Younger employees may be more prone to committing workplace deviance for three main reasons. First, younger employees

may be better able to learn and integrate information into decision making and may have overconfidence in decisions (Taylor, 1975). Secondly, as they received their education more recently, younger employees have superior technological knowledge (Bantel and Jackson, 1989). Third, younger employees may be able to take risks because their concerns about safety and career are far away (Vroom and Pahl, 1971; Barker and Mueller, 2002). Older employees who are prone to risk aversion and with security and career concerns tend to choose more conservative stocks, while younger managers may be more willing to risk it. When employees mature, there is a decrease in physical and mental vigor, which can lead to a reduction in deviant behavior in the workplace. Although, studies indicate that the pre-retirement age can be critical in relation to bullying at work (Vveinhardt and Štreimikienė, 2017).

Finally, we find no evidence of the relation between gender and either type of workplace deviance. By contrast, healthcare researchers have demonstrated a correlation between gender differences and non-ethical behavior, e.g. empathy or compassion (Hamblin et al., 2015) in clinical staff. Socialization theories are a widely used framework supporting the existence of this gender effect. In this sense, it is argued that family and educational institutions socialize women to make them look nicer and friendlier than men (Hamblin et al., 2015), and by nature they are more cautious than men (Mendes et al., 2017; Lunkes et al., 2019). However, empirical results in psychology and management literature are inconclusive concerning the relation between gender differences and ethical and deviant work behavior (Peterson, 2002; Henle, Giacalon, and Jurkiewicz, 2005).

The literature on the differences between men and women in the workplace is not conclusive. For example, there are studies that provide evidence that women have greater communication skills and an effective leadership style in the contemporary environment (Peni, 2014) and that increases organizational equity (Cook and Glass, 2015). One factor is that women are more conservative than men (Croson and Gneezy, 2009).

Other studies argue that women can increase conflict, reduce cooperation, and impair performance in the workplace (Cook and Glass, 2015). Faccio et al. (2016) pointed out some of the possible causes for women's conservative behavior, such as lack of confidence, preference for fixed remuneration and for companies with low risk, greater fear of unemployment and women's difficulty in becoming CEO. A survey by Grant Thornton points out that half of the companies in Brazil (57%) do not have women in leadership positions. The country ranks 3rd among the least advantaged women. This lack

of possibilities of professional growth can generate frustrations in women and increase the possibilities of workplace deviance.

Some limitations of this study should be highlighted. First, the characteristics of the setting, the small size of the sample and the self-reported nature of the data call for a prudent interpretation and generalization of the results. Second, our model only includes a set of demographic variables. Several authors claim the need to further examine and clarify the potential interaction between demographic variables and attitudes (Hirshfield and Underman, 2016). Further research must analyze the relationship between demographic characteristics, attitudes and employee deviance in hospitals. Future research in healthcare management could also broaden the focus to explore the design of organizational control mechanisms (e.g. enabling vs. coercing) to support hospital managers in aligning individual and organizational interests (De Harlez and Malagueño, 2016).

## **6. Practice Implications**

These findings have substantial implications on healthcare organization managers. The prevalence of workplace deviance at hospitals and its capacity to threaten the well-being of the organization is a great challenge to these institutions. Control systems are formal procedures that managers may use to increase motivation as well as to influence employee behavior by means of different strategies: punishing, rewarding, or a combination of both (Bolin and Heatherly, 2001; Lopez-Valeiras, Gomez-Conde, and Lunkes, 2018).

Management control system literature has traditionally drawn on economic and psychological theories to explain the effectiveness of each of these strategies in function of individual employee characteristics and the features of the task performed by the employee, among other issues. For instance, it has been argued that a control system directed towards coercing and punishing could harm performance in tasks that involve creativity and non-mechanical skills (Lopez-Valeiras, Gomez-Conde, and Lunkes, 2018). By signaling age, tenure and professional group as variables predicting deviant behavior, this paper allows managers to design and implement more accurate control systems that could reduce this dysfunctional behavior and its negative impact on organizations and society.



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